



Building Bridges: States Respond to Substance Abuse and Welfare Reform

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Building Bridges: States Respond to Substance Abuse and Welfare Reform

EXECUTIVE SUMMARY

Substance abuse and welfare dependency are two of our nation's most pressing problems, and they are elaborately interconnected. Both are difficult and complex situations that develop over time. Escape from either requires persistence, support, courage, and help. As state officials become more aware of the connections between substance abuse and poverty, they have started to think differently about their programs and are testing new methods for helping welfare participants reduce their substance abuse, find jobs, and leave welfare.

Studies conducted prior to 1997 suggested that 16% - 37% of the nearly 4 million women on welfare at that time experienced substance-related problems (CASA, 1995; Grant & Dawson, 1996; Olson & Pavetti, 1996; Sisco & Pearson, 1994; USDHHS, 1994). This proportion is likely to grow as people without significant barriers to work move off welfare, leaving people with substance abuse and other problems increasingly comprising the remaining caseload. Unless states find ways to meet the complex needs of these families, those most vulnerable will be at even greater risk of homelessness and abject poverty, and welfare reform itself will fail.

Building Bridges: States Respond to Substance Abuse in Welfare Reform gives voice to those who are working on the front line in our nation's welfare offices, job training programs, and substance abuse agencies. We surveyed 51 states, interviewed key government officials in 12 states, and conducted 5 case studies among front line workers and administrators. From their experiences and experiments we derive insight and direction about what works and what does not. We look to them to build and cross the bridges that span the worlds of substance abuse treatment, welfare, and work. This report is the result of a two-year study by The National Center on Addiction and Substance Abuse at Columbia University (CASA) and the American Public Human Services Association (APHSA), supported by the Substance Abuse Policy Research Program of The Robert Wood Johnson Foundation.

HIGHLIGHTS OF THE STUDY:

- Five key factors influenced state ability to address substance abuse within welfare reform: collaboration among agencies, leadership of and support from political and legislative officials, capacity of organizations to meet new challenges, availability of funds and resources, and control and participation at the local level.
- Although TANF (Temporary Assistance to Needy Families) administrators identified substance abuse among participants as a problem, many states had not yet established adequate data collection, training, and other systems to identify, assess, and treat that abuse.

- Few states reported employment-related services that addressed substance abuse problems. Most administrators felt that the level of treatment services available to TANF participants with substance abuse problems was inadequate.
- State officials and staff had undertaken many innovative practices to respond to substance abuse within their welfare reform efforts. We selected five of these practices for case studies.

FINDINGS FROM THE SURVEY OF STATE ADMINISTRATORS:

- ***Substance abuse among TANF participants is a significant concern to administrators.*** State TANF administrators consistently identified substance abuse among participants as a pervasive problem, despite the fact that it is generally not viewed as the number one concern.
- ***A variety of state structures for meeting the employment and treatment needs of participants are in place.*** Most TANF programs are state administered and fall within the same agency as employment and training, child welfare or Medicaid. Mental health and substance abuse services are less likely to be housed with TANF services. Substance abuse treatment is generally delivered by private providers and paid for entirely by federal funds or Medicaid.
- ***Policies and practices to identify and track substance abuse are undeveloped.*** States lack mechanisms to identify and track substance abuse among participants, and workers lack training in identifying or assessing substance abuse problems.
- ***Substance abuse counselors are rarely available to welfare or employment staff.*** This finding is particularly noteworthy because there is only limited training available for front-line staff in identifying and addressing substance abuse among TANF participants, yet front-line staff are the main identifiers of substance abuse among TANF participants.
- ***Specialized employment and treatment services for substance abusing TANF participants are just beginning to be instituted.*** State TANF and Substance Abuse Treatment administrators generally perceive the availability and funding of treatment services to be a “severe problem” and in most cases, employment services had not been designed with the substance abusing TANF population in mind.

INNOVATIONS: FIVE CASE STUDIES

- ***Taking control locally: Oregon's local partnerships in linking substance abuse with welfare***

Oregon established a strong commitment to investing authority and resources in its communities by allowing and providing support them to design and execute programs for substance abusing TANF participants. The *Steps to Success* program in the Portland area is an innovative example of these partnerships. Oregon's local partnerships established a broad, community-based approach to welfare reform that provides comprehensive services aimed at moving participants into employment, while also making substance abuse-related TANF programs more responsive to the specific needs of participants and staff.

- ***Gaining political and legislative support: Maryland's Medicaid Managed Care provides substance abuse services***

Maryland designed an ambitious program to build bridges between managed care health providers and county welfare offices. In 1997 the Maryland Legislature required its Medicaid managed health care system (HealthChoice) to cover substance abuse assessment and treatment for most enrollees, including welfare participants, and it added new state funds to expand treatment capacity. By August 1998, approximately 400,000 Medicaid participants had been enrolled in HealthChoice, including 40,000 TANF cases, or about 125,000 participants. In building new bridges between welfare and managed care, Maryland fostered participant employability by using state funds to enhance treatment capacity, and has improved collaborative relationships among agencies that serve welfare participants.

- ***Securing adequate funding and resources: Nevada's social workers help TANF participants with multiple barriers to work***

Nevada made a bold and conscious decision to address the needs of TANF participants with multiple severe barriers to work, including substance abuse. The state deployed 30 social workers and two supervisors into the 19 district welfare offices to help those participants and to build bridges between social work services, welfare, and substance abuse treatment. This innovation increased TANF staff capacity to address the needs of participants with multiple severe barriers to work, and changed the way substance abuse is addressed in welfare offices by redefining the character of services for people with numerous barriers to work.

- ***Fostering collaboration among agencies: North Carolina's Qualified Substance Abuse Professionals assist DSS workers***

North Carolina designed an ambitious initiative that placed Qualified Substance Abuse Professionals (QSAPs) in every county Department of Social Services office. The QSAP positions were created as part of the state's 1997 Work First Substance Abuse Initiative, and are employed by 40 local Mental Health Authorities across the state. By April 1999, 61 QSAPs had become the linchpins in the screening, assessment, treatment planning, and care coordination for Work First participants with substance abuse problems. The QSAP program increased TANF staff capacity to identify and address substance use among participants and redefined the character of services provided to participants who abuse substances.

- ***Building organizational capacity: Illinois' statewide substance abuse training program for TANF workers***

Assisting the Client--Putting the Assessment Pieces Together is a creative initiative of the Illinois Department of Human Services to prepare nearly 3,000 of its TANF staff to identify, screen, and refer TANF participants to assessment and treatment. By investing in staff development, this innovation changed the way TANF workers deliver services to participants with substance abuse problems and enhanced the capacity of DHS to meet new challenges required by welfare reform.

FACTORS THAT INFLUENCE STATE ABILITY TO ADDRESS SUBSTANCE ABUSE WITHIN WELFARE REFORM:

Five factors facilitated and/or inhibited the ability of states to serve substance abusing TANF participants within their welfare reform programs.

- ***Collaboration among agencies.*** State TANF administrators identified interagency collaboration as the number one facilitator of addressing substance abuse within reform. Lack of such collaboration was perceived to be the second most common inhibitor of addressing substance abuse within reform. Administrators identified state-level coordination and uniform vision as essential to achieving program goals, followed by coordination involving local agencies, guidance from top level officials, cross training, and cross-agency tracking systems.
- ***Support from political and legislative officials.*** TANF administrators identified political and legislative support as second only to collaboration among agencies in facilitating their welfare reform programs. They described such support as meaning legislative mandates and leadership of top-level politicians and administrators, followed by

integrated policy development and public opinion.

- ***The capacity of organizations to meet new challenges.*** TANF administrators cited organizational capacity as the third most important influence on their ability to achieve program goals. They spoke about the challenges to their agencies in screening and assessing participants for substance abuse, and in training their staff to conduct these screens and assessments. They also mentioned the degree to which state programs fell within the same agency, the reluctance of front-line workers to talk to participants about substance abuse, and the ability of their organizations to collect data to identify and track substance abuse among TANF participants.
- ***Availability of funds and resources.*** TANF administrators felt that limitations on funding and resources were the number one inhibitor of addressing substance abuse within reform. General TANF funding was the most commonly noted element, followed by Medicaid-related funding, funding and availability of treatment services, and funding and availability of employment-related services.
- ***Control and participation at the local level.*** TANF administrators viewed local participation and control as the fifth most important influence on their reform efforts. Local participation in state-level decision making was noted most often, followed by local control of TANF program, local collaboration between agencies, and the general ability of communities to maintain reform.

CONCLUSION AND RECOMMENDATIONS

Building Bridges offers policy makers, administrators and service providers a framework and basic tools for addressing substance abuse within the context of welfare reform. While it is a rough and preliminary picture of the current policy landscape, the experiences and perceptions of states point us in the direction of some promising pathways.

This study also alerts us to some avoidable pitfalls to building bridges between recovery and reform. To avoid these barriers, states can:

- ***Involve workers at all levels of these agencies, from front-line workers to top-level management.*** Establish clear mechanisms that promote communication between, and clarify the responsibilities of, agencies at each level of government that serve substance abusing TANF participants.
- ***Elicit the political support of top-level politicians and administrators, and other stakeholders*** in developing and implementing policies and practices to address substance abuse within the context of welfare reform.

- ***Continually assess and improve data collection, staff training, substance abuse screening and assessment***, and other systems to identify and address substance abuse among TANF participants.
- ***Identify a mix of treatment and employment-related services that address the multiple needs of substance abusing TANF participants in all regions***. Allocate sufficient funding to provide these services, using flexibility allowed in the federal TANF legislation to develop innovative funding strategies.
- ***Involve local agencies in developing state strategies to address substance abuse in the welfare system, and clearly communicate these strategies***. Encourage flexibility and local coordination in implementation so that local agencies can address the particular needs of TANF participants in their regions.

Both welfare reform and recovery from substance abuse will be more successful if we are able to identify substance abuse early, offer comprehensive assessment and case management, allocate adequate funding for treatment, expand and customize services, design and use better information technology systems, and employ mechanisms that more specifically and strategically build bridges between treatment and work. It is through meeting these goals that both welfare reform and substance abuse recovery can be achieved.

Chapter I

INTRODUCTION

Substance Abuse and Welfare Reform: Building Bridges between Two Systems

Substance abuse and welfare dependency are two of our nation's most pressing problems, and they are elaborately interconnected. Both are difficult and complex conditions that develop over time. Escape from both requires persistence, support, courage, and help. As state officials become more aware of the connections between substance abuse and poverty, they have started to think differently about their programs and are testing new methods for helping welfare participants reduce their substance abuse, find jobs, and leave welfare.

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 placed significant new pressure on state policy makers and administrators to confront the problems of substance abuse among welfare participants. Whereas welfare was formerly run according to policies set by the federal government that guaranteed cash support to families whose income fell below a defined level, today's system gives states broad discretion over whom they will serve, how they will serve them, and for how long.

Studies conducted prior to 1997 suggest that 16% - 37% of the nearly 4 million women on welfare at that time experienced substance-related problems (CASA, 1995; Grant & Dawson, 1996; Olson & Pavetti, 1996; Sisco & Pearson, 1994; USDHHS, 1994). This proportion is likely to grow, as people without significant barriers to work are no longer on welfare, leaving the remaining caseload comprised increasingly of people with drug and other problems. Unless states find ways to meet the complex needs of these families, our most vulnerable families will be at even greater risk of homelessness and abject poverty, and welfare reform itself will fail.

Building Bridges gives voice to those who are working on the front lines in our nation's welfare offices, job training programs, and substance abuse agencies. Their experiences and experiments are too often overlooked, yet they give us important insight and direction about what works and what does not. This report is the result of a two-year study by The National Center on Addiction and Substance Abuse at Columbia University (CASA) and the American Public Human Services Association (APHSA), supported by the Substance Abuse Policy Research Program of The Robert Wood Johnson Foundation.

The two objectives of the report are:

1. *Identify and summarize state policies and practices that target TANF participants with substance abuse problems, and*
2. *Offer ideas and tools to help local, state and federal agencies succeed in their welfare reform strategies.*

The findings and analyses in this report are based on data from a 1997/1998 survey of 51 states and territories and 5 case studies conducted by CASA and APHSA during the fall and winter of 1998. (Refer to Appendices A and D for detailed descriptions of the report's survey and case study methodologies).

Chapter II offers a comprehensive picture of how U.S. states and territories were approaching substance abuse among TANF participants in the early phases of welfare reform.

Chapter III offers in-depth descriptions of the development and implementation of innovative strategies to address substance abuse for TANF participants for five states: Illinois, Maryland, Nevada, North Carolina, and Oregon.

Chapter IV discusses factors identified by administrators that either facilitate or inhibit their efforts to serve substance abusing TANF participants.

Chapter V provides recommendations and a checklist of questions that administrators and others can use to assess and bolster their capacity to link substance abuse recovery and welfare reform. In developing these guidelines, we have drawn on state experiences as highlighted in their survey responses and evidenced by their innovative practices.

Each chapter starts with a brief summary of the theme of that chapter and its main findings. The remainder of the chapter provides extensive information about those themes and findings. In presenting each chapter this way, we hope the report will be useful to staff at all levels working in a variety of agencies.

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Chapter II

KEY FINDINGS

How States Are Approaching Substance Abuse Problems Among TANF Recipients

This chapter offers a comprehensive picture of how states and territories approached substance abuse problems among TANF participants in the early phases of welfare reform. The analysis is based on data from a 1997-98 CASA/APHSA survey investigating the substance abuse and welfare reform policies and practices of 51 U.S. states and territories (hereafter referred to as states).¹ The survey included several sections, each designed to explore a particular area of information. (Refer to Appendices A and B for a full description of the survey methodology and a blank survey questionnaire. Refer to Appendix C for additional analyses of survey findings).

We were interested in learning about how states were addressing substance abuse among welfare participants, including areas such as: different state structures for addressing substance abuse and welfare reform; the degree to which substance abuse recovery was integrated into welfare and employment programs; and the ways in which states funded substance abuse for TANF families. In gathering data, we targeted the state administrators most informed in these areas: the state Temporary Assistance for Needy Families (TANF) administrator, Employment and Training administrator, Substance Abuse Treatment administrator, and Medicaid administrator. This approach gave us a rich description of state-level welfare programs as seen through the eyes of the multiple players responsible for running them.²

Main findings include:

- ***Substance abuse among TANF participants was a significant concern to administrators.*** State TANF administrators consistently identified substance abuse among participants as a pervasive problem, despite the fact that it is generally not viewed as the number one concern.
- ***A variety of state structures for meeting the employment and treatment needs of participants are in place.*** Most TANF programs are state administered and fall within the same agency as employment and training, child welfare or Medicaid. Mental health and substance abuse services are less likely to be housed with TANF services. Substance abuse treatment is generally delivered by private providers and paid for entirely by federal funds or Medicaid.

¹ CASA and APHSA conducted the survey in late 1997 and early 1998. Fifty-one of 54 states responded, resulting in a 94 percent response rate.

² The National Governors' Association provides a useful summary of general state-level welfare requirements. Refer to their March 1999 "Round Two Summary of Selected Elements of State Programs for Temporary Assistance for Needy Families" Table.

- ***Policies and practices to identify and track substance abuse are undeveloped.*** States lack mechanisms to identify and track substance abuse among participants. Workers lack training in identifying or assessing substance abuse problems. Most states did not make substance abuse counselors available to welfare or employment staff. This last finding is particularly noteworthy because there was only limited training available for front-line staff in identifying and addressing substance abuse among TANF participants, yet front-line staff were the main identifiers of substance abuse among TANF participants.
- ***Specialized employment and treatment services for substance abusing TANF participants are just beginning to be instituted.*** State TANF and Substance Abuse Treatment administrators generally perceive the availability and funding of treatment services to be a “severe problem” and in most cases, employment services had not been designed with the substance abusing TANF population in mind.

Two caveats are worth noting when interpreting the survey findings. First, this survey was administered in the initial phases of TANF implementation. As a result, it provides an early snapshot of a dynamic system that is still evolving. Second, since all respondents were state-level administrators, their responses describe policies and practices that derive from the state level; thus, responses do not encompass the full range of activity throughout the state. Chapter III presents case studies of innovative practices at the local as well as the state level, thus adding important operational insights to the survey findings.

STATE POLICIES AND PROGRAMS' RESPONSES TO SUBSTANCE ABUSE AMONG WELFARE PARTICIPANTS

We drew from the survey responses regarding state policies, programs, and practices to frame our analysis around these four main questions:

- How concerned were state administrators about substance abuse among TANF participants?
- How were states organized to administer TANF and to provide and fund substance abuse treatment services?
- What state policies and procedures existed to identify and assess substance abuse among TANF participants?
- What employment and treatment services were available to address substance abuse among TANF participants? How adequate was the supply of these services?

The remainder of this chapter analyzes state administrators’ responses to these questions, based on their responses to the survey.

³ To estimate the prevalence of substance abuse among TANF participants, we asked TANF administrators the

How concerned were state administrators about substance abuse among TANF participants? State TANF administrators consistently identified substance abuse among TANF participants as a pervasive problem, although it was generally not viewed as the number one concern.

- *Did administrators believe substance abuse to be a problem?*³ About half of the state TANF administrators (21 of 40) reported that 20 percent or more of TANF participants needed to address their substance abuse problems. This was a substantially higher estimate of need than many prevalence studies have documented.⁴ Almost the same number estimated that fewer than 20 percent of TANF participants needed to address their substance abuse problems.
- *How did administrators compare substance abuse with other problems?* An overwhelming majority viewed substance abuse as an important problem—alcohol and drug abuse on average ranked third out of seven potential challenges to meeting the states’ work requirements, behind participants’ low skill levels and transportation problems and ahead of child care availability, job scarcity, poor participant motivation or attitudes, and domestic violence;⁵
- *Did administrators believe that substance abuse would affect employment goals?* There was substantial agreement that substance abuse was likely to affect states’ achievement of TANF work requirements. A majority (33 of 51) responded that substance abuse was likely to interfere “somewhat,” and another 6 felt that substance abuse would interfere “a great deal.” The remaining 12 administrators answered “not much” or “not at all.”
- *Had state officials developed forums for agencies to address substance abuse?* Thirty-five TANF administrators reported the existence of at least one task force, commission, or other statewide group to address drug or alcohol abuse (though not necessarily as it relates to welfare reform).⁶ The 3 issues most frequently addressed

following question: “There have been many estimates about the degree to which drug and alcohol abuse interferes with TANF recipients’ employment. While we know that no one is completely certain about the extent of this problem, we would like to know your *best estimate* of the percentage of TANF recipients in your state whose employment plans should include activities to address their drug or alcohol abuse problems.”

⁴ An Urban Institute report (Olsen and Pavetti, 1996) examines four available national surveys that compare substance use in welfare families to the general population. All of them agree that there is more substance use and abuse in welfare households, though how much more depends on which substance is examined and how abuse is defined. For example, a DHHS study found that 4.9% of female AFDC participants have a “significant functional impairment” due to alcohol or drug use (compared to 1.3% in the general population), and 10.6% of female AFDC participants are “somewhat impaired” (compared to 6% in the general population).

⁵ Interpretation of these results is discussed more fully in the “Leadership of Top Level Politicians/Administrators” portion of Section II: Support from Political and Legislative Officials covered in the next chapter.

⁶ TANF administrators had also actively involved employers in the initial phases of welfare reform. A little more than half of TANF administrators (26 of 51) report active employer involvement in shaping the state’s welfare-to-work

by these groups were: general substance abuse, with a focus on treatment (17 responses); substance abuse and welfare reform or employment (8 responses), and preventing substance abuse among youth (7 responses).

How were states organized to administer TANF and to provide and fund substance abuse treatment services? Most TANF programs were state administered, with TANF in the same agency as employment and training, child welfare, or Medicaid. Mental health and substance abuse services were less likely to be housed with TANF services. Treatment tended to be delivered by private providers, and funded entirely by federal funds or through Medicaid.

- *How many welfare agencies were state versus locally administered?* Most TANF programs (39 of 51) were supervised and administered by the state. The remainder were supervised by the state and administered locally.
- *How many and what functions were housed within the TANF agency?* A number of functions fell under the TANF agency; however, mental health and substance abuse treatment offices were often not among them. In fact, these were among the least likely to be housed in the same agency as TANF. Most states placed TANF in the same agency as Employment and Training (36 states), Child Welfare (35 states) and Medicaid (32 states), while fewer states had combined TANF offices with Mental Health (19 states), Substance Abuse Treatment (17 states), and Health Services (12 states).
- *Who provided substance abuse treatment services?* Private providers were the most common providers of publicly funded treatment services for TANF-eligible women (reported by 34 Treatment administrators), while only nine states were providing services through state or local government agencies.⁷ Private agencies were the sole providers of treatment services for 20 of the 24 states reporting that one source delivers 100 percent of such services.
- *Who funded treatment services?* Treatment administrators reported two sources of funds that most frequently covered a portion of treatment services: 100 percent federal funds (34 states) and Medicaid (33 states).⁸ In addition, 21 of the 29 states indicating that one funding source covers at least half of all treatment services for medically indigent women, reported that source to be 100 percent federal funds.

strategies through one of the following activities: serving on commissions to design welfare-to-work strategies, providing feedback to states on their needs for hiring TANF participants, and committing to hiring TANF participants.

⁷ Five administrators did not respond, two administrators reported the most common funding source to be other sources, and one administrator reported that local government agencies and private providers each delivered half of publicly funded services in the state.

⁸ Federal funding refers to federal block grants and categorical funding. Categorical funding is defined in the survey instrument as Substance Abuse or Social Services Block Grants.

- *How did Medicaid fund and provide services?* States utilized fee-for-service funding most frequently, yet treatment and medicaid administrators reported substantial usage of managed care to fund and provide treatment for TANF-eligible women. Treatment administrators reported both types of arrangements as covering some portion of treatment services (14 for capitation, 19 for fee-for-service)⁹, and a majority of state Medicaid programs were using state fee-for-service (41 responses) or managed care (30 responses) approaches to provide drug or alcohol abuse treatment benefits to this population.¹⁰

What state policies and procedures existed to identify and assess substance abuse problems among TANF participants? States lacked mechanisms to identify and track substance abuse among participants. Workers lacked training in identifying or assessing substance abuse problems. Few states positioned substance abuse professionals as resources to workers.

- *Who identified substance abusers?* In a majority of states (42 of 51), case managers or a combination of case managers and eligibility workers were responsible for identifying substance abuse; only 4 states relied on eligibility workers alone. Eleven states had combined eligibility worker and case manager roles into one position. In the 40 states in which case management was separate from eligibility, responsibility rested with both workers in 16 states, case managers in 15 states, eligibility workers in 4 states, and neither in 5 states.¹¹
- *How did workers detect substance abuse?* States relied on case managers and eligibility workers (“front-line workers”) and on informal means to detect substance abuse. The most common detection methods were participants’ self-declaration (42 states) and behavioral or appearance cues (39 states). Fewer states were using other methods: arrests for drug-related activities (27 states), history of drug treatment (21 states), history with the child welfare system (21 states), positive response to question on application form (18 states), drug or alcohol screening questionnaires (15 states), and drug testing (1 state).¹²

⁹ The same number of Treatment administrators (three responses each) also reported that Medicaid managed care and Medicaid fee for service cover a majority of treatment services.

¹⁰ The forms of managed care were as follows: capitated carve-in (13 responses), other types of managed care arrangements (9 responses), and capitated carve-out (8 responses). Capitated carve-out is defined as a “set amount paid to organization other than main medical provider for providing substance abuse services to a certain group of clients.” Capitated carve-in is defined in the survey as “payments made to the managed care provider for substance abuse services that are apart from the basic Medicaid rate.”

¹¹ The five states reporting “neither role” are states that either have county-controlled welfare departments that are difficult to generalize, had an undeveloped system at the time of the survey, or did not respond to the question.

¹² In open-ended responses, two states reported giving urine tests before participants could participate in work programs and one state gave a drug test to those who reported having received substance abuse treatment.

- *Did workers receive training?* A majority of states had not trained front line workers to identify substance abuse; even fewer had provided training in techniques to motivate participants to enter treatment. Administrators reported that eligibility workers in 7 states, case managers in 19 states, and workers performing both functions in 5 states had received training in how to identify substance abuse among participants. In addition, eligibility workers in 4 states, case managers in 14 states and workers performing both functions in 4 states assigned to identify abuse had received training both in identifying substance abuse and in motivating participants to seek treatment.
- *What happened when workers identified abuse?* Front-line workers tended to take one of two actions after identifying a substance abuse problem: they referred the participant for further assessment (38 states); or they referred the participant to treatment (37 states). Other actions included notifying the child welfare agency (14 states) and assessing the participant themselves (6 states). Of the 40 states where eligibility workers and case managers were different individuals, fewer than half of them (16 responses) indicated that eligibility workers had the authority to mandate treatment for TANF participants, and 12 reported that eligibility workers called the treatment provider on behalf of the participant.¹³
- *Did eligibility workers and case managers have access to each other or to substance abuse staff in assessing whether TANF participants have substance abuse problems?* Response was mixed. On the one hand, in 36 of the 40 states where eligibility workers and case managers are different individuals, these staff were co-located in at least some locations. However, only one-third of all states made full- or part-time drug or alcohol abuse counselors available to assist or advise the TANF or employment and training offices.
- *Were states monitoring substance abuse prevalence and referrals to treatment?* Only 14 TANF administrators stated they had data collection mechanisms to estimate the number of TANF participants with drug or alcohol problems. In addition, almost half the states (22 of 48) did not have a policy requiring TANF offices to determine whether participants referred to treatment in fact attended and completed treatment.

¹³ The survey did not request data on how many case managers mandated treatment and called the treatment provider.

What employment and treatment services were available for states to address substance abuse among TANF participants? How adequate was the supply of these services?

States were only beginning to institute specialized employment programs for substance abusers. Nonetheless, state TANF and Treatment administrators generally perceived the availability and funding of treatment services to be a severe problem.

- *Did states consider treatment as a work activity, or did they exempt participants from work requirements while they were in treatment?* State policy regarding treatment appeared to be mixed. Although administrators in 29 states said their TANF programs count treatment as a work activity for the purpose of TANF eligibility, a majority of Employment and Training administrators (31 of 44 responding) indicated that participants who were identified as substance abusers were offered some type of deferral or exemption from work activities.
- *Were there sufficient treatment services available?* In general, treatment administrators perceived treatment services to be scarcer than did TANF administrators. In fact, a majority (from 27 to 35, depending on the treatment modality) of treatment administrators rated the availability of every treatment service, except for methadone maintenance to be a severe problem.¹⁴ The widest difference in perception between treatment and TANF administrators was in the area of outpatient services: whereas 32 treatment administrators viewed availability of outpatient treatment to be a severe problem, only 8 TANF administrators felt that way. The availability of long-term residential treatment (and to a lesser extent, short-term residential treatment) was a shared concern, with most (35 treatment and 25 TANF administrators) ranking it a severe problem.
- *Was there sufficient funding for treatment?* Treatment administrators reported that funding for the following services was a severe problem: long term residential (37 states), detoxification (36 states), outpatient services (33 states), and short-term residential (28 states).
- *What employment services were available?*¹⁵ General Employment and Training services seemed to be more available than substance abuse services. Employment and Training administrators reported a relatively high level of services for TANF participants with substance abuse problems, including: childcare (39 states); drug or alcohol abuse treatment (31 states); and post-employment support and monitoring

¹⁴ A majority of treatment administrators rated the availability of the following services a severe problem: long-term residential (35 states), detoxification (32 states), outpatient services (32 states), and short-term residential (27 states).

¹⁵ This information is based on Employment and Training administrators' responses to the following question:

“Does the state pay for or provide the following employment-related programs for TANF participants with drug or alcohol abuse problems?” Employment-related programs include: drug or alcohol abuse treatment, education and training, job search and employment, child care while adult gets drug or alcohol abuse treatment, post-employment support and monitoring for recovering drug or alcohol abusers, and other.

(27 states). In addition, 21 states paid for or provided all 3 types of services to TANF participants.

- *Were there specialized services for TANF participants with substance abuse problems?* Specialized employment programming for substance abusers was just beginning. Two states reported having employment programs that served only TANF participants with substance abuse problems. In addition, 14 states reported having a work program that specifically integrated drug and alcohol treatment into work activities.
- *Was there cross training?* Relatively few Employment and Training administrators (8 of 47) reported efforts at cross-training case managers and substance abuse treatment providers. In the 39 states that lacked such training, 16 state administrators knew of no cross-training attempts, 13 states estimated that cross-training occurs in 25 percent or fewer of their counties, 5 reported such training in more than 25 percent of their counties, and 5 did not provide an estimate.

Chapter III

INNOVATIONS

Five States' Approaches to Integrating Substance Abuse Treatment and Welfare Reform

Chapter III brings to life the themes that emerged from the survey by illustrating how those themes play out in five locations. The case studies also examine the factors that were important to the successes in the efforts of these states to build bridges between substance abuse and welfare reform. The programs we highlight are:

- *Illinois'* Substance Abuse Training Program for TANF Workers;
- *Maryland's* Provision of Substance Abuse Services through Medicaid Managed Care;
- *Nevada's* Social Workers Help TANF Participants with Multiple Barriers to Work
- *North Carolina's* Qualified Substance Abuse Professionals Assist TANF Workers
- *Oregon's* Local Partnerships Link Substance Abuse with the Welfare System.

It was difficult to decide which states to select, and which innovation to highlight in the final case study sites. These 5 states were selected from a pool of 12 states that appeared to be dealing most effectively with welfare reform and substance abuse based on their survey responses. The case studies are based on three-day visits to each state by CASA/APHSA staff from August to December 1998. The visits included in-depth individual and group interviews, observations at two or more field offices (including observations of interviews with TANF applicants or participants) and focus groups with line staff. (Refer to Appendix D for a complete description of case study methodology).

Each case study starts with a short overview of the state innovation and a description of the state structure for delivering welfare, employment and substance abuse services. Then, it gives some background describing how the innovation evolved, followed by a description of the innovation itself.

Next, we analyze each innovation using the framework developed earlier; that is, we examine the innovation using the five key factors identified by TANF administrators as facilitating or inhibiting state ability to achieve its goals: collaboration among agencies; support from political and legislative officials, capacity of organizations to meet new challenges; availability of funding and resources, and control and participation at the local level. We hope that this format offers examples of how those factors play out in real-life situations.

Finally, each case study concludes with information about promising results and next steps. (Refer to Appendix E for a staff contact in each state)

OREGON'S LOCAL PARTNERSHIPS

SUMMARY AND CONTEXT

Oregon developed a strong commitment to investing authority and resources in its communities, allowing and supporting them in designing and executing programs for substance abusing TANF participants. The *Steps to Success* program in the Portland area is an innovative example of one local partnership.

Oregon's continued support of local partnerships has influenced the state's welfare reform by:

- establishing a broad, community-based approach to welfare reform providing comprehensive services aimed at moving participants into employment; and
- improving the responsiveness of substance abuse-related TANF programs to the specific needs of participants and staff.

Organizational Context and Key Welfare Provisions

The Oregon Department of Human Resources (DHR) is responsible for welfare reform and for substance abuse services.¹⁶ The Adult and Family Services (AFS) division directs the TANF program, food stamps, and a variety of job-related services. Oregon is a state administered system, and AFS utilizes 15 district and 55 branch offices to deliver its services. DHR has placed significant emphasis on local planning and decision-making and on the formation of partnerships with local service and support organizations. The Office of Alcohol and Drug Abuse Programs (OADAP) is responsible for substance abuse prevention and treatment services. Outpatient, intensive outpatient, and methadone treatment are reimbursed by the Oregon Health Plan, the state's Medicaid program. Residential treatment is funded through the Federal Substance Abuse Block Grant. OADAP staff provide training and technical assistance, including 14 courses from general to more specialized topics (e.g., women and substance abuse), and they train and certify Alcohol and Drug Assessment specialists in the branch offices.

Oregon received a federal waiver for its welfare reform in July 1996. Key provisions include:

- **24 month cash assistance.** *Participants receive cash assistance for 24 out of 84 months, excluding months they cooperate with case plan requirements. Case managers may grant extensions if participants are making diligent efforts to find work*
- **Substance abuse services:** *Substance abuse diagnosis, counseling, and treatment for participants are mandatory if 1) they are required for the participant to succeed at work and 2) they are available without cost to the participant. Participation in these services becomes part of case plans, and noncompliance results in progressive sanctions (starting with a \$50 per month grant reduction).*
- **Treatment as work.** *Counts mandated participation in treatment as part of the work plan, and hours are counted by the state as an employment activity. However, participants are not exempt or deferred from work. Substance abuse treatment usually occurs in conjunction with employment-related programs and other support activities.*

BACKGROUND

¹⁶ The DHR is a large umbrella agency that provides or purchases most of the state's human services, including adult and family services, services for children and families, medical assistance programs, food stamps, health services, mental health and developmental disabilities services, substance abuse services, child welfare services, senior and disabled services, and vocational rehabilitation services.

Oregon's strong local partnerships between substance abuse and welfare reform grew out of the state's rich history of innovation in welfare programs and a political commitment to local decision-making. The state learned from experiences with programs implemented in the mid-1980s that participants would best meet long-term employment goals through a combination of work, personal responsibility, and support services. The governor has promoted collaboration among counties and local agencies, and the DHR director has made addressing local community needs one of his top priorities. Accordingly, the DHR has recognized substance abuse as a barrier to long-term employment and developed strong local partnerships to help welfare participants overcome this barrier.

THE INNOVATION

The integration of employment and substance abuse-related services at the local level is the defining characteristic of this innovation. AFS has 15 district Job Opportunities and Basic Skills (JOBS) planning committees that plan and coordinate much of the district-level welfare reform, including substance abuse services. Local communities within each district develop a comprehensive array of services for participants based on participant needs and on the capacity of service partners in the community. The 55 AFS branch offices strive to co-locate TANF, employment, substance abuse, mental health, childcare, child welfare, and related staff wherever possible.

Welfare assistance workers and employment specialists have been combined into a case manager position that determines welfare eligibility and carries out case planning. During interviews conducted as part of the CASA/APHSA site visit, case managers consistently identified their core function as brokering for services. AFS district managers coordinate with substance abuse treatment providers and with a prime contractor (usually the Job Training Partnership Act (JTPA) agency or community college) who subcontracts with alcohol and drug service partners to prepare alcohol and drug (A&D) specialists. All district offices have drug and alcohol counselors available to assist case managers, and in most districts such counselors are co-located full-time in the TANF office.

The *Steps to Success* program is a local partnership serving participants from four Portland AFS branch offices. Mt. Hood Community College is the prime contractor, in partnership with AFS, Portland Community College, Portland Public Schools, the Private Industry Council, and the Oregon Employment Department. Services are provided to TANF participants by a multidisciplinary team of staff housed in the same office. Team members include AFS case managers, Mt. Hood alcohol and drug clinical assessment specialists, and various education, employment, training, social services, and health workers from other partner organizations. The common goal among staff is to assist welfare participants in accessing the services necessary to become economically self-sufficient.

At one *Steps to Success* site, the Thompson Center in east Portland, Steps to Success provides a range of services including the following:

- adult basic education;
- alcohol and drug treatment;
- mental health counseling;

- teen parent services;
- short-term training, including job search and interviewing skills;
- specialized job development;
- volunteer and subsidized work experience;
- non-native English speakers job placement; and
- other classes, such as parenting, domestic violence education, transitioning off welfare.

Steps to Success has integrated substance abuse screening, assessment, and treatment into its comprehensive service package in two ways:

- All new TANF applicants participate in an “Addictions Awareness Class” within two weeks of initial intake. The class includes a film and a two-hour presentation about addiction. At this time, applicants complete the Substance Abuse Subtle Screening Inventory (SASSI) and the Zung Depression scale. The Alcohol and Drug specialist scores the instruments and advises the participant and case manager in writing about the test results and next steps.
- Participants are referred to the Alcohol and Drug specialist from a variety of sources, particularly from AFS case managers and staff conducting the Addictions Awareness Class. The specialist conducts an in-depth clinical evaluation of the TANF participant. Because the specialist is working in the welfare office, these evaluations have been convenient to conduct. If the specialist concludes that substance abuse treatment is needed, the specialist and the participant schedule an appointment with a treatment provider. The specialist notifies the case manager regarding the treatment plan and regarding whether the participant is available for work. The case manager revises the participant’s Employment Development Plan to include mandatory attendance at substance abuse treatment. When possible, an immediate meeting is held between the participant, the specialist, and the case manager to talk about the participant’s treatment needs and to plan for the participant entry into treatment. The case manager and specialist jointly monitor the participant’s progress through treatment.

KEY FACTORS THAT FACILITATED OR INHIBITED OREGON’S LOCAL PARTNERSHIPS

The next section describes how some of the key factors analyzed in Chapter II have facilitated or inhibited the ability of Oregon’s local partnerships to achieve their goals.

➤ Factors that Facilitated the Ability of Oregon’s Local Partnerships to Achieve their Goals

Funding and Resources—Building on Lessons and State Commitment to Funding. Oregon’s local partnerships reflect policies, practices, and services that earlier welfare reform experiences suggest are most effective. Since the mid-1980s, the state has experimented with both labor force attachment and human capital investment models of helping welfare participants. In 1985, Oregon’s Welfare Incentive program (WIN) relied on job search activities that placed participants in jobs but offered only limited

support services. While WIN was effective in achieving short-term job placement goals, a significant number of participants did not retain employment and returned to the caseload. Therefore, in 1986 the state changed direction, and through a voluntary program, encouraged AFDC participants to attend school or participate in job training programs. Independent evaluations of this model showed that job placement rates were low, and dropout rates were high.

In 1990, Oregon implemented the JOBS (Job Opportunities and Basic Skills) program, which integrates components of earlier programs and also includes job search, life-skills training, and mutual-responsibility contracts. The Oregon Option Waiver granted in July 1996 encompasses the JOBS program components and builds from the states prior efforts to reform its welfare programs.

Oregon developed a strategy to encourage innovation among local service providers and to reinvest TANF funds into continued services for participants. Under its Reinvestment Program, savings from the TANF program may be reallocated to local service providers. The providers submit proposals to secure additional funding for programs that will serve participants and improve employment outcomes.

Political and Legislative Support—Consistent State Support for Local Decision-making. From the outset of welfare reform, Oregon state officials used a variety of mechanisms to encourage local decision-making regarding substance abuse and welfare reform. First, the state established the Reinvestment Program discussed above. In addition, the DHR has emphasized the importance of local planning and decision-making and the formation of partnerships among local organizations. For example, although the state has set clear parameters for the delivery of welfare services, the district planning committees actually design their local welfare programs.

Organizational Capacity—Creating a High-performance Organization. Oregon changed its organizational structure in a way that expanded staff capacity and enhanced local authority to create and operate new partnerships. Oregon “flattened” the structure in its field operations, eliminating layers of hierarchy and creating decentralized work-teams authorized to make and carry out decisions. In addition, staff and teams were held accountable for outcomes—job placements, wages at job entry, and welfare recidivism. Moreover, state leaders encouraged local offices to embrace attributes of “learning organizations” as well as embracing the DHRs mission. It was clear during the site visit that these values permeated the organization at all levels, and at both central office and in the field.

Collaboration Among Agencies-- Linking TANF Services. Oregon has taken several steps to ensure that TANF services are linked, thus improving service delivery for participants and enhancing understanding among staff. Each community has assembled and co-located multidisciplinary teams drawn from among the partner agencies. Moreover, the DHR established a six-member Community Partnership Team to facilitate local partnerships and integrated service delivery, including substance abuse. This team, each member of which has community-organizing experience, provides technical assistance to local communities in techniques for building and sustaining partnerships. The team receives many requests for help, and its staff is on the road most of the time.

⇒ **Factors that Inhibited the Ability of Oregon's Local Partnerships to Achieve Program Goals**

Organizational Capacity—Need to Train Case Managers. Some welfare case managers had not been exposed to information about substance abuse and were either skeptical or unaware of drug or alcohol problems among TANF participants. During the course of developing local referral procedures, it became apparent that these workers were unfamiliar with the policy for referring participants to the Alcohol and Drug Specialists. Therefore, OADAP provided training for the approximately 750 state welfare case managers. The training goals were to increase worker understanding of alcohol and drug dependency, improve their capacity to identify substance abuse problems and make referrals, enhance their ability to intervene with participants, and help them participate effectively in local interagency networks.

Collaboration Among Agencies—Bridging Disciplinary Perspectives. One of the challenges in using interdisciplinary teams lies in developing joint participant service plans that incorporate multiple goals. Steps to Success occasionally encountered tension between case managers whose primary goal was job placement and substance abuse specialists whose focus was expediting access to substance abuse treatment. As a result, some case managers were reluctant to refer participants to A&D specialists, and some specialists did not fully understand the importance of timely work participation.

Staff at Steps to Success took steps to improve joint service planning by promoting a clearer connection between the case managers and the A&D specialists. Since the specialists are on-site with the case managers, they are available to provide timely consultation to case managers, help case managers understand the nature of substance abuse, and to improve case manager skills in addressing substance abuse with a welfare participant. These efforts have improved the case managers' understanding of substance abuse and improved the A&D specialists' understanding of the opportunities to use a "Work First" policy to integrate substance abuse treatment and self-sufficiency.

In addition, staff at Steps to Success developed three key written tools that clarify the roles of case managers and substance abuse specialists. One tool gives step-by-step guidelines for how different partners may coordinate group screening, individual assessment, and treatment procedures. Another specifies the types of work activities that are appropriate during particular types of substance abuse treatment, including detoxification, in-patient/residential treatment, out-patient treatment, and methadone

maintenance. For example, a participant may be attending outpatient treatment but is able to remain in his or her own housing, and attends treatment during the daytime or in the evening. Treatment times may be flexible and can often be arranged so they do not conflict with job-related activities.

Finally, the Steps to Success staff has developed a “Pre-Assessment Checklist—When Do I Need to Make a Referral to an A&D Assessment Specialist?” Because substance abuse may not be identified through formal screening, this form gives workers guidance regarding how to interpret physical symptoms and signs, behavioral observations, and historical experiences that warrant a referral to an A&D assessment specialist.

These three practical written materials have helped to standardize information and bridge differing perspectives among co-located staff--promoting a common understanding of how, working together, staff can best assist participants with substance abuse problems.

PROMISING RESULTS

Once local district offices establish relationships with substance abuse providers, substance abuse services are addressed as the case plan is developed, rather than only after the participant has had unsuccessful attempts at employment. The training provided to case managers and employment program staff has enabled them to become more adept at designing integrated services that both address substance abuse problems and prepare the participant for employment. At the same time, substance abuse service providers have greater understanding of Oregon’s Work First approach, and are developing creative strategies to serve TANF participants within the Work First framework. For example, providers schedule outpatient treatment at times that do not conflict with employment program activities, and they conduct joint case planning with employment and treatment program staff to address all barriers to the participant’s participation in both treatment and work.

The impact of this approach is illustrated by the data from Steps to Success in Multnomah County. From July 1997 to July 1998, about 5,000 families in the county received TANF benefits. During that time, Steps to Success provided the following substance abuse intervention activities:

Table 1. Substance Abuse Activities in Steps to Success Program

Intervention Activity	Participants Served
Participant referred from welfare staff to A&D specialist	762 (15% of TANF families)
Assessments performed	318 (42% of referrals)
Referrals to treatment	260 (82% of assessments)
Completion of treatment	139 (53% of referrals)

Case managers’ assessments regarding potential substance abuse created the flow of referrals to A&D specialists for screening and intervention services. While nearly half of these referrals led to assessments, A&D specialists also identified participants who were in recovery from substance abuse and who

needed referral to support groups, either for themselves or to help them cope with family members involved with substances. Since 82 percent of the participants assessed screened positive for substance abuse and were referred to treatment, the referral and screening process seems to be quite effective. The fact that 53 percent of all participants referred to treatment actually complete treatment is encouraging compared to national data on substance abuse treatment outcomes.

NEXT STEPS

The governor initiated the “Oregon Strategy for Social Support” that aims “to empower Oregonians to be as independent, productive, and self-sufficient as possible.” As part of this process, the Access to A&D Treatment work group has set the following priorities:

- To develop a coordinated service delivery system for the state
- To develop data sharing mechanisms so that participant progress can be followed through the entire state system
- To offer statewide training to educate state agencies about best practices for drug and alcohol treatment

The work group has also identified the following components of an “ideal” service delivery system. These components mirror many of the local partnerships developed as part of welfare reform:

- early identification and referral;
- objective assessment and placement;
- a range of treatment options, including specialized settings;
- participant-centered supports;
- maintenance or aftercare; and
- access to self-help programs.

These priorities and recommendations will be considered by the Oregon legislature as it deliberates a proposed \$8 million appropriation to expand alcohol and drug prevention and treatment services. Upcoming deliberations will focus on the following:

- identifying and implementing additional programs that integrate treatment with job preparation and placement;
- increasing collaboration with local treatment providers to expand access to treatment for TANF participants and those in transition from TANF to employment;

- integrating multiple funding streams to provide more consistent levels of reimbursement, reduce eligibility gaps, and increase participant-centered supportive services;
- developing a consistent, inter-agency data system to track service and payment information so that participant progress and outcomes can be shared with referring agencies; and
- instituting cross training targeted at case managers and substance abuse and mental health staff to improve services for participants with co-occurring mental health and substance abuse conditions.

MARYLAND'S MEDICAID MANAGED CARE PROGRAM

SUMMARY AND CONTEXT

Maryland designed an ambitious program to build bridges between managed care organizations and welfare offices. In 1997, the Maryland legislature required its new Medicaid managed health care system (HealthChoice) to provide substance abuse assessment and treatment for most enrollees, including welfare participants. At the end of August 1998, approximately 400,000 Medicaid participants had been enrolled in the managed care, including 40,000 TANF cases with about 125,000 participants. This ambitious linking of two large systems—welfare and substance abuse treatment has benefited Maryland's welfare reform by:

- fostering participant employability by using state funds to enhance treatment capacity; and
- improving collaborative relationships among to integrate substance abuse treatment into the state's welfare reform strategy.

Organizational Context and Key Welfare Provisions

The Maryland Department of Human Resources (DHR) is responsible for TANF, welfare reform employment and training, and childcare. The Family Investment Administration (FIA) in DHR is responsible for TANF cash assistance and employment services. The Department of Health and Mental Hygiene (DHMH) administers Medicaid, health, alcohol and drug abuse services, and mental health programs. The Alcohol and Drug Abuse Administration (ADAA) within DHMH is responsible for substance abuse services.

Local Departments of Social Services (LDSSs) deliver services to 23 counties and the City of Baltimore through a state supervised and locally administered system. Local offices have considerable flexibility in implementing the state FIA programs, including determining programs' organizational structures, eligibility and employment staffing configurations, and participant intake procedures.

Maryland's TANF program is called Temporary Cash Assistance (TCA). For this section, however, the acronym TANF will be used to maintain consistency. Key provisions of Maryland's welfare reform include:

- **Time limits.** *Limits TANF benefits to 60 months. Participants must also meet work participation requirements within 24 months of receiving TANF;*
- **Treatment as work.** *Counts substance abuse treatment toward a participant's work requirements. Participants receive childcare services during treatment. TANF participants who do not comply with assigned and available substance abuse treatment are removed from the TANF grant, with the children's portion paid to a third party.*

BACKGROUND

Maryland concurrently redesigned its Medicaid program and its system for assessing and treating

substance abuse among TANF participants, and it seized on these changes to build bridges linking the two. The foundation for these bridges was based on a few key actions. First, the state received a federal waiver to implement a Medicaid managed care program, HealthChoice, which would serve the majority of Medicaid participants. Second, the Maryland legislature authorized \$3.5 million for FY 1998 to fund expanded residential substance abuse treatment services for TANF participants. The legislature's commitment to welfare reform, and particularly its attention to substance abuse within welfare reform, became clear with passage of the state's 1997 Welfare Innovation Act (WIA). Therefore, the simultaneous development of the Medicaid waiver and passage of WIA called for two large state agencies and HealthChoice providers to coordinate efforts in addressing substance abuse among TANF participants.

THE INNOVATION

The linkage between the LDSSs and managed care organizations (MCOs) is the defining characteristic of this innovation. In response to the WIA requirement that all adult and minor parent participants be screened for substance abuse, LDSS workers have built the CAGE screening instrument into the welfare application process. If a worker suspects that a TANF applicant has a substance abuse problem, he or she reports the suspicion to HealthChoice MCOs. The MCOs are required by law to assess and treat substance abusers (including TANF participants) either directly, through behavioral health organizations or through authorized treatment providers. The DHMH has built reimbursement for such services into its capitation rate. State law also requires MCOs to notify LDSSs of positive screenings for substance abuse, referrals to and the results of comprehensive substance abuse assessment, and treatment provided. These notification requirements allow local offices to monitor participant needs and compliance with mandatory treatment activities. Each LDSS and MCO has designated a liaison to expedite communication and resolve problems.

The DHR and DHMH have developed procedures and forms to facilitate communication between LDSS offices and MCOs. Three forms are particularly important:

1. *Consent for the Release of Confidential Alcohol and Drug Treatment Information Form*: The TANF participants sign this form, authorizing MCOs and providers to release information back to the LDSS. Applicants must sign this form in order for their welfare application to be processed.
2. *Screening Referral Form*: LDSSs use this form to alert MCOs if: (a) a participant screens positive for substance use during the employability assessment; (b) a participant acknowledges that he or she has a substance abuse problem and requests a treatment referral; or (c) a case manager refers a participant based on observation.
3. *Substance Abuse Identification and Treatment Notification Form*—MCOs and their providers send this form back to LDSSs with information on 11 events that the participant has authorized for release. This tracking form offers critical feedback to LDSS staff about how the participant is progressing through assessment and treatment. The 11 events are as follows:

- a. Failure to appear for initial health screening within 90 days of enrollment
- b. Initial screening, follow-up diagnostic testing, or treatment yield a positive screening for substance abuse
- c. Referral for comprehensive substance abuse assessment
- d. Failure to keep appointment for substance abuse assessment
- e. Assessment indicates no need for substance abuse treatment
- f. Referral for treatment
- g. Failure to schedule or appear for initial appointment
- h. Treatment vacancy unavailable
- i. Enrollment in treatment program
- j. Failure to maintain active attendance/participation in treatment
- k. Successful program completion

The exchange of information via these forms is not automated; however, the DHR has modified its participant-management information tracking system to accept data received from the MCOs. Maryland does not plan to automate the TANF reporting and notification process until the procedures for identification, notification, and treatment are finalized and until resources currently devoted to the state's Year 2000 computer project can be made available for this project.

At the inception of the TANF/Managed Care program, both DHR and DHMH also embarked on an extensive training program to familiarize LDSSs and MCOs with requirements, procedures, and forms. This training included daylong regional sessions for LDSS front-line staff, supervisors, and administrators; sessions for MCO staff; joint training of MCO and LDSS liaisons; and new Action Transmittals to state and local staff. In response to feedback from MCOs, the state also made changes to notification forms and procedures to accommodate different methods of referral.

A second round of regional refresher training for LDSS staff took place in May 1999, incorporating the new Action Transmittal and a clearer explanation of procedures and forms. The second round of training was well received:

Staff indicated they found the policy and procedures more meaningful, fostering a deeper understanding of the importance of early identification of substance abuse among participants as well as an appreciation of the roles of other agencies in providing treatment for these participants.

KEY FACTORS THAT FACILITATED OR INHIBITED MARYLAND'S MEDICAID MANAGED CARE PROGRAM

The next section describes how some of the key factors identified in Chapter II facilitated or inhibited Maryland's attempts to build bridges between managed care providers and welfare offices.

⇒ Factors that Facilitated Maryland’s Medicaid Managed Care Program¹⁷

Support from Political and Legislative Officials—Interest, Investment, and Oversight. From the outset, the Maryland legislature has been committed to welfare reform, including how best to address substance abuse among participants. In addition to passing critical programmatic legislation, the legislature appropriated \$3.5 million in FY 1998 to increase substance abuse treatment capacity. The secretaries of the DHR and DHMH report regularly to a Joint Legislative Committee on Welfare Reform and, on specific matters regarding the status of TANF participants referred for substance abuse treatment, to the state’s chairpersons of the Senate Finance Committee and House Appropriations Committee. This ongoing interest and oversight reinforce the high priority the legislature has assigned to this innovation.

Organizational Capacity—Improving Ability to Identify and Solve Problems. DHRs approach to welfare reform reflects techniques of a “high performance” organization, including a unique combination of planning, risk-taking, and assertive approaches to change. The agency has developed a process to identify gaps between where the innovation currently stands and where it is headed and to take definitive steps to narrow the gap through data collection, analysis, action, and evaluation. This process is repeated continually as changes are introduced. For example, surveys of local office staff and MCOs have provided information to identify problems in the current referral and treatment process before they escalate to crises. Maryland has also developed a detailed written Corrective Action Plan for resolving problems encountered in implementing this innovation.

Participation and Control at the Local Level—Multiple Strategies for Implementing Reform. The DHR has promoted a high level of local involvement in the development and implementation of the TANF/Managed Care program. The DHRs organization model represents a system of communication and decision-making that vests authority throughout the organization. Local offices enjoy considerable flexibility in implementing their own versions of welfare reform:

The Secretary of the DHR indicated that counties have “a lot of local discretion but within relatively clear parameters.”

This emphasis on local control over the innovation promotes an environment sensitive to the needs both of TANF participants and local staff.

¹⁷ The University of Maryland’s School of Social Work, a long-time research partner with the Maryland DHR, provides independent verification of the facilitators discussed in this section through three interim reports from a large-scale, longitudinal study, *Life After Welfare*, based on administrative data drawn from a random sample of cases leaving welfare during the first eighteen months of the reform initiative. While these studies do not explore substance abuse treatment issues specifically, the March 1999 report concludes that “Maryland’s bi-partisan, empirically-grounded, locally-driven reformed welfare system continues to work well and we find no evidence to suggest that mid-course corrections are needed.”

⇒ **Factors that Inhibited Maryland’s Medicaid Managed Care Program**

Organizational Capacity—Inconsistent Assessment and Treatment Placement Instruments.

Initially, the managed care program was hampered because assessment and treatment placement criteria were not standard across the MCOs. Advocates expressed concern that the considerable latitude granted MCOs in implementing substance abuse assessment and treatment requirements would result in their under-providing treatment services that could be expensive. During the first year, individual MCOs made placement decisions according to their own criteria, making it difficult for the DHMH to evaluate those determinations and make comparisons among providers. For example, when participants were discharged from residential care and needed outpatient treatment, the DHMH did not know whether the nine MCOs were using the same criteria to make referral determinations.

After a year of leaving assessment and treatment decisions up to the MCOs—and amid mounting concerns—the legislature passed a law requiring MCOs to use uniform assessment and treatment placement instruments--the Addiction Severity Index (ASI) assessment tool and American Society of Addiction Medicine (ASAM) Patient Placement Criteria II. To expedite usage of the ASAM Criteria, the DHMH paid for the manuals and training for MCO staff in how to use this instrument. MCOs are now required to conduct a full health assessment, including the ASI, for every TANF participant, regardless of whether substance abuse is suspected at welfare intake. If the assessment indicates that the participant is a substance abuser, MCO staff uses the ASAM to make treatment placement decisions.

This ability to change procedures early in the process is indicative of Maryland’s commitment to increasing the effectiveness of the initiative.

Organizational Capacity—Start-up Challenges. As with any major change in complex systems, some basic start-up problems arose as Maryland launched the managed care/TANF program. In February 1998, the Family Investment Administration (FIA) conducted a survey of MCOs to assess the level of coordination between LDSSs and MCOs. While there were several areas of confusion, two seemed to be most significant: 1) the state’s new HealthChoice medical assistance numbers and 2) the means for identifying which of the nine MCOs the participant had selected. The state took several steps to address these problems:

- Top officials reinforced that LDSSs needed to submit accurate forms to the MCOs;
- The consent form was redesigned to include information that would help MCOs identify and track TANF participants; and
- Through an Action Transmittal Addendum, LDSS staff was provided with additional guidance on procedures that had been confusing to them.

Consistent with the state’s commitment to evaluating the TANF/Managed Care Program, a follow-up

survey was conducted by the FIA three months later. Results of this survey indicated that the actions were effective—the forms exchanged between the LDSSs and the MCOs were complete and accurate. DHMH surveys in the winter and spring of 1999, however, indicate that despite these improvements, some problems with completeness and accuracy remain. This follow-up survey enabled the state to assess, reassess, and make progress in resolving this problem.

Interagency Collaboration—Delayed Implementation of Notification Procedures. The LDSSs reported to the DHR that they were receiving fewer than expected *Substance Abuse Identification and Treatment Notification* forms from MCOs, primary care providers, and substance abuse assessment and treatment providers. From the survey of MCOs, the DHR and DHMH determined that MCOs had not developed ways to monitor whether primary care providers were complying with the notification requirement. As a result, data on the number of individuals assessed as needing treatment, the number referred to and receiving substance abuse treatment, and their treatment status and compliance were not available. As a result, the DHR was unable to respond appropriately to TANF participants regarding their participation in mandatory treatment or to monitor requirements of the state's WIA.

The DHMH has taken a number of actions to improve MCO compliance with notification requirements, including biweekly meetings with MCO executives to stress their responsibility for ensuring providers' compliance with notification requirements. In early October 1998, the DHR and DHMH also submitted a formal 11-point Corrective Action Plan to the legislature's Joint Committee on Welfare Reform:

The plan identifies the sources of continuing difficulties in identifying and bringing TANF participants into substance abuse treatment. It also addresses new efforts to train providers, LDSS case managers and MCO liaisons, measures to improve compliance by MCOs, and surveys that will be administered to continue to assess progress.

The Corrective Action Plan demonstrates Maryland's commitment to identify and resolve administrative and service barriers to providing effective substance abuse assessment and treatment.

PROMISING RESULTS

The DHMH added a staff person to coordinate placements into residential, which has resulted in changes to the importance of residential treatment in needs assessments. Between September 1998 and February 1999, a total of 106 TANF participants were placed in residential treatment at a cost of \$927,000 drawn from the special pool of funds set aside by the legislature.¹⁸

¹⁸ The state does not yet have sufficient feedback from the MCOs to report a full range of outcomes for substance abuse services.

There was a four-fold increase in the number of notification forms returned from MCO during the course of one quarter, indicating that efforts to improve the flow of information between the MCOs and LDSSs have succeeded. In October 1998, the DHR instituted a new statewide monthly reporting system to improve collection of participant status data. Each LDSS substance abuse liaison reports the number of consent forms and positive substance abuse screenings sent to the MCOs, as well as the total number of substance abuse notification forms received back from the MCOs. In the quarter from October through December 1998, LDSS staff sent 299 positive screenings to the MCOs, and 43 notification forms were returned to the LDSSs. In the quarter from January through March 1999, the LDSSs sent 200 positive screenings to the MCOs and received 168 notification forms from the MCOs.

This improved information flow is important for two reasons: it helps develop a tracking system for following participants through treatment and it helps staff for monitor overall program outcomes.

NEXT STEPS

In response to the procedural obstacles that arose at the program's start, the DHMH and DHR continue to monitor compliance with the Corrective Action Plan. The TANF/Managed Care program is complex, and the DHMH may soon propose some methods for streamlining it. In addition, in April 1999 Maryland announced three new initiatives in April 1999 targeted to increase the flow of TANF participants into substance abuse treatment:¹⁹

1. A pilot program will place addiction specialists (from local health departments) in select high-volume LDSS offices in Baltimore City and Prince George's County (suburban Washington, D.C.). These professionals will screen all TANF applicants, assess those with positive screenings, and make immediate referrals to treatment.²⁰
2. LDSS case managers will refer TANF applicants to ADAA-funded providers. The providers are instructed, first, in how to bill Medical Assistance once the TANF applicant becomes a participant and, then, how to manage the transition when the TANF participant enrolls in an MCO.
3. Persons enrolled in MCOs, including TCA enrollees, may make one self-referred visit to any ADAA-certified substance abuse provider that will be reimbursed by the MCO. For the consumer ready for treatment, this self-referral option removes perceived obstacles associated with seeking referrals from a primary care provider.

¹⁹ Other promising initiatives include a Baltimore City Health Department pilot project underway to provide outreach education in substance abuse screening to primary care providers. This training also addresses the legal requirements for screening and treating of TCA participants. In addition, TCA substance abuse treatment information is now on the DHMH HealthChoice website.

²⁰ In the nine other Baltimore City offices, all TCA participants who screen positive or who request referrals for treatment are coordinated and referred by the Baltimore Substance Abuse Systems (BSAS), the city's ADAA grant-funded entity. This ensures appropriate referrals and links to BSAS sub-grantees, as well as coordination with such support services as skills training, transportation, childcare, and housing.

Maryland's creative attempts to identify and treat substance abusing women on welfare led CASA to award the state one of the CASAWORKS for Families grants, supported by CASA through The Robert Wood Johnson Foundation. Maryland began implementing CASAWORKS in January 1999. The results of the three-year demonstration project are intended to inform and assist states in policy, program, and practice development toward addressing the challenges of substance abuse and welfare reform.

NEVADA'S SOCIAL WORKERS HELP TANF PARTICIPANTS WITH MULTIPLE BARRIERS TO WORK

SUMMARY AND CONTEXT

Nevada made a bold and conscious decision to focus its attention on those participants with multiple severe barriers to work, including substance abuse. The state deployed 30 social workers and two supervisors in the state's 19 district welfare offices to provide a variety of services for TANF participants with the most barriers to work-- those involved with substance abuse, mental health, and domestic violence. Integrating social workers into the welfare system means that more of the most vulnerable TANF participants can receive substance abuse and psychosocial assessments, treatment referrals, case management, home visits, and support from multidisciplinary teams. Nevada's innovative response to assisting participants with numerous barriers to employment has benefited the state's welfare reform efforts by:

- focusing on those with the most barriers to work, instead of targeting programs to individuals with fewer barriers to employment; and
- increasing TANF staff capacity to address the hard-to-serve population through new staff resources and specialized programming;

Organizational Context and Key Welfare Provisions

The Welfare Division within Nevada's Department of Human Resources (DHR) is responsible for the TANF cash assistance and employment and training programs.²¹ Nevada utilizes a state-administered system for its human services, which are delivered by 19 district offices. The Bureau of Alcohol and Drug Abuse (BADA) was relocated from the Department of Employment, Training, and Rehabilitation to DHR's Health Division. BADA certifies substance abuse treatment providers and purchases treatment services but it does not directly provide treatment. Nevada did not have a federal demonstration waiver. Effective January 1997, the TANF plan's key provisions include:

- **24-month time limit.** *Limits participants to 24 months of cash assistance, followed by at least 12 months off assistance. This cycle may continue until reaching the 5-year lifetime limit.*
- **Work first philosophy and quick referrals.** *Occurs at the time of application, immediate referral to the Welfare Division's employment and training program for employability assessment and access to job-related services. Requires a Personal Responsibility Plan.*
- **Work requirement.** *Requires that participants work when WD staff has determined them to be ready, but no later than 24 months after first receipt of cash assistance. Establishes an incremental, three-level sanctioning process for failure to comply with work requirements and mandated treatment (can result in full case closing).*
- **Treatment as a work activity.** *Policy to count required substance abuse treatment as work activity but not toward the state's federal work participation rate;*
- **Unified funding.** *Blends TANF and Welfare-to-Work funds to serve those hardest to employ.*

²¹ The Welfare Division is also responsible for the following: welfare-to-work program, ChildCare Development Fund, Medicaid eligibility determination, child support enforcement, food stamps, low income home energy assistance, aged, blind supplement, and homeless grant assistance.

BACKGROUND

Several key political actions influenced the decision to add social workers to the Welfare Division staff. Social workers had not worked in the Welfare Division since the mid-1980s. In 1994, the Governor's Welfare Reform Task Force, a broadly representative policy-oriented group, recommended incorporating social workers into the welfare intake process. In 1995, the Welfare Division Administrator requested five social-worker positions from the legislature to serve the hardest to employ welfare participants. The legislature went beyond this request by establishing *ten* new worker positions and one supervisory position, primarily in response to overarching political support from the community, advocates, and interest from within the legislature itself. During the next biannual session in 1997, the legislature allocated TANF funds to create 20 additional social-worker positions and another supervisor.

THE INNOVATION

Social workers have become an integral, specialized resource for helping TANF families with the most barriers to work.

Their responsibilities include participant assessment, case planning, case management, and service coordination activities for those participants deemed in need of special assistance. In providing these services, social workers are members of a local team that also includes the Welfare Division's Eligibility Certification Specialists (ECS) and Employment and Training Specialists (ETS), BADA staff, and community treatment and service providers

The social workers are certified to administer and score the Substance Abuse Subtle Screening Inventory (SASSI). They screen those participants suspected by ECS or ETS staff of using drugs or alcohol if such use affects their ability to work or to parent their children.²² If the results of the SASSI indicate probable substance abuse or if the participant self-discloses substance abuse, the social worker shares relevant information with a designated BADA staff member. Within two workdays, the BADA partner makes arrangements with a BADA-certified provider to complete a more in-depth assessment. If substance abuse is determined to be a problem, the provider then identifies the best course of treatment, using the ASAM Placement Criteria. These treatment requirements become part of the participant's Personal Responsibility Plan, and sanctions can occur for refusing further assessment and treatment.

²² In early 1998, Nevada began screening all TANF applicants for potential substance abuse that would affect the applicant's ability to work. ECS staff conduct intake-screening assessments with TANF applicants using a comprehensive form with CAGE questions embedded within it (as well as questions about domestic violence and mental health issues). If the applicant is approved for TANF, the ETS conducts a post-approval assessment, with more specific and in-depth exploration of barriers to employment, including substance abuse.

In addition to administering the SASSI assessment, the social workers conduct detailed psychosocial assessments of participants with severe multiple barriers to employment. These barriers include substance abuse, domestic violence, and relationship and child-rearing problems that may undermine economic independence. The psychosocial assessment involves interviews with family members, a home study, and interviews with school and medical care professionals when needed, and it can include additional referrals to obtain more information regarding mental functioning.

Social workers also become the case managers for TANF participants facing severe multiple barriers to self-sufficiency. In this capacity, they perform a number of important functions. First, they develop and amend the Personal Responsibility Plan with participants. They also engage in many case management activities, such as monthly follow-up visits with families until barriers are alleviated or resolved. Subsequent home visits are conducted at least quarterly.

In a creative display of local coordination, social workers also convene multidisciplinary teams of service providers in each community to coordinate participant services. Participants share information, discuss program changes, conduct case “staffings”, and determine the most appropriate interagency actions for the participants in that community. In some communities, a team composed of a smaller number of providers jointly staffs cases.

KEY FACTORS THAT FACILITATED OR INHIBITED NEVADA’S SOCIAL WORKER PROGRAM

The next sections describe how some of the key factors analyzed in Chapter II facilitate or inhibit the ability of Nevada's social worker program to achieve its goals.

⇒ Factors that Facilitate the Ability of Nevada’s Social Worker Program to Achieve its Goals

Collaboration Among Agencies—Formal and Informal Relationships Between The Welfare Division and BADA. The Welfare Division and BADA took several deliberate steps to ensure that social workers would be integrated into the welfare office. First, they developed a contract specifying their strategy to work together in serving TANF participants with substance abuse. In a significant demonstration of commitment to this relationship, the Welfare Division allocated \$379,400 in FY 1998 and \$758,800 for FY 1999 of its own budget to purchase treatment services through BADA-certified providers, using BADA’s fee-for-service schedule and sliding-fee scale. An accompanying protocol specifies selected performance standards (such as a treatment plan within two days of referral).

During the site visit, we observed that this collaboration has been realized at the local level. Since signing the contract in spring 1998, Welfare Division social workers have worked closely with the BADA staff in referring TANF participants in need of treatment.

Organizational Capacity—Culture Change Training and the Professional Development Center.

The Welfare Division helped change the traditional culture its offices through an innovative training initiative called “We Have a New Attitude.” We Have a New Attitude was designed to support the Division’s emphasis on helping those with multiple severe barriers to work. Over a three-month period, 10 teams of 3 front-line staff conducted mandatory weeklong training for all 800 employees from all levels of the Welfare Division. The training covered five courses, addressing the following topics:

- the meaning of culture change and the way in which different functions (especially those of the new social workers) support the agency’s welfare reform objectives;
- the importance of mutual responsibility;
- methods for assisting participants to pursue employment and other goals, as well as helping them attain a feeling of empowerment;
- strategies for “making job finders job keepers”;
- problems related to substance abuse and domestic violence that act as barriers to TANF participants.

By the end of the training, staff generally understood where they “fit” in the larger agency strategy for serving TANF participants, and how the evolving roles of the new social workers assisted participants and staff.

The new Professional Development Center further illustrates Nevada’s commitment to training. The center was established by the Welfare Division in 1998, and offers, among other resources, a training environment for the Welfare Division and other staff. In 1998, for example, the Professional Development Center provided standardized training for the most recent academy of eligibility, child support, and employment and training workers in all southern Nevada field offices.

Funding and Resources—The Professional Development Center and Welfare Division Funding.

Besides offering training to relevant staff, the Professional Development Center also provides the following resources to TANF participants:

- training facilities and classrooms to help them develop job skills and abilities;
- an on-site, licensed child care facility for participants while they attend classes or work activities.

The Welfare Division continued its commitment to adequate funding and resources for the social worker program by committing almost \$1.4 million in FY 1998 and FY 1999 in its budget to purchase treatment services for TANF participants through BADA-certified providers. This funding, along with the establishment of the Professional Development Center, represents a tangible step toward ensuring that the Nevada welfare system has sufficient funding and resources to address the needs of TANF participants—including those with substance abuse problems. Welfare Division staff now has a direct financial relationship with BADA staff, creating an important vehicle for ongoing collaborative efforts.

⇒ **Factors Inhibiting the Ability of Nevada’s Social Worker Program to Meet its Goals**

Organizational Capacity—Limited Acceptance of Social Workers and Need for Clarification of Roles. Despite the culture-change training, some Eligibility Certification Specialists (ECS) and Employment and Training Specialists (ETS) were reluctant initially to accept the new social workers. Social workers were seen as different from traditional Welfare Division workers; they were expected to perform different functions for which they received higher salaries and served lower caseloads (the average social worker’s caseload is 35 families, while ECS and ETS caseloads average about 130 and 100 cases, respectively). Social workers undergo training and certification in administering the SASSI and are experienced in conducting psychosocial assessments, making home visits, and managing difficult cases. At the same time, social workers were characterized as generalists with a range of skills for assisting TANF participants in surmounting a variety of employment barriers (e.g., mental health problems and domestic violence).

In addition, ECS and ETS workers were uncertain as to how the social workers’ duties would affect their own work. For example, in the past an ETS conducted assessments and developed case plans with participants. Substance abuse may or may not have been addressed in the plan. The ETS might have exempted the participant from employment and training requirement, an option that may be less feasible now, under welfare reform. Or, the ETS may have believed the social workers were not necessary because the ETS had traditionally performed functions now assigned to social workers. Finally, with the introduction of social workers, existing staff questioned what went on during home visits or during multidisciplinary team meetings.

In a concerted effort to alleviate the concerns of staff, social workers and their supervisors created a number of opportunities to helping Welfare Division staff understand the new roles of social workers within the Welfare Division. In addition, the social workers actively collaborated with staff to address the needs of individual participants, thus serving as “on call” resources to staff. Specifically, social workers have:

- coordinated brown bag lunches to explain their roles, answer questions about participant services, and discuss how they were dealing with the changing responsibilities;
- invited other staff to accompany them on home visits--some staff have accepted;
- staffed referred cases with ETS supervisors to help them understand what acceptable referrals and expectations are and to clarify the types of cases best suited to social workers’ skills and the ways other workers can best work with each case.

Over time, Welfare Division staff began to approach the social workers for advice on cases, and these

exchanges have become more common as the positive results of the social workers' case management have become evident. A particularly promising development finds ECS and ETS workers now requesting that their units "build the confidence and competencies" evidenced by the social workers to increase their own effectiveness in addressing the needs of hard-to-serve TANF participants.

Funding and Resources—Service Delivery Challenges in a Frontier State. The ability of social workers to connect with the population hardest to serve was hampered by the fact that they needed to deliver services over a vast, sparsely populated area. Nevada is a frontier state with a population density of 15 persons per square mile, including eleven counties with fewer than 10 persons per square mile. Accordingly, the social worker often must cover hundreds of miles and serve multiple small towns.

In creative attempts to overcome this barrier, social workers have actively reached out to Welfare Division staff and other agencies to coordinate services. First, they maintain a number of key contacts with TANF participants when feasible, often utilizing other service partners within and without the agency for support: initial face-to-face assessments, monthly telephone updates, face-to-face meetings at least quarterly. When necessary, social workers coordinate with the ECS to check on participant activity, relay messages, or gather information. Social workers also coordinate and collaborate with other services providers in the area—including social workers on Native American reservations, staff at Employment Security, and JTPA providers. In developing these crucial support systems, social workers extend their "eyes and ears" in the community, as well as enlist service partners in TANF cases.

PROMISING RESULTS

A total of 123 different TANF participants received some form of substance abuse assessment and treatment since the Welfare Division and BADA protocol went into effect in July 1998. The Welfare Division estimates that were it not for this program, most of those individuals would be on a waiting list for services or not seeking services at all. It is too early in the innovation to assess treatment outcomes.

Social worker activity during March 1999 offers another view of the impact of this innovation. During March, 28 social workers served 662 TANF participants confronting serious barriers to employment. The most frequent primary diagnoses of these participants were mental health problems (28 percent), substance abuse (21 percent), domestic violence (17 percent), and medical/health problems (15 percent). Because social workers address multiple problem cases, the number of participants with substance abuse as a primary or secondary problem in March was 220, or one-third of the social workers' caseloads. The social workers also supervise university social-work interns assigned to the division's Supporting Teens Achieving Real-life Success (STARS) program. In March 1999, there were 199 STARS cases.

In addition to reaching a greater number of hard-to-serve TANF participants, social workers have contributed to these promising results:

The multidisciplinary teams facilitated broad-based community relationships to address the barriers TANF faced by TANF participants. These teams are critical in coordinating services and developing communication mechanisms that allow social workers to work effectively with the hard-to-serve population.

Private treatment providers have met with Welfare Division staff at the welfare office, thus creating an important opportunity for interagency collaboration. This allows both the Welfare Division staff and providers to better understand the processes and expectations of each organization. It also creates chances for Welfare Division staff to receive additional training in substance abuse assessment and treatment. In one office, for example, the provider conducts assessments at the local welfare office rather than asking participants to come to the provider--virtually eliminating "no shows" at the initial assessment and allowing timely development of a new participant plan.

Barriers between the Welfare Division and BADA are dissolving, and competition among treatment providers is increasing. The contractual agreement between the two agencies specifies that TANF funds may be used for services provided by the 23 BADA-certified treatment providers. This arrangement allows providers to bill the Welfare Division directly using the BADA fee schedule. It also vests the Welfare Division with authority to communicate and enforce expectations regarding identifying and providing treatment and to impose sanctions when participants fail to comply with treatment requirements. The training about substance abuse assessments provided by BADA to the social workers also helped dissolve barriers between the two agencies.

Because the Welfare Division purchases treatment services directly from providers, competition among treatment providers is increasing, resulting in provider bids offering increasingly innovative programs. In one Las Vegas area office, providers offer TANF participants full access to treatment, including crucial support services.

NEXT STEPS

Three emerging practices hold additional promise for the social worker program:

- The Welfare Division and BADA signed a formal Memorandum of Understanding in June 1999. This MOU recognizes that Welfare Division social workers have developed the requisite skills to refer TANF participants directly for assessment and treatment.
- The Welfare Division and BADA are conducting an impressive amount of training. Both groups continue to offer cross training, and BADA is financing refresher training in substance abuse signs and symptoms for 700 Welfare Division staff. The Welfare Division is also planning to train its social workers in the ASAM Placement Criteria to further their skills in referring participants for treatment.
- The Welfare Division plans to utilize social workers as internal mentors in building other

Welfare Division staff members' competencies concerning substance abuse identification, treatment, and related areas.

NORTH CAROLINA'S QUALIFIED SUBSTANCE ABUSE PROFESSIONALS

SUMMARY AND CONTEXT

North Carolina designed an ambitious initiative that placed Qualified Substance Abuse Professionals (QSAPs) in every county Division of Social Services (DSS) office. The QSAP positions were created as part of the state's 1997 Work First Substance Abuse Initiative, and are employed by 40 local Mental Health Authorities across the state. The 46 full-time and 15 part-time QSAPs have become the linchpins for screening, assessment, treatment planning, and care coordination for Work First participants with substance abuse problems. North Carolina's commitment to addressing the needs of the substance abusing TANF population has benefited the state's welfare reform efforts by:

- increasing TANF staff capacity to identify and address substance use among participants; and
- shifting the way that substance abuse is addressed in welfare offices by redefining the character of services provided to participants who abuse substances.

Organizational Context and Key Welfare Provisions

The DSS within North Carolina's Department of Health and Human Services' (DHHS) is responsible for the TANF program, including employment services. North Carolina is a locally administered system in which benefits are delivered by 100 county DSS offices with support from four regional field offices. The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (MH/DD/SAS) is also part of the DHHS. Services are delivered through 40 area mental health authorities (or area programs) covering all 100 counties. The Women's Services Coordinator in SAS oversees the implementation and operation of substance abuse programs and activities for TANF participants.

North Carolina implemented welfare reform before passage of federal legislation. After the governor announced the state's Work First policy in March 1995, North Carolina obtained federal waivers that dramatically changed the way welfare services were delivered. These waivers were implemented in July 1996, and largely constituted the state's Work First welfare reform program and they were adopted as the state's TANF plan effective January 1997. Key provisions include:

- ***A focus on work.*** Includes a required mutual responsibility agreement.
- ***Time limits.*** Participants involved in the work program may receive benefits for two years, and may reapply for benefits if they have not received benefits for a period of three years. Requires participants to spend the appropriate portion of a 35-hour per week work requirement in work activities counted by federal law and the remainder in activities (such as treatment) that support work and self-sufficiency.
- ***Local flexibility and planning.*** Emphasizes partnerships among localities, community-based organizations, and state agencies;
- ***Job Search Requirement.*** Requires participants to perform job searches before determining eligibility by registering at the county First Stop program run by the state Employment Security Commission.

BACKGROUND

North Carolina's Work First incorporates a number of substance abuse-related recommendations that

were generated by a broadly representative state task force. The Work First Substance Abuse Initiative addresses many substance abuse-related barriers to employment, and both state officials and the General Assembly believe that the QSAPs will be essential to its success. Because local substance abuse counselors are stationed in welfare offices, the initiative also builds bridges between welfare reform and substance abuse treatment at the operational level, where both welfare and substance abuse services are delivered.

THE INNOVATION

The QSAP positions were the linchpins for implementing the Substance Abuse Initiative in local offices. The Substance Abuse Services Section of MH/DD/SAS funded the recruitment, training, and deployment of QSAPs for each area program²³. QSAPs have a BA and two years' supervised experience in the substance abuse field, or an MA and one year of such experience, or are certified substance abuse counselors.²⁴ They are paid for by TANF block grant funds. Counties with TANF caseloads above 2,000 employ two full time equivalent QSAPs, and counties with smaller caseloads have one full-time equivalent or share one position among two or more counties. QSAP duties include:

- Serving as liaison between the county DSS and area mental health program;
- Conducting initial screening of TANF applicants and participants for substance abuse;
- Conducting comprehensive assessments, including determining of level of care needed and referral and follow-up;
- Providing care coordination, including collaboration with DSS staff to ensure that barriers to treatment are addressed;
- Tracking participants through the treatment system
- Ensuring that random toxicology screens are administered during treatment;
- Reporting to and consulting with DSS staff;
- Providing basic substance abuse education for Work First participants;
- Cross-training DSS staff;
- Collecting data about screening, assessment, and behavioral observation checklist; controlled-substance felons; toxicology results; and referrals and admissions to treatment.

QSAP and DSS Staff Roles in Screening TANF Participants for Substance Abuse Problems

Effective May 1998, all Work First applicants and participants must be screened for alcohol and substance abuse. Each county DSS has the flexibility to determine who will conduct screenings, which are required before the TANF application is processed, at case review or re-certification (if not done at application), and/or at any other time deemed appropriate. Using local memoranda of agreement (based on a state model), the county DSS and area mental health program determine the screening procedure that works best for them. Therefore, primary responsibility for screening varies among counties. For example, in a large metropolitan county with four QSAPs (two of whom are locally

²³ North Carolina's substance abuse services are delivered through 40 area mental health authorities --or area programs-- covering all 100 counties.

²⁴ Some QSAPs have a BA and/or MA and are certified substance abuse counselors.

funded), the QSAPs conduct the initial screening of new Work First applicants, while DSS staff serve as backup and they screen current Work First participants. In contrast, two smaller, more rural counties share one QSAP, and therefore the DSS workers conduct all screenings

If either or both of North Carolina's screening tools (the nationally validated Alcohol Use Disorder Identification Test (AUDIT) and the Drug Use Questionnaire (DAST – 10)) indicate that substance use is a problem, the TANF participants is referred to the QSAP for in-depth assessment. The QSAPs use the comprehensive Substance Abuse Disorder Diagnostic Schedule (SUDDS IV) as the primary assessment instrument for determining whether the substance abuse requires treatment services.

QSAP and DSSs Roles in Assessing and Treating Substance Abuse among Work First Participants

If the QSAP determines that a Work First participant needs substance abuse treatment, the participant must participate satisfactorily in an individualized plan of treatment as a condition of receiving benefits. The county Work First staff and the QSAP coordinate efforts to ensure that the applicant/participant receives support services required participating in an appropriate treatment plan. The services most often needed are child care and transportation assistance.

The QSAP must notify Work First staff if the participant fails to comply with the treatment plan, as stipulated in the Personal Responsibility Contract that has been developed by Work First staff. If a participant fails to comply with the treatment plan, he or she is ineligible for cash assistance but remains in the Work First Family Assistance case; that is, he or she continues to receive Medicaid, the time clock continues, and the participant is still required to participate in the employment program. Children continue to receive cash assistance through a third-party protective payee.

KEY FACTORS THAT FACILITATED OR INHIBITED NORTH CAROLINA'S QSAP PROGRAM

The next section describes how some of the key factors analyzed in Chapter II facilitated or inhibited the ability of the QSAP program to serve substance-abusing Work First participants.

➤ Factors that Facilitate the Ability of North Carolina's QSAP Program to Serve Substance Abusing Work First Participants

Support from Political and Legislative Officials—Clear Mandates from the General Assembly.

The General Assembly mandated that TANF participants receive assessment and treatment for substance abuse, and it authorized creation of the new QSAP positions. This level of involvement reinforced the importance of building bridges between state and county welfare and substance abuse programs. It also gave them guidance regarding how those programs would work together, thus reinforcing the development of new partnerships.

Funding and Resources—Investments by the General Assembly. The General Assembly reinvested

\$4.3 million of TANF block grant funds to support the new QSAP staff and to add coverage for services not reimbursable by Medicaid (including substance abuse treatment services). In making this investment, the General Assembly demonstrated explicit programmatic and financial commitment to the QSAP initiative.

Collaboration among Agencies—Effective State Memoranda of Agreement. Early in 1998, the state DSS and the MH/DD/SAS developed and signed a Memorandum of Agreement (MOA) that specified the responsibilities of each in reducing substance abuse-related barriers to employment. The MOAs served two important purposes: they specified how new funds were to be allocated across agencies, and they described explicitly the nature of the collaborative efforts required to serve substance abusing Work First participants. For example, under the terms of the MOA, SAS funds area mental health programs to hire QSAPs who work at the county DSS offices, and SAS provides funding for services not covered by Medicaid. The MOA also clarifies other responsibilities of each agency, such as training and technical assistance, enhanced Employee Assistance Programs (EAPs), and confidentiality protocols. Each county developed its own MOA between the local mental health program and the county DSS office, using the state agreement as a model.

The state MOA also designates the liaison for each partner agency—the DSSs Chief of Economic Independence and MH/SA/SASs Chief of Substance Abuse Services through the Women’s Services Coordinator.

The DSS liaison commented that one of the reasons the collaboration has been successful is that liaisons and their “respect our differences and allow each other to do what they do best and produce a very productive give-and-take” in accomplishing mutual objectives.

Reflecting the state model, under the local MOAs, DSS offices and area mental health programs designate staff to provide collaborative leadership to the initiative in their county.

Participation and Control at the Local Level—Devolution of Decision-Making Regarding Program Implementation. Counties used the framework established by the state MOA (e.g., areas of QSAP responsibility, use of specific screening and assessment tools), but they also have considerable latitude in developing local MOAs that reflect their own needs. For example, local DSSs and area mental health programs decide which staff will conduct substance abuse screenings and how the two agencies will address participant transportation and childcare needs. In one county, staff from the area mental health program provides childcare and transportation for applicants whose Work First applications are still pending, and the DSS staff take responsibility once the case is approved. Finally, the MOAs set the framework for ongoing communication and collaboration between the agencies, including specifying reciprocal representation on Work First and Substance Abuse planning committees.

Organizational Capacity—Extensive Training to Support QSAP Effectiveness. North Carolina’s commitment to training about its Work First Substance Abuse Initiative helped DSS staff to integrate and use the new QSAP resources within the welfare system. North Carolina’s DSS and MH/DD/SAS

contracted with the Behavioral Health Care Resource Program at the University of North Carolina (UNC) – Chapel Hill School of Social Work UNC to deliver a range of training under the general heading “The Key to Successful Welfare Reform: Work First and Substance Abuse Services.”

UNC provided two types of training throughout the state.²⁵ First, local DSS and area mental health program staff met for two days to learn about each other’s roles, responsibilities, values, perspectives, and limitations. The meeting also began to establish a process by which collaboration could occur, by allowing participants the time they needed to address barriers to collaboration, and to discuss confidentiality protocols. Second, UNC trained staff in most of the counties in how to use screening instruments and behavioral indicators, and how to become more comfortable performing these new tasks. During the CASA/APHSA site visit, it was clear that staff felt the UNC training was of the key reasons for the successful integration of the QSAPs in the local offices.

⇒ **Factors that Inhibit the Ability of North Carolina’s QSAP Program to Achieve its Goals**

Organizational Capacity—DSS Workers’ Initial Discomfort with Screening. Front-line workers were worried about their ability to screen participants for possible substance abuse. The UNC training addressed this reluctance and apprehension by making sure the concerns were discussed. In particular, training time was spent helping DSS workers learn how to interview Work First participants and how to incorporate screening procedures into their participant interviews. Even after the training, workers generally acknowledged that the specially trained QSAPs were more likely to “pick up on something than I would.”

Local DSS staff reported that, as they worked with QSAPs on individual case situations, their apprehension was reduced.

This increased comfort appeared to occur most quickly in offices where Work First workers and QSAPs are physically co-located full-time. As one administrator commented, “Being part of the office makes all the difference in the world.”

It seems that co-location allows for ease of access to staff, clarifies roles, delineates areas of expertise, makes it easier to build trust, and affords many opportunities for consultation, crisis assistance and case coordination.

Organizational Capacity—Limitations of Substance Abuse Screening Tools. Staff realized that the screening instruments were not always effective in identifying substance abuse. Work First applicants may not always respond honestly to alcohol and drug use screening questions. In one county, “the word on the street is teaching TANF applicants how to manipulate the screening process.” An

²⁵ Some area programs chose to train the local DSSs in their catchment areas, utilizing the training curriculum developed by the UNC Behavioral Health Care Resource Program in collaboration with the SAS Section. Topics included understanding values, unique concerns of -- and best-practice models for -- female clients, and cross-cultural challenges.

applicant for cash assistance has a number of reasons not to disclose a substance abuse problem. In addition to the very strong denial aspect of substance abuse itself, applicants are concerned about the effect that their substance use may have on the custody of their children. One of the most important and consistent messages workers in North Carolina and the other states we visited are trying to send to participants is, “We are interested in getting you needed treatment, not in taking your children.”

To help overcome the limitations of the screening instruments, North Carolina developed a substance abuse behavioral indicators checklist. The checklist was designed to help staff identify substance abuse problems among participants who passed the initial paper screen, but who were nonetheless suspected by the DSS to have substance abuse problems. The checklist describes specific appearances, psychomotor impairments, speech, history of substance abuse-related problems, and other behaviors suggesting that the participant is abusing substances. Positive responses to certain specific items on the checklist require a QSAP referral (e.g., alcohol on breath, loss of license for DWI), while a combination of two or more of other items require a referral. Staff from the UNC Behavioral Health Care Resource Program trained front-line staff on how to use the checklist, how to discuss it with participants, and on how to make referrals to the QSAP.

The checklist makes it clear to Work First staff that they must observe participants and take action at any time particular behaviors, appearances, and patterns appear. The earlier workers can become aware that a participant has a substance abuse problem, the more quickly the participant can be assessed and helped into treatment. There are still many barriers to such early identification, and North Carolina’s behavioral indicators checklist offers workers a solid tool and a structured process to overcome some of these barriers.

PROMISING RESULTS

Data from North Carolina’s Work First Substance Abuse Initiative indicate that a growing number of Work First participants are being served through the assessment and referral process. Although the official effective date of the QSAP initiative was May 1998, due to the need to hire new staff, the actual “start date” varied among the counties. Data below are for the start date through September 1998 and then for the six-month period between October 1998 and March 1999. Since the QSAPs started, 1,226 Work First participants have been admitted to substance abuse treatment.

Table 2. Number of Work First Participants Served through the Assessment and Referral Process

Action	<u>Start Date Through Sept. 1998</u>	<u>Oct. 1998 Through March 1999</u>	<u>Totals from Start Date Through March 1999</u>
Referred for assessment	N = 2,513	N = 3,234	N = 5,747
Percentage of referrals for assessment as a result of checklist	11%	27%	20%

Percentage of assessment referrals receiving assessment	62%	67%	65%
Percentage of those assessed referred to substance abuse treatment	57%	46%	51%
Percentage of those referred to treatment admitted to treatment	64%	66%	65%

NEXT STEPS

North Carolina has taken five steps to enhance the effectiveness of its revised welfare system:

- UNC’s Behavioral Healthcare Resource Program, in collaboration with Substance Abuse Services (SAS), developed a two-day “Gender Specific Treatment” training curriculum. This curriculum was designed to help substance abuse services staff understand the challenges serving substance abusing women and their children: barriers to treatment, domestic violence, child custody concerns, sexual and physical abuse, service needs of children, health care, and supportive services. In addition, a half-day “Gender Specific Treatment” training curriculum is being prepared to assist DSS staff in understanding these challenges.
- The Horizons Program at UNC-Chapel Hill was awarded a CASAWORKS for Families grant— supported by CASA through the Robert Wood Johnson Foundation—and began implementation in January 1999. Horizons is a state-funded program for substance abusing women who are pregnant or parenting and their children. The results of the three-year demonstration project are intended to inform and assist states in policy, program, and practice development toward integrating substance abuse treatment within welfare reform.
- The 1998 General Assembly appropriated funds for a Work First/Substance Abuse Coordinator position to manage the QSAPs and Work First/Substance Abuse Initiative (along with the Women’s Services Coordinator); this position was filled in May 1999. The coordinator is working in the SAS Section of the Division of MH/DD/SAS.
- Effective April 1, 1999, North Carolina implemented a new Work First Substance Abuse Reporting Form that will capture data at all steps, from initial DSS screenings and behavioral checklists through QSAP assessments, referrals to treatment, and admissions and non-admissions for treatment. This data should enable administrators and workers to monitor and enhance the program.

- North Carolina has taken steps to evaluate its Substance Abuse Initiative. The Division of MH/DD/SAS is working with the Research Triangle Institute to determine the effectiveness of the screening instruments and strategies to address barriers to treatment. The UNC School of Social Work also received a \$90,000 grant to evaluate the Enhanced Employee Assistance Program (EAP) developed by the SAS Section to address job retention among substance abusing TANF participants.

ILLINOIS' SUBSTANCE ABUSE TRAINING FOR TANF WORKERS

SUMMARY AND CONTEXT

“Assisting the Client—Putting the Assessment Pieces Together” is a creative initiative of the Illinois Department of Human Services (DHS) to prepare its TANF staff to help TANF participants with problems of substance abuse. This program used internal staff to train nearly 3,000 DHS workers to identify substance abuse among TANF participants, to screen them and refer them for assessment and treatment, thus developing significant new staff capacity within the department. This innovative approach to developing TANF worker skills has benefited the state’s welfare reform efforts by:

- changing the way TANF workers deliver services to participants with substance abuse problems; and
- empowering staff in improving the welfare reform system.

Organizational Context and Key Welfare Provisions

In July 1997, Illinois consolidated programs spanning six state agencies into the Department of Human Services (DHS). This DHS administers TANF, food stamps, Medicaid eligibility, employment and training, child care and family services and substance abuse services. It is a state-administered system, and the Division of Community Operations supervises five regional offices that oversee at 131 offices in 101 counties. Also operating within the DHS, the Office of Alcoholism and Substance Abuse (OASA) contracts with community providers to assess and treat TANF participants and others.

Illinois received a federal welfare demonstration waiver, effective July 1996, which subsequently became the state TANF plan. Key provisions include:

- **A Work Pays policy.** *Permits TANF participants to retain more of their grant—two of every three dollars earned—through a generous income disregard.*
- **Time Limits.** *Establishes a 60-month time limit for cash assistance, although the benefit time clock stops for months in which the participant works for at least 25 hours per week (30 hours beginning October 1999). Also requires TANF applicants to initiate a job search during the first 30 days pending approval of the application.*
- **An Individualized Responsibility and Service Plan for each TANF participant.** *Establishes progressive sanctions for failure to follow the plan—from a 50 percent grant reduction to full termination of cash benefits.*
- **Use of the CAGE instrument.** *Occurs during the TANF intake assessment.²⁶ Those identified with substance abuse are referred to community providers for assessment and treatment.*
- **Mandatory Treatment.** *Participants with substance abuse problems posing a barrier to maintaining employment must attend treatment in order to continue receiving TANF benefits.*
- **An extensive, income-based childcare subsidy system.** *Supports the newly employed TANF participant and continues after cash assistance is terminated.*

BACKGROUND

²⁶ Illinois is developing a new screening instrument to improve substance abuse screening.

The impetus for the Illinois substance abuse training initiative came from two sources. First, in July 1997 six agencies were consolidated into the new DHS, creating a unique opportunity for change. This reorganization required fundamental changes in the way local offices delivered services, and it required new methods for working effectively with families experiencing substance abuse problems. The DHS leadership decided that a statewide training effort would be essential to supporting staff in performing their jobs in the new environment. The second source prompting substance abuse training came from Illinois' TANF plan, which had embraced training and staff development as central to supporting advances in local offices. This strong commitment to changing the structure and culture of DHS and to creating knowledge among staff was critical to initiating the substance abuse training innovation.

THE INNOVATION

Most of the training occurred between June and September 1998²⁷ and was aimed, as expressed in the state TANF plan, at furnishing supervisors and caseworkers with two key skills: 1) an increased ability to design local initiatives addressing self-sufficiency and 2) improved interpersonal skills in working with families. Training objectives specifically linked with substance abuse empowered DHS staff to:

- explore their own, and their participant's, values and preconceptions related to substance use;
- understand the indicators of substance use and its related behaviors;
- reduce professional enabling of participant substance use;
- understand the substance-use screening tool and its relationship to case planning and referral;
- make informed decisions about substance abuse assessment and treatment referrals.

The program targeted supervisors and caseworkers in all 131 DHS local offices, and was aimed at helping workers understand the threat that substance abuse poses to a participant's long-term self-sufficiency. Therefore, the training had to help workers shift their focus away from participants' immediate employment needs and toward removing all barriers to employability and at improving job retention. This shift underscored the importance of communication between participants and workers in making sure that assessments addressed the steps that each participant had to take to attain long-term employment. Finally, the training program stressed that:

“the key component of the potential success of DHS staff is the quality of the interactions they have with participants. Addressing attitudes and bias and increasing knowledge during training is an integral piece of assuring the success of this new program.”

Illinois was particularly creative and thoughtful in the way it designed the training program. The curriculum was developed by outside consultants working in conjunction with a group of 23 DHS staff. Internal staff—including regional and local office administrators, regional trainers, local office

²⁷ Managers attended either their local office training or a session specifically for Local Office Administrators. Training is still been conducted for newly hired staff and for staff identified by regional and local administrators as promising candidates for training.

supervisors, and caseworkers—either volunteered or were nominated to become trainers. For three days, these trainers worked with the consultants in teams of five or six per region to review, refine, learn, and teach the curriculum. Following this “training of trainers,” the core DHS staff conducted similar sessions in each local area of the state. This strategy produced an invested, enthusiastic group of trainers and a practical, meaningful curriculum well tailored to the needs and perspectives of local DHS staff.

Trainers used a variety of techniques to share their knowledge with DHS staff, including lectures, role-playing, brainstorming, tests of knowledge, group discussion, small group activities, and feedback. The training program was designed to offer workers practical “tool kits” in areas such as communication, motivational strategies, problem-solving, substance abuse screening, and removing barriers to employment. The training in substance abuse lasted for one day and consisted of six modules:

1. Healthy Partnerships: Helping professionals, labeling, attitudes, beliefs and assumptions
2. Here are the Facts: “Is it true?” activity, defining drug terms, reasons for using substances, risk factors for substance abuse
3. Addiction: Process of addiction, observable signs, types of treatment, troubled families
4. Tools for Helping Professionals: Characteristics of effective helpers, common barriers to treatment, listening skills, asking questions
5. Participant Characteristics: Defense mechanisms, resistance, cultural blocks, enabling
6. Confidentiality and More: Special emphasis on role-playing different confidentiality issues

To build the basis for community collaboration, substance abuse assessment and treatment providers funded by the local Office of Alcohol and Substance Abuse (OASA) were encouraged to attend local training sessions. Providers who attended the sessions shared information about their services and, in turn, learned about changes in local DHS offices, especially regarding referrals and follow-up procedures.

KEY FACTORS THAT FACILITATED OR INHIBITED ILLINOIS’ TRAINING PROGRAM

The next sections describe how some of the key factors identified in Chapter II facilitated or inhibited the ability of Illinois’ training program to achieve its goal.

⇒ Factors that Facilitated the Ability of Illinois’ Training Program to Achieve its Goals

Participation and Control at the Local Level—Building on Prior Experiences. Three earlier human-services projects contributed to Illinois’ success in coordinating new strategies in multiple communities (See Table 3). The lessons from these projects were applied to the training initiative and offered critical guidance to staff, particularly regarding the importance of: building and nurturing local service collaborations; enlisting the early support of staff, unions, and providers; increasing

responsiveness to requests from staff and from communities; and enhancing continuity across policy, programs, and practice.

Table 3. Illinois' Prior Human-services Projects

Project	Time Frame	Description
Annie Casey Foundation-funded Federation Project	Initiated in 1995 and maintained through present day	Consists of pilots in five communities to better serve children and families by establishing creative collaborations between local public and private agencies and their state counterparts.
Substance Abuse Pilot Projects	Initiated in fall 1996 and no longer considered a pilot	Targeted three communities with significant substance abuse problems. Guided Illinois' response to TANF participants with alcohol and drug problems through innovative experiments in coordinating public and private resources for assessing and treating substance abuse.
State and Local Administrator Re-engineering Projects	Concentrated between fall 1997 and summer 1998	Promoted decentralized decision-making, reorganization of the work and structure of local offices, and local collaboration. Local offices maintain many of these activities.

Participation and Control at the Local Level—The Significant Role of Regional Staff. Because regional staff was involved in all aspects of planning and executing the training program, it has been sensitive to the programmatic and logistical needs of each region.²⁸ For example, the regional teams were able to plan training around the timing of other local activities. Moreover, the trainers believe that their ability to maintain a dialogue with colleagues regarding newly acquired concepts and skills is an important element in sustaining the changes introduced during training. For all of these reasons, the DHS considers this new decentralized approach to training very successful.

Support from Political and Legislative Officials—Strong Support from Key Staff. A number of key state officials, public employee unions, and TANF staff members supported the training program, giving it credibility and political backing. DHS leadership in several divisions²⁹ have committed to the yearlong training initiative—a significant gesture, given that thousands of staff members were involved. Public employee unions were involved in the program and supported it. In fact, the DHS has encouraged union participation with respect to welfare reform generally and this training specifically.

Organizational Capacity—Investing in Professional Development. The Illinois DHS instituted important formal support mechanisms to strengthen the organizational capacity and adaptability of DHS offices to handle changes in the welfare system. To help staff understand the overarching organizational and management environment within which welfare reform operates, DHS held three Community Operations Leadership Academies for Local Office Administrators and select central office staff. These

²⁸ An example of logistical planning is the staggering of training by the regional training teams in order to avoid shutting down very small offices.

²⁹ This leadership includes the Secretary of DHS, Director of Community Operations, Associate Director of OASA, and Regional and Local Office Administrators within Community Operations.

Academies focus on key processes that promote organizational ability, including re-engineering local offices, streamlining hiring practices, improving performance trends, and strategies to attain improved outcomes for families.

In addition, DHS has supported community collaboration in welfare reform through its recent annual assembly for DHS management staff, “Working Together for Change—Creating Success Cooperatively.”³⁰ This assembly enabled staff and others working in the areas of alcohol and substance abuse, mental health, and domestic violence to develop regional strategies geared toward improving services offered to TANF participants.

⇒ **Factors that Inhibited the Ability of Illinois’ Training Program to Achieve its Goals**

Organizational Capacity—Worker Concerns About Increased Workload. The Illinois training initiative was conducted during a time of major organizational changes within and outside of DHS, and in the early phases of welfare reform. Some participants in the initial training were concerned about workload increases arising from their changing roles in managing participant cases. Their biggest concern was that the “Assisting the Client” training was designed to prepare them to confront participants about substance abuse problems, which they feared would result in new and difficult responsibilities such as finding treatment programs and monitoring participant compliance with treatment.

Staff in Illinois has taken steps to address these concerns. For example, they have prompted discussions among trainers and front-line workers, designed to help workers understand the critical role that substance abuse plays in inhibiting staff and agency efforts to return TANF participants to work. These discussions make three main points:

- The role of the worker is to assist participants in overcoming barriers to long-term self-sufficiency--including substance abuse;
- This responsibility may seem more demanding than the old AFDC eligibility model;
- Ultimately, if workers can screen, assess, and refer participants to treatment, they will have more time to serve participants and will be able to serve them more effectively. Treatment services ease the burden on DHS staff by incorporating help from a qualified provider partner. In the long run, workers will create additional work for themselves by not addressing substance abuse--as participants cycle in and out of welfare.

It is noteworthy that front-line workers helped this dialogue from one of the three substance abuse pilot sites (listed in Table 3) that reported that substance abuse screenings and referrals did not create additional work. In fact, effective automation procedures have expedited referrals to treatment providers, who, in turn, have provided timely information about the treatment plan and the participants’

³⁰ DHS holds an annual Assembly for the entire management staff (about 350 people) to support system change.

progress. (This DHS office had developed effective partnerships as part of the pilot program, including co-locating with community service providers.)

The workers emphasized that co-locating providers and workers made screening and assessment easy and effective and that they are comfortable referring participants based on their own experience, intuition, and observation rather than relying exclusively on the CAGE interview questions.³¹

“The most valuable aspects of having the providers on-site are the personal relationships and the trust between staff,” one worker said. “When you have providers on-site you really see results.”

Organizational Capacity—Staff also Struggle with Substance Abuse. Trainers perceived that part of the initial staff discomfort appeared to derive from the experiences of staff with substance abuse among themselves, their families, or their friends. Since the training directly addressed the values, biases, and attitudes everyone brings to the complex issue of substance abuse, it resulted in some staff facing their own personal struggles with substance abuse (e.g., own use, active recovery, co-dependency). The trainers had to address these feelings and reactions. For example, they challenged misconceptions and biases among staff—“If my Uncle Joe could just quit drinking when he decided to, why can’t my client?” Trainers also led discussions regarding the dangers of professional enabling of participant substance abuse, and offered specific techniques for workers to use in guarding against it.

Illinois also provided an opportunity for staff to seek assistance for themselves. Since the CASA/APHSA site visit in November 1998, Illinois has taken additional steps to help those workers who want help. Based on an Employee Assistance Program (EAP) model already in place in a few offices, DHS increased the number of EAP coordinators in every region, and it agreed to conduct an employee-awareness campaign aimed at encouraging employees to use EAP services. The EAP coordinators will serve as the point of first contact for employees seeking help with substance abuse or other personal or family problems, and will facilitate a confidential connection with either the union-sponsored EAP for line staff or the state-sponsored EAP for non-union employees.

PROMISING RESULTS

As of spring, 1999, nearly 3,000 DHS staff members—almost 60 percent of the total staff—have attended “Assisting the Client” training sessions. In four regions, more than 1,700 local DHS staff attended 82 sessions conducted by teams of two DHS trainers. Using the same curriculum, in Region 1 (Cook County/Chicago), the consultant trainers trained 1,000 employees over 40 training sessions.

Referrals of TANF participants to substance abuse assessment and treatment have increased. Approximately 50 referrals were recorded in April 1998—before the training began—compared with 289 referrals in March 1999, after initial training was completed. Officials in Illinois note that other factors, such as co-locating welfare and substance abuse treatment staffs have also contributed to the

³¹ Illinois’ TANF intake assessment includes substance abuse screening using the CAGE instrument. (Illinois is developing a new screening instrument to improve substance abuse screening.)

increase in assessments and referrals. Illinois has also been changing its data reporting system to more accurately and expeditiously gather data on referrals for substance abuse assessment, treatment, and subsequent outcomes.

Participant evaluations of “Assisting the Client—Putting the Assessment Pieces Together” indicate that participants found two aspects particularly effective: first, trainers were drawn from the field; and second, the trainers used role-playing and other specific techniques to help staff identify substance abuse and make referrals for treatment. Participants have also praised the practical resource materials and tools to use on the job as well as the participation of community substance abuse providers in the training sessions—their knowledge of services, the networking opportunities, and technical assistance. The chief concern about the training cited by trainees was the pressure of competing priorities within a limited work period.

Staff trainers believe that generic aspects of the training, such as characteristics of effective helpers and listening skills, have enhanced worker capacity beyond assisting substance-abusing participants. Trainers reported that staff members are open to the training because of its timeliness and relevance to the “working differently” context of welfare reform.

“Line staff were hungry for the information and permission the training gave them,” one trainer observed.

The trainers also noted an increase in referrals for substance abuse assessment and treatment immediately following the training.

NEXT STEPS

Building on the success of “Assisting the Client—Putting the Assessment Pieces Together,” the Illinois DHS is planning ongoing training to sustain these gains. To address a concern that referrals may decrease over time, refresher and in-service training will be conducted. In many local DHS offices the local substance abuse provider(s) conducts in-service programs for staff, offers on-the-job technical assistance, participates in joint case staffing and shares office space with welfare staff. In addition to increasing the number of participants who are referred for substance abuse treatment and enhancing DHS staff ability to identify, refer, and manage cases, these activities reduce the number of conflicting case plans, increase the scope of support services to help participants succeed in treatment, and lead to better treatment and service plans.

The FY 2000 DHS budget includes training funds for DHS to prepare staff for co-case management—in which staff from multiple agencies will function as a team to develop joint case plans, utilize effective staffing patterns, and solve problems collectively in ways that draw from the expertise of each team member. In keeping with Illinois’ strong commitment to local partnerships, this next level of training will focus on offering practical strategies and skills required to ensure that collaboration works. To support this goal, the DHS has been conducting provider meetings across the state, designed to enhance

relationships among agencies, build a common base of knowledge, and to improve the ability of local agencies to solve problems.

Furthermore, using the substance abuse pilot programs described above as models, the Illinois DHS has initiated a pilot program in which treatment providers will locate staff full-time in six DHS offices in Chicago. The provider agency staff will conduct assessments, refer participants to treatment, coordinate and monitor services, and participate with welfare and other staff in case management. The pilot programs will be evaluated to determine if they are effective. One measure of effectiveness will be the impact of substance abuse treatment on employment outcomes of TANF participants.

The six pilot offices are also implementing an early intervention program to modify the information, attitudes, and behavior among select TANF participants who have substance abuse problems that were not identified through routine screening or assessment. For example, a participant who is a sporadic, “recreational” user of marijuana and who does not exhibit signs of substance abuse but fails potential employers’ drug tests will be served under this early intervention program. This education effort, similar to DUI education, will provide participants with information on how to make better choices for themselves while also creating opportunities for staff to intervene with participants earlier in their cycle of abuse or dependence. The three treatment providers who are co-locating staff at the six Chicago offices have agreed on a common model, standards, and curriculum for this early intervention effort. This level of coordination will allow the program to be evaluated and replicated if it is deemed effective.

Chapter IV

KEY FACTORS

Issues that Facilitate or Inhibit Integrating Substance Abuse Treatment and Welfare Reform

In Chapter IV we group responses to closed and open-ended questions into five factors that administrators identified as significant in facilitating or inhibiting their efforts to serve substance abusing TANF participants. These factors offer practical insights into the successes and challenges states have experienced as they designed their TANF programs. In particular, our analysis is framed around responses to the following two open-ended survey questions, supplemented with data from other questions:

1. “Which three to five factors in your state do you think **contribute most** to the effective coordination of policies and practices regarding drug and alcohol treatment, Medicaid, and employment services necessary for welfare reform participants to leave welfare successfully?”
2. “Which three to five factors in your state do you think are the **biggest barriers** to the effective coordination of policies and practices regarding drug and alcohol treatment, Medicaid, and employment services necessary for welfare reform participants to leave welfare successfully?”

The emergent factors are: collaboration among agencies; support from political and legislative officials; availability of funds and resources; the capacity of organizations to meet new challenges; and participation and control at the local level. Each factor is broken into several elements that describe it in more detail. In total, 40 administrators identified elements that facilitated their efforts, and 41 identified elements that inhibited those efforts. Table 4 places their responses into the five factors, and Sections I – V in this chapter examine each of these factors in greater detail.

Table 4. Summary of Factors Facilitating and Inhibiting State Responses to Substance Abuse within Welfare Reform

Key Factor and its Elements	Percentage of Administrators Identifying as a Facilitator (N = 40)	Percentage of Administrators Identifying as an Inhibitor (N = 41)
Collaboration among agencies <ul style="list-style-type: none"> ➤ State-level coordination/uniform vision ➤ Coordination involving local agencies ➤ Guidance from top-level officials ➤ Cross training ➤ Cross-agency tracking systems 	83%	68%
Support from political and legislative officials <ul style="list-style-type: none"> ➤ Leadership of top-level politicians/administrators ➤ Legislative mandates ➤ Integrated policy development ➤ Public opinion 	50%	32%

Table Continued

Key Factor and its Elements	Percentage of Administrators Identifying as a Facilitator (N = 40)	Percentage of Administrators Identifying as an Inhibitor (N = 41)
<p>Capacity of organizations</p> <ul style="list-style-type: none"> ➤ Screening and assessment procedures and training ➤ State offices housed in the same agency ➤ Resistance of front-line workers to address substance abuse ➤ Data collection to identify and track substance abuse 	50%	41%
<p>Availability of funding and resources</p> <ul style="list-style-type: none"> ➤ Overall TANF funding ➤ Medicaid-related funding ➤ Funding/availability of treatment services ➤ Funding/availability of employment-related services 	40%	76%
<p>Participation and control at the local level</p> <ul style="list-style-type: none"> ➤ Local participation in state-level decision-making ➤ Local control of TANF program ➤ Local collaboration between agencies ➤ General ability of communities to maintain reform 	30%	5%

COLLABORATION AMONG AGENCIES

Welfare reform requires extensive collaboration among many agencies. This collaboration provides the foundation for the bridge between the welfare system, the substance abuse treatment system and the employment and training system. Collaboration was the factor most often identified by TANF administrators as key to addressing substance abuse as part of welfare reform. Under the umbrella of collaboration, state-level coordination and uniform vision were the elements most commonly noted, followed by: coordination involving local agencies, guidance from top-level officials, cross training, and cross-agency tracking systems.

Overall, there were 33 responses identifying ways collaboration facilitated state ability to achieve program goals, and 28 responses noting how problems in collaboration inhibited state ability to achieve those goals. Table 5 summarizes these findings.

Table 5. Elements of Collaboration among Agencies

Element	Percentage of Administrators Reporting as Facilitator (N = 33)	Percentage of Administrators Reporting as Inhibitor (N = 28)
• State-level coordination and uniform vision	49%	68%
• Cross coordination involving local agencies	24%	4%
• Guidance from top-level officials	21%	-
• Cross training	6%	14%
• Cross-agency tracking systems	-	14%

COLLABORATION AMONG AGENCIES

Element #1: State-Level Coordination and Uniform Vision

Coordination among state agencies was the element most commonly identified by state TANF administrators as necessary to address to substance abuse among welfare participants.

How state-level coordination and uniform vision facilitated state ability to serve substance abusing welfare participants. Characteristics relating to state coordination and a uniform vision among state agencies were the most commonly noted facilitators to achieving program goals (16 of 33 responses). One state administrator mentioned a:

“breakdown of turf--clients are not ‘my clients’ but ‘our clients’; we are partners with an integrated service approach.” Other states mentioned “collaborative working relationships

toward a common vision and plan,” “coordinated efforts to provide program services,” and “sincere interest and willingness to work together.”

How problems with state-level coordination and uniform vision inhibited state ability to serve substance abusing welfare participants. Several administrators discussed the lack of coordination between agencies and the reluctance of agencies to give up their traditional jurisdictions. One mentioned a difficulty in “getting everyone ‘on the same page.’” Other comments suggest that this difficulty resulted from the number of agencies involved in reform, as described by the administrator: “the number of state agencies and private entities involved in the delivery of services can inhibit close cooperation.” An additional barrier to close coordination seemed to be problems in overcoming agency reluctance to redefine jurisdictional boundaries:

“issues of turf and increased competition between agencies for state funding can cause duplication of effort and a fragmented system of case management.” Similarly, six states experienced a lack of uniform strategy for reform between agencies with different mandates. Comments about “lack of uniform strategy for dealing with substance abusers” and “lack of program and outcome measures” illustrated this frustration.

Another survey question asked TANF administrators to list those programs located under the jurisdiction of the TANF office. Although many functions were located with the TANF agency only one-third of states had housed their Substance Abuse Treatment program for TANF participants within the TANF agency. This separation may pose challenges to states in coordinating activities between TANF and Treatment agencies.

Element #2: Coordination Involving Local Agencies

Eight administrators identified coordination involving local agencies--those agencies that provided direct services to welfare participants--as facilitating the success of state substance abuse policies and programs and only one identified lack of such coordination as inhibiting efforts to achieve that success.

Some administrators focused on the relationship between state and local agencies, noting “effective coordination between state agencies and divisions at the state and local level” and “involvement of all staff at all levels in developing program procedures.” Others mentioned that there were effective inter-agency relationships at the local level. For example, one state administrator commented on the “quality of local communications and understanding among the TANF office, treatment facilities, and employment placement program staff.” These observations highlight the importance of strong interagency collaboration, at all levels among agencies involved in welfare reform.

Element #3: Guidance from Top-level Officials

Guidance from top-level officials was noted by 7 of 33 administrators as facilitating interagency

collaboration, particularly in terms of the ability of strong leaders to bring together a number of agencies with different mandates. One administrator highlighted “integrated policy development at the state level so the programs reinforce movement from dependency to self-sufficiency.” A number of other states mentioned the existence of state-level task forces and meetings to foster a shared strategy for implementing welfare reform, as exemplified by the regular committee meetings at one state that promoted: “ongoing meaningful communication among the agencies and individuals involved in policy and procedural development.”

Element #4: Cross Training

Few state TANF administrators identified cross training efforts (that is, training staff from each agency in the programs and services offered by other agencies) as either facilitating or inhibiting the achievement of program goals. However, unless staff have a basic understanding of substance abuse and know what resources are available to help people with substance abuse problems, those problems will go unnoticed and will cause greater difficulties as participants are unable to find or maintain work. Findings from other parts of the survey suggest that states were just beginning to institute cross training.

How cross training facilitated achievement of program goals. Two TANF administrators specifically identified cross training between agency staff as facilitating their ability to serve TANF participants with problems of substance abuse. Despite the infrequency with which the administrators as a whole highlighted this element, one described how cross training could widen the perspectives of staff from different agencies:

“cross-training of local TANF case workers and treatment providers so that each is aware of the factors influencing client behavior and the role each service plays in the client’s life.”

How limitations in cross training inhibited achievement of program goals. Four administrators noted that lack of cross training inhibited their ability to serve TANF participants with substance abuse problems. One stated that a barrier for the state has been a “lack of cross-agency training regarding the subject of substance abuse, identification of abuse, etc.” Lack of training suggests that some states may be missing a chance to improve the capacity of workers to understand how substance abuse plays out in the lives of participants, thus limiting the capacity of programs to reinforce each other. To the extent that substance abuse specialists are available to front-line TANF staff, the need for cross training may be reduced, but as noted elsewhere, these specialists were available in only 17 states.

Employment and Training administrators provided additional evidence that cross training efforts were just beginning at the time the survey was conducted. Of 47 administrators who responded, only 8 reported that their state had policies that “require or encourage” cross training of case managers and substance abuse treatment providers. Of the 39 states without these requirements, 16 administrators knew of no cross-training attempts, 13 reported cross training in 25 percent or fewer of their counties, 4 reported such training in more than 25 percent of their counties and 5 did not respond.

Element #5: Cross-agency Tracking Systems

Only four administrators cited challenges in sharing data among agencies (for reasons of confidentiality or due to a more general lack of data sharing) as affecting their ability to address substance abuse among TANF participants. However, the barriers related to confidentiality warrant acknowledgment. One administrator reported that the “Department of Health is unable to share data on this population because of confidentiality requirements...” Another overarching concern was the difficulty agencies encountered in sharing information: “Lack of data exchange of identified TANF recipients who require drug or alcohol abuse treatment with Medicaid and employment services.”

SUPPORT FROM POLITICAL AND LEGISLATIVE OFFICIALS

Political and legislative support was the factor second most frequently mentioned by state TANF administrators as facilitating their ability to serve participants with substance abuse problems. Administrators most frequently identified legislative mandates and leadership from top-level politicians and administrators as elements of political and legislative support. Integrated policy development and public opinion were also identified as facilitators.

Twenty-one administrators identified ways that political and legislative support facilitated state ability to achieve program goals, and 13 responses identified how a lack of such support can inhibit ability to achieve those goals. Table 6 summarizes the number of administrators identifying each element:

Table 6. Elements of Political and Legislative Support

Element	Percentage of Administrators Reporting as Facilitator (N = 21)	Percentage of Administrators Reporting as Inhibitor (N = 13)
<ul style="list-style-type: none"> • Leadership of top-level politicians/ • Administrators 	33%	31%
<ul style="list-style-type: none"> • Legislative mandates 	29%	39%
<ul style="list-style-type: none"> • Integrated policy development 	38%	15%
<ul style="list-style-type: none"> • Public opinion 	-	15%

SUPPORT FROM POLITICAL AND LEGISLATIVE OFFICIALS

Element #1: Leadership of Top-level Politicians/Administrators

Political and administrative leaders can convey strong signals that substance abuse and welfare reform are connected, while the absence of such leadership can contribute to a lack of cohesion and inadequate resources for services. State officials were somewhat more likely to identify involvement of politicians and administrators as facilitating their ability to achieve program goals than as inhibiting their capacity to do so.

How support from political and legislative leaders facilitated state capacity to achieve program goals. Seven administrators indicated that leadership by top-level politicians and administrators facilitated their ability to integrate substance abuse services within the welfare system. One administrator noted that the “commitment of top-level administrators of all affected agencies to address the problem of substance abuse among TANF recipients”, had been a facilitator. Another stated that “substance abuse and welfare reform have the direct attention of the governor.” The attention from these politicians and administrators seemed to provide an extra level of support for allocating resources

to state substance abuse policies and programs.

Other responses from the same administrators suggest that there was substantial awareness of the need to create welfare programs that addressed the needs of substance-abusing TANF participants. For example, about half of the administrators estimated that 20 percent or more of TANF participants’ employment plans needed to address alcohol and drug abuse--a substantially higher estimate of need than some prevalence studies have documented.³²

However, a somewhat different picture emerges when administrators were asked to rank substance abuse along with other barriers to work. An overwhelming majority viewed substance abuse to be a moderately important problem. Alcohol and drug abuse ranked as the third most challenging problem to meeting the states’ work requirements on average--behind participants’ low skill levels and transportation problems and ahead of child care availability, job scarcity, poor participant motivation or attitudes, and domestic violence. Table 7 lists potential challenges in order of the mean rank given to each—1 being the most important, 7 being the least.

Table 7. TANF Administrators’ Ranking of Potential Challenges to Meeting States TANF Work Participation Requirements

	Mean Rank	High (1 - 2)	Middle (3 - 5)	Low (6 - 7)
Participants’ lack of skills	2.6	58%	29%	13%
Transportation problems	3.1	48%	39%	13%
<i>Alcohol and drug abuse</i>	4.0	14%	70%	16%
Child care supply	4.3	27%	42%	31%
No available jobs	4.7	20%	39%	41%
Motivation/attitudes	4.7	20%	34%	45%
Domestic violence	4.8	11%	51%	38%

Different interpretations of these responses result in different conclusions about the importance of substance abuse to administrators. To the degree that TANF administrators perceived welfare reform as a holistic process requiring attention to all the needs of TANF participants, then substance abuse was a high priority problem within welfare reform (receiving the third highest average rank). However, to the degree administrators had resources only to address what they perceived to be high-priority problems, then substance abuse became less important.³³

How problems with political and legislative leadership inhibited state ability to achieve program goals. Four state administrators expressed that inadequate state and federal political leadership was a

³² An Urban Institute report (Olsen and Pavetti, 1996) examined four available national surveys that compare substance use in welfare families to the general population. Please see footnote 4 for more information.

³³ Similarly, when asked whether substance abuse was “likely to interfere with your state’s ability to meet its TANF work participation requirements,” a majority (65 percent) of TANF administrators responded that substance abuse is likely to interfere “somewhat.” Only 12 percent of state administrators felt that substance abuse would interfere “a great deal,” and 22 percent answered “not much” or not at all.”

barrier to reform. One administrator stated that the state had a “lack of detailed and consistent direction from the federal government.” Another state administrator noted that “willingness to invest time in communicating across the activities is crucial--this requires leadership.”

Element #2: Legislative Mandates

Legislation addressing substance abuse within welfare reform can provide legal support to state initiatives regarding substance abuse among TANF participants, while the lack of such legislation can inhibit these initiatives.

How legislative mandates facilitated state ability to serve substance abusing TANF participants. Six administrators reported that legislative mandates regarding eligibility and work participation helped them by giving TANF workers legal authority to address substance abuse among TANF participants. For example, one administrator highlighted “mandatory participation in treatment program as condition of continuing eligibility for welfare benefits.” Another wrote: “The requirement for all adult TANF recipients to participate in work activities is an added incentive for staff and recipients.”

How problems with legislative mandates inhibit state ability to serve substance abusing TANF participants. Five administrators said that problems with legislative mandates inhibited their ability to achieve program goals. They noted in particular the lack of policies to allow time for participants to enter treatment, a limited number of activities that count toward work participation, no statute mandating provision of prevention services, and restrictive federal regulations. It seems that either the absence of legislative mandates or legislative mandates that were not responsive to the needs of participants weakened the ability of some states to address the needs of TANF participants with substance abuse problems.

Element #3: Integrated Policy Development

According to TANF administrators, integrated policy development through state leadership generally facilitated state ability to achieve program goals.

How integrated policy development facilitated state ability to achieve program goals. Eight of 21 administrators who believed that political and legislative support helped them reported that their state had a state-directed strategy on policy development. One commented that a key factor contributing to integrating reform efforts in the state had been “integrated policy development at the state level so that the programs reinforce movement from dependency to self-sufficiency.” A number of states described task forces and regular meetings at the state level that enhanced coordination of policies. As one administrator noted, “A task force has been formed for the purposes of filling gaps that need to be addressed due to welfare reform. The team includes representatives from many parts of the Department.” Similarly, another administrator described “state-level meetings that include affected

agencies (Corrections, Child Welfare, Employment, etc.).”

In response to another question, 35 of 51 TANF administrators reported the existence of at least one task force, commission, or other statewide group to address drug or alcohol abuse in general. The three topics most frequently addressed by these groups were: general substance abuse with a focus on treatment (17 states), substance abuse and welfare reform or employment (8 states) and preventing substance use among youth (7 states). As one administrator reported, “Each community has formed a welfare reform community advisory council to address a variety of local welfare reform issues—including drug and alcohol abuse.” This state also had a task force to develop substance abuse screening tools for use by staff in public assistance programs. Another administrator described a Substance Abuse Sub-Committee within a state-level Community Advisory Group that studied “issues of substance abuse and welfare reform, i.e., work requirements, sanctions, requiring treatment, etc.”

How problems in policy development inhibited state ability to achieve program goals. Two administrators commented about problems with inconsistent policies for dealing with TANF participants with problems of substance abuse. One wrote: “Competing program mandates. Different agency policies. No uniform definition for substance abuse. No definite lead agency...” as characterizing the way in which the lack of political support could inhibit different agencies from working together to implement welfare reform.

Element #4: Public Opinion

Two administrators noted that public opinion about welfare participants and substance abuse affected state ability to serve participants with problems of substance abuse. One administrator observed that “public perception of the issue minimizes concern as it relates to welfare recipients.” This lack of concern can act as a barrier to drawing sufficient political and community attention to the need for integrating welfare reform and substance abuse programs and policies.

CAPACITY OF ORGANIZATIONS TO MEET NEW CHALLENGES

In order for staff to effectively serve TANF participants with problems of substance abuse, they must learn to operate within a dynamic, changing environment. Useful data, strong systems of staff training and development, effective substance abuse screening and assessment procedures, and other mechanisms that promote creative problem solving must support them. State TANF administrators cited elements of organizational capacity as the third most important facilitator and inhibitor of their ability to address substance abuse within welfare reform. Screening and assessment procedures and worker training were mentioned most frequently, followed by: the number of functions housed within one agency, reluctance by front-line workers to address substance abuse, and lack of data collection systems to identify and track substance abuse.

In general, 20 TANF administrators identified elements of organizational capacity that facilitated their agency’s ability to achieve its goals, and 17 reported areas in which limitations in their organizations inhibited their ability to achieve goals. Table 8 summarizes the responses from administrators regarding these elements.

Table 8. Elements of Capacity of Organizations to Meet New Challenges

Element	Percentage of Administrators Reporting as Facilitator (N = 20)	Percentage of Administrators Reporting as Inhibitor (N = 17)
• Screening and assessment procedures and training	60%	53%
• Jurisdiction of Agency	30%	-
• Reluctance of front-line workers to address substance abuse	-	29%
• Data collection to identify and track substance abuse	10%	18%

ORGANIZATIONAL CAPACITY

Element #1: Screening and Assessment Tools and Procedures, and Training in How to Use Those Tools and Procedures

Twenty-one administrators commented on this element. Although more administrators viewed screening and assessment procedures and training programs for workers to perform these tasks as facilitating their ability to meet program goals, other indicators suggested that organizational procedures and staff training were inadequate to support effective state responses to substance abuse.

How Screening, Assessment, and Training facilitated the agency's capacity to serve substance abusing TANF participants. Of the 12 administrators who cited screening and assessment procedures and training as helping them achieve their goals, eight spoke to the importance of effective and flexible procedures and communication. Most of their comments related to screening procedures. For example, one state's welfare office

“convened a work group of state, local, and advocacy individuals to create a screening tool to be used by front-line eligibility workers to screen for employability, prior work experience, childcare, transportation, and barriers to employment. Substance abuse is a major area covered during the screening process.”

The other four TANF administrators reported that staff training and staff knowledge in general was a critical factor in supporting their welfare reform efforts. One administrator noted “the casework experience of the staff who worked in the AFDC and Jobs programs.” Another mentioned training initiatives that “allow the Department to look at the whole picture and all factors which affect families.”

As described earlier, a third of states made substance abuse counselors available to TANF or Employment and Training workers.³⁴ These counselors were available on-call as needed in most or all locations in a little less than half of these states (7 of 17), and seven states reported “other” arrangements.³⁵ Almost all administrators providing a description of these other arrangements indicated that counselors' most common task was to participate in the assessment process.³⁶ For example, one state reported using counselors to determine whether a participant with substance abuse problems should be deferred from work requirements.

How limitations in screening, assessment, and training inhibited organizational capacity to serve substance abusing TANF participants. Most administrators commenting on this element found procedures for identifying substance abuse particularly troubling, primarily due to inadequate screening tools and lack of staff training in this area. Comments from one administrator express this overriding concern:

“The welfare (cash assistance) system has not formerly dealt with

³⁴ This figure was determined by TANF and Employment Administrators responses to two questions. First was a positive response to the question “Is it state policy to have a drug or alcohol abuse counselor available to assist or advise the TANF/Employment and Training offices (on either a full- or part-time basis)?” Second was a positive response about different arrangements for making counselors available to front-line staff in either “all” or “most” locations. Note that an additional six states without a formal state policy reported making counselors available to front-line staff in “some” locations.

³⁵ Only two states reported that counselors were co-located in TANF offices full-time, and one state reported co-location part-time. If we include all states that reported arrangements in at least “some” locations and then examine the number of states reporting arrangements in “all,” “most,” or “some” locations, we find that: 15 states had counselors available on call, 11 states had counselors co-located in TANF offices part-time, 10 states had other arrangements, and seven states had counselors either co-located in TANF offices full-time or available as “floaters.”

³⁶ One state noted that counselors serve as liaisons in county offices to resolve issues.

clients with substance abuse in an effective way in terms of getting them identified, treated, and into the workforce; under JOBS, these individuals were usually exempted.”

Administrators’ responses to other survey questions further suggested challenges in agency capacity to identify and assess substance abuse among TANF participants. One of the more significant challenges was linked to the finding that:

a majority of state welfare and employment and training offices (34 states) do not have a drug or alcohol abuse counselor available to assist front-line staff in the assessment of TANF participants with substance abuse programs. This figure was particularly disconcerting given reports of lack of training for front-line staff in identifying and addressing substance abuse among TANF participants -- even though front-line staff seemed to be the main identifiers of substance use among TANF participants and were the first staff connection that TANF participants made in the welfare process.

Table 9 illustrates that, in general, front-line workers did not have access to training in how to identify substance abuse among participants or how to help motivate participants to enter treatment.

- Only some front-line workers were trained in how to identify substance abuse. Of these, case managers receiving the most training (in 19 of 40 states); followed by eligibility workers (in 7 of 40 states), and workers with joint eligibility and case management responsibilities (in 5 of 11 states).
- Even fewer staff received training both in how to identify substance abuse and how to help motivate participants to seek treatment. Case managers in 14 states, eligibility workers in 4 states, and workers in joint roles in 4 states received training in both procedures.

Table 9. Number of States with Identification and “Motivation to Treatment” Training for Front-line Workers

Type of Worker	Number of States with Worker	Number of States Reporting ID Training	Number of States Reporting <u>both</u> ID and “Motivation to Treatment” Training
Workers in joint roles	11	5	4
Eligibility workers	40	7	4
Case managers	40	19	14

These findings suggest that at the time of the survey, training systems to address substance abuse among TANF participants were not yet reaching a majority of front-line workers in most states, even though these workers were expected to identify substance among TANF participants.

Moreover, most states had not designed formal methods to help front-line workers identify the use and abuse of alcohol and/or drugs, relying instead on informal methods. Administrators reported their states used the following methods, including, participants' self-declaration (in 42 states) and behavioral or appearance cues (39). Fewer states used arrests for drug-related activities (27), history of drug treatment (21), history with the child welfare system (21), positive response to question on application form (18), drug or alcohol screening questionnaire (15), and drug testing (1).³⁷ Although it is possible that these informal methods were adequate to identify substance abuse, a number of indications suggest that informal methods were not adequate, including the responses from 9 of 41 that limitations in their screening procedures inhibited their welfare reform efforts.

In particular, many factors seemed to inhibit participant self-declaration -- an informal method at substance abuse identification in widespread use. First, it is common knowledge that there are reasons for participants to withhold information about their drug use, such as concerns about stigma in general and fears of losing their children. In addition, we note that at the time of the survey many states imposed penalties on participants who had been involved with the criminal justice system. Thirty-two states reported they denied benefits to persons convicted of drug-related felonies, and 37 states reported they denied benefits to persons violating probation or parole.³⁸ In identifying persons convicted of felonies, states reported a reliance on self-declaration.³⁹ Relying on participants to self-declare behavior that will result in loss of benefits raises questions about whether the welfare office was perceived by participants as a "safe" place to discuss alcohol and drug use.

Element #2: Jurisdiction of Agency

Staff capacity to perform the different tasks required to identify and address substance abuse among TANF participants may improve if relevant functions are housed within the same umbrella agency and if there are effective mechanisms for these functions to share information. Identified by six administrators as facilitating state responses to substance abuse in their welfare programs, one administrator observed, "Since substance abuse programs, Medicaid, and TANF programs are administered by the same agency, the divisions work together for the benefit of all participants." Another survey question asked TANF administrators to list all programs within the health and human service agency's jurisdiction:

³⁷ In open-ended responses, two states reported giving urine tests before clients could participate in work programs, and one state gave a drug test to those who report having received substance abuse treatment.

³⁸ Specifically, administrators were asked the following questions: 1) "Do you deny benefits to persons convicted of drug-related felonies?" and 2) "Do you deny benefits to persons violating parole?" In response to the first question, 32 states said "yes" and 12 said "no." Five states provide "other" answers, such as denying benefits only for more serious offenses, reducing benefit levels rather than denying them, or requiring treatment in order to receive benefits.

³⁹ Few states reported other procedures. Some mentioned that probation and parole offices are supposed to contact the TANF agency if they learn that one of their clients is applying for TANF assistance, but no systems for cross-checking state records were described. One administrator reported that an affirmative response to the drug felony question leads to a drug test, with a payment reduction for a positive result. Another administrator noted that participants might have to produce court records.

Table 10. Functions Housed in the Same Agency as TANF

Programs	Number of States with Programs Housed in Same Agency
<i>TANF Office Housed with:</i>	
Employment/training	36
Child welfare	35
Medicaid	32
Mental health	19
Substance abuse treatment	17
Medicaid and substance abuse treatment	14
Employment/training and substance abuse treatment	13
Health	12

Table 10 illustrates that while TANF and substance abuse treatment programs did not tend to be located under the same agency’s jurisdiction, a majority of states reported TANF offices housed in the same agency as either employment and training, child welfare or Medicaid.

Element #3: Reluctance of Front-Line Workers to Address Substance Abuse

As the nature and goals of welfare have changed and evolved under welfare reform, five states reported challenges in helping TANF staff adjust to their changing roles in identifying and addressing substance abuse. An administrator in one of these states described the problem as follows:

“Old ways of doing business. The slowness of agencies... to find new ways of doing business to adjust to consumer needs and the needs of potential employers is a barrier to successfully addressing needs of participants on welfare.”

Three other administrators described discomfort among front-line staff in addressing substance abuse among TANF participants. As one administrator noted, “a reluctance of TANF case managers to get involved with this issue and make referrals to treatment.” Another reported that “TANF case managers are reluctant to confront participants with alcohol and drug problems--even with consistent and clear criteria (the screening test).” These reports illustrate how staff discomfort with new and sensitive tasks can inhibit a state’s capacity to identify problems among TANF participants and work effectively to address those problems.

Element #4: Data Collection to Identify and Track Substance Abuse

Data collection revolved around two general areas: data indicating the prevalence of substance abuse

among TANF participants, and data that allowed agencies to track the progress of participants through identification, assessment, and treatment. Despite indications that states lacked adequate mechanisms to identify and track substance abuse among TANF participants, few TANF administrators reported that a lack of data collection systems as inhibiting their state's responses to substance abuse. In fact, few administrators highlighted this characteristic as either a facilitating or inhibiting factor.

How data collection facilitated achievement of program goals. Two administrators indicated that effective data collection has been key to addressing substance abuse in their state welfare programs. One described an impressive data source:

“Good data about the costs of not treating addiction. Good data about the benefits of treating addiction. Good data about the increased benefits of treatment and vocational/employment services regarding increased earnings post treatment.”

Responses to other survey questions yielded examples of states' attempts to collect data. The majority of states' TANF administrators (26 of 48) reported that their state had a policy requiring TANF staff to determine whether participants referred to treatment in fact attended and completed treatment. TANF administrators in 14 states reported that their state had data collection mechanisms to estimate the number of TANF participants with drug or alcohol problems. Two were especially noteworthy. As one administrator remarked:

“The data includes: information from an alcohol and drug abuse brief screening process; assessment, treatments, admission, discharge and a sampling of client data on progress six months following completion of treatment.”

The other state recorded “the results of drug abuse screening in the local department of social services and screening and treatment at the managed care organization...in our client information system.”

Although it seems that most states were still developing their data collection mechanisms at the time the survey was conducted, a few had implemented useful systems, even in the early phases of TANF.

How problems with data collection inhibited achievement of program goals. Only 3 of 17 responses suggested that lack of knowledge regarding the number of TANF participants requiring substance abuse treatment inhibited a state's ability to achieve its program goals. Furthermore, other survey questions revealed only one-third of states (14 of 51) even collected data to estimate that number and slightly more than half reported they had a policy to determine if TANF participants actually attended and completed treatment. The responses to open-ended questions from states that did track data regarding the prevalence of substance abuse among the TANF population suggested that in 12 of 14 cases, data sources could not fully identify and follow substance abusers throughout the welfare system. Administrators reported weaknesses in data-tracking systems in the following three areas:

- *Screening Process:* Seven administrators indicated that their state had attempted to collect substance abuse data at some point during the intake process. Unfortunately, these systems provided incomplete information to administrators, for reasons ranging from difficulties in transcribing case notes collected by front-line workers to an inability to track individuals identified as having substance abuse problems.
- *Population Surveys:* Two administrators used statewide population surveys to estimate prevalence of substance abuse among TANF participants; however, the incidence of substance abuse in the overall population may not have reflected the prevalence within the TANF population.
- *Data from Other Agencies:* Three states received information from either the state Medicaid or treatment agencies or were developing procedures to collect this data. Because this data was being collected for a different population (e.g., the Medicaid population), it could only provide a partial estimate of the number of TANF participants with substance abuse problems.

Inability to track TANF participants with substance abuse problems from the point at which substance abuse is identified to the point at which the participants leaves welfare limits the capacity of states to determine what policies have worked and what policies need to be changed.

Substance abuse treatment agencies also struggled with incomplete information about the number of TANF participants with substance abuse problems. Treatment administrators in five states reported that publicly funded alcohol and drug treatment programs were collecting data on whether participants remained on or left TANF. On the other hand, these programs reported collecting a wide range of data on people in treatment--much of it required by the Substance Abuse and Mental Health Services Administration (SAMSHA) of the U.S. Department of Health and Human Services. For example, data on employment status is collected in 43 states, on drug abstinence in 30 states, on recidivism in 38 states, and on criminal behavior in 22 states.

AVAILABILITY OF FUNDING AND RESOURCES

TANF administrators identified limitations in funding and resources as the most significant inhibitors of policies to address substance abuse within welfare reform. These concerns ranged from concerns regarding levels of funding to concerns about the restrictions of funding or complexity of funding streams. General concerns about TANF funding were noted most commonly, followed by Medicaid-related funding, funding and availability of treatment services, and the funding and availability of employment-related services.

In general, 16 administrators identified elements of funding and resources that facilitated their ability to achieve their goals, while 31 identified elements that inhibited those attempts. Table 11 illustrates how administrators perceived the availability of funding and other resources.

Table 11. Elements of Funding and Resources Availability

Element	Percentage of Administrators Reporting as Facilitator (N = 16)	Percentage of Administrators Reporting as Inhibitor (N = 31)
➤ General TANF funding	57%	30%
➤ Medicaid-related funding	31%	20%
➤ Funding/availability of treatment services	6%	30%
➤ Funding/availability of employment-related services	6%	20%

AVAILABILITY OF FUNDING AND RESOURCES

Element #1: General TANF Funding

General TANF funding was the element noted most frequently by TANF administrators as key to addressing substance abuse in the state welfare program. The complexity of funding sources targeted to substance abuse programs, as well as the degree to which funding was allocated for these programs, were highlighted with particular frequency.

How TANF funding facilitated state ability to achieve program goals. Nine of 16 administrators noted that the general availability of TANF funding helped them serve substance abusing TANF participants. As one administrator commented, there had been a “reprioritization of federal and state substance abuse funds in order to serve the TANF population with substance abuse problems.” It also seems that flexibility in managing these funds was important:

One administrator noted that a contributing factor to reform had been “unified funding (Medicaid and non-Medicaid) at the single-state agency, regional MCO, and service network levels (flexibility).”

Substance Abuse Treatment administrators provided further evidence that a number of states were adapting (or planning to adapt) funding strategies to secure treatment for people with drug or alcohol problems, including TANF participants. Treatment administrators were asked to identify “approaches or procedures in your state for combining different funding streams to fund drug or alcohol abuse services that you would characterize as innovative.”

Their responses to this question fell into three categories. First, ten said that their state had developed innovative ways to combine state funding and Medicaid. Second, eight administrators reported efforts that combined state funds other than Medicaid. As one administrator explained, the state addiction services and rehabilitation services agencies “are jointly funding projects to provide comprehensive AOD treatment with Employment Services...these collaborative efforts are increasing access to AOD services by expanding our funding base.” Eight indicated that efforts had been made to expand access to treatment at the local level. One administrator commented: “The 1997-98 State Budget includes a \$12 million TANF program initiative for local Social Services districts to purchase substance abuse outpatient treatment and prevention services for families on TANF.” It is noteworthy that four states have used this particularly innovative approach to integrating substance abuse treatment and TANF. This strategy might be explored further as a way to make treatment available to women who need it in order to work.

How limitations of TANF funding inhibited state ability to achieve program goals. Of 31 TANF administrators, 8 discussed either a general lack of funding/resources or multiple funding sources as a barrier to addressing substance abuse among TANF participants. Regarding overall shortages in funding, common responses included “inadequate funding for services,” “lack of effective services, especially in rural areas,” and “lack of statewide programs to address substance abuse and TANF.” Another concern of TANF administrators related to the difficulty inherent in integrating complex funding sources.

Element #2: Medicaid-Related Funding

Administrators reported Medicaid-related funding as both facilitating and inhibiting state responses to substance abuse within welfare reform efforts.

How Medicaid funding facilitated state ability to address substance abuse among TANF participants. Five administrators described efforts to increase Medicaid coverage for substance abuse related services. For example, one mentioned a “commitment by state Medicaid agency to modify its state plan in order to cover substance abuse treatment for women of childbearing age.” Another

administrator discussed Medicaid coverage of alcohol and drug rehabilitation for parents.

The responses of treatment administrators to the question regarding innovative funding streams highlighted the importance of Medicaid in serving substance abusing TANF participants. Interestingly, five of these responses cited the creation of a Medicaid managed care program as a promising funding structure for substance abuse treatment services:

One state “is instituting a new public-sector Medicaid managed care pilot program combining federal substance abuse block grant funds, Medicaid substance abuse funds, and state substance abuse funds.”

How limitations of Medicaid funding inhibited state ability to address substance abuse among TANF participants. Six administrators highlighted the limitations of Medicaid. Some Medicaid programs did not cover adults entering substance abuse treatment facilities or other forms of rehabilitation. One Treatment administrator felt the Medicaid program was inflexible and another sought to privatize the Medicaid agency.

Element #3: Funding/Availability of Treatment Services

Eleven state TANF administrators felt a shortage of treatment services inhibited the development of state policies and practices to address substance abuse in their welfare reform strategies, and only one administrator felt that an adequate supply of treatment services facilitated the development of these policies. They highlighted several deficiencies in treatment, including inadequate number of treatment facilities, lack of treatment beds, “shortage of available residential treatment centers,” and “inadequate sources for treatment options.”

From another survey question, the perceptions of TANF administrators and those of Treatment administrators regarding the availability of treatment services overlapped in some areas and diverged in other areas. When asked about the supply of treatment services in their state, TANF and Substance Abuse Treatment administrators alike viewed the supply of these services as insufficient in a number of ways. Nearly one-third of TANF administrators, however, expressed “no opinion” with regards to treatment availability.⁴⁰ This apparent lack of knowledge may suggest that TANF offices are unaware of what services are available, and may therefore be underutilizing state treatment resources.

Even though many TANF administrators reported no opinion regarding the availability of substance abuse treatment services, the responses of both TANF and Treatment administrators indicated that both did perceive there to be shortages in many treatment modalities, particularly in residential treatment.

⁴⁰ A number of TANF administrators responded “no opinion” for each type of treatment service listed: 14 for detoxification, 13 for outpatient, 13 for short-term residential, 12 for long-term residential, and 17 for methadone maintenance. Treatment administrators were not given the option to respond “no opinion.”

- Treatment administrators felt treatment was scarcer than did TANF administrators.
- The two groups of administrators differed most in their assessment of outpatient services; 32 Treatment administrators believed lack of availability to be a severe problem, while only 8 TANF administrators felt that way.
- A majority of Treatment administrators rated the adequacy of every service except methadone maintenance, to be a “severe problem”: long-term residential (35 states), detoxification (32), outpatient services (32), and short-term residential (27).
- TANF administrators in 25 states rated long-term residential treatment as a severe problem, and one third of them perceive short-term residential treatment to be a severe problem.

Table 12 more fully describes the perceptions of both TANF and Treatment administrators regarding several types of treatment:

Table 12. Ratings by TANF and Treatment Administrators Regarding Availability of Treatment Services

Type of Service	No Problem with Availability	Moderate Problem with Availability	Severe Problem with Availability
Detoxification			
TANF administrators	10	9	9
Treatment administrators	5	11	32
Outpatient services			
TANF administrators	16	5	8
Treatment administrators	7	9	32
Short-term residential			
TANF administrators	6	7	17
Treatment administrators	12	8	27
Long-term residential			
TANF administrators	3	2	25
Treatment administrators	8	5	35
Methadone maintenance			
TANF administrators	5	11	7
Treatment administrators	15	16	13

The perceptions of Treatment administrators regarding the adequacy of funding for treatment reflected their opinions regarding the availability of these services.⁴¹ Table 13 illustrates that a majority believed

⁴¹ TANF administrators were not asked about adequacy of funding.

funding of many services to be a severe problem: long-term residential treatment (37 states), detoxification (36), outpatient services (33), and short-term residential treatment (28).

Table 13. Ratings by Treatment Administrators Regarding Funding of Their States' Treatment Services

Type of Service	No Problem with Funding	Moderate Problem with Funding	Severe Problem with Funding
Detoxification	2	10	36
Outpatient services	4	11	33
Short-term residential	8	9	28
Long-term residential	4	5	37
Methadone maintenance	11	16	15

Element #4: Funding/Availability of Employment-Related Services

Employment related services included employment activities, childcare, transportation, housing, and domestic violence services. While administrators tended to identify limited availability of these services as inhibiting their attempts to integrate substance abuse treatment and welfare reform, responses to other parts of the survey suggest that states were attempting to provide these services to substance-abusing TANF participants.

How employment services facilitated state ability to address substance abuse among TANF participants. Although only one state TANF administrator specifically noted employment and training services that were adequately funded or supplied, Employment and Training administrators provided some evidence that most states were attempting to pay for or provide employment-related services to substance users.

Employment and Training administrators were asked, “Does the state pay for or provide the following employment-related programs for TANF recipients with drug or alcohol abuse problems?” Their responses are summarized in Table 14:

Table 14. State Employment Services for Substance-abusing TANF Participants

Employment Service	Number of States Paying for or Providing Service
Job search and employment	48
Education and training	47
Child care while adult gets drug or alcohol abuse treatment	39

Drug or alcohol abuse treatment	31
Post-employment support and monitoring of recovering drug or alcohol abusers	27

While these figures reflect only the existence of services and not their intensity or availability, and none except for treatment itself may be aimed specifically at participants with substance abuse problems, administrators' responses indicated that a majority of states offered all of them to substance abusing TANF participants. The high percentages of states offering child care, drug and alcohol abuse treatment, and post-employment support and monitoring is a promising sign that states were, at a minimum, attempting to provide more innovative, less traditional services to TANF participants with substance abuse problems.

How limited availability of employment services inhibited state ability to address substance abuse among TANF participants. Six TANF administrators identified shortages in employment-related services as a barrier to addressing the needs of TANF participants. One administrator noted that the state had a "lack of resources to develop creative programming that truly integrates employment at a living wage." These responses highlight the multiple services required of welfare programs to address the needs of TANF participants with substance abuse problems.

Employment and Training administrators provided additional evidence that, at least during the early phases of TANF, employment services may have been inadequate to meet the needs of substance abusing participants. Few apparent attempts had been made to create new employment services for substance abusers and to shape existing services to the specified needs of substance abusers:

Only two states had employment and training programs that exclusively serve TANF participants with alcohol and drug problems. Only three administrators reported that "all" or a "great many" employment and training programs attempt to integrate drug and alcohol treatment into a work program (such as a job search or job skills program). These attempts had been made in "some" programs in seven states and in a "few" programs in four states.

PARTICIPATION AND CONTROL AT THE LOCAL LEVEL

Whether a state welfare program is state or locally administered, the ability of local agencies to participate in making decisions and to shape welfare programs to their communities can facilitate that state’s ability to serve TANF participation with substance abuse problems. Similarly, if local talent and resources are underutilized, it can be very difficult to translate policies into action. State TANF administrators viewed local participation and control as the fifth most important influence on their welfare reform initiatives for substance abusing participants. They mentioned local participation in state-level decision making most frequently, followed by local control of TANF program, collaboration among local agencies, and the general ability of communities to sustain reform.

In general, 12 administrators indicated that local participation and control facilitated their ability to achieve program goals, and two indicated that problems in local participation and control inhibited their ability to achieve those goals. Table 15 summarizes the responses of administrators to questions regarding local participation and control.

Table 15. Elements of Local Participation and Control

Element	Percentage of Administrators Reporting as Facilitator (N = 12)	Percentage of Administrators Reporting as Inhibitor (N = 2)
▪ Local participation in state-level decision-making	58%	-
▪ Local control of TANF program	25%	-
▪ Collaboration among local agencies	17%	-
▪ General ability of communities to maintain reform	-	100%

LOCAL PARTICIPATION IN STATE-LEVEL DECISION-MAKING

Local Element #1: Participation and Control

The most common response (7 of 12) addressed the relationship between state and local agencies. Administrators made observations regarding “involvement of staff at all levels in developing program procedures” and “effective coordination between state agencies and divisions at state and local level.” It seems that strong channels of communication between state and local agencies had enabled states to create a more integrated, comprehensive TANF program that incorporated a range of options that responded to local differences.

Local Element #2: Local Control of TANF Program

Administrators in three states reported that local control over the TANF program had served as a key factor in addressing substance abuse within welfare reform efforts. In particular, administrators noted that the flexibility of local agencies to mold programs to address localized needs was a critical factor in the success of their programs.

Local Element #3: Collaboration Among Local Agencies

Two administrators described how effective collaboration among different local agencies had helped address the needs of TANF participants with substance abuse problems. As one described:

“There is a fairly well-developed infrastructure at a local or regional level [between] substance abuse providers and other services. Many of these entities have a long history of working together to solve problems.”

These administrators highlighted the importance of enhancing the ability of local agencies to develop multidimensional programs that could respond to the different and unique needs of TANF participants in their communities.

Local Element #4: General Ability of Communities

Only two administrators suggested that general limitations of local communities had inhibited efforts to address substance abuse among TANF participants. One administrator described the general inability of local communities to carry out welfare reform policies and procedures effectively:

“Community development of effective programs is uneven. Some communities function very well to provide coordinated human services. Others require more development.”

Although this problem was not identified by many administrators, these comments highlight the challenges that can arise when local resources are not utilized effectively in behalf of welfare reform strategies.

Chapter V

IMPLICATIONS

Moving Forward with Substance Abuse Treatment and Welfare Reform

The experiences described in this report illustrate the multiple strategies that states have and can deploy to address substance abuse among TANF participants. Because states vary so much, we do not espouse a particular set of policies and practices. Rather, in this chapter we offer recommendations and a checklist for administrators and others to use as they move forward with their welfare reform efforts. The analysis is framed around the five factors identified in Chapter IV as key to reform and it draws on state experiences as described in their survey responses and evidenced by their innovative practices.

We conclude this chapter with some suggestions regarding areas for further research that will help states succeed in their efforts to serve welfare participants struggling with problems of substance abuse.

COLLABORATION AMONG AGENCIES

Recommendation: Establish clear mechanisms that promote communication between, and clarify the responsibilities of, agencies at each level of government that serve substance abusing TANF participants. Involve workers at all levels of these agencies, from front-line workers to top-level management.

Questions for Administrators:

- What is your strategy for linking welfare reform and substance abuse? Does it delineate the role of each agency? How do you know whether it has been effectively communicated to all levels of staff in all agencies?
- What are ways that state agencies collaborate to serve substance abusing TANF participants? How do local and state agencies work together, and how do local agencies work among themselves? Does collaboration exist at all levels: front-line workers, middle management and senior officials? How do you determine whether collaboration is adequate?
- Have you identified people to facilitate collaboration among state agencies, between state and local agencies and among local agencies? Who functions, or would function, best as a lead agency? What conditions allow an agency liaison to promote communication between different agencies? Are those conditions present?
- What is the span of the TANF agency (i.e. – how many functions are housed in the same agency as TANF)? How do agencies exchange information on TANF participants with substance abuse

problems? Are confidentiality requirements acting as barriers to inter-agency collaboration?

- What cross-training programs are in place to help agency staff understand the role of staff in other organizations? How do you know that these programs reach staff at different levels?

SUPPORT FROM POLITICAL AND LEGISLATIVE OFFICIALS

Recommendation: Elicit the political support of top-level politicians and administrators, as well as other relevant groups (e.g., not-profit service agencies, unions) in developing and implementing policies and practices to address substance abuse within the context of welfare reform.

Questions for Administrators:

- How important do your legislature, agency heads, job training agencies and others believe substance abuse among TANF participants to be? Are they sufficiently informed about the linkage between substance abuse problems and welfare reform? What actions are they taking to build bridges that connect substance abuse and welfare reform initiatives?
- Are other political actors (e.g., unions, employers, constituents) supportive of policies and programs to address substance abuse and engaged in policy and program implementation?
- Are there state-level task forces or other groups that focus on substance abuse in your state? Are any specifically aimed specifically on substance abuse and welfare reform? What is your authority in these task forces? How do you determine whether they are effective?
- Is there sufficient state funding for substance abuse services within the context of welfare reform?
- What state policies and legislative mandates affect the way in which substance abuse is integrated within welfare reform? Do any policies conflict or inhibit effective substance abuse treatment in the context of welfare reform?
- Is there a lead agency in the state to direct the implementation of substance abuse policies and procedures within the welfare program?

CAPACITY OF ORGANIZATIONS TO MEET NEW CHALLENGES

Recommendation: Continually assess and improve data collection, staff training, substance abuse screening and assessment, and other systems to identify and address substance abuse among TANF

participants.

Questions for Administrators:

- Does each agency have a clear mission and set of responsibilities that reflect state policies? Is the mission understood by all staff, at all levels? How do you determine that this communication is effective?
- What employee incentive systems can the agency offer to reinforce its priorities?
- Is staffing adequate to support the organizational mission and responsibilities? Is training adequate to enable staff to do their jobs? Do they have access to resources that are necessary to do their jobs? How do you determine whether staff has training or resources to perform their functions?
- What are the barriers to identifying substance abuse among participants? How can the state devise screening procedures that reduce these barriers?
- How do workers address substance abuse once it is identified? Do they have access to substance abuse treatment counselors to assist them in serving these participants? Are there mechanisms that promote regular and effective communication among staff in TANF, Medicaid, Employment and Training, Substance Abuse Treatment and other offices? How do you determine whether these mechanisms are effective?
- How does your state view treatment in relation to work participation requirements? Do your policies and practices enable TANF participants to address their substance abuse and also find and maintain work? Are there policies that provide for continued help once participants are employed? Are there policies that undermine your ability to build bridges between substance abuse treatment and employment? How do you determine whether policies and practices are sufficient?
- Are there data tracking systems in place to follow TANF participants from the identification of substance abuse to treatment and employment outcomes? Is your information useful to managers and staff, as well as to funding organizations? Do organizations use this data to evaluate programs for substance abusing TANF participants? If yes, are there clear, objective criteria to evaluate programmatic success?

AVAILABILITY OF FUNDING AND RESOURCES

Recommendation: Identify a mix of treatment and employment-related services that address the multiple needs of substance abusing TANF participants in all regions. Allocate sufficient funding to

provide these services, using flexibility allowed in the federal TANF legislation to develop innovative funding strategies.

Questions for Administrators:

- What are the treatment, employment, and other resources necessary to prepare substance abusing TANF participants for work and sobriety? Are these services different for women or for participants who have problems with different substances?
- What treatment and employment services does your state provide to TANF participants with substance abuse problems? Are they sufficient to address the needs of substance abusing participants, and to the needs of women with children? How do you know? If these services are not adequate, what are their shortcomings? How can the state increase its capacity to provide these resources?
- Do the state TANF and Substance Abuse Treatment administrators agree on the desired services, and existing service gaps, for TANF participants with substance abuse problems?
- Is the state using the most effective mix of funding streams to provide treatment, employment, and other services? Are there other ways to combine funding streams that the state could try? Is the state using the full range of options allowed by federal legislation?
- How does Medicaid fund treatment services? Are there sufficient linkages between the Medicaid program and other offices that serve TANF participants with substance abuse problems? How do you determine whether these linkages are in place and working effectively?
- Are there other barriers to delivering treatment and employment-related services to TANF participants with substance abuse problems (e.g., geography, lack of staff resources, inadequate coordination between delivery agencies)? How can the state overcome these barriers?

PARTICIPATION AND CONTROL AT THE LOCAL LEVEL

Recommendation: Involve local agencies in developing state strategies to address substance abuse in the welfare system, and clearly communicate these strategies. Encourage flexibility and local coordination in implementation so that local agencies can address the particular needs of TANF participants in their regions.

Questions for Administrators:

- If your welfare system is state administered, what are the linkages between state agencies and local TANF offices and other local agencies? How do you determine whether these linkages are

sufficient? Do local agencies have adequate organizational capacity and inter-agency relationships to link TANF and substance abuse services? How do you know? What vehicles are in place to allow local offices to share experiences with each other?

- If your welfare system is locally administered, do local agencies have adequate organizational capacity and inter-agency relationships to effectively link TANF and substance abuse services? How do you know? What vehicles are in place to allow local offices to share experiences with each other?
- How are local agencies involved in state-level decision making? Are there adequate channels of communication between state and local agencies? How do you determine whether this communication is effective?
- What mechanisms exist to communicate state policies to local TANF agencies and others? How do you determine whether these mechanisms are effective? Are there barriers to implementing state policies and procedures at the local level? What can the state do to overcome these barriers?
- Are the programs related to substance abuse within welfare reform sufficiently sensitive to the needs of different communities and populations within the state? What can local agencies do to maintain programs most relevant to the local TANF population? What policies can your agency develop to promote local participation and control?

Survey Methodology

In developing our strategy for conducting the survey reviewed in the main report, we adopted a plan for each of the following areas: survey goals, target respondents, research questions, research design and data collection, and data analysis.

Goals

The main goals of the survey research were as follows:

- to learn how each state identified and addressed drug and alcohol abuse problems among Temporary Assistance for Needy Families (TANF) participants; and
- to examine the degree to which substance abuse treatment was linked to work activities in the states' welfare programs.

Respondents

The questionnaire was geared to administrators in 50 U.S. states, the District of Columbia, and three territories. In gathering these data, we targeted each of the survey's six sections to the state administrator most informed about the requested information: the state TANF administrator, Employment and Training administrator, Substance Abuse Treatment administrator, and Medicaid administrator. This approach was grounded in the belief that since state-level welfare programs involve multiple players, their responses could provide us with a rich description of state-level welfare policies and practices.

Research Questions

The survey was designed to explore four main areas of information. These four areas, as well as sample research questions within each topic, are as follows:

1. State structure for dealing with substance abuse

- Do administrators view substance abuse as a high-priority problem?
- Where in the state is the substance abuse agency housed?
- Are there senior-level coordinating structures focused on issues of substance abuse (e.g., governor's cabinets, commissions, and task forces)? If so, who participates? How broad is the scope of these groups?
- Have employers participated in developing state policies to reform welfare systems?

2. Integration of substance abuse diagnoses into the welfare eligibility process

- Are there eligibility rules targeted directly at substance abusing participants?
- Do questions about drug and alcohol use appear on the welfare application forms? What other methods do workers use to identify substance use?
- What training do workers receive to recognize substance abuse problems?

- Do workers have lists of substance abuse treatment programs available to offer clients who need them?
- Are there procedures to safeguard the confidentiality of persons who admit to substance abuse problems?
- If the applicant/participant admits to drug problems, is there a system to track treatment referrals and outcomes?
- Does the state have information about the proportion of welfare clients with substance abuse problems?

3. Integration of substance abuse considerations into the employment program

- How is substance abuse considered in terms of participation in work activities (exempt, temporarily exempt, exempt with conditions, deferred)?
- If treatment is required as a condition of eligibility, is it available? If so, what types of treatment? How is participation monitored?
- Does the program allow for investment in treatment, education and training, or is it focused more directly on job search and work?
- Do any programs explicitly integrate substance abuse treatment and work readiness into the same program?
- Is there cross training of treatment providers and employment workers?

4. Funding streams for addressing substance abuse

- What substance abuse-related services are covered by Medicaid?
- What is the status of Medicaid Managed Care with regard to substance abuse?
- What restrictions or limitations are placed on Medicaid funds for substance abuse-related conditions?
- To what degree are federal substance abuse treatment block-grant funds allocated for low income people, for women with children, for welfare recipients?
- What other federal funds are used for treatment for this population?
- To what degree does the state complement federal funds with state funds, and to which populations are those funds targeted?
- Does the state offer public drug treatment programs? If so, what kinds? How many? Where are they located? How many individuals do they serve?

Research Design and Data Collection

To craft the most appropriate survey instrument, we took the following steps:

- an advisory panel of experts in substance abuse, TANF, Medicaid and research methods convened at CASA to review the subject areas covered by the questionnaire;
- the Eagleton Institute of Politics at Rutgers University designed the question wording and questionnaire format under direction from CASA and APHSA;
- this survey instrument was field-tested in two states to ensure that the questions were both clear and answerable by the target respondents; and

- after modifying the questionnaire in response to feedback from field-testing, we disseminated the final survey to the human services commissioner of each state. Fifty-one states (94 percent) returned the final survey.

Data Analysis and Supplementary Tables

To explore state responses to the topic areas covered in the questionnaire, we performed the following analyses:

- With the guidance of Eagleton staff, CASA researchers coded administrators' responses to all open-ended questions. We used this coding to construct frequency distributions of open-ended questions, as well as to guide a qualitative analysis of responses to those questions not lending themselves to a more quantitative study.
- We next examined the frequency distribution of answers to each question to highlight typical responses, strengths, weaknesses, and gaps in current practice. These analyses were targeted to provide policy makers and researchers with a greater understanding of themes and patterns that exist across states.
- Administrators' responses offered a unique opportunity to investigate characteristics identified by administrators as facilitating and/or inhibiting the integration of responses to substance abuse within the context of welfare reform. To conduct this analysis, we used coded responses to two open-ended questions (see Section III of survey findings for specific wording of these questions). We supplemented this information with administrators' responses to other survey questions when appropriate.
- We also compared states that reported select substance abuse policies and procedures and a number of state characteristics. The analysis was based on cross tabulations of select state characteristics and policies and practices to identify, assess, or address substance abuse. (Refer to Appendix C)

**SURVEY ON STATE POLICIES AND PRACTICES
REGARDING SUBSTANCE ABUSE, MEDICAID, AND EMPLOYMENT
NEEDS OF WELFARE RECIPIENTS**

The main objective of the questionnaire that follows is to learn how each state identifies and addresses drug and alcohol abuse problems among Temporary Assistance for Needy Family (TANF) recipients. Since drug and alcohol abuse has traditionally been considered a barrier or impediment to employment, it is particularly important to understand how the states are dealing with drug or alcohol abuse in the context of the work orientation of welfare reform.

Since questionnaires generalize, some questions and the response choices offered may not adequately represent the policies or practices of your state and its individual approach to the issue of drug or alcohol abuse. In such cases, please include your personal comments on the questionnaire to further explain the experiences that you are having in your state. We are also aware that many welfare reform programs are still undergoing significant changes, and that the answers to some questions may not be known. We have included response choices to accommodate this. Please note, however, that some questions ask for opinions rather than definitive assessments; we ask that you answer these questions as best you can.

The questionnaire has six main sections. It has been designed so the person in your state who is the best informed about each section can report on the information they are most familiar with. Please indicate the name and the title of the person who is completing each section. All sections should be returned to you and you should fax the full questionnaire to Gary Cyphers (fax: 202-289-6555) at the American Public Welfare Association (APWA). After faxing, please send him a hard copy of the questionnaire, at the following address: American Public Welfare Association, 810 First Street NE, Suite 500, Washington, DC 20002-4267. If you have any questions, his phone number is 202-682-0100, x245 or e-mail gcyphers@apwa.org. The sections are as follows:

<i>STATE</i> _____	<i>CONTACT PERSON</i> _____	Name and Title of Person Completing Each Section
	<u>Department to Complete Section</u>	
A. General Background	TANF AGENCY	_____ _____
B. Implementation of Welfare Reform	TANF AGENCY	_____ _____
C. Drug and Alcohol Abuse and Cash Assistance	TANF AGENCY	_____ _____
D. Drug and Alcohol Abuse and the Employment Process	TANF EMPLOYMENT AND TRAINING SERVICES	_____ _____
E. Drug and Alcohol Abuse Treatment	ALCOHOL AND OTHER DRUG ABUSE TREATMENT AGENCY	_____ _____
F. Medicaid and Drug and Alcohol Abuse Treatment	MEDICAID OFFICE	_____ _____

**SURVEY ON STATE POLICIES AND PRACTICES
REGARDING SUBSTANCE ABUSE, MEDICAID, AND EMPLOYMENT
NEEDS OF WELFARE RECIPIENTS**

November, 1997

Name of state: _____

Person coordinating survey response in your state: _____

Title: _____

Agency: _____

Address: _____

Phone: _____

Fax: _____

E-mail: _____

**Please fax this face sheet to Gary Cyphers at APWA (202-289-6555) or e-mail
gcyphers@apwa.org
as soon as the survey coordinator is designated. Thank you.**

**SURVEY ON STATE POLICIES AND PRACTICES
REGARDING SUBSTANCE ABUSE, MEDICAID, AND EMPLOYMENT
NEEDS OF WELFARE RECIPIENTS
SECTION A: General Background**

Name:

Title:

Agency:

Address:

Phone:

Fax:

E-Mail:

You have been designated by your State Human Service Administrator to complete the attached section of a comprehensive questionnaire.

The main objective of the Survey on State Policies and Practices Regarding Substance Abuse, Medicaid, and Employment Needs of Welfare Recipients is to learn how each state identifies and addresses drug and alcohol abuse problems among Temporary Assistance for Needy Family (TANF) recipients. Since drug and alcohol abuse has traditionally been considered a barrier or impediment to employment, it is particularly important to understand how the states are dealing with drug and alcohol abuse in the context of the work orientation of welfare reform.

Since questionnaires generalize, some questions and the response choices offered may not adequately represent the policies or practices of your state and its individual approach to the issue of drug or alcohol abuse. In such cases, please include your personal comments on the questionnaire to further explain the experiences that you are having in your state. We are also aware that many welfare reform programs are still undergoing significant changes, and that the answers to some questions may not be known. We have included response choices to accommodate this. Please note, however, that some questions ask for opinions rather than definitive assessments; we ask that you answer these questions as best you can.

The questionnaire has six main sections. It has been designed so the person in your state who is the best informed about each section can report on the information they are most familiar with.

AFTER YOU HAVE COMPLETED THE QUESTIONNAIRE, PLEASE RETURN IT TO YOUR SURVEY COORDINATOR:_____

If you have any questions about this survey, please call Gary Cyphers (202/682-0100) or e-mail gcyphers@apwa.org at the American Public Welfare Association (APWA).
--

A-3. There have been many estimates about the degree to which drug and alcohol abuse interferes with TANF recipients' employment. While we know that no one is completely certain about the extent of this problem, we would like to know your *best estimate* of the percentage of TANF recipients in your state whose employment plans should include activities to address their drug or alcohol abuse problems:

1. Less than 10%
2. 10 - 19%
3. 20 - 39%
4. 40 - 60%
5. More than 60%
6. Do not know (no opinion)

A-4. In your opinion, to what degree are TANF recipients' drug and alcohol abuse problems likely to interfere with your state's ability to meet its TANF work participation requirements?

1. A great deal
2. Somewhat
3. Not very much
4. Not at all

A-5. Listed below are some potential challenges to meeting your state's TANF work requirements over the next three years. Please rank them from 1 to 8 in the order in which you believe they will pose the greatest challenge, with A1 indicating the most challenging problem and A8" the least challenging.

Ranking:

- _____ Drug or alcohol abuse
- _____ Domestic violence
- _____ Insufficient private sector jobs
- _____ Low skill levels among recipients
- _____ Low motivation/negative attitude of recipients
- _____ Transportation
- _____ Adequate supply of child care

In the space below, please list any other potential challenges you think you will have to address to meet the TANF work requirements.

A-6. Does your state collect any data that would enable it to estimate how many TANF recipients have drug or alcohol abuse problems?

1. Yes
2. No

If A Yes,≡ please briefly describe what data you collect and its source.

A-7. Below, please list any Task Forces, Commissions, or other state-wide governmental (or quasi-governmental) groups that your state has put in place to address drug or alcohol abuse generally. These may be ad hoc or permanent groups.

A-8. Are there any approaches in your state to address drug and alcohol abuse among TANF recipients that you consider innovative or promising?

1. Yes
2. No

If A Yes,≡ please briefly describe these innovative or promising approaches, and/or attach appropriate materials and include them when you return the questionnaire.

A-8a. If you are a state with a locally administered system, do you know of any counties or cities that are particularly innovative in dealing with drug or alcohol abusing TANF recipients?

1. Yes
2. No

If A Yes,≡ please list the names of the two or three counties or cities that you feel are the most innovative:

A-9. Which 3 to 5 factors or elements in your state do you think contribute most to the effective coordination of policies and practices regarding drug and alcohol abuse treatment, Medicaid, and employment services necessary for welfare reform participants to leave welfare successfully?

A-10. Which 3 to 5 factors or elements in your state do you think are the biggest barriers to the effective coordination of policies and practices regarding drug or alcohol abuse treatment, Medicaid, and employment services necessary for welfare reform participants to leave welfare successfully?

COMMENTS

THANK YOU VERY MUCH FOR YOUR COOPERATION.

***PLEASE RETURN THIS QUESTIONNAIRE TO THE PERSON IN YOUR STATE
WHO IS COORDINATING THIS SURVEY.***

If you have any questions about this survey, please call Gary Cyphers, APWA, 202/682-0100, x245 or gcyphers@apwa.org.

FOR OFFICE USE ONLY

This state welfare system is:

1. State supervised/state administered
2. State supervised/local administered

**SURVEY ON STATE POLICIES AND PRACTICES
REGARDING SUBSTANCE ABUSE, MEDICAID, AND EMPLOYMENT
NEEDS OF WELFARE RECIPIENTS
SECTION B: IMPLEMENTATION OF WELFARE REFORM**

Name:

Title:

Agency:

Address:

Phone:

Fax:

E-Mail:

You have been designated by your State Human Service Administrator to complete the attached section of a comprehensive questionnaire.

The main objective of the Survey on State Policies and Practices Regarding Substance Abuse, Medicaid, and Employment Needs of Welfare Recipients is to learn how each state identifies and addresses drug and alcohol abuse problems among Temporary Assistance for Needy Family (TANF) recipients. Since drug and alcohol abuse has traditionally been considered a barrier or impediment to employment, it is particularly important to understand how the states are dealing with drug and alcohol abuse in the context of the work orientation of welfare reform.

Since questionnaires generalize, some questions and the response choices offered may not adequately represent the policies or practices of your state and its individual approach to the issue of drug or alcohol abuse. In such cases, please include your personal comments on the questionnaire to further explain the experiences that you are having in your state. We are also aware that many welfare reform programs are still undergoing significant changes, and that the answers to some questions may not be known. We have included response choices to accommodate this. Please note, however, that some questions ask for opinions rather than definitive assessments; we ask that you answer these questions as best you can.

The questionnaire has six main sections. It has been designed so the person in your state who is the best informed about each section can report on the information they are most familiar with.

AFTER YOU HAVE COMPLETED THE QUESTIONNAIRE, PLEASE RETURN IT TO YOUR SURVEY COORDINATOR: _____

If you have any questions about this survey, please call Gary Cyphers (202/682-0100) or e-mail gcyphers@apwa.org at the American Public Welfare Association (APWA).

**SURVEY ON STATE POLICIES AND PRACTICES
REGARDING SUBSTANCE ABUSE, MEDICAID, AND EMPLOYMENT
NEEDS OF WELFARE RECIPIENTS**

B. IMPLEMENTATION OF WELFARE REFORM

To be completed by the Temporary Assistance for Needy Families (TANF) agency.

Guidelines for Survey Completion

- 1) Each section should be filled out by the person in the state most qualified to do so.
- 2) Each section should be returned to the survey coordinator when completed.
- 3) Please fill out the survey using black ink.
- 4) It is important to us that we receive complete and accurate information because the results will be disseminated widely. If, however, there is a particular question where you feel strongly that you do not want your response attributed publicly, please indicate so next to the question. On questions requiring a written response or on questions where you feel merely checking off an option would not accurately depict your state's situation, please elaborate by including additional comments.

B-1. Following these instructions is a chart asking about some of the issues related to TANF, e.g., eligibility for drug felons. For each issue in the chart please do the following:

- (1) **Read the question** in the first column.
- (2) In the second column, **circle the response** that best matches your state's policy on that issue
- (3) **Clarify and comment** as much as possible upon your state's policy in the third column (please feel free to attach additional sheets of comments).
- (4) In the fourth column, please **write in any expected changes** in your state's policy on that particular issue that you foresee happening before September 1, 1998. If you do not expect any changes, you can leave this column blank.
- (5) For Ae≡ and Af≡, please also **describe the procedures**, if any, your state uses while implementing the policy.

If you would like more room for response, please attach additional sheets.

Example

Question	Answer	Comments	Expected changes before 9/1/98
e. Do you deny benefits to persons convicted of drug-related felonies? (Please elaborate →) Describe procedure, if any, for determining if a person is convicted of a drug-related felony	Yes No Other	We have conditional receipt of TANF benefits for felons, requiring all persons convicted of drug-related felonies to go through drug treatment for 30 days in order to be eligible to receive benefits. Dependent children of drug felons deemed ineligible for benefits are still eligible for TANF. Procedure: Disclosure requested at application by a question on the application form, and parole officers are instructed to inform TANF office if they suspect such a client of having applied for TANF assistance.	Once the supply of treatment providers has increased, we will extend the amount of time required in drug treatment (to 60 days) for persons convicted of drug-related felonies.

<p>benefits for a maximum of 60 months?</p> <p>(Please elaborate →)</p>	<p>No</p> <p>Other</p>		
<p>b. Do you require work participation of TANF recipients at 24 months?</p> <p>(Please elaborate →)</p>	<p>Yes</p> <p>No</p> <p>Other</p>		
<p>c. Do you require community service of TANF recipients?</p> <p>(Please elaborate →)</p>	<p>Yes</p> <p>No</p> <p>Other</p>		
<p>d. Do you terminate Medicaid for persons whose cash assistance is terminated for failure to work?</p> <p>(Please elaborate →)</p>	<p>Yes</p> <p>No</p> <p>Other</p>		

<p>persons convicted of drug-related felonies?</p> <p>(Please elaborate →)</p> <p>Describe procedure, if any, for determining if a person is convicted of a drug-related felony</p>	<p>No</p> <p>Other</p>		
<p>f. Do you deny benefits to persons violating probation or parole?</p> <p>(Please elaborate →)</p> <p>Describe procedure, if any, for determining if a person is a probation or parole violator</p>	<p>Yes</p> <p>No</p> <p>Other</p>		

B-2. Has your state decided to count drug or alcohol abuse treatment as a work activity for the purpose of TANF eligibility?

1. Yes
2. Yes, with conditions (please describe these conditions in the space below)
3. No

Description of conditions:

B-2a. Do you expect your policy on whether participation in drug or alcohol abuse treatment counts as a work activity or work readiness activity to change in the coming year?

1. Yes
2. No

If A Yes \equiv Please describe how it will change.

B-3. Below are some ways that employers in your state may be involved in shaping your state's welfare-to-work strategies. Please indicate if there is active involvement, modest involvement, little involvement, or no involvement on the part of employers in the various activities. Also, please comment on other welfare-to-work involvement on the part of employers in your state.

	<u>Active Involvement</u>	<u>Modest Involvement</u>	<u>Little Involvement</u>	<u>No Involvement</u>
Employers participate in commissions to design welfare to work strategies	1	2	3	4
Employers provide feedback to the states on what they need in order to hire TANF recipients	1	2	3	4
Employers seek to hire TANF recipients	1	2	3	4
Other:	1	2	3	4

COMMENTS

THANK YOU VERY MUCH FOR YOUR COOPERATION.

*PLEASE RETURN THIS QUESTIONNAIRE TO THE PERSON IN YOUR STATE
WHO IS COORDINATING THIS SURVEY.*

If you have any questions about this survey, please call Gary Cyphers, APWA, 202/682-0100, x245 or gcyphers@apwa.org.

**SURVEY ON STATE POLICIES AND PRACTICES
REGARDING SUBSTANCE ABUSE, MEDICAID, AND EMPLOYMENT
NEEDS OF WELFARE RECIPIENTS
SECTION C: DRUG AND ALCOHOL ABUSE AND CASH ASSISTANCE**

Name:

Title:

Agency:

Address:

Phone:

Fax:

E-Mail:

You have been designated by your State Human Service Administrator to complete the attached section of a comprehensive questionnaire.

The main objective of the Survey on State Policies and Practices Regarding Substance Abuse, Medicaid, and Employment Needs of Welfare Recipients is to learn how each state identifies and addresses drug and alcohol abuse problems among Temporary Assistance for Needy Family (TANF) recipients. Since drug and alcohol abuse has traditionally been considered a barrier or impediment to employment, it is particularly important to understand how the states are dealing with drug and alcohol abuse in the context of the work orientation of welfare reform.

Since questionnaires generalize, some questions and the response choices offered may not adequately represent the policies or practices of your state and its individual approach to the issue of drug or alcohol abuse. In such cases, please include your personal comments on the questionnaire to further explain the experiences that you are having in your state. We are also aware that many welfare reform programs are still undergoing significant changes, and that the answers to some questions may not be known. We have included response choices to accommodate this. Please note, however, that some questions ask for opinions rather than definitive assessments; we ask that you answer these questions as best you can.

The questionnaire has six main sections. It has been designed so the person in your state who is the best informed about each section can report on the information they are most familiar with.

AFTER YOU HAVE COMPLETED THE QUESTIONNAIRE, PLEASE RETURN IT TO YOUR SURVEY COORDINATOR: _____

If you have any questions about this survey, please call Gary Cyphers (202/682-0100) or e-mail gcyphers@apwa.org at the American Public Welfare Association (APWA).

**SURVEY ON STATE POLICIES AND PRACTICES
REGARDING SUBSTANCE ABUSE, MEDICAID, AND EMPLOYMENT
NEEDS OF WELFARE RECIPIENTS**

C. DRUG AND ALCOHOL ABUSE AND CASH ASSISTANCE

To be completed by the Temporary Assistance for Needy Families (TANF) agency.

Guidelines for Survey Completion

1. Each section should be filled out by the person in the state most qualified to do so.
2. Each section should be returned to the survey coordinator when completed.
3. Please fill out the survey using black ink.
4. **It is important to us that we receive complete and accurate information because the results will be disseminated widely.** If, however, there is a particular question where you feel strongly that you do not want your response attributed publicly, please indicate so next to the question. On questions requiring a written response or on questions where you feel merely checking off an option would not accurately depict your state=s situation, please elaborate by including additional comments.

For the questions that follow, please use the following definitions:

Eligibility Worker: refers to any TANF worker who either (1) determines whether an individual applicant will begin to receive TANF cash assistance, or (2) determines whether an individual recipient will continue to receive TANF cash assistance. Across the states, these workers are called by various titles including Aself-sufficiency workers, Afamily assistance specialists, and Acash assistance workers.

Clients: refers to TANF recipients and applicants.

In Questions C-1 through C-5, we will be asking about state policies and practices for the activities of eligibility workers. We understand that many of these policies and practices may vary from county to county, especially if your state is locally administered. We ask, then, that you do the following:

- 1) If the policy or practice in question is statewide, circle A1 for AYes, statewide.
- 2) If the policy or practice in question is not statewide but, in your opinion, affects the rough majority of the state=s population, please circle A2 for AYes, for most.
- 3) Otherwise, circle A3 for ANo.

Again, please feel free to clarify your state=s policy or practice through comments.

C-1. Have eligibility workers in your state received any of the following types of classroom or in-service training?

	<u>Yes, Statewide</u>	<u>Yes, For Most</u>	<u>No</u>
a. Identifying clients with drug or alcohol abuse problems	1	2	3
b. Being aware of clients= drug or alcohol abuse problems	1	2	3
c. Referring clients with drug or alcohol abuse problems to treatment	1	2	3
d. Motivating clients with drug or alcohol abuse problems to participate in treatment	1	2	3
e. Other	1	2	3

In the space below, please describe any other drug and alcohol abuse training eligibility workers have received

C-2. Do the eligibility workers identify TANF applicants or recipients as drug or alcohol abusers?

- 1. Yes ----->Please continue with C-3 to C-5
- 2. No ----->Please go to Question C-6

Other (please describe):

C-3. Do eligibility workers use any of the methods listed below to identify clients with drug or alcohol problems?

	<u>Yes, Statewide</u>	<u>Yes, For Most</u>	<u>No</u>
a. Behavioral cues (e.g., appears drunk)	1	2	3
b. Appearance cues (e.g., track marks)	1	2	3
c. Client's self-declaration	1	2	3
d. Question on application form	1	2	3
e. Drug or alcohol screening questionnaire	1	2	3
f. Urine toxicology (drug test)	1	2	3
g. Client is known to the child welfare system	1	2	3
h. History of drug treatment	1	2	3
i. Arrests for drug related activities	1	2	3
j. Other			

In the space below, please describe any other methods that eligibility workers use to identify clients with drug or alcohol problems.

C-4. For each of the following stages in the TANF process, do eligibility workers identify clients with drug or alcohol abuse problems and make a referral or take some other action on the basis of this identification?

	<u>Yes, Statewide</u>	<u>Yes, For Most</u>	<u>No</u>
a. At the initial application for TANF	1	2	3
b. During recertification of eligibility	1	2	3
c. During the meeting to design a client's self-sufficiency (personal responsibility) plan	1	2	3
d. During participation in job readiness and skill training	1	2	3
e. During participation in the work program	1	2	3
f. Upon notification from the child welfare agency	1	2	3
g. Other	1	2	3

In the space below, please describe any other stage(s) in the TANF process where workers identify clients with drug or alcohol abuse problems.

C-5. When eligibility workers identify a client as having a drug or alcohol abuse problem, do they:

	<u>Yes, Statewide</u>	<u>Yes, For Most</u>	<u>No</u>
a. Provide for further clinical assessment by:			
1. Referring the client to fuller assessment	1	2	3
2. Conducting a fuller assessment him or herself	1	2	3
3. Other (please describe)	1	2	3
b. Refer the client to treatment by:			
1. Giving the client a list of treatment providers	1	2	3
2. Giving the client a referral to a particular treatment program	1	2	3
3. Calling the provider to arrange for an appointment	1	2	3
4. Making treatment a requirement of TANF eligibility	1	2	3
5. Other (please describe)	1	2	3
c. Exempt (or defer) client from work requirements	1	2	3
d. Respond by:			
1. Imposing additional recertification requirements	1	2	3
2. Finding the client ineligible for TANF	1	2	3
3. Notifying the child welfare agency	1	2	3
4. Requiring Aprotective≅ or Avendor≅ payments		1	2 3
5. Other (please describe)	1	2	3

PLEASE NOTE: ALL STATES SHOULD ANSWER THE FOLLOWING QUESTIONS

C-6. Is there a state policy requiring TANF offices to determine whether TANF clients who are referred to treatment actually attend and complete treatment?

1. Yes
2. No

C-7. Does your state have any programs (treatment or other, e.g. employment) that serve only drug or alcohol abusing TANF recipients, as opposed to programs that serve all drug or alcohol abusers or all TANF recipients?

1. Yes
2. No

If A Yes, please describe briefly. You may also attach any information about these programs to this questionnaire when you return it.

C-8. Is it state policy to have a drug or alcohol abuse counselor available to assist or advise the TANF offices (on either full-time or part-time basis)?

1. Yes
2. No

C-8-a. Please answer the questions below regarding different arrangements for having counselors available to the TANF offices. Circle a A1" if the arrangement exists in all (or nearly all) locations, a A2" if it exists in most, a A3" if it exists in some, and a A4" if it does not exist in any location.

	<u>All</u>	<u>Most</u>	<u>Some</u>	<u>None</u>
a. Counselors are co-located in TANF offices full-time (Please go to C-8b)	1	2	3	4
b. Counselors are co-located in TANF offices part-time (Please go to C-8b)	1	2	3	4
c. Counselors are on-call as needed	1	2	3	4
d. Counselors are available as Afloaters	1	2	3	4
e. Other (please describe)	1	2	3	4

C-8-b. For counselors that are co-located in some, but not all counties= TANF offices, please list the counties where they are co-located.

Counties where counselors are co-located:

Full-time
Part-time

C-9. Please answer the questions below regarding the availability of the following drug and alcohol abuse treatment services for TANF recipients by circling a number from 1 to 5. A 1" indicates A no problem≡ with the availability of the service and a 5" indicates a Severe shortage.≡ If you have no opinion about the availability of a particular service, please circle the A9".

	<u>No Problem</u>				<u>Severe Shortage</u>	<u>No Opinion</u>
a. Detoxification services (helps people through the process of withdrawal from addiction)	1	2	3	4	5	9
b. Outpatient care (day treatment or evening programs)	1	2	3	4	5	9
c. Short-term residential treatment (2 months or less)	1	2	3	4	5	9
d. Long-term residential treatment (more than 2 months)	1	2	3	4	5	9
e. Institutional inpatient care	1	2	3	4	5	9
f. Methadone maintenance	1	2	3	4	5	9
g. Other (please describe)	1	2	3	4	5	9

C-10. Please provide any additional information about what your state does to identify and treat TANF clients with drug or alcohol abuse problems as part of the welfare reform process. You may also attach any information about these programs to this questionnaire when you return it.

COMMENTS

***THANK YOU VERY MUCH FOR YOUR COOPERATION.
PLEASE RETURN THIS QUESTIONNAIRE TO THE PERSON IN YOUR STATE
WHO IS COORDINATING THIS SURVEY.***

If you have any questions about this survey, please call Gary Cyphers, APWA, 202/682-0100, x245 or gcyphers@apwa.org.

**SURVEY ON STATE POLICIES AND PRACTICES
REGARDING SUBSTANCE ABUSE, MEDICAID, AND EMPLOYMENT
NEEDS OF WELFARE RECIPIENTS
SECTION D: DRUG AND ALCOHOL ABUSE AND THE EMPLOYMENT PROCESS**

Name:

Title:

Agency:

Address:

Phone:

Fax:

E-Mail:

You have been designated by your State Human Service Administrator to complete the attached section of a comprehensive questionnaire.

The main objective of the Survey on State Policies and Practices Regarding Substance Abuse, Medicaid, and Employment Needs of Welfare Recipients is to learn how each state identifies and addresses drug and alcohol abuse problems among Temporary Assistance for Needy Family (TANF) recipients. Since drug and alcohol abuse has traditionally been considered a barrier or impediment to employment, it is particularly important to understand how the states are dealing with drug and alcohol abuse in the context of the work orientation of welfare reform.

Since questionnaires generalize, some questions and the response choices offered may not adequately represent the policies or practices of your state and its individual approach to the issue of drug or alcohol abuse. In such cases, please include your personal comments on the questionnaire to further explain the experiences that you are having in your state. We are also aware that many welfare reform programs are still undergoing significant changes, and that the answers to some questions may not be known. We have included response choices to accommodate this. Please note, however, that some questions ask for opinions rather than definitive assessments; we ask that you answer these questions as best you can.

The questionnaire has six main sections. It has been designed so the person in your state who is the best informed about each section can report on the information they are most familiar with.

AFTER YOU HAVE COMPLETED THE QUESTIONNAIRE, PLEASE RETURN IT TO YOUR SURVEY COORDINATOR: _____

If you have any questions about this survey, please call Gary Cyphers (202/682-0100) or e-mail gcyphers@apwa.org at the American Public Welfare Association (APWA).

**SURVEY ON STATE POLICIES AND PRACTICES
REGARDING SUBSTANCE ABUSE, MEDICAID, AND EMPLOYMENT
NEEDS OF WELFARE RECIPIENTS**

D. DRUG AND ALCOHOL ABUSE AND THE EMPLOYMENT PROCESS

To be completed by the person in the state agency responsible for employment and training services for TANF clients who knows the most about how TANF clients with drug or alcohol abuse problems are served by this system.

Guidelines for Survey Completion

1. Each section should be filled out by the person in the state most qualified to do so.
2. Each section should be returned to the survey coordinator when completed.
3. Please fill out the survey using black ink.
4. **It is important to us that we receive complete and accurate information because the results will be disseminated widely.** If, however, there is a particular question where you feel strongly that you do not want your response attributed publicly, please indicate so next to the question. On questions requiring a written response or on questions where you feel merely checking off an option would not accurately depict your state=s situation, please elaborate by including additional comments.

The following definitions will be used for this section of the questionnaire.

Employment Worker: refers to any worker who is responsible for motivating and assisting TANF recipients prepare for and find work. This may correspond to workers with different titles in different states, including Acase managers,≡ Afamily independence workers,≡ or Aemployment counselors.≡

Eligibility Worker: refers to any TANF worker who either (1) determines whether an individual applicant will begin to receive TANF cash assistance or (2) determines whether an individual recipient will continue to receive TANF cash assistance. Across the states, they are called by various titles including Aself-sufficiency workers,≡ Afamily assistance specialists≡ and Acash assistance workers.≡

Client: refers to TANF applicants and recipients.

D-1. Are the employment workers in your state the same individuals as the eligibility workers?

1. Yes ----> Please skip questions D-2 through D-7 and go directly to question D-8.
2. No ----> Please continue with D-2.

In the next few questions, we will be asking about state policies and practices on employment and training services for TANF recipients with drug or alcohol abuse problems. We understand that many of these policies and practices may vary from county to county, especially if your state is locally administered. We ask, then, that you do the following:

- 1) If the policy or practice in question is statewide, circle A1" for AYes, statewide.≡
- 2) If the policy of practice in question is not statewide but, in your opinion, affects the rough majority of the state=s population, please circle A2" for AYes, for most.≡
- 3) Otherwise, circle A3" for ANo.≡

Again, please feel free to clarify your state=s policy or practice.

D-2. In the space below, please write in the name of the state agency(s) or department(s) responsible for employment, training and other work activities and services for TANF recipients.

D-3. Are employment workers co-located with eligibility workers :

1. In all locations
2. In most locations
3. In some locations
4. Not in any locations

D-4. Do employment workers receive the following classroom or in-service training?

	<u>Yes, Statewide</u>	<u>Yes, For Most</u>	<u>No</u>
a. Identifying clients with drug or alcohol abuse problems	1	2	3
b. Being aware of clients= drug or alcohol abuse problems	1	2	3
c. Referring clients with drug or alcohol abuse problems to treatment	1	2	3
d. Motivating clients with drug or alcohol abuse problems to participate in treatment	1	2	3
e. Other (please describe)	1	2	3

D-5. Do employment workers identify applicants or recipients as drug or alcohol abusers?

1. Yes -----> Please continue with D-6 and D-7
2. No -----> Please go to question D-8

D-6. Do employment workers use any of the following methods listed below to identify clients with drug or alcohol abuse problems?

	<u>Yes, Statewide</u>	<u>Yes, For Most</u>	<u>No</u>
a. Behavioral cues (e.g., appears drunk)	1	2	3
b. Appearance cues (e.g., track marks)	1	2	3
c. Client's self-declaration	1	2	3
d. Question on application form	1	2	3
e. Drug or alcohol screening questionnaire	1	2	3
f. Urine toxicology (drug test)	1	2	3
g. Client is known to the child welfare system	1	2	3
h. History of drug treatment	1	2	3
i. Arrests for drug related activities	1	2	3
j. Other (please describe):	1	2	3

D-7. Do employment workers do any of the following if they identify a client as having a drug or alcohol abuse problem?

	<u>Yes, Statewide</u>	<u>Yes, For Most</u>	<u>No</u>
a. Refer client to treatment	1	2	3
b. Refer client to fuller assessment	1	2	3
c. Conduct a fuller assessment him or herself	1	2	3
d. Notify the child welfare agency	1	2	3
e. Notify eligibility worker	1	2	3
f. Other (please describe):	1	2	3

D-8. Once it has been determined that a TANF recipient has been identified as a drug or alcohol abuser, the state may respond in a number of ways. Please circle the number in front of your state's response. If your state has another policy or allows for more than one response, please circle the number in front of AOther≡ and explain the details of the policy below.

1. Exempt from work requirements
2. Exempt from work so long as they attend treatment
3. Exempt with other conditions (please describe):

4. Deferred from work requirements
(How long does the deferral last?)
5. Not exempt or deferred from work activities
6. Other (please describe):

D-9. Does the state pay for or provide the following employment-related programs for TANF recipients with drug or alcohol abuse problems?

	<u>Yes, Statewide</u>	<u>Yes, For Most</u>	<u>No</u>
a. Drug or alcohol abuse treatment	1	2	3
b. Education and training	1	2	3
c. Job search and employment	1	2	3
d. Child care while adult gets drug or alcohol abuse treatment	1	2	3
e. Post-employment support and monitoring for recovering drug or alcohol abusers	1	2	3
f. Other (please describe):	1	2	3

D-10. Is it state policy to have a drug or alcohol abuse counselor available to assist or advise the employment and training offices (on either full-time or part-time basis)?

1. Yes
2. No

D-10-a. Please answer the following regarding different arrangements for having counselors available to the employment and training offices. Circle a A1" if the arrangement exists in all (or nearly all) locations, a A2" if it exists in most, a A3" if it exists in some, and a A4" if it does not exist in any location.

	<u>All</u>	<u>Most</u>	<u>Some</u>	None
a. Counselors are co-located in employment & training offices full-time (Please go to D-10b)	1	2	3	4
b. Counselors are co-located in employment & training offices part-time (Please go to D-10b)	1	2	3	4
c. Counselors are on-call as needed	1	2	3	4
d. Counselors are available as Afloaters≡	1	2	3	4
e. Other (please describe)	1	2	3	4

D10-b. For counselors that are co-located in some, but not all counties= employment and training offices, please list the counties where they are co-located.

Counties where counselors are co-located:

Full-time
Part-time

D-11. Does your state have any employment or training programs that exclusively serve TANF recipients with drug or alcohol abuse problems?

1. Yes
2. No

D-12. Do any of the employment programs for TANF recipients in your state *specifically integrate* drug or alcohol abuse treatment into the work program (including job readiness, job search, or job skills programs)? If yes, please attach any information describing the program(s).

1. Yes, all of them
2. Yes, a great many
3. Yes, some
4. Yes, just a few
5. None of them

If Yes, in your opinion how effective has this employment-treatment integration been in helping TANF recipients?

1. Very effective
2. Somewhat effective
3. Not very effective
4. Not at all effective

D-13. Do you have a state policy that requires or encourages cross training between drug or alcohol abuse treatment providers and employment workers (i.e., giving treatment providers training in employment services and vice versa)?

1. Yes
2. No

D-14. If there is no state cross-training policy, and decisions about cross-training between drug or alcohol treatment providers and employment workers are made at the local level, what is your best estimate of the percentage of counties in your state that conduct such cross-training?

1. None
2. 1% - 25%
3. 26% - 50%
4. 51% - 75%
5. 76% - 100%

COMMENTS

THANK YOU VERY MUCH FOR YOUR COOPERATION.

*PLEASE RETURN THIS QUESTIONNAIRE TO THE PERSON IN YOUR STATE
WHO IS COORDINATING THIS SURVEY.*

If you have any questions about this survey, please call Gary Cyphers, APWA, 202/682-0100, x245 or gcyphers@apwa.org.

**SURVEY ON STATE POLICIES AND PRACTICES
REGARDING SUBSTANCE ABUSE, MEDICAID, AND EMPLOYMENT
NEEDS OF WELFARE RECIPIENTS
SECTION E: DRUG AND ALCOHOL ABUSE TREATMENT**

Name:

Title:

Agency:

Address:

Phone:

Fax:

E-Mail:

You have been designated by your State Human Service Administrator to complete the attached section of a comprehensive questionnaire.

The main objective of the Survey on State Policies and Practices Regarding Substance Abuse, Medicaid, and Employment Needs of Welfare Recipients is to learn how each state identifies and addresses drug and alcohol abuse problems among Temporary Assistance for Needy Family (TANF) recipients. Since drug and alcohol abuse has traditionally been considered a barrier or impediment to employment, it is particularly important to understand how the states are dealing with drug and alcohol abuse in the context of the work orientation of welfare reform.

Since questionnaires generalize, some questions and the response choices offered may not adequately represent the policies or practices of your state and its individual approach to the issue of drug or alcohol abuse. In such cases, please include your personal comments on the questionnaire to further explain the experiences that you are having in your state. We are also aware that many welfare reform programs are still undergoing significant changes, and that the answers to some questions may not be known. We have included response choices to accommodate this. Please note, however, that some questions ask for opinions rather than definitive assessments; we ask that you answer these questions as best you can.

The questionnaire has six main sections. It has been designed so the person in your state who is the best informed about each section can report on the information they are most familiar with.

AFTER YOU HAVE COMPLETED THE QUESTIONNAIRE, PLEASE RETURN IT TO YOUR SURVEY COORDINATOR: _____

<p>If you have any questions about this survey, please call Gary Cyphers (202/682-0100) or e-mail gcyphers@apwa.org at the American Public Welfare Association (APWA).</p>

**SURVEY ON STATE POLICIES AND PRACTICES
REGARDING SUBSTANCE ABUSE, MEDICAID, AND EMPLOYMENT
NEEDS OF WELFARE RECIPIENTS**

E. DRUG AND ALCOHOL ABUSE TREATMENT

To be completed by the state alcohol and other drug abuse treatment agency.

Guidelines for Survey Completion

1. Each section should be filled out by the person in the state most qualified to do so.
2. Each section should be returned to the survey coordinator when completed.
3. Please fill out the survey using black ink.
4. **It is important to us that we receive complete and accurate information because the results will be disseminated widely.** If, however, there is a particular question where you feel strongly that you do not want your response attributed publicly, please indicate so next to the question. On questions requiring a written response or on questions where you feel merely checking off an option would not accurately depict your state=s situation, please elaborate by including additional comments.

E-1. Please name the state alcohol and other drug abuse treatment agency.

E-2. Is your state alcohol and other drug abuse treatment agency a cabinet-level agency or part of a larger organization?

1. Cabinet-level agency (reports directly to governor)
2. Part of a larger organization.

Please name this organization: _____

E-3. What percentage of publicly-funded drug or alcohol abuse treatment services for medically indigent women who are age 19 or older and who have dependent children or are pregnant are delivered by:

- ____ % State agencies
 ____ % Local government agencies
 ____ % Private providers (both for-profit and non-profit)
 ____ % Other (please describe)
 100% Total

E-4. What percentage of your state's publicly-funded drug and alcohol abuse treatment, for medically indigent women who are age 19 or older and who have dependent children or are pregnant, is funded by:

- ____ % Medicaid managed care under MCO (Managed Care Organization)
 ____ % Medicaid managed care under PCCM (Primary Care Case Management)
 ____ % Medicaid fee for service
 ____ % Federal block grants and categorical funding (including Substance Abuse Block Grant, Social Services Block Grant)
 ____ % State only funds
 ____ % County/local funds
 ____ % Other (please specify): _____
 100% Total

E-5. On the table below, please indicate which drug or alcohol abuse treatment modalities are available in your state for medically indigent women who are age 19 or older and who have dependent children or are pregnant. In each category, please circle all that apply.

	Not Available Through Publicly <u>Funded Sources</u>	Available Under Medicaid <u>Fee For Service</u>	Available Under Medicaid <u>Managed Care</u>	Available Through Non-Medicaid Public Funding <u>Sources</u>
1. Detoxification services				
a. Inpatient hospital	1	2	3	4
b. Non-hospital residential	1	2	3	4
c. Outpatient	1	2	3	4
2. Ambulatory care				
a. Hospital outpatient	1	2	3	4
b. Community mental health center	1	2	3	4
c. Intensive outpatient (e.g. 30 hrs per	1	2	3	4
d. Other (please describe)				
-----	1	2	3	4
-----	1	2	3	4
-----	1	2	3	4
-----	1	2	3	4
3. Short-term residential (non-detox)	1	2	3	4
treatment				
4. Long-term residential (non-detox)	1	2	3	4
treatment				
5. Institutional inpatient care for mental	1	2	3	4
disease				
6. Methadone maintenance	1	2	3	4
7. Case management	1	2	3	4
8. Transportation assistance	1	2	3	4
9. Rehabilitative services (please describe)				
-----	1	2	3	4
-----	1	2	3	4
10. Other (please describe)				
-----	1	2	3	4
-----	1	2	3	4
-----	1	2	3	4
-----	1	2	3	4

1

¹Please include any special programs including waiver demonstrations that focus on drug or alcohol abusing medically indigent women who are age 19 or older and who have dependent children or are pregnant.

E-6. Do you expect the drug or alcohol treatment services your state provides or purchases for medically indigent women who are age 19 or older and who have dependent children or are pregnant to change in the coming year? Changes can include types and amount of services, eligibility for services, etc.

1. Yes
2. No

If A Yes, please describe how you expect them to change.

E-7. Does your agency collect the following information on publicly-funded alcohol or drug treatment programs on a case-by case basis?

	<u>Yes</u>	<u>No</u>
a. Job retention	1	2
b. Employment status	1	2
c. Drug abstinence	1	2
d. Reduction in criminal behaviors	1	2
e. Returns to alcohol or drug treatment (recidivism)	1	2
f. Departures from TANF	1	2
g. Other: (please describe)	1	2

E-8. Does your agency compile the above case-by case information into a statewide aggregate report for any of the following?

	<u>Yes</u>	<u>No</u>
a. Job retention	1	2
b. Employment status	1	2
c. Drug abstinence	1	2
d. Reduction in criminal behaviors	1	2
e. Returns to alcohol or drug treatment (recidivism)	1	2
f. Departures from TANF	1	2
g. Other: (please describe)	1	2

- E-9. Please answer the following by rating the adequacy of the supply of and the sufficiency of funding for drug and alcohol abuse treatment that is appropriate for medically indigent women who are age 19 or older and who have dependent children or are pregnant. Please rate the adequacy of supply of and the sufficiency of funding by circling a number from 1 to 5 in each category, with 1 indicating No problem and 5 indicating a Severe problem. Please remember that you can use any number between 1 and 5 for your rating.

<u>Types of Services</u>	<u>Adequate Supply</u>					<u>Sufficient Funding</u>				
1. Detoxification Services										
a. Inpatient hospital	1	2	3	4	5	1	2	3	4	5
b. Non-hospital residential	1	2	3	4	5	1	2	3	4	5
c. Outpatient	1	2	3	4	5	1	2	3	4	5
2. Ambulatory Care										
a. Hospital outpatient	1	2	3	4	5	1	2	3	4	5
b. Community mental health center	1	2	3	4	5	1	2	3	4	5
c. Intensive outpatient	1	2	3	4	5	1	2	3	4	5
d. Other (specify): _____	1	2	3	4	5	1	2	3	4	5
3. Short-term residential (non-detox) treatment (2 months or less)	1	2	3	4	5	1	2	3	4	5
4. Long-term residential treatment (more than 2 months)	1	2	3	4	5	1	2	3	4	5
5. Institutional inpatient care for mental disease	1	2	3	4	5	1	2	3	4	5
6. Methadone maintenance	1	2	3	4	5	1	2	3	4	5
7. Case management	1	2	3	4	5	1	2	3	4	5
8. Transportation assistance	1	2	3	4	5	1	2	3	4	5
9. Rehabilitative services (specify)										
a. _____	1	2	3	4	5	1	2	3	4	5
b. _____	1	2	3	4	5	1	2	3	4	5
10. Other (specify) ²										
a. _____										
b. _____										

² Please include any special programs including waiver demonstrations that focus on drug or alcohol abusing Medicaid beneficiaries.

E-10. Are there approaches or procedures in your state for combining different funding streams to fund drug or alcohol abuse services that you would characterize as innovative?

1. Yes
2. No

IF AYes≡ Describe briefly

If your state has a locally administered system, please answer E-9-a.

E-10-a. As far as you know, are there some counties which have innovative funding procedures?

1. Yes
2. No

If AYes,≡ Which counties are they? _____

COMMENTS

THANK YOU VERY MUCH FOR YOUR COOPERATION.

**PLEASE RETURN THIS QUESTIONNAIRE TO THE PERSON IN YOUR STATE
WHO IS COORDINATING THIS SURVEY.**

If you have any questions about this survey, please call Gary Cyphers, APWA, 202/682-0100, x245 or gcyphers@apwa.org.

**SURVEY ON STATE POLICIES AND PRACTICES
REGARDING SUBSTANCE ABUSE, MEDICAID, AND EMPLOYMENT
NEEDS OF WELFARE RECIPIENTS
SECTION F: MEDICAID AND DRUG AND ALCOHOL ABUSE TREATMENT**

Name:

Title:

Agency:

Address:

Phone:

Fax:

E-Mail:

You have been designated by your State Human Service Administrator to complete the attached section of a comprehensive questionnaire.

The main objective of the Survey on State Policies and Practices Regarding Substance Abuse, Medicaid, and Employment Needs of Welfare Recipients is to learn how each state identifies and addresses drug and alcohol abuse problems among Temporary Assistance for Needy Family (TANF) recipients. Since drug and alcohol abuse has traditionally been considered a barrier or impediment to employment, it is particularly important to understand how the states are dealing with drug and alcohol abuse in the context of the work orientation of welfare reform.

Since questionnaires generalize, some questions and the response choices offered may not adequately represent the policies or practices of your state and its individual approach to the issue of drug or alcohol abuse. In such cases, please include your personal comments on the questionnaire to further explain the experiences that you are having in your state. We are also aware that many welfare reform programs are still undergoing significant changes, and that the answers to some questions may not be known. We have included response choices to accommodate this. Please note, however, that some questions ask for opinions rather than definitive assessments; we ask that you answer these questions as best you can.

The questionnaire has six main sections. It has been designed so the person in your state who is the best informed about each section can report on the information they are most familiar with.

AFTER YOU HAVE COMPLETED THE QUESTIONNAIRE, PLEASE RETURN IT TO YOUR SURVEY COORDINATOR:_____

If you have any questions about this survey, please call Gary Cyphers (202/682-0100) or e-mail gcyphers@apwa.org at the American Public Welfare Association (APWA).
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**SURVEY ON STATE POLICIES AND PRACTICES
REGARDING SUBSTANCE ABUSE, MEDICAID, AND EMPLOYMENT
NEEDS OF WELFARE RECIPIENTS**

F. MEDICAID AND DRUG AND ALCOHOL ABUSE TREATMENT

To be completed by the state Medicaid office.

Guidelines for Survey Completion

1. Each section should be filled out by the person in the state most qualified to do so.
2. Each section should be returned to the survey coordinator when completed.
3. Please fill out the survey using black ink.
4. **It is important to us that we receive complete and accurate information because the results will be disseminated widely.** If, however, there is a particular question where you feel strongly that you do not want your response attributed publicly, please indicate so next to the question. On questions requiring a written response or on questions where you feel merely checking off an option would not accurately depict your state=s situation, please elaborate by including additional comments.

<p>NOTE: All of the following questions concern Medicaid benefits for TANF recipients. For the purpose of this survey, please consider TANF recipients to be medically indigent women who are age 19 or older and who have dependent children or are pregnant.</p>

- F-1. Does your state Medicaid plan explicitly prohibit Medicaid coverage of alcohol or drug abuse treatment services?
1. Yes
 2. No
 3. Other (please explain)

F-2. For medically indigent women who are age 19 or older and who have dependent children or are pregnant, please circle the number that best describes the extent each of these services are covered by your state (where A1" means services are very limited and A5" means services have no restrictions). If a service is not covered at all by Medicaid, please circle the A9".

Note that this question only concerns services covered by Medicaid, not services that may be provided with other public funding.

	Limited Coverage	Few Restrictions	No Restrictions			Not Covered By Medicaid
1. Detoxification Services						
a. Inpatient hospital	1	2	3	4	5	9
b. Non-hospital residential	1	2	3	4	5	9
c. Outpatient	1	2	3	4	5	9
2. Ambulatory Care						
a. Hospital outpatient	1	2	3	4	5	9
b. Community mental health center	1	2	3	4	5	9
c. Intensive outpatient (e.g. 30 hours a week)	1	2	3	4	5	9
d. Other (please describe)	1	2	3	4	5	9
3. Short-term Residential (non-detox) treatment (2 months or less)	1	2	3	4	5	9
4. Long-term residential treatment (more than 2 months)	1	2	3	4	5	9
5. Institutional inpatient care for mental disease	1	2	3	4	5	9
6. Methadone maintenance	1	2	3	4	5	9
7. Case management for drug or alcohol treatment	1	2	3	4	5	9
8. Transportation assistance	1	2	3	4	5	9
9. Rehabilitative services (please specify)						
a. _____	1	2	3	4	5	9
b. _____	1	2	3	4	5	9
10. Other (please describe) Please include any special programs including waiver demonstrations that focus on drug or alcohol abusing Medicaid beneficiaries.						
a. _____	1	2	3	4	5	9
b. _____	1	2	3	4	5	9

F-3. What percentage of your state’s publicly-funded drug and alcohol abuse treatment, for medically indigent women who are age 19 or older and who have dependent children or are pregnant, is funded by:

- ____% Medicaid managed care under MCO (Managed Care Organization)
- ____% Medicaid managed care under PCCM (Primary Care Case Management)
- ____% Medicaid fee for service
- ____% Federal block grants and categorical funding (including Substance Abuse Block Grant, Social Services Block Grant)
- ____% State only funds
- ____% County/local funds
- ____% Other (please specify): _____
- 100% Total

F-4. In your state, approximately what percentage of medically indigent women who are age 19 or older and who have dependent children or are pregnant are covered, as of September 1, 1997, by Medicaid Managed Care or Primary Care Case Management?

- ____% Medicaid Managed Care
- ____% Primary Care Case Management

F-5. Of those persons in question F-4 who are covered by Medicaid Managed Care or Primary Care Case Management, what percentage are served by carved out mental health care or drug or alcohol abuse services?

- ____% Only mental health benefits carved out
- ____% Only drug or alcohol abuse treatment benefits carved out
- ____% Mental health benefits and drug and alcohol abuse treatment benefits carved out

F-6. Does your state Medicaid program use any of the following approaches to provide drug or alcohol abuse treatment benefits to medically indigent women who have dependent children or are pregnant? Circle all that apply. Please circle AN/A,≠ not applicable, if your state Medicaid program explicitly prohibits Medicaid coverage of alcohol or drug abuse treatment services.

	<u>Yes</u>	<u>No</u>	<u>N/A</u>
a. State fee for service	1	2	3
b. Capitated carve-out (set amount paid to organization other than main medical provider for providing substance abuse services to a certain group of clients)	1	2	3
c. Capitated carve-in (payments are made to the managed care provider for substance abuse services that are apart from the basic Medicaid rate)	1	2	3
d. Other types of managed care arrangements	1	2	3
e. Other (please describe)	1	2	3

F-7. Who determines the scope of covered benefits for drug and alcohol abuse treatment services for medically indigent women who are age 19 or older and who have dependent children or are pregnant in pre-paid Medicaid plan arrangements? (Circle all that apply.)

1. The Medicaid agency as purchaser
2. The state's mental health/drug and alcohol abuse treatment department/agency
3. The contracted pre-paid plan
4. The Primary Care Case Management provider
5. Medicaid does not cover drug or alcohol abuse services
6. Other (please describe)_____

COMMENTS

THANK YOU VERY MUCH FOR YOUR COOPERATION.

***PLEASE RETURN THIS QUESTIONNAIRE TO THE PERSON IN YOUR STATE
WHO IS COORDINATING THIS SURVEY.***

If you have any questions about this survey, please call Gary Cyphers, APWA, 202/682-0100, x245 or gcyphers@apwa.org.

Comparison of State Characteristics with Policies and Programs to Identify and Treat Substance Abuse

This appendix is a first cut at exploring the association between state characteristics and selected policies to identify, assess, and treat substance abuse among TANF participants. First, it draws on five characteristics that emerged from survey responses:

- States with locally administered welfare systems;
- States in which TANF is in the same agency as Employment and Training and Substance Abuse Treatment, or Medicaid;¹
- States whose TANF administrators perceive that substance abuse was likely to interfere “a great deal” with meeting work participation requirements;
- States with a policy that counts substance abuse treatment as a work activity; and
- States in which eligibility workers could make treatment a requirement of TANF eligibility.

We then selected a number of state policies and practices to identify and treat substance abuse among TANF participants in four main areas:

- Policies to identify and assess substance abuse: welfare staff training or availability of substance abuse counselors;
- Data collection systems: data collection to estimate the number of substance abusing TANF participants or state policies to track treatment outcomes;
- Treatment availability: the adequacy of long-term residential, outpatient, or detoxification treatment services; and
- Policies to integrate substance abuse into work activities: work programs that include substance abuse treatment or cross training of substance abuse treatment providers and employment and training workers.

Finally, we examine whether states reporting any of the characteristics listed above also tended to report any of the selected policies and practices to identify and treat substance abuse among TANF participants, as compared to states that did not have these characteristics. (Refer to the end of this appendix for our methodology and summary tables of all frequencies)

Characteristics that Affected Resources to Identify and Assess Substance Abuse

States with the following four characteristics also tended to report that they trained welfare staff or provided substance abuse treatment specialist resources to them²:

- TANF, Employment and Training, and Substance Abuse Treatment in the same agency;

¹ We also explored states that reported having their TANF and Treatment offices, and their TANF and Employment and Training offices, housed in the same agency. In general, we found stronger results in those states with all three offices housed in the same agency. Accordingly, these are the results we report here.

² Training programs refer to the training of front-line workers in both identifying substance abuse among TANF participants and motivating participants to attend treatment.

- A TANF administrator who perceived that substance abuse would interfere a great deal with meeting work requirements
- A policy to count substance abuse as a work activity; and
- Eligibility workers who could mandate treatment.

In addition, states with TANF and Medicaid offices in the same agency tended to provide substance abuse training to front-line workers.

Characteristics that Affected Data Collection Systems

States with one of these characteristics were more likely to have mechanisms both to identify the number of substance abusing TANF participants and to track treatment outcomes among them:

- TANF, Employment and Training and Treatment functions were housed in the same agency;
- A TANF administrator who viewed substance abuse as interfering with meeting work requirements; and
- Eligibility workers who could mandate treatment

In addition, states that reported a state administered TANF system or a policy to count substance abuse as a work activity were more likely to report policies to track treatment outcomes (but not to identify the number of participants with substance abuse problems).

Characteristics that affected the Availability of Treatment Services

States that viewed the availability of treatment as a severe problem were more likely to report one of these characteristics:

- TANF and Medicaid were in the same agency (possibly suggesting that administrators in these states became more aware of constraints of their states' treatment funding capacities)
- States in which treatment counted as a work activity; and
- Eligibility workers who could mandate treatment (along with the second bullet, possibly suggesting that limited treatment capacities made it difficult for these states to link treatment with work activities).³

Characteristics that Affected Policies to Integrate Substance Abuse into Work Activities

States reporting that their work programs included substance abuse treatment also tended to have the following characteristics:

³ An exception to this general tendency was the relationship between states that counted treatment as a work activity and also viewed long-term residential treatment as a severe problem.

- A locally administered TANF system;
- TANF in the same agency as Medicaid;
- A TANF administrator who viewed substance abuse as interfering with work participation requirements;
- A policy to count substance abuse as a work activity; and
- Eligibility workers who could mandate treatment

States housing TANF in the same agency with Medicaid, or with Employment and Training and Treatment were also more likely to report a state policy to cross-train employment and training workers and substance abuse treatment providers. The same was true for states reporting a policy to count treatment as a work activity. Interestingly, these states were also more likely to have training programs for identifying and assessing participants with substance abuse problems (see above).

Methodology and Supporting Table

Table A-1 summarizes those state characteristics associated with select policies targeted at identifying, assessing, and addressing substance abuse among TANF participants. Each percentage summarized in this table represents the number of states reporting a particular state characteristic that also report the listed policy for identifying, assessing, and addressing substance abuse. We determined the difference between these percentages for each characteristic, and Tables A-1 and A-2 report percentages for those characteristics where 10% more states had a particular substance abuse policy in place than the alternate characteristic.

Table A-1. Comparison of State Characteristics and Policies for Identifying and Treating Substance Abuse (SA) Among TANF Participants⁴

<i>Characteristics:</i>	Welfare system is administered by...	TANF was in same agency as...	Administrator believed SA interfered with work...	Policy to count SA treatment as...	Action that eligibility worker can take regarding
<i>Identification &</i>					

⁴ The number of observations differs for most cells because this figure depends on the number of administrators reporting on the substance abuse policy and state characteristic for each cross tabulation.

<i>Treatment:</i>					treatment...
Training of front-line workers to identify SA and motivate participants to attend treatment	< 10% difference	<u>Medicaid:</u> 15 of 28 (54%) <u>No Medicaid:</u> 5 of 18 (28%) <u>E&T/Trtmt:</u> 8 of 12 (67%) <u>No E&T/Trtmt:</u> 12 of 34 (35%)	<u>A Great Deal:</u> 5 of 6 (83%) <u>Somewhat:</u> 11 of 29 (38%) <u>< Somewhat:</u> 4 of 11 (36%)	<u>Work:</u> 13 of 26 (50%) <u>Not as Work:</u> 7 of 18 (39%)	<u>Mandate:</u> 11 of 16 (69%) <u>No Mandate:</u> 4 of 12 (33%)
Access of front-line workers to SA treatment specialists	< 10% difference	<u>E&T/Trtmt:</u> 6 of 13 (46%) <u>No E&T/Trtmt:</u> 11 of 38 (29%)	<u>A Great Deal:</u> 4 of 6 (67%) <u>Somewhat:</u> 9 of 33 (27%) <u>< Somewhat:</u> 4 of 12 (33%)	<u>Work:</u> 12 of 29(41%) <u>Not as Work:</u> 5 of 19 (26%)	<u>Mandate:</u> 10 of 16 (63%) <u>No Mandate:</u> 3 of 13 (23%)
Data collection system to estimate the # of participants with SA problems	< 10% difference	< 10% difference	< 10% difference	< 10% difference	<u>Mandate:</u> 7 of 16 (44%) <u>No Mandate:</u> 4 of 13 (31%)
State policy to track treatment outcomes for TANF participants referred to treatment	<u>State:</u> 21 of 37 (57%) <u>Local:</u> 5 of 11 (46%)	<u>E&T/Trtmt:</u> 8 of 12 (67%) <u>No E&T/Trtmt:</u> 18 of 36 (50%)	<u>A Great Deal:</u> 5 of 6 (83%) <u>Somewhat:</u> 16 of 32 (50%) <u>< Somewhat:</u> 5 of 10 (50%)	<u>As Work:</u> 17 of 27(63%) <u>Not as Work:</u> 9 of 18 (50%)	<u>Mandate:</u> 13 of 16 (81%) <u>No Mandate:</u> 6 of 13 (46%)
Data collection for estimating SA and treatment outcomes	< 10% difference	<u>E&T/Trtmt:</u> 4 of 12 (33%) <u>No E&T/Trtmt:</u> 5 of 37 (14%)	<u>A Great Deal:</u> 2 of 6 (33%) <u>Somewhat:</u> 5 of 33 (15%) <u>< Somewhat:</u> 2 of 10 (20%)	< 10% difference	<u>Mandate:</u> 6 of 16 (38%) <u>No Mandate:</u> 2 of 13 (15%)

<i>Characteristics:</i>	Welfare system is administered by...	TANF was in same agency as...	Administrator believed SA interfered with work...	Policy to count SA treatment as...	Action eligibility worker can take regarding treatment...
<i>Identification & Treatment:</i>					
Supply of detoxification services was a "severe problem" ⁵	< 10% difference	<u>Medicaid:</u> 22 of 31 (71%) <u>No Medicaid:</u> 10 of 17 (59%)	<u>A Great Deal:</u> 4 of 5 (80%) <u>Somewhat:</u> 22 of 31 (71%) <u>< Somewhat:</u>	<u>Not as Work:</u> 16 of 27 (59%) <u>As Work:</u> 14 of 19 (74%)	< 10% difference

⁵ The determination that each service is in severe shortage is based on responses by Treatment administrators that its availability was a "severe problem."

			6 of 12 (50%)		
Supply of long-term residential treatment services was a "severe problem" ⁶	< 10% difference	<u>Medicaid</u> : 24 of 31 (77%) <u>No Medicaid</u> : 11 of 17 (65%)	<u>< Somewhat</u> : 8 of 12 (67%) <u>Somewhat</u> : 25 of 31 (81%) <u>A Great Deal</u> : 2 of 5 (40%)	<u>As Work</u> : 21 of 27 (78%) <u>Not as Work</u> : 12 of 19 (63%)	<u>No Mandate</u> : 10 of 11 (91%) <u>Mandate</u> : 9 of 15 (60%)
Supply of outpatient services was a "severe problem"	<u>Local</u> : 9 of 11 (82%) <u>State</u> : 23 of 37 (62%)	<u>No Medicaid</u> : 13 of 17 (77%) <u>Medicaid</u> : 19 of 31 (62%)	<u>A Great Deal</u> : 4 of 5 (80%) <u>Somewhat</u> : 22 of 31 (71%) <u>< Somewhat</u> : 6 of 12 (50%)	< 10% difference	< 10% difference
Work program that only served participants with SA problems or that integrates treatment ⁷	<u>Local</u> : 6 of 12 (50%) <u>State</u> : 8 of 37 (22%)	<u>Medicaid</u> : 11 of 31 (36%) <u>No Medicaid</u> : 3 of 18 (17%)	<u>A Great Deal</u> : 3 of 6 (50%) <u>Somewhat</u> : 8 of 31 (26%) <u>< Somewhat</u> : 3 of 12 (25%)	<u>As Work</u> : 10 of 29 (35%) <u>Not as Work</u> : 4 of 18 (22%)	<u>Mandate</u> : 5 of 16 (31%) <u>No Mandate</u> : 1 of 11 (9%)
Cross training of case managers and substance abuse treatment providers	< 10% difference	<u>Medicaid</u> : 7 of 30 (23%) <u>No Medicaid</u> : 1 of 17 (6%) <u>E&T/Trtmnt</u> : 4 of 13 (31%) <u>No E&T/Trtmnt</u> : 4 of 34 (12%)	< 10% difference	<u>As Work</u> : 7 of 27 (26%) <u>Not as Work</u> : 1 of 18 (6%)	< 10% difference

⁶ We also compared these characteristics with the supply of short-term residential treatment services. The relationships are similar to those between long-term residential treatment and these state characteristics.

⁷ We also examined the relationship between the state provision or funding of childcare, treatment, and post-employment support and monitoring for substance abusing TANF participants and these state characteristics. The relationships are similar to those between a work program that integrated substance abuse and these state characteristics.

Case Study Methodology

In developing our strategy for conducting the five case studies reviewed in the main report, we adopted a plan for each of the following areas: case study goals, site selection, information gathering, and relevant research questions.

Goals

The goals of the case study research were as follows:

- to elicit in-depth information on the development and implementation of innovative and useful strategies; and
- to identify facilitators and inhibitors that accompanied the innovation so as to better understand how states are benefiting from facilitators and resolving inhibitors.

Site Selection

The case study site selection consisted of three phases:

- a survey, mailed to all states and territories, that addressed current policies and practices for integrating welfare reform, employment, and substance abuse services; (see Appendices A and B for survey methodology and a blank survey instrument)
- in-depth telephone interviews with at least four key individuals in 12 states that, based on survey responses, appeared to be dealing most effectively with these issues; and
- site visits to five of the 12 states that appeared to have implemented the most innovative and promising policies and practices.

In determining the final mix of states, CASA also considered which would provide the most comprehensive view of innovations and developments aimed at integrating welfare reform and substance abuse programs. The specific characteristics indicating this potential were as follows:

Illinois:

- Concurrent with the implementation of welfare reform, a consolidation of many services into a new Department of Human Services
- Experience with prior human service collaborations and pilot programs guiding state efforts to address substance abuse barriers among Temporary Assistance for Needy Families (TANF) clients
- Devolution of responsibilities for TANF implementation with an emphasis on local decision-making and service partnering
- Work requirement policies and supports, such as earned-income disregards, for placing TANF recipients in the workforce
- Progressive child care subsidies allowing TANF participants to enter the workforce and continue to benefit from subsidies as part of a comprehensive program serving all poor working families in the state

Maryland:

- The state legislature's early and continuing leadership and involvement in welfare reform generally and substance abuse issues specifically
- Maryland's Medicaid waiver permitting coverage of virtually all substance abuse treatment services for Medicaid recipients, including three levels of residential care just for Temporary Cash Assistance (TCA) recipients
- Use of uniform substance abuse screening, assessment, and treatment placement instruments by local TANF agencies and managed care organizations
- Coordination and collaboration among state welfare reform, Medicaid, and substance abuse agencies
- Several longitudinal studies conducted by the University of Maryland reporting success for Maryland's welfare reform efforts after 18 months

Nevada:

- Proactive approach to dealing with substance abuse as a barrier to employment
- Interagency agreements, protocols, and funding for assessment and treatment of TANF clients with substance abuse problems
- A standardized screening instrument developed collaboratively and used statewide
- Commitment to staff training, including a professional development center/academy
- Unique challenges presented by the gaming industry as a major employer

North Carolina:

- State leadership promoting collaborative approaches to welfare reform
- The state legislature's direction, support, and funding of substance abuse initiatives in welfare reform
- Local authorities empowered to develop and implement creative approaches to substance abuse issues
- Partnerships with the private sector to place welfare participants in unsubsidized employment
- Substance abuse cross-training provided for welfare reform and substance abuse workers by the Jordan Institute for Families at the University of North Carolina at Chapel Hill
- Work First applicants utilizing the state's First Stop Employment Assistance program (enhanced Job Services) just like other unemployed residents

Oregon:

- Comprehensive Department of Human Resources with high levels of coordination and collaboration among TANF, employment services, substance abuse services, and medical assistance
- Welfare reform that has evolved through a number of earlier phases, including a welfare reform demonstration waiver
- Utilization of case managers to integrate eligibility and employment functions that emphasize "brokering for services"
- A welfare reform program that combines drug abuse treatment with work activity requirements

- A Medicaid waiver that includes drug and alcohol treatment services in the benefits package of the unique Oregon Health Plan

Information Gathering Process

Prior to the site visits, project staff requested and reviewed written materials from each state regarding welfare reform and substance abuse. These materials included, but were not limited to, the following information:

- state human-service agency mission statements, mandates, goals, and related materials;
- relevant sections of the state TANF plan and subsequent amendments/revisions;
- relevant policy and procedures manuals, including written transmittals or guidance to local offices;
- training curricula, especially those dealing with identifying substance abuse and referring participants for treatment;
- employability screening and assessment instruments;
- interagency agreements;
- other materials that would provide helpful background in advance of the site visit.

Project staff engaged each of the five states for a three-day visit, consisting of the following activities:

- An initial meeting with senior-level staff to present goals and plans for site visits, briefly discuss the state's responses to survey and phone interviews (including policies/practices of greatest interest), and answer any questions. During this group interview, project staff obtained a senior management's perspective on the integration of welfare reform, work, and substance abuse issues in the state.
- Individual interviews with six or more people at different levels within the welfare reform and substance abuse systems, using a semi-structured interview guide modified for each state and job category. The individuals interviewed in each state occupied, but were not limited to, the following positions:
 - Human Services Commissioner/Secretary or Deputy
 - Director of state alcohol- and substance abuse agency
 - Senior representative from welfare employment program
 - Staff trainer—at either the state, regional, or county level
 - Middle manager
 - Senior representative from state budget office
 - Other people designated by the state, taking into account unique organizational structures and processes
- Observations at two offices—site visits to two service settings judged by the state to be most innovative in welfare reform/substance abuse efforts. Project staff observed operations, talked with TANF cash assistance and employment workers, substance

abuse staff, trainers, and collaborative partners and observed TANF participant interviews (with the approval of participant and worker).

- At one of the service offices, a focus group of approximately 12 front-line workers. This session explored the practical implementation of welfare reform and substance abuse policies and whether some workers have been able to develop practices that are not part of formal procedures.

Research Questions

The following five research questions guided the site visits and case study research:

1. What are the state's most innovative policies, programs, or practices for addressing substance abuse problems within welfare reform?
2. Which supports (facilitators) have had the greatest influence in allowing these innovations to be effective?
3. Which key obstacles or barriers (inhibitors) has the state had to overcome in implementing the innovations, and how did the state resolve or reduce those obstacles?
4. What are the most promising results of the innovations?
5. What next steps are envisioned for the innovations?

State Contact Persons for each Case Study Site

This appendix lists the state contact person for each case study site that is available to provide further information to interested readers.

Illinois

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Maryland

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Nevada

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Fax: 775-687-1079
Email: rosaschi@govmail.state.nv.us

North Carolina

Starleen Scott Robbins, Women's Services Coordinator
Substance Abuse Services

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Raleigh, NC 27603
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Fax: 919-733-9455
Email: srobbins@dhr.state.nc.us

Oregon

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Chairman of the Board of Allen and
Company Incorporated
(Former President of The Coca-Cola Company)

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Alan I. Leshner, Ph.D.

CEO, Executive Publisher, Science, American
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Directors Emeritus

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Mary Fisher (1996-2005)

Betty Ford (1992-1998)

Douglas A. Fraser (1992-2003)

Barbara C. Jordan (1992-1996)

Leo-Arthur Kelmenson (1998-2006)

LaSalle D. Leffall, Jr., M.D., F.A.C.S. (1992-2001)

Nancy Reagan (1995-2000)

Linda Johnson Rice (1992-1996)

George Rupp (1993-2002)

Michael I. Sovern (1992-1993)

Frank G. Wells (1992-1994)