A Look at State Welfare Reform Efforts to Address Substance Abuse

Pre-Release Draft, July, 2000

SAMHSA/CSAT Case Study Report

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INTRODUCTION

The Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996 brought profound changes to Federal welfare policy, making welfare assistance temporary and work a necessity. In the three years since implementation of PRWORA, welfare caseloads have plummeted, resulting in a 46 percent decline nationally. The strong economy and changes in the welfare delivery system's culture from income maintenance to *"Work First"* has assisted in moving people, who are employable, quickly into employment. However, those remaining on the welfare rolls are more likely to be long-term welfare recipients with multiple barriers to employment. Substance abuse is recognized as one of the most common barriers to employment among the hard-to-employ Temporary Assistance to Needy Families (TANF) recipients. If States are to be successful in transitioning families from welfare to work, State policies and local programs must focus on addressing substance abuse problems.

A Look at State Welfare Reform: Efforts to Address Substance Abuse is an eight-State case study that examines different State and County strategies in serving TANF recipients with substance abuse problems. This year-long comparative case study was commissioned by the Center for Substance Abuse Treatment (CSAT) to document efforts underway to address substance abuse as a barrier to employment. Given caseload dynamics and the flexibility provided to States by the TANF and Welfare-to-Work (WtW) programs, there is a critical need for States to exchange information about program strategies and innovative approaches to meet the needs of these TANF families. We interviewed the TANF, WtW, Alcohol and other Drug (AOD) and Medicaid officials in eight states—Colorado, Delaware, Kansas, New Jersey, North Carolina, Ohio, Oregon and Utah. In addition, given the devolutionary nature of welfare reform policies and practices, we spoke to TANF officials and local treatment providers in 24 counties.[1] These discussions provided us with insights about the policies, processes and protocols being experimented with on the State and County level to address the issue of substance abuse among the TANF population. This look at State systems suggested some key learnings about systems changes underway in States and Counties to address this issue. Also, it allowed us to identify some of the remaining challenges to effectively move these TANF clients from welfare to work and these families onto a pathway to self-sufficiency.

KEY LEARNINGS AND ONGOING CHALLENGES

States were selected to participate in this study based on a variety of factors. One of the most important, however, was that State officials recognized the need to address the issue of substance abuse among the TANF population, and were utilizing TANF funding to support some element of this effort. This report does not purport to identify model programs or suggest that these eight State experiences represent the national norm. This case study was conducted to provide us with a better understanding about the different approaches States and Counties have taken to address the issue of substance abuse among their welfare population. Each of these States/Counties is at a different place in developing its initiatives, and all of them are discovering successes and shortcomings in their programs. Making comparisons across all of these States/Counties provides insights about the different approaches, and allows us to draw conclusions about the ongoing challenges. The following highlights the key learnings and ongoing challenges uncovered in this case study.

[1] See page 15 in the Introduction section of the report for a full listing of the State and County offices/providers interviewed as a part of this study. Appendix F lists all resource contacts.

■ Instituting service integration or interagency collaboration policies on the State level eases the ability of front line workers to work across agencies to provide services to TANF clients with substance abuse problems

PRWORA provided significant program flexibility to States, allowing them to design programs to meet the individual needs of their State TANF population. The States in this study have attempted to maximize program flexibility and reengineer their service delivery systems to meet the needs of their TANF families who have alcohol and drug problems. This reengineering or restructuring of services often required co-location of TANF and AOD staff. When the AOD agency and the TANF agency were organized within the same cabinet level department, coordination and communication between these agencies was eased, and services better integrated to meet the needs of these TANF families. Also, when a Memorandum of Understanding (MOU) or an Interagency Agreement (IA) was in place on the State level between the TANF and AOD agencies, collaboration on the front line was apparent through multidisciplinary teamings such as in New Jersey, one-stop center approaches such as those implemented in Utah, or the care coordination systems in place in North Carolina and Delaware. Front line staff appeared to be more tolerant of cross-agency goals, and issues, such as confidentiality, was more easily addressed.

■ Changing the culture of the delivery system requires extensive and ongoing training

The nation's welfare delivery system that has functioned for at least the last three decades has been replaced with a complex, cross-sector, cross-governmental level, interagency assemblage that reflects more of a welfare reform puzzle than a system. Inherent in this "new system" is a culture change that requires modifications and adjustments in relationships among State agencies, as well as between States and communities and community based organizations, as they work to address the myriad of issues facing TANF families with substance abuse problems. In order to effectively change the culture of the delivery system, States in this case study stressed the importance of investing in ongoing cross-training of staff. The training and retraining of TANF caseworkers about substance abuse identification and treatment is a necessary step if States/Counties hope to appropriately identify clients with AOD problems. Also, given the increasing work demands and responsibilities on the part of the TANF caseworker, it is critical that AOD professionals clearly understand the issues that these workers face. It is important to build relationships between the AOD clinicians and the TANF caseworkers so that the professionals in each agency understand the practices, procedures and concerns of the other.

■ Integrating the Welfare to Work entities into a collaborative infrastructure with TANF and AOD partners is necessary

In addition to the flexibility and resources available under TANF, the Federal government further expanded States' ability to address the specific needs of the hard-to-employ population through the Welfare-to-Work legislation. The primary purpose of the WtW funds is to provide transitional assistance to move the hardest-to-employ TANF recipients into employment. Many WtW entities have struggled with developing effective strategies to identify clients with alcohol and drug problems, and have not been able to build the necessary connections with the alcohol and drug treatment systems in their communities. Not only is there a lack of integration between AOD and WtW in addressing the needs of these families, but in most communities across the nation, and as documented in this case study, the infrastructure connecting local TANF offices and WtW entities (most often Private Industry Councils—PICs or Workforce Development Boards—WDBs) is not yet in place. This lack of service integration

significantly damages the ability of the WtW agencies to work meaningfully with TANF families who have AOD problems. Currently, there are limited program models to evaluate, and thus, little understanding about the effectiveness of various WtW strategies that address the needs of TANF families with substance abuse problems.

■ Maximizing the funding flexibility allowed under TANF needs to be implemented

The case study findings suggest that the most effective method to fund AOD services for TANF families is to coordinate Federal and State funding streams from the various different agencies: TANF Federal funds, State TANF Maintenance of Effort (MOE) funds, Welfare-to-Work funds, Medicaid, Substance Abuse and Treatment Block Grant or other State AOD funds. This funding coordination is only possible if there is a spirit of collaboration between the varying sponsoring agencies. The case study found that States are hesitant to maximize the funding flexibility allowed under TANF, and in fact, States most often turn to Medicaid and Block Grant funds to support treatment services for these TANF recipients. While the States in this case study have begun utilizing TANF funding to support a variety of substance abuse services, such as screening, assessment, case management, transportation, child care, work readiness, and staff training, there is consistent lack of willingness to use TANF funds to expand treatment capacity. For the most part, this reluctance to utilize TANF funds stems from States' lack of knowledge about the flexibility allowed by the TANF program. These agencies need more information about how flexible TANF money is and how it can be used to support treatment programs for TANF recipients.

■ Developing appropriate tools and protocols to identify clients is critical to program success

Based on the findings of this cross-State comparative study, there is a commitment in these States to appropriately identify clients with AOD problems. The State and local TANF agencies in this case study are utilizing both formal and informal screening tools and procedures to identify clients with potential AOD problems. Based on information from this case study, screening for AOD was universally conducted at the TANF office by TANF caseworkers, sometimes with results being evaluated by on-site AOD professionals. Each State/County participant in this case study questioned the appropriateness of the screening instrument that they were using, and expressed frustration with the inconsistency of cross-State policies and findings regarding the "right" instrument and protocol for identifying clients with AOD problems. No instrument has yet been validated for use in a welfare office by a non-AOD clinician. Thus, the challenge to the AOD community is to develop appropriate guidance for identifying the welfare population with alcohol and other drug problems.

■ Crossing critical policy junctures empowers States to be more effective at addressing the substance abuse problems of TANF recipients

[2] Personal responsibility contracts are widely used by TANF agencies across the country as employment agreements with TANF clients. TANF clients agree to seek employment, and the TANF agencies spell out the cash benefits, as well as the supportive services available to the client, if the client meets the requirements of the contract. These personal responsibility contracts take on different names in different states: Colorado: Self Sufficiency Agreement; Delaware: Contract of Mutual Responsibility; Kansas: Self Sufficiency Agreement; New Jersey: Individual Responsibility Plan; North Carolina: Mutual Responsibility Agreement; Ohio: Self Sufficiency Contract; Oregon: Employment Development Plan; and Utah: Employment Plan.

[3] States/Counties implement different sanction policies. A full-family sanction means that the entire cash benefit for the family is terminated. Several States/Counties implement a "head-of-household" or individual sanction, meaning that the cash support for the children continues, but the parent is sanctioned off the grant.

In this case study we discovered that there were several policy junctures at which States could take different paths with varying results for TANF clients with AOD problems. Through sanction policies, TANF caseworkers can encourage clients to get into and stay in treatment. However, these sanction policies are only effective if they are tied in with the TANF client's personal responsibility contract. Once clients have screened positive for AOD problems, several States/Counties have utilized the personal responsibility contract[2] to link their cash assistance to fulfillment of the assessment or treatment requirement. If treatment is defined as an eligible "work activity" in a personal responsibility contract, then TANF caseworkers and their AOD partners have a mechanism by which to mandate client participation in treatment, or the client loses her/his cash benefits. If the State/County has a full-family sanction[3] then all cash benefits are terminated. If cash assistance is completely terminated, or even if the adult is removed from the cash grant, the family must make due on food stamps and other support services. Although this might be an effective "stick" for the TANF/AOD agencies, there are probable negative impacts for the TANF family—launching the children in the family even deeper into poverty. Thus, it is critical that States and Counties consider maximizing the use of the personal responsibility contracts to engage the client in treatment and to assist the entire family in getting the necessary support services to stay as an intact family and move towards self-sufficiency.

■ Creating measures and benchmarks to determine program success and effectively track results is crucial

Welfare reform has been called the "Devolution Revolution" emphasizing the fact that welfare policy has been devolved to the State level, and in most cases, decisions about welfare policy implementation is devolved to the County and community level. Thus, this devolution has resulted in extremely diverse practices on the local level, even in States that are State administered. This diversity in policy and practice, though arguably a good thing because it reflects local needs, is difficult to track. There is a dearth of information about what "works." Most States/Counties are not tracking individual outcome data. Management information systems, which allow for monitoring successes or failures of program approaches, are not in place. States in this case study were hesitant to discuss what was really working at the front-line because of the allowed flexibility and local control of policy implementation, and the lack of any data on which to buttress their position. States in the study are only beginning to launch evaluation efforts, but given the complexity of the network that needs to be monitored, most of these efforts are limited. Given the diversity of program approaches from one State to another, even if individual State/County data were available, the ability to make cross-State comparisons would be very difficult. Regardless, it is important that new systems be put in place to enable States and localities to assess if their goals are being achieved and that the lessons learned in one State or County be shared with others.

■ Establishing systems is necessary, but not sufficient

This is the final, and probably the hardest lesson learned from this case study. All of the States and Counties in this case study worked diligently to develop the necessary infrastructure to integrate services to best serve TANF clients with AOD problems. However, developing these systems—even the most collaborative of efforts—was not enough to result in significant outcomes for these TANF families. Based on the findings of this case study, we have seen that training and even re-training of TANF workers is not sufficient enough to allow for appropriate identification of TANF clients with AOD problems. We have learned that co-location and care coordination systems between the TANF and AOD agencies is not enough to get a large number of TANF clients into treatment and to stay in treatment. Establishing collaborative systems is necessary, but not sufficient.

States do need to address the re-engineering and re-tooling of their agencies so that they can effectively develop identification and referral systems. This new infrastructure needs to be a collaborative undertaking between the TANF and AOD agencies. However, these new "systems" are not sufficient if they do not include a critical client outreach component. Entering and staying in treatment is most often a personal choice and a personal decision. Many TANF clients are willingly "self-excluding" themselves from the TANF system because they refuse to comply with treatment requirements. They forfeit their cash grant assistance, and "fall out" of the TANF caseload. Often, once these families "fall out" of the TANF caseload, it is also likely that they do not utilize other support systems, such as food stamps, Medicaid, child care, etc. It is critical that States invest in interagency service integration, and that they also engage community based organizations in this collaboration to work with these disenfranchised families.

Executive Summary

INTRODUCTION

The passage of the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996 dramatically altered State public assistance policies and significantly changed the way public welfare agencies work with families who receive Temporary Assistance for Needy Families (TANF) block grant assistance. PRWORA imposed strict limits on the length of time individuals may receive benefits, as well as significant requirements on States to ensure that the TANF population engages in work. This shift in focus of welfare—from an on-going income maintenance program for poor families, to temporary assistance for families as they transition into work, created a whole new set of demands on the existing public assistance delivery system in this country. Regardless of individual State TANF policies, in order to meet the Federal work requirements, it is necessary for State public assistance delivery systems to develop collaborative relationships with their State partners in other agencies, as well as engage their local partners and front-line workers to change the way in which they work with TANF families. If States are to be successful in moving people from welfare to work, it is critical for State programs to not only focus on work placement, but also to address a broad range of personal challenges that exist for these TANF families, not the least of which includes alcohol and other drug (AOD) problems.

In the three years since the implementation of PRWORA, States have successfully moved a large portion of their TANF caseload off the rolls, resulting in a 46 percent[4] decline in caseload nationally. Some suggest this caseload reduction reflects the economic prosperity of the country. Experts in the field propose that the large caseload decrease is due to the fact that that those exiting the rolls are the ones who are most likely to become employed. As a result, States are being left with a large proportion of their caseload comprised of harder-to-serve clients. This hypothesis is supported by the Department of Health and Human Services' (DHHS) report to Congress, which states that although the TANF caseloads are dropping significantly, there has been a steady increase in the percentage of the caseload that are long-term recipients—between 19 to 24 percent.[5] To assist this population, States need to focus their efforts on enabling families with a range of problems to take steps toward becoming more self-supporting (General Accounting Office, 1999).

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To date, few studies have examined the effect of welfare reform on vulnerable subgroups of welfare recipients—long-term recipients who may exhibit one or multiple problems such as substance abuse, learning disabilities, mental health, and domestic violence (Legal Action Center, 1999). In fact, due to the varying findings of studies attempting to define the welfare population with substance abuse problems, the prevalence of alcohol and other drug (AOD) abuse among this population has yet to be clearly established. These studies—both State and program specific—have provided general estimates of what this prevalence might be; yet the estimates vary between 5 and 60 percent.[6] The 1991 National Household Survey on Drug

The 1991 National Household Survey on Drug Abuse found that alcohol and drug abuse was more prevalent among the welfare population than the general public.

[4] Statistics obtained from www.acf.dhhs.gov/news/stats/caseload.htm.
[5] Temporary Assistance for Needy Families (TANF) Program: First Annual Report to Congress, August 1998. Available on the World Wide Web at http://www.acf.dhhs.gov/news/welfare/congress/index.htm.
[6] National estimates of the percentage of the welfare population with substance abuse problems range from 5 to 27%, while State and local estimates range from 9 to 60% (Johnson and Meckstroth, 1998).

Abuse found that alcohol and drug abuse was more prevalent among the welfare population than the general public.[7] These variations in estimates may be reflective of the differences in definitions used, population studied, and type of study or research design utilized. For example, estimates based on a narrow definition of "alcohol or drug dependence" will tend to be much lower than estimates based on "alcohol and drug use" (Johnson and Meckstroth, 1998). Demographic characteristics of the population—education level and geographic location—can also vary findings (Olson and Pavetti, 1996). Finally, a research design that asks clients to self-identify a substance abuse problem may obtain lower estimates than a research study that requires clients to be tested through a blood or urine sample because of the issue of denial or fear of the stigma associated with substance abuse.

Regardless of the varying findings, these studies make clear that substance abuse exists among the welfare population and that it poses a barrier to employment and self-sufficiency. Despite this, there has been limited research on the effectiveness of welfare agency efforts in assisting TANF recipients with substance abuse problems. This lack of research data is primarily due to the fact that many States have yet to implement specific programs to address the needs of TANF recipients with AOD problems. Also, even when specific policies and programs do exist, they vary widely from State to State, as well as County to County within States, making a cross-State comparative study almost impossible to conduct. In addition, even for those States that have established a clear course of action, client outcome data is only now being collected. Thus, there is minimal impact or outcome data to show what strategies are effective at addressing the needs of TANF recipients with AOD problems. Although the population of welfare recipients with substance abuse problems has not been clearly established, and there is not ample data to determine the merits of one TANF program strategy over another, there is a large amount of research on the effectiveness of substance abuse treatment provided by the alcohol and drug treatment system.

UNDERSTANDING SUBSTANCE ABUSE AND TREATMENT OPTIONS

Addiction to alcohol and other drugs (AOD) is a process that progresses from social and experimental use to dependency and addiction.[8] Experimental and social use of drugs and alcohol is characterized by occasional use. Experimentation often begins between the ages of 12 and 15 as a means to gain social acceptance among peers and to test and defy parental control. As AOD use continues, individuals may begin increasing both the frequency of use and the amount of drugs or alcohol consumed. The positive feelings associated with experimental and social use still exist but are often followed by feelings of depression and discomfort. It is during this stage that individuals may begin suffering consequences for AOD use, including work-related difficulties, family problems, illness, financial and legal problems, and personality changes.

For some individuals, the use of alcohol and other drugs continues and they reach the third stage—dependency/addiction. Addiction is defined as "a chronic, progressive, relapsing disorder characterized by compulsive use of one or more substances that results in physical, psychological, or social harm to the individual and continued use of the substance or sub-

[7] In this 1991 survey, 5.2 percent of all women reported any illicit drug use in the past month, while the comparable figure for welfare recipients was 10.8 percent. Likewise, 3.8 percent of all women reported heavy drinking in the past month, while the comparable figure for welfare recipients was 8.2 percent (U.S. Department of Health and Human Services, 1994).

[8] Crowe, A. & Reeves, R. (1994). Treatment for Alcohol and Other Drug Abuse: Opportunities for Coordination. (Technical Assistance Publication No. 11). Rockville, MD: Substance Abuse and Mental Health Services Administration Center for Substance Abuse Treatment.

stances despite this harm." [9] The pleasurable side effects of AOD use no longer exist and continued drug use is required just to feel "normal" and the consequences of AOD use continue to escalate. It can take 5-10 years for an individual to progress to addiction. Significant physiological changes have occurred, making an individual incapable of returning to a pre-addictive state. For this reason, persons with a history of addiction who discontinue drug use are described as being "in recovery" as opposed to "cured" by treatment.

Although addiction cannot be cured, appropriate treatment can move individuals into a state of recovery, in which they are abstinent from AOD use and experience improved physical, social, and psychological functioning. There is no single treatment approach that is effective for treating all individuals with AOD problems. Matching individuals to the most appropriate treatment approach, based on each individual's needs, is critical to the success of substance abuse treatment.

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There are different types of substance abuse treatment programs that vary in terms of the services they offer. Outpatient drug-free programs offer individual and group counseling as well as an array of ancillary services. Long-term residential programs typically offer 6 to 12 months of care, and usually treat substance abusers with long histories of drug abuse, serious criminal involvement, and/or impaired social functioning. Short-term residential care usually involves a three to six week inpatient program followed by intensive outpatient therapy. Many programs work together with 12-step programs such as Alcoholics Anonymous (AA) during and after treatment. Methadone maintenance programs are targeted toward opiate users, and offer medication to block the effects of opiate use and the associated physical cravings for the drug.

Although sparse in relation to need, in recent years, in response to requirements in the Substance Abuse Treatment and Prevention Block Grant, there has been a proliferation of programs to address the special health, social and economic challenges that women who use drugs often face. Traditional treatment programs may not be appropriate for women because they do not address the special needs of women, particularly pregnant and parenting women. Effective treatment programs for women provide comprehensive services, including transportation, child care, medical care, social services, job training, parenting training, and mental health care.

AOD use and abuse is a major barrier to economic self-sufficiency and, if left untreated, can interfere with the ability to find and keep employment. Research has shown that substance abuse treatment is effective in reducing illicit drug use, improving physical and mental health, and reducing criminal activity. Most importantly for the welfare population, substance abuse treatment also results in improved financial self-sufficiency. Studies of the effects of substance abuse treatment programs have consistently shown that employment rates improve among individuals who participate in substance abuse treatment. Results from the National Treatment Improvement Evaluation Study (NTIES) indicated that employment increased 19 percent fol-

Results from the National Treatment Improvement Evaluation Study (NTIES) indicated that employment

[9] Schnoll, S. (1986). Getting Help: Treatments for Drug Abuse. New York: Chelsea House Publishers.

lowing treatment.[10] A second analysis of outcomes for women in the NTIES study showed an even greater increase in employment; one year after treatment, reported employment among women increased by 27 percent (from 36% prior to treatment to 45% post treatment).[11] Yet another analysis of NTIES data demonstrated a 58 percent decrease in unemployment among clients who remained abstinent from drugs and alcohol during the 12-month period following treatment.[12] Gerstein et al. reported a 30 percent increase in employment among individuals who completed more than four months of residential treatment.[13]

Substance abuse treatment programs can be instrumental in moving individuals off welfare; studies of substance abuse treatment have shown a significant decline in the receipt of welfare among substance abuse treatment clients after participation in treatment. Results of the NTIES study revealed an 11 percent overall decrease in welfare receipt following treatment.[14] Among women in the NTIES study, those clients receiving welfare declined from 62 percent before treatment to 57 percent after treatment.[15] In a study of substance abuse treatment in California, Gerstein et al. found a 22 percent decrease in welfare receipt after treatment.[16] The NTIES study examined a population in welfare before reform measures were put in place. Given welfare reform efforts and their emphasis on work, it is probable that these efforts might yield better outcomes today.

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Several studies have documented the cost-effectiveness of substance abuse treatment. In a study of California substance abuse treatment clients, Gerstein et al. reported that:[17]

- The number of women with children who received welfare income decreased by 39 percent among cocaine users, 48 percent among amphetamine users, 14 percent among heroin users, and 26 percent among alcohol users.
- The benefit of substance abuse treatment exceeded the cost by 2 to 1 for women with children who were on welfare.
- The estimated cost saving was $7.00 for every $1.00 spent on treatment, due largely to reductions in drug-related crime.

A recent NIDA report indicated that when savings related to health care costs are added to the savings due to crime, total savings could exceed costs by a ratio of 12 to 1. Major savings can also come from drops in interpersonal violence, improvements in workplace

[10] U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment. (1997). *The National Treatment Improvement Evaluation Study.* Rockville, MD.
[11] National Evaluation Data Services. (1999). Women in Treatment in the National Treatment Improvement Evaluation Study (NTIES). Rockville, MD: Center for Substance Abuse Treatment.
[12] National Evaluation Data Services. (1999). Criminal Behavior and Employment Outcomes Associated with Post-Treatment Drug Use. Rockville, MD: Center for Substance Abuse Treatment.
[13] Gerstein, D., Johnson, R., Larison, C., Harwood, H. & Fountain, D. (1997). Alcohol and Other Drug Treatment for Parents and Welfare Recipients: Outcomes, Costs, and Benefits. Washington, DC: U.S. Department of Health and Human Services.
[14] U.S. Department of Health and Human Services. The National Treatment Improvement Evaluation Study. Rockville, MD:Author
[15] National Evaluation Data Services. (1999). Women in Treatment in the National Treatment Improvement Evaluation Study (NTIES). Rockville, MD: Center for Substance Abuse Treatment.
[16] Gerstein, D., Johnson, R., Larison, C., Harwood, H. & Fountain, D. (1997). Alcohol and Other Drug Treatment for Parents and Welfare Recipients: Outcomes, Costs, and Benefits. Washington, DC: U.S. Department of Health and Human Services.
[17] Ibid.

productivity and reductions in drug-related accidents.[18] The value of providing treatment services to individuals with substance abuse problems cannot be ignored. A recent analysis indicated that every American pays over $1,000 each year to cover the costs of untreated substance abuse. It would cost each American only $45 per year to provide comprehensive treatment services—less than five percent of the current per person toll for lack of treatment.[19]

The importance of substance abuse treatment in promoting economic self-sufficiency is clear. In order for welfare reform to succeed, substance abuse treatment must become a component of welfare-to-work strategies. The need for substance abuse treatment, however, can not preclude clients from participating in work-related activities. Therefore, welfare-to-work programs can reasonably expect most clients to gain and keep employment while simultaneously participating in treatment for their AOD problems. Substance abuse treatment should, therefore, be viewed as a component of a larger constellation of work-related strategies and activities.

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OPPORTUNITY FOR PROGRAM COLLABORATION

While the new law has magnified the focus on work, there is general consensus at both the Federal and State level that support services are necessary to successfully move families with AOD problems onto a pathway of self sufficiency. Given what we know about treatment options that work, it is critical that collaborations be developed among State TANF, Welfare-to-Work and AOD agencies, as well as between County TANF agencies, local Private Industry Councils (PICs)/Workforce Development Boards (WBDs) and community treatment providers, to effectively meet the needs of these TANF families. The creation of this new collaborative infrastructure requires these different entities to be innovative and flexible in how they go about their individual goals and objectives of serving these TANF families.

PRWORA provided significant program flexibility to States, allowing them to design programs to meet the individual needs of their State TANF population. In addition to this program flexibility, there is also an abundance of resources available to support innovative approaches to meet the needs of TANF families with AOD problems. A recent GAO report found that due to caseload reductions, States had approximately $4.7 billion of additional money available to spend on poor families under TANF in 1997, than was available under the Aid to Families with Dependent Children (AFDC) program (General Accounting Office, 1998). Several States have attempted to maximize program flexibility and TANF funding to reengineer their service delivery systems to meet the needs of their TANF families who have alcohol and drug problems. These States have used TANF funds to pay for universal AOD screening services; drug testing initiatives; extensive cross-training of TANF staff on addiction and treatment

Several States have attempted to maximize program flexibility and TANF funding to reengineer their service delivery systems to meet the needs of their TANF families who have alcohol and drug problems.

[18] National Institute on Drug Abuse. (1999). Principles of Drug Addiction Treatment: A Research Based Guide. Bethesda, MD: Author.

[19] Dubey, J. (1997). Drugs on our minds: Perspectives on "modifiers of affect." Psychiatry Times, pp.52-54.

options, as well as how to identify clients with AOD problems; on-site AOD assessment staff; cross-agency intensive case management programs; and to support a variety of non-medical components of treatment, i.e. counseling, work readiness efforts and supported work activities. Given that State Maintenance of Effort (MOE) funds are not subjected to the same restrictions as TANF funds, several States have used State MOE funds to expand treatment capacity as well as pay directly for medical treatment for their TANF families with AOD problems.[20]

The Federal government further clarified and re-emphasized State flexibility in the issuance of the final TANF rules.[21] For example, the final rules proclaim that States define the "work activities" that recipients engage in, and can determine what activities count towards the State work requirement. In essence, States can determine that client participation in a job readiness component of treatment program can count as an eligible work activity. In the Arapahoe/Douglas Works Program in Colorado, the TANF agency supports a range of case management and work readiness services for clients as a part of their work requirements. In addition, the final rules clarify the term "assistance," and specifically exclude services such as "counseling, case management, and peer support" as "assistance to the individual." The clarification of activities that are to be included in the term "assistance" is critical to States. The definition of "assistance" determines whether recipients are subject to key TANF requirements, including work requirements, time limits, data collection and reporting, and child support assignment.[22] This range of services may be provided to the TANF client with TANF monies and not tracked to the individual client, thus releasing her/him from Federal time limit requirements and work participation reporting. For example, TANF dollars can support a transit line or extended hours on a bus route in a geographic area in which it is documented that many TANF families reside.

In addition to the flexibility and resources available under TANF, the Federal government further expanded States' ability to address the specific needs of the hard-to-serve population with additional funding opportunities through the Welfare-to-Work (WtW) grants (see Exhibit 1).[23]

Exhibit I
Welfare-to-Work Funding

Funding provided through the WtW program is distributed through three distinctive mechanisms:

- Formula Grants - Seventy five percent of the funds are distributed to States according to a formula set by the WtW statute and require that States spend $1 of non-federal funds for every $2 received.
- Competitive Grants - Twenty five percent of the funds are awarded to local communities, Private Industry Councils (PICs), Workforce Development Boards (WDBs), political subdivisions, and private entities. These funds do not require a state match.
- Special Set Asides - A small amount of the funds are set aside for funding Indian Tribes, program evaluation, and performance bonuses.

The primary purpose of the WtW funds is to provide transitional assistance to move

[20] States are required to spend 80 percent of their 1994 or 1995 AFDC requirements on the TANF population. However, if they meet their work participation rates, States are only required to spend 75 percent of their 1994 or 1995 AFDC funds. States can choose to (1) have their MOE funds co-mingled with their Federal TANF funds, thus the MOE funds are subject to all of the restrictions and requirements of Federal TANF funds; or (2) segregate into a separate MOE fund, thus allowing MOE monies to pay for medical treatment.

[21] ACF issued the Final Rules for the TANF program on April 12, 1999.

[22] Available on the Administration for Children and Families (ACF) Web site at: http://www.acf.dhhs.gov/programs/of a/pa-99-1.htm

[23] In recognition of the challenge faced by States to place hard-to-serve clients in gainful employment, the Balanced Budget Act of 1997 authorized $3 billion dollars for the Department of Labor (DOL) to provide Welfare-to-Work (WtW) grants to States and localities for welfare to work activities for fiscal years 1998-1999.

hard-to-employ welfare recipients into self-sufficiency and lasting unsubsidized employment. Similar to the TANF program, WtW funding grantees have broad flexibility in how they design their WtW strategies. In fiscal years 1998 and 1999, the Department of Labor (DOL) awarded

Exhibit II
Welfare-to-Work Eligibility Requirements

Signed into law on November 29,1999 as part of the Consolidated Appropriations Act for FY 2000, the Welfare-to-Work and Child Support Amendments of 1999 made several significant changes to the WtW program, most notably loosening the program eligibility requirements.

A. 70 Percent Eligibility Criteria - Funds Targeting "Hard to Employ"

Under the old requirement, at least 70 percent of the WtW grant had to be expended to provide services to long-term TANF recipients who met two of the three specified barriers to employment. These barriers included (1) no high school degree or GED and has low skills in reading or math, (2) requires substance abuse treatment for employment, and/or (3) poor work history (worked no more than three consecutive months in past 12 calendar months). The 1999 WtW Amendments remove the requirement that long-term TANF recipients must meet additional barriers to employment in order to be eligible for WtW. Now, TANF recipients are eligible under the 70 percent criteria as "hard-to-employ" if they meet *one* of the following criteria:

- Received TANF (or AFDC) for at least 30 months (not required to be consecutive)
- Will become ineligible for assistance within 12 months due to Federal or State-imposed time limits
- Exhausted their receipt of TANF due to time limits

In addition, noncustodial parents are now eligible under the 70 percent criteria if they meet *all* of the following criteria:

- Unemployed, underemployed, or have difficulty paying child support obligations
- Their minor children are eligible for TANF benefits, receive TANF benefits, received TANF benefits during the preceding year, or are receiving/eligible for assistance under the Food Stamps program, the Supplemental Security Income program, Medicaid, or the Children's Health Insurance Program
- Enter into a personal responsibility contract under which they commit to cooperating in establishing paternity and paying child support, participating in services to increase their employment and earnings, and supporting their children

B. 30 Percent Eligibility Criteria - Funds Targeting Individuals with "Long-Term Welfare Dependence" Characteristics

WtW grantees can also spend up to 30 percent of grant funds on recipients who have characteristics that are predictive of long-term welfare dependence. In order to qualify for services under these funds, the individual must meet *both* of the following criteria:

- Is receiving TANF assistance
- Has characteristics associated with long-term welfare dependence, such as
  - Being a school dropout
  - Teenage pregnancy
  - Poor work history
  - Significant barriers to self-sufficiency under criteria established by the PIC
  - Youth aged 18 to 25 whom have "aged out" of foster care

The 30 percent eligibility requirement may also include individuals who meet the "long-term welfare dependence" characteristics listed above but are no longer receiving TANF assistance due to the Federal or State-imposed time limits. Furthermore, the 1999 WtW Amendments also included custodial parents with incomes below the poverty line (regardless of whether or not they are or have been a TANF recipient) as eligible under the 30 percent criteria.

approximately $2 billion in formula grants to 44 states,[24] the District of Columbia, and three territories; grant awards ranged from $2.5 to $190 million in different states. To date, DOL has also awarded three rounds of competitive grants to 190 grantees for a total of nearly $695 million. Several of these competitive grants were aimed specifically at assisting TANF families with AOD problems. Furthermore, the third round of competitive grants placed a high priority on funding applications targeted at specific populations facing particular challenges in moving from welfare to work: non-custodial parents, individuals with disabilities, individuals who require substance abuse treatment, victims of domestic violence, and individuals with limited English proficiency.

Many WtW entities have struggled with developing effective strategies to identify clients with alcohol and drug problems, and have not been able to build the necessary connections with the alcohol and drug treatment system in their communities. Not only is there a lack of integration between AOD and WtW in addressing the needs of these families, but in most communities across the nation, the infrastructure connecting local TANF offices and WtW entities (most often PICs/WDBs) is not yet in place. This lack of service integration significantly damages the ability of WtW agencies to work meaningfully with TANF families who have AOD problems. Most WtW agencies are only starting to develop policies to address the AOD issue. Currently, there are limited program models to evaluate AOD issues, and thus, little understanding about the effectiveness of various WtW strategies that address the needs of TANF families with substance abuse problems.

FILLING THE INFORMATION GAP

Since the passage of PRWORA, there has been a myriad of research, evaluation, and technical assistance efforts regarding the implementation of the TANF program. The majority of these initiatives, however, have not specifically focused on strategies and approaches to successfully address the needs of the welfare population with substance abuse problems. Given caseload dynamics and the flexibility provided to States by the TANF and WtW programs, there is a critical need for States to exchange information about effective program strategies and innovative approaches to successfully meet the needs of this population. To assist in this endeavor, the Center for Substance Abuse Treatment (CSAT) commissioned this comparative eight-State case study to document initiatives underway to address substance abuse as a barrier to employment.

The States included in the study are Colorado, Delaware, Kansas, New Jersey, North Carolina, Ohio, Oregon, and Utah. These eight States were selected to participate in the study primarily based on the following factors:

- A history of interagency collaboration—in the AOD community, or in the children and families arena
- Utilization of TANF funding to assist TANF clients with AOD problems
- Some level of effort at establishing performance measures and tracking program outcomes.

It was also important to have equal representation of States with different locus of control (i.e., State-administered vs. County-administered programs) of their TANF program.[25] This diversity permitted a documentation of the influence of "administrative control" on the

[24] Six states (Idaho, Mississippi, Ohio, South Dakota, Utah, and Wyoming) elected not to receive WtW formula grant dollars in both FY 1998 and 1999. An additional three states (Arizona, Delaware, and North Dakota) elected not to receive WtW formula grant dollars in FY 1999.

[25] State administered systems included Kansas, Delaware, Oregon and Utah. County administered systems included Colorado, North Carolina, New Jersey and Ohio.

substance abuse initiatives being implemented within a State. It was also important to incorporate States that had been targeting substance abuse for many years through Federal waivers as well as those who had just begun to implement substance abuse initiatives. Waiver States sometimes have more flexibility in implementation than States bound by all PRWORA rules.[26] Lastly, efforts were made to balance the size of participating States (by population), and to select States that were geographically dispersed.

Findings from this qualitative study were based on discussions[27] with State and County officials. Phone interviews were conducted with four different State agencies in each State: (1) the TANF agency; (2) the Welfare-to-Work agency (which was usually the Department of Labor); (3) the State Alcohol and Other Drug (AOD) agency; and, (4) the State Medicaid agency. This comprehensive approach—interviewing officials from the four different State agencies that deal with TANF families with AOD problems—provided a cohesive framework for understanding each State's approach to removing substance abuse as a barrier to employment. As a part of these discussions, each State agency was asked to recommend Counties in their State that had developed innovative or integrated approaches to address the needs of TANF families with substance abuse problems. These Counties were then contacted and made a part of the case study. Since much of the policy and practice of welfare reform initiatives has been devolved at the local level, this County level data provided a closer look at the working relationships between local welfare agencies, treatment providers and local PICs/WDBs. Information was gathered from eight States and 24 localities. Exhibit III indicates the specific State locality that participated in the case study.

Exhibit III
Case Study Participants
County Level

	TANF	WtW	AOD
DE	Statewide	Service Area DE[28]	Brandywine Counseling Center DE
CO	Arapahoe/Douglas CO	Jefferson County, CO Larimer County, CO	Arapahoe County, CO
NJ	Essex, NJ Middlesex, NJ	Burlington County, NJ Hudson County, NJ	Union County, NJ
KS	Chanute, KS Wichita, KS	Chanute, KS Wichita, KS	Wichita, KS
NC	Gaston, NC Mecklenberg, NC	Durham, NC Gaston County, NC	Mecklenberg, NC
OH	Marion, OH	Ashtabula, OH Athens, OH Columbus/Franklin, OH	Marion Counseling Center, OH
OR	Salem, OR Springfield/Eugene, OR	Salem, OR Springfield/Eugene, OR	Multnomah/Portland, OR
UT	Salt Lake, UT St. George, UT	Salt Lake, UT St. George, UT	Weber County, UT

[26] There were nine States that received Statewide waivers prior to the passage of PRWORA. A number of States carried these waivers over as their TANF programs. Only four States received waivers regarding substance abuse prior to PRWORA: Oregon, Utah, South Carolina and Kansas. Three of these States, Oregon, Utah and Kansas were included in this case study.
[27] Separate discussion guides were used with each agency interviewed.
[28] The WtW office in Delaware serves the entire State.

The focus of the case study was to document approaches taken to build the necessary infrastructure between the TANF, WtW and AOD communities. Within the umbrella of "collaboration" or "service integration," the study looked at the following three areas:

- AOD Screening, Assessment and Testing Protocols
- Treatment Compliance and Sanction Practices
- Funding Streams for AOD Services.

The key learnings in each of these areas as well as the ongoing challenges facing these States/Counties are summarized in the final chapter.

AOD Screening, Assessment and Testing

Clearly, substance abuse problems serve as an impediment to an individual's employability. Given the time limits imposed by the new welfare reform law, there is an urgency for States to address the issue of substance abuse among TANF families. The first step in addressing this issue is appropriate and accurate client identification. States have developed a full array of approaches to screening and assessment. State and local welfare agencies in this case study engaged in a variety of strategies, from simple reliance on client self-disclosure to employing clinically trained staff utilizing formal screening tools such as the Substance Abuse Subtle Screening Inventory (SASSI). The majority of the States in this case study have implemented State-wide policies to screen *all* TANF clients for substance abuse and to refer those positively identified for further assessment. Those States that have not implemented Statewide policies to screen TANF clients, have provided their localities with the flexibility to implement those policies.

We found in this case study that screening of clients is usually conducted by a "trained" TANF caseworker,[29] but clients who were positively identified as having AOD problems were referred for further assessment by a certified clinician or other AOD professional. While TANF caseworkers are being trained in the *screening* process, there is a common practice among these welfare agencies that an AOD clinician or other expert would conduct the *assessment*. The assessment phase is a critical step to fully identify the severity of the AOD problem, and the mechanism that allows for referral to treatment. However, often, individuals who screen positive and are asked to continue onto assessment "fall out" of the system. Based on the anecdotal information gathered in this case study, women with AOD problems typically may not feel that they have a substance abuse "problem," fear loss of their children, or do not want to enter a treatment program.

While TANF caseworkers are being trained in the screening process, there is a common practice among these welfare agencies that an AOD clinician

Assessments are usually conducted on-site at the TANF office, at a local substance abuse or mental health office, or at a community treatment facility. Although without firm data, case study respondents stressed that when the assessment professional was co-located at the TANF agency, there was a greater likelihood that the client would continue on to the assessment phase. The placement of on-site assessment professionals at the TANF office also increased the likelihood that the AOD professional and the TANF caseworker collaborated on developing a comprehensive plan for the TANF client. This collaboration permitted issues such

[29] Staff training on screening for substance abuse was/is uneven in the States. Even though training was conducted in all the States that participated in this case study, there was a concern voiced about the possible reluctance and "unease" of caseworkers who were asked to delve into these personal issues with TANF clients.

as transportation needs, child care needs, work requirements, treatment activities and sanctions to be incorporated into a cohesive treatment plan that best suited the client's needs. Co-location and the establishment of a single cohesive treatment employment and treatment plan for the TANF family also helped address the issue of client confidentiality, which is often raised as a concern by the AOD professionals.

Co-location of TANF/AOD offices and the establishment of a single cohesive employment and treatment plan for the TANF family also helped address the issue of client confidentiality, which is often raised as a concern by the AOD professionals.

Another strategy used to identify substance use is the testing of individuals through a variety of methods including blood, urine, hair, and sweat samples. Drug testing has been continued for many years in a variety of different settings (i.e., employment sites, probation courts, treatment providers) with different program goals. The most common method of drug testing is through a urinalysis. However, these test have limitations, in that it can only detect recent drug use, not drug abuse, and does not capture alcohol use (Legal Action Center, 1997). To monitor drug use effectively, urine screens must be performed often, within short periods of time, and with confirmatory tests to decrease the number of false-positive and false-negative estimates. Thus, the use of drug testing in welfare settings to identify substance use may be costly and may not serve the goals of the welfare program. One of the provisions of PRWORA allows States to perform drug tests on welfare recipients and to sanction those who test positive. States, however, have the option of implementing the provision in its entirety, modifying the provision, or completely opting out of the provision. No Case Study State is engaged in universal State wide testing. In fact, according to the National Governors' Association, forty-four States/territories reported that they do not require drug testing and ten States (FL, **KS**, MN, NV, NY, **NC**, **OH,** PA, SC, WI) indicated that they test under certain circumstances.[30] For example, in Kansas, one of their TANF initiatives is a two to four month employment training program, which upon completion, the TANF recipients are guaranteed jobs with Boeing Airlines. To be considered for this program, the TANF recipient must submit to a drug test.

Treatment Compliance and Sanction Practices

In 1994, the Federal government estimated that nearly 4 million Americans needed treatment for chronic and persistent drug problems, but only 1.8 million received assistance (Legal Action Center, 1997). As welfare agencies identify clients with substance abuse problems, they must also identify the treatment resources available within their communities to assist this population. Two of the major concerns expressed by TANF agencies about the challenge of serving the needs of welfare recipients with substance abuse problems were: (1) the lack of capacity to meet the needs of public assistance recipients entering treatment programs; and (2) inadequacy of the available treatment programs in addressing the unique needs of women and mothers. The unavailability of treatment programs for women is not a new phenomena and is not occurring as a result of PRWORA. Prior to the implementation of PRWORA, a majority of women on AFDC who needed treatment for AOD-related problems were not receiving treatment (Young, 1996).

Historically, referrals out of the welfare system for treatment have been low. This "new" welfare system might well be an impetus to do a more thorough job of identifying women with children in need of alcohol or drug treatment. In fact, all case study States have altered their TANF eligibility processes to incorporate some AOD screening/assessment protocol. Prior to

[30] Source: National Governors' Association, Center for Best Practices Web site (http://www.nga.org/Welfare/TANF1998.PDF). Round Two of Selected Elements of State Programs for Temporary Assistance for Needy Families, May 24, 1999.

the passage of welfare reform, these protocols were not in place. However, through these screening and assessment processes, these clients might be being asked to wrestle with their AOD problems for the first time. As clients are referred to treatment, there is a significant "falling off" or a number of "no shows," at treatment centers. Thus, it is critical that the TANF/WtW and AOD agencies work hand-in-hand to put in appropriate screening/assessment protocols to address the issues of non referrals and this "falling-off."

Participation in treatment and employment or active engagement in work activities are not mutually exclusive. Treatment may also be determined as a "work activity" for state purposes. Findings from this case study indicate that when the AOD professional and the TANF caseworker collaborate, and build treatment into an employability plan, then it is more likely that the individual will go into treatment. When treatment is incorporated into an employability plan, the TANF caseworker can enforce these requirements through the use of sanctions. Under TANF, however, States have the flexibility to define "work activities" and can therefore count participation in substance abuse treatment as a work activity.

Findings from this case study indicate that when the AOD professional and the TANF caseworker collaborate and build treatment into an employability plan, it is more likely that the individual will go into treatment.

The Federal TANF law requires States to sanction recipients who do not engage in required work activities without good cause. While sanctioning is required, PRWORA also gives States a great deal of flexibility in determining sanction policy and structure. Under PRWORA, States and Counties are able to individually determine the definitions of what constitutes noncompliance, the type and severity of the penalty, the changes in penalties for continued violations, and efforts taken to avoid sanctioning altogether. This study found a large degree of variation among the sanctioning policies targeted at noncompliance with AOD treatment program requirements. For the most part, there was much reluctance to simply "cut-off" a family from TANF assistance because the TANF recipient did not abide by treatment requirements. Most sanctioning policies required a gradual reduction in benefit based on non-compliance with the employability plan. Based on the findings from this case study, when TANF recipients were in non-compliance, and there was a collaborative structure in place between the TANF and AOD workers, most often these workers would form a case management team and intensely work with the family to get them into compliance.

Funding Streams for AOD Services

The case study findings suggest that the most effective method to fund AOD services for TANF families is to coordinate Federal and State funding streams from the various different agencies: TANF Federal funds, State TANF MOE, WtW funds, Medicaid, Substance Abuse and Treatment Block Grants or other State AOD funds. This coordination requires both common vision about how to serve these TANF families and active collaboration among the different State agencies that manage these funds. TANF and WtW agencies are often not aware of the limitations on Medicaid funding[31] for AOD treatment, and look only to Medicaid or AOD Block grant monies as a source to pay for substance abuse treatment. These agencies need more information, about how flexible TANF money is and how it can support AOD programs for TANF recipients, as well as a better understanding of WtW funding flexibility.

[31] In many communities, Medicaid is not a significant source of funding for alcohol and drug treatment programs. Treatment services are optional under Medicaid and thus, some States cover little services. For example, residential treatment programs serving women must decide either to limit their size to 16 or fewer treatment beds or forego Medicaid as a source of funding. There is also the concern that in States with managed Medicaid programs, clients are not referred to appropriate and adequate care (Legal Action Center, 1999).

The case study found that States are beginning to utilize their TANF program funds to support recipients' substance abuse treatment service through a variety of activities:

- Specialized case management services
- Staff training on screening, work readiness, and prevention services
- Wrap-around services in the form of child care and transportation
- Salary for staff who conduct screening, work readiness, and vocational services
- Treatment expansion, specifically outpatient treatment
- Non-medical treatment services
- Client monitoring services
- Mental health services
- Job Club, Job Skills classes, and short-term training.

While the States in this case study have begun using TANF funding to support a variety of substance abuse treatment services, States have hesitated to use their Federal TANF funds or State MOE to expand treatment capacity in communities. For the most part, this reluctance to utilize TANF funds stems from States' lack of knowledge about the flexibility allowed by the TANF program, a "Work First" culture in the TANF office, and the lack of referrals to treatment.

The findings regarding the utilization of Welfare-to-Work funds for substance abuse treatment services have not been as varied. States have struggled with the stringent requirements and criteria attached to the WtW funding stream. States and localities can utilize WtW funds for substance abuse screening, treatment, and support services when existing resources are not otherwise available to the participant. The majority of case study WtW participants said that they are willing to provide AOD services if other funds are not available to cover these services, however, there is general confusion about what funding is available through Medicaid, AOD agencies and TANF monies. A number of States and localities noted that they use utilizing WtW funds to cover similar services as those bulleted above. Specific State examples of how TANF and/or WtW funds are being utilized for substance abuse services are included in each of the individual States profiles.

Continuing Barriers and Ongoing Challenges

As the infrastructure for this new service delivery system is being developed and refined, there are continuing barriers and on-going challenges, which must be dealt with at both the State and local level. Lack of a clear vision, "turfism," lack of active communication, and murky definitions of roles and responsibilities for the various partners can quickly destroy any collaboration. Findings from this case study suggest that a first step in addressing these challenges is for the TANF and WtW agencies to clearly understand that even in a "Work First" culture, participation in treatment programs benefits the short-term and long-term success of this TANF family becoming self-sufficient. Many clients can participate in treatment while they simultaneously are employed. TANF and WtW agencies need to utilize the flexibility granted by PRWORA to define certain treatment components as work activities so that the activities offered by providers can meet the requirements of the law. Likewise, the AOD agencies and local treatment providers must adjust their treatment protocols to address the need of TANF recipients to be engaged in work related activities. By offering a range of care, treatment providers and welfare agencies can allow some clients to participate in treatment services while completing job training or working, while accommodating those who are more impaired with the more intensive levels of care (Young, N. & Gardner, S., 1997); (Pavetti, Kirby, Kauff, Tapongna, 1999).

A critical barrier to creating this new collaborative infrastructure is the lack of performance data about what "works." Most States are not tracking individual outcome data. Management information systems, which allow for monitoring successes or failures of integrated programs across agencies, are not in place. Several States in this case study have only begun to launch evaluation efforts, but given the complexity of the network that needs to be monitored, most of these efforts are limited. Regardless, it is important that cross-agency culture changes occur and that new systems be put in place to enable States and localities to assess if their goals are being achieved and that lessons learned in one State or locality can be shared with others.

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CONCLUSION

This report presents the key findings of this case study, and provides a context for understanding the implementation of each of the eight State's substance abuse policies and practices. The following chapters provide information on each State, and highlights the lessons learned about that State's efforts at addressing the needs of TANF recipients with substance abuse problems. The final chapter summarizes key lessons learned across all States, and outlines the ongoing challenges and barriers to implementing an integrated service delivery system.

OVERVIEW

Substance abuse is recognized as one of the most common barriers to employment among hard-to-employ TANF recipients. One goal of this case study was to identify and examine strategies in serving TANF recipients with substance abuse problems. The following chapters outline what we have learned from each of the eight States participating in this case study. This Overview section highlights some innovative practices underway in each of the States, as well as providing data to allow for cross-state comparison. This analysis provides a context for better understanding each state profile. While national welfare caseloads have decreased substantially since the passage of PRWORA, individuals remaining on welfare assistance are likely to be the hardest-to-serve and employ. Exhibit IV, State Welfare Recipient Caseload Reductions, shows the reduction in recipient caseloads between January 1993 and June 1999, both nationally and for the eight States participating in the case study. In addition, recipient caseloads from January 1996 were included to serve as a reference point for reductions in caseload size since implementation of PRWORA. As shown in the Exhibit, nearly all of the eight States in the case study experienced caseload reductions greater than the national average of 51 percent.

EXHIBIT IV
STATE WELFARE RECIPIENT CASELOAD REDUCTIONS

State	January 1993	January 1996	June 1999	Percent Reduction ('93-'99)
National	**14,114,992**	**12,876,661**	**6,889,315**	**51%**
Colorado	123,308	99,739	35,469	71%
Delaware	27,652	23,153	15,599	44%
Kansas	87,525	70,758	32,532	63%
New Jersey	349,902	293,833	159,721	54%
North Carolina	331,633	282,086	124,432	62%
Ohio	720,476	552,304	258,773	64%
Oregon	117,656	92,182	44,565	62%
Utah	53,172	41,145	28,909	46%

Exhibit V shows which States obtained Federal waivers regarding substance abuse prior to the implementation of PRWORA and compares which States elected to retain the Federal maximum allowed time limit on assistance of 60 months and maximum time an individual can receive assistance before engaging in work activities, set at 24 months. It also compares which States opted out of the Federal provision to deny TANF benefits to individuals convicted of drug felonies.

Exhibit VI provides information regarding TANF funds and expenditures, including State Maintenance of Effort (MOE) expenditures and requirements. The first column, Total Award, is the amount each State received through the first quarter of FY 1999. The second column, Available for TANF, reflects the total award less any funds transferred to either the Child Care and Developmental Fund (CCDF) or the Social Services Block Grant (SSBG). The third column, Total Expenditures, shows the total amount of TANF funds already spent while the fourth column, Unliquidated Obligations, represents the total amount of Federal TANF funds that a State has committed to spend but has not yet spent. The fifth column Unobligated Balance, represents the amount of Federal TANF funds that a State has neither spent nor committed to spend.

EXHIBIT V CONTINUED WAIVERS AND STATE PROGRAM REQUIREMENTS				
State	Continued Waivers[32]	Time Limits	Work Requirements	Deny TANF to Drug Felons
Colorado	No	60 months	24 months	No[33]
Delaware	No	24 months[34]	24 months	Yes
Kansas	Yes	60 months	24 months	Yes
New Jersey	No	60 months	24 months	Yes[35]
North Carolina	No	24 months[36]	12 weeks	Yes[37]
Ohio	No	36 months in 60 months	Immediate	Yes
Oregon	Yes	24 months within 84 months	Immediate	No
Utah	Yes	36 months	Immediate	No

The last three columns in Exhibit VI describe FY 1998 State Maintenance of Effort information. The legislation requires States to spend a minimum amount of their own funds every year on qualified expenditures through Separate State Programs (SSP) on behalf of eligible families. In order to receive the total Federal TANF award, a State must spend at least 80 percent of what it spent in FY 1994.[38] The first of these three columns shows the total amount expended by each State on both TANF and SSPs. The second column shows the dollar amount that each State was required to expend (either 80% or 75% depending on whether they met work participation requirements) and the last column demonstrates what percentage of combined state expenditures they actually achieved.

EXHIBIT VI STATE TANF AND MOE FUNDING AND EXPENDITURES								
	TANF Awards, Transfers, & Expenditures First Quarter FY 1999					State MOE Data FY 1998		
State	Total Award	Available for TANF	Total Expenditures	Unliquidated Obligations	Unobligated Balance	Combined Expenditures (TANF & SSPs)	State MOE Requirement at 80%	Combined State Expenditures as % of MOE Level
Colorado	30,089,270	30,089,270	-	30,089,270	-	105,503,229	88,395,622	95%
Delaware	8,072,745	8,072,745	6,926,337	1,146,408	-	25,691,053	23,222,474	89%
Kansas	101,931,061	101,931,061	10,003,137	-	91,775,159	62,925,691	65,866,230	76%
New Jersey	53,453,016	27,002,161	8,045,282	-	18,956,879	300,160,007	320,170,674	75%
North Carolina	79,962,210	79,962,210	-	-	79,962,210	170,146,891	164,454,147	83%
Ohio	110,554,611	110,554,611	7,252,377	103,302,234	-	419,102,642	416,886,662	80%
Oregon	167,808,448	167,808,448	11,892,973	155,915,475	-	91,636,300	97,745,386	75%
Utah	20,791,188	20,791,188	3,138,271	-	17,652,917	25,290,550	26,976,586	75%

Exhibits VII and VIII show basic information regarding WtW formula grants and WtW competitive grants awarded to each State. Exhibit VII includes data specific to the amount of Federal formula funds and State funds available for the WtW program as well as the way that the funds are allocated. Ohio and Utah did not accept WtW formula funds and are therefore excluded from Exhibit VII.

[32] This column refers to States included in the case studies that had statewide Federal waivers regarding substance abuse and chose to continue those waivers following implementation of PRWORA.
[33] Colorado provides assistance as long as assessment reveals the client is moving toward rehabilitation.
[34] Delaware provides 24 months of assistance followed by 24 months of workfare and a one-month extension.
[35] Individuals convicted of drug use or possession felonies may receive TANF once they complete a 60-day treatment program.
[36] Recipients may reapply for assistance after 36 months with a lifetime limit of 60 months. Counties designated as "electing" are given further flexibility to define time limits.
[37] Individuals convicted of drug use or possession felonies are eligible for assistance if appropriate treatment is available.
[38] If a State meets the minimum work participation requirements, it is required to spend at least 75 percent of it own funds on qualified expenditures.

EXHIBIT VII STATE WELFARE-TO WORK FORMULA GRANTS						
	Colorado	Delaware	Kansas	New Jersey	North Carolina	Oregon
Administering Agency	Department of Labor & Employment	Department of Health and Social Services, Division of Social Services	Department of Human Resources, Division of Employment and Training	Department of Labor, Division of Employment & Training	Department of Commerce, Division of Employment & Training	Department of Human Resources, Adult & Family Services Division
Date Approved	7/27/98	4/29/98	3/2/98	6/29/98	6/29/98	4/23/98
Federal Funds Awarded	$9,878,865	$2,761,875	$6,668,399	$23,257,092	$25, 332,173	$8,636,930
State Match	$5,000,000	$1,380,938	$3,300,000	$11,628,546	$12,666,087	$4,554,500
Source of Matching State Funds	50% = state 50% = in-kind	100% = State	Not provided	Primarily State, some in-kind	100% = State	100% = State
Sub-state Allocation Formula*	50% = P 25% = TANF 25% = U	N/A single Service Delivery Area	50% = P 50% = TANF	50% = P 25% = TANF 25% = U	50% = P 50% = TANF	50% = P 50% = TANF

EXHIBIT VIII STATE WELFARE TO-WORK COMPETITIVE GRANTS							
	Colorado	Kansas	New Jersey	North Carolina	Ohio	Oregon	Utah
Total Amount of Round I Awards	$1,460,864	$0	$9,914,297	$ 6,641,89539	$19,145,556[39]	$9,912,658[39]	$0
Total Amount of Round II Awards	$16,456,990[39]	$1,999,917	$21,196,864[39]	$12,264,384[39]	$39,683,864[39]	$12,996,535[39]	$3,000,000
Total Amount of Round III Awards	$3,053,968	$3,767,968	$3,098,695	$1,086,006	$8,769,028	$0	$1,667,476
Total Amount of All Rounds	$20,971,822	$5,767,885	$34,209,856	$19,992,285	$67,598,448	$22,909,193	$5,667,476

Exhibit VIII shows the amount of WtW funds received through competitive grants for each of the three rounds. Amounts are reflective of both individual state competitive grant awards and any multi-site competitive grant awards. Delaware is not included in Exhibit VIII because it did not receive any WtW competitive grants.

Exhibit IX on following page compares statewide policies on screening, assessment and testing. It also lists the specific instrument used to screen TANF applicants/recipients for Alcohol and Other Drug (AOD) abuse. Lastly, it distinguishes whether or not the State includes AOD treatment in the TANF employability plan and whether AOD treatment is considered a valid work activity.

In examining these charts, it is obvious that many similarities and differences exist among these States. Each State has developed a variety of initiatives to address the AOD issues of their TANF clients. The following section highlights several of these innovative approaches described in detail in the the following state profiles.

[39] The amount shown includes at least one multi-site competitive grant award.

EXHIBIT IX STATEWIDE ALCOHOL AND OTHER DRUG (AOD) POLICIES						
State	Screening Policies for Applicants	Screening Tool(s)	Assessment Policies for Applicants	Testing Policies for Applicants	AOD Treatment Included in Employability Plan	AOD Treatment Considered a Work Activity
Colorado	Local flexibility	Local flexibility	Local flexibility[40]	Local flexibility	Local flexibility	Local flexibility
Delaware	Yes	CAGE-AID	Yes	No	Yes	Yes
Kansas	Yes	SASSI	Yes	No	Yes	Yes
New Jersey	Yes	CAGE-AID	Yes[41]	No	No	Yes
North Carolina	Yes	AUDIT & DAST-10	Yes	Yes[42]	Yes	Yes
Ohio	Local flexibility	Local flexibility	Local flexibility	Local flexibility	Local flexibility	Local flexibility
Oregon	Local flexibility	Local flexibility[43]	Yes[44]	No	Yes	Yes
Utah	Local flexibility	Local flexibility	Local flexibility	Local flexibility	Yes[45]	Yes

COLORADO

The Arapahoe/Douglas Works program in Colorado has assigned one Workforce Specialist or caseworker to work with all alcohol and other drug abuse and mental health related cases. This individual is responsible for managing all cases and is familiar with all of the resources available in the Service Delivery Area for this population. The Workforce Specialist also acts as a liaison between Vocational Rehabilitation, Mental Health, and the treatment provider to coordinate the provision of services for these clients. The assignment of TANF clients with substance abuse problems to one caseworker within the Arapahoe/Douglas Works program office is possible because the agency is a rather small one, which prevents this worker from having an unmanageably high caseload. This initiative is particularly important because the clients' involvement with this single worker facilitates the identification, referral, and follow-through process for those clients requiring substance abuse treatment services.

DELAWARE

In Delaware, the Department of Social Services recognizes that TANF caseworkers have limited experience and knowledge of substance abuse issues and, despite their use of the CAGE-AID screening tool, are likely to "miss" the signs of addiction. As a result, the Department has contracted with two agencies to work with TANF clients throughout the State on their SA problems. The "Bridge Agencies" reassess clients' need for a clinical alcohol and other drug assessment. In addition, these agencies assess the clients' need for supportive services, such as child care and transportation, that may hinder their ability to comply with their work and/or treatment requirements. The goal of this initiative is to ensure that clients' needs are appropriately identified and provided for so that they may become self-sufficient.

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[40] State legislation and regulations require that, at a minimum, County welfare agencies provide referrals for available support services.
[41] In New Jersey, clients are referred for further assessment by the caseworker but participation is voluntary.
[42] The Work First plan in North Carolina includes AOD testing as a mandatory component of treatment programs, however results are not used to determine compliance with the requirements of program. Individual Counties may incorporate AOD testing into the application process as a screening tool.
[43] Oregon does not mandate use of a particular screening instrument, however, the majority of districts utilize the SASSI instrument.
[44] In Oregon, in-depth assessments must be conducted by certified professional and must use set of national criteria when determining appropriate treatment.
[45] Utah does not have State-wide policies for screening applicants, but it does have State-wide policies to address applicants or recipients who are abusing drugs or alcohol. Applicants or recipients who are identified (self-identified) as having AOD problems are sent directly to an AOD treatment facility and the treatment activity is included in their Self-Sufficiency or Employability Plan.

KANSAS

To ensure the coordination of services between the referral for assessment and participation in treatment, the Wichita area TANF agency has appointed an individual to serve as liaison between the TANF agency and the Regional Alcohol and Drug Assessment Centers (RADACs) who is responsible for the coordination of substance abuse treatment services. The liaison is responsible for maintaining contact with the RADAC and obtaining information on clients' follow-through with their referrals and participation in treatment. In essence, the TANF agency has established a system to facilitate communication and the exchange of information among various agencies working with TANF clients with substance abuse problems.

NEW JERSEY

Realizing the need to address the substance abuse problems of TANF recipients, several human service agencies in New Jersey formed interagency agreements and set aside funding to specifically address the needs of this population. Funding was provided for the support of direct treatment services for TANF recipients as well as to place "Care Coordinators" in local TANF agencies in all 21 Counties. The Care Coordinators are substance abuse professionals, located on-site at the TANF agency, who are responsible for conducting in-depth substance abuse assessments. Most importantly, however, based on each clients' treatment needs, the Care Coordinators are able to identify the clients' ability to engage in work activities and are able to work with County and municipal TANF caseworkers to incorporate work with treatment based on each client's need.

In addition to the Care Coordinator system, New Jersey is one of the few States that has made efforts to evaluate its substance abuse initiative. This initiative, entitled the Substance Abuse Research Demonstration (SARD), is funded through State funds and also received Federal and Foundation funding. The goal of the SARD is to evaluate the effectiveness and utility of specific services and interventions provided in conjunction with substance abuse treatment. Among these services are intensive case management and support services, enhanced service coordination and delivery, brief interventions to prevent drug dependency, family and child interventions, and incentives and sanctions to encourage participation in treatment. This evaluation is particularly important because the results will help the State better understand the most effective strategies for identifying and treating welfare recipients with substance abuse problems.

NORTH CAROLINA

In an effort to identify clients with substance abuse problems, North Carolina's Division of Social Services has implemented a number of requirements regarding the screening and assessment for substance abuse among all Work First applicants and participants. In addition to requiring mandatory screenings for all applicants and recipients, the State has also instituted policies requiring the use of a standardized screening tool in all of the State's 100 Counties. To further improve upon the probability that clients' substance abuse problems are identified, the State also allocated TANF funds for the hiring of at least one Qualified Substance Abuse Professional (QSAP) in each of the State's 39 Area Mental Health, Developmental Disabilities, and Substance Abuse Authorities. The QSAP is responsible for assessing the client's substance abuse problem, and her/his need for treatment services, referring the client to treatment, and then tracking the client's progress and compliance with treatment.

North Carolina has also realized that TANF clients may not only suffer from substance abuse problems but that there are other problems preventing clients' successful participation in work activities. These problems, however, are likely to go undetected if the TANF agency and caseworkers are not adequately prepared to address them. A large number of clients with substance abuse problems also have mental health problems that often go undetected. As a result, the TANF agency and the Division of Substance Abuse Services are currently collaborating to develop a screening tool to address both substance abuse and mental health issues. In addition to developing the screening tool, the State has initiated plans to train all QSAPs on the use of the screening tool.

OHIO

Although the TANF program is operated in a county-administered system, the State of Ohio has been very proactive in ensuring that the needs of TANF clients with substance abuse problems are addressed. While allowing Counties the flexibility to design and operate their own TANF program, the Ohio Department of Human Services has taken on the role of facilitator, serving as a resource for information and services related to TANF clients with substance abuse issues. In collaboration with other human services, one of which is the Department of Alcohol and Drug Addiction Services (ODADAS), the Department issued a Memorandum providing Counties with guidance on how to enhance local substance abuse services for TANF clients. This initiative served as a vehicle to promote local linkages and collaboration between County human service agencies and local treatment providers.

OREGON

Oregon was one of the first States to implement a performance indicator data analysis process that includes specific performance objectives in every treatment provider contract. To support State agencies in their efforts to serve individuals affected by alcohol and drug abuse, the Office of Alcohol and Drug Abuse Programs (OADAP) collects data on clients at admission to and discharge from substance abuse treatment programs. This data collection effort is facilitated through the Client Process Monitoring System (CPMS) which collects information on all clients admitted to emergency non-hospital detoxification services, two levels of residential treatment for adults, specialized residential treatment for women and pregnant women and youth, and outpatient services including methadone maintenance. This system allows State agencies to track clients' changes in treatment and trends in treatment provider performance over time.

UTAH

While Utah does not have statewide policies for screening TANF applicants for alcohol and drug abuse, the State has implemented policies to address substance abuse as a barrier to employment by referring TANF recipients to assessment and treatment services. In addition, the State has established a statewide system for monitoring the compliance of TANF clients engaged in substance abuse treatment by including participation in treatment in the client's employment plan and tying non-compliance with treatment to the State's sanction policies. The State's sanctioning process, however, is not designed to penalize the client but is designed to assess the client's barriers for non-participation in relation to the requirements outlined in his/her employment plan. A client's first time refusal to comply with his/her requirements results in a "problem solving" session between the

employment counselor and the client. The goal of the session is to revisit the employment plan and determine the barriers that are causing the client's non-compliance. When the reasons for non-compliance are not acceptable to the employment counselor, the counselor brings together the client and other case managers, supervisors, and other staff working with the client to conduct a "case staffing" or more intensive "problem solving" session in an effort to resolve the client's issues. These problem solving sessions and case staffings are critical to TANF clients whose multiple barriers to employment impede their compliance with their personal responsibility contract and/or work requirements and who may be inadvertently sanctioned by the TANF caseworker with limited knowledge about the client's problems.

Effective Service Integration

The Colorado Department of Human Services (CDHS) was established in July 1994 to manage, administer, oversee, and deliver human services in the State. The Department resulted from a merger of the former Department of Social Services, Department of Institutions,[46] and the Alcohol and Drug Abuse Division (ADAD), which had been in the Department of Public Health and Environment. The Department consists of five different divisions which include: Office of Children, Youth and Families, Office of Direct Services, Office of Health and Rehabilitation, Office of Self Sufficiency, and the Division of Youth Corrections. In order to accomplish its mission "to help individuals and families achieve and maintain positive outcomes," CDHS ensures the delivery of needed services through one of three avenues:

- State-operated facilities and programs
- County operated departments of social services
- Contracts with public and private human service providers.

The structure of the Department of Human Services (DHS) fosters the development of collaborative relationships and initiatives both at the State and local level. Though the majority of coordination among the Department's divisions exists at the local level, program planning and design, which occurs at the State level, often requires input from numerous agencies. This collaboration is especially important when addressing the needs of the hard-to-serve TANF population, who often face barriers to employment such as substance abuse and mental illness. For example, the State ADAD was instrumental in creating the current treatment provider system that is utilized to serve TANF recipients with substance abuse problems.

The CDHS also collaborated with the Department of Labor and Employment in the development of the Welfare-to-Work (WtW) program. The formula block grant, administered through the Department of Labor and Employment, is channeled to nine individual Private Industry Councils (PIC)/Service Delivery Areas (SDA) throughout the State.[47] Each individual PIC/SDA is responsible for developing and executing employment activities according to the needs of their population.

The State TANF program, **Colorado Works**, was first implemented in 1997 and, although it is a county-administered program, it is supervised by the Office of Self Sufficiency within CDHS. Uniform eligibility standards and benefit levels for the TANF program are set by CDHS, however, each of the 63 Counties in Colorado is responsible for developing and operating its own TANF plan for the local community. These County TANF plans must enumerate the specific services to be provided under the program and provide assurances that all contract providers are meeting required levels of performance. The following highlight some of the more significant aspects of the Colorado Works program:

Counties are required to assess all applicants and recipients and enter into an individual responsibility contract (IRC) with each recipient.

- Counties are required to assess all applicants and recipients and enter into an individual responsibility contract (IRC) with each recipient
- Counties reserve the right to design their own assessment tools and contracts as long as they are confined to matters directly related to seeking and maintaining education, training, or employment
- Counties may determine at what point recipients will be required to work within the 24-month Federal requirement

[46] The Department of Institutions is currently the Division of Youth Correction within the CDHS.
[47] The State expects to add an additional ten PICs/SDAs next year for a total of nineteen PICs/SDAs.

- The State defines a range of sanction penalties from which Counties have discretion to choose.

Despite the autonomy that Counties are afforded in the development of their local welfare programs, the CDHS wanted to ensure that the same agency coordination present at the State level would also exist at the local level. To accomplish this goal, CDHS required that each County submit a County TANF plan describing their local TANF program. Within this plan, each County TANF agency details the formal linkages and relationships established with County/local alcohol and other drug (AOD) treatment providers, PICs, Mental Health, and Child Welfare agencies. For example, at the local level, most TANF agencies coordinate with the Department of Labor and Employment in the operation of the WtW Program throughout the State. Local TANF agencies are responsible for providing each of the PICs/SDAs with copies of clients' assessment data and individual responsibility contract (IRC)[48] so that PICs/SDAs are well aware of each client's needs and requirements. In turn, the SDA is responsible for reviewing the information received from the TANF agency on each client and contacting and providing referral information to those clients who may be eligible for special services such as WtW. Additionally, the PICs/SDAs coordinate with their County service providers to design marketing strategies for employers to get WtW clients successfully employed. In an effort to enhance substance abuse services for WtW recipients, ADAD funded and coordinated meetings between ADAD staff and the nine WtW Councils. These one-time meetings took place at the inception of the WtW program in an effort to provide each WtW Council with information on the agencies to contact and contract for the delivery of substance abuse services.

...each County TANF agency details the formal linkages and relationships established with County/local alcohol and other drug (AOD) treatment providers, PICs, Mental Health, and Child Welfare agencies.

AOD Screening, Assessment and Testing Protocols

To assist welfare recipients achieve self-sufficiency, the Colorado Works program includes a number of features such as up-front and ongoing assessment, individual responsibility contracts (IRC), participation in work activities, and the provision of a range of support services. Through Colorado Works, the CDHS mandates that **all** families applying for basic cash assistance benefits are assessed to identify the services and/or assistance required to achieve self-sufficiency. The State requires that such assessments take place within 30 days of application and evaluate the recipient's basic skills, employability, educational level and other barriers to employment. Counties have the option of deciding whether the assessment is conducted formally by TANF case managers and/or provided by vendors via contract, or informally through a form completed by the recipients prior to meeting with the TANF case manager. If during the assessment, an applicant/recipient is determined to be a victim of domestic violence, homeless, in need of mental health services or in need of substance abuse services, State legislation and regulations require that, at a minimum, County welfare agencies provide referrals for available support services. The CDHS also mandates that County TANF offices develop an individual responsibility contract (IRC) with the family describing both the family and the agency's responsibilities. Based on the results of the assessment, required services and benefits are included in the family's IRC.

The goal of the up-front assess-

[48] The IRC is a contract signed by the client outlining the client and the agency's responsibility to assist the client in achieving self-sufficiency.

The goal of the up-front assessment and IRC are to identify and highlight individual barriers to employment (e.g., substance abuse) and create a plan for overcoming them.

Though there are no statewide policies specifically addressing substance abuse, the County-administered structure of the Colorado Works program allows each County discretion to determine its own procedures for screening, assessing, and testing TANF recipients for substance abuse by including such requirements in their individual County TANF plans. For example, Las Animas County, where there is a high rate of unemployment, generational alcoholism and poverty, has incorporated substance abuse screening for all County TANF recipients. Based on County information, 92 percent of all Las Animas County TANF recipients have screened positive for substance abuse.

92 percent of all Las Animas County TANF recipients have screened positive for substance abuse.

The Arapahoe/Douglas Counties Colorado Works program, on the other hand, does not institute mandatory substance abuse screening for TANF applicants. Instead, clients participate in a group orientation where they are required to complete an assessment form that includes a locally devised self-attestation questionnaire regarding AOD issues. If the initial screening reveals the existence of an AOD problem, the applicant or recipient may be referred to the Workforce Specialist[49] for further AOD assessment. The Arapahoe/Douglas Works program has designated one Workforce Specialist within the agency to work with all AOD and mental health cases in the service delivery area (SDA). This individual is familiar with all of the available resources in the SDA for this population and acts as the liaison between Vocational Rehabilitation, Mental Health, and the treatment provider to coordinate the provision of services accordingly.

Upon referral, the Workforce Specialist meets with clients and discusses how the AOD problems are affecting both their work and other aspects of their life. TANF clients for whom substance abuse constitutes a barrier to employment are referred to a treatment provider for treatment services. The Arapahoe/Douglas Works program has established a contract with Arapahoe House to provide both residential and outpatient treatment services to the County TANF population. In addition to these services, there is an Arapahoe House addiction alcohol counselor (AAC) located on-site at the TANF agency who works with clients on AOD and mental health issues.

The Arapahoe/Douglas Works program has established a contract with Arapahoe House to provide both residential and outpatient treatment services to the County TANF population.

Treatment Compliance and Sanction Practices

In Colorado, failure to comply with substance abuse treatment cannot be a sanctionable offense unless it is included as a work requirement in each individual County's TANF plan. Because of the complex nature of Colorado's county-administered system, it is important to understand how substance abuse treatment fits into the County TANF structure of employment activities. In general, three fundamental concepts are used by Counties to develop policies regarding implementation of work requirements[50]: job ready, job readiness barriers, and work activities. Only the concepts of job readiness barriers and work activities have particular relevance to the incorporation of substance abuse treatment as a sanctionable program requirement.

[49] In Arapahoe/Douglas WORKS, TANF caseworkers or case managers are referred to as "Workforce Specialists."

[50] Berkeley Planning Associates (1999). Evaluation of the Colorado Works Program: Interim Report on Caseload Characteristics, Program Eligibility and County Policies. Oakland, CA.

(1.) **Job Readiness Barrier:** This includes circumstances identified during the assessment process that prevent a recipient from immediately being classified as job ready and required to participate in a work activity.

(2.) **Work Activity:** All TANF recipients are required to participate in a work activity to remain eligible for benefits. These work activities include those defined by PRWORA[51] as well as any additional work activities identified in the County plan.

Counties may adopt *additional work activities*, such as substance abuse treatment and mental health services, as long as they are designed to lead to self-sufficiency as determined by the County and outlined in the IRC. In doing so, participation in these additional activities enables a recipient to fulfill the work requirements and remain eligible for benefits until s/he reaches the 60-month lifetime limit. Treatment included in a client's IRC, as an additional work activity, becomes a sanctionable offense. The following table describes the additional work activities identified in some County TANF plans:

Exhibit X
Additional Work Activities Approved by Counties Through 2/3/99

Work Activity	Number of Counties (N = 44)
Substance Abuse Treatment	11
Mental Health Services	11
Vocational Rehabilitation	7
Receiving or Recovering from Medical Treatment	7
Domestic Violence Services or Treatment	3
Domestic Violence[52]	2

Source: Information based on data available as of 2/3/99[53]

In contrast, if Counties define substance abuse as a job readiness barrier, the recipient may not be required to participate in a work activity until the "barrier" is eliminated. Therefore, in the case of a substance abuse problem, while receiving treatment, the client is exempt from having to engage in work activities until determined job ready or until s/he reaches the 24-month work requirement. In this case, since the substance abuse is identified as a barrier as opposed to a work activity, the client is not subject to sanctions for non-compliance with work activities.

The State defines sanction penalties for failure to comply with work requirements[54] but as previously mentioned, Counties have discretion in determining when to implement and remove these sanctions.[55] For example, the Arapahoe/Douglas Works program chose not to include substance abuse treatment as an additional work activity in their TANF County Plan to the State. Therefore, although clients' referral to treatment is recorded in the IRC, the County cannot sanction clients for failing to comply with these treatment activities.

[51] Federally recognized work activities include: unsubsidized and subsidized employment, work experience, on-the-job training, job search and readiness, community service programs, vocational educational training, provision of child care for participants in community service, job skills training directly related to employment, education directly related to employment and satisfactory attendance in secondary school or GED.
[52] Two Counties listed domestic violence as a work activity in their plans but did not state whether treatment is required.
[53] Source: Attachment G of the Memorandum of Understanding between the CDHS and Boards of County Commissioners.
[54] State sanctions include: 25 percent and 50 percent reduction in the family's grant for one to three months for a first and second violation, respectively, and termination of the family's cash benefits for three to six months for a third violation.
[55] Effective 7/1/99, a County may choose to require participation in substance abuse treatment. Such a requirement may be included in the participant's IRC. Failure to comply may result in a sanction.

Counties also have the autonomy to develop their own system for monitoring treatment compliance for substance abuse treatment services. For example, in the Arapahoe/Douglas Works program, treatment is monitored by both the TANF agency, through the Workforce Specialist, and the treatment provider, Arapahoe House. TANF clients must sign a release form allowing the treatment provider to share information with the TANF specialist. In this particular SDA, treatment is monitored through attendance in treatment and participation in other employment-related activities, such as computer training, as required in the County plan.

In 1999, the Colorado Department of Human Services (CDHS) implemented drug testing policies for TANF recipients with substance abuse problems. As part of this policy, Counties are allowed to conduct drug testing of TANF recipients in an effort to monitor compliance with treatment. Counties had not begun implementing this policy at the time this case study was conducted.

Funding Streams for AOD Services

Prior to the implementation of the Colorado Works program in 1997, the State Alcohol and Drug Abuse Division (ADAD) had over thirty separate contracts with alcohol and drug treatment providers across the State. At the start of the new program, the agency released a Request for Proposal (RFP) to solicit the management of the health provider networks in the seven regions of the State. As a result of the RFP, the ADAD currently contracts with the following four managed service organizations (MSO) who then subcontract to provide treatment services to the local community:

At the start of the new program, the agency released a Request for Proposal (RFP) to solicit the

- Boulder County Health Department
- Signal Behavioral Health Care
- United Health
- Options/West Slope CASA.

The ADAD allows Signal Behavioral Health Care (SBH),[56] to manage the provision of AOD services in three of the seven regions within the State. SBH has the option of either subcontracting for the provision of core services or operating and providing services itself. For example, in the Arapahoe/Douglas Counties, SBH contracts with the Arapahoe House New Directions program for the provision of AOD services to women, including women with dependent children. The New Directions program is currently funded by the Department of Housing and Urban Development (HUD), Economic Development Initiative, TANF funds as well as child welfare funding which is part of the State Maintenance of Effort (MOE) for TANF.

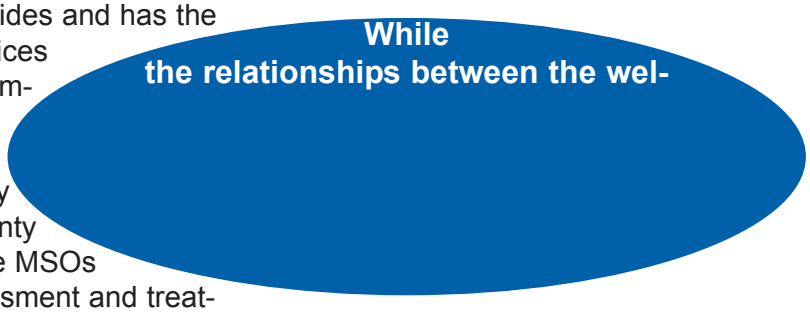
In response to the Child Welfare Settlement Agreement (CWSA) signed on February 13, 1995 between the Colorado's Lawyer's Committee and the State of Colorado,[57] both the State ADAD and State Division of Child Welfare, redirected approximately $2.5 million from

[56] Signal Behavioral Health Care was the recipient of one of the four contracts awarded in the State. Signal Behavioral Health Care is a provider-owned managed care organization. The Arapahoe House substance abuse treatment program is one of five providers that make up Signal Behavioral Health Care.

[57] The CWSA states that Core Services "shall be available for abused and neglected children and their families within their home County...when the need for services is specified in the case plan to prevent the child from being taken into governmental custody or to enable the child to leave governmental custody." The CWSA requires that substance abuse treatment services, among others, are made available.

their respective budgets to make substance abuse treatment services available to children and families at risk of out of home placement. The ADAD funds were used to provide services, through either ADAD licensed providers or MSOs, for eligible children and families referred by County Child Welfare Departments. The funds allocated by the Division of Child Welfare were allocated down to the County Child Welfare Departments for substance abuse treatment services. The implementation of these services are relevant to the TANF population in that much of the literature suggests an overlap between welfare dependence, substance abuse and child abuse and neglect. In essence, if TANF recipients are eligible for Child Welfare benefits, they would also have access to these substance abuse treatment services.

Although the State utilized some TANF funds to provide training on AOD screening and testing to agency staff, the majority of State TANF dollars have been allocated to each of the local TANF agencies. These local agencies can utilize TANF funds to contract with any certified ADAD provider, including MSOs, to provide AOD services to the TANF population. At the local level, each County decides and has the flexibility to contract for the services that are most needed in their community. While the relationships between the welfare agencies and the provider community may differ, for the most part, the County TANF agencies contract with the MSOs to coordinate and provide assessment and treatment services to TANF recipients. In the larger Counties, treatment providers under contract with the MSOs utilize TANF funds to pay for non-medical treatment services and supportive services including:



- AOD screening
- AOD assessment
- Family therapy
- AOD drug/alcohol testing
- AOD treatment
- Education.

For example, in the Arapahoe/Douglas Works program, TANF funds are used to provide a wide range of AOD treatment services through the Arapahoe House. With regard to AOD treatment, local TANF funds are used to provide non-medical services through a contractual agreement with Arapahoe House. Services include specialized case management, vocational services, and training of TANF agency staff on AOD screening, assessment, and testing.

Additional services provided by Arapahoe House but not paid for by TANF funds include:

- Life skills training
- Pre-vocational services
- Expanded day care
- Joint case management
- On-site dependent care
- Job readiness
- Rehabilitation
- Transportation for job searches
- Job club (e.g., bi-monthly job fair).

As previously stated, the State WtW funds are allocated to the nine local PICs/SDAs that service the State. Each of these PICs/SDAs is responsible for developing and executing

employment activities according to the needs of their population. Also, joint funds were provided by the State WtW and ADAD agencies to pay for an ADAD staff person to meet with each of these nine Councils in an effort to disseminate information on appropriate agencies to contact and contract with for the provision of substance abuse services.

Joint funds were provided by the State WtW and ADAD agencies to pay for an ADAD staff person to meet with each of these nine Councils in an effort to disseminate information on appropriate agencies to contact and contract with for the provision of substance abuse services.

Colorado's Medicaid program provides health coverage to the State's low-income population. The program allows benefits for the medically necessary inpatient and outpatient services related to the treatment of alcohol and drug abuse, when these services are provided by an acute care Medicaid-enrolled hospital. Services include alcohol and drug detoxification and rehabilitation services.[58]

Evaluation Efforts/Performance Measurement

The ADAD has established performance-based contracts with the MSOs for the provision of treatment services. The current MSO treatment contracts require specific outcome measurements including:

- Changes in behavior between admission and discharge of AOD clients
- Changes between admission and follow-up of AOD clients
- Administration of a customer satisfaction survey.

To assess substance abuse prevalence, the ADAD Evaluation and Information Services Section (EISS) conducts general population surveys, and collects and analyzes alcohol and drug related social indicator data. For measurement of prevention program effectiveness, ADAD is in the process of implementing the multi-faced Prevention Evaluation Partnership (PEP), an integrated outcome evaluation system. With this data system, ADAD will collect, analyze, and report on both process (e.g., number of individuals served by prevention strategy) and outcome data (e.g., reduction in risk factors and enhancement of protection factors related to specific prevention strategies).

[58] National Conference of State Legislatures, March 1999. Substance Abuse Treatment Coverage in State Medicaid Programs.

Effective Service Integration

Delaware's **A Better Chance (ABC)** welfare reform program was implemented in October 1995 as a waiver demonstration, which ultimately became the basis of its TANF plan filed in 1997. Delaware's welfare reform initiative is a joint effort between the Department of Health and Social Services, Division of Social Services (DHSS/DSS), the Department of Labor (DOL), and the Delaware Economic Development Office (DEDO). Under ABC, cash benefits are time limited to 24 cumulative months, during which time employable adults are required to aggressively seek, obtain, and maintain employment. To receive benefits for an additional 24 cumulative months, families must participate in a pay-after-performance work experience position. This policy allows participants to receive welfare benefits only in proportion to the hours worked.

To streamline the provision of services to needy families, Delaware applied for and was granted a waiver which made the DHSS/DSS the statewide administrator of the WtW grant, rather than disseminating the funds to the Private Industry Council (PIC) for distribution decisions. In so doing, the State manages the TANF and WtW programs as an overall welfare reform effort aimed at reducing clients' barriers to self-sufficiency. This program, operated statewide, takes place through a collaborative partnership between the ABC team comprised of the DHSS/DSS, DOL,[59] the DEDO, and the Department of Transportation. While Delaware's welfare reform initiatives are focused on self-sufficiency through employment, the State recognizes that TANF recipients face multiple barriers to employment such as substance abuse, learning disabilities, and domestic violence. Through a collaborative relationship, DHSS/DSS conducts assessments of clients' employability and, if problems are identified, caseworkers will make referrals for assistance to other agencies or organizations. DHSS/DSS has entered into formal and informal agreements with various other state agencies including the Department of Alcohol, Drug and Mental Health (DADAMH) and non-profit organizations to address the issue of substance abuse among the TANF population.

Through a collaborative relationship, DHSS/DSS conducts assessments of clients' employability and, if problems are identified, caseworkers will make referrals for assistance to other agencies or organizations.

AOD Screening, Assessment, and Testing Protocols

As part of its effort to screen for a wide range of potential barriers to employment, the State of Delaware screens all TANF recipients for alcohol and other drug (AOD) problems at eligibility. The caseworker utilizes the CAGE-AID[60] instrument to ask questions to clients. This screening is part of the eligibility interview protocol, called a Family Development Profile,[61] which also addresses issues of self-esteem and domestic violence. In addition to the screening conducted at eligibility, recipients are also screened when the TANF caseworker determines that there is an alcohol or other drug problem, based on a number of behavioral indicators.

[59] Delaware's only Private Industry Council is located within the Department of Labor (DOL).
[60] The CAGE-AID is a revised version of the CAGE instrument that addresses both alcohol and drug issues. See Appendix E, Exhibit E-V.
[61] The Family Development Profile is a comprehensive four-page questionnaire.

In order to increase identification of TANF clients with alcohol and/or drug (AOD) problems early in the process, the Division of Alcoholism, Drug Addiction, and Mental Health (DADAMH) has trained TANF caseworkers on AOD issues and on the identification of clients with AOD problems. Training has specifically addressed the following issues:

In order to increase identification of TANF clients with alcohol and/or drug (AOD) problems early in the process, the Department of Alcohol, Drug and Mental Health (DADAMH) has trained TANF caseworkers on AOD issues and the identification of clients with AOD problems.

- Facilitating communication between the worker and the client
- Making appropriate referrals
- Increasing workers' knowledge and comfort level with the issue of alcohol and drug abuse.

DADAMH has trained TANF caseworkers on the use of the CAGE-AID screening tool and how and when to refer clients for further assessment. With the implementation of WtW, the DADAMH has coordinated with the ABC team to address the needs for non-medical substance abuse treatment services, as specified by the Federal WtW program.

In addition to this training, DHSS/DSS is currently working with its contractors to provide appropriate training to staff on how to ask the "right questions" when conducting screenings and initial assessments in order to increase the referral rates. For example, Delmarva Rural Ministries and Brandywine Counseling have provided numerous training sessions to TANF caseworkers, as well as one-on-one training with role-playing exercises to increase caseworkers' comfort level with clients with substance abuse problems. Despite these training sessions, however, the number of clients referred by TANF caseworkers has been very small.

When issues of drug or alcohol involvement arise during screening, these issues are included in the client's Contract of Mutual Responsibility (CMR) and referrals are made for further assessment. The TANF agency does not require clients to submit to drug testing, but the agency does inform clients when employers utilize drug testing as a pre-employment requirement. When informed of the employer's testing policy, clients are given the opportunity to state whether they have an AOD problem before proceeding with the interview so that this barrier to employment may be appropriately addressed by the TANF agency.

TANF clients who are identified as having a substance abuse problem must sign their CMR as well as a consent form for referral to one of the Bridge Agencies. Given the TANF caseworker's limited experience with AOD issues, this referral allows Bridge Agency staff to re-assess the client's need for a clinical alcohol and drug assessment. The Bridge Agency staff conducts a needs assessment[62] that addresses children and family issues, housing and immediate needs, employment and education training, drug and alcohol history, medical, mental health, and domestic violence issues, and the client's legal history. After assessing the

TANF clients who are identified as having a substance abuse problem must sign their CMR as well as a consent form for referral to one of the Bridge Agencies. Given the TANF caseworker's limited experience with AOD issues, this referral allows Bridge Agency staff to re-assess the client's need for a clinical alcohol and drug assessment.

[62] The needs assessment questionnaire is a ten-page questionnaire.

client's needs, the Bridge Agency staff determine whether the client is in need of clinical substance abuse assessment and treatment services. As part of the case management provided to clients, the Bridge Agencies assist clients in obtaining the necessary authorization forms from their Managed Care Organization (MCO) and facilitate the necessary support services so that clients can enter and complete treatment.

In addition to training and assessment services, through a contractual agreement, the Bridge Agencies serve as a liaison between the DSS and DADAMH and the treatment provider community serving the needs of TANF recipients with AOD problems. Delmarva Rural Ministries provides case management services, including client assessments and referrals to treatment in the Kent and Sussex County areas, while Brandywine Counseling provides client assessments, case management, and substance abuse treatment services in the New Castle County area.

The Bridge Agencies also serve as a reporting and information sharing mechanism between the various partners working with TANF clients. When clients require treatment, the agencies must help these clients work through the Managed Care system that provides and pays for treatment services. The agencies must also ensure that clients have advanced authorization for assessment and proper referrals for treatment. When clients need additional treatment services and Medicaid will not cover those services, the agencies are required to contact DADAMH to explore how additional funds can be obtained from the State to continue the client's treatment. In addition, the organizations should ensure that the client is linked to the appropriate support services and resources necessary to continue their treatment program (e.g., child care, housing, transportation, etc.). However, the use and success of these strategies is heavily dependent on the referrals from the TANF agency to the Bridge Agencies.

Treatment Compliance and Sanction Practices

Delaware has implemented stringent policies to sanction clients who refuse to comply with their CMR requirements. The State's sanction policies fall into three categories:

- Adult responsibility sanctions
- Work and training sanctions
- Teen responsibility sanctions.

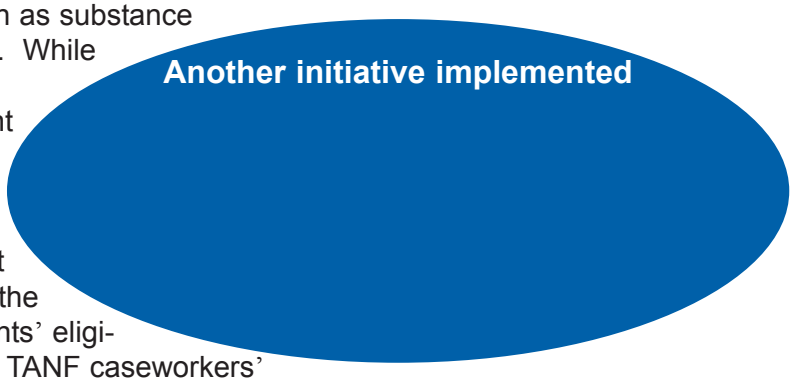
Clients with substance abuse problems can be most impacted by the adult responsibility sanctions. For example, clients who are positively identified as having AOD problems are referred to the Bridge Agency for further assessment, and into treatment, if required. This referral is included in the client's CMR and becomes a requirement tied to the client's TANF grant. Clients who do not comply with their assessment and/or treatment requirements receive an adult responsibility sanction equal to a $50 per month reduction in their TANF grant. These sanctions are incremental for each instance of non-compliance.

...clients who are positively identified as having AOD problems are referred to the Bridge Agency for further assessment, and into treatment, if required. This referral is included in the client's CMR and becomes a requirement tied to the client's financial TANF grant.

Additionally, clients with AOD problems may also be impacted by the work and training sanctions. These sanctions are imposed on clients who refuse to comply with work activities and can equal one-third to two-thirds of the total family TANF grant. These work sanctions are

also incremental; the third sanction keeps the client off TANF assistance for eight years. For example, if a TANF client is informed by the TANF caseworker that a job interview requires a drug test and the client goes to the interview but refuses to take the test, then that client is in non-compliance with a work activity and sanctioned accordingly. The determination of whether or not to count substance abuse treatment as a work activity is left to the employment and training contractor, with whom the client has established an on-going relationship. This determination is clearly critical to TANF clients with AOD problems, given the severe sanctions tied to work and training activities.

Because of the severity of Delaware's sanction policies and their potential detriment to TANF clients and their families, there are certain safeguards in place to ensure that clients are not unfairly sanctioned. One of these safeguards is that sanctions cannot be imposed if services relating to the provisions, such as substance abuse treatment, are not available. While this safeguard is important given issues around insufficient treatment capacity across the country, it is also important to know how TANF caseworkers interpret this safeguard. This is especially important because TANF caseworkers have the primary authority to determine clients' eligibility for TANF benefits. Therefore, TANF caseworkers' interpretation of these safeguards plays a critical role in whether or not clients are unjustly sanctioned.



Another initiative implemented by the State Social Services agency is a contract with the Psychotherapeutic Children Services (PCS) agency to do follow-up assessments of TANF clients who have reached their 3rd sanction and are at risk of having their benefits terminated for eight years. Through this initiative, the agency hopes to prevent the client from being sanctioned by gaining a better understanding of what is happening with the client and determining the appropriateness of the sanction. Additionally, the assessment allows the agency to examine what other services are available to assist the client achieve self-sufficiency.

Funding Streams for AOD Services

The provision of AOD services for TANF clients can occur through a number of funding streams including TANF, WtW, Medicaid and funding available from the State AOD agency either from its Substance Abuse Prevention and Treatment Block Grant or other State funds. In 1999, the State received approximately $5.5 million from the Substance Abuse Prevention and Treatment Block Grant. In Delaware, health care services, including substance abuse treatment services, are primarily provided by and paid for by the State's Medicaid program through a MCO that delivers these services. Therefore, TANF clients requiring AOD treatment services must be assessed by the physicians within these MCOs and placed in treatment services based on need.

In addition to the AOD services provided by Medicaid, the DADAMH provides public drug and alcohol treatment services for non-Medicaid eligible adults, primarily through contracts with private agencies. For example, the DADAMH funds a special program for pregnant women and women with infants. The program utilizes specific treatment guidelines for the treatment of women and guidelines for the treatment of women with children including the referral of children for appropriate services. While these services may be available for

Medicaid-eligible clients, the services are targeted to clients who may not have access to these services because of their Medicaid inegibility.

To address the special circumstances faced by TANF clients with substance abuse problems, DSS has been proactive in utilizing TANF funds to assist this population transition out of welfare and into employment. To facilitate the provision of AOD services to the TANF population, DSS transferred approximately $413,000 in TANF funds and entered into a Memorandum of Understanding (MOU) with the DADAMH to provide case management and supportive services to TANF recipients.

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In addition to the funding provided to the DADAMH for the Bridge Program, TANF funds also cover the following AOD-related services:

- Screening
- Referral and information on AOD
- Specialized case management services
- Wrap-around services (transportation and child care)
- Work readiness
- Outreach
- Awareness
- Education
- Early intervention.

While Delaware had integrated the WtW program into its TANF program at the time of this case study, the State had not begun spending its WtW formula funds. However, the State was developing a strategic plan to begin serving the WtW population. Also, the State noted that although WtW funds were not being spent on substance abuse treatment and supportive services, these funds can pay for non-medical AOD-related services if no other funds are available.

Evaluation Efforts/Performance Measurement

Since the implementation of the ABC program, Delaware has entered into a contractual relationship with a private contractor for the evaluation of the program. DHSS is currently reviewing the findings from the evaluation, specifically the effectiveness of sanctions in getting clients to comply with their CMR and employment and training requirements. Specifically, DHSS is examining how to best utilize sanctions for substance abuse treatment and assessment purposes. Generally, the evaluation found that sanctions were not conclusively a deterrent of certain client behavior and did not get clients to engage in training or work activities.

Because most of the services provided to TANF clients are provided through performance-based contracts with community-based organizations and other non-profits, the State is interested in tracking mechanisms and interested in sponsoring a workshop with non-profits and for-profits on outcome management, tracking, and evaluation.[63]

[63] The workshop was being developed with the Rensselaerville Institute, an independent non-profit educational center that helps individuals, communities, and organizations to become more inventive and effective in meeting change and solving problems.

Effective Service Integration

In an effort to coordinate service delivery and minimize the duplication of effort by social service agencies, Kansas has structured the Department of Social and Rehabilitation Services (SRS) to serve as an umbrella agency. Located within SRS are the Division of Integrated Services Delivery, Finance, Information Technology and Administration, Children and Family Policy, and Health Care Policy.

With the passage of PRWORA, Kansas implemented the **Temporary Assistance for Families (TAF)** and the **Kansas Works** (also known as **KanWork**) programs. Implemented in October 1996, the programs provide temporary cash assistance and employment services to Kansas families and place a strong emphasis on work by encouraging employment, education, and training. The programs are State-administered under the direction of the Economic and Employment Support Division within the Integrated Services Delivery section of the Department of Social and Rehabilitation Services (SRS). Although State administered, the State provides management areas[64] with great flexibility to design programs to meet specific local needs.

Continuing its focus on interagency collaboration, the State implemented its Welfare-to-Work (WtW) program through a collaborative effort between the Kansas Department of Human Resources (KDHR), Employment and Training unit, and the SRS.[65] While WtW is administered through KDHR, the program is developed jointly by the local Private Industry Councils (PICs) and the local SRS staff. In essence, the KDHR provides guidance, oversight, funding and information regarding regulations. At the local level, the Kansas Works staff conducts the intake and client employability assessment for all applicants. Those applicants meeting the WtW eligibility criteria are then referred to the local PIC office for services.

From March 1998, when the program was first approved, through March 1999, the WtW program received approximately 1,050 referrals from the TANF agencies. Between October 1998 and April 1999, approximately 375 clients completed intake with the WtW program and approximately 69 of those clients indicated they had a substance abuse problem. Based on this sample of the WtW population and through prevalence statistics obtained from a Southeast Kansas study of TANF, mandatory work program participants, the SRS estimates that approximately 20 percent of work program participants have an AOD problem.

Department of Social and Rehabilitative services estimates that approximately 20 percent of work program participants have an AOD problem.

To address the specific barriers of the TANF population, the Substance Abuse Treatment and Recovery (SATR)[66] unit within the Health Care Policy Division plays an integral role in the provision and coordination of substance abuse services. For example, the SATR provided for the development of Regional Alcohol and Drug Assessment Centers (RADACs) across the State. The RADACs have four primary functions specific to substance abuse issues:

- Provide a central point of entry to substance abuse treatment services
- Determine financial eligibility for these services

[64] There are 11 management areas within the State, each comprising a number of Counties.

[65] The KDHR and the Kansas Department of SRS share a long history of collaboration and coordination of services. The WtW initiative is overseen by the Kansas Workforce Investment Partnership (KWIP), composed of three former groups that deal with employment and training issues: the Kansas Council on Employment and Training, the Commission on School-to-Work, and the One-Stop Career Center Partnership Steering Committee.

[66] The Substance Abuse Treatment and Recovery (SATR) unit was previously the Alcohol and Drug Abuse Division (ADAS). The ADAS was recently subsumed by the Mental Health and Developmental Disabilities Commission, which became the Substance Abuse, Mental Health, and Developmental Disabilities (SAMHDD) Commission and is now the Health Care Policy Division.

- Provide assessments for alcohol and drug abuse
- Provide referral to appropriate treatment programs.

By establishing the RADAC to serve as the intermediary between treatment providers and TANF agencies, the SATR unit fosters communication between the two entities. In addition, the SATR unit is responsible for monitoring the statewide network of treatment providers to ensure standards of care and compliance with State regulations.

AOD Screening, Assessment and Testing Protocols

Kansas has established a number of statewide policies for substance abuse screening, assessment and referral for treatment of **all** TANF recipients in its 105 geographic areas. The State first introduced the idea of alcohol and drug screening in the KanWork program through a pilot project mandated by the Legislature in May 1996. As a result of this mandate, the State requested and obtained a waiver from the Federal Department of Health and Human Services to require that all KanWork participants receiving cash assistance, who were diagnosed with an alcohol or drug addiction problem, participate in and complete a substance abuse treatment program. A refusal to comply with either the screening or the treatment program results in termination of a portion or all cash assistance benefits for the recipient. While this mandate ended in July 1998, the State renewed its statewide policy for substance abuse screening, assessment, and treatment as a part of its TAF and Kansas Works programs.

The State first introduced the idea of alcohol and drug screening in the KanWork program through a pilot project mandated by the Legislature in May 1996.

To date, the screening of TANF clients is a coordinated effort between the TANF agency and the five RADACs across the State.[67] According to the State program manual, screening for AOD is to be administered by the TANF caseworker at eligibility during the client's employability assessment. Clients who exhibit indications of substance abuse problems are then referred to one of the RADACs for further assessment. Based on the client's need, the TANF caseworker develops a self-sufficiency agreement outlining the client's employability and barriers to employment including alcohol and drug abuse. The self-sufficiency agreement stipulates the client's requirements and the applicable sanctions imposed for failure to comply with those requirements.

Although there are statewide policies for the screening, assessment, and referral to treatment of TANF clients, in practice, not all management areas adhere to these policies. For example, not all management areas conduct universal screening of all TANF applicants for alcohol and drug abuse at eligibility. In addition, although the State is moving toward the implementation of a statewide, standardized screening tool, there is no such requirement yet. While the majority of the management areas are beginning to utilize the SASSI instrument to screen for AOD abuse, some areas are still utilizing the CAGE-AID instrument. The State has also established a set of State-defined criteria that management areas use in the screening process (see Exhibit XI). If a client meets at least one of the five State-defined criteria at any point during program participation, the TANF caseworker can refer the individual to a RADAC for more in-depth assessment.

[67] The five RADACs are geographically dispersed throughout the State to accommodate the needs of the State's population. Nevertheless, the RADAC in the Western part of the State has a large geographic area to cover due to the large rural area of the State, therefore, the RADAC has developed a centralized scheduling system to relieve some of the staff's travel from locality to locality.

Exhibit XI
State Defined Criteria

- A positive outcome from administering a series of questions in a drug and alcohol screening instrument
- Well-documented incidence of intoxication while in the SRS office
- Dismissal from employment or any employment placement services (EPS) activity for substance abuse related causes
- Any substance abuse related legal problems such as a DUI conviction
- Participant admission or a medical diagnosis that an alcohol or drug-related problem with abuse or dependency exists.

In the Chanute management area,[68] all TANF *recipients* are screened for AOD abuse by the TANF caseworker during a group orientation session utilizing the SASSI instrument. As in most local areas, administration and scoring of the test is done by the TANF caseworker while evaluation of the results is conducted by the RADAC. In contrast, the Wichita TANF program institutes mandatory screening policies for AOD abuse for *both applicants and recipients*. The screening is conducted by TANF caseworkers at the TANF agency both at intake and at any other point during program participation, as deemed necessary. Recently, the Wichita area began utilizing the SASSI instrument to conduct the screening of TANF clients.

To facilitate the referral for further assessment, local area TANF offices have established Qualified Service Organization Agreements (QSOA) with the RADACs for the provision of treatment services. In addition, the QSOA facilitates the sharing of information between the agencies and helps establish proper procedures addressing confidentiality concerns. Upon referral from the TANF agency, the RADAC determines the extent of the substance abuse problem, utilizing a statewide standardized instrument known as the Kansas Client Placement Criteria Screening Instrument—an adaptation of the American Society of Addiction Medicine Patient Placement Criteria (ASAM)—and the Addiction Severity Index (ASI). Both instruments are used to determine the appropriate level of care, continuing care, and recovery period needed by the individual to achieve self-sufficiency. Though the Kansas Client Placement Criteria Screening Instrument is used statewide, it is meant to serve as a guide for the treatment provider and may therefore be altered as appropriate. The Kansas Client Placement Criteria examines six different dimensions requiring evaluation when determining the level of care:

- Acute intoxication and/or withdrawal potential
- Biomedical conditions
- Emotional/behavioral conditions or complications
- Treatment acceptance/resistance
- Relapse potential
- Recovery environment.

If the RADAC determines that a TANF recipient is in need of alcohol or drug treatment, the area TANF agency is notified and the information is incorporated into the individual's self-sufficiency agreement. The RADAC also provides the TANF agency with information on the number of hours the client is required to participate in treatment and whether the client can engage in a work activity while in treatment. If a client is involved in less than 30 hours of outpatient treatment per week, the TANF caseworker will assign the individual to additional work activities, as appropriate. The State allows substance abuse treatment to count as a work activity, but does not mandate that management areas abide by this policy. For example, in the Wichita area, under the local WtW plan, AOD treatment is not considered a work activity,

[68] The management area includes eleven Counties in Southeast Kansas.

but a support service. Therefore, in order to receive treatment, a client must also be participating in a work activity. However, in most local areas, treatment is considered a valid work activity, with the idea that outpatient treatment should be coupled with some other work component if possible. Clients participating in residential treatment services are not required to engage in additional work activities, unless the treatment program has specific "work activity" requirements for the patients.

In most local areas, treatment is considered a valid work activity, with the idea that outpatient treatment should be coupled with some other work component if possible.

Although the Economic and Employment Support Division chose not to include mandatory statewide testing policies in the Kansas Works plan, it did not prohibit local areas from incorporating drug testing into their intake procedures. Currently, Wichita is the only area that conducts up-front drug screening and testing of TANF clients, but only does so on an "as needed" basis. Typically, drug testing through a urinalysis is conducted if a TANF recipient plans to participate in specific employment projects available in the local area. These special projects are designed to link TANF recipients with private sector employers that provide specialized training. To gain employment with one of these employers, clients must be drug free and are therefore tested by the employer accordingly. The Wichita area TANF agency incorporated this policy as a way to ensure that TANF recipients are drug free and pass employer drug tests *before* referring them to these programs.[69]

Treatment Compliance and Sanction Practices

Once the TANF agency has referred a TANF recipient to the RADAC and treatment is determined necessary to achieve self-sufficiency, monitoring of treatment program compliance primarily becomes the responsibility of the RADAC. The TANF agency defines compliance by the recipient's adherence to the requirements set forth in their self-sufficiency agreement. Therefore, clients can only be sanctioned for non-compliance with their AOD treatment requirements if treatment is included in their self-sufficiency agreement. Although the State defined mandatory sanctions for non-compliance with the requirements set forth in each recipient's self-sufficiency agreement, in practice, because these sanctions are so strict, local areas have some flexibility over when they implement the sanctions. According to the State TANF regulations, a first violation will result in the closure of the TANF case for the entire family for a period of up to two months. Although stringent, this sanctioning policy gives clients the opportunity to come into compliance at any point after the sanction has been imposed, whether compliance takes place an hour or a week after the sanction. If a second violation occurs, however, families receive a reduction in their TANF grant for two consecutive months. During this time period, clients cannot come into compliance with their requirements. Most TANF agencies avoid the implementation of sanctions by meeting with clients prior to instituting a first time sanction with the goal of identifying strategies for regaining compliance and alternative resources. For example, if a client is referred for participation in residential treatment, the agency must examine whether the necessary supports are available for that client's children,

Most TANF agencies avoid the implementation of sanctions by meeting with clients prior to instituting a first time sanction with the goal of identifying strategies for regaining compliance and alternative resources.

[69] When the program was first implemented, the organizations began by training the recipients and conducting the AOD testing after the training. Based on the testing, 60 percent of those who underwent the training program tested positively. As a result of this initial finding, to participate in the employment training program, the organizations require that recipients first be tested for drug abuse.

while the client is participating in treatment.

Because the Chanute management area includes AOD treatment in the client's employability plan, participation in treatment is a sanctionable process tied to the sanction policies specified above. In addition, the management area allows the client's participation in treatment to count as a work activity. Clients who are engaged in outpatient treatment, however, must also participate in some form of work component. Typically these work component activities are designed to be low intensity (e.g., life skills) or short term training (e.g., two to six weeks) consisting of the development of living skills, employment search, basic education or alternative work experience. Similarly, in the Wichita area, substance abuse treatment services count as a primary work activity for adults. On the other hand, because PRWORA requires pregnant and parenting teens to engage in high school or GED preparation, participation in substance abuse treatment services for this portion of the TANF population is considered a secondary work component that must be combined with another work activity.[70]

In both areas, a client's compliance with substance abuse treatment is defined by how closely the client meets attendance, participation, and follow-through requirements. Through their agreement with the RADAC, treatment providers are required to provide the RADAC with information on the client's compliance with their treatment requirements. Upon receiving this information, the RADAC, in turn, reports the information back to the area TANF agency, which when required, will implement the appropriate sanction. In the Wichita area, there is an alcohol and other drug abuse (AOD) liaison whose sole responsibility is to maintain contact with the RADACs and obtain reports on client's follow through with referrals and participation in treatment. The AOD liaison reports the information to the area TANF agency that then takes appropriate action to ensure client's compliance with their substance abuse treatment requirements (e.g., contact clients who fail to follow through with referrals).

In the Wichita area, there is an alcohol and other drug abuse (AOD) liaison whose sole responsibility is to maintain contact with the RADACs and obtain reports on clients' follow through with referrals and participation in treatment.

Funding Streams for AOD Services

Most of the substance abuse services available to the TANF population in Kansas are funded either by the State's Medicaid program or SATR unit. For example, the SATR funds the five RADACS that provide on-site assessment and referral services. In an attempt to improve the referral rate of TANF clients with substance abuse problems, the State legislature has recently approved the transfer of $600,000 in State TANF funds to the State SATR office to place AOD certified counselors in each of the State's twelve welfare center offices. This is the first instance where the State has designated TANF funds specifically for the purpose of enhancing substance abuse services.

In an attempt to improve the referral rate of TANF clients with substance abuse problems, the State legislature has recently approved the transfer of $600,000 in State TANF funds to the State SATR office to place AOD certified counselors into each of the State's twelve welfare offices.

In July 1997, the Kansas Legislature mandated that the SRS implement a statewide

[70] The other work activity is most often an educational activity towards obtaining a high school diploma or a GED. Pregnant and parenting teens must participate in these activities for at least 25 hours in order for the State to fulfill its Federal participation requirements.

Medicaid managed care program to serve the health needs of the State's population. In response, the State developed and implemented HealthConnect Kansas and PrimeCare Kansas. HealthConnect is a statewide primary care case management program administered through community-based treatment programs that are reimbursed on a fee-for-service basis at specific rates set by the State. Providers also receive a $2 fee for the provision of case management services. PrimeCare Kansas, on the other hand, is based on a capitated payment model by which providers receive a per member per month fee to meet each individual's health services. According to the Kansas State Plan,[71] Medicaid will reimburse service providers for the following alcohol and drug abuse treatment services:[72]

- Outpatient services
- Residential treatment
- Substance abuse case management
- Substance abuse/dependency screening, assessment and referral.
- Intensive outpatient services
- Youth intermediate treatment (i.e., residential treatment)
- Reintegration counseling

To receive reimbursements through Medicaid, the above services must be made available by community-based residential or day treatment providers. Clients who are not Medicaid-eligible, however, are charged on a sliding fee scale for the provision of services.

In addition to the substance abuse services provided by the State's Medicaid managed care program, the SATR unit recently awarded $11.1 million in grants to 61 alcohol and drug treatment programs statewide to help fund substance abuse treatment services to low-income Kansas. Services are available to individuals with incomes up to the 200 percent of the Federal poverty level, based on a sliding scale. Prior to this initiative, State-funded alcohol and drug treatment services were provided to this population through a contract with a management organization. The contract ended in June 1999, at which point SRS began working directly with the funded treatment providers. Approximately $6.5 million of these funds come from Federal sources through the Substance Abuse Prevention and Treatment Block Grant, while $4.6 million are State funds.

Evaluation Efforts/Performance Measurement

To date, Kansas has not conducted any statewide evaluations regarding the TANF population with substance abuse problems. However, based on a needs assessment of the general TANF population, the SRS estimates that the percentage of TANF recipients with substance abuse problems is approximately 20 percent, which may vary by locality. The State documents the success of its treatment provider agencies by using the Addiction Severity Index (ASI) as a measure of treatment success. The ASI is administered at admission and discharge. In addition, Kansas State University administers a follow-up survey of recipients who complete their substance abuse treatment programs 6 months after completion of the program. Results of these surveys have shown that after receiving treatment, the number of days of alcohol and cocaine use drops, client income increases, and a reduction in dependency on public cash assistance occurs.

[71] Source: The Kansas Medicaid State Plan (Attachment 3.1-A #13.d, Page 14d.1)
[72] Because AOD services are "carved out" of Medicaid, managed care providers are not required to provide these services.

Effective Service Integration

In Executive Order No. 36 issued in 1995, Governor Whitman created a comprehensive workforce development system, **Workforce New Jersey**, which focuses on the preparation of all workers. The goal of this integrated system was to meet the needs of dislocated workers, the underemployed, and welfare recipients. This new system required a significant level of collaboration among a number of State departments, particularly the Department of Labor (DOL), the Department of Human Services (DHS) and the Department of Health and Senior Services (DHSS). With the passage of PRWORA in 1996, New Jersey began to initiate a number of dramatic changes in its welfare program. As a part of this overarching workforce strategy, **Work First New Jersey** (WFNJ) was implemented in March 1997 as the State-supervised, locally-administered TANF program.

Work First New Jersey operates under three guiding principles:

- Replacing welfare with work
- Fostering individual responsibility
- Supporting efficient administration.

In line with these guiding principles, recipients are expected to engage in intensive job search and work readiness activities including: job placement, community service employment, work/study, vocational and on-the-job training, substance abuse and mental health treatment, and supported employment. The Division of Family Development (DFD), within the Department of Human Services (DHS) oversees the implementation and management of WFNJ through the County and municipal welfare agencies. Also housed under DHS are New Jersey's Child Welfare, Mental Health and Medicaid programs, allowing ease of collaboration among these programs.

The need to address the substance abuse problems of welfare recipients resulted in a formal interagency agreement between the Department of Health and Senior Services, Division of Addiction Services (DHSS/DAS) and the Department of Human Services (DHS) totaling over $20 million. This *Work First New Jersey Substance Abuse Initiative (*WNJF SAI), funded with both Federal and State TANF Maintenance of Effort (MOE) dollars,[73] provided over $14 million to support direct treatment services for TANF recipients, and approximately $4.5 million to place "Care Coordinators" in local TANF agencies in all 21 Counties in the State. In addition, to support the evaluation component of this initiative, DHS has allocated approximately $2.7 million.

Also, as a part of the effort to integrate workforce service delivery, through Executive Order No. 36, the Department of Human Services (DHS) local TANF offices were required to serve as the primary point of entry for TANF recipients to the One-Stop Center system established under Workforce New Jersey. For example, in Union County, the TANF agency conducts the intake and initial evaluation of the client. Clients are assessed for job readiness skills. Once this is completed, TANF caseworkers develop an Individual Responsibility Plan (IRP) for the client, which stipulates expectations and requirements placed on the client. If needed, these caseworkers convene a multidisciplinary team to work with the client and establish a system to ensure coordination among the various departments. Clients are then tracked for progress.

If needed, these caseworkers convene a multidisciplinary team to work with the client and establish a system to ensure coordination among the various departments.

[73] Of the $20 million, $5 million is a Federal transfer of funds from the Title XX Social Services Block Grant (SSBG), $1.2 million is from a New Jersey Department of Health funding pool for treatment services, and approximately $13 million is State TANF MOE funds.

The Division of Addiction Services (DHSS/DAS) has been working extensively with the treatment provider community to assist in their efforts to better serve the welfare population. The DHSS/DAS has provided approximately four training sessions for treatment providers each year on the American Society of Addiction Medicine (ASAM II) placement criteria and the Addiction Severity Index (ASI). These sessions also focus on understanding how to bill fee-for-service and the overall billing system. DHSS/DAS stated that since the implementation of WFNJ and the receipt of TANF funds, treatment providers have altered their programs to include such services as life skills training, job readiness, pre-vocational services, on-site dependent care, and transportation. Treatment providers also collaborate with the TANF agencies by identifying TANF recipients who enter treatment on their own.

AOD Screening, Assessment, and Testing Protocols

While New Jersey has no statewide policies requiring recipients to participate in alcohol or other drug (AOD) screening, assessment and treatment, **all** welfare recipients are screened by trained TANF caseworkers. WFNJ recipients reserve the right to refuse screening except at eligibility and re-certification. In addition, while recipients with substance abuse problems are referred to a Care coordinator for further assessment and treatment, the individuals may refuse to participate in either activity without incurring penalties as long as the AOD problem does not inhibit them from successfully maintaining their work requirements. Newly implemented legislation now requires clients who have already received a sanction for non-compliance with their requirements to participate in alcohol or drug abuse assessment and treatment, if applicable. The WFNJ SAI mandated the inclusion of the CAGE-AID screening instrument as a part of the intake process conducted by TANF caseworkers. The Individual Responsibility Plan (IRP) that is developed helps the caseworker identify each individual's potential and readiness for work, as well as any potential barriers to employment. The client signs the IRP, which stipulates the expectations placed on him/her to receive cash assistance or support services. In addition to eligibility, the State requires that recipients submit to these screenings at re-certification when the IRP is renegotiated.

If during screening or re-certification a caseworker suspects that substance abuse poses a barrier to employment, they refer the TANF recipient to a Care Coordinator (CC) for further assessment.

The WFNJ SAI is also responsible for creating New Jersey's system of Care Coordination for assessment and referral. If during screening or re-certification a caseworker suspects that AOD poses a barrier to employment, they refer the TANF recipient to a Care Coordinator (CC) for further assessment. The CC is a substance abuse professional, located on-site at the TANF agency or near-site. The CC conducts in-depth substance abuse assessment using the Addiction Severity Index (ASI). After identifying the intensity of the substance abuse problem, the CC places the recipient into one of a continuum of treatment categories according to the American Society of Addiction Medicine Patient Placement Criteria II (ASAM II).[74] Using these four levels of treatment, the Division of Addiction Services (DHSS/DAS) developed a "Work Activities and Treatment Matrix."[75] The Matrix designates the specific work

[74] The ASAM II is an instrument that assigns individuals into categories within four different levels as shown in the following table:

ASAM II LEVELS OF TREATMENT	
Level I	Low Intensity Outpatient
Level II	Intensive Outpatient, Partial Care, or Hospitalization
Level III	Halfway House, Clinical Residential Program and Sub-Acute Residential Program
Level IV	Acute Inpatient-Medically Managed Program

[75] A copy of New Jersey's Work Activities and Treatment Matrix is located in Exhibit B-1 in Appendix B.

activities that recipients are able to engage in based on the intensity of the substance abuse problem and the treatment they are receiving. The Care Coordinators use this instrument to determine the extent to which work may be integrated with treatment, and then work with County and municipal TANF caseworkers to incorporate work with treatment.

Currently, participation in assessment and treatment are voluntary under the WFNJ SAI. Substance abuse treatment becomes mandatory only when a client has already been sanctioned for failure to comply with work requirements due to AOD problems. The State allows participation in treatment to count as a work activity for the recipient. However, only if treatment is included in the IRP as a work requirement can the client be sanctioned for not participating in treatment. In July 1999, however, the State passed a mandatory SAI regulation requiring the imposition of sanctions on clients who fail to comply with their assessment and treatment requirements. As of this date, TANF clients who have received a first or second sanction, and the sanction(s) is believed by the TANF caseworker to be a result of a AOD problem, can be mandated to participate in both AOD assessment and treatment. The State requires those clients who are mandated into treatment to show their intent to comply by participating for at least two consecutive weeks. The goal of this initiative is to get clients for whom substance abuse poses a barrier to employment to comply with treatment. Alcohol and other drug testing is not a requirement under the WFNJ SAI. Typically, drug testing is conducted by treatment providers at the treatment site and results are not shared with TANF caseworkers.[76]

Because the Substance Abuse Initiative is mandated statewide, all 21 Counties must adhere to the above mentioned policies and procedures, however, Counties maintain a certain autonomy to adjust or tailor the program to best suit the needs of the area. For example, in Middlesex County, the agency recognized that many of the caseworkers were uncomfortable approaching the topic of substance abuse with clients. To most effectively address this challenge, the County identified two experienced interviewers, skilled at addressing these sensitive topics, to serve as the primary contact in each of the offices. These individuals have become the single point of entry for all TANF applicants and conduct all the substance abuse screenings, thereby reducing the likelihood that substance abuse problems go undetected.

In Middlesex County, the agency recognized that many of the caseworkers were uncomfortable approaching the topic of substance abuse with clients.

Middlesex County has also hired what they call "SAI liaisons" that serve as the link between the caseworkers and the Care Coordinators. These individuals help ease the burden on the CCs by scheduling assessments and completing the associated paperwork. Using a Microsoft® Excel application, the County created a database that stores information on caseworker referrals and CC feedback. This information is then entered into the system by the SAI liaison that sends it on to the appropriate unit. These individuals also have a role in the County's "pre-sanctioned" outreach process. TANF case managers send the Care Coordinators referrals of "pre-sanctioned" clients—those who are not cooperating with job search activities. The liaison then contacts these individuals by mail and by phone to: (1) discuss their reasons for non-compliance; (2) inform them of possible sanctions; (3) inquire as to whether AOD is an issue; and (4) explain the options available under the WFNJ SAI. The goal of this outreach is to offer clients an opportunity to come into compliance with their requirements, avoid the

Middlesex County has also hired what they call "SAI liaisons" that serve as the link between the caseworkers and the Care Coordinators.

[76] Federal confidentiality laws and regulations do not cover testing as part of a screening mechanism. On the other hand, Federal confidentiality laws and regulations do cover testing by a treatment provider that is intended for diagnosis purpose or as part of a treatment regimen.

implementation of sanctions, and inform the client that if substance abuse is a barrier, the agency will work with the client. Additionally, the outreach provides the agency with information on whether substance abuse treatment would enable clients to comply with the work requirements established in their IRP. The agency does not currently track the effectiveness of this initiative in getting clients to identify substance abuse as a barrier to complying with their IRP requirements.

The following table shows the total number of referrals made by caseworkers for in-depth assessments, the actual number of assessments completed, and the number of WFNJ recipients who entered treatment for each of the New Jersey Counties included in this case study as well as the entire State. These figures highlight the fact that while the State is being very proactive about developing systems and processes to identify substance abuse problems among TANF recipients, these systems and processes are not effectively identifying the subset of TANF clients with AOD problems.

Exhibit XII
WFNJ SAI Referrals, Assessments, and Clients Entering Treatment
July 1998 - June 1999

Area	TANF Caseload	Referrals for Assessment	Completed Assessment	Participation in (Entering) Treatment
Essex County	19,697	513	316	233
Middlesex County	1,622	211	140	95
State Total	43,418	925	649	483

Source: Department of Human Services, Office of Policy and Planning

Treatment Compliance and Sanction Practices

WFNJ did not set forth any statewide policies specifically regarding sanctions for individuals refusing to comply with AOD screening, assessment or treatment. While substance abuse treatment can be included in a recipient's Individual Responsibility Plan, it is not a statewide mandate. TANF agencies may include substance abuse treatment in the client's IRP when the client identifies substance abuse as a problem or when an employer identifies substance abuse as a barrier to employment. However, if it is not included in the IRP it is not considered a sanctionable offense. While there are many differences in the way Counties address the issue of substance abuse, there are general guidelines that the local TANF offices adhere to:

- If a substance abuse problem does not interfere with the work activity, then the issue is generally not addressed
- If a client is not participating in a work activity and self-reports a substance abuse problem, the caseworker informs the client of the treatment programs available, but cannot require participation
- If a client refuses to participate in a treatment program, the caseworker refers the client to a work activity.[77]

[77] The TANF case worker refers the client to community service employment, job search, or other "sheltered" work activities.

Recipients not complying with work requirements due to an alcohol or drug problem can avoid being sanctioned by opting to participate in a treatment program. If a recipient has voluntarily entered into a substance abuse treatment program and is not complying with treatment activities, the client is removed from the treatment program and placed in another work activity[78] but is not sanctioned, unless participation in treatment is included in the IRP. As a result of new State legislation, clients who have been sanctioned because of a perceived substance abuse problem, are now required to participate in assessment, to further determine if substance abuse is a barrier to employment, and if enrollment treatment is necessary.

Current sanctions for non-compliance with substance abuse treatment are no different than sanctions for non-compliance with any other work requirements. New Jersey institutes graduated penalties for on-going violations. The first instance of non-compliance results in loss of cash benefits for the recipient for a minimum of one month, but not longer than three months. If compliance is not regained at the end of three months, the case is closed and the individual must reapply in order to receive cash assistance. A second instance of non-compliance also results in the loss of a recipient's cash benefits for a minimum of one month. If non-compliance continues, by the end of the first month, the entire family, and not just the recipient head of household, loses their cash assistance for the following month, at which time the case will be closed if compliance is not attained. Third and subsequent offenses result in the loss of cash benefits for all family members for a minimum of three months, at which time, if the recipient is still non-compliant, the case is closed.

As a result of new State legislation, clients, who have been sanctioned and the sanction is believed to be a result of a substance abuse problem, are now required to participate in assessment to further determine if substance abuse is a barrier to employment, and to participate in treatment.

Currently, compliance is defined by the State as attaining a 75 percent attendance rate in the activity, whether it is a work activity or substance abuse treatment. Once the Care Coordinator has referred a WFNJ recipient to a treatment program, and the individual has agreed to participate, it primarily becomes the responsibility of the AOD treatment provider to monitor the client's compliance with treatment. Information concerning participant attendance and progress in treatment is communicated from treatment providers to the TANF agencies once consent is obtained from the client. This information is communicated via the Care Coordinators, who serve as the liaison between the two entities.

Information concerning participant attendance and progress in treatment is communicated from treatment providers to the TANF agencies once consent is obtained from the client.

Funding Streams for AOD Services

Because WFNJ SAI serves both the TANF and non-TANF (General Assistance) population, the State integrated its Federal TANF, State MOE and other State funds to implement this project. Of the $20 million in funding, approximately $4.5 million was used to purchase substance abuse Care Coordination services. Through a Request for Proposal (RFP) process, the Department of Human Services (DHS) obtained a vendor—the State chapter of the National Council on Alcohol and Drug Dependence (NCADD)—to provide Care

[78] The State is currently working with the employment providers and training providers to understand and recognize behaviors related to alcohol and drug abuse so that this information is provided to the TANF caseworker.

Coordination services. The remaining $14 million was made available to the Division of Medical Assistance and Health Services (DHS/DMAHS). DHS/DMAHS contracted with a vendor, Unisys, to manage all Medicaid reimbursement of treatment providers for services provided to WFNJ participants. This funding will continue in FY 2000. In addition to this funding in 1999, the State received approximately $45 million from the Substance Abuse Prevention and Treatment Block Grant for the provision of treatment services. Approximately $10 million of these funds were allocated to the women's set aside program which is specifically intended for the provision of substance abuse services to women.

Through this agreement, the WFNJ SAI altered and increased its reimbursement rates over current Medicaid rates for substance abuse services, thus increasing the likelihood that providers would render these services for TANF clients. This change in reimbursement rates increased the supply of substance abuse services to Medicaid-eligible TANF clients. Currently, there are 125 entities or treatment organizations offering services to clients referred for treatment.

Through this agreement, the WFNJ SAI increased its reimbursement rates for substance abuse services, thus increasing the likelihood that providers would render these services for TANF clients.

Similar to the WFNJ SAI, the Medicaid system currently instituted in New Jersey is based on a fee-for-service model. Substance abuse treatment is "carved out" of managed care for all Medicaid populations. Substance abuse treatment is reimbursed on a fee-for-service basis at uniform rates to community-based Medicaid treatment providers for a limited menu of services approved by the Health Care Finance Administration under the clinic option. Alcohol and drug dependence services are reimbursable at inpatient and outpatient hospital settings at payment levels through a prospective Diagnostic Related Group (DRG) system and a cost-based allowable charge system, respectively. The following table highlights the services covered as part of the Medicaid clinic option.

Exhibit XIII
AOD Services Funded by Medicaid Clinic Option

- Inpatient acute detoxification
- Counseling
- Physician services
- Methadone treatment for opiate addiction
- Outpatient hospital services
- Diagnostic assessment
- Urinalysis.

Additionally, New Jersey received approximately $4 million in grant funding from the National Institutes of Drug Abuse (NIDA), approximately $300,000 for the Anne E. Casey Foundation, and $400,000 from the Administration from Children and Families (ACF), U.S. Department of Health and Human Services (DHHS), to support an evaluation effort known as the Substance Abuse Research Demonstration (SARD) that will continue over the next five years. The demonstration project takes place in Essex and Atlantic Counties and focuses on providing enhanced services and treatment through a more holistic approach to family issues.

Evaluation Efforts/Performance Measurement

In a recent effort between the DHSS/DAS and the Eagleton Institute of Rutgers University, a survey was conducted in 15 Counties throughout the State to assess the prevalence of substance abuse among female TANF recipients. In 1998, over 1,300 participants were asked to contribute hair samples to test use of cocaine, heroin and amphetamines among this population. Based on a random sample of this group (29%), approximately 27

percent of those tested were found to have used at least one drug in the last three months, with 11 percent being heavy users. While the analysis identified cocaine as the most abused and most underreported drug, it did not consistently detect marijuana which participants reported using and which other studies have found to be of high prevalence use among the welfare population. The percentages identified by the study, however, falls within the range of national prevalence rates of 13 to 34 percent documented by the State.[79]

Based on a random sample of this group, approximately 27 percent of those tested were found to have used at least one drug in the last three months, with 11 percent being heavy users.

In addition to the expansion of services under the WFNJ SAI, with support from NIDA and the Annie E. Casey Foundation, DHS will provide and test enhanced treatment services and other interventions through the SARD initiative. The goal of the project is to evaluate the effectiveness and utility of specific services and interventions. The services that are available through the SARD project include:

- Intensive case management and support (e.g., pre and post-treatment, advocacy, home visits, job coaching, mentoring and relapse prevention)
- Enhanced services coordination and delivery (e.g., primary care, mental health, domestic violence, housing, child support, work-readiness activities, employment, and treatment or social services)
- Brief interventions (to prevent drug dependency and to promote job retention)
- Family and child interventions (specifically targeting children of women in treatment)
- Contingency management (e.g., incentives and sanctions used to encourage participation in treatment).

The purpose of the SARD is to evaluate the utility and effectiveness of two separate approaches: (1) WFNJ SAI which includes Care Coordination and treatment services, and (2) the WFNJ SAI plus intensive case management, enhanced services, and mandatory participation in substance abuse treatment when substance abuse is identified as a barrier to employment. This second approach also examines the benefits of using positive incentives (e.g., phone cards and food vouchers), combined with sanctions, to encourage participation in treatment. The project includes a comprehensive evaluation studying the group of TANF recipients who will receive the demonstration services and a comparable group who will receive only the services available under the WFNJ SAI. Based on the results of the SARD, New Jersey hopes to better understand the most effective strategies for identifying and treating welfare recipients with substance abuse problems.

Based on the results of the SARD, New Jersey hopes to better understand the most effective strategies for identifying and treating welfare recipients with substance abuse problems.

[79] Source: Kline, A., Mammo, A., Rodriguez, G., & French, J. (1999). Substance Abuse Among New Jersey TANF Recipients; Relationship to Length of Welfare Dependence.

Effective Service Integration

North Carolina implemented its TANF program, **Work First**, in January 1997 that emphasizes three key strategies to serve the TANF population: diversion, work, and retention. One of the most significant provisions of the Work First program is the devolution of TANF program development to the local level. While the program is State-administered through the Department of Health and Human Services (DHHS), Division of Social Services (DSS), all services and benefits are delivered locally through County DSS offices across the State. As a result of this devolution, each of the 100 Counties in the State is designated as either standard or electing.[80] Standard Counties operate under the policies of the State's Work First program while electing Counties are given additional flexibility in program design. All Counties, regardless of whether they are standard or electing, maintain maximum flexibility in designing their employment programs with the intent that programs be tailored to match the needs of the local community. Additionally, Counties that have small Work First caseloads are permitted by law to design their entire program, including eligibility criteria and benefit levels.[81]

In addition to providing monitoring for the Work First program, DHHS serves as the umbrella agency to the Division of Social Services, Division of Mental Health, Developmental Disabilities and Substance Abuse Services (Division of MH/DD/SAS) and the Division of Medical Assistance (DMA) that administers the State's Medicaid program. This configuration helps foster working relationships among the State and local agencies and facilitates a seamless system of service delivery to TANF recipients with substance abuse problems. For example, DSS and the Division of MH/DD/SAS entered into a Memorandum of Agreement (MOA) describing the responsibilities of each Division regarding the provision of services to Work First applicants and recipients identified as having a substance abuse/dependence problem. To further ensure the success of service delivery for this population, the State also required each local DSS office in all counties, to establish a similar Memorandum of Agreement with the Area MH/DD/SAS Authority. Typically the Area Authority is responsible for providing the substance abuse treatment services themselves or establishing contracts with local treatment providers to do so. Each of the 39 Area MH/DD/SAS Authorities worked with the providers to train and inform them of expectations for treatment protocols in working with TANF clients. As a result of this training, some of the providers have altered their programs to include such services as job readiness, pre-vocational services, care coordination via Qualified Substance Abuse Professionals (QSAPs), expanded daycare, and transportation.

To further ensure the success of service delivery for this population, the State also required each local DSS office to establish a similar Memorandum of Agreement with the Area MH/DD/SAS Authority.

In consultation with DHHS, the Substance Abuse Services (SAS) Section of the Division of MH/DD/SAS developed a process for the early identification, referral and care coordination of substance abusing Work First applicants and recipients. DSS and SAS adopted the AUDIT and DAST-10, a gender-sensitive, easy to use, screening and assessment tool.[82] In addition, the agencies developed an Enhanced Employee Assistance Program (EEAP) that specifically targets Work First clients with substance abuse problems. The program, which began as a demonstration project in Fiscal Year 1998-1999,[83] is overseen by the Employee Assistance Program Branch of SAS and has three primary goals:

- Reduce the rate of substance abuse among Work First participants
- Increase the hiring rate of Work First participants by businesses

[80] Counties had to notify DHHS of their desire to be designated as electing or standard by October 1997.
[81] In order to qualify, Counties must contain no more than 15.5% of the State's Work First cases as of September 1, 1997.
[82] U.S. Department of Health and Human Services Administration for Children and Families. (1999). *Welfare Peer Technical Assistance Newsletter, March 1999.* Volume 1, No. 1.
[83] The program began in the State Fiscal Year 1998-1999.

- Increase the rate of employment and employment retention among Work First participants.

One of the key components of the EEAP is the mentoring services provided to employees. The primary objective of the mentoring initiative is to provide employees with increased skills in areas including: work culture, ethics, identification, problem solving, substance abuse relapse prevention, networking and accessing community resources. This component of the EEAP is particularly critical for Work First recipients who may not have a long work history and may lack the skills required to succeed in their employment.

In addition, SAS developed a comprehensive Statewide training program for substance abuse service providers and Departments of Social Services. SAS contracted with the School of Social Work at the University of North Carolina at Chapel Hill to develop and implement a training curricula to assist local DSS offices and substance abuse treatment providers in understanding each other's duties, responsibilities, and programs. The training has covered topics such as interagency collaboration, cultural competency, and utilization of screening tools.

Further emphasizing State and local partnerships, the State's General Assembly required the implementation of the First Stop Employment Assistance Program to deliver job placement services for Work First clients. The program was developed in February 1998 through collaborative efforts between the North Carolina Departments of Commerce,[84] Community Colleges, Health and Human Services, and Employment Security Commission. The First Stop program, overseen at the local level by Job Service Employer Committees (JSEC), serves as the primary deliverer of job placement services to the Work First community. County Departments of Social Services can contract with JESC to provide employment services including job search, job placement, or referral to a community service placement.[85] The JSEC determines the applicant's job readiness, referring those who are "job-ready" for employment and those who are not to the County DSS office for eligibility determination for support services. SAS and the EEAP portion of the Division have been actively involved in the Employment Retention Committee, whose goal is to ensure that Work First clients receive the necessary support services to obtain and retain employment. Once the client has received the necessary support services or skills training, they are referred back to the JSEC for job placement. As a requirement of Work First, all applicants are required to register for the First Stop program with their local JESC; a refusal to do so disqualifies applicants for receipt of benefits.

Through case staffings and case reviews, the agencies collaborate to integrate service delivery so that Work First clients receive the necessary services to overcome their barriers to self-sufficiency.

Another example of collaborations developed to assist Work First clients achieve self-sufficiency is the development by DHHS of the Success Initiative. This initiative, to be implemented in the coming year, will pull together all partners and social service agencies involved with Work First clients. Through case staffings and case reviews, the agencies will collaborate to integrate service delivery so that Work First clients receive the necessary services to overcome their barriers to self-sufficiency. Another initiative that is currently under development by SAS is the screening of Work First clients for mental health in addition to substance abuse problems. To date, a 13 question mental health screening tool has been developed and will

Another initiative that is currently under development by SAS is the screening of Work First clients for mental health in addition to substance abuse problems.

[84] The Department of Commerce (DOC) is also the lead agency for the State's Welfare-to-Work (WtW) program.
[85] At the time of this study, Welfare-to-Work funds were not being utilized for this initiative.

be tested with Work First clients. In addition, in January 2000, SAS began piloting testing an integrated mental health/substance abuse screening tool in an attempt to address the interactions between both issues. The Jordan Institute has begun training Qualified Substance Abuse Professionals (QSAPs) on the application of the new mental health screening tool.

AOD Screening, Assessment and Testing Protocols

The State recognizes the potential barrier that substance abuse problems present for individuals trying to secure employment. In a conscientious effort to identify individuals with such problems, DSS has implemented a number of requirements regarding the screening, assessment and testing for substance abuse among all Work First applicants and participants. The first of these requirements, which became effective in April 1998, includes mandatory substance abuse screening for all Work First applicants and recipients. These screenings must be conducted prior to completion of the Work First application using a standardized screening tool[86] adopted by the State. The screening is typically conducted by TANF caseworkers, but it may also be conducted by a Qualified Substance Abuse Professional (QSAP) located on-site at the local County DSS office. To ensure the co-location of alcohol and drug abuse professionals in the TANF office, the State allocated TANF funds for the hiring of at least one QSAP in each of the 39 Area MH/DD/SA Authorities. In addition to the standardized tool, Counties may use the Substance Abuse Behavioral Indicator Checklist, a tool that was adapted from North Carolina's Department of Transportation Reasonable Suspicion Checklist. Between May 1998 and June 1999, approximately 1200 Work First recipients were referred for further assessment based on the results of the Substance Abuse Behavioral Indicator Checklist. At application, if an applicant refuses to cooperate with substance abuse screening, the family is rendered ineligible to receive TANF benefits, however, the DSS staff member continues to evaluate the family for Medicaid eligibility. According to State policy, alcohol and other drug (AOD) screenings must be conducted by County DSS offices every one to 12 months for all recipients. While each DSS office is allowed to set the frequency with which these reviews occur within the one to twelve months time frame, all Counties are required to implement this State policy.

In a conscientious effort to identify individuals with such problems, DSS has implemented a number of requirements regarding the screening, assessment and testing for substance abuse among all Work First applicants and participants.

If the results of the AOD screening reveal the client is at risk for a substance abuse problem, a referral to the QSAP is made for further assessment and recorded in the individual's Mutual Responsibility Agreement (MRA). The QSAP utilizes the Substance Use Disorder Diagnostic Schedule IV (SUDDS IV) to determine the extent of the substance abuse problem and determine if treatment is appropriate. In order to standardize and improve the level of care provided to both substance abuse and mental health clients through the 39 Area MH/DD/SAS Authorities, the State Division of MH/DD/SAS developed a Clinical Guidelines Series addressing substance abuse and several major psychiatric disorders.[87] Distribution of the Guidelines Series was preceded by the distribution of the American Society of Addiction Medicine (ASAM) Level of Care Index developed specifically for the placement of substance abuse clients into treatment. These resources, however, were created to serve as guides, allowing each Area Program the opportunity to adopt the assessment forms provided or borrow from them in the creation of their own.

[86] When conducting screenings, all 100 Counties use a combination of the AUDIT and DAST-10 to determine the existence of a substance abuse problem.

[87] The assessment portion of these Guidelines is based largely on the American Psychological Association's "Psychiatric Evaluation of Adults", developed in 1995.

When a client requires substance abuse treatment, the QSAP refers the client to a treatment provider within the County. The QSAP continues to work with the County DSS caseworker to jointly develop the client's MRA and ensure the client's successful transition to employment. Once the client is enrolled in the treatment program, the QSAP serves as the client's care coordinator, tracking progress and compliance, and reporting back to the County DSS office. Based on data obtained through this case study, Exhibit XIV, shows the number of Work First clients in Mecklenberg County[88] who were screened, recommended for assessment, assessed, referred for treatment, and in compliance with treatment from July 1998 through April 1999.

Exhibit XIV
Work First Clients Referred for Substance Abuse Screening, Assessment, and Treatment Services in Mecklenberg County

	July 1998 - April 1999 Total Caseload = 4,840
Total Screened	3,448
Recommended for Assessment	477[89]
Total Assessed	477
Referred for treatment	460
Complied with referral for treatment	169

Drug testing is conducted by the treatment providers as part of the treatment program and does not serve as a client sanctioning mechanism. Typically, the client signs a consent form allowing the QSAP to obtain information from the treatment provider about compliance with treatment program requirements. Information obtained with appropriate consent by the client is then reported back to the DSS office by the QSAP.

Treatment Compliance and Sanction Practices

Under Work First, County DSS staff work with recipients to develop a Mutual Responsibility Agreement (MRA), detailing the recipient's obligations in order to receive TANF benefits. Currently, all 100 Counties, both standard and electing, require families to enter into these agreements upon application. A family whose parent or caretaker refuses to sign the MRA loses its TANF benefits for at least one month; the benefits are not restored until the parent/caretaker signs this part of the agreement.

Work First participants who fail to meet the terms and conditions established in their MRA are subject to sanctions. The statewide sanction policy for all standard Counties in North Carolina differs from many of the other States in that these Counties have instituted a pay-after-performance structure. In a pay-after-performance structure, the individual does not receive TANF benefits until s/he is once again in compliance with their MRA requirements. In standard Counties,[90] a first time failure to comply with the requirements in the MRA results in a 25 percent reduction in TANF benefits for the individual, and not the entire family, for three months. For example, Work First clients whose referral for substance abuse assessment is included in the MRA but fail to follow through with

The statewide sanction policy for all standard Counties in North Carolina differs from many of the other States in that these Counties have instituted a pay-after-performance structure.

[88] Data were only available for Mecklenberg County.
[89] This figure also included clients recommended for assessment due to family/domestic violence and mental health issues.
[90] The Counties that participated in this case study, Gaston and Mecklenberg Counties, are both standard Counties. Therefore, the sanction policies noted apply to both Counties.

their assessment will receive a 25 percent reduction in their TANF benefits. A second incidence of non-compliance results in pay-after-performance for the individual for a minimum of three months. At this point, families are notified that if compliance is not reached by the end of the three months, their Work First case will be closed. On the other hand, counties that are designated as electing reserve the right to develop their own Work First policies and procedures, including sanction policies.

Each County DSS office is responsible for developing a system for monitoring client's progress and compliance with the treatment program. Typically, this involves participation from the DSS office, the AOD treatment provider, and the QSAP. The treatment provider and the QSAP work together to determine whether or not the recipient is in compliance with his/her treatment requirements. In Gaston County, for example, the DSS office receives monthly reports on each of the Work First clients participating in substance abuse treatment. While participation in substance abuse treatment is included in each client's MRA, the client is not sanctioned for noncompliance with treatment unless they are also engaged in work activities while in treatment. For example, the State mandates that clients have 35 hours of chargeable work activity per month. Therefore, clients requiring substance abuse treatment may be required to complete 25 hours in a work activity and 10 hours in substance abuse treatment. In that instance, clients who refuse to comply with their treatment requirements are also refusing to comply with their work activities. On the other hand, clients who are exempt from work activities and are solely participating in substance abuse treatment have their allocation reduced for refusal to comply with his or her treatment requirements. The remaining payment is paid to a protective payee until the individual complies with treatment.

While participation in substance abuse treatment is included in each client's MRA, clients are not sanctioned for noncompliance with treatment unless they are also engaged in work activities while in treatment.

Funding Streams for AOD Services

Substance abuse services in North Carolina are funded through the Single State Agency by the Substance Abuse Prevention and Treatment Block Grant funds, State funds allocated through the North Carolina General Assembly, and the State's Medicaid Program. In 1999, the State received approximately $33 million from the Substance Abuse Prevention and Treatment Block Grant. Access to substance abuse services comes through the 39 Area MH/DD/SAS Authorities that are required to either provide or coordinate substance abuse services for the Work First population. Mental health and substance abuse services are provided on a fee-for-service basis paid by Medicaid for Medicaid-eligible clients or on a sliding fee scale for non-Medicaid eligible clients and include assessment and evaluation, individual and group therapy, case management, crisis intervention, outpatient treatment, and medical inpatient detoxification.

Access to substance abuse services comes through the 39 Area MH/DD/SAS Authorities that are required to either provide or coordinate substance abuse services for the Work First population.

The Substance Abuse Services Section of MH/DD/SAS received $5.3 million in TANF funds[91] to provide for on-site substance abuse professionals (i.e., QSAPs) at each County DSS office to conduct client assessments, to pay for the drug testing used in tandem with treatment, and to pay for non-Medicaid reimbursable services. $1 million of the $5.3 million was used to fund the EEAP.

Evaluation Efforts/Performance Measurement

Prior to the implementation of Work First, the State made an effort to determine the prevalence of substance abuse among the welfare population. The Division of MH/DD/SA entered into a contractual agreement with a research and evaluation firm to conduct a telephone survey to determine the extent of alcohol and other drug abuse among the welfare population. The survey showed that approximately 33 percent of adults living in households with phones were found to be in need of comprehensive treatment and had received either AFDC, SSI, Food Stamps and/or had no health coverage. North Carolina has contracted with this research firm to measure the need for services among the TANF population. A report based on this evaluation is expected by December 2000. The following list describes some of the factors being assessed as a part of this evaluation:

- Employment status of Work First parents
- Measures of family income
- Percentage of families involved in work or training activities.

[91] These funds were appropriated as a result of State Law 1997-443.

Effective Service Integration

Ohio implemented its TANF program, **Ohio Works First (OWF)**, in October 1997. OWF is administered by the Ohio Department of Human Services (ODHS), which also administers the State's Medicaid and Child Welfare programs. OWF is operated in a State-supervised, County-administered system that devolves all policies related to the operation of the program to the 88 Counties within the State[92]. Although there is much local flexibility in program operation, there are some elements of the program that are mandated by the State. State policy places a time limit on cash assistance of 36 months, after which time, recipients remain ineligible for assistance for 24 months. After this two-year period, if good cause exists, the recipient may be eligible for up to an additional 24 months of cash assistance. Secondly, the Counties must adhere by the requirement regarding development of a Self-Sufficiency Contract (SSC). The SSC, which is signed by the client, defines the rights and responsibilities of both the recipient and the County Department of Human Services. It includes: the recipient's plan to achieve self-sufficiency, details about each adult's work assignments, sanctioning procedures, and all assistance and services being provided.

Despite the high level of flexibility provided to the Counties for the design and operation of the OWF program, there has been much collaboration and leadership at the State level to ensure that the needs of welfare families are adequately addressed. For example, while the State did not accept the Federal WtW formula funds because of the restrictions placed by the legislation and the matching requirement, the State created its own Employment and Training (E&T) program to assist harder-to-serve recipients in becoming employed. To accomplish this task, the ODHS set aside $44 million for State Fiscal Years 1999 and 2000 from its unobligated TANF funds to be separately earmarked as TANF E&T funds. This figure is equal to the Federal amount that the State would have received in Federal WtW formula dollars. To access these funds, each local community is required to develop an E&T plan in conjunction with their local TANF agency and Private Industry Council (PIC). However, communities can determine what services to provide to assist this population become self-sufficient. At this time, the ODHS has received 16 County plans that include substance abuse in their menu of services for the E&T program.

While the State did not accept WtW funding it created its own Employment and Training (E&T) program to assist harder-to-serve recipients become employed.

A number of incentive programs have been created within OWF to assist individuals making the transition from welfare to work. An example of an innovative partnership to assist welfare to work recipients is a model developed by the Montgomery County Alcohol, Drug Addiction and Mental Health Services Board (ADAMHS) and the Montgomery County Department of Human Services.

The Montgomery County Job Center is a one stop, full service model designed to link OWF clients to programs addressing the barriers to continued full-time employment. The Montgomery County ADAMHS Board funds an onsite certified chemical dependency counselor to provide a comprehensive screening for alcohol or other drug dependency. Clients in need of a more comprehensive assessment are referred to the Crisis Care Center. Specifically, the Job Center utilizes a "treatment-based work first employment strategy" for this population. This strategy includes treatment, job skills training and employment stabilization. The emphasis of this integrated program is on the development of a wrap-around self-sufficiency plan for each welfare to work participant that includes the following:

[92] The State establishes statewide eligibility and benefit levels for cash assistance.

- Crisis intervention
- Psychological/emotional support
- Substance abuse treatment services
- Physical health care
- Vocational/educational services
- Spiritual/cultural support
- Social/recreational opportunities
- Financial planning.

Realizing the challenges faced by Counties working with TANF clients with substance abuse problems, the ODHS has taken the role of facilitator, serving as a resource for information and services related to TANF clients with AOD issues. For example, ODHS has advised Counties that to meet the State work participation rate, alcohol or drug abuse addiction services can be considered either an alternative work activity[93] or a developmental work activity provided in conjunction with allowable activities.

ODHS has advised Counties that to meet the State work participation rate, alcohol or drug abuse addiction services can be considered either an alternative work activity or a developmental work activity provided in conjunction with allowable activities.

The Ohio Department of Alcohol and Drug Addiction Services (ODADAS) has also been very involved in welfare reform.[94] In a collaborative effort between the ODHS, the ODADAS, and the Public Children Services Association (PCSA), a Memorandum was issued to provide County Commissioners with guidance on how to enhance local AOD services for TANF clients (see Appendix C). Through this initiative, County Commissioners received a menu enumerating AOD services that can be purchased with local TANF funds, services reimbursable through Medicaid, as well as allowable County DHS administrative expenditures. In addition to this Memorandum, ODHS provided Commissioners with a planning and program model designed to help improve the availability of AOD services. This model of service delivery wraps enhanced AOD services around the traditional treatment services for TANF clients that are covered by Medicaid.

The Memorandum serves as a vehicle to promote local linkages and collaborations between the County departments of human services, the local PCSAs, and the local AOD boards and providers. The role of ODHS is to push for these local linkages so that more needs are being met within the current funding structures and regulations. Additionally, because cross-training of TANF caseworkers on substance abuse issues is key to ensuring the success of effectively addressing the needs of TANF recipients with substance abuse problems, the ODADAS collaborates with ODHS to provide localities:

- Information on the use of TANF funds to pay for substance abuse treatment
- Training on the AOD treatment process
- Training on the Medicaid program.

In response to this Memorandum, the Marion County DHS, the Crawford-Marion County Alcohol, Drug Addiction and Mental Health (ADAMH) Services Board, and the Marion County Counseling Center entered into a contractual agreement to make substance abuse treatment and support services and employment placement services available to the County's TANF population. Through this formal agreement, the following programs are available in Marion County to assist the TANF population transition from welfare to work:

[93] Only 20 percent of the TANF population can engage in alternative work activities.
[94] The agency provides funding and oversight to local AOD boards and providers.

- Promoting Recovery and Employment Project (PREP)
- Employee Assistance Program
- Job Assistance and Mentoring Program.

Through the PREP, the Counseling Center has provided a full-time counselor on-site at the County TANF agency for the screening and referral of TANF clients, as well as a part-time counselor to engage in outreach activities and ensure the linkage to treatment is effective and that barriers are addressed. PREP also conducts training of County Departments of Human Services' staff on issues related to substance abuse including:

- Information about alcoholism and other drug abuse and the nature of addictions
- How to handle obstinate or hostile clients
- How to refer clients
- What responsibilities local staff have regarding monitoring the treatment progress of clients
- How to recognize and inquire about clients' substance abuse and addiction problems
- What alcohol and other drug treatment services are available
- How to recognize and handle relapse
- Confidentiality regulations protecting persons receiving alcohol and other drug addiction treatment services.

The Marion County Counseling Center also provides employee assistance services for TANF recipients through the Employee Assistance Program (EAP). The goal of this initiative is to promote the hiring and retention of TANF participants and to increase retention of employment for high-risk TANF clients. As a result of this formal agreement, two full-time Counseling Center staff provide job development, job placement, job coaching, and job follow-up to all TANF clients. The Job Assistance and Mentoring Program is part of the Ohio Healthy Start program that also serves TANF families with children ages 0 to 3. This program provides families with the skill building and educational support necessary to help them become employable. Once families are deemed "employable," they are referred to the EAP for vocational assistance.

AOD Screening, Assessment, and Testing Protocols

Under OWF, a local TANF agency may conduct an assessment of any family receiving assistance and should design and implement support services that are appropriate to meet the family's needs to become self-sufficient. Although there are no statewide policies or directives requiring AOD agencies to identify Ohio Work First recipients with substance abuse problems, various Counties have instituted policies to identify this population. In Marion County, the PREP program facilitates the screening of TANF clients. The screening is conducted by a Marion County Counseling Center counselor, located on-site at the TANF agency, through the use of the SASSI instrument. The screening is likely to take place after a TANF case-worker observes a problem with the client or interprets AOD as a barrier to employment, based on the results of a strength-based assessment.[95] In addition to administering the SASSI, the counselor scores the results, discusses the results, and negotiates next steps with the client. Part of this negotiation includes the development of a Self-Sufficiency Contract (SSC) that includes the referral for further assessment.

Although there are no statewide policies or directives requiring AOD agencies to identify Ohio Work First recipients with substance abuse problems, various Counties have instituted policies to identify this population.

[95] The strength-based assessment is a locally devised form with one question on alcohol and other drug abuse.

Clients who are positively identified as having AOD problems are referred directly to the Marion County Counseling Center where they receive a thorough assessment that includes the development of a treatment plan, based on need. To facilitate this procedure, the TANF agency has also contracted with the Counseling Center for a half-time person to coordinate treatment services for this population. This coordination includes the determination of whether clients can concurrently participate in work activities while they are engaged in substance abuse treatment services. For example, based on the client's need and their participation in work activities, AOD treatment services can be considered a work activity. However, there are limitations. For example, for clients engaged in developmental work activities, only 10 hours of AOD treatment services would count as a work activity; they would be required to make up the other 20 hours in other allowable activities. This requirement would be towards meeting the State's Participation work rate.

Exhibit XVI
TANF Clients Screened, Assessed, and Referred for Substance Abuse Treatment Services in Marion County

	Jun 1998 – June 1999 Caseload (Total caseload = 551)
Total Screened	500
Recommended for Assessment	163
Referred for and Participating in Treatment	80

Similarly, in Montgomery County, clients receive a comprehensive assessment of their employment barriers and the need for supportive services. Those clients who are identified as having a likely substance abuse problem as a result of the initial screening are referred to the Crisis Care Center for a more comprehensive assessment. If the Crisis Care clinician assesses a chemical dependency problem, then the appropriate level of care is determined so a referral to a certified treatment program can be made. Based on the participant's need, an individualized treatment plan is developed with the participant, the Crisis Care clinician and a representative from the treatment agency. Once the participant is referred for treatment this can become part of the participant's SSC. According to the Montgomery County ADAMHS Board almost 4,000 assessments were conducted in the past year for alcohol or other drug dependency for participants in the Job Center program.

In addition to screening applicants, the TANF agency also notes that recipients identified as having AOD problems can be subjected to random urinalysis. In general, however, drug testing is not utilized as a screening tool and testing results are not a sanctionable offense.

Treatment Compliance and Sanctions Practices

The Ohio Works First program maintains a statewide sanctioning system imposed on OWF recipients who fail to comply with the requirements of the program as specified in their SSC. Despite State sanction policies, each County maintains much discretion over defining the circumstances of non-compliance that are specified within each individual SSC. In fact, most Counties view sanctions as a last option, often employing other techniques such as home visits and intensive case management/staffing before sanctioning. If these methods are ineffective or a client refuses to participate in AOD treatment, then the County has the authority to sanction the individual. According to the State, the first incidence of non-compliance

results in a full-family sanction for either one month or until the client becomes compliant, whichever is longer. The second incidence results in a full-family sanction for three or more months, while a third incidence results in a full-family sanction for six or more months. State law, however, requires that before a sanction is implemented, the TANF caseworker must send a letter to the client's home to inform the client of the sanction. Before the sanction is implemented, the client is given 10 days to request a face to face meeting with the caseworker to explain their reasons for non-compliance and fulfill the requirements of their self-sufficiency contract.

Most Counties view sanctions as a last option, often employing other techniques such as home visits and intensive case management/staffing before sanctioning.

In Marion County, OWF recipients may be sanctioned for a refusal to comply with their AOD assessment or treatment requirements. However, clients are given ample opportunity to come into compliance with their requirements prior to being sanctioned. The County takes the following steps prior to the enforcement of a sanction policy:

In Marion County, OWF recipients may be sanctioned for a refusal to comply with their AOD assessment or treatment requirements.

- The Counseling Center advises the recipient of the possibility of a sanction
- The CDHS sends a person to the client's home to inform the client that s/he will be sanctioned
- The sanction is announced through a formal letter or other correspondence.

Once the sanction is announced, however, clients are given 15 days to establish good cause and prevent the sanction from being enforced.

In Montgomery County the Crisis Care Center Coordinator is responsible for monitoring the client's participation in treatment. The treatment provider works with the TANF case manager to ensure participation and compliance with the treatment program. The County TANF agency, the treatment provider and the Crisis Care Center obtain consent forms from the client to share this information with each other. Clients who fail to comply with their treatment requirements are sanctioned accordingly. In Marion County, the Montgomery County DHS gives clients ample opportunity to come into compliance with their requirements prior to being sanctioned, including sending a case manager to the client's home to advise the client of the implementation of the sanction.

Funding Streams for AOD Services

As previously stated, ODHS also administers the State's Medicaid program that provides for the health care benefits of the State's indigent population. Substance abuse coverage is provided in the State's 88 Counties through the State's Medicaid fee-for-service system, as well as through managed care programs in select Counties. In a collaborative effort between ODHS and the Ohio Department of Alcohol and Drug Addiction Services (ODADAS), the two agencies share administrative responsibility for substance abuse coverage in the State. Reimbursement for services under the managed care program occur on a capitated payment model by which providers receive a per member per month fee. Counties that do not have an HMO system of health care can also make inpatient detoxification and outpatient alcohol and drug services available to their population. These services are deliv-

ered by private providers who contract with the individual Counties for the provision of services on a fee-for-service basis, paid by Medicaid for Medicaid-eligible clients or on a sliding fee scale for non Medicaid-eligible clients.

In addition to services provided through Medicaid managed care, the ODADAS administers the State's community Medicaid AOD program on a fee-for-service basis (see Exhibit A-II in Appendix A for FY2000 rates). The community Medicaid program is a statewide program that provides the following alcohol and drug treatment services:

- Alcohol and/or drug urinalysis screening
- Assessment
- Case management
- Group counseling
- Individual counseling
- Crisis intervention
- Intensive outpatient treatment
- Methadone maintenance
- Ambulatory medical and social detoxification
- Medical/somatic services

In 1999, the State received approximately $65 million from the Substance Abuse Prevention and Treatment Block Grant for the provision of substance abuse services. Approximately $12.5 million of these funds are utilized to support the provision of substance abuse prevention and treatment services for women.[96] In addition, ODADAS is currently implementing an early intervention program for women which includes group counseling designed to help them feel free to talk about issues, such as family, child, marital, AOD, and domestic violence issues, and to help them overcome their fears about discussing such matters. The agency also funds a toll-free hotline available to help clients with AOD concerns or public assistance questions. According to the agency, the hotline is heavily utilized and considered very effective at disseminating information.

Through its Memorandum to the County Commissioners, ODHS and ODADAS identified a menu of AOD services that Counties could purchase with local TANF funds. In Marion County, the CDHS utilizes TANF funds to provide the following AOD services:

- Wrap-around services (e.g., child care, transportation)
- Training to agency staff on AOD issues
- Training to agency staff on screening and assessment
- Salary for staff who conduct screening and testing
- Work readiness and vocational services
- Prevention services
- Mentoring
- Outreach

TANF funds were also utilized to support the various employment preparation and mentoring activities available through the Marion County Counseling Center. For example, through its contract with the Counseling Center, the County Department of Human Services provided $47,800 in TANF funds and the ADAMH Board provided administrative and financial support in a cash match

TANF funds were also utilized to support the various employment preparation and mentoring activities available through the Marion County Counseling Center.

[96] There are currently 94 gender-specific prevention and treatment programs in the State.

of $15,000 for the development of the Promoting Recovery and Employment Project. Also, the Marion County DHS provided $69,000 to the Counseling Center for the provision of vocational services for TANF recipients through the Employee Assistance Program. The Marion County DHS also provided the Counseling Center with $181,000 for the provision of mentoring services through the Job Assistance and Mentoring Program. In addition to these services, TANF clients receive the following substance abuse treatment services from the Marion County Counseling Center, paid for by the State's Medicaid program on a fee-for-service basis, and the ADAMH Board:

- Assessment
- Group counseling
- Crisis intervention
- Case management
- Individual counseling
- Intensive outpatient services.

Evaluation Efforts/Performance Measurements

Approximately a year ago, Marion County conducted a county-wide assessment to determine the extent of AOD abuse among its population. This assessment, however, was not specific to the TANF population and thus, the County is not fully aware of the magnitude of substance abuse problems among TANF recipients. Nevertheless, based on caseworkers' feedback about their interactions with clients, the County estimates that approximately 50 percent of the TANF population is chemically dependent. Part of the difficulty in determining the extent of AOD problems among the welfare population is that the County Department of Human Services does not have an automated system that can track client's entry into and exit from treatment. For example, the current client level data system cannot differentiate TANF clients with AOD problems from other clients. Without a system to track TANF clients who enter substance abuse treatment, it is difficult for agencies to determine the extent of substance abuse as a barrier to employment. Similar to other States, Ohio is investing in a new system that will track mental health and AOD clients by facility, services, and costs.

Through its contracts with the Marion County Counseling Center, the Marion County DHS has clearly established outcome and performance measures to determine the success of each individual initiative in assisting the hard-to-serve population of TANF clients achieve self-sufficiency. Outcome measures include the number of persons referred who are working after 90 days and at the end of six months, the hourly rate of salaries, fringe benefits, and any changes/increases obtained in salary and benefits, and consumer and employer satisfaction surveys.

Part of the difficulty in determining the extent of AOD problems among the welfare population is that the County Department of Human Services does not have an automated system that can track client's entry and exit into treatment.

Effective Service Integration

Recognizing that a work-oriented approach to welfare would need to actively address substance abuse issues among the welfare population, Oregon became one of the first States to incorporate such initiatives into its welfare program through Federal waivers. The first Federal waiver, granted in July 1992, allowed the Adult and Family Services (AFS) Division of the Department of Human Services[97] to implement specific policies to remove clients' barriers to self-sufficiency. Among other policies,[98] the waiver also required Aid to Families with Dependent Children (AFDC) participants to engage in drug, alcohol, or mental health treatment services when these issues were identified as barriers to employment. Prior to PRWORA, TANF agencies could not place these requirements on AFDC participants unless authorized by a Federal waiver.

In March 1996, Oregon was granted another set of waivers by the Federal government known as the **Oregon Option** waivers, incorporating many of the provisions established under the 1992 waiver. The Oregon Option waivers, which remain effective through June 2003, further emphasized the State's work-first approach by establishing mandatory participation in self-sufficiency activities, reducing time limits, creating progressive sanctions for non-compliance and providing for subsidized employment, support services, and extended child care assistance. Combined, these waivers made non-compliance with substance abuse treatment a statewide sanctionable offense. With the passage of PRWORA in 1996, Oregon rolled these waivers into its Temporary Assistance for Needy Families (TANF) plan, allowing the State to continue to implement its substance abuse policies and practices. In addition, the State received Welfare-to-Work formula funds that have been blended with TANF funds to provide employment and training programs to TANF recipients.

The Oregon Option waivers made non-compliance with substance abuse treatment a statewide. sanctionable offense.

Oregon's TANF plan, which became effective October 1996, is based on the assumption that all adults receiving TANF cash benefits will participate in employment and self-sufficiency services through the **Job Opportunity and Basic Skills (JOBS)** program. The JOBS program provides employment preparation, training and placement services, and may also place individuals currently receiving welfare, Food Stamps, or Unemployment Insurance into newly created positions in public and private businesses. Work activities available under the JOBS program include:

- Life and job skills training
- Work-site training
- Mental health and substance abuse treatment
- Education
- Job search
- Support services.

The State stresses integration and local flexibility, evident in the design and operation of Oregon's Department of Human Services (DHS). The Department houses ten offices and/or divisions,[99] three of which play important roles in the provision of substance abuse services to the TANF population. Among these Offices/Divisions are the Adult and Family Services Division (AFS), which administers the TANF program, the Office of Alcohol and Drug Abuse Programs (OADAP) which administers alcohol and drug treatment programs, and the Office of Medical Assistance Programs (OMAP), which administers the Medicaid component of the Oregon Health Plan. This organizational structure allows the

[97] AFS is the administering agency for Oregon's TANF program.

[98] Additional pieces of the waiver included requirements that more clients participate in the JOBS program and that teen parents finish high school.

[99] The Department of Human Services (DHS) consists of the following Offices/Divisions: Adult and Family Services Division, Community Partnership Team, Governor's Advocacy/Ombudsman Office, Health Division, Mental Health and Developmental Disability Services Division, Office of Alcohol and Drug Abuse Programs, Office of Medical Assistance Programs, Senior and Disabled Services Division, State Office for Services to Children and Families and Vocational Rehabilitation Division.

State to overcome many of the challenges inherent in multi-agency collaboration efforts including differences in policies, philosophies, regulations, and funding streams. The State also encourages an integrated service delivery model and supports this model by providing assistance with local level planning, dissemination of information, and staff training on substance abuse issues.

The State also encourages an integrated service delivery model and supports this model by providing assistance with local level planning, dissemination of information, and staff training on substance abuse issues.

AFS and OADAP have a history of collaboration both at the State and local level with regard to development and access to the current treatment provider system. There are 33 OADAP branch offices that have the responsibility of establishing contracts with local treatment providers for referrals/assessments and ensuring the availability of alcohol and other drug (AOD) services. At the state level, AFS has annually contracted with OADAP in the coordination of State and local staff training on alcohol and drug abuse topics. OADAP has designed a substance abuse training program to retrain the State's entire staff to act as service brokers between the welfare and treatment agencies. Specific goals of the training include an increased understanding of alcohol and drug dependency, an ability to identify problems and to make referrals to appropriate resources, improved skills for intervening when and where appropriate, and encouraging the establishment of local interagency networks. Training has focused on the following topics:

- Behavioral and physical indicators of substance abuse
- Basic screening and referral to treatment providers
- Development of self-sufficiency plans and client interaction.

As previously noted, OMAP, the State Medicaid office, is also located within DHS. Through the Oregon Health Plan (OHP), OMAP manages the provision of medical and dental services for public assistance and low-income Oregonian residents. The U.S. Department of Health and Human Services first approved section 1115 waivers for a five year Oregon Health Plan Demonstration beginning February 1994. The project includes three key features: 1) expanded eligibility; 2) prioritization of health care benefits; and 3) managed care. The waivers also allowed mental health and chemical dependency services to be included in the demonstration's benefit package, with the stipulation that the services provided be defined as medical services. On March 31, 1998, Oregon was granted a three-year extension of the State's demonstration authority, which permits the project to continue through January 2002.[100]

At the local level, the presence of these three agencies is often felt at each TANF branch office, where initial AOD screening, medical and TANF benefits, and employment services are integrated and provided at the same time. For example, eligibility for both TANF and Medicaid is determined by caseworkers in the TANF office. Additionally, AOD screenings and assessments are often conducted by treatment provider staff located on-site at the TANF office. Given the flexibility of the State plan, each area has the opportunity to develop programs and establish agency relations at the local level to address the issue of substance abuse. For example, three AFS branches in Linn and Benton Counties have established "Step Up" teams to work with welfare clients who have serious barriers to employment, such

At the local level, the presence of these three agencies is often felt at each TANF branch office, where initial AOD screening, medical and TANF benefits, and employment services are integrated and provided at the same time.

[100] Source: Oregon Statewide Health Reform Demonstration Fact Sheet, Health Care Financing Administration. Available at http://www.hcfa.gov/medicaid/orfact.htm.

as drug and alcohol abuse. Each branch has a team comprised of AFS staff and County mental health and substance abuse experts. The program focuses on the early identification of barriers to employment and direct assistance or the coordination of community resources to overcome these barriers. The program also provides intensive case management and support services to increase the client's ability to cope with the everyday requirements of working life.

To further encourage coordination, the State created the Community Partnership Team (CPT) within DHS, to help forge partnerships among State and local government, non-profit groups, neighborhoods, schools, and local partners. CPT works to achieve DHS's goals and outcomes, including the reduction of alcohol and drug abuse and increasing access to health care, by integrating the work of both State and community partners. The Team's efforts revolve around three program areas: service integration, volunteer services, and life-span respite care. The Service Integration Program supports DHS's work to integrate human services with schools, County governments, Tribes, non-profits and other partners. Currently, DHS operates nearly 40 service integration projects in 34 Oregon Counties. Each project blends service integration, community involvement, resource development and direct service strategies to accomplish its goals. CPT staff provide technical assistance, training, information, facilitation and other resources to assist local partnerships.

AOD Screening, Assessment and Testing Protocols

One of the key aspects of Oregon's TANF program is the devolution of program design and operation to the local level. Although the JOBS program is State-administered through the AFS Division of DHS,[101] each individual District is responsible for developing local policies and procedures. Currently, there are no State mandates requiring local offices to screen TANF recipients for substance abuse. However, recognizing the importance of screening, more than half of the 15 Districts have incorporated screening into the welfare assistance application process, with the remaining Districts conducting alcohol and other drug screenings on an "as needed" basis. Similarly, while the State has not established the utilization of any specific screening instrument or tool, the majority of Districts utilize the SASSI screening tool.

Recognizing the importance of screening, more than half of the fifteen Districts have incorporated screening into the welfare assistance application process, with the remaining Districts conducting alcohol and other drug screenings on an "as needed" basis.

In the Springfield/Eugene District there are five local TANF offices that have developed their own system for identifying AOD problems among TANF clients. In the majority of these offices, the screening is conducted at eligibility by the TANF caseworker using the SASSI instrument. In some offices, however, TANF staff choose to take a more behavioral approach to screening. This strategy is typically employed with clients who have been in and out of assistance and are not considered long-term TANF recipients. In such instances, the caseworker develops certain impressions based on interactions with the client, and may ask the client AOD related questions when the worker believes there is a substance abuse problem. On the other hand, in the Tri-county area of Salem, which includes Marion, Polk, and Yamhill Counties, AOD screening is conducted on a more individual basis. For example, both new and on-going clients are monitored by TANF caseworkers for any suspicious or abnormal behavior (e.g., not showing up for appointments) and if drug abuse is believed to be a factor, clients are screened. In this particular area, the Counties have an arrangement through the JOBS contract, where a specialist from the County Health Department comes into the TANF

[101]The JOBS program is jointly administered by the State's Employment Department.

office to conduct the screening. The screening consists of a urinalysis[102] and a set of questions similar to the Michigan Alcohol Screening Test (MAST) and the Drug Abuse Screening Test (DAST) (see Appendix E, Exhibits DAST-10 and MAST-VI).

If after conducting the screening a caseworker feels that a client needs further assessment for AOD abuse, the State requires that an in-depth assessment be conducted by a certified substance abuse professional. The State also requires that the substance abuse professional utilize a national set of criteria to determine the appropriate type of treatment for the individual. Currently, all fifteen Districts have a substance abuse professional located on-site, with four of these being full-time assignments. In the Salem area, clients are referred to a treatment provider for a further assessment. During December 1998, there were a total of 18,549 JOBS participants in the State and approximately five percent of these participants were engaged in one or more hours of AOD treatment.[103]

Oregon has not instituted mandatory policies regarding the testing through urinalysis of TANF recipients for AOD abuse. However, such procedures are not prohibited at the local level. Currently, there are five Districts across the State that include AOD testing as a standard component of formal assessment. Generally, the testing is used to serve as baseline information on the client's condition or designated as a condition of employment by area employers. The remaining Districts use testing on a more limited basis.

Though Oregon has established few statewide requirements, there are certain policies that must be incorporated into each of the local TANF plans. One of these statewide policies is the development of an Employment Development Plan (EDP) for each TANF recipient describing the work requirements and strategies for achieving self-sufficiency. If a TANF recipient is assessed as having an AOD problem and treatment is necessary, the State requires that the TANF agency include this in the individual's EDP. Once it is included in the EDP, participation becomes a required work activity and subsequently the recipient may be sanctioned for non-compliance with treatment.

Treatment Compliance and Sanction Practices

According to State policy, clients who fail to comply with the activities prescribed in their EDP, including participation in substance abuse treatment, may receive a reduction in their TANF grant up to the total amount of the grant. The State has established a progressive sanction policy for on-going violations of the requirements set forth in the EDP. Based on this sanction policy, sanctions range from a $50 reduction in case benefits for a first time violation to no TANF eligibility for the whole family unit until the non-cooperating adult demonstrates cooperation by completion of the required JOBS activity.

To discourage the occurrence of sanctioned case closures, the State mandates that each TANF office conduct a community staffing session with the client after the fourth month of non-compliance. The purpose of the session is to resolve any issues, problems, or barriers that may be impeding the client's compliance with the EDP requirements and identify alternative resources for the family. The session includes the client, TANF caseworker, mental health and AOD professional, and representatives from any other agency (e.g., child welfare) involved with the client. Despite these sanction policies, most local areas have some leeway in the application of these sanctions.

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[102] The incorporation of the urinalysis test for AOD screening developed as a result of the working relationship between the local AFS office and local employers for pre-employment screening, testing, and assessment purposes.

[103] Pavetti, L., Kirby, G., Kauff J., & Tapogna, J. (1999). Integrating Alcohol and Drug Treatment into a Work-Oriented Welfare Program: Lessons from Oregon. Washington, D.C.: Mathematica Policy Research, Inc.

Before a recipient is admitted into a treatment program, the recipient signs a consent form to allow for the sharing of information between the TANF agency and the treatment provider. In Oregon, each District/County decides how to monitor compliance with treatment program requirements. Typically, the local AFS office works with the treatment provider to establish a reporting mechanism to monitor both attendance and progress in the treatment program. These relationships are informal with progress often being tracked through provider reports, attendance reports, case staffings, communication with the on-site AOD professional or some combination of the four.[104] In addition, individual Districts may, and often do, monitor participant outcomes for those involved in substance abuse treatment. For example, since 1994, Lane District has set outcomes for all JOBS activities, including mental health and alcohol and drug treatment. The following outcomes, which include both qualitative and quantitative measures, were developed by representative groups and are collected each quarter:

The local AFS office works with the treatment provider to establish a reporting mechanism to monitor both attendance and progress in the treatment program.

- Number of JOBS clients participating in and successfully completing either mental heath or alcohol and other drug activity
- Number of clients who successfully completed treatment and show positive outcomes.[105]

Funding Streams for AOD Services

Nearly all of the services provided under the OHP are delivered through a managed care system, which uses a combination of fully capitated health plans (FCHPs) and partial-service prepaid health plans, such as physician care organizations, dental care organizations, mental health organizations, and primary care case managers. Oregon utilizes a combination of both Federal and State funds (40 to 60%) to pay for the medical treatment services covered under Medicaid, with specific capitation rates varying by location and risk factors associated with an area's client composition.[106] In addition, the State's managed care system is based on a prioritized list of medical conditions and treatments. The Oregon Health Plan places chemical dependency conditions in the top quarter of this priority list, thus ensuring the availability of funding for chemical dependency services. Since implementation of this system in 1994, the State has reduced waiting lists for AOD treatment 85 percent.[107] Currently, OMAP is working with OADAP to complete a study examining the medical cost saving of patients that complete substance abuse treatment programs.

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[104] Pavetti, L., Kirby, G., Kauff J., & Tapogna, J. (1999). Integrating Alcohol and Drug Treatment into a Work-Oriented Welfare Program: Lessons from Oregon. Washington, D.C.: Mathematica Policy Research, Inc.

[105] These outcomes are defined as "continuing active participation in JOBS placement (whether or not it closes the grant), or grant closure (for reasons other than placement)."

[106] Pavetti, L., Kirby, G., Kauff J., & Tapogna, J. (1999). Integrating Alcohol and Drug Treatment into a Work-Oriented Welfare Program: Lessons from Oregon. Washington, D.C.: Mathematica Policy Research, Inc.

[107] Source: Department of Human Services (DHS), Office of Medical Assistance Fact Sheet. Available at: http://www.hr.state.or.us/dhrinfo/facts-omap.html.

A similar study conducted in February 1996 demonstrated a savings of up to $5.62 per every dollar spent on treatment.[108]

In addition to the health services provided through the OHP, each of the fifteen Districts across the State receives one portion of State funding to design their own TANF program and provide the necessary services.

In addition to the health services provided through the OHP, each of the 15 Districts across the State receives State funding to design their own TANF program and provide the necessary services. The only State requirements placed on Districts is that the services provided through the TANF program provide the necessary components of the State JOBS Plan and emphasize work attachment. Because the OHP provides funding for most alcohol and drug treatment, Districts use the allocated funds to provide a variety of substance abuse support services. The following chart describes the types of substance abuse services that are typically paid for with either TANF or Welfare-to-Work (WtW) funds.[109]

Exhibit XVIII
Substance Abuse Services Funded by TANF and WtW

Services Paid for with TANF funds	Services Paid for with WtW funds
■ On-site mental health & substance abuse professionals ■ Wrap-around services ■ Client monitoring ■ Staff training on drug screening, assessment & testing	■ Case management ■ Work readiness ■ Vocational services ■ AOD prevention for teen parents & non-parenting teens

Currently, all the local TANF offices provide non-medical substance abuse services to the TANF community using one of two mechanisms. The first of these consists of a direct arrangement between the AFS office and local substance abuse treatment providers. These arrangements are currently paid for through the reinvestment of TANF funds—funds unused as a result of reduced caseloads.[110] The second allows local TANF offices to utilize the TANF funds to arrange for either full-time staff hires through their prime contractor or to subcontract with local treatment providers to have staff on-site for the provision of AOD assessment and referral for treatment services.

Evaluation Efforts/Performance Measurement

Based on a 1997 Oregon DHS client characteristics report, an estimated 50 percent of the State's remaining welfare caseload admitted having alcohol and/or drug-related issues.[111] While this does not mean that half of the welfare population is in need of intensive substance abuse treatment, it emphasizes the importance of making these services available to the TANF population. According to the latest data reported by AFS, between July and October of 1999, 1,932 TANF recipients received at least one hour of AOD services.

[108] Office of Alcohol and Drug Abuse Programs (OADAP) Web site: http://www.oadap.hr.state.or.us/societal.html
[109] Oregon chose not to establish a separate Welfare-to-Work program and instead integrated the funds into their JOBS program. Therefore, the funds are used alternatively to provide support services to all eligible TANF recipients.
[110] The Options waiver also allowed the State to retain and reinvest some of the Federal savings from its caseload reductions, which normally would be returned to the Federal government.
[111] Pavetti, L., Kirby, G., Kauff, J., & Tapogna, J. (1999). Integrating Alcohol and Drug Treatment into a Work-Oriented Welfare Program: Lessons from Oregon. Mathematica Policy Research, Inc.

Furthermore, AFS estimates that, on a monthly basis, approximately 1,100 clients (about five percent of the TANF population) receive AOD services as part of their JOBS plan.

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To effectively support State agencies in their efforts to serve individuals affected by alcohol and drug use, OADAP currently collects data on clients at admission and discharge from treatment for alcohol and other drug abuse problems. The client data is collected through the Client Process Monitoring System (CPMS) which was first initiated in 1982. CPMS collects information on all clients admitted to emergency non-hospital detoxification services, two levels of residential treatment (conventional and intensive) for adults, specialized residential treatment for women and pregnant women and youth, and outpatient services including methadone maintenance. The CPMS database allows both providers and OADAP to:

- Profile the clients entering treatment in terms of client demographics and characteristics
- Provide information regarding the primary substance(s) used, degree of impairment, and the usual route of administration
- Provide information concerning the treatment services utilized by clients currently and in the past and the clients' characteristics
- Provide information regarding the "outcome" of treatment and reason(s) for discharge
- Provide performance indicators measuring the clients' improvement from the time of admission to discharge.

These performance measures are used not only to assess a client's improvement but also to assess the specific treatment provider's program. Oregon was one of the first States to implement a performance indicator data analysis process that includes specific performance objectives in every treatment provider contract. The performance indicators provide a quantifiable measure of performance and a method of tracking trends in treatment provider performance over time. The performance indicator data analysis system involves a series of specific, measurable indicators,[112] established by service element (e.g. adult, youth, or women-specific), in an effort to assure the quality of alcohol and drug abuse treatment services. For example, each contractor/provider receives a quarterly report detailing their performance against a minimum standard, as well as a comparison of their performance to current statewide performance averages for the reporting period. Providers are required to perform above the minimum standard on more than half of the indicators during each quarter. Providers that fail to meet the minimum required standards are obligated to create an action plan that details the specific steps they will take to improve performance. Furthermore, if providers fail to meet the requirements for three consecutive quarters, OADAP has the authority to re-allocate the resources to other programs.

Oregon was one of the first States to implement a performance indicator data analysis process that includes specific performance objectives in every treatment provider contract.

[112] See the Appendix D for a list of performance indicators collected through the CPMS.

Effective Service Integration

Utah implemented its TANF program, the **Family Employment Program (FEP*)*, on September 1996, including both the TANF provisions incorporated by the State, as well as two former waiver demonstration projects. Among these waivers[113] is the Single Parent Employment Demonstration (SPED) Project implemented in 1993. As a result of the SPED, the State can require participation in substance abuse treatment as a condition of public assistance receipt for those clients identified as having a substance abuse problem. The FEP or State TANF program is State-administered by the Department of Workforce Services (DWS). The DWS was created in 1997 to consolidate all job placement, job training, and welfare into one integrated service delivery system.[114] While the program is State-administered, the State recognizes the importance of local flexibility in program operation. As a result, the FEP is administered through five State regions and implemented by Employment Centers[115] in those regions. The decision to implement the FEP through the Employment Centers goes hand in hand with the program's emphasis on self-sufficiency through employment placement.

As the administering agency of the State's TANF program, the DWS has worked to establish collaboration and linkages between State and local agencies. For example, a representative from the Division of Substance Abuse (DSA), Department of Human Services (DHS),[116] serves on the "long-term TANF extension committee." This committee has been charged with determining whether alcohol and other drug (AOD) abuse can serve as a disability for TANF recipients, allowing the extension of TANF benefits beyond the 36-month time limit. As a result of the committee's work, clients with substance abuse problems can receive an extension on their time limit if they are participating in substance abuse treatment and substance abuse impedes their participation in employment. The DSA also made recommendations to the DWS on the use of AOD screening instruments to be used with TANF recipients and provided training to Workforce Services staff on the administration of the screening tool, as well as training on confidentiality issues.[117] The agencies work together on ways to provide and coordinate the provision of services for TANF clients.

As a result of the committee's work, clients with substance abuse problems can receive an extension on their time limit if they are participating in substance abuse treatment and substance abuse impedes their participation in employment.

DWS also coordinates with a Steering Committee at the State level and the Families and Agencies and Communities Together (FACT) Local Interagency Councils that work to bring together non-profit and private entities to take a more holistic approach to serving families. FACT identifies children in the school system with problems (e.g., behavior, schoolwork, and emotional problems), and then teams of staff from Division of Child Services, DSS and DWS coordinate to identify and provide eligible services for the entire family. Among the services provided to families through the FACT are substance abuse prevention and treatment services and domestic violence services. For example, in the St. George area, the Southwest Mental Health, a member of a five-County Interagency Council,[118] provides individual and group counseling, intensive outpatient services, and residential treatment services to families identified by the FACT. The provision of substance abuse related services are funded through the State Division of Substance Abuse and the State's Medicaid program on a fee-for-service

[113] The State also integrated the Employment Assistance to Utah Families (EAUF) Act, passed in the 1996 State legislative session.

[114] The agencies and programs brought into the Department of Workforce Services include: Office of Family Support, the Department of Employment Security, the Office of Child Care, the Office of Job Training, and the Turning Point Program which served displaced homemakers.

[115] The Department of Labor (DOL) awarded Utah a One-Stop Implementation Grant to create a comprehensive one-stop system. Through this grant, 48 Employment Centers are created where customers can access jobs and obtain support services.

[116] The Department of Human Services (DHS) houses the following Divisions: Aging and Adult Services, Child and Family Services, Mental Health, Substance Abuse, and Youth Corrections.

[117] The DSS recommended the use of the CAGE screening tool for TANF recipients with substance abuse problems. This recomendation has not been implemented statewide.

[118] The Counties represented in the Interagency Council include Washington, Iron, Garfield, Kane, and Beaver Counties.

basis. While the FACT is not specific to TANF families, a large number of families served are TANF recipients, and are therefore able to benefit from the services provided.

In addition to administering the State's TANF program, DWS and the Department of Health have responsibility for the administration of the State's Medicaid program. The Medicaid agency contracts with managed health care organizations to provide medical and mental health services to Medicaid eligible clients. Medicaid typically pays a monthly fee for each Medicaid client enrolled in a health maintenance organization (HMO) and/or Prepaid Mental Health Plan (PMHP). In turn, each plan is responsible for all health care services specified in the contract for Medicaid clients enrolled in that plan.

AOD Screening, Assessment, and Testing Protocols

Currently, Utah does not have statewide policies for screening TANF applicants for alcohol and drug abuse. The State is currently developing statewide policies requiring all Counties to utilize the CAGE screening tool to screen all TANF clients for substance abuse problems. The State is beginning training programs for all employment counselors on the utilization of the CAGE. Currently, TANF clients with substance abuse problems may choose to self-disclose this information to a TANF case manager or employment counselor. Additionally, if an employment counselor suspects that a client has a substance abuse problem, the employment counselor may ask the client about the problem. For example, in Salt Lake County, the TANF agency utilizes a locally devised assessment interview guide, administered by the employment counselor that asks clients to report or identify whether they have an AOD problem. On the other hand, in the St. George area, the TANF agency does not utilize a specific instrument but allows the client to self-disclose substance abuse problems. In addition, TANF recipients can be asked questions about their AOD problems after 12 and 18 months of receiving assistance and at any other point in time when they meet with the employment counselor.

Although the State has not implemented statewide policies to identify substance problems among TANF recipients, the State has implemented policies to address substance abuse as a barrier to employment by referring TANF recipients to assessment and treatment services. If a client discloses an AOD problem, or if the problem is obvious to the employment counselor, the client is referred to a social worker from the State Department of Mental Health, located within DWS, for further assessment.[119] In the Salt Lake County area, clients can be referred to a social worker within the TANF agency or to a social worker at a treatment provider facility. If it is the first time the client is identified as having AOD problems, the client is referred to a social worker within the agency. To facilitate this process and ensure the provision of assessment services, the TANF agency has entered into a contractual agreement with Valley Mental Health to provide TANF clients with substance abuse assessment and referral to treatment services.[120] The social worker conducts a clinical assessment and gives feedback to the TANF agency on the client's assessment. On the other hand, if the client has had AOD problems in the past and has undergone treatment, the client is referred to a treatment facility for further assessment and treatment services. Similarly, the social worker in the St. George area TANF agency conducts

To facilitate this process and ensure the provision of assessment services, the TANF agency has entered into a contractual agreement with Valley Mental

[119] A client may also be referred for further assessment when an employer notes poor job performance on the part of the client.

[120] Valley Mental Health also provides mental health assessment and referral to treatment, as well as intensive employment-related case management services for long-term TANF recipients.

an initial assessment with the client and based on need, the client is referred to the County Mental Health agency for appropriate treatment services. In Utah, credentialed substance abuse treatment providers utilize the Addiction Severity Index (ASI) as the standard tool to assess clients' substance abuse problems.

When an employment counselor believes that a client has a substance abuse problem, either because the client self-identified or as a result of the client's behavior, the referral for further assessment is included in the client's employment plan. Similarly, if the assessment reveals an AOD problem, the referral to treatment is also included in the individual's employment plan. In December 1999, the State's caseload totaled 6,200 and approximately 98 TANF recipients were participating in substance abuse treatment services. As a result of its Federal waiver, the State can count a client's participation in substance abuse treatment as a valid work activity, when participation in treatment is included in the client's employment plan.[121] To ensure the sharing of information between the TANF agency and the treatment provider, clients must sign a consent form allowing the TANF agency to contact and obtain information from the treatment provider about the client's participation in treatment.

To ensure the sharing of information between the TANF agency and the treatment provider, clients must sign a consent form allowing the TANF agency to contact and obtain information from the treatment provider about the client's participation in treatment.

Treatment Compliance and Sanction Practices

Utah has established a statewide system for monitoring the compliance of TANF clients engaged in substance abuse treatment. In general, the substance abuse treatment program monitors the client's compliance with treatment. The social worker becomes the point of contact between the local TANF agency, and the treatment provider, and works toward streamlining the services provided to the client. Because a large number of clients with substance abuse problems are also involved with the criminal justice system, participation in treatment may be a probation requirement, and as a result, compliance with treatment is also monitored in coordination with the probation counselor. In addition, the State has chosen to provide TANF benefits to those clients convicted of a drug felony offense. Because participation in substance abuse treatment becomes part of the client's employment plan and treatment is considered a valid work activity, non-compliance with treatment is a sanctionable offense tied to the State's sanction policies.

Because participation in substance abuse treatment becomes part of the client's employment plan and treatment is considered a valid work activity, non-compliance with treatment is a sanctionable offense tied to the State's sanction policies.

The sanctioning process in the state of Utah is a three-part conciliation process designed to assess the client's barriers for non-participation with the requirements outlined in his/her employment plan. The first incidence of non-compliance[122] results in a "problem solving" session between the employment counselor and the client. The goal of the session is to revisit the employment plan and determine what barriers are causing the client's non-compliance. If the employment counselor feels that the reasons for non-compliance are not acceptable, the next step is to conduct a "case staffing." The case staffing brings together the TANF client, TANF employment counselor, other case managers and supervisors, and any additional

[121] States may allow substance abuse treatment to count as a work activity for the State requirements without a Federal waiver.
[122] For clients participating in substance abuse treatment, the treatment agency defines non-compliance with treatment.

staff working with the client to conduct a more intensive "problem solving" session in an effort to resolve the client's issues.

Funding for AOD Services

In Utah, substance abuse services are provided by local County government with administrative oversight and monitoring conducted by the Department of Human Services through the Division of Substance Abuse. All local substance abuse authorities are required to plan and provide a full continuum of substance abuse services, based on the needs of each locality, that include substance abuse prevention, intervention, and treatment services. Under State law, all local County governments were given the option to operate substance abuse service programs as single County entities or to band together in multi-County organizations referred to as service Districts. There are currently thirteen local substance abuse authority Districts operating a statewide system of care for all Utah citizens.

In conjunction with County authorities, each County approves their service providers. In turn, those service providers furnish services through the State's managed care program or bill Medicaid for the services rendered (see Exhibit A-III in Appendix A for applicable fees). For physical health, a Medicaid-eligible resident can enroll in a health maintenance organization (HMO) or join the case management program, known as the primary care physician plan.[123] For mental health services, Medicaid clients receive care through the Prepaid Mental Health Plan (PMHP), which in some Counties is the community mental health center that has contracted with the Medicaid agency for the provision of mental health services. Utah's Medicaid program carves out substance abuse services from both physical and mental health Medicaid managed care programs. The physical health program covers inpatient detoxification, but all other substance abuse services are reimbursed on a fee-for-service basis. Therefore, persons who require substance abuse services can receive those services from substance abuse providers who are paid by Medicaid on a fee-for-service basis. The State's Medicaid program covers substance abuse services on a fee-for-service basis as detailed in Exhibit XIX.

Exhibit XIX
Medicaid Reimbursable Substance Abuse Services

■ Diagnostic evaluation	■ Individual behavior management
■ Psychological testing	■ Group behavior management
■ Individual therapy	■ Individual skills development
■ Group therapy	■ Group skills development
■ Psychiatric evaluation and medication management	■ Targeted case management

Based on the specific needs of the TANF population, a number of treatment providers have altered their treatment protocols to include life skills training, job readiness, vocational rehabilitation services, expanded daycare, transportation, on-site dependent care, and joint case management services. For this population, Medicaid pays for the treatment services, but the State utilizes funding from the Substance Abuse Prevention and Treatment Block Grant to pay for these patients' room and board. In 1999, Utah received approximately $14 million in funding from the Substance Abuse Prevention and Treatment Block Grant.

Counties also utilize TANF funds for the provision of substance abuse services to TANF recipients. For example, TANF funds are utilized to pay for a number of AOD services including:

[123] Each Medicaid client is assigned to a primary physician or provider. Clients who require services by other providers must obtain a referral from his/her primary physician or provider before Medicaid will pay for medical services rendered.

- AOD assessment
- AOD testing
- AOD case management
- AOD treatment[124]
- Referral and information
- Wrap around services (e.g., transportation and child care)
- Training for agency staff on AOD assessment
- Work readiness and vocational services for all AOD recipients.

A number of TANF agencies also contract with AOD treatment providers to provide TANF recipients participating in substance abuse treatment with job development, job skills training, and job coaching.

Evaluation Efforts/Performance Measurements

Utah is one of 19 States currently participating in the Treatment Outcome and Performance Pilot Studies Enhancement (TOPPS II) sponsored by the Center for Substance Abuse Treatment (CSAT), Substance Abuse and Mental Health Administration (SAMHSA). The goal of the initiative is to enable Single State Authorities (SSAs) to collect information on Substance Abuse Prevention and Treatment Block Grant funded treatment services and to monitor common substance abuse treatment effectiveness data measures across various State management information systems (MIS). TOPPS II will help States develop or enhance their MIS and outcome monitoring systems (OMSs) for evaluation of clients as they progress through their State's substance abuse treatment system. In addition, TOPPS II adds a consensus-developed set of common data elements (Core Data Set) for the coordinated measurement of outcomes across all participating States.[125] The State AOD representative noted that Utah's TOPPS II study will also include treatment outcomes related to TANF recipients who participated in substance abuse treatment.

The goal of the initiative is to enable Single State Authorities (SSAs) to collect information on Substance Abuse Prevention and Treatment Block Grant funded treatment services and to monitor common substance abuse treatment effectiveness data measures across various State management information systems (MIS).

According to statistics provided by the State AOD representative, seven percent of persons admitted into treatment indicate, upon admission, that welfare is a primary source of income. Also, a recent study[126] conducted by the University of Utah found that 39.7 percent of long term TANF recipients[127] reported alcohol and/or drug abuse as barrier to employment. This study is of particular interest to the State TANF agency, as well as the State legislature, in gaining insights into the number of TANF clients with substance abuse problems and the potential of these TANF families running up against their life time limit on assistance.[128]

[124] The St. Lake County area contracts with Valley Mental Health for the provision of substance abuse treatment for TANF recipients.
[125] Source: Treatment Outcomes and Performance Pilot Studies Enhancement (TOPPS II). State Division of Substance Abuse Web site: http://www.hsdsa.state.ut.us/TOPPS_II_Page.htm.
[126] Understanding Families with Multiple Barriers to Self Sufficiency. Social Research Institute, University of Utah. February 1999.
[127] In this study, long term TANF recipients were defined as those receiving assistance for three or more years. In addition, the 39.7 percent is a cumulative percentage of both reported alcohol (20.1%) and drug abuse (19.6%).
[128] A large number of TANF clients hit their 36-month life time limit on assistance by December 31, 1999.

KEY LEARNINGS AND ONGOING CHALLENGES

There has been much debate and discussion on the national level regarding the prevalence of alcohol and drug (AOD) problems among the welfare population. As previously discussed, estimates of the problem, based on national and State studies, have ranged from 5 percent-60 percent. Yet, three years into welfare reform, there is little clarity about the severity of the AOD problem among TANF clients. States and Counties have hesitated to invest in comprehensive needs assessments to document the extent of the AOD problem among its TANF population. This case study provides insights about the challenges to appropriately identifying TANF clients with AOD problems, the difficulty of referring them into treatment, and keeping these clients engaged in treatment. Based on the information gathered from these eight States and 24 Counties, we synthesized several key learnings regarding screening tools, screening and assessment protocols and referral policies and procedures being utilized by TANF agencies. Based on these learnings, we identified several ongoing challenges that need to be addressed by national and State policy makers. The following highlights the key learnings and ongoing challenges uncovered in this case study.

KEY LEARNINGS

- **Instituting service integration or interagency collaboration policies on the State level eases the ability of front line workers to work across agencies to provide services to TANF clients with substance abuse problems.**

PRWORA provided significant program flexibility to States, allowing them to design programs to meet the individual needs of their State TANF population. The States in this study have attempted to maximize program flexibility and reengineer their service delivery systems to meet the needs of their TANF families who have alcohol and drug problems. This reengineering or restructuring of services often required co-location of TANF and AOD staff. When the AOD agency and the TANF agency were organized within the same cabinet level department, coordination and communication between these agencies was eased, and services better integrated to meet the needs of these TANF families. Also, when a Memorandum of Understanding (MOU) or an Interagency Agreement (IA) was in place on the State level, collaboration on the front line was apparent through multidisciplinary teamings such as in New Jersey, one-stop center approaches as those implemented in Utah, or the care coordination systems in place in North Carolina and Delaware. Front line staff appeared to be more tolerant of cross-agency goals, and an issue, such as confidentiality, was more easily addressed.

Based on our findings, there was no indication that there was a willingness or desire on the part of the TANF agency for caseworkers to conduct AOD assessments, but in fact, these TANF caseworkers relied heavily on their AOD partners. If a client screened positive for an AOD problem, the TANF caseworker referred the client to a trained AOD clinician for further assessment. The States and Counties in this study utilized different procedures and practices for this referral process. In a number of States/Counties, such as in New Jersey, North Carolina and Colorado, substance abuse professionals were co-located at the TANF office so that they might (1) interpret questionable findings from a screening instrument for the TANF caseworker; and (2) be readily available to conduct further assessment. In some cases, these AOD professionals were State/County employees provided to the TANF agency as a part of an Interagency Agreement or Memorandum of Understanding. In other cases, these AOD professionals were community treatment providers under contract to the TANF agencies. Regardless, the States/Counties in this study indicated that co-location was an important element in keeping the client engaged with the assessment process. Co-location of AOD professionals at TANF offices also allowed for a more collaborative relation-

ship between the agencies to develop, yielding more effective integrated service delivery for the client.

■ Changing the culture of the delivery system requires extensive and ongoing training.

The nation's welfare delivery system that has functioned for at least the last three decades has been replaced with a complex, cross-sector, cross-governmental level, interagency assemblage that reflects more of a welfare reform puzzle than a system. Inherent in this "new system" is a culture change that requires modifications and adjustments in relationships between State agencies, as well as between States and communities and community based organizations, as they work to address the myriad of issues facing TANF families with substance abuse problems. In order to effectively change the culture of the delivery system, States in this case study stressed the importance of investing in ongoing cross training of staff.

The States and localities participating in this case study recognized the importance of staff training for the screening of alcohol and drug dependency. All states have trained their TANF caseworkers regarding the importance of identifying clients with AOD problems, what to look for, and how to administer the designated screening instrument. Often, the State AOD agency took the lead in conducting this training for TANF caseworkers. Sometimes, the County TANF agency contracted with a local treatment provider to do this training. For example, in the Springfield/Eugene office in Oregon, TANF staff have been provided with an extensive three-day training on basic AOD addition, screening instruments and protocols, and referral processes. After staff complete this basic training, these staff engage in a more intensive training, which is provided by the local treatment provider at the treatment site.

The training of TANF caseworkers about substance abuse identification and treatment is a necessary step if States/Counties hope to appropriately identify clients with AOD problems. In most cases, these TANF caseworkers were eligibility workers prior to the implementation of PRWORA. Welfare agencies across the nation have undergone enormous changes in the responsibilities being placed upon welfare workers. These workers have only recently been asked to provide a range of services to the clients—services outside of eligibility that require increased interaction with clients. They have gone from being eligibility clerks to "self-sufficiency workers," "family independence workers," "case managers," and "employment service specialists." These changes in work requirements have placed immense pressures and demands on TANF caseworkers. In addition, most States are "Work First" States meaning that TANF caseworkers are expected to get the TANF client quickly engaged in an employment situation. In order to identify barriers to work, most of these TANF caseworkers are being asked for the first time to talk to clients about personal issues, such as domestic violence, learning disabilities and alcohol and drug problems. It is not surprising that the interaction between worker and client may fail to yield a true indication of AOD problems. Also, there is a stigma associated with addiction which must be addressed in the training programs, so that case workers can recognize their own biases.

Thus, given the recent changes in work responsibilities on the part of the TANF caseworker, it is critical that AOD professionals clearly understand the issues that these workers face. It is important to build relationships between the AOD clinicians and the TANF caseworkers so that the professionals in each agency understand the practices, procedures and concerns of the other. Staff turnover requires to significant level of re-training. Cross-training of these agencies means putting them together in the same room for the same training about how to address the issues of TANF clients with AOD problems—identifi-

cation, referral and treatment protocols. It is important to build relationships between the AOD clinicians and the TANF caseworkers so that the professionals in each agency understand the practices, procedures and concerns of the other, and can appropriately address the AOD needs of TANF families as efficiently as possible.

■ Integrating the Welfare-to-Work entities into a collaborative infrastructure with TANF and AOD partners is necessary.

In addition to the flexibility and resources available under TANF, the Federal government further expanded States' ability to address the specific needs of the hard-to-employ population through the Welfare-to-Work legislation. The primary purpose of the WtW funds is to provide transitional assistance to move the hardest-to-employ TANF recipients into employment. Many WtW entities have struggled with developing effective strategies to identify clients with alcohol and drug problems, and have not been able to build the necessary connections with the alcohol and drug treatment systems in their communities. Not only is there a lack of integration between AOD and WtW in addressing the needs of these families, but in most communities across the nation, and as documented in this case study, the infrastructure connecting local TANF offices and WtW entities (most often Private Industry Councils—PICs or Workforce Development Boards—WDBs) is not yet in place. This lack of service integration significantly damages the ability of the WtW agencies to work meaningfully with TANF families who have AOD problems. Currently, there are limited program models to evaluate, and thus, little understanding about the effectiveness of various WtW strategies that address the needs of TANF families with substance abuse problems.

■ Maximizing the funding flexibility allowed under TANF needs to be implemented.

The case study findings suggest that the most effective method to fund AOD services for TANF families is to coordinate Federal and State funding streams from the various different agencies: TANF Federal funds, State TANF Maintenance of Effort (MOE) funds, WtW funds, Medicaid, Substance Abuse and Treatment Block Grants or other State AOD funds. This funding coordination is only possible if there is a spirit of collaboration between the varying sponsoring agencies. The case study found that States are hesitant to maximize the funding flexibility allowed under TANF, and in fact, States most often turn to Medicaid and Block Grant funds to support treatment services for these TANF recipients. While the States in this case study have begun utilizing TANF funding to support a variety of substance abuse services, such as screening, assessment, case management, transportation, child care, work readiness, and staff training, there is consistent lack of willingness to use TANF funds to expand treatment capacity. For the most part, this reluctance to utilize TANF funds stems from States' lack of knowledge about the flexibility allowed by the TANF program and of the present funding mechanisms to support treatment. These agencies need more information about how flexible TANF money is and how it can be used to support treatment programs for TANF recipients.

■ Developing appropriate tools and protocols to identify clients is critical to program success.

Based on the findings of this cross-State comparative study, there is a commitment in these States to appropriately identify clients with AOD problems. The State and local TANF agencies in this case study are utilizing both formal and informal screening tools and procedures to identify clients with potential AOD problems. Based on information from this case study, screening for AOD was universally conducted at the TANF office by TANF caseworkers, sometimes with results being evaluated by on-site AOD professionals. Each

State/County participant in this case study questioned the appropriateness of the screening instrument that they were using, and expressed frustration with the inconsistency of cross-State policies and findings regarding the "right" instrument and protocol for identifying clients with AOD problems. No instrument has yet been validated for use in a welfare office by a non-AOD clinician.

States and Counties in this case study are clearly committed to addressing the AOD problems of their TANF clients. Although there is no validated and reliable screening instrument, through available instruments and varied protocols, these States/Counties have attempted to identify and refer TANF clients with AOD problems to appropriate support services. They invested TANF funds to build systems and expand services to address this issue. However, the referral rate of TANF clients to treatment remains low, even though there is sufficient evidence to indicate a high percent of clients who remain on welfare have AOD problems.

In this study, drug testing, such as, urinalysis—is not generally utilized as a screening mechanism. These States and Counties primarily relied on five different AOD instruments[129] to identify clients:

- Cage Questionnaire
- Cage-AID Questionnaire
- AUDIT
- DAST-10
- SASSI.

None of these instruments have been validated for use in a welfare office by a non-AOD clinician. Most of these instruments or screening tools are incorporated into an interview package that is used by TANF caseworkers to develop a profile of the TANF family and determine TANF eligibility. Although the SASSI instrument was frequently used by States/Countries, for the most part this tool was simply a mechanism by which to ask clients to self-disclose their AOD problems.

States' experiences have demonstrated that asking clients to self-disclose may not always prove to be successful because clients are often in a state of denial about their own problems, fear loss of their children, have concern that disclosure will negatively impact their financial grant, or even involve them in the criminal court system. As shown in the New Jersey profile, the New Jersey Department of Health conducted a needs assessment in various Counties through the use of a self-report questionnaire and a voluntary hair study. Of the 90 percent who completed the questionnaire and did not disclose an AOD problem, 27 percent tested positively in the hair analysis. This large difference between the self-report and the hair sample analysis is only one example of the discrepancy between self-disclosure and the utilization of formal screening mechanisms in determining the extent of AOD abuse among the TANF population. Thus, it is critical that appropriate screening tools and protocols be developed to identify the specific needs of the TANF population with AOD problems.

- **Crossing critical policy junctures empower States to be more effective at addressing the substance abuse problems of TANF recipients.**

In this case study we discovered that there were several policy junctures at which States could take different paths with varying results for TANF clients with AOD problems.

[129] Explanations of these instruments can be found in Appendix E.

Through sanction policies, TANF caseworkers can encourage clients to get into and stay in treatment. However, these sanction policies are only effective if they are tied in with the TANF client's personal responsibility contract.[130] Once clients have screened positive for AOD problems, several States/Counties have utilized the personal responsibility contract to link their cash assistance to fulfillment of the assessment or treatment requirement. If treatment is defined as an eligible "work activity" in a personal responsibility contract, then TANF caseworkers and their AOD partners have a mechanism by which to mandate client participation in treatment, or the client loses his/her cash benefits. If the State/County has a full-family sanction[131] then all cash benefits are terminated. If cash assistance is completely terminated, or even if the adult is removed from the cash grant, the family must make due on food stamps and other support services. Although this might be an effective "stick" for the TANF/AOD agencies, there are probable negative impacts for the TANF family—launching the children in the family even deeper into poverty.

In this case study, particularly at the County level, there is real reluctance to sanction a family. In fact, in most instances, caseworkers and their AOD partners would form case management teams, conduct home visits and team staffings to work with the family so that the client would be in compliance. Unfortunately, it is more likely that the client "self-excludes" him/herself from the TANF system. The client refuses to comply with treatment requirements, forfeits their cash grant assistance, and "falls out" of the TANF caseload. Often, once these families "fall out" of the TANF caseload, it is also likely that they do not utilize other support systems, such as food stamps, Medicaid, child care, etc. Thus, it is critical that States and Counties consider maximizing the use of the personal responsibility contracts to engage the client in treatment and to assist the entire family in getting the necessary support services to stay as an intact family and move towards self-sufficiency.

■ Creating measures and benchmarks to determine program success and effectively track results is crucial.

Welfare reform has been called the "Devolution Revolution" emphasizing the fact that welfare policy has been devolved to the State level from the Federal level, and in most cases, decisions about welfare policy implementation is devolved to the County and community level. Thus, this devolution has resulted in extremely diverse practices on the local level, even in State administered States. This diversity in policy and practice, though arguably a good thing because it reflects local needs, is difficult to track.

There is a dearth of information about what "works." Most States/Counties are not tracking individual outcome data. Management information systems, which allow for monitoring successes or failures of program approaches, are not in place. States in this case study were hesitant to discuss what was really working at the front-line because of the allowed flexibility and local control of policy implementation, and the lack of any data on which to buttress their position. States in this study are only beginning to launch evaluation efforts, but given the complexity of the network that needs to be monitored, most of these efforts are limited. Given the diversity of program approaches from one State to

[130] Personal responsibility contracts are widely used by TANF agencies across the country as employment agreements with TANF clients. TANF clients agree to seek employment, and the TANF agency spells out the cash benefits, as well as the supportive services available to the client, if the client meets the requirements of the "contract." These personal responsibility contracts take on different names in different States: Colorado: Self Sufficiency Agreement; Delaware: Contract of Mutual Responsibility; Kansas: Self-sufficiency Agreement; New Jersey: Individual Responsibility Plan; North Carolina: Mutual Responsibility Agreement; Ohio: Self-sufficiency Contract; Oregon: Employment Development Plan; and Utah: Employment Plan.

[131] States/Counties implement different sanction policies. A full-family sanction means that the entire cash benefit for the family is terminated for varying amounts of time. Several States/Counties implement a "head-of-household" or individual sanction, meaning that the cash support for the children continues, but the parent is sanctioned off the grant.

another, even if individual State/County data were available, making cross-State comparisons are very difficult. Regardless, it is important that new systems are put in place to enable States and localities to assess if their goals are being achieved and that the lessons learned in one State or County are shared with others.

- **Establishing systems is necessary, but not sufficient.**

This is the final, and probably the hardest lesson learned from this case study. All of the States and Counties in this case study worked diligently to develop the necessary infrastructure to integrate services to best serve TANF clients with AOD problems. However, developing these systems—even in the most collaborative of efforts—was not enough to result in significant outcomes for these TANF families. Based on the findings of this case study, we have seen that training and even re-training of TANF workers is not sufficient enough to allow for appropriate identification of TANF clients with AOD problems. We have learned that co-location and care coordination systems between the TANF and AOD agencies is not enough to get a large number of TANF clients into treatment and staying in treatment. Establishing collaborative systems is necessary, but not sufficient.

States also need to address the re-engineering and re-tooling of their agencies so that they can effectively develop identification and referral systems. This new infrastructure needs to be a collaborative undertaking between the TANF and AOD agencies. However, these new "systems" are not sufficient if they do not include a critical client outreach component. Entering and staying in treatment is most often a personal choice and a personal decision. Many TANF clients are willingly "self-excluding" themselves from the TANF system because they refuse to comply with treatment requirements. They forfeit their cash grant assistance, and "fall out" of the TANF caseload. Thus, it is critical that States not only invest in interagency service integration, but also engage community-based organizations and faith based organizations in this collaboration. This integrated service delivery system needs to be responsive to the needs of the clients—reaching out to bring them into a treatment program, but also assist in meeting the needs of the whole family.

Ongoing Challenges

While the States/Counties participating in this case study have put systems in place to address the substance abuse barriers of their TANF population, they are also experiencing continuing challenges in successfully addressing the needs of this population. Specifically, States identified the following challenges and on-going concerns with working with the TANF population with substance abuse problems:

- Identification of clients with substance abuse problems
- Engagement of clients in substance abuse treatment
- Availability of substance abuse treatment services for the TANF population.

Based on discussions with States and County representatives, it appears that these continuing challenges are interrelated and intricately tied to the issue of culture change and how State policy and practices have been altered as a result of welfare reform. For example, welfare reform not only brought about changes in policy by setting time limits on clients' TANF assistance, but it also required changes in the workplace in how front-line workers need to work with clients with multiple barriers to employment. Based on the findings of this case study, these States have had difficulty in successfully transferring changes in policy to actual practice. Therefore, States need to ensure that changes in policy are translated to everyday practice at the frontline level.

■ Identification of clients with substance abuse problems

Despite efforts to serve the needs of the TANF population so that they may become self-sufficient, a large number of States expressed concern about their ability to successfully identify those clients for whom substance abuse is a barrier to employment. States' inability to identify clients with substance abuse problems is related to worker training, the appropriateness of the screening tools and instruments available, and the issue of culture change. While all States have invested and continue to invest in the training of caseworkers working with TANF clients, this training has not yielded the results that agencies expected to obtain. While training of workers is an essential component to identifying clients with substance abuse problems, training in and of itself is not sufficient if the appropriate identification procedures are not available. As has been previously noted, States are utilizing a number of screening instruments to identify substance abuse barriers among the TANF population, however, they are appropriately wary about the utility of these instruments for use with the TANF population.

Further compounding this challenge is the fact that despite training, caseworkers remain uncomfortable dealing with alcohol and other drug abuse issues. Caseworkers' level of comfort with substance abuse issues is related to their own personal comfort with the issue but also with the fact that many believe that they are breaching confidentiality rules by questioning clients about their substance abuse problems. As a result of caseworkers' discomfort with the screening of clients for substance abuse, many States noted that early detection of substance abuse problems is not occurring and clients' substance abuse problems are not identified until clients are unable to fulfill their work responsibilities. This delay in the identification process is extremely problematic because the time clock on these clients' continues to tick through this process.

The challenge to both the TANF and AOD agencies is to develop effective outreach efforts in communities with faith based organizations and non-profit community entities to engage these families in treatment options that will allow many of them to move from homelessness-to-welfare/treatment-to-work. For these outreach efforts to be successful, they must be a part of an overall effective integrated service delivery system. The AOD community and the TANF agencies must work collaboratively to address the needs of these TANF families with AOD problems. Both the AOD and TANF agencies must share the vision of moving these families—parents and children—onto a path of self-sufficiency.

■ Engagement of clients in substance abuse treatment

Another challenge identified by a majority of States in this case study is that despite their efforts to work with clients with substance abuse problems, these attempts are hindered by their inability to engage clients into treatment. Therefore, while TANF agencies are able to identify substance abuse problems among some TANF recipients, even when the problem is identified, the agencies are not able to engage clients into the treatment process. This on-going challenge can be attributed to both the client and the agency. For example, many clients are in denial of their own substance abuse problems and may prefer to remain ineligible for TANF assistance or be sanctioned rather than participate in treatment services. In addition to clients' denial, many clients refuse to participate in treatment services because they fear that as a result of their substance abuse problem they will lose their children to the State's child protective system (CPS). TANF and CPS agencies must work together to find ways to assist these clients while protecting their families.

■ Availability of substance abuse treatment services for the TANF population

In addition to their inability to identify clients with substance abuse problems and engage those clients for whom substance abuse problem is a barrier to employment, a large number of States also expressed concern about their inability to place clients in appropriate substance abuse treatment services. Many States noted that there are limited treatment options available for TANF recipients with substance abuse problems. Specifically, States expressed concern about the limited residential treatment available. As a result of this treatment capacity issue, many States are forced into referring TANF clients to outpatient treatment services which may not be appropriate and may not adequately meet the treatment needs of this population. Another concern is that even when residential treatment services are available, there is lack of treatment capacity for women with children who require treatment. This treatment capacity issue is a major concern for women with children who do not have the necessary family support to care for their children while they are in treatment and who could benefit from entering treatment with her children in order to support and develop more effective family functioning. While States recognize that increasing treatment capacity requires additional funding, they fail to recognize that there is an abundance of TANF funds available to facilitate this process and thus, enhance treatment availability.

CONCLUSION

A Look at State Welfare Systems: Efforts to Address Substance Abuse examines the various approaches these eight States and 24 Counties have undertaken to address the issue of substance abuse among their TANF population. We have found that welfare reform has caused a culture change in welfare agencies across the country. This culture change has resulted in frontline workers paying more attention to the barriers that TANF recipients face in trying to find and keep employment—particularly the issue of substance abuse. TANF agencies are investing Federal and State TANF resources in training caseworkers on AOD issues, and there is a willingness for staff from the AOD and TANF agencies to work together collaboratively to assist these TANF families.

Unfortunately, we also learned that there are some "holes" in the existing infrastructure to serve TANF families with AOD problems. WtW entities are not as far along or seemingly well positioned to serve these TANF recipients. These agencies are not developing the same type of relationships with their community AOD partners as are being developed by the local TANF agencies. We also discovered that even where the TANF/AOD collaboration is evident, there is a lack of referrals of TANF recipients into treatment. In addition, there continues to be a hesitancy on the part of State and County TANF agencies to be as flexible as they can be in spending down the TANF funds and investing these resources to expand treatment capacity in communities. Finally, there is a lack of State/County investment in tracking outcomes for these families who either "fall off" the caseload because of refusal to enter treatment, or those that successfully enter and stay in treatment. Better tracking tools need to be developed to allow this type of evaluation to take place.

INTRODUCTION

Appendices A, B, C, and D consist of documents obtained from the case studies relevant to substance abuse treatment for welfare recipients. Also, included in Appendix E is a brief description of the common AOD screening instruments used to identify TANF clients with substance abuse problems. The documents presented in these appendices were not available from each State. As a result, we are only able to include the States for which this information was accessible. Lastly, Appendix F is a resource list with the names and contact information of State and County representatives who participated in the case study.

Appendix A consists of three exhibits that provide the Medicaid reimbursement rates for New Jersey (Exhibit A-I), Ohio (Exhibit A-II) and Utah (Exhibit A-III).

Appendix B consists of the Treatment to Work Continuum matrix that is utilized by the TANF agencies and treatment providers in New Jersey when placing clients with substance abuse problems into the appropriate type of treatment/work activity.

Appendix C contains a copy of a Memorandum of Understanding (MOU) created as a result of collaborative efforts between the Ohio Department of Human Services (ODHS), the Ohio Department of Alcohol and Drug Abuse Services (ODADAS) and the Public Child Services Association (PCSA). This MOU was designed to provide County Commissioners with guidance on enhancing local treatment services for the TANF population and includes a menu of AOD services that are available for purchase using TANF funds, Medicaid reimbursable, or considered allowable County DHS administrative expenditures.

Appendix D provides a list of the performance indicators collected by Oregon's Office of Alcohol and Drug Abuse Programs (OADAP) for their Client Process Monitoring System (CPMS) both at client admission to treatment and at discharge. The CPMS database allows providers and OADAP to profile clients in terms of demographics and characteristics, to provide information regarding the treatment services being utilized, to provide information regarding the outcome of treatment, and to provide performance indicators measuring the clients' improvement from time of admission to discharge. These indicators are used to assess both the effectiveness of specific treatment provider programs and clients' improvement. OADAP has separated the performance indicators by service element including adults, women, and youth.

Appendix E includes a brief description and example of the most common AOD screening instruments used by the States and localities participating in this case study. Each instrument consists of a set of questions that caseworkers/substance abuse professionals ask TANF clients in an effort to determine the existence of a substance abuse problem. The instruments referenced in this appendix include the SASSI (Exhibit E-I), AUDIT (Exhibit E-II), DAST-10 (Exhibit E-III), CAGE Questionnaire (Exhibit E-IV), CAGE AID Questionnaire (Exhibit E-V), and the MAST (Exhibit E-VI).

Appendix F is a contact list of the State and County TANF, WtW, AOD, and Medicaid representatives who provided information for the case study.

Appendix A-F

Appendix A: Medicaid Reimbursement Schedules

EXHIBIT A-I WORK FIRST NEW JERSEY SUBSTANCE ABUSE TREATMENT SERVICES REVISED MEDICAID REIMBURSEMENT RATES EFFECTIVE 5/1/99		
Treatment Service	**Substance Abuse Rate**	**HCPCS Code**
Family therapy rendered in a substance abuse treatment center	$45.00/hr	Z3348
Family conference rendered in a substance abuse treatment center	35.00/visit	Z3349
Prescription visit rendered in a substance abuse treatment center	4.50/visit	Z3353
Psychotherapy rendered in a substance abuse treatment center (full time)	45.00/hr	Z3354
Group therapy rendered in a substance abuse treatment center (per person)	50.00/hr	Z3355
Psychological testing rendered in a drug treatment center (per hour – maximum of five hours)	15.00/hr	Z3356
Methadone treatment rendered in a drug treatment center	4.00/visit	Z3357
Psychotherapy rendered in a substance abuse treatment center (half-session)	23.00/half hour	Z3358
Urinalysis for drug addiction	5.20	Z3359
Comprehensive intake evaluation	45.00	Z3333
Case Management, limited to one hour per week (only for residential providers)	45.00	Z3363
Sub acute residential detoxification, per diem	190.00	Z3334
Short-term residential substance abuse treatment, per diem	135.00	Z3335
Short-term residential substance abuse treatment for woman and child, child portion, per child, per diem	30.00	Z3336
Therapeutic Community substance abuse treatment, per diem	55.00	Z3337
Therapeutic Community substance abuse treatment for woman and child, child portion, per child, per diem	30.00	Z3338
Substance abuse halfway house, per diem	46.00	Z3339
Substance abuse halfway house for woman and child, child portion, per child, per diem	30.00	Z3343
Substance abuse partial care treatment, per diem	77.00	Z3344
Substance abuse partial care treatment for woman and child, child portion, per child, per diem	20.00	Z3345
Intensive outpatient substance abuse treatment, per diem	65.00	Z3346
Intensive outpatient substance abuse treatment for woman and child, child portion, per child, per diem	10.00	Z3347

EXHIBIT A-II OHIO DEPARTMENT OF ALCOHOL AND DRUG ADDICTION SERVICES (ODASAS) MEDICAID RATE CEILINGS STATE FISCAL YEAR 2000		
Service Code	**Service Names**	**Rate Ceilings**
01	Alcohol/drug screening analysis	$60.00
02	Assessment	96.24
03	Case management	78.17
04	Group counseling, per person, per group	38.08
05	Individual counseling	87.27
08	Detoxification – ambulatory	193.87
09	Crisis intervention	129.59
10	Intensive outpatient	136.90
12	Medical/somatic	176.28
13	Methadone maintenance[1]	16.38

[1] Methadone Administration and/or services means the provision of the drug methadone by an alcohol and/or other drug program licensed by the State of Ohio to conduct a methadone program. Methadone is measured per contact and must be billed under the Service Code 13 (Methadone Maintenance) not Service Code 12 (Medical/somatic)

EXHIBIT A-III UTAH FEE-FOR-SERVICE SCHEDULE SUBSTANCE ABUSE SERVICES	
Substance Abuse Services	**Applicable Fee[2]**
Diagnostic evaluation	$27.77
Psychological testing	27.73
Individual therapy	22.77
Group therapy	5.30
Psychiatric evaluation and medication management by an RN	34.10/Session
Psychiatric evaluation and medication management by an MD	78.00/Session
Individual behavior management	14.05
Group behavior management	4.78
Individual skills development	11.82
Adult group skills development	3.03
Children group skills development[3]	3.05
Children intensive group skills development[4]	3.70
Targeted case management	11.42

[2] The following fees are based on the provision of the above listed services in 15-minute increments, unless noted otherwise.
[3] Serving children up to 18 years of age.
[4] Serving children up to 12 years of age.

EXHIBIT B-I
WORK FIRST NEW JERSEY TREATMENT TO WORK CONTINUUM MATRIX

Work Activities and Treatment Matrix

ASAM*	Level I	Level II		Level III			Level IV
TREATMENT	Low Intensity Outpatient	Intensive Outpatient	Partial Care or Hospitalization	Halfway House	Clinical Residential Structured Program *7-Days per week*	Sub-Acute Residential *Detox and Structured Daily Program*	Acute Inpatient *Medically Managed Stabilization Program*
WORK ACTIVITIES ASSESSMENT	☐ No difference in work tasks between substance abusers and non-substance abusers	☐ Modified work tasks ☐ Structured Therapy ☐ Reassess Job Readiness as needed, but at least every 4 weeks	☐ Modified work tasks ☐ Structured Therapy ☐ Reassess Job Readiness as needed, but at least every 6 weeks	☐ Modified work tasks ☐ Structured Therapy ☐ Reassess Job Readiness as needed, but at least every 6-8 weeks	☐ Restricted work tasks ☐ Structured Therapy with life skills education ☐ Reassess Job Readiness at transition to less intensive LOC, but at least every 4 weeks	☐ Restricted work tasks ☐ Structured Therapy with life skills education ☐ Reassess Job Readiness at transition to less intensive LOC, but at least every 4 weeks	☐ No work tasks ☐ Structured Therapy with life skills education ☐ Reassess Job Readiness at transition to less intensive LOC, but at least every 4 weeks
☐ Diploma ☐ Recent Work History	☐ Job Search - group or individual ☐ Job Search Skills ☐ Job Readiness Education	☐ Job Search Skills ☐ Job Readiness Education Training	☐ Job Search Skills ☐ Job Readiness Education Training	☐ Job Search Skills ☐ Job Readiness Education Training	☐ AWEP ☐ Reassess	☐ Reassess	☐ Reassess
☐ Diploma ☐ Recent Work History ☐ Unsuccessful at Job Search or Poor Work History	☐ Job Search Skills ☐ Job Readiness Education ☐ Work Supplement ☐ On-the-Job Training (OJT) ☐ CWEP	☐ Job Search Skills ☐ On-the-Job-Training (OJT) ☐ CWEP ☐ AWEP	☐ Job Search Skills ☐ On-the-Job-Training (OJT) ☐ AWEP	☐ Job Search Skills ☐ On-the-Job-Training (OJT) ☐ AWEP	☐ AWEP ☐ Reassess	☐ Reassess	☐ Reassess
☐ No HS Diploma ☐ No or Irregular Work History ☐ Irregular Work History ☐ Over 19 y.o.a.	☐ OJT ☐ AWEP ☐ CWEP ☐ GED Education ☐ Voc. Assessment ☐ Job Readiness Education	☐ Job Readiness Assessment ☐ Voc. Assessment ☐ CWEP ☐ AWEP ☐ Motivational Skills	☐ Job Readiness Assessment ☐ Voc. Assessment ☐ AWEP ☐ Motivational Skills	☐ Job Readiness Assessment ☐ Voc. Assessment ☐ AWEP ☐ Motivational Skills	☐ Life Skills Education ☐ AWEP ☐ Reassess	☐ Reassess	☐ Reassess
☐ Limited education ☐ No or Irregular Wo History	☐ AWEP ☐ CWEP ☐ Supported OJT ☐ GED Education	☐ Literacy Assessment ☐ Voc. Assessment ☐ CWEP ☐ AWEP	☐ Job Readiness Assessment ☐ Voc. Assessment ☐ AWEP	☐ Job Readiness Assessment ☐ Voc. Assessment ☐ AWEP	☐ Life Skills Education ☐ AWEP ☐ Reassess	☐ Reassess	☐ Reassess

Appendix B

EXHIBIT B-I (continued)
WORK FIRST NEW JERSEY TREATMENT TO WORK CONTINUUM MATRIX

Work Activities and Treatment Matrix							
ASAM*	**Level I**	**Level II**		**Level III**			**Level IV**
TREATMENT	Low Intensity Outpatient	Intensive Outpatient	Partial Care or Hospitalization	Halfway House	Clinical Residential Structured Program *7-Days per week*	Sub-Acute Residential *Detox and Structured Daily Program*	Acute Inpatient *Medically Managed Stabilization Program*
☐ No observable barriers ☐ May have complete a work activity ☐ No unsubsidized employment	☐ Voc. Assessment ☐ Job Readiness Educati	☐ Motivational Skills ☐ Life Skills ☐ Specialized Tutoring ☐ GED	☐ Motivational Skills	☐ Motivational Skills			
☐ Limited Education ☐ No Work History ☐ Disability or observable barriers to employment	☐ Assessment of Barriers ☐ AWEP ☐ CWEP ☐ Supported OJT ☐ Voc. Assessment ☐ Literacy Assessment	☐ Assessment of Barriers ☐ AWEP ☐ CWEP ☐ Life Skills ☐ Voc. Assessment ☐ Literacy Assessment	☐ Assessment of Barriers ☐ AWEP ☐ Voc. Assessment ☐ Literacy Assessment	☐ Assessment of Barriers ☐ AWEP ☐ Voc. Assessment ☐ Literacy Assessment	☐ Life Skills Education ☐ AWEP ☐ Reassess	☐ Reassess	☐ Reassess

*Opioid Maintenance Therapy (OMT) is a separate service that can be provided in any level of care. Work activities would depend upon level of care placement.

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TO: County Commissioners

FROM: Arnold Tompkins, Director
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Luceille Fleming, Direct
Ohio Department of Addiction Services

DATE: July 28, 1998

RE: STATE/LOCAL ALCOHOL AND OTHER DRUG SERVICE ENHANCEMENT

At the request of County Commissioners' Association of Ohio, Ohio Human Services Directors' Association, Public Children Services Association of Ohio, Ohio Association of ADAMHS Boards, and ADAS Federation, staff from ODHS and ODADAS have been working with local representatives to enhance alcohol and other drug addiction services for Ohio Works First participants and families involved in the child protection system. This memorandum provides guidance to assist county commissioners' efforts to enhance local alcohol and other drug (AOD) service systems by utilizing funds from their current Temporary Assistance to Needy Families (TANF) allocation.

ODHS, ODADAS and their local partners are all committed to ensuring that AOD problems not be a barrier to self-sufficiency for Ohio Works First individuals transitioning to employment. Equally important is the commitment to enable communities to use TANF funds to help Ohio Works First families involved with the child protection system to solve their problems. Appropriate and timely AOD prevention -and treatment services are an important tool for Ohio Works First/Child Protection System families to attain self-sufficiency and personal responsibility.

Attached is an AOD menu identifying services which may be purchased with local TANF funds, services which are Medicaid reimbursable and other services counties may claim as administrative expenses. AOD services (other than those separately funded by, Medicaid) may be included in OWF participants' self-sufficiency plans, thereby becoming allowable OWF expenditures. Local representatives have indicated that many unique local collaboratives could become possible once ODHS and ODADAS provide guidance as to the allowability of certain expenses. This memorandum serves that purpose.

Also attached is an example of a planning and program model to assist county commissioners seeking to improve the availability of AOD services for OWF/CPS families. By selecting from the full menu of services, a county could help fund a full continuum of AOD prevention and treatment services for local communities. The menu approach allows the county the flexibility to wrap services around the Medicaid benefit which is funded by ODADAS, local boards and ODHS.

ODHS and ODADAS staff are ready to provide technical assistance to local public systems. In addition, planning is underway for a series of regional meetings to assist counties as they plan their individual AOD service enhancements.

Please contact your local account manager for ODHS and/or Shari Aldridge, ODADAS, (614) 466-3445, with questions and/or requests for on-site technical assistance.

ODADAS and ODHS look forward to learning of the local successes resulting from this important state/local collaboration.

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Enclosures

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Susan Wolf, Ohio Human Services Directors' Association
Representative Joan Lawrence
Representative Kerry Metzger
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AOD TANF/CPS SERVICE OPTIONS

AOD SERVICES which may be purchased with TANF funds if recorded on participant's individual self-sufficiency contract	Brief Screening Referral and Information Outreach Awareness Education Early Intervention Room/Board/Rent Subsidy/ (Drug-free Housing) Family Therapy Employee Assistance Program (EAP)
ODADAS Community Medicaid Treatment Services (Non-TANF reimbursable)	Assessment Urine Screening Analysis Case Management Group Counseling Individual Counseling Ambulatory Detoxification Crisis Intervention Intensive Outpatient Medical/Somatic Methadone Administration
Allowable CDHS Administrative Expenditures (Cost-allocated)	Training Hotline
Other Allowable CDHS Expenditures Transportation set-aside in TANF allo- cation; Medicaid EMT Services; Child Care Development Fund(CCDF)	Childcare Transportation

OHIO DEPARTMENT OF ALCOHOL AND DRUG ADDICTION SERVICES
AND
OHIO DEPARTMENT OF HUMAN SERVICES

Example of a Planning and Program Model for OWF/CPS Families

MODEL PLANNING PROGRESS

County commissioners, work- with CDHS, Child Welfare Agency, ADAS/ADAMHS Boards and AOD service providers. to identify service gaps to enable OWF/CPS families to reach self-sufficiency. Available TANF funding is matched to the county's. selections from the attached menu of services. The: CDHS contracts with Boards and/or providers to purchase services. The county assesses the need for AOD training for OWF caseworkers and/or on-site screening and referral by qualified AOD professionals. Service combinations should reflect participant's AOD prevention and treatment needs and augment services already available through the Medicaid benefit and other state/local funding sources. Protocols are established for referral and identification of needed services on a participant's self-sufficiency contract. Counties may offer brief screening and referral for all or some of the OWF population. Those participants found not to be currently experiencing problems with alcohol and other drugs may be offered prevention services as part of their self-sufficiency contract. Similarly. counties might choose to identify services similar to an employee assistance program on participant's self-sufficiency contract. Counties should document their planning process to demonstrate the collaborative activities which take place. ADAS/ADAMHS Boards and AOD providers should use ODADAS clinical protocols in their planning.

MODEL PROGRAM IDEAS

On-site credentialed AOD staff conduct an AOD brief screening to identify the need for an AOD referral for assessment.

Referral for an assessment and treatment (if necessary) is made to an ODADAS certified treatment provider. An appropriate release of information is obtained, and the results of the assessment and subsequent treatment plan are recorded in the participant' s self-sufficiency contract. The participant becomes obligated to complete the treatment activities. Services can be selected to supplement the Medicaid benefit, and these supplemental services can be allowable TANF expenditures, if recorded on the participant's self-sufficiency contract.

If the brief screening does not indicate the need for a full assessment, other allowable services could be provided to the participant, such as awareness, education and employee assistance program.

AOD staff on-site at the CDHS coordinate a participant's treatment progress with concurrent OWF self-sufficiency contract and CPS reunification plan activities (if applicable).

Additional allowable TANF services could be provided including education to address domestic violence and codependency. for example. If included in the participant's self-sufficiency contract, these services become TANF allowable expenditures.

For participants who have entered recovery through abstinence, services such as employee assistance program could be offered, as indicated on the participants self-sufficiency contract. For participants gaining unsubsidized employment, a county could choose to make these continuing AOD services eligible under a PRC plan, and the expenditures could be charged to PRC.

Appendix D: Oregon Performance Indicators

This exhibit provides an overview of the performance indicators currently collected by Oregon's Office of Alcohol and Drug Abuse Programs (OADAP) on clients at admission and discharge from treatment for alcohol and other drug abuse problems. The client data is collected through the Client Process Monitoring System (CPMS), which was first initiated in 1982. CPMS collects information on all clients admitted to emergency non-hospital detoxification services, two levels of residential treatment (conventional and intensive) for adults, specialized residential treatment for women and pregnant women and youth, and outpatient services including methadone maintenance. The indicators noted below are utilized to assess the effectiveness of specific treatment provider programs as well as clients' improvements while in treatment.

EXHIBIT D-I
PERFORMANCE INDICATORS COLLECTED BY THE OREGON OFFICE OF ALCOHOL AND DRUG ABUSE PROGRAMS (OADAP) FOR THE CLIENT PROCESS MONITORING SYSTEM

Adult Performance Indicators	Women-Specific Performance Indicators
■ Change in employability ■ Employment improvement ■ Educational advancement ■ Participated in self help ■ Not arrested during treatment ■ Referral to self help ■ Referral to A&D treatment ■ Abstinent/drug free ■ Mother abstinent 30 days before delivery ■ Complete treatment	■ Employment maintained (full/part time) ■ Employment status improved ■ Progressed in school or training ■ Participated in self help ■ Not arrested ■ Reduced use ■ Abstinent ■ Completed treatment ■ Complied with Children's Services Division Agreement

Appendix D: Oregon Performance Indicators

EXHIBIT E-I

SUBSTANCE ABUSE SUBTLE SCREENING INVENTORY (SASSI)

The SASSI is a 78-item, one-page questionnaire designed to screen for chemical dependency. It is targeted for use with both adolescents and adults. Scoring results in classification of individuals as either chemically dependent or non-chemically dependent. The SASSI is resistant to efforts at faking and/or trying to conceal chemical dependency problems. The SASSI has eight subscales that can be used to assess defensiveness and other chemical dependency characteristics. While the administration of the SASSI requires training, the questionnaire can be self-administered via computer or pencil and paper, and takes approximately 10 to 15 minutes to complete, which has made it one of the most commonly used screening instruments.

For information on training, contact the SASSI Training Office at 800-697-2774 or visit the SASSI Training page at http://www.sassi.com.

For more information on the SASSI contact:
The SASSI Institute
R.R. 2 Box 134, Springville, IN 47462
800-726-0526; FAX 800-546-7995

Reference: Miller, G. (1985). *The Substance Abuse Subtle Screening Inventory (SASSI): Manual*. Bloomington, IN: Spencer Evening World.

EXHIBIT E-II

ALCOHOL USE DISORDERS IDENTIFICATION TEST (AUDIT)

The AUDIT is a 10-item questionnaire designed to identify individuals whose alcohol use has become hazardous to their health. Three subscales assess amount and frequency of drinking, alcohol dependence, and problems caused by alcohol. The AUDIT is targeted for use with adults and can be used in a number of settings. Clinicians can administer the AUDIT as an interview or clients can self-administer the questionnaire using pencil and paper. This questionnaire can be completed in about one minute.

Reference: Babor, T., de la Fuente, J., Saunders, J. & Grant, M. (1992). *AUDIT: The Alcohol Use Disorders Identification Test: Guidelines for Use in Primary Health Care.* Geneva, Switzerland: World Health Organization.

Questions:

How often do you have a drink containing alcohol?
(0) never (1) monthly (2) 2-4 times a month (3) 2-3 times a week (4) 4 or more times a week

How many drinks containing alcohol do you have on a typical day when you are drinking?
(0) 1-2 (1) 3 or 4 (2) 5 or 6 (3) 7-9 (4) 10 or more

How often do you have six or more drinks on one occasion?
(0) never (1) less than monthly (2) monthly (3) weekly (4) daily or almost daily

How often during the last year have you found that you were unable to stop drinking once you started?
(0) never (1) less than monthly (2) monthly (3) weekly (4) daily or almost daily

How often during the last year have you failed to do what was normally expected of you because of drinking?
(0) never (1) less than monthly (2) monthly (3) weekly (4) daily or almost daily

How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?
(0) never (1) less than monthly (2) monthly (3) weekly (4) daily or almost daily

How often during the last year have you felt guilt or remorse after drinking?
(0) never (1) less than monthly (2) monthly (3) weekly (4) daily or almost daily

How often during the last year have you been unable to remember what happened the night before because of drinking?
(0) never (1) less than monthly (2) monthly (3) weekly (4) daily or almost daily

Have you or someone else been injured as the result of your drinking?
(0) no (1) yes, but not in the last year (2) yes, during the last year

Has a friend, relative, or doctor or other health worker been concerned about your drinking or suggested you cut down?
(0) no (1) yes, but not in the last year (2) yes, during the last year

Total Score: _____

Exhibit E-III

DRUG ABUSE SCREENING TEST (DAST-10)

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

These questions refer to the past 12 months.

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

Score: _____

EXHIBIT E-IV

CAGE QUESTIONNAIRE

The CAGE is a 4-item questionnaire designed to screen for alcoholism. CAGE is an acronym for four questions that pertain to lifetime drinking behaviors. The CAGE questions can easily be adapted to screen for use of illicit drugs as well. The CAGE is used primarily on adults and adolescents over the age of 16. Clinicians may administer the CAGE as an interview, or allow clients to self-administer the questionnaire using pencil and paper or a computer. The CAGE can be completed in less than one minute.

Responses to the four items are scored 0 or 1, with a 1 indicative of alcohol problems. A total score of 2 or more is indicative of alcoholism.

Reference: Mayfield, D., McLeod, G. & Hall, P. (1974). The CAGE questionnaire: Validation of a new alcoholism instrument. American Journal of Psychiatry, 131, 1121-1123.

Client Name: _____ **Case Number:** _____

Questions:

1. Have you ever felt you should cut down on your drinking?
2. Have people annoyed you by criticizing your drinking?
3. Have you ever felt bad or guilty about your drinking?
4. Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover (an "eye opener")?

[1] CAGE originally published in: J.A. Ewing, "Detecting Alcoholism: The CAGE Questionnaire," *Journal of the American Medical Association*, Vol. 252 (1971), pp. 1905-1907.

EXHIBIT E-V

CAGE-AID QUESTIONNAIRE

The CAGE-AID is an expanded version of the CAGE questionnaire. This screening tool contains the four original CAGE questions, plus five additional questions about the use of alcohol or drugs. The CAGE-AID can be completed in less than two minutes.

Client Name: _____ **Case Number:** _____

Questions:

1. Do you now or have you ever used drugs or alcohol?
2. Have you ever felt you should cut down on your drinking or drug use?
3. Have people annoyed you by criticizing your drinking or drug use?
4. Have you ever felt bad or guilty about your drinking or drug use?
5. Have you ever had a drink or drug first thing in the morning to steady your nerves or get rid of a hangover (an "eye opener")?
6. Do you use any drugs other than those prescribed by a physician?
7. Has a physician ever told you to cut down or quit use of alcohol or drugs?
8. Has your drinking/drug use caused family, job or legal problems?
9. When drinking or using drugs have you ever had a memory loss (blackout)?

EXHIBIT E-VI

MICHIGAN ALCOHOLISM SCREENING TEST (MAST)

The MAST is a 25-item questionnaire designed to quickly screen for lifetime alcohol-related problems and alcoholism. The MAST is targeted for use with adults, and can be administered as an interview or as a pencil and paper self-administered questionnaire. Several shorter versions of the MAST also are available; the Brief MAST contains 10 items; the Short MAST contains 13 items; and the Malmo modification (Mm-MAST) contains 9 items. The MAST can be completed in five minutes.

Points are assigned for responses that indicate trouble with alcohol use. Five points or more places an individual in the "alcoholic" category. Four points is suggestive of alcoholism. Three points or less indicates the client is not alcoholic.

Reference: Selzer, M. (1971). The Michigan Alcoholism Screening Test: The quest for a new diagnostic instrument. American Journal of Psychiatry, 127, 1653-1658.

NAME: _____ **NO.:** _____ **DATE:** _____

MICHIGAN ALCOHOL/DRUG SCREENING TEST

Questions		Answers	
1.	Do you feel you are a normal drinker or drug user?	Yes ___	No ___
2.	Have you ever awakened in the morning after some drinking or drug use the night before and found that you could not remember a part of the evening before?	Yes ___	No ___
3.	Does your spouse, parent, or other near relative ever worry or complain about your drinking or drug use?	Yes ___	No ___
4.	Can you stop drinking or using drugs without a struggle after one or two drinks or doses?	Yes ___	No ___
5.	Have you ever felt guilty about your drinking or drug use?	Yes ___	No ___
6.	Do friends or relatives think you are a normal drinker or drug user?	Yes ___	No ___
7.	Do you ever try to limit your drinking or drug use to certain times of the day or to certain places?	Yes ___	No ___
8.	Are you always able to stop drinking or using drugs when you want to?	Yes ___	No ___
9.	Have you ever attended a meeting of Alcoholics Anonymous (AA) or similar self-help group for drinking or drug abuse?	Yes ___	No ___
10.	Have you gotten into physical fights when drinking or using drugs?	Yes ___	No ___

11.	Has drinking or drug use ever created problems with your spouse, parent, or other near relative?	Yes ___	No ___
12.	Has your spouse (or other family member) ever gone to anyone for help about your drinking or drug use?	Yes ___	No ___
13.	Have you ever lost friends or girlfriends/boyfriends because of drinking or drug use?	Yes ___	No ___
14.	Have you ever gotten into trouble at work or school because of drinking or using drugs?	Y es ___	No ___
15.	Have you ever lost a job because of drinking or using drugs?	Yes ___	No ___
16.	Have you ever neglected your obligations, your family, or your work for two or more days in a row because you were drinking or using drugs?	Yes ___	No ___
17.	Do you drink or use drugs before noon fairly often?	Yes ___	No ___
18.	Have you ever been told you have liver trouble and/or cirrhosis?	Yes ___	No ___
19.	After heavy drinking or drug use have you ever had delirium tremens (DTs), severe shaking, heard voices, or seen things that weren=t there?	Yes ___	No ___
20.	Have you ever gone to anyone for help about your drinking or drug use?	Yes ___	No ___
21.	Have you ever been in a hospital because of drinking or drug use?	Yes ___	No ___
22.	Have you ever been a patient in a psychiatric hospital or on a psychiatric ward of a general hospital where drinking or drug use was part of the problem?	Yes ___	No ___
23.	Have you ever been seen at a psychiatric or mental health clinic, or gone to a doctor, social worker, counselor, or clergyman for help with an emotional problem where drinking or drug use was part of the problem?	Yes ___	No ___
24.	Have you ever been arrested, or taken into custody even for a few hours, because of drunk or intoxicated behavior?	Yes ___	No ___
25.	Have you ever been arrested for drunk driving, driving while intoxicated, or driving after drinking or using drugs?	Yes ___	No ___

Selzer, M.L. The Michigan Alcoholism Screening Test: The quest for a new diagnostic instrument. American Journal of Psychiatry, 1971, 127, 1653-1658. See also: Skinner, H.A. The Drug Abuse Screening Test. Addictive Behaviors, 1982, 7, 363-371.

Appendix E

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Appendix F

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