

**INTEGRATING ALCOHOL
AND DRUG TREATMENT
INTO A WORK-ORIENTED
WELFARE PROGRAM:
LESSONS FROM OREGON**

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Table of Contents

- Acronyms i
- Executive Summary: Integrating Alcohol and Drug Treatment into a Work-Oriented Welfare Program: Lessons from Oregon iii
- Chapter 1: The Promise and Challenge of Integrating Alcohol and Drug Treatment into a Work-Oriented Welfare Program 1
- Chapter 2: The Oregon Experience: Integrating Alcohol and Drug Treatment into a Work-Oriented Welfare Program 13
 - Section I: Specifying the State Policy Framework 16
 - Section II: Creating a Shared Vision 24
 - Section III: Developing an Approach to Integration 30
 - Section IV: Creating a Local Office Infrastructure that Supports Service Integration 35
 - Section V: Identifying Clients with Alcohol and Drug Problems 43
 - Section VI: Connecting with the Treatment System 50
 - Section VII: Measuring Program Performance 59
- Chapter 3: Applying the Lessons from Oregon in Different Policy and Programmatic Environments 63
- Appendices
 - Appendix A: District and Branch Offices: Total JOBS Participants and Total Participants Engaged in Alcohol and Drug Treatment, December 1998 69
 - Appendix B: Authorization for Release of Information 71
 - Appendix C: Interfacing A&D Clients With Other JOBS Activities 73
 - Appendix D: District Arrangements for the On-Site Presence of Alcohol and Drug Abuse Professionals in the Welfare Office 75
 - Appendix E: Alcohol and Drug Upfront Services 78
- References 81

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Acronyms

A&D:	Alcohol and Drug
AFDC:	Aid to Families with Dependent Children
AFS:	Adult and Family Services Division
ASAM:	American Society of Addiction Medicine
DHR:	Department of Human Resources
DHHS:	U.S. Department of Health and Human Services
EDP:	Employment Development Plan
FCHP:	Fully capitated health plans
FTE:	Full time equivalent
JOBS:	Jobs for Oregon's Future (Oregon's TANF employment program)
OADAP:	Office of Alcohol and Drug Abuse Programs
OHP:	Oregon Health Plan
OMAP:	Office of Medical Assistance Programs
PRWORA:	Personal Responsibility and Work Opportunity Reconciliation Act
SASSI:	Substance Abuse Subtle Screening Inventory
TANF:	Temporary Assistance for Needy Families

Integrating Alcohol And Drug Treatment Into A Work-Oriented Welfare Program: Lessons From Oregon

As welfare caseloads near record lows, states are increasingly looking for ways to help the remaining recipients make the transition from welfare to work. Many of the recipients remaining on the welfare rolls face a myriad of personal and family challenges. Oregon has long been viewed as a leader in addressing such issues, especially when alcohol and drug problems are involved. Since 1992, the state has required local welfare offices to address alcohol and drug problems in their welfare program plans.

Over the past seven years, these offices have strengthened their commitment to helping clients overcome the challenges that alcohol and drug problems pose for employment, and they have found ways to integrate alcohol and drug treatment into their welfare programs. Oregon's experience can provide important insights about how states can address alcohol and drug problems as a part of their effort to shift to a temporary, work-oriented assistance system. The key lessons from Oregon's experience are summarized below.

Strong leadership at the state level and a clear vision of the role of alcohol and drug treatment in easing the transition to employment greatly facilitate the process of creating an infrastructure for integrating alcohol and drug treatment into a work-oriented welfare program at the local level.

As early as 1992, the state welfare agency in Oregon created a shared vision and a consistent policy context for integration by requiring each local district to address alcohol and drug treatment in their program plans. This requirement reinforced the message that treatment is an important key to self-sufficiency and made local offices accountable for addressing alcohol and drug abuse problems among their clients. With this vision in place, local office managers felt they could focus on the details of actually integrating treatment into their programs rather than first having to debate the need to do so.

VISION AND GOALS

Welfare programs can address alcohol and drug problems without compromising the emphasis on rapid employment.

Oregon's welfare program emphasizes helping recipients to enter the labor force as quickly as possible. Applicants for assistance are required to look for work immediately, and all recipients are required to participate in activities that will help them to become self-sufficient. The prevailing philosophy in Oregon regarding the relationship between employment for welfare recipients and alcohol and drug use is that the need for alcohol and drug treatment does not render one unemployable or incapable of participating in work-related activities. Clients in treatment are expected to simultaneously work toward economic self-sufficiency. Furthermore, while alcohol and drug treatment can be a component of a client's self-sufficiency plan, and at times may be the primary activity, it rarely is the only activity. There is a close interaction between local welfare offices and alcohol and drug treatment providers in determining the appropriate mix of activities that will accompany treatment. The bottom line is that whenever possible, treatment is combined with work or work-related activities. Even when treatment is not combined with work, it is perceived and presented as the first step in helping a recipient to become employable.

Integrating alcohol and drug treatment into welfare employment programs provides an opportunity to engage individuals in treatment who may otherwise never see the need or be referred for treatment.

Many clients enter welfare employment programs with alcohol and drug problems that have gone undetected or unaddressed. Such problems can lead to failure in work and contribute to low self-esteem. A welfare system that incorporates alcohol and drug treatment into the standard package of services may present the first opportunity for these clients to admit and address their problems—giving them the push they need to break the cycle of dependency and make progress toward self-sufficiency. To date, many alcohol and drug treatment programs have not specifically targeted women with children. The welfare system may provide an efficient and effective way to identify women with children in need of alcohol or drug treatment, although this could overload an already stressed system that is striving to provide treatment to those seeking help.

POLICY AND PROGRAMMATIC FRAMEWORK

Alcohol and drug problems can be addressed through existing welfare policies as long as these policies define acceptable program activities broadly.

Other than the mandate for local offices to include a strategy for addressing alcohol and drug problems in their welfare plans, Oregon has no policies specific to providing alcohol and drug treatment to welfare recipients. Instead, the state has defined work-related activities broadly enough to include alcohol and drug treatment. By placing treatment on par with other allowable work-related activities, Oregon has given local-

ities the tools—such as sanctions and supportive services—to enforce treatment-related requirements just as they enforce and support all other work-related activities.

Making alcohol and drug treatment services more accessible to low-income individuals through the Medicaid system makes it much simpler to address alcohol and drug problems as a part of ongoing efforts to move welfare recipients into the labor force.

Coverage of alcohol and drug treatment through the Oregon Health Plan (Oregon’s Medicaid program) makes it feasible for substantial numbers of welfare recipients to access existing alcohol and drug treatment programs. The Oregon Health Plan (OHP) is the primary source of alcohol and drug treatment coverage for families in poverty in Oregon, including welfare recipients. The OHP includes all medical-related alcohol and drug dependency services in its basic health services package that is available to all participating individuals. Because federal regulations stipulate that TANF funds only be used for nonmedical components of alcohol and drug treatment, the OHP goes a long way toward making medical-related services more accessible to welfare recipients.

Alcohol and drug problems can be addressed by integrating existing policies and service structures as long as there is a commitment to ongoing collaboration between the welfare and the alcohol and drug treatment systems.

Addressing alcohol and drug problems in the welfare population does not require the development of a new service delivery system. Rather, it can be accomplished within the framework of existing welfare and alcohol and drug treatment systems by identifying the opportunities for collaboration and the avenues open for the integration of services. Successfully integrating these systems means establishing communication between them and educating each about the other. To be successful it is essential that welfare and alcohol and drug treatment agencies build solid and sustainable relationships based on a common understanding of their individual and shared goals.

Giving staff from the welfare and the alcohol and drug treatment systems the opportunity to better understand the policies and procedures of each system makes it easier for staff to create an infrastructure that accounts for the strengths and limitations of both systems.

Welfare staff and alcohol and drug treatment professionals have typically worked in very different environments, focusing on very different goals. Early on, Oregon planned conferences for staff from both systems to discuss how and when alcohol or drug treatment could be integrated with work activities. The issue of confidentiality was a key component of these discussions. Such opportunities for communication — not only

COORDINATION AND COLLABORATION

between program administrators but also between line staff — are the foundation for an infrastructure that reflects the nature of both systems.

Training is essential to effective communication between welfare and alcohol and drug treatment staff, and to an effective, coordinated service delivery system.

Staff from the welfare office often know very little about alcohol and drug problems, and about how to help recipients access treatment services. Similarly, alcohol and drug professionals often know very little about the policies that govern the receipt of welfare benefits. Consequently, successfully integrating alcohol and drug treatment into the welfare program means training staff from each system in the interests and operations of the other. Oregon's Office of Alcohol and Drug Abuse Programs provides ongoing training to all welfare staff. Staff are taught to spot situations in which alcohol or drug problems may be contributing to a recipient's inability to find or keep a job. Staff are also trained in procedures for referring recipients to alcohol and drug professionals for further assessment and screening.

PROGRAM DESIGN AND STRUCTURE

A broad state policy framework gives local offices the freedom to develop a service approach that reflects their clients' needs, their preferred approach to helping welfare recipients find work, and the alcohol and drug treatment resources in their community.

Although Oregon has a state-administered welfare program, local agencies have substantial discretion over policy-setting and implementation. State policies on integrating alcohol and drug treatment into the welfare program are intentionally broad, allowing localities to tailor programs to their own needs. As a result, local programs have been able to experiment with different strategies, adjust their approach over time to better meet program objectives, and make the best use of resources. In addition, a flexible state policy has allowed each district to build, at their own pace, close alliances with local alcohol and drug treatment providers.

Universal drug testing is not a prerequisite for identifying clients with alcohol and drug problems or for integrating alcohol and drug treatment into a work-oriented welfare program.

Universal drug testing (through blood or urine samples) is not used to screen clients for alcohol and drug problems in Oregon. Rather, candidates for treatment are identified in three ways: at intake through professionally recognized alcohol and drug screening instruments, later on by the case manager who has developed a trusting relationship with a client, or through a client's failure to follow through with an agreed-upon employment plan. Testing can, however, be useful for collecting more information on the presence or nature of a problem during an in-depth assessment or to convince clients in severe denial that they have

a problem that needs to be addressed. Tests are administered by certified alcohol and drug treatment professionals only, and program staff are extremely careful in making decisions related to testing. These and other measures have contributed to the lack of legal or other challenges around the use of drug testing in Oregon.

Co-locating certified alcohol and drug professionals in the welfare office greatly facilitates the interface between the two systems and lets welfare offices stretch their limited case management resources.

Perhaps the most effective means of integrating alcohol and drug treatment into the welfare to work process is to actually physically locate alcohol and drug treatment professionals in the welfare offices. All the districts in Oregon have certified alcohol and drug treatment professionals on site in their local offices for some scheduled time each week to provide the up-front services that engage a client in treatment such as conducting education classes, screening clients for alcohol and drug problems, providing referrals for treatment, and helping to develop clients' self-sufficiency plans. The fact that these professionals have a "presence" in the district offices keeps the program focused on alcohol and drug problems and takes the pressure off of case managers for performing tasks they may not be trained for and do not have the time to address effectively.

Monitoring the success or failure of integrating alcohol and drug treatment into a welfare program is a complicated endeavor.

Oregon has deliberately decided not to separately examine or report on program outcomes for welfare recipients who are referred to or who participate in alcohol or drug treatment programs. This decision to monitor all outcomes together reflects the state's philosophy that alcohol and drug treatment, for most recipients, is simply one of many equally important elements in a plan to help recipients become self-sufficient. Consistent with its emphasis on high rates of quality job placements and job retention for all recipients, Oregon assesses program performance on the basis of six performance measures that affect service to all welfare recipients: total job placements, wage at placement, percentage of families who remain off assistance at 18 months, percentage of teen parents in school, percentage of eligibility decisions processed on time, and measures of efficiency in delivering program benefits. Many individual districts maintain data on the number of recipients referred for alcohol and drug assessments, screening and/or treatment, but they do so at their own discretion. This reflects Oregon's decision to hold the local districts accountable for outcomes instead of process.

MONITORING PROGRAM PERFORMANCE

ADAPTABILITY OF OREGON'S MODEL

Oregon's experience can be valuable to other states that are contemplating whether or how to integrate alcohol and drug treatment into their welfare program.

Specifically, there are important lessons to be learned from the decisions made by state and local administrators in Oregon about designing integrated programs and about meeting the challenges related to implementing such programs. The success local offices in Oregon have had in integrating alcohol and drug abuse treatment may be attributable to institutional structures that may or may not be present in other states. However, it is not necessary for other states to have similar structures in place in order to learn from Oregon's experiences and to use parts of Oregon's model in their own programs. Concepts and processes embedded in Oregon's model can be used by others as Oregon has used them, or they can be tailored to work in different policy and organizational environments. The task for other states is to critically assess their own systems and objectives to determine the most efficient and effective methods for incorporating alcohol and drug treatment into their own welfare programs. The lessons outlined above and detailed throughout this report can inform and guide that process.

The Promise And Challenge Of Integrating Alcohol And Drug Treatment Into A Work-Oriented Welfare Program

POLICY CONTEXT

The new welfare environment has dramatically changed the way states work with families who receive assistance through the Temporary Assistance for Needy Families (TANF) block grant. Now more than ever, states have a vested interest in helping these families overcome obstacles to self-sufficiency, including alcohol and drug problems. Specifically, time limits on the receipt of assistance and steadily increasing work participation requirements have made it imperative for states to find new ways of helping families who face a broad range of personal and family challenges make the transition to employment.

Before federal welfare reform, states had already begun to shift the focus of their welfare programs from income maintenance to work-oriented, transitional assistance. The Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996 solidified this new approach to welfare at the federal level, creating a policy framework that would support states as they structured their own assistance programs to move families from dependence to self-sufficiency. This new environment of welfare reform, with an emphasis on work, presents both opportunities for and challenges to addressing alcohol and drug problems among welfare recipients. The opportunities arise from smaller case-loads, more financial resources per recipient, and more concerted, innovative efforts to reach families who have found it difficult to find or keep a job. The challenges stem from the very need to move more TANF recipients quickly into work and integrate two systems that have had very little contact with one another.

A handful of states recognized early on that a work-oriented approach to welfare needed to aggressively address alcohol and drug problems among the welfare population. Utah, Kansas, South Carolina, and Oregon received waivers from the federal government (prior to federal welfare reform) that allowed them to require alcohol and drug treatment as a condition of welfare receipt (WIN 1997). This report takes a close look at how this approach has played out in Oregon, beginning with its policy roots and tracing the steps the state took to fully integrate alcohol and drug treatment into its welfare program. In this chapter, we discuss the study methodology, the rationale for addressing alcohol and drug problems in a

work-oriented welfare program, and the opportunities and challenges associated with doing so. The second chapter explains how Oregon actually went about addressing alcohol and drug problems within the framework of its welfare program. The report concludes with general guidance from Oregon's experience for state and local policymakers as they attempt to address the needs of welfare recipients with alcohol and drug problems and make further strides toward serving *all* families.

METHODOLOGY

Oregon started integrating alcohol and drug treatment into its welfare program in 1992. This report presents the findings of a case study of Oregon's approach to integrating alcohol and drug treatment into its welfare program six years later — in late 1998. The case study is based on telephone interviews with representatives from the 15 administrative districts that administer the state's welfare program, including the state's TANF-funded work program known as Jobs for Oregon's Future (still commonly referred to by the acronym, JOBS). The respondents in each district varied. We spoke with a mix of district managers, community resource coordinators, case managers, contract or hired alcohol and drug professionals, and staff from the prime contractor for the JOBS program.¹ Respondents were selected by district managers as the individuals most knowledgeable about the district's approach to and arrangements for addressing alcohol and drug problems among their welfare caseload. Two additional interviews were conducted with state staff at the Oregon Department of Human Resources, including a representative from the Adult and Family Services Division (AFS), which administers the welfare program in Oregon, and a representative from the Office of Alcohol and Drug Abuse Programs (OADAP). All interviews were conducted in September and October 1998. Before turning to the findings of the case study we examine the rationale, opportunities and challenges associated with integrating alcohol and drug treatment into a welfare employment program.

¹Oregon has a state-administered welfare system. Adult and Family Services, a division within the Department of Human Resources oversees program operations. Over the years, Oregon has devolved considerable responsibility for program operations to its 15 district offices. The district offices typically oversee more than one local office, known in Oregon as branch offices. Districts can decide how to define staff responsibilities, but offices generally use an "integrated worker model" in which one worker has full responsibility for providing assistance to a family, including eligibility determination, supportive services, and case management. Services for the JOBS program are provided through a prime contractor, generally the local community college or Job Training Partnership Act (JTPA) administrative agency. The prime contractor may also subcontract some services to other providers in the community.

There are three key reasons for integrating alcohol and drug treatment into a work-oriented welfare program:

- A substantial portion of the welfare caseload appears to be affected by alcohol and drug problems.
- Completing alcohol and drug treatment is associated with increases in employment.
- Treating alcohol and drug problems can reduce the costs associated with health care, criminal justice, child welfare and income support programs.

There are no precise estimates on the prevalence of alcohol and drug problems among the welfare population. However, a rough, often quoted estimate is that one in five welfare households is headed by an adult with an alcohol and/or drug problem. This estimate is an “educated guess” based on findings from a number of studies.²

There is a general consensus that alcohol and drug problems among welfare recipients *are* issues that program administrators must contend with. However, measuring the precise *extent* of alcohol and drug problems among recipients and determining what these problems mean for work-oriented welfare programs has eluded researchers, policymakers, and program staff alike. Nearly every study available uses a different definition of alcohol and drug problems, making it impossible to compare estimates across studies.

- Studies that attempt to measure alcohol or drug *dependence*, or functional impairments related to alcohol and drug use generally find the lowest rates of alcohol or drug problems. For example, a 1996 analysis determined that 7.6 percent of all welfare recipients 18 years of age and older abused or were dependent on alcohol, and that 3.6 percent abused or were dependent on other drugs (Grant and Dawson 1996). An earlier study found that among female welfare recipients between the ages of 18 and 44, 4.9 percent were significantly impaired, and 10.6 percent were somewhat impaired by alcohol or drug use (DHHS 1994).
- Studies that define alcohol and drug problems more broadly find substantially higher rates of alcohol and drug problems among the welfare population. For example, the Center on Addiction and Substance Abuse (CASA 1994) estimated that 37 percent of the welfare population between the ages of 18 and 24 had an alcohol or drug problem, defined as binge drinking two or more times or any use of drugs (including marijuana) during the last year.

²For an overview of study findings on the prevalence of alcohol and drug problems among the welfare population refer to Young, N. “Alcohol and Other Drug Treatment: Policy Choices in Welfare Reform.” Prepared for the Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration. 1996.

- Regardless of whether alcohol and drug problems are broadly or narrowly defined, studies find that these problems are more common among welfare recipients than among nonrecipients. For example, the U.S. Department of Health and Human Services found that 10.8 percent of women 15 years of age or older receiving welfare reported past-month illicit drug use, compared with 5.2 percent of all women in that age group (DHHS 1994). CASA (1994) also found that women 18 years of age and older who received welfare were likely to abuse or to be addicted to alcohol and illicit drugs at a rate two times higher than women not receiving welfare.

Only a handful of states have estimates of the prevalence of alcohol and drug use among people who receive welfare. Among these states is Oregon. A 1997 Oregon Department of Human Resources client characteristics report estimated that 50 percent of the state's welfare caseload admitted to having alcohol- and/or drug-related problems (Oregon Adult and Family Services 1997). This does not mean that half of Oregon's caseload is in need of intensive treatment and cannot pursue work activities, but that the problem is pervasive enough to demand attention. A substantial decline in the number of families receiving welfare in Oregon and concerted efforts to identify recipients dealing with alcohol and drug problems may explain the high rates of alcohol and drug use reported in Oregon compared with national studies.

There is a general consensus that alcohol and drug problems among welfare recipients are issues that program administrators must contend with.

Studies that examine the employment experience of people who complete alcohol and drug treatment consistently find improvements in the rates of employment and/or the wages of these individuals. Studies that examine dependence on welfare also find a drop in the reliance on public benefits programs for people who complete treatment programs.

There is no research that *proves definitively* that participation in alcohol or drug treatment improves employment outcomes or reduces dependence on welfare.³ However, studies that examine employment outcomes, either by comparing participants' employment experiences before and after treatment or by comparing the employment experiences of individuals who do and do not complete treatment, find that employment outcomes improve for individuals who complete treatment. Like the studies on the prevalence of drug problems, studies on employment and drug use measure outcomes in different ways and so are not directly comparable to one another. Still, they provide evidence of the range of improvement in employment outcomes that might result if more welfare recipients with alcohol and drug problems participated in alcohol or

³To definitively prove that alcohol or drug treatment increases employment and reduces welfare receipt, persons identified as needing alcohol or drug treatment would need to be randomly assigned to two groups with one group receiving treatment and the other not receiving treatment. For ethical reasons, such studies generally are not undertaken to evaluate the effectiveness of alcohol or drug treatment programs.

drug treatment. Studies that have examined changes in the receipt of public assistance also find that the use of welfare goes down after participating in treatment.⁴

- At the national level, the National Treatment Improvement Evaluation Study (NTIES), a five-year study commissioned by the Center for Substance Abuse Treatment, found a 19 percent increase in employment among persons who completed treatment. In addition, there was an 11 percent decrease in the number of clients who received welfare after treatment (Center for Substance Abuse Treatment 1997).
- A California study that examined treatment outcomes for a random sample of persons who received drug and alcohol treatment services during 1991-92 (when the country was in a deep recession) found a 30 percent increase in employment among persons who completed more than four months of residential treatment compared with their participation in the work force before treatment (Legal Action Center 1997). A second study using the same data to examine outcomes for welfare recipients found a 22 percent decrease in welfare participation after treatment (Gerstein *et al.* 1997).
- A study of individuals who completed a publicly funded alcohol and drug treatment program in Oregon found that these individuals earned wages that were 65 percent higher than people who did not complete treatment. Wages were higher for all individuals who engaged in some level of treatment over those who did not, although those who completed treatment had the greatest overall increase in wages (Finigan 1996).

The increase in wages and/or employment and decreases in welfare receipt that can result from alcohol and drug treatment are consistent with the goals of work-oriented welfare programs. These findings do not, however, suggest that alcohol and drug treatment will result in increased employment and/or reduced welfare receipt for *all* recipients who participate in treatment. Rather, they suggest that, *on average*, it is reasonable to expect that welfare recipients who participate in alcohol or drug treatment will have higher rates of employment and lower rates of welfare receipt than recipients with alcohol and drug issues who do not participate in treatment.

The available research on employment outcomes for persons participating in alcohol and drug treatment suggests that it is reasonable to expect improvement in the employment prospects of welfare recipients who participate in treatment.

⁴It is possible for participation in welfare programs to increase when individuals enroll in alcohol and drug treatment programs. Treatment programs may screen participants for eligibility for welfare programs. Residential programs, in particular, have been able to use clients' welfare and food stamp benefits to help pay for room and board. This may dampen positive findings about the reduction in the use of welfare benefits for persons who participate in alcohol or drug treatment.

The benefits of treatment for alcohol and drug problems are not confined to individuals participating in treatment — they accrue to many areas of public services. In particular, treating alcohol and drug problems can reduce costs associated with state health care, criminal justice, child welfare, and income support services.

A number of state-level studies have demonstrated the cost-effectiveness of using public dollars to support alcohol and drug treatment because of the savings generated in multiple areas of public concern.⁵ For example:

- In California, researchers estimated a cost savings of approximately \$7.00 for every \$1.00 invested in alcohol and drug treatment. This savings accrued to a number of service areas but was largely concentrated in criminal justice because of reductions in crime that are associated with drug use. Cost savings for welfare recipients with children exceeded the cost of treatment by a ratio of 2.5 to 1 (Gerstein *et al.* 1997). This lower benefit-to-cost ratio for welfare recipients can be explained, in part, by the lower rate of crime committed by mothers with children on welfare. However, this study does not estimate savings that may have accrued to the child welfare system. Had these savings been included, the cost savings for welfare recipients participating in treatment would likely have been higher than these estimates suggest.
- In Oregon, researchers found that the state saved \$5.60 in direct public costs for each dollar spent on alcohol and drug treatment (Finigan 1996). Savings were generated across the areas of criminal justice, child welfare, food stamp and other public assistance programs, and health care services.

Given the emphasis on mandatory participation in welfare-to-work programs, it is likely that many welfare recipients may end up participating in alcohol and drug treatment because they are required to do so, rather than because they acknowledge their alcohol and drug problems and/or the need for treatment. Studies in the late 1980s of alcohol and drug treatment programs in the criminal justice system suggest that client outcomes are similar regardless of whether treatment is compulsory or voluntary, and that the mandatory nature of treatment does not interfere with the effectiveness of any treatment mode (Gostin 1991). The different circumstances surrounding treatment and the incentives for treatment in the welfare system warrant a closer look at how this process will play out in this policy area.

⁵For comprehensive syntheses of state cost effectiveness and client outcomes studies see Young, N. "Alcohol and Other Drug Treatment: Policy Choices in Welfare Reform." Prepared for the Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration. 1996; and "Invest in Treatment for Alcohol and Other Drug Problems: It Pays." National Association of State Alcohol and Drug Abuse Directors, 1994.

Time limits and the requirement to meet increasing work participation rates have made it more urgent for states and local welfare offices to address the personal and family challenges — such as alcohol and drug problems — that can come between welfare recipients and self-sufficiency. Because the most “job ready” recipients already have left the welfare caseload, more and more state and local offices are looking for ways to help those left behind. The new welfare policy environment gives states a unique opportunity to do this by integrating alcohol and drug treatment into their welfare programs. In particular,

- Welfare caseloads are at an all-time low, freeing up staff and financial resources to address alcohol and drug problems.
- As time limits intensify the need to move welfare recipients into jobs, people and organizations at the community level have come together to make this happen.

Shrinking caseloads and flexible funding have combined to give welfare offices more resources than they once had to address the needs of welfare recipients, including those with alcohol and drug abuse problems.

A strong, robust economy with low inflation along with unprecedented policy and programmatic changes in the welfare system have spurred a significant decline in the number of families receiving cash assistance. Between January 1993 and June 1998, the number of families receiving cash assistance fell by 39 percent, from 4.96 to 3.03 million families. Sixteen states experienced at least a 50 percent reduction in the number of families receiving assistance. Oregon’s caseload fell by 57 percent, the seventh largest decline in the country (Administration for Children and Families 1998).

As a result of this dramatic drop in welfare caseloads, most states have been able to implement major work-based reforms in a resource-rich environment. A recent study by the General Accounting Office (GAO 1998) found that the amount of TANF funds available to states for 1997 was \$4.7 billion larger than the amount they would have had under the old AFDC formula. The median increase for states was 22 percent. Since PRWORA was enacted, states have also achieved budgetary savings by reducing expenditures on welfare programs to the 75 or 80 percent “maintenance of effort” (MOE) required by federal law. Even with the budgetary savings, 21 states have been spending more per recipient under TANF than they were before TANF (GAO 1998). On top of their TANF funding, states and localities also will have access to close to \$3 billion in additional funds over the next several years from the Welfare-to-Work grants program (legislated in 1997) to implement work-based strategies for hard-to-employ welfare recipients, including those with alcohol and drug problems.

The unprecedented decline in welfare caseloads and the funding available to states through the TANF block grant has prompted states to look for additional investments they can make to improve the employment prospects of the welfare recipients remaining on the welfare rolls.

As a result of the dramatic drop in welfare caseloads, most states have been able to implement major work-based reforms in a resource-rich environment.

There are several ways in which states can use welfare funding to pay for alcohol and drug treatment:⁶

- Use federal TANF funds to pay for components of treatment (such as counseling or supported work activities) that are not “medical services.”
- Transfer federal TANF funds to the Social Services Block Grant (SSBG) allowing families with an income below 200 percent of poverty to qualify for services, regardless of whether they were receiving TANF benefits.
- Use state MOE funds to pay for alcohol and drug treatment. State MOE funds are not subject to the same restrictions as TANF funds, making it possible to use them to pay for a broader range of services, including medical services.
- Use Welfare-to-Work funding to design programs for welfare recipients (and non-custodial parents) with alcohol and drug problems. Alcohol and drug treatment falls within the scope of job retention and supportive services that can be provided with these funds.

Because of the high stakes associated with lifetime time limits, there is an unprecedented emphasis on cross-system collaboration.

Historically, the welfare system has interacted very little with other service systems. However, the emphasis on employment and the ticking of the “benefits clock” has raised the stakes for welfare families and encouraged far greater cross-system collaboration. In communities across the country, state and local officials, community and religious leaders, and service providers have come together to rethink how limited resources can be used more efficiently to support families’ efforts toward self-sufficiency. Agencies that previously have not been a part of welfare-to-work efforts have now joined this discussion, expanding the resources available to help families make the transition.

Whether these community efforts result in better long-term outcomes for families will depend, at least in part, on the degree that communities are able to break with the past and create an integrated service system that adequately addresses the challenges families will face when income from paid employment is expected to fully replace welfare as their main source of support. Clearly, alcohol and drug problems are key challenges that communities will need to address to improve the long-term employment outcomes for many families on welfare. Although the stakes for families are very high, the integration of programs across systems with different goals, organizational structures and funding streams, has always involved and will continue to involve numerous challenges.

⁶See “Welfare Reform: How States Can Use TANF Funding to Pay for Alcohol and Drug Treatment” (September 1998) prepared by the Legal Action Center, for a more detailed discussion of these options.

Despite the fact that states and local welfare offices are in a better position to address alcohol and drug problems than they have ever been before, there are many challenges they will need to overcome to successfully integrate alcohol and drug treatment into their welfare programs. The key challenges include:

- Creating a social service infrastructure that promotes and supports integration through coordination and collaboration among service systems that have no or very little history of working together.
- Meeting the demand for alcohol and drug treatment through an already stretched service system.
- Identifying ways to make the alcohol and drug treatment system more responsive to the needs of women with children.

Coordination and collaboration is difficult under even the best circumstances. Given that the welfare and alcohol and drug treatment systems have a limited history of working together, substantial time and hard work will be needed to create an infrastructure that fully supports the integration of alcohol and drug treatment into a work-oriented welfare program.

In the past, the welfare office's primary function was to determine eligibility for benefits. Education and training and/or job placement services were provided for a small and often select portion of the welfare caseload. Since persons with alcohol and drug problems often were not part of this group, staff from the welfare office rarely, if ever, had any reason to interact with the alcohol and drug treatment system. Conversely, although alcohol and drug treatment programs may have encouraged their participants to apply for public benefits, they rarely had any reason to interact with the welfare system. Consequently, integrating alcohol and drug treatment into the welfare program means building procedures and relationships essentially from scratch.

The following are the specific tasks that are likely to be critical to the development of a consistent and coordinated approach to addressing the alcohol and drug problems of welfare recipients:

- Developing a set of goals and expectations common to agencies on "both sides of the fence."
- Examining the strengths and limitations that each system brings to a coordinated delivery system; in particular, assessing the policies and procedures that will contribute to and detract from a coordinated approach.
- Clearly defining agency and staff roles and responsibilities.
- Training staff to carry out their assigned roles and responsibilities.

In addition to working together, the alcohol and drug treatment and welfare systems will need to identify other systems that may need to be part of their efforts to maximize their chances for success. Relationships with the child welfare and mental health systems are likely to be especially important. Connecting with the child welfare system is important

because a system that provides welfare and alcohol and drug treatment must be able to respond to parents who fear losing their children if they agree to enter treatment. In addition, staff in the welfare and treatment systems may discover abuse and neglect that must be reported to the child welfare system by law. Connecting with the mental health system is important because mental health problems often co-exist with alcohol and drug problems, and staff from both systems will need to know how to address these issues.

Although there is a sense of urgency in the welfare system about addressing alcohol and drug problems, the alcohol and drug treatment system in many communities is already having difficulty meeting the demand for treatment.

If, indeed, more individuals are referred to alcohol and drug treatment because of systemized efforts by welfare staff to identify candidates for treatment, a state's treatment system may initially be stretched to deal with the growing demand for services. Recent research estimated that the public treatment system can currently meet about 50 percent of the need for treatment (Woodward *et al.* 1997). Although there are constraints on the kinds of services for which TANF funds can be used, states do have the flexibility to use these funds to expand treatment capacity especially in outpatient programs. However, given the range of services for which TANF funds can be used, alcohol and drug treatment programs will be competing with many other interests for a limited pool of financial resources. This situation is compounded by the fact that the stigma associated with alcohol and drug problems may make it especially difficult to garner enough support for using TANF funds to expand alcohol and drug treatment capacity. It also is possible that welfare agencies will be reluctant to spend TANF dollars on alcohol and drug treatment services because they believe the alcohol and drug treatment system should be funding these services. Ironing out these issues means that both systems will need to develop clear goals for integration and a clear understanding of the strengths and limitations of each service system.

Alcohol and drug treatment programs have not always adequately addressed the needs unique to women, especially women with children.

Historically, alcohol and drug problems have been viewed and approached primarily as a "male" problem. It is true that a larger percentage of the male than the female population has been documented as facing an alcohol or drug problem, but there is a large and growing need to address alcohol and drug problems among women. Women addicted to drugs and/or alcohol tend to have less education and work experience, and fewer marketable skills than men who are similarly addicted (Nelson-Zlupko 1995). As a result, these women also tend to have fewer financial resources than their male counterparts. They also remain the primary caretakers of their children, shouldering this responsibility not

Given the range of services for which TANF funds can be used, alcohol and drug treatment programs are likely to be competing with many other interests for a limited pool of financial resources.

TABLE 1. Barriers and Approaches to Treatment for Women

Entry	
Stigma	Women often develop a higher degree of denial than do men about alcohol and drug problems. This reaction stems from the <i>stigma</i> associated with being alcohol- or drug-involved, bringing on feelings of guilt and shame. This denial can be particularly strong among mothers as they fear attacks on their suitability as a parent. The guilt, shame, and low self-esteem that manifest themselves as denial can keep women from seeking assistance and can put a strain on encounters with professionals who believe there is a problem. Overall, heavy denial makes women less likely to be either identified or referred for treatment by professionals they do come into contact with (Finkelstein 1994).
Fearful of Consequences	As caretakers, women are <i>fearful of the consequences</i> of entering treatment because they do not trust the social service system. There is the fear of prosecution, either for criminal activity with drugs or for negligence as a parent (Kumpfer 1991). The greater fear is loss of custody of their children.
Treatment Approach	
Safe, Supportive, and Non-confrontational	Substance-abusing women need a <i>safe, supportive and non-confrontational treatment environment</i> to deal with the events and circumstances that bring them to this point. The onset of drug abuse in women is often the result of a particular traumatic event such as physical or sexual abuse, or a significant disruption in family life (Nelson-Zlupko <i>et al.</i> 1995). Treatment methods developed for men have traditionally been confrontational in nature. This approach often backfires with women who are dealing with feelings of guilt and low self-esteem, and who have other important psychological issues that may be at the root of their disease. Women-only groups are one way to provide an atmosphere that lends itself to the discussion of sensitive personal issues and to build a network of support among peers.
Family-centered	Friends and families of women facing alcohol and drug problems can often be as much a part of the denial process as women themselves, voicing significant opposition to treatment particularly if a woman plays a critical care-taking role in the family. For this reason, many experts promote a <i>family-centered approach</i> to treatment that addresses the full range of family issues and involves close friends and relatives (Finkelstein 1996).
Supportive Services	Women, particularly those with children, are in need of <i>supportive services</i> to help them enter and participate in alcohol and drug treatment and assist them in longer-term recovery. The most critical support is child care, either as part of a residential program or provided on-site for out-patient services. On a larger scale, experts advocate for a comprehensive and coordinated approach to treatment involving intensive case management that would ensure assistance with transportation and housing needs, and that would encourage participation in parenting and health education classes.

Numerous experts have identified barriers to treatment for women and women with children, suggesting that certain components of treatment can lower these barriers.

only without strong financial support, but often without enough family and/or social support as well.

Only in the past 20 years has the federal government tried to address the needs specific to women, and women with children, in alcohol and drug treatment. The government has worked largely through funding mechanisms and regulations that required states to direct a portion of their treatment funding to programs for women. This effort has, however, waxed and waned over its brief history (Kumpfer 1991), and there is still a gap between funding for female-oriented programs and women's needs.

Numerous experts have identified barriers to treatment for women and women with children, suggesting that certain components of treatment can lower these barriers (Table 1). Because the TANF population is overwhelmingly comprised of single-parent, female-headed households, integrating alcohol and drug treatment into the welfare program can assist in removing these barriers. For instance, coordination between the alcohol and drug treatment and the welfare systems may be especially helpful in building trusting relationships between women and their case managers and treatment professionals to eliminate their fears about going into treatment (especially fears about losing their children to the child welfare system). By providing women with access to child care and transportation, the welfare system may also be able to fill a gap in providing the supportive services mothers need to succeed in treatment and to make the transition to work.

Overall, the integration of alcohol and drug treatment into a state's welfare program can work to the advantage not only of welfare recipients but of the system as well. Recipients with alcohol and drug problems could address their addiction as part of their efforts toward self-sufficiency, and the partnership between the welfare and treatment systems could spawn a more coordinated and comprehensive alcohol and drug treatment approach. The process of integrating the two systems is a complicated and ambitious endeavor. For states beginning this journey toward integration, Oregon's experience maps the challenges and opportunities for success they will face along the way.

The Oregon Experience: Integrating Alcohol And Drug Treatment Into A Work-Oriented Welfare Program

Oregon is viewed as a leader in the effort to address the alcohol and drug problems of welfare recipients in a welfare employment program. This case study of Oregon's experience is based on interviews with representatives from the 15 administrative districts that operate the state's welfare program, Jobs for Oregon's Future still commonly referred to as JOBS. (Refer to Appendix A for a list of the district and branch offices.) Our step-by-step analysis of Oregon's experience is designed to give policymakers and program administrators insight into the tools needed to make alcohol and drug treatment for welfare recipients a regular part of state welfare program activities.

This case study is presented in seven sections each addressing a different aspect of integrating alcohol and drug treatment into a welfare employment program:

- Specifying the state policy framework
- Creating a shared vision
- Developing an approach to integration
- Creating a local office infrastructure that supports service integration
- Identifying clients with alcohol and drug problems
- Connecting with the alcohol and drug treatment system
- Measuring program performance

The first two sections focus on state policy and state level coordination that gave local administrators the leverage and flexibility they need to give alcohol and drug problems a firm place on their own welfare agendas. The remaining sections focus on the details of integrating alcohol and drug treatment into a work-oriented welfare program across the 15 districts—the **decisions** they made and why they made them, the **challenges** they confronted and how they addressed them, and the **lessons** they learned.

Table 2 summarizes the key decisions made by the districts. All 15 feel strongly about the importance of integrating alcohol and drug treatment into their welfare programs and have created the infrastructure to support this approach. This framework for integration consists of three key components that have been adopted throughout the state:

- Alcohol and drug treatment is placed on par with other work-related activities in client self-sufficiency plans.
- Noncompliance with treatment, if included in a client’s self-sufficiency plan, is subject to sanctions.
- There is an alcohol and drug (A&D) professional on-site in district welfare offices.

Despite this consistency in implementing integration, the districts vary in the decisions they made about some details. Most notably, they are split nearly down the middle in their approach to treatment (whether or not to mandate treatment) and in their approach to screening clients for alcohol and drug problems (whether to conduct broad or targeted screens). There are also subtle differences in the activities in which on-site A&D professionals are involved, but all the districts maintain the distinction between case management and alcohol and drug counseling.

TABLE 2. Key Local Decisions Regarding the Integration of Alcohol and Drug Treatment into the Welfare System		
Key Decisions	District Specific Decisions	
Developing an Approach to Integration		
Alcohol and Drug Treatment is Incorporated into Self-Sufficiency Plans	In all 15 districts alcohol and drug treatment is placed on par with any other work-related activity in a client’s self-sufficiency plan.	
Approach to Treatment	8 districts strongly encourage, but do not mandate treatment.	7 districts mandate treatment.
Ability to Sanction	All districts report that sanctions are important to the process but they are used to varying degrees across the districts.	
Creating a Local Office Infrastructure that Supports Service Integration		
Staff Roles	Divisions between case management and alcohol and drug counseling roles are clear across all districts.	
On-site Presence of an Alcohol and Drug Professional	<p>All 15 districts have an A&D professional on-site, but the hours and arrangements vary, largely based on total caseload size.</p> <ul style="list-style-type: none"> • 4 districts have full-time arrangements (40 hours or more per week) • 9 have at least half-time arrangements (20 hours to less than 40 hours per week) • 2 have less than half-time arrangements (less than 20 hours per week) 	

TABLE 2. (continued)

Key Decisions	District Specific Decisions	
Identifying Clients with Alcohol and Drug Problems		
Approach to Screening for Alcohol and Drug Problems	8 districts conduct broad screens of TANF recipients early in the process.	6 districts conduct targeted screens of TANF recipients as necessary; 1 district does not conduct screening at all.
Staff Who Conduct the Screen	In 13 districts, the A&D professional conducts the screen.	In 1 district, the case manager conducts screens.
Approach to Drug Testing	<p>Drug testing is not used as a universal screening tool in any district, however, districts do use drug testing for other non-treatment purposes.</p> <ul style="list-style-type: none"> • 1 district does not use any form of non-treatment drug testing • 5 districts use drug tests as part of in-depth assessments • 9 districts use drug tests on clients who deny a problem and refuse a referral for treatment 	
Connecting with the Alcohol and Drug Treatment System		
Contracts with Providers for Treatment	Not necessary due to coverage of alcohol and drug treatment services under the Oregon Health Plan, but all districts actively engage providers with the welfare-to-work process.	
Alcohol and Drug Treatment is Combined with other Work-Related Activities	All 15 districts balance treatment with other activities in client self-sufficiency plans. The degree of emphasis on job search and direct work activities varies across the districts.	
Monitoring Treatment	<p>All 15 districts monitor a client's participation and progress in treatment as it relates to self-sufficiency plans.</p> <ul style="list-style-type: none"> • In 5 districts, case managers monitor attendance through TANF client self-reports and progress through provider reports • In 7 districts, case managers monitor attendance and progress through provider reports • 3 districts rely on their on-site A&D professional to gather information from providers on a regular basis and provide comprehensive reports to case managers 	
Measuring Program Performance		
Collecting and Reporting Client Outcomes	Six performance measures for the welfare program are collected and reported in all 15 districts. There are no measures specific to clients with alcohol and drug problems.	

SECTION I

Specifying The State Policy Framework

OVERVIEW

The state Division of Adult and Family Services (AFS) of the Department of Human Resources oversees operations for the welfare program in Oregon. Welfare program policy development, accountability, and reporting are centralized to some degree in AFS. Direct responsibility for program operations lies with 15 administrative districts, which generally consist of a number of local, or branch, offices. Staff throughout the district and local offices are state employees. Program managers in the 15 districts have a great deal of discretion for policy-setting and implementation. And in this vein, there are not many state policies or procedures that prescribe local efforts to integrate alcohol and drug treatment into the welfare program. However, specific procedures regarding alcohol and drug treatment are handled by the Office of Alcohol and Drug Abuse Programs (OADAP) or the Office of Medical Assistance Programs (OMAP) also located in the Department of Human Resources.

OREGON'S WELFARE POLICIES DESIGNED TO ENCOURAGE WORK

Rapid entry into the labor market or other work-related activities

Oregon's ultimate goal for all welfare recipients is unsubsidized employment. To this end, the state's welfare policies are intended to move recipients into jobs as quickly as possible—beginning with an up-front job search period. All nonexempt adult applicants for assistance must conduct a job search before their application for benefits is approved and payments begin. Those who do find employment receive enhanced work supports such as higher asset and vehicle equity limits and more child care assistance. Those who do not find employment must continue to look for work, or they may be placed in subsidized employment; a limited number of applicants may be placed in short-term education or training programs.

Universal participation in JOBS

Oregon requires full participation in JOBS with few exceptions.⁷ To implement this policy, the state expanded program activities and support services, developed stronger ties with community agencies that provide specialized services, and intensified the training for caseworkers. In fiscal year 1997, Oregon reported a 97 percent work participation rate among all families on welfare, the highest of any state (DHHS 1998). The state counts a large portion of its caseload in its work participation rate, choosing not to

⁷The only exceptions are for (1) single parents caring for a child under the age of three months; (2) women in their ninth month of pregnancy and other pregnant women experiencing medical complications; (3) persons who must travel an unreasonable distance from their homes or remain away from homes overnight to participate in program activities; (4) dependent children under age 16 who are not custodial parents; (5) persons age 60 or older; and (6) VISTA volunteers.

use the leeway of a 20 percent exemption allowed by federal law. However, using the flexibility provided by a pre-TANF waiver, the state has a more relaxed definition of work in that it counts job search, regardless of length of time or employment outcomes, as well as participation in alcohol and drug treatment or mental health counseling.

Steadily increasing penalties for noncompliance with proactive measures to protect the well-being of children

Oregon's sanction policy, known in the state as disqualification, includes three levels of progressively tougher sanctions that end in case closure after six months of noncompliance. This tiered procedure is designed to send a clear message to recipients that participation in program activities is a requirement, not a choice. But, full TANF benefits can be reinstated at any time if individuals comply with the required activities. Sanctions are permanent to a client's record. Later episodes of noncompliance spark sanctions at the same level at which the client left off in the disqualification process. Before a TANF case can be closed, a complete family assessment with multiple agencies—public and non-profit—is conducted. The assessment focuses on the well-being of the children and how they may be affected by a full family sanction.

Broad access to work supports

Work supports are an important part of Oregon's efforts to promote self-sufficiency among welfare recipients. For instance, the state has made it easier for recipients to receive child care assistance when they become employed. Transitional child care has been extended indefinitely, and families are no longer required to receive cash assistance for three out of six months before they can qualify for transitional child care. Since 1994, Oregon has combined Medicaid funds with state general funds through the Oregon Health Plan to extend basic health care coverage to all individuals and families with an income below the federal poverty level. The program covers approximately 40 percent more families than were covered under the original Medicaid program. In addition, case managers can authorize special payments to help with small emergencies that require a one-time payment, such as fixing a car or having dental work completed.

The vehicle equity limit and the asset limit are also quite generous. The vehicle equity limit is \$9,000, and the asset limit for JOBS participants who are moving ahead in their self-sufficiency plans is \$10,000. The earned income disregard for eligibility and benefit determination has also increased under TANF.

The Oregon Health Plan (OHP) is the primary source of alcohol and drug treatment coverage for poor families, including TANF recipients

Through a mix of federal and state funds (40 and 60 percent), the OHP currently covers 574 medical treatments. While the plan ranks 745 medical condition/treatment pairs in order of effectiveness, it only cov-

HEALTH CARE
COVERAGE AND
ALCOHOL AND DRUG
TREATMENT SERVICES
FOR THE POOR

Under the Oregon Health Plan, the number of clients treated for chemical dependency has increased by more than one third.

ers the number of treatments possible under existing funding levels. Because of the preventive nature of chemical dependency services, they are in the top quarter of all ranked services.

Medical-related alcohol and drug dependency services are included in the basic OHP health services package and are managed as an integral part of an individual's overall health care. Eligible persons receive a medical card that they present to plan providers so that approved treatments can be covered. OADAP data for the first three years of the OHP indicate that the number of clients treated for chemical dependency increased by more than one third; this is not exclusive to TANF recipients but includes all those who qualify for coverage under the OHP (OADAP 1997). The extended coverage under the OHP has enabled OADAP to focus services on families with an income between 100 and 200 percent of poverty.

Alcohol and drug treatment services are accessed through managed care providers

Under the OHP, health care services are delivered through managed care whenever possible. Approximately 84 percent of OHP clients receive their coverage through fully capitated health plans (FCHPs), up from 33 percent prior to the OHP. The Office of Medical Assistance Programs (OMAP), which administers the OHP, contracts with 15 FCHPs to provide health care services, including alcohol and drug treatment services. The OHP pays each FCHP a set monthly fee (capitation rate) for each enrolled person it serves, and the FCHP manages each client's care from regular examinations to hospitalization.

Capitation rates vary by location and by risk factors associated with a given plan's client composition. For TANF families, the monthly average statewide capitation rate for all basic health services for a family of three is \$383. Of that amount, \$14 represents the capitated monthly rate for alcohol and drug treatment services. In that FCHPs manage services and costs for all the families served, the costs associated with families who need more extensive alcohol and drug treatment are balanced by the costs associated with families who do not use alcohol and drug treatment services. (This principle applies to all covered services, not just alcohol and drug treatment.)

Within these capitated levels, FCHPs negotiate service agreements with individual alcohol and drug treatment providers throughout their area. TANF recipients and other OHP clients can choose their providers from a pool of providers under contract to the FCHP. OMAP requires plans to refer at least 50 percent of clients to providers who have traditionally offered diagnostic or treatment services in a community. Policymakers believe that this requirement is essential to the survival of the nonprofit A&D treatment network that has traditionally served welfare and other low-income families.

OADAP purchases nonmedical services that are not covered by the OHP, including room and board for welfare recipients and other low-income people in need of detoxification and residential treatment

OADAP supports the needs of TANF recipients and other poor families with an income below 200 percent of poverty for more intensive alcohol and drug treatment, such as residential and detoxification services. OADAP payments cover room and board, as well as nonmedical support and training activities. Private health plans, or the OHP for TANF recipients, are responsible for costs associated with the medical care a client receives in a residential setting. OADAP purchases “slots” for residential and detox services from providers on an annual basis. Providers set aside a designated number of slots in their program for those who are eligible for subsidized treatment based on their income. Clients are referred across counties and districts, as necessary, to use the slots that are available. Costs per bed per year range from \$8,250 for a standard residential program for alcohol treatment to \$33,900 for an intensive residential treatment program for youth. OADAP purchases community detoxification beds for \$16,200 per bed per year.

Table 3 shows how these state policies affect the process of integrating alcohol and drug treatment into the welfare program. Districts have further defined policies within this broader state framework as described throughout the sections that follow.

Welfare reform at the federal level presents states with a number of decisions that affect TANF recipients who have alcohol and drug problems. Because these policy options are in conflict with Oregon’s approach to helping clients achieve self-sufficiency, they decided not to use the policy options for addressing alcohol and drug abuse made available to states in the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA).

DECISIONS ON PRWORA OPTIONS THAT AFFECT TANF RECIPIENTS WITH ALCOHOL AND DRUG PROBLEMS

No state ban on TANF and food stamp benefits to individuals convicted of a drug felony

Oregon has not banned convicted drug felons from receiving welfare benefits because state policymakers believe that individuals convicted of a drug felony, if they have properly served their time, should have the same rights and access to assistance as other state citizens. They also believe that there could be unintended consequences if a person is denied TANF assistance; without access to welfare, these persons may show up in the criminal justice system, and their children, in child protective services.

No universal drug testing for TANF applicants and recipients

Although Oregon may be more aggressive than other states in identifying TANF applicants and recipients who may be candidates for alcohol and drug treatment, the state has not implemented universal drug testing. Broad testing for drug use can be expensive for the state and

TABLE 3: STATE POLICY FRAMEWORK AFFECTING THE INTEGRATION OF ALCOHOL AND DRUG TREATMENT INTO THE WELFARE PROGRAM IN OREGON	
Eligibility/Program Requirements	<i>Policy:</i> Participation in alcohol and drug treatment, when included in a client's Employment Development Plan, is a JOBS program requirement. It is a TANF eligibility requirement for clients exempt from JOBS participation.
	<i>Procedural tools:</i> Sanctions or no case opening.
Screening	<i>Policy:</i> There is no mandatory alcohol or drug screen for welfare recipients. Local offices can decide if, when, and how to screen clients for alcohol and drug problems as well as who will conduct these screens.
	<i>Procedural tools:</i> No standard screening tool, although AFS and OADAP are currently collaborating on a recommendation.
	<i>Payment:</i> TANF funding can be used to cover screening.
Assessment	<i>Policy:</i> In-depth assessments of alcohol and drug abuse must be conducted by certified professionals.
	<i>Procedural Tools:</i> Assessments are conducted using criteria established by the American Society of Addiction Medicine (ASAM) to guide decisions about the appropriate level of treatment for clients.
	<i>Payment:</i> OHP covers in-depth assessments conducted by providers to inform the treatment plan.
Treatment	<i>Policy:</i> Treatment can be interpreted as mandated due to its ties with eligibility and program requirements.
	<i>Procedural Tools:</i> Sanctions for non-compliance; Individual release forms (DHR 2100) enable A&D providers to discuss the client's treatment status in general terms with AFS offices, particularly as it relates to the client's progress in other JOBS activities. (DHR 2100 is included in Appendix B.)
	<i>Payment:</i> OHP covers all medical-related alcohol and drug services for individuals in poverty. OADAP covers nonmedical-related services associated with residential and detoxification treatment (e.g. room and board) for individuals with incomes up to 200 percent of poverty.
Supportive Services	<i>Policy:</i> No specific state policy regarding supportive services for participation in alcohol and drug treatment. Implied policy is that the services that are provided for other JOBS activities are also provided for alcohol and drug treatment.
	<i>Payment:</i> TANF supportive service funds.

intrusive for clients. In addition, because universal drug testing is a point-in-time test, it does not necessarily identify all users. One administrator described the work-oriented welfare program as an attempt to work “with” clients and not “on” them. A culture of teamwork and support relies on trust, which administrators believe, cannot be built under the shadow of across-the-board mandated drug tests.

Addressing the restriction that TANF funds only be used for nonmedical components of alcohol and drug treatment

Restricting the use of TANF funds to nonmedical purposes only has less of an impact in Oregon than it may have in other states because the OHP covers the medical costs of alcohol and drug treatment for individuals who are eligible for TANF. Under state policy, through the OHP specifically, TANF recipients have access to a wider range of alcohol and drug treatment services than may be true under other states’ Medicaid or state health insurance programs. The state does use TANF funding for nonmedical services such as screening or case management to enhance the up-front services that clients can receive in the welfare office.

Three decisions inherent in Oregon’s policy framework are reflected in the state’s approach to integration of alcohol and drug treatment into the welfare program.

KEY DECISIONS

Alcohol and drug problems among welfare recipients are addressed through integrating existing policies and structures rather than by creating a new framework.

Oregon never considered creating a new system or set of policies to address alcohol and drug treatment among welfare recipients. Rather, the state expected to find ways to address the issue by integrating the existing welfare and alcohol and drug treatment systems. As a result, state policies involving alcohol and drug treatment for welfare recipients are broad: few welfare policies are specific to alcohol and drug use, and few policies in the treatment system are specific to welfare recipients. The two “communities” must manage the welfare/treatment interface with the policies and resources available in their existing systems.

The state built local flexibility into its policy framework.

Flexibility is a word that appears often throughout the state guidance for JOBS planning. The theme of local flexibility underlies not only the issue of alcohol and drug treatment but also the state’s overall message to districts about welfare reform in general: that it is still evolving, and the ability to adapt to change is important. The catalyst for this philosophy is the transition Oregon made to a welfare system focused on employment and self-sufficiency, which required major administrative as well as policy and programmatic changes. For instance, responsibility for the design and operation of programs has shifted from the state level to the 15 district and 52 branch offices. Furthermore, the state both

strongly emphasizes cultural change in welfare offices and promotes flexibility and decision-making authority at the local level.

The state holds local offices accountable for outcomes, not process.

In Oregon, flexibility is accompanied by accountability. As the state has given districts the freedom to administer the welfare program, it has also made them accountable for program outcomes. Oregon requires districts to report on six measures of program performance in their area: total job placements, wage at placement, percentage of families who remain off assistance at 18 months, percentage of teen parents in school, percentage of eligibility decisions processed on time, and measures of efficiency in delivering program benefits. None of the performance measures are specific to clients with alcohol and drug problems, but they apply to outcomes that are likely to be affected by decisions that involve these harder-to-employ clients—especially decisions about reducing barriers to self-sufficiency.

Practically speaking, this relationship between flexibility and accountability plays out as follows. At the local level, case managers and supervisors manage a case according to “principle-based decision making.” This means that, instead of making decisions on the basis of a prescribed set of rules for every situation, case managers and supervisors are encouraged to use their best judgment in making decisions. For difficult cases in particular, they are expected to enlist the help, as necessary, of additional staff of other public and private agencies familiar with a case. They must also document and justify all decisions.

LOCAL ATTITUDES TOWARD STATE POLICY

The 15 district offices that administer the welfare program in Oregon are generally pleased with the state policy framework under which they must address alcohol and drug problems among their clients. Local offices are accustomed to having broad state direction and greater local control over program implementation, and district AFS representatives do not feel that additional state guidance or policy is needed in the area of alcohol and drug treatment under welfare.

Few district AFS staff interviewed feel that state policies inhibit the integration of alcohol and drug problems into the welfare program. In the following discussion of the advantages and disadvantages of flexibility, the potential problem of ambiguity was not mentioned by AFS representatives in a majority of the districts, but it was the only policy challenge that was mentioned by more than one district AFS representative.

Local discretion is highly valued and makes continual program improvement easy.

Local offices value the state policy that lets them design and redesign their own approach to alcohol and drug problems among welfare recipients. Local representatives widely agree that the flexibility built into the state policy framework gives them important leeway to tailor their pro-

gram to local needs. Of equal value is their ability to adjust their approach if and when they see fit. If local offices are expected to be accountable for program outcomes, the freedom to adjust gives them a way to do this under changing local and programmatic conditions.

Local discretion also breeds experimentation. Many of the local managers expressed a sense of freedom related to their ability to make decisions about new approaches and to build alliances with new partners. Building close partnerships with local A&D providers took a great deal of ground-work and many adjustments on both sides along the way. Local offices needed the flexibility to move at their own pace through this process.

Flexibility can result in ambiguous procedures.

Flexibility comes at the expense of consistency in procedures. If each district is given the freedom to implement the welfare program according to its own needs, procedures, though legitimately falling within the state policy framework, may be inconsistent from district to district. For example, one district may screen all applicants for alcohol and drug problems, while another will rely solely on case managers to refer clients who may be candidates for treatment.

Case management can also vary as a result of principle-based decision making. The latitude given to case managers for making decisions is viewed as very important to the process, yet local AFS representatives also feel that case managers may have their own issues that influence their decisions. OADAP is generally uncomfortable with the level of flexibility related to decisions made about client alcohol and drug problems in the AFS office, such as the absence of a standard screening tool and the timing of referrals to A&D professionals. If expectations were set, if not by state policy then by local protocols, some of the ambiguity that enters the process during case management might disappear.

In terms of specifying a policy framework, Oregon's experiences offers one, but one very important, lesson.

Integrating alcohol and drug treatment into the welfare program does not require a new policy framework.

In Oregon's experience, integrating alcohol and drug treatment into the welfare program neither developed from nor entailed a new policy or service delivery structure. The state integrated the two systems under the existing framework by piecing together the welfare and alcohol and drug treatment policies that apply to the TANF population and by looking for avenues of cross-system collaboration.

Local representatives widely agree that the flexibility built into the state policy framework gives them important leeway to tailor their program to local needs.

KEY LESSON

SECTION II

Creating A Shared Vision

OVERVIEW

Oregon was one of the first states to address alcohol and drug problems within the context of its welfare program, taking this step even before the onset of welfare reforms nationwide. In 1992, Oregon made the first official move toward a partnership between its welfare offices and local alcohol and drug (A&D) treatment providers. The Division of Adult and Family Services (AFS) of the Oregon Department of Human Resources (DHR) secured a waiver from the U.S. Department of Health and Human Services allowing the state to require AFDC recipients to participate in alcohol and drug treatment as a condition of receiving benefits. In turn, AFS required districts to specifically address alcohol and drug problems in their Job Opportunity and Basic Skills (JOBS) program plans. This requirement remains in place under the Temporary Assistance to Needy Families (TANF) block grant.

By devolving responsibility to district and branch offices for addressing alcohol problems among welfare recipients, AFS made these offices accountable for client outcomes and reinforced the message that alcohol and drug treatment is an important avenue leading to client self-sufficiency. This state policy also put participation in alcohol and drug treatment on par with other prescribed JOBS activities such as job search, participation in approved training classes, and actual work hours. Over the course of the past state fiscal year (July 1, 1997 to June 30, 1998), a total of 4,927 welfare clients participated in at least one hour of drug and alcohol treatment (AFS 1998). During a given month—for example, December 1998—about 5 percent of welfare clients participated in one or more hours of drug and alcohol treatment.⁸

Before setting this policy to paper, AFS had already initiated communication at the state and local levels to address the implementation challenges such a policy would present. So in this case, the actual legislation confirmed the collaboration that already existed. The formal legislation was necessary, however, to create a consistent policy context in which branch and district offices statewide would address alcohol and drug problems among the welfare population.

KEY DECISION

District welfare offices must specify their plans for addressing alcohol and drug problems in their JOBS plans.

In Oregon, alcohol and drug treatment is viewed as an integral part of a service system that promotes and supports the transition to work. So incorporating treatment services into local JOBS plans makes such services part of the overall process to move clients toward self-sufficiency and explicitly justifies treating alcohol and drug problems as other

⁸Refer to Appendix A for the number of clients participating in one or more hours of drug and alcohol treatment by district.

JOBS components are treated. Cooperation with alcohol and drug treatment, when included in a client's Employment Development Plan (EDP), is a requirement for JOBS participants and a TANF eligibility requirement for those exempt from JOBS participation (although these clients make up a very small portion of the caseload).

The requirement to include alcohol and drug treatment in JOBS plans came with few other state directions. The policy intent was to provide local offices with the authority and tools needed to approach alcohol and drug abuse as a serious barrier to self-sufficiency, but specific policy interpretation was left to the districts. For example, decisions about the degree to which treatment is "mandated" are made within districts in the context of their own program goals, local culture, and resources.

Rationale:

The philosophy behind Oregon's welfare program acknowledges that there are different paths to self-sufficiency. While work is the ultimate goal for every recipient, there is an understanding that the preliminary steps toward this goal may vary by recipient. The state does not advocate certain work activities over others, although job search is required before a TANF case is opened. However, the state requires universal participation in JOBS, meaning that every recipient must engage in *some* activity that will help them move closer to work. In Oregon, the definition of work-related activity for JOBS participation is purposely broad in order to include the many paths that lead to self-sufficiency.

The prevailing state philosophy can set the tone for approaches at the local level. The state AFS regards alcohol and drug abuse as a barrier to self-sufficiency that must be addressed within the context of the welfare program. Through a state mandate, AFS sent the message to districts that addressing alcohol and drug abuse must be part of the comprehensive approach that prepares clients for the work force.

The mindset in the welfare office and in the alcohol and drug community needed to shift before the integration of alcohol and drug treatment into the welfare process could become a reality. This philosophical change was the greatest challenge to creating a vision of how an integrated system might come about and work.

Changing the welfare philosophy to enable service integration.

In the early 1990s, welfare offices in Oregon, as in most states, focused on providing income support to families, not on actively building service connections that would help move families from welfare to work. Alcohol and drug services, although available, were not directly connected to the welfare office. As work-oriented welfare began to germinate in Oregon at that time, the perspective on service connections within the welfare system broadened, and the opportunity for collaboration became more viable. The shift in the thinking behind welfare from

While work is the ultimate goal for every recipient, there is an understanding that the preliminary steps toward this goal may vary by recipient.

KEY CHALLENGES

income support to work made integration of alcohol and drug treatment an easier task.

Broadening the alcohol and drug treatment philosophy to include work-related activities.

The alcohol and drug treatment community was initially wary of an approach that combined treatment with work requirements. While some treatment programs incorporate work activities, there were concerns that work requirements would apply more pressure on individuals who needed to focus on overcoming their addiction. A partnership between a work-oriented welfare office and a treatment-oriented alcohol and drug community needed to be “finessed” if both sides were to feel that their service goals could continue to be met.

Overcoming the skepticism in both systems meant opening the lines of communication between them and cultivating an environment that would nurture a shared vision. Communication through vertical and horizontal channels was critical—vertically between the AFS state and local offices and horizontally at all levels between the welfare and A&D communities.

APPROACH TO CHALLENGES

Developing a working knowledge of the alcohol and drug system at the state and local levels.

State-level AFS representatives believed that the first building block of integration was to understand the A&D structure and treatment philosophy. In their mind, this understanding would be the basis for developing shared goals between A&D providers and welfare offices, making them partners rather than strangers. AFS approached the state Office of Alcohol and Drug Abuse Programs (OADAP) in 1990, inviting a dialogue about how alcohol and drug treatment could be integrated into the welfare process. Once communication began at the state level, both offices agreed that the approach needed input and insight from the local level. AFS formulated a grassroots campaign to bring local AFS and OADAP players together to think about how to provide treatment services to welfare clients at the local level.

Building understanding and communication between the welfare and A&D systems is an ongoing process in Oregon, and full consensus is not yet a reality.

Initially, conferences at the local level involving A&D and AFS staff began to build an understanding of each other’s processes and service goals. Discussions focused on identifying the existing overlap between these systems and goals. These meetings also opened the dialogue on issues such as how and when treatment could be integrated with work activities and what information was necessary to share with AFS on a client’s treatment progress. Various partners from around the state were then involved in larger meetings that tackled similar issues but in a broader context. These meetings were true working sessions that produced specific recommendations for procedures to make collaboration easier. For example, the individual release form (DHR 2100) now used statewide was developed in direct response to some of the confidentiality concerns expressed during these sessions. (Refer to Appendix B for a sample of this form.)

Building understanding and communication between the welfare and A&D systems is an ongoing process in Oregon, and full consensus is not yet a reality. But as the process has evolved, representatives from both systems have recognized the value of continued sharing and learning. To this end, the state-level AFS office covered the salary of its field services liaison for a one-year placement in the state-level OADAP office. She returned to AFS and her liaison work with a deeper understanding of OADAP and of how AFS offices can both build on and contribute to the strengths of the A&D system.

A discussion of the communication between AFS local offices and A&D providers at the local level is presented in Section VI, “Connecting with the Treatment System.”

[Sending clear expectations to local offices.](#)

To initially turn the attention of local AFS offices to the issue of alcohol and drug treatment, the state AFS office used the most powerful means it had—purse strings. In 1990, the state earmarked funding in local JOBS allocations for addressing alcohol and drug problems among clients. These funds could support additional staff or staff reassignments that would best meet the needs of clients with alcohol and drug problems. This was the first committed funding stream for such a purpose in the state. At the same time, the discussions described above were engaging local AFS staff in tackling the issues associated with integrating alcohol and drug treatment into their welfare program. Through this two-pronged approach, local offices were provided with both the funding and the know-how to bring about this service integration.

As the message of integration seeped into local planning efforts, local managers wanted greater control over the amount of JOBS funding they could direct to their efforts rather than having to meet state mandated set-asides for funding. Including alcohol and drug treatment into JOBS plans was a direct response to this call for local discretion. The requirement made integration an official policy goal but gave local offices greater flexibility over how they would achieve this goal within their own funding schemes. Alcohol and drug abuse was thus placed on par with other program activities, removing it from its position as an ancillary service.

[Providing ongoing support and guidance to local offices.](#)

For the local offices, the state now plays a support role in this integration in three areas: planning, information sharing, and training.

Assistance with local planning. The state provides initial guidance for the local planning process for the JOBS program. Alcohol and drug treatment is a service area that is very visible in this state guidance. Each local office must identify their service delivery strategy for alcohol and drug abuse just as they do for employment and training, support services, and retention services. The state provides comments and suggestions on local level plans to address alcohol and drug problems just as it does for any other component of the JOBS plan.

The State-Level Perspective

In conjunction with agency and community partners, we have implemented a system of assessment, counseling, and treatment for alcohol and drug abuse issues, to meet the needs of families. From the initial contacts with our agency, through employment readiness and post-employment, families have access to drug and alcohol services. It is crucial that access to these services be available throughout their self-sufficiency continuum.

Efforts to remove drug and alcohol barriers are extremely important to the well-being of the individual participant and their families. We strive to continue our outstanding relationship with the drug and alcohol community as it is seen as critical to the success of the families we serve.

Sandie Hoback
Administrator
Oregon Adult and Family
Services Division
Oregon Department of
Human Resources

Local offices find it helpful to learn about the methods other offices are using to meet program goals.

Sharing information. State AFS staff also serve as information brokers, helping local offices share information on best practices throughout the state. Again, they do this for alcohol and drug abuse as they do for many areas of the welfare program. Because state policy is broad and local implementation can vary, local offices find it helpful to learn about the methods other offices are using to meet program goals.

Some statewide practices have developed as a result of this information sharing. For example, more districts began co-locating A&D professionals in AFS local offices as the success of such arrangements was noticed. Five districts initiated such arrangements early on, but now all but two districts have an A&D professional in the AFS office at least half-time (20 hours per week). These arrangements are detailed in Section IV, “Creating a Local Office Infrastructure that Supports Service Integration.”

Training on alcohol and drug problems. For many years, AFS has contracted with OADAP to conduct a three-day training on alcohol and drug abuse for its state and local staff. The training program—“Understanding, Recognizing, and Intervening with the Alcohol or Drug-Affected Client”—outlines key behavioral and physical indicators of an alcohol and drug problem, describes how to refer clients to a provider, and suggests how to intervene with clients in denial. The training also details the chemical composition of drugs and their interactions with the nervous system. Trainees also participate in a role-playing exercise that demonstrates an assessment strategy.

Specific to its integration of alcohol and drug treatment into the welfare program at the local level, AFS has incorporated sessions on alcohol and drug abuse into all JOBS workshops. These workshops are conducted on a quarterly basis and reach the majority of local staff. In addition, the state AFS office has contracted with the state OADAP office to provide one-day training sessions that go into greater depth on selected drugs. These training sessions cover topics such as the effect of the drug, symptoms of abuse, and case planning with clients who abuse this drug. The one-day sessions complement the 3-day OADAP general training by providing local AFS staff with information specific to their interactions with clients and planning for self-sufficiency. AFS contends that training is likely to increase in this area because harder-to-employ clients, such as those facing alcohol and drug problems, now make up a large portion of the caseload.

KEY LESSONS

There are two key lessons from Oregon’s experience in creating a vision that encourages and supports the integration of alcohol and drug treatment into the welfare program.

State leadership in creating a vision that promotes alcohol and drug treatment as an integral component of the welfare-to-work agenda is important to implementation.

Regardless of whether a state has a strong centrally administered welfare system or leaves many decisions to local offices, the state welfare office plays a significant leadership role in setting the tone for poli-

cy. In Oregon, the state AFS office concluded that an increased emphasis on work would present new and different challenges, including how to address the needs of clients who face alcohol and drug problems. Local managers throughout Oregon expressed appreciation that the state AFS office paved the way for offices to integrate treatment into their program by providing them with a solid policy foundation.

Any substantial departure from “the usual” practice often needs state-level justification to ease implementation at the local level. By setting the policy agenda at the state level, Oregon made the change in the approach toward alcohol and drug abuse happen at the same time throughout the state. This made it unnecessary to break down the resistance to change in each district at different times and local managers were free to focus on integration instead of first debating its necessity.

Early communication between the welfare and the treatment communities is essential to integration.

Integrating alcohol and drug treatment into the welfare program means uniting what are often two very separate communities that do not necessarily agree with each other. Success in getting clients into treatment and monitoring their progress hinges on the ability of the two systems to communicate, sharing concerns and triumphs, from the start of the process. Open communication to build a partnership needs to occur at all levels in the welfare and A&D communities. Beginning the dialogue at the state level can increase the success of communication at the local level by creating a policy environment that encourages trust, open-mindedness, and collaboration.

Open communication to build a partnership needs to occur at all levels in the welfare and A&D communities.

SECTION III

Developing An Approach To Integration

OVERVIEW

All districts in Oregon share the same basic philosophy about integrating alcohol and drug treatment into their work-oriented welfare programs. The philosophy has two main components:

- Alcohol and drug abuse is a major barrier to self-sufficiency and family stability and, unless treated, can affect a client's ability to gain and maintain employment.
- The need for alcohol and drug treatment does not render one unemployable or incapable of participating in work-related activities. Clients are expected to work toward economic self-sufficiency while they work to achieve independence from alcohol and/or drug problems. To this end, treatment should not occur in isolation, but in conjunction with other work-related activities.

Districts have put this philosophy into practice in a number of ways. Primarily, all districts handle alcohol and drug (A&D) treatment as they would any other activity that might be included in the Employment Development Plan (EDP), such as job search or work experience. In all districts, participation in treatment can be incorporated into clients' EDPs. When included in the plan, it counts toward the AFS work requirement, and entitles clients to the same supportive services available to other TANF clients. While the districts share a basic philosophy on the importance of addressing A&D problems among their clients, they vary in the degree to which they mandate treatment and use sanctions to enforce participation.

KEY DECISIONS

[Alcohol and drug treatment is integrated into the Employment Development Plan.](#)

The state requirement that districts include a strategy for addressing alcohol and drug problems among TANF recipients in their JOBS plans sets the policy for integrating alcohol and drug treatment in a work-oriented welfare program. The 15 district offices implement this policy by incorporating alcohol and drug treatment into a client's EDP, or self-sufficiency plan. All 15 districts handle alcohol and drug treatment as they would any other activity that advances an individual's progress toward self-sufficiency. If a client is in need of alcohol and drug treatment then the hours that she pursues such treatment are counted toward her hours of "work" effort in her EDP.

Rationale:

The 15 districts share the philosophy that A&D treatment is a critical element in working toward self-sufficiency because it can affect employment and family outcomes. As such, treatment is included in a

client's self-sufficiency plan when alcohol and drug problems are identified and a further assessment indicates the need for treatment. By placing alcohol and drug treatment on par with other work-related activities the districts have two important tools available to address alcohol and drug problems: support services and sanctions for noncompliance.

Alcohol and drug treatment is strongly encouraged in some districts and mandated in others.

While all 15 districts firmly believe that alcohol and drug problems must be addressed among clients in a work-oriented welfare program, and they all refer clients identified as having alcohol and drug problems to treatment, only half (seven) of the districts specifically mandate treatment. All clients who are engaged in alcohol and drug treatment and have such treatment incorporated into their EDP are required to follow the terms of the treatment plan to comply with their EDP and avoid sanctions. However, in eight districts there is some leeway granted to clients who may "opt-out" of treatment for other work-related activities, and therefore rearrange their EDP.

Districts that do not mandate treatment do not necessarily have a lesser view of the importance of alcohol and drug treatment, and they do not proactively offer clients the option of refusing treatment. The districts that allow clients to replace alcohol and drug treatment with other work-related activities in the EDP do so as a reaction to a client's insistence on pursuing other activities over treatment. One district decided not to mandate treatment because local A&D treatment providers advised against it on the premise that treatment is most effective if entered into voluntarily. Often, these districts use intensive case management to strongly encourage participation in treatment. Their decisions are made on a case-by-case basis, with consideration given to the probability of the client's success in other activities and the impact that not following through with treatment may have on the children. Clients who do not pursue treatment in these districts are expected to progress in their EDP activities, and if problems occur, then treatment is more likely to be enforced.

Rationale:

The seven districts that mandate treatment do so to break the cycle of alcohol and drug abuse. These districts assert that alcohol and drug abuse must be addressed as soon as it is identified to enable a successful, long-term transition to self-sufficiency and that if treatment is not mandated up front, alcohol and drug problems will persist. Even if clients are initially successful in work, they are likely to relapse or fall deeper into addiction if the alcohol or drug problem is not addressed. These clients, along with their children, are likely to re-enter some door of AFS over and over again.

Alternatively, the districts that do not mandate treatment generally chose this approach in order to offer clients the flexibility and support

By placing alcohol and drug treatment on par with other work-related activities the districts have two important tools available to address alcohol and drug problems: support services and sanctions for noncompliance.

they need to find and keep a job. If clients want to demonstrate their abilities in a work or training setting, these districts are willing to give them the opportunity to do so. Clients must be engaged in a positive activity and make progress on the agreed-upon EDP. If clients can be successful in work activities without treatment, these AFS offices will support them in their efforts. If these clients do not exhibit progress toward self-sufficiency, the treatment issue will resurface and AFS will push it with greater intensity.

The threat of sanctions is used to engage clients with alcohol and drug problems in treatment.

The districts universally use sanctions or the threat of sanctions to encourage compliance with alcohol and drug treatment, but they generally use them sparingly and strategically. The intensity and frequency of actual sanctions vary among districts. Offices will generally pursue first-level sanctions (a \$50 decrease in the total grant) with greater frequency, but try to avoid subsequent sanctions (removal of the adult from the grant and then case closure).⁹ Actual case closures due to sanctions—for any reason—are rare across the districts. Many offices reported using money management—case managers make direct payments to vendors with a minimal or no cash grant to the client—as a strategy to get clients to comply with treatment without using sanctions.

The majority of AFS offices found the threat and, if necessary, use of sanctions to be particularly useful with clients in denial of alcohol and drug abuse. Sanctions are an effective way to show resistant clients that treatment is necessary and are often the only way to get a client's attention to break the denial. Districts believe it is important, however, to try to engage the client through intensive case management before sanctioning becomes necessary. Given that the full disqualification process can take up to six months, most offices have found that clients comply before a full sanction is employed.

Rationale:

Districts view the ability to hold clients accountable for alcohol and drug treatment as a critical component to addressing substance use and abuse among clients. The 15 districts may employ sanctions to various degrees, but all agree that sanctions support AFS' seriousness regarding the importance of alcohol and drug treatment and that sanctions send a clear message to clients that there are real financial consequences to their choices.

Specific district philosophies that guide the extent of sanctions are motivated by different rationales. On one hand is the argument that no

TIPS FROM THE FIELD

Use of Incentives

One district also uses incentives to encourage compliance with alcohol and drug treatment. Beyond the basic supports of transportation and child care assistance, the office will provide extra supports such as work clothes or school supplies as incentives for active cooperation.

⁹Sanctions: The 1st level is a \$50 deduction from TANF benefits for the first and second months of noncompliance. For the 2nd level, the noncomplying adult is removed from the TANF grant for the third and fourth months of noncompliance. Clients who reach the third level have their total grant withheld for the fifth and sixth months of noncompliance. After the sixth month, the case is closed and the recipient must reapply for assistance.

sanction in Oregon is final as clients are always able to renew their grant if they comply. Offices with this philosophy may use sanctions more readily, but still in a measured way. On the other hand, despite the ability to reinstate full benefits at any point through compliance, sanctions are indelibly marked on a client's record. Clients who are sanctioned, then comply and then fall into noncompliance again re-enter the disqualification process at the level they left off. For example, clients who are disqualified and then reapply have only one opportunity for compliance thereafter. Any noncompliance brings them back to a third-level sanction. Some offices are, therefore, reluctant to impose sanctions. In some instances, clients may already have a number of sanctions before alcohol and drug problems are identified, and further sanctioning can be very difficult on the client.

Case managers must make decisions about balancing work-related activities and treatment in client self-sufficiency plans.

Case managers must work with all clients to formulate a mix of work and work-related activities in their EDPs that will address their self-sufficiency goals. Developing the plan for clients with alcohol and drug problems can be particularly challenging. Case managers must be mindful of the overall goal of work for each client, but for clients with alcohol and drug problems, this goal must be balanced with the need to address their addiction. Because case managers are not A&D specialists, they are generally not aware of the time and emotional demands that particular treatment plans will place on clients. Without this knowledge, an effective balance between work and treatment can be difficult to achieve.

Approach to Challenge:

An EDP for a client with alcohol and drug problems is often formulated through a discussion between a client, a case manager, and an A&D professional (either on-site staff or off-site provider). In 10 districts, this process is more formal with case managers and A&D professionals, and/or the treatment providers sharing responsibility for the plan development. Five districts indicated that case managers are solely responsible for this task, but that they often consult with on-site A&D professionals or provider staff on appropriate complementary activities to treatment. A partnership with A&D professionals can help case managers develop a combination of activities that will maximize a client's progress toward self-sufficiency.

Aggressiveness in addressing alcohol and drug problems requires a support structure that can help clients deal with personal challenges.

The decision to focus on alcohol and drug problems within the context of a work-oriented welfare program takes more than a change in philosophy and program approach. The majority of the districts found that as they approached alcohol and drug problems in a more systematic and

KEY CHALLENGES

TIPS FROM THE FIELD

Balancing Treatment and Work in the EDP

In District 2, A&D clinicians have developed a quick reference sheet that outlines the demands and requirements of different treatments. Case managers use this as a guideline in developing a self-sufficiency plan with a client. These guidelines are helpful in determining the point in treatment when it is logical to engage a person in work activities and at what level. (Refer to Appendix C.)

active manner, they uncovered a breadth and a depth to the problem that they had not expected. The old structure for dealing with A&D problems, which essentially ended with a case manager's referral for assessment, was no longer effective in ensuring that clients pursued and followed through with treatment. By the same token, case managers were overwhelmed with culture change and new responsibilities as Oregon moved from a cash assistance to a work-oriented welfare program. A process and support structure for managing the integration of alcohol and drug treatment into client self-sufficiency plans was necessary to deal with these more intensive needs.

Approach to Challenge:

The districts are addressing multiple service needs by building early connections between welfare and alcohol and drug treatment services. Over the last few years, the districts have made varying degrees of progress in building support systems by locating A&D professionals in welfare offices. These structures, as described in Section IV, are critical in a welfare environment that is focused on work and can no longer afford to overlook clients' underlying, persistent personal barriers that block the path to long-term self-sufficiency.

KEY LESSONS

Alcohol and drug treatment can be integrated into the welfare program without reducing the emphasis on work.

Oregon's welfare program is focused on helping recipients enter the labor force as quickly as possible. Applicants for assistance are required to look for work immediately, and all recipients are required to engage in activities that will help them become self-sufficient. By working toward independence from alcohol and drug problems, clients will also improve opportunities for obtaining and maintaining a job. However, participation in treatment is not promoted as a "stand-alone" activity. While substance abuse treatment can be a component of a client's EDP and at times may be the primary activity, it rarely is the only activity.

A mixed approach of work and alcohol and drug treatment is compatible if the necessary supports and tools exist.

Changing an approach to a problem first requires a reasoned philosophy and then requires the resources and follow-through that will make the new approach work. In Oregon, managers at the state and district level realized that integrating alcohol and drug treatment into their welfare approach required not only a process change, but a change in the support structures. It would be difficult to justify requiring treatment and employing sanctions for noncompliance if additional assistance was not provided to ease a client's access to and participation in treatment. Just as offices make the link for clients to JOBS services for job search and skill development, managers realized that a clearer and supported path to treatment would make a more reasonable and credible argument for requiring alcohol and drug treatment in combination with other work activities.

Creating A Local Office Infrastructure That Supports Service Integration

With a consensus within AFS that local offices would integrate alcohol and drug treatment into their welfare programs, the question turned to what form this integration would take and how it would be achieved. Local managers had to make decisions about who would play what roles in dealing with clients with alcohol and drug problems. Specific decisions centered around case management roles and how these roles would or would not be supplemented or complemented by A&D professionals. Local offices also had to decide how the services of professional A&D staff would be accessed if they were to be more heavily relied on.

In Oregon, all districts have made clear decisions to increase awareness of alcohol and drug abuse in case management services while maintaining a clear distinction between case management and counseling roles. To this end, each district has made arrangements to bring A&D professionals into the AFS office. While the specific arrangements and extent of services provided on-site vary, each district has at a minimum covered the front-end components of education, identification and engagement in treatment.

This section will describe the key decisions local offices have made about the roles of staff in addressing alcohol and drug problems among welfare clients, the arrangements instituted to accommodate these roles, and the support necessary to sustain distinct, yet supportive roles between case managers and A&D professionals.

[Welfare offices must maintain the distinction between case management and counseling roles in dealing with alcohol and drug problems.](#)

Incorporating alcohol and drug treatment into self-sufficiency plans for welfare recipients requires case managers to take an increased role in an area that was formerly handled through a separate process. A decision must be made, however, about what the new role entails, and, specifically, where the dividing line should be drawn between case management responsibilities and responsibilities of trained A&D professionals.

In Oregon, all 15 districts expect case managers to have a heightened awareness of alcohol and drug problems as well as an understanding of the demands that the treatment process will place on their clients. However, this increased knowledge and awareness is intended to improve case management practices, not to serve as a mechanism for turning case managers into alcohol and drug counselors. Across the board, district representatives conveyed that a case manager's role is that of monitoring and supporting a client's treatment (for example, with supportive services). Professionals trained in alcohol and drug problems are

OVERVIEW

KEY DECISIONS

TIPS FROM THE FIELD

Specialized Case Managers

Two districts have instituted a specialized case manager model in which one case manager deals exclusively with all the clients facing alcohol and drug problems. Clients are referred to these case managers once A&D problems are identified. This model is one of organization and still does not change the essential nature of the case management role. It does, however, promote a more centralized team case management approach in that there is a closer connection between the A&D professional and just one (or two) case manager(s). Two other districts are transitioning into this model and an additional two districts are considering this route.

responsible for the specific processes relating to identification, assessment, and treatment of alcohol and drug abuse. In the majority of districts, the A&D professional enters the process at the first stage of screening for alcohol and drug problems.

Rationale:

At the same time that district representatives recognize the importance of addressing alcohol and drug problems as part of their welfare-to-work strategy, they also recognize the boundaries of welfare staff in dealing with these problems. Alcohol and drug abuse is a chronic and relapsing condition that requires the attention of trained professionals. Using the analogy of one district representative, case managers would not attempt to diagnose or prescribe treatment for clinical depression, and therefore, should not cross the line from case manager to counselor in addressing another clinical problem, that of alcohol and drug abuse. Without the proper training and certification, case managers are not qualified to deal with alcohol and drug problems with their clients.

Case managers, however, play a critical role in both the culture and process changes necessary to effectively address alcohol and drug abuse. It is important from the outset that case managers share an appreciation of the value of alcohol and drug treatment in working toward a client's self-sufficiency and develop the knowledge to set realistic expectations in self-sufficiency plans for their clients with alcohol and drug problems.

Alcohol and drug abuse professionals work in the welfare office to facilitate the early integration of services.

District and branch offices have found that the most effective and successful means of integrating alcohol and drug treatment into the welfare-to-work process is through the physical integration of service delivery within the AFS office. The majority of branch offices in each district now have a certified A&D professional in the welfare office for some scheduled time each week. Most striking is that representatives in each district, regardless of the approach to alcohol and drug abuse screening and treatment, believe the presence of on-site A&D professionals is one of the best decisions they have made. The importance and success of the co-location model are conveyed by districts that conduct blanket screening as well as by districts that do not conduct broad screens for alcohol and drug problems up-front and by districts that mandate treatment, as well as by those districts that do not.

On-site professionals assume the primary role in identifying clients for and connecting them with alcohol and drug treatment. Actual treatment, for the most part, occurs off-site at local A&D service providers' facilities. Only two districts have one-stop arrangements and provide treatment services on site. A handful of districts indicate that some initial counseling occurs on site, but ongoing treatment is provided at outside facilities.

Rationale:

Formalizing an arrangement for on-site A&D professionals solidifies the boundaries for case management staff. The additional support that A&D professionals provide also alleviates some pressure on case managers for the more intensive case management necessary in dealing with these harder-to-employ clients. Offices have also found that the on-site presence of A&D professionals fosters increased communication that helps case managers meet individual clients' needs in balancing required work and treatment activities.

There also are benefits from the treatment perspective. Early interactions with A&D professionals can help clients feel more comfortable with taking the next step toward formal treatment. By administering screens and conducting group sessions shortly after a client's application for TANF—as occurs in many of the AFS offices—those clients with alcohol and drug problems have an early introduction to professional staff that can break down personal barriers and fears in order to progress to the next stage. Providers have found that the ability to build rapport with clients within the welfare setting has decreased the number of clients who get lost in the referral between service systems. For example, without an on-site professional, clients would be referred off-site at an earlier stage for screening and assessment, creating an increased likelihood that clients would not follow through on referrals.

Districts have implemented different models of co-location to respond to local needs and circumstances.

The districts throughout Oregon have implemented the physical integration of alcohol and drug services within the welfare setting in a variety of ways. (Refer to Appendix D for details on district co-location arrangements.) Many of the decisions are driven by the size of TANF case-loads handled by the branch offices and by the local environment for alcohol and drug services. The extent of needs and the local service delivery structure are the primary influences on arranging any co-location.

There are three dimensions that contribute to the varied arrangements for the co-location of A&D professionals across AFS offices.

Number of hours that an A&D professional is on site at AFS. The number of hours that A&D professionals are on site varies mostly because of caseload size and how urban the area is. More rural areas with limited numbers of providers generally feel less need for intense up-front services, and clients may have better access to providers than to the welfare office. In most of the districts, the offices that serve a larger number of TANF recipients have a more extensive co-location arrangement than smaller branch offices. Overall, four districts have full-time professionals in their larger branch offices; an additional nine districts have on-site A&D professionals at least half-time (at least 20 hours per week) in their larger branch offices. Only two districts enlist the services of A&D professionals less than half-time (less than 20 hours per week) in any of their

TIPS FROM THE FIELD**Benefits of Co-location**

In District 4, the local A&D provider has decreased its costs due to the significant reduction in “no-show” appointments. The savings have been so noticeable that the provider has offered to pay for the cost of placing another half-time staff person on site in the AFS office.

TIPS FROM THE FIELD

Splitting a Full-Time Position

District 12 identified the need for a full-time A&D professional to serve all the branch offices. Rather than hiring one person to cover the full district area, they have an agreement with the Umatilla County Mental Health Department (UCMH) to provide one full-time equivalent (FTE) to cover the three branch offices. Three A&D professionals split this FTE among the AFS offices and have additional responsibilities with UCMH to supplement their time not covered by AFS. The AFS office believes this arrangement is more effective in that it eliminates work time lost to travel between the sites and provides stability for both the AFS office and the contracted staff in dealing with clients.

branch offices. The two districts with the most limited number of on-site hours of professional A&D staff expressed an interest in expanding these hours but have run into difficulties due to provider concerns over confidentiality and hesitancy to relinquish supervisory control over a full-time staff person.

Alcohol and drug abuse professionals as hired staff vs. contracted staff from local providers. None of the welfare offices in Oregon directly employs A&D professionals in terms that officially make them AFS staff. Only those AFS offices that have made a commitment to a full-time professional have made hiring arrangements distinct from local providers.

- Three districts employ full-time A&D professionals that are staff of third parties. They are not AFS staff, and they are not on the staff of any local provider. In two districts, the co-located professionals are staff of the prime JOBS contractor. In one district, the A&D professional is on the staff of a local community-based organization that does not provide alcohol and drug abuse services.
- One district has a one-stop arrangement that includes the AFS office, an A&D provider, and other service providers in a shared office space.
- Eleven districts have contracted on-site A&D professionals who are employees of one or a number of local A&D service providers.

Hiring on-site A&D professionals who are not connected with a specific service provider has its advantages. Specifically, this method avoids the potential for conflicts of interest and can alleviate the pressures of a competitive service environment. There are concerns that using staff from a specific provider will result in exclusive (or at least more) referrals for services to that provider. A treatment diagnosis potentially could be influenced by the services offered by a particular provider. A broader concern is that client choice could be limited if clients are not fully informed of the available options. It may be in the best interest of the welfare office to hire a third-party person who is distinct from both the welfare program and local providers, particularly in areas with large numbers of local A&D service providers, to avoid these concerns. Such an approach establishes the welfare offices' neutrality with regard to services and can help ensure that clients are directed to service providers based on need and availability of services. In smaller areas with only one or two providers, this typically is not an issue.

The advantage in contracting with local A&D providers for professional staff is that it can be cost efficient for the welfare office and can help build the necessary connections with local providers. The majority of districts share staff with local providers out of necessity because they either have not encountered the need for a full-time staff person or do not have funds to support a full-time position. The use of contracted staff, particularly in areas with only one or a few main service providers, can also ease the process of monitoring treatment. AFS staff believe that

providers are more comfortable sharing information on a client's progress with someone who is "one of their own" and not AFS staff. Providers expressed an interest in having on-site staff maintain a connection with a service agency to keep their feet grounded in alcohol and drug treatment practice so as not to be subsumed by AFS-directed goals.

Contracting mechanisms and funding sources. There are three methods through which district offices arrange the funding for an on-site A&D professional. These methods are not necessarily mutually exclusively, however, most districts rely most heavily on one form.

- *Through the prime JOBS contract:* Five of the districts have arranged either for full-time staff hires directly by their prime contractor or for subcontracts with local A&D service providers for staff hours on site at the AFS office. These arrangements are supported with TANF funds.
- *Contract agreements at the state level between AFS and OADAP:* Nine districts use a contract mechanism that is arranged at the state level. AFS and OADAP negotiate a blanket list of up-front services that local AFS offices can access through local OADAP-designated providers. (Refer to Appendix E for a list of these services.) The AFS office determines the amount of TANF funds to direct toward A&D services through this route. These funds flow through OADAP to county mental health agencies and then to local A&D designated providers. AFS does not have a choice in the provider selected, but must use the providers already affiliated with the OADAP network. This existing state contracting route eliminates the need for the districts to write their own contracts for on-site A&D staff.
- *Direct contracts between district AFS offices and local service providers:* Three offices have direct arrangements with local providers. These arrangements are relatively informal in the sense that long-term contracts are not in place. This may be possible due to the relationships that have developed between AFS branch offices and local providers over time as attention has turned toward alcohol and drug problems. The three offices that pursue this route use TANF reinvestment funds (funds that are savings resulting from caseload declines). These offices all believed that they would turn to Welfare-to-Work funds to support on-going integration efforts.¹⁰ Only one of these offices does not have any other contract mechanism in place.

¹⁰The Balanced Budget Act of 1997 authorized \$3 billion in Welfare-to-Work (WtW) grants to states and local communities through the U.S. Department of Labor to promote job opportunities and employment preparation for the hardest-to-employ TANF recipients. The need for alcohol and drug treatment is one of the factors that determines if a TANF recipient is eligible to receive services under WtW.

KEY CHALLENGES

Case managers face a variety of difficult issues in dealing with alcohol and drug problems among clients.

Case manager responsibilities in getting clients to commit to treatment and keeping them engaged with treatment to avoid possible sanctions, even with the assistance of on-site A&D professionals, are challenging. Each step in the process opens up increased opportunities for confrontation for which case managers may be unprepared. Because they lack experience with alcohol and drug problems, case managers may also be overly encouraged by a client's progress and then be personally affected when a client who appeared to be doing well relapses, which is a normal part of the recovery process.

Additionally, addressing alcohol and drug problems head-on can unmask other problems. Through alcohol and drug treatment, clients are faced not only with overcoming their addiction but also dealing with the reason(s) for their addiction. Many women with alcohol and drug problems initiated their use because of a traumatic event or series of events in their lives such as sexual abuse, domestic violence, or dealing with the illness or death of a close friend or family member. Other clients may be dual-diagnosed with mental health and alcohol and drug problems. It is important, but difficult, for staff in welfare offices to be prepared to address these issues as they move through the welfare-to-work process.

Approach to the Challenge: Training

To deal with the many challenges case managers face, local-level AFS management has made an increased commitment to training around alcohol and drug problems. Training in this area is intended to increase the case managers' comfort level in dealing with substance-abusing clients by learning how to handle confrontations, learning some of the causes of alcohol and drug abuse, and understanding the cycles of use and abuse. Training is not focused on counseling or treatment issues, but on knowledge that can help enhance case management skills. A significant amount of management support for training exists in the districts, and supervisors participate in training in most districts.

Local level offices supplement the state offerings for training (discussed in Section II, "Creating a Shared Vision") through both formal and informal arrangements with local A&D service providers. Four districts mentioned formal arrangements that specify the number of hours of training they contract from local providers each year. In all but two of the remaining 11 districts, more informal training arrangements are made on a continual basis with the on-site A&D professional. In these offices, on-site A&D professionals give presentations at regularly scheduled staff meetings, or arrange in-service training as needed. Both AFS management and case managers often mentioned the importance of the on-going, hands-on training that occurs because an A&D professional is in the AFS office working side-by-side with case managers. AFS representatives found this interaction particularly critical given the time pressures that can limit the interest and ability of case managers to participate in the number of training sessions scheduled for them.

TIPS FROM THE FIELD

"Drug of the Month" Training

District 3 conducts a "drug of the month" meeting for all case managers in addition to other trainings. Local police have written primers for AFS on specific drugs. AFS then researches use, distribution, street names, dependence, histories and effects on the body for both high- and low-level use. This information is relayed to case managers to help them understand the lingo and recognize the warning signals and symptoms of use of specific drugs.

Differences between the welfare and alcohol and drug treatment philosophies can affect on-site staff relationships.

The introduction of new staff and new ideas can be threatening in almost any environment. In a work environment that faces its own culture change, these tensions can be exacerbated. The change throughout Oregon's welfare offices to a work-oriented program opened the doors for inviting A&D professionals into AFS offices. At the same time, however, the emphasis on immediate work activities needed to be balanced with the demands of treatment. At times, alcohol and drug treatment professionals accused case managers of being too hard on clients and sometimes punitive; and case managers felt that on-site staff were over-protective and territorial with clients.

Approach to the Challenge: Time, training, and communication

As case managers became more familiar with alcohol and drug problems and A&D professionals came to understand the workings of an AFS office, they found common ground. Through constant communication, staff on both sides realized that they were all working to build a supportive structure for clients; they were not on opposing sides. Case managers became more familiar with the demands of varying levels of treatment and worked with A&D professionals to formulate work activities that could complement, not interfere, with treatment.

Much of this progress is attributed, again, to having A&D staff on site. Without such an arrangement, the communication and eventual understanding would have taken much longer to foster. As staff have shared a work place and have had on-going discussions of particular cases, the philosophical divides have lessened. The districts report that the current relationship between case managers and A&D professionals is educational, productive, and harmonious.

Establish a management philosophy that clearly distinguishes the roles of case managers and A&D professionals.

KEY LESSONS

There is a gray area introduced when alcohol and drug treatment is integrated so closely with welfare services. As TANF recipients' primary contact, the case manager has a significant role in the services clients receive and the self-sufficiency plans they develop. There can be a danger that case managers may overstep their bounds in helping clients address alcohol and drug problems.

It is important to be clear up front about the role that is expected of case managers in handling alcohol and drug cases and where they need to draw the line. AFS managers were consistent in stating that case managers must remain case managers for clients with alcohol and drug problems as they are with all clients; they are brokers of services and monitors of progress. Any counseling, even if very preliminary, is the domain of trained A&D professionals.

One model for the on-site presence of A&D professionals in the welfare office does not fit all offices in Oregon and is unlikely to in other states.

The co-location of A&D professionals within AFS offices is important to integration efforts and can work in a number of ways.

Without exception, the district offices believe that having an A&D professional on site is key to their success in addressing alcohol and drug problems among TANF recipients. Beyond this universal agreement, however, districts vary in what the particular arrangements look like and how they are made. One model does not fit all in Oregon, and is unlikely to in other states. Specific caseload needs and service environments at the local level will influence decisions about the co-location of welfare and alcohol and drug abuse services.

Training, training, training.

Many district representatives adopted this mantra to get across their message about the importance of training case managers and supervisors on alcohol and drug problems. Training that builds awareness of the signs of alcohol and drug abuse and about what to expect from substance-abusing clients is critical to helping staff feel comfortable in dealing with clients. Case managers need the tools that training provides to constructively and effectively address alcohol and drug problems among welfare recipients.

There is still some room for improvement in training. Every office agreed that training is important, yet OADAP has had to cancel a number of scheduled local training sessions due to a lack of participation. Building and maintaining interest in training around alcohol and drug problems can be challenging in a constantly changing environment with many competing demands for case manager's time.

Identifying Clients With Alcohol And Drug Problems

Identifying clients with alcohol and drug problems is one of the most critical stages in the process of integrating treatment into the welfare program. Some districts have chosen to screen all applicants and recipients, thereby casting the broadest net for identifying possible alcohol and drug problems. Other districts have taken a narrower approach, screening only clients whose behavior or lack of progress toward goals in the self-sufficiency plan could be an indication of an alcohol or drug problem.

Like screening, the use of drug testing for nontreatment purposes also varies across the districts, although none of the districts conduct blanket drug tests to identify clients with alcohol and drug problems. Decisions about screening and drug testing typically reflect district size, resources, and case management philosophy.

Screening Approach: Who and When to Screen

Deciding who to screen drives the decision about when to screen. In general, broad screens of the full caseload occur early in the TANF process. In Oregon, all the districts that screen broadly do so during an initial 45-day intake and assessment period. Targeted screening occurs as needed, i.e., when a case manager perceives a problem.

Screening Approach	Who to Screen	When to Screen
Broad Screening	All clients	Early in TANF process
Targeted Screening	Clients as identified	On an as needed basis

In Oregon, 8 of the 15 districts screen all TANF applicants and new recipients, typically in a group setting during the application or orientation process. Seven other districts screen only those clients whose behavior—such as interactions with the case manager or other staff, difficulties in assigned activities, or repeated sanctions—suggests that an alcohol and drug problem may exist. When a case manager or other professional perceives a problem, her or she refers the client to A&D professionals for screening.

This on-going referral process plays an important role in districts with broad screens as well. Because screening tools are not 100 percent effective in identifying alcohol and drug use, and because this problem may develop later in the welfare process, case managers throughout all the districts always have the responsibility for referring clients who seem to have a problem to A&D professionals.

A positive screen generally leads to a clinical assessment to determine if, in fact, treatment is required and at what intensity. Districts report that among clients screened, between 20 and 60 percent are in

OVERVIEW

KEY DECISIONS

NOTES FROM THE FIELD

Identification of Substance Abuse Helps Long Term Success

For four years, “Missy” was in and out of employment. She had an abusive boyfriend who fathered her two children. Though Missy had no trouble getting a job, she always had difficulty keeping them. Over this period, Missy had the same welfare caseworker who opened and closed her case every five months. Each time Missy convinced herself and her caseworker that she would leave her boyfriend and find and keep a job. Yet, the situation remained the same.

Finally, the case manager referred Missy to a mental health counselor due to signs of depression. The counselor identified alcohol as a contributing factor to her depression and referred her for a drug and alcohol assessment. Missy was diagnosed with advanced alcohol and marijuana dependence.

Missy was referred to and completed intensive outpatient treatment in an all women’s group. She also left her boyfriend, completed pre-apprenticeship training in the construction trade, and has been working steadily.

—Christa Sprinkle
Mt. Hood Community College

need of further assessment. Assessments may occur on- or off-site, but are always conducted by certified staff.

Rationale for Broad Screening

The eight districts that conduct broad screens do so for the following five reasons:

- **Broad, up-front screening can provide cost and time savings**

Identifying alcohol and drug problems early on can circumvent subsequent difficulties related to completing or fulfilling the requirements of training or work-related activities. If clients with alcohol and drug problems are scheduled for activities they are not ready for, AFS has wasted some case management time in developing the self-sufficiency plan and in identifying opportunities for work and training.

- **Broad, up-front screening is beneficial to clients**

Undetected problems can lead to failure in work activities. Many clients with alcohol and drug problems often have low self-esteem. Identifying alcohol and drug problems early on can move clients closer to self-sufficiency by limiting the possibility of failure in work activities.

- **Broad screens are a valuable pre-employment measure for all concerned**

Many employers now administer drug tests before hiring. If case managers identify alcohol and drug problems before employers do, clients are not set up to fail in their job search, and AFS can present a better image to employers if they identify problems rather than waiting for employers to detect them.

- **Dealing with alcohol and drug abuse is critical to long-term self-sufficiency and family health**

Alcohol and drug abuse is a critical barrier to steady employment and a healthy family environment. Identifying the need for treatment and requiring treatment at a time when other income, employment, and supportive services are available through the welfare process can be beneficial for parents and their children.

- **Broad screening acts as an intervention and as an educational opportunity for clients**

Broad screening is generally accomplished in a group setting using a relatively straightforward “pencil-and-paper” test. The screening is less threatening and will not appear to be discriminatory if it is administered as part of a group or life skills class. Group discussions may offer the additional advantages of giving clients information and providing a supportive environment that can help them confront their own issues.

The majority of districts that conduct broad screens mandate client participation in the screening process; noncompliance can result in a sanction. In addition, five of the eight districts that use broad, up-front screening also mandate alcohol and drug treatment (other work-related activities

cannot substitute for treatment in the client's self-sufficiency plan). The predominant philosophy in these districts is that the chronic nature of alcohol and drug abuse must be addressed and should be addressed early.

Rationale for Targeted Screening

Representatives in seven districts offer the following reasons for conducting targeted, rather than broad, screening to identify alcohol and drug problems among clients:

- **Broad, up-front screening can be costly and time-consuming**
Rather than generating cost savings, broad screening can incur expenses that exceed subsequent savings. It may not be resource prudent—in terms of funding or staff time—to screen every individual, including those who do not have any indications of alcohol and drug problems.
- **Broad screening can be disrespectful to clients**
Broad screening implies a distrust of clients, requiring them to “prove” their independence from drugs and alcohol.
- **Clients with alcohol and drug problems can be successful in work or work-related activities; it is only when they prove otherwise that the welfare office should intervene**
It is desirable to work with clients to determine what they are capable of achieving. Through a continuing case manager-client relationship, barriers and issues that need to be addressed, such as alcohol and drug abuse, will surface.

Two of the seven districts that do not conduct broad screens mandate treatment for affected individuals. In the other five districts, the overall case management philosophy holds that while it is important to address alcohol and drug problems within a work-oriented welfare program, the issue is not pursued unless the client has a problem achieving self-sufficiency goals. In these five districts, alcohol and drug use that does not impede a client's performance in work-related activities may go undetected and untreated.

Screening Procedures: Who Conducts Screens and What Tool Do They Use?

Regardless of whether the approach to identifying clients with alcohol and drug problems is broad or targeted, offices must decide who will administer the screen and what screening tool will be used. The districts in Oregon are in general agreement on these decisions.

- **A&D professionals conduct screening procedures and share the general results with case management staff**
In all but two districts, the on-site A&D professional administers and scores the screening tool. One district does not use a screening tool at all but refers clients with potential problems directly for assessment. In another district, the case manager administers the screen, but the A&D professional scores the results. General results of screens are routinely shared with case managers so that

together, the client, case manager, and A&D professional can devise a plan for addressing the problem.

Rationale:

Districts assign screen administration to A&D professionals because they are trained to identify and deal with critical issues that arise during the screening process. The screening procedure begins to draw the distinction between counseling and case management roles. Introducing an A&D professional at this point is the earliest opportunity to ensure that this distinction remains intact. Results are shared with case managers at this early stage so that they too are invested in the process and understand the steps a client must take, if necessary, to receive a complete assessment and enter treatment.

- **A standard screening tool is not employed, but the SASSI is the preferred tool across the districts**

Most districts use the Substance Abuse Subtle Screening Inventory (SASSI) as their primary screening tool. The SASSI is a formalized screening tool that addresses sensitive subjects, such as lying and addictive behavior, in a subtle manner. A few districts use other tools similar to the SASSI or instruments they devised on their own based upon other formalized scales.

Rationale:

Welfare staff are not familiar with or knowledgeable about the screening tools available. This is an area in which A&D professionals are generally relied on to suggest an appropriate tool. Eleven of the 15 districts use the SASSI. As a straightforward paper and pencil test, it is relatively easy and efficient to administer and score. These are advantages, particularly in districts with broad screening processes.

Drug testing is not used as a screening tool to identify alcohol and drug problems, but it is used by AFS offices for other purposes that often engage clients in treatment.

Universal drug testing (through blood or urine samples) is not used to screen clients for alcohol and drug problems in Oregon. It is used, however, by local AFS offices prior to the treatment phase, or what is referred to as nontreatment drug testing.¹¹ Nontreatment drug testing is generally used for one of two purposes: to convince clients in severe denial that there is a problem or to collect more information on the presence and nature of the alcohol and drug problem during the assessment phase. All but 1 of the 15 districts use nontreatment drug testing to some extent, though in most districts, it is done only on a very limited basis.

¹¹Drug tests are often used by alcohol and drug abuse service providers to monitor compliance with treatment. This use of drug tests is common. We only cover the use of drug testing within the framework of the welfare program—or the nontreatment uses.

One of the 15 districts is philosophically opposed to drug testing by AFS for any purpose outside of treatment; 5 districts make use of drug tests as a standard component of in-depth assessments that are conducted by an on-site A&D professional after an initial screen suggests that a problem exists; and 9 districts drug test only clients who deny a problem and refuse a referral for treatment when a problem appears obvious.

Nontreatment drug testing is often administered by the A&D professional on-site (rather than off-site at a provider location). Samples are sent to labs for analysis, and the results are most often provided directly to and maintained by the A&D professional because of the sensitivity of the issue.

Rationale:

None of the districts have considered blanket drug testing as a screen for reasons of cost, utility, and respect. Drug testing can be expensive when used for the whole caseload, particularly if results are interpreted and confirmed by an outside laboratory, as is the practice in Oregon. The districts are also not convinced that blanket drug testing adds to their screening/identification process. Screening tools that test for behavioral patterns connected with drug use and abuse may be more effective than a point-in-time test to identify addiction. Finally, the general philosophy in Oregon is that a trusting relationship between case manager and client will do much to help clients help themselves. Drug testing can establish an adversarial relationship from the onset between the welfare office and clients, which could work against the joint effort between case manager and clients to reach self-sufficiency goals.

District representatives do, however, value tools that can advance the message that they are serious about their expectations for clients. If a client has continued difficulties with work-related activities and exhibits behavior indicative of alcohol and drug abuse yet denies a problem, some districts report that drug testing may be the only way to break the client of his/her denial in order to make progress toward self-sufficiency.

The district approaches to drug testing and their procedures have contributed to the fact that no district has faced a legal or community challenge to drug testing. The following factors help alleviate the need for concern:

- AFS staff are not officially connected with drug testing. AFS offices are prohibited from picking and choosing clients for drug testing; if AFS administers drug tests, the agency must use a random sample taken from the entire caseload. Any drug tests are requested of the client by the on-site A&D professional; tests are also conducted by this professional on site or by a local treatment provider off site. Case managers are not involved with the request made to clients or the collection of the sample for drug tests.
- Most districts send samples to a reputable outside laboratory, which confirms positive results by performing a second, more rigorous, test.
- Those clients tested on the premise of severe denial almost always have positive results.

NOTES FROM THE FIELD

Breaking Down Denial through Drug Testing

“Jane” vehemently denied that substance abuse was an issue for her, as many individuals do since addiction is a disease of denial. Yet, the diagnosis of the Alcohol and Drug Assessment Specialist indicated methamphetamine abuse and dependence. The client was furious with the Assessment Specialist and her case manager for accusing her of being a druggie.

She was sent for a urinalysis drug test which returned positive for methamphetamine. Upon receiving the results of the test, Jane broke down, admitted she needed treatment but that she was afraid she would lose her children. She was assured that participation and completion of treatment will help prevent that. Jane enrolled in an intensive outpatient treatment program with an agency that provided on-site childcare. As treatment progressed, Jane began taking work search classes in preparation for eventual job search and began the road to recovery and increased self-sufficiency.

—Christa Sprinkle
Mt. Hood Community College

- Clients are never sanctioned solely on the basis of a positive drug test. Sanctions are tied to noncompliance with JOBS activities; if a client has a positive drug test but will cooperate with treatment, a sanction is not considered.

KEY CHALLENGES

The use of a broad screen does not lessen the need for case managers to tune into signs of alcohol and drug abuse.

Screening tools are not foolproof and can vary in their effectiveness.

Initial screens for alcohol and drug problems, particularly in those districts that use broad screens, may not indicate a problem for some clients. In many districts, regardless of whether broad or targeted screening is used, a significant number of clients are referred for assessment by case managers who observe behaviors that suggest a potential problem. The use of a broad screen, therefore, does not lessen the need for case managers to tune into signs of alcohol and drug abuse.

In addition, there is some concern that AFS offices have not adopted a standard screening tool. A lot of care should be given to selecting a screening tool. Oregon's widespread use of the SASSI has occurred largely by default, rather than as part of a systematic decision-making process.

Approach to Challenge:

Training for case managers in alcohol and drug problems must give them the skills they need to identify clients who may have a problem. In Oregon, state and locally designed training sessions cover the behaviors that can accompany substance use to help case managers in identifying a problem. The sessions also discuss methods case managers can use to facilitate a conversation with a client about a referral to an A&D professional.

The districts themselves are not uncomfortable or unsatisfied with the screening tools they use. However, state level AFS and OADAP staff are discussing standardization in screening and assessment practices as part of a larger state strategy to develop shared practices and systematic approaches across agencies and offices that deal with similar client populations.

Targeted screening can be threatening for some clients.

In districts that use targeted screening, clients may be aware that they are singled out for testing and they may show some resistance to the screen stemming from denial. In districts that use broad screens, the same will be true for clients referred at a later time in the TANF process.

Approach to Challenge:

Districts try to provide counseling and case management support to resistant clients before administering the screen. Some districts also offer alternatives to the standard written test screen, such as a face-to-face interview with an A&D professional that feels more like a conversation than a test. A couple of districts that use targeted screens still try to administer the screen in a small group setting in order to raise a client's comfort level and let them know that they are not being singled out as the only one who faces a problem.

Continual referrals for screening are important in identifying clients with alcohol and drug problems.

An on-going referral process to identify clients with alcohol and drug problems is critical in districts with and without broad, up-front screens. In all the districts, a basic knowledge and awareness of alcohol and drug abuse is expected from staff so that they can spot potential problems and make referrals to the professional A&D staff as necessary. In addition, the change from a cash assistance to a work-oriented welfare program has made it necessary for staff to deal with harder-to-employ clients and to be willing and prepared to serve as a link for clients to the services they need. In an environment with a heightened awareness of alcohol and drug problems, such problems that are likely to impede a client's progress toward self-sufficiency are less likely to go unnoticed or unaddressed, regardless of the initial screening approach.

The screening process is the time to draw the distinction between the role of case managers and the role of professional A&D staff.

All the districts assert that a division between case management and counseling responsibilities is important in ensuring that clients receive the assistance they need to address alcohol and drug problems. The division in responsibilities begins early in the process — at the identification stage. Clients with alcohol and drug problems are generally identified with formalized screening tools. These tools may be relatively straightforward to administer, but they can be more effective when delivered by a trained professional who can present the screen in a non-threatening manner and interpret results objectively.

Caution and clarity in making decisions about drug testing can limit adverse reactions.

Notably, no district in Oregon has been challenged by the legal system or advocacy groups regarding the nontreatment uses of drug testing. Some policies and procedures that govern drug testing limit the districts' vulnerability to such challenges. However, most district representatives feel that it is the conscientious and judicious approach to drug testing statewide that has kept the issue relatively controversy-free. Drug testing is not approached as a punitive measure but as a means to address a significant barrier to self-sufficiency. As such, districts have found that external concerns can be addressed through mindful decision-making and relatively straightforward and defensible explanations for pursuing testing.

Connecting With The Treatment System

OVERVIEW

Welfare offices throughout Oregon had existing relationships with A&D providers, but these relationships needed strengthening to build a partnership focused on moving clients with alcohol and drug problems from welfare to work. Incorporating alcohol and drug treatment into client EDPs increased the need for AFS to closely monitor client progress in treatment components. In addition, AFS took a more active interest in the treatment options available to clients and the time and personal demands of treatment.

Alcohol and drug treatment plans are developed by local A&D providers, typically based on client assessments using criteria established by the American Society of Addiction Medicine (ASAM). Treatment plans are not influenced by a client's connection with TANF. The difference for TANF clients is that they must meet work participation requirements through some combination of treatment and work or work-related activities. For providers and the AFS office, the juxtaposition of work activities and treatment necessitates greater communication in developing the client's EDP and monitoring progress through activities.

KEY DECISIONS

No formal agreements on the delivery of alcohol and drug treatment services to TANF clients are needed due to the Oregon Health Plan, but treatment providers needed to be engaged in the welfare-to-work process.

Outside of co-location agreements, none of the 15 districts formally negotiate treatment services for TANF recipients who face alcohol and drug problems because the Oregon Health Plan (OHP) covers these services. While formal agreements are not necessary, it is necessary for AFS offices to open communication with A&D providers whose partnership is needed in gauging client progress and abilities. AFS offices generally had relationships with a number of A&D providers, but there were some providers that were introduced into the process by managed care and the OHP. In some cases, these providers had not previously geared services to lower-income individuals and welfare clients and were not accustomed to the myriad of issues and needs of this clientele.

The districts found the key to partnership stemmed from early and frequent discussions with providers. The districts listed a number of methods for increasing communication, from attending provider network meetings to opening the doors for more informal and formal meetings around particular client needs.

The 15 AFS districts in Oregon report that they now have positive and productive working relationships with the network of local service providers that deliver alcohol and drug treatment services to TANF recipients. In turn, treatment providers have come to appreciate the useful partnership that has evolved with AFS. For providers, there are a

TIPS FROM THE FIELD

Informal Gatherings to Strengthen Communication

District 10 has hosted potluck luncheons to foster interaction between AFS case managers and provider staff. Their philosophy is that the more time people are together and talking, the better the relationship will be.

number of advantages from the improved connections with the welfare office including:

- Access to a large population in need and the ability to prevent significant problems of use and abuse rather than dealing predominantly with crisis situations
- Increased service levels that, in a managed care environment, are helpful in leveraging additional resources
- Insights into client barriers from case managers who may have had longer and sustained contact with clients prior to treatment.

Rationale:

AFS does not play a role in the payment of treatment services and, therefore, does not need formal contracts with alcohol and drug treatment providers for off-site services. The Oregon Health Plan covers the costs of treatment services for TANF recipients, who have categorical eligibility for the program. The absence of formal arrangements places greater importance on building communication between AFS and A&D providers. AFS relies on local A&D providers as partners in a program that combines work with treatment in order to move clients toward greater self-sufficiency.

Out-patient treatment is the preferred treatment method and can be effectively combined with other work-related activities.

In most districts out-patient services are the primary treatment method. For the majority of clients, out-patient services — including individual or group counseling sessions, educational and support groups, and aftercare — can address their treatment needs and are widely available. Once a treatment plan for out-patient services is developed, AFS schedules other activities that do not interfere with treatment, but complement it (for example, life skills classes, parenting classes, stress management or work experience placements).

Generally, there is no typical Employment Development Plan for those clients undergoing alcohol and drug treatment, but rather each plan addresses the best way for the individual client to get from point A to point B. The mix of activities in the EDP will vary depending upon the client's level of treatment, treatment schedule, and skills and abilities. Often, the EDP will have a heavy focus on treatment early in the process, and various work activities will be added as treatment progresses.

Most districts explicitly mentioned that other EDP activities are built around treatment, an indication that AFS has placed a priority on treatment. The advantage to out-patient services is that, in most of the districts, sessions are available during weekend and evening hours so that other work-related activities are possible. Out-patient services also generally entail frequent communication between the client, case manager, provider, and A&D professional so that EDP requirements can be updated as progress is made or as relapse occurs. This constant communication has helped remove the impression that AFS takes an “aggres-

NOTES FROM THE FIELD

Team Approaches to Case Management for Harder to Serve Clients

“Joe” was injured on the job some years ago and could not continue to work in his chosen field. As a father of three, he was on and off welfare for 12 years. He had sporadic contact with a vocational rehabilitation specialist and was involved with child protective services. After several failed attempts to engage Joe in job search activities, his case manager scheduled a meeting with all staff involved with Joe and his family.

Through discussion of Joe's case with other workers Joe was referred for a psychological evaluation and a substance abuse assessment. Indeed, the evaluation results revealed a learning disability and severe alcohol dependence.

Joe agreed to seek substance abuse treatment to prevent the removal of his three children from his home. The assistance he received to address his learning disability and his abstinence from alcohol greatly lessened his aggressive tendencies and his extreme anger.

The team of workers have remained in contact with Joe and with each other to support his life changes. His children now express pride in their father, rather than fear of him. He and his children are excited over his accomplishments in completing treatment, not drinking any more, and getting a job in a new field.

—Christa Sprinkle
Mt. Hood Community College

TIPS FROM THE FIELD

A typical self-sufficiency plan that integrates alcohol and drug treatment, as suggested by District 7, would include the following components:

Comply with alcohol and drug treatment plan for prescribed number of hours per week;

Attend Life Skills or Self-Esteem classes 4 hours per day for 6 weeks;

Keep appointment with domestic violence counselor next week;

Comply with Child Protective Services plan;

Complete a job search component.

From their experience, clients with alcohol and drug problems generally have to attend to a number of other personal and family issues. An EDP for such clients would likely include a number of different “treatment” components with alcohol and drug treatment heading the list.

sive” or “punitive” approach with clients and that providers are “over-protective” of clients in treatment.

AFS does not interfere when the diagnosis for treatment includes in-patient, or residential, care. Clearly, other EDP activities cannot apply, and treatment must be the sole focus for the client. The problem in many districts is that residential care is not widely available. In these cases, clients will receive intensive out-patient services until an in-patient slot becomes available. The expectations for additional activities placed on these clients may be minimal.

Rationale:

AFS offices have adopted the philosophy that alcohol and drug treatment, while a critical component to a client’s plan in achieving self-sufficiency, is but one component and must be combined with other activities that will support and sustain a transition from welfare to work.

AFS must work with treatment providers to arrange reporting schedules and mechanisms in order to gauge client progress through treatment as an EDP activity.

AFS offices work with treatment providers to establish reporting systems to collect information on client attendance and progress through treatment. Because AFS does not have contracts with providers for treatment services, AFS has no mechanism to exert leverage over providers to submit progress reports. Only one district reported a semi-formal agreement between AFS and local providers over reporting requirements.

Every district has a method for monitoring treatment; however, no one plan has emerged. The districts rely on different combinations of periodic provider reports, client attendance reports, case staffings, and communications with the on-site A&D professional to track client progress:

- Five districts require clients to submit a weekly or monthly attendance time card and also receive either weekly or monthly progress reports from the treatment provider.
- Seven districts receive either weekly or monthly progress and attendance reports only from the treatment provider.
- Three districts rely on their on-site A&D professionals to serve as a go-between, gathering information from providers and sharing it with AFS case managers.

Six districts use periodic case staffings that bring the case manager, on-site A&D professional, provider staff, and sometimes the client, together for a discussion of the case as an additional method for exchanging information.

In one county, providers have access to the on-line narrative section of the client’s AFS case record so they can directly enter progress reports, make comments on supportive service needs, and flag the record for non-compliance, due to lack of attendance, if necessary.

Rationale:

Tracking client attendance and performance in any EDP activity, including alcohol and drug treatment, is important for case management decisions, including sanctions. With alcohol and drug treatment on par with other JOBS activities and integrated into a client's EDP, case managers must track a client's participation and progress in treatment. On a basic level, clients must attend the treatment sessions prescribed to meet the requirements of their EDP. Gauging progress in treatment also helps case managers — often in consultation with the provider or on-site A&D professional — decide how the mix of required activities should change. As clients reach the end of their treatment plan, more intensive work-related activities are introduced; if a client has a relapse, requirements for other activities may be eased.

If the approach is not clear, gaining the support of the alcohol and drug treatment community for integration can be difficult.

As welfare offices increased attention on alcohol and drug abuse among TANF recipients, some A&D professionals initially felt threatened. First, came a struggle over territory as local service providers wondered how structures could be integrated and what impact integration might have on their caseloads. Second, there was a struggle over approach. AFS perceived a hesitancy on the part of the treatment community about an approach that addressed alcohol and drug problems with the combined pressure of work requirements that were reinforced by sanctions. AFS believed that treatment providers questioned whether AFS motives, driven by the goal of work, would interfere with long-term treatment goals. The treatment community emphasized that alcohol and drug abuse cannot be addressed with quick, Band-aid approaches but often requires intensive services over time. Providers wanted assurances from AFS that realistic expectations would be set for clients and that clients would not be required to take on too much at once.

Approach to Challenge:

In easing the first concern, AFS needed to clearly draw the line between up-front identification and education services and treatment services. Only the former would be provided by any on-site professional (a direct hire or contracted provider staff). AFS' role would be to provide the front-end services that would help get clients through the right door to treatment, but treatment would remain the domain of local service providers.

Bridging the philosophical divide took great efforts in communication and negotiation. Both sides believed in the benefits of treatment combined with work or work-related activities, but needed to reach understandings about how and when these activities could be introduced effectively. AFS invited provider input into the planning process so that mutual understandings and common goals could be developed. Local AFS administrators and case managers learned that frequent communi-

KEY CHALLENGES

AFS invited provider input into the planning process so that mutual understandings and common goals could be developed.

cation was the key to sustaining relationships and building trust with treatment providers.

Timely and consistent information on treatment from providers can be difficult to obtain without formal contracts in place and until confidentiality issues are addressed.

The first step in effective monitoring is to address provider concerns over confidentiality.

Concerns over confidentiality can initially inhibit monitoring efforts. Treatment providers must place priority on client confidentiality and may hesitate to form a partnership with AFS until there is a clear understanding about what information will be shared.

Aside from confidentiality issues, the lack of formal contracts between welfare offices and A&D providers means that reporting relies on the goodwill of providers. Four districts report significant problems in obtaining reports from all the local treatment providers and two other districts have difficulty in acquiring reports from the providers not connected with a contracted on-site A&D professional. Some provider staff do not see AFS reporting as part of their responsibility. Other providers, particularly smaller ones, simply do not have the resources or sophistication to provide AFS with client reports in any systematic manner.

Approach to Challenge:

The first step in effective monitoring is to address provider concerns over confidentiality. AFS needed to clarify with providers that the information they need is general, not clinical, in nature. AFS is interested in client information that will improve case management and inform decisions regarding the composition of a client's EDP and client compliance with EDP requirements. For example, at the screening stage, case managers are informed whether a client is in need of further assessment, but not the details of what the screen may have inferred. At assessment, case managers are informed whether a client needs treatment and at what intensity, but are not given the details of a client's drug or alcohol use patterns. During treatment, case managers are informed of client attendance, general progress, and supportive service needs, but not of the personal and clinical issues involved with treatment. Strictly clinical information remains confidential between the provider and the client.

Once confidentiality concerns are addressed, the strength of the relationship between AFS and the provider(s) will often determine the extent and schedule of reporting. AFS representatives learned that an early discussion with providers that built shared goals in meeting client needs would facilitate a better partnership around monitoring client progress.

Even with strong relationships, case managers often need to be proactive in obtaining reports. While nine districts did not report major problems in monitoring treatment, most agreed that AFS initiated the responsibility and commitment to tracking, and then providers responded. Case managers will often place calls to counselors and other provider staff to obtain verbal progress reports and feedback. In some areas, case managers visit treatment facilities regularly to personally collect progress information and ease providers' reporting burden.

A few districts believe that competition is one tool that can help bring providers on board with reporting. AFS, as a service customer of treatment providers, can refer clients to providers that meet AFS reporting needs. Providers interested in maintaining the service base of TANF recipients may find it in their best interest to provide the requested client reports.

The Oregon Health Plan has generally increased access to alcohol and drug treatment services, but managed care has had differential effects on client choice.

The Oregon Health Plan has been met with mixed reviews by AFS staff and providers, largely due to the introduction of managed care. On the whole, most district representatives believe that the OHP has eased access to treatment services for TANF recipients by including such services in the basic health services package. However, while access has improved, options have not necessarily increased. In nearly one-third of all the districts — predominantly rural areas — there is only one A&D treatment provider available to TANF recipients through the Oregon Health Plan. However, although clients lack choice within these areas, none of these districts indicated a problem with waiting lists for outpatient services. (Residential care is, however, severely limited or not available in many of these areas.) In larger areas, the effect of managed care through the OHP has had differential impacts. Some have seen the number of providers and available services increase; others, particularly areas with greater initial competition, have witnessed a decrease in the service and provider options available.

Approach to Challenge:

There is little that the welfare office can do to expand client choice. But, it is important that the providers who are part of the local managed care system cater to the particular needs of low-income families. Local managed care organizations are required by the Office of Medical Assistance Programs to refer at least 50 percent of clients to traditional community providers for treatment services. This ensures that in every area, providers who have traditionally served welfare and low-income families are not excluded from the OHP.

The lack of residential treatment in many areas can limit the success of treatment goals for clients.

Four districts do not have any residential care providers in their areas, and in areas where residential treatment does exist, waiting lists are often long. A client may have to wait for residential treatment anywhere from a couple of weeks to a couple of months. The limited availability and accessibility to residential treatment poses a threat to the often narrow window of opportunity during which clients are ready and willing to enter an intensive, in-patient program. If clients must wait for such treatment, denial or fear may take root and keep them from enrolling when a slot becomes available.

Approach to Challenge:

Co-located A&D professionals often serve as advocates for TANF clients and are, at times, successful in reducing the wait for residential treatment. Districts will also pay transportation costs so that clients can get to any open spot in a residential treatment program, even across the state, if necessary. When in-patient care cannot be accessed, a couple of districts reported that they will cover costs to relocate a family out of a neighborhood and away from contacts that support a client's addiction in order for intensive out-patient care to be more effective.

A couple of districts have pursued another, more controversial route, purchasing "priority" beds in residential treatment programs. AFS offices have provided additional funds to residential programs to reserve a number of slots for TANF recipients. The payment from AFS is in addition to the regular payment made by OADAP to cover the costs of room, board and nonmedical services connected with in-patient care. This approach does not open up more spaces for low-income individuals, but places AFS clients on the top of the list for care. This practice can, therefore, disrupt service to non-AFS clients.

TIPS FROM THE FIELD

Residential Family Friendly Treatment

The HOME program administered by OnTrack, Inc., a non-profit organization in District 8, is an innovative family-oriented residential program that allows all the children (up to age 8) to live with their mother during treatment. While mothers participate in treatment, their children benefit from therapeutic day care designed to lessen the effects of parental alcohol and drug abuse. Beyond the treatment of chemical dependency, the HOME program emphasizes family preservation and reunification and family self-sufficiency.

Separating children from the parent during residential treatment is disruptive to the family and can result in a TANF case closure.

Some residential programs do not allow children to remain with a parent, limit women to bringing only one or two children, or only allow children under a certain age to reside with the parent. For the female majority of TANF caseloads who care for two or more children, this can cause another significant obstacle to treatment. Case managers will work to locate a family member capable and willing to take in the children during treatment, but fear of losing her children may derail efforts to get a client into residential treatment.

In addition, if the children are separated from the parent, the parent can lose eligibility for a TANF grant. This may not pose a problem while a client is in treatment, but a client can find herself without benefits when she completes the program, a time when resources will particularly be needed. From OADAP's perspective, TANF case closures mean that OADAP must cover the entire cost of room and board for residential treatment programs because clients come to the programs with no cash income. This causes additional budgetary pressure on the agency.

Approach to Challenge:

The districts were not aware of any specific efforts under way to increase the supply of residential programs that can take children. TANF case closures are something that AFS can, and has, addressed. Parents can now maintain TANF eligibility as part of the household for up to 90 days while they are in a residential alcohol or drug treatment facility (DHR 1999).

Supportive services, particularly transitional housing are lacking in many areas and can affect a client's longer term success with treatment.

In addition to the standard supports of child care and transportation, clients going into and coming out of treatment, often have special needs. For instance, while housing is an issue for many welfare recipients, locating housing that provides an environment that is free of the influences of drugs and alcohol can be particularly difficult to arrange. In most districts, transitional after-care housing is scarce. Housing prospects can also be limited for these clients who have often burned bridges with landlords or who have a history of evictions. Another need particularly prevalent among clients with alcohol and drug problems is housing that is safe and provides support around domestic violence issues.

Approach to Challenge:

This is an area that is in need of particular attention and solutions, which at this time are scarce. Ideally, as a “required” activity on the EDP, clients should have access to child care and transportation supports during and following treatment, but providers have been frustrated to find gaps in these services that create obstacles to a client's participation and progress in treatment.

To address the gaps in transitional housing, some districts take an approach similar to that described in addressing the lack of residential treatment. AFS will cover moving costs for the family to relocate into a “cleaner” environment in which the parent has a greater probability of remaining drug- or alcohol-free.

Connections between the welfare program and treatment providers do not need to be formal to be effective.

KEY LESSONS

In Oregon's experience, the integration of alcohol and drug treatment into the welfare program did not involve specialized contracts with providers at the local level. AFS is not creating an entirely new service population for providers, but is expanding the cooperation between two systems in meeting the needs of the population on welfare who face alcohol and drug problems. The key is building the relationships with A&D providers that already serve the low-income population to ease the referral process and to maintain contact throughout treatment. By identifying common goals and addressing confidentiality concerns, AFS can obtain the information it needs about client progress from A&D providers, and providers can benefit from stronger links with case managers who can offer insights into client issues and assist with additional supports for clients.

Issues of confidentiality can be addressed appropriately through careful planning and clear communication with providers.

The manner in which confidentiality concerns were addressed in Oregon is an example of the effectiveness of dealing with issues early in the planning process. At the state level, a standard individual release form (DHR 2100) was developed to obtain client consent for AFS to receive general progress and attendance reports regarding treatment from A&D providers. This tool was put in place before localities fully implemented integration. At the local level, A&D providers were unclear about what AFS efforts at integration meant for sharing information about clients. These concerns were addressed from the outset by clarifying what AFS does and does not need to know and by building relationships based on shared goals for client self-sufficiency.

The alcohol and drug treatment system needs additional resources to increase residential, family-centered, and additional supportive services.

An integrated approach to addressing the alcohol and drug problems of TANF recipients in Oregon has improved the up-front, education services that can engage clients in treatment, but it has not come with increased resources for treatment services themselves. Oregon, like all states, is restricted in its use of TANF funding for medical components of alcohol and drug treatment. However, there are opportunities to expand non-medical services in such areas as counseling and peer support groups. Issues around residential treatment are perceived as the domain of the treatment community. However, there are increased incentives for the welfare program to become an active partner in leveraging additional resources for treatment in both out- and in-patient settings that can benefit their clients with alcohol and drug problems.

SECTION VII

Measuring Program Performance

Oregon has a series of standard measures to gauge performance within its welfare program. Each of the 15 districts report to the state on six standard measures. The state AFS office compiles the district data and releases a quarterly performance update that reports the measures at an aggregate state-level. The six standard measures include:

- Total job placements
- Wages at placement for full-time jobs
- Percentage of families who are off welfare 18 months after TANF case closure due to employment
- Percentage of teen parents in school
- Program benefits, program delivery, and administrative costs
- Percentage of eligibility decisions processed on time

Performance Measures, April-June 1998

- AFS helped more than 1,550 people find work each month
- The average wage at job placement was \$7.08
- More than 92% of those who left welfare for employment were not receiving TANF benefits 18 months after case closure
- 96% of TANF teen parents had an education equivalent to a high school diploma or were in educational activities
- 89 cents of every AFS dollar provided program benefits, 8.4 cents was spent on direct client services, and 2.4 cents was used to cover administrative costs
- 99% of eligibility decisions were processed within the time frame specified by regulations

Source: Quarterly Performance Update for the period ending June 1998. Adult and Family Services Division, Oregon Department of Human Resources.

Across the board, the districts believe that their efforts to address alcohol and drug problems have resulted in improved client outcomes. This is largely based on the case histories with which they are familiar. While Oregon has an outcomes-focused program, outcomes are not examined for specific populations. Districts report performance measures as aggregates and do not look at outcomes specific to clients who have undergone alcohol and drug treatment.

Client outcomes are collected and reported for the entire caseload but are not tracked exclusively for clients with alcohol and drug problems.

Districts are required to report data that relate to the six specified performance measures. These measures, which include client employ-

OVERVIEW

KEY DECISION

ment outcomes, rely on case-level information. As such, it is possible that districts could flag the cases in which the adult recipient was, at some point, engaged in alcohol and drug treatment activities to assess outcomes among this population. None of the 15 districts, however, has taken this step.

A number of the districts track process measures related to alcohol and drug treatment at regular intervals. These process measures include the number of clients assessed, the number of clients referred to treatment, and the number of clients who complete treatment.

District 2 (Portland) tracks process measures for clients with alcohol and drug problems. Over a 12-month period, it found that:

- 15% of all TANF clients were referred for a drug and alcohol assessment;
- Of those clients referred, 42% showed up and were assessed;
- Of those assessed, 82% were referred for treatment;
- Of those referred for treatment, 53% completed treatment.

Rationale:

Tracking client self-sufficiency outcomes is emphasized in Oregon. However, it is not in the state philosophy to break these outcomes down by specific subpopulations of the caseload. Achieving self-sufficiency, both in the short and long term, is viewed as a process. There are many factors that play into that process, including the various JOBS activities that help clients get their first job and eventually move off welfare. Alcohol and drug treatment is only part of a client’s move toward self-sufficiency. More likely than not, such treatment would not be the only factor contributing to a client’s success or failure in gaining and maintaining employment. For these reasons, the state does not promote and the districts do not pursue performance measurement exclusively for clients who have engaged in some form of alcohol and drug treatment.

Throughout the districts, respondents based their positive impressions of their alcohol and drug treatment efforts on client experiences. They considered success in terms of individual client progress, focusing on clients who have made lifestyle changes, who have progressed in their treatment plans, and who have regained custody of their children. Intermediate measures such as these, although not often collected formally, give AFS staffers the impression that they are headed in the right direction in addressing the needs of clients with alcohol and drug problems.

District representatives reported an interest in increased outcome measurement but felt constrained by time and resources.

As often happens with service programs, staff and financial resources exist to deliver services but are limited for outcome measurement. Many of the districts expressed an interest in learning more about outcomes for clients with alcohol and drug problems, but given limited resources, they did not envision greater efforts in this area.

TIPS FROM THE FIELD

Family Self-Sufficiency Scale

District 8 has Community Service Integration Teams that bring together a comprehensive array of human service and other community partners. These teams have developed intermediate measures of progress with a “Family Self-Sufficiency Scale.” This holistic framework for performance measurement looks at areas such as stable housing, employment, school attendance of children, parental education, child abuse, health and criminal justice.

KEY CHALLENGE

Districts also reported an interest in examining measures of family and child health and well-being that extend beyond the outcome measures currently collected around welfare receipt. The measures districts are interested in include:

- How are clients faring in the longer-term, such as 6, 12, and 18 months after treatment? What are their post welfare experiences? How does their health and well-being change over time?
- How often do clients who have received treatment come back into the system? What happens to clients who have received treatment who do not come back into the system?
- What is the rate of completion of treatment and entry into employment for clients with alcohol and drug problems? How often do these clients transition in and out of the labor market?
- How do the children of clients with alcohol and drug problems fare? What are the children's own experiences with substance use and abuse and with the welfare system?

Approach to Challenge:

Districts do not currently have plans to pursue additional outcome measurement. They must rely on the research community to follow through with many of these types of questions.

Outcome measurement for alcohol and drug treatment is complicated and must be done carefully to be done well.

KEY LESSON

Client outcomes around employment are likely to be less favorable among harder-to-employ populations, including those with alcohol and drug problems, compared with the entire TANF caseload. When harder-to-employ clients do obtain employment, earnings can often be lower and job retention shorter than that found among other TANF recipients who tend to have slightly higher levels of education and more recent work experience.

Consequently, if outcome measurement for clients who pursue alcohol and drug treatment are carved out from the larger caseload, the findings might be disappointing and could be misleading. A more appropriate comparison would be between clients with alcohol and drug problems who do not pursue treatment and those who do. Such data is not routinely collected as a part of the TANF application process. Therefore, to adequately address the outcomes associated with participation in treatment, one would need to establish specialized data collection procedures. Alternatively, one could compare clients' employment experiences before and after treatment.

Applying The Lessons From Oregon In Different Policy And Programmatic Environments

Oregon began to integrate alcohol and drug treatment into its welfare program long before the passage of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA). This early commitment made Oregon a front-runner in the effort to create a work-oriented assistance system that is flexible enough to respond to families who need more than job search assistance to make the transition to stable employment. Strong leadership at the state level, flexible welfare policies, and coverage of alcohol and drug treatment services for low-income families through the Oregon Health Plan have all contributed to Oregon's ability to integrate alcohol and drug treatment into their welfare program.

Given the diversity of state approaches to creating a work-based assistance system, states and localities that are interested in integrating alcohol and drug treatment into their welfare programs are not likely to find themselves in a policy or programmatic environment that is identical to Oregon's. Some states will be able to readily replicate aspects of Oregon's approach, while others may be constrained by their own policies and programs—in terms of both legislative language and the extent to which policies provide for coverage of alcohol and drug treatment services for welfare recipients. To make the most of Oregon's experience, states and localities will need to examine the lessons from Oregon through the lens of their own policy and programmatic environment. We offer some ideas about how to integrate alcohol and drug treatment into a welfare program in the absence of the policies that support Oregon's approach.

In the absence of strong leadership that supports the integration of alcohol and drug treatment into the welfare program, welfare agencies and alcohol and drug treatment providers will need to take the initiative for building support at the local and, where necessary, at the state level.

Local staff in Oregon responsible for integrating alcohol and drug treatment into their welfare programs repeatedly credited state officials for giving alcohol and drug treatment a firm place on the welfare policy agenda. Even so, the local offices had a hand in bringing the issue to the

WHEN STRONG STATE LEADERSHIP IS ABSENT

surface and drawing more state attention to it. If state leadership on this issue is not immediately forthcoming, local offices can take the initiative in garnering support for an integrated approach in their local communities. This course is made more feasible by the new welfare environment, which gives localities more freedom to design and implement “customized” welfare-to-work strategies.

Local administrators can move alcohol and drug treatment closer to the welfare-to-work agenda by communicating more closely with community alcohol and drug treatment agencies. This communication, by linking the welfare and drug treatment agencies, can improve service connections for clients with alcohol and drug problems—whether or not the end result is the actual integration of treatment services into the welfare office.

In a community environment that is less favorable than in Oregon for integrating alcohol and drug treatment into a welfare employment program, the involvement of alcohol and drug treatment professionals may be even more critical. Local welfare officials in Oregon believe that co-locating substance abuse professionals in their welfare offices has been critical to their success in integrating alcohol and drug treatment into their welfare programs. Alcohol and drug abuse professionals bring a knowledge of alcohol and drug problems that far exceeds what can be expected of even the best trained case managers. These professionals also have the skills and the commitment to create a bridge between the welfare and the alcohol and drug treatment systems. These attributes are likely to be even more important in settings where there are more programmatic hurdles to overcome.

Local welfare agencies can also assume responsibility for educating local policymakers and, in some cases state officials, about the benefits of integrating alcohol and drug treatment into their welfare program. As local and state officials come to recognize integration as a worthwhile financial investment in a system that moves welfare recipients into jobs, alcohol and drug problems will more readily take their place on the welfare agenda.

LACK OF FORMAL TOOLS FOR ENFORCING AND SUPPORTING ALCOHOL AND DRUG TREATMENT

States and localities that do not broadly define participation in program activities will need to identify alternative strategies for enforcing and supporting participation in alcohol and drug treatment programs.

In Oregon, participation in alcohol and drug treatment is handled as participation in all other program activities is handled: case workers can sanction recipients required to get treatment but who do not do so, and they can provide child care and other supportive services while recipients participate in treatment. Welfare staff from the local offices in Oregon feel that sanctions are a powerful tool for encouraging participation in alcohol or drug treatment, and that supportive services can remove barriers that might inhibit participation in treatment.

In Oregon’s experience, clients are rarely sanctioned solely for not participating in alcohol or drug treatment. Most often, a client who is

not meeting *treatment* requirements also is not fully participating in the *work activities* that are part of their self-sufficiency plan (possibly due to the alcohol and drug problems they are facing). In addition, the mere threat of being sanctioned for not participating in work activities is often the catalyst for getting recipients to admit to an alcohol or drug problem and enter treatment. Therefore, even in states that do not broadly define program activities to include alcohol or drug treatment, sanctions designed to enforce participation in work activities can be used indirectly to enforce or encourage participation in alcohol or drug treatment.

States and localities that are unable to provide supportive services for participation in alcohol or drug treatment through the welfare program may be able to make use of funds from other sources to pay for supportive services in their communities. They could also build partnerships with other local agencies in order to remove potential barriers to treatment. In addition, where they exist welfare offices should take advantage of alcohol and drug treatment programs that include a work component, provide on-site child care, or offer other supportive services, to better meet the needs of their clients with alcohol and drug problems.

In states and/or localities where alcohol and drug treatment does not count toward a state's work participation rate, states and localities will need to focus on long-term, rather than short-term, participation goals with regard to clients with alcohol and drug problems.

ALCOHOL AND DRUG
TREATMENT IS NOT
A "COUNTABLE"
ACTIVITY

Oregon is one of the few states that had a waiver in place prior to the passage of PRWORA that allowed the state to require participation in alcohol and drug treatment as a condition of receiving welfare benefits. Since Oregon has chosen to maintain its waiver, it can count persons participating in alcohol and drug treatment (along with many other activities not allowable under PRWORA) as meeting the work participation requirement. As a result, in FY 1997, 97 percent of Oregon's caseload that was subject to a work requirement was identified as participating in work activities. For nearly every other state, participation in substance abuse treatment does not satisfy an individual's work participation requirement.

The strength of the economy, in combination with caseload declines, has allowed many states to meet a substantial portion of their work participation rate through the caseload reduction credit. In this environment allowing participation in substance abuse treatment is not likely to adversely affect a state's ability to meet current participation requirements, particularly because the proportion of clients in need of treatment is generally small. For example, even in Oregon's well-established program, only a small fraction (approximately 5 percent) of its total caseload is participating in alcohol or drug treatment activities in any given month. In addition, most are combining alcohol and drug treatment with a traditional work activity such as job search.

Allowing participation in treatment may become more difficult as the number of hours in work-related activities needed to meet federal

work participation rates increases. It may be difficult for some individuals to participate in work activities for 30 hours a week *and* then participate in alcohol or drug treatment. For alcohol and drug treatment to be a viable option for welfare recipients, states and/or localities may need to agree to allow some recipients to participate in program activities that will not count toward their federally mandated work participation rate for a specified period of time. However, given that most alcohol and drug treatment programs are quite short, this should not have a significant impact on a state's ability to meet their work participation targets.

UNIVERSAL DRUG TESTING

States that rely on universal drug testing may need to supplement it with other ways to identify candidates for treatment in order to fully integrate alcohol and drug treatment into their welfare programs.

Oregon does not rely on universal drug testing to identify recipients who may need alcohol or drug treatment. Rather, the state sees this effort as an ongoing responsibility of case managers and alcohol and drug abuse professionals who are stationed in the welfare offices. Although about half the districts have an up-front screening process to identify recipients with alcohol and drug problems, many recipients throughout all the districts are identified only after they develop a trusting relationship with a case manager, they fail to participate in work-related activities, or they lose their job.

Universal drug testing, as the only means to identify candidates for treatment, will not successfully identify *all* the recipients with alcohol and drug problems. For example, recipients addicted primarily to alcohol and those whose addiction or abuse has not surfaced at the time of testing will be missed. For these reasons, training case managers to identify suspected drug and alcohol problems is an important component of any state effort to integrate treatment into a welfare program—with or without universal drug testing.

LIMITED COVERAGE OF TREATMENT SERVICES

In states where Medicaid does not cover alcohol and drug treatment services for the low-income population, the connections between the state welfare and alcohol and drug systems will be even more important.

In Oregon, the OHP provides coverage for most alcohol and drug treatment services as part of the basic health services package to residents with income under the federal poverty level, which includes welfare recipients. As a result, while local welfare offices in Oregon had to find a way to connect welfare recipients to treatment providers, they did not have to negotiate contracts or make specific arrangements with providers to ensure access to treatment services for their clients. The connections that were made between the welfare and alcohol and drug offices at the state level in Oregon, were largely around the up-front services of education and screening that could occur within the welfare office.

Unlike Oregon, many states do not have the benefit of additional funding for treatment services that comes through an expanded Medicaid or state health insurance program like the OHP. Consequently, local welfare programs will have to rely on the services of alcohol and drug treatment providers that have been developed to serve the low-income population through the state alcohol and drug treatment system (funded in large part by the Substance Abuse Block Grant). The welfare offices may have to negotiate contracts with treatment providers to ensure access to services for welfare recipients. But, these benefits could come at the expense of limiting access for other low-income individuals and families. In this type of environment, it is particularly important that welfare and alcohol and drug program officials, at both the local and state level, work together to develop approaches to meeting the demand for services. A combined force may be more effective in leveraging additional resources—either directly within the community or at the state level.

Oregon has made a clear commitment to addressing alcohol and drug problems as a part of its strategy to move welfare recipients into the labor market. The state's approach to integrating treatment for substance abuse rests on a foundation that acknowledges that some welfare recipients need more assistance than others to make the transition to stable employment. That foundation has given the local offices the backing they need to integrate alcohol and drug treatment services into their welfare programs. The structures now in place in the local offices in Oregon have evolved over time, and it is likely that they will continue to do so. Given the diversity of state approaches to making welfare recipients self-sufficient, the lessons from Oregon's experience, though useful, are not an exact prescription for integrating alcohol and drug treatment services into the welfare program. The lessons can, however, help states and localities to think *strategically* about what it might take to successfully integrate alcohol and drug treatment services into their own welfare programs.


CONCLUSION

District And Branch Offices: Total JOBS Participants And Total Participants Engaged In Alcohol And Drug Treatment, December 1998

District and Branch Offices	Total JOBS Participants	Clients Engaged in at Least One Hour of Drug and/or Alcohol Treatment
District 1	449	20
Astoria St. Helens Tillamook		
District 2	4,701	214
Albina Beaverton Gresham Hillsboro Southeast Portland West Portland Northeast Portland East Portland Outer Southeast Portland St. Johns Family Center Tigard		
District 3	2,739	91
Dallas McMinnville North Salem South Salem Woodburn		
District 4	1,200	52
Albany Corvallis Lebanon Newport		
District 5	3,609	227
Cottage Grove Eugene Florence Junction City Springfield West Eugene		

Appendix A (continued)		
District and Branch Offices	Total JOBS Participants, December 1998	Clients Engaged in at Least One Hour of Drug and/or Alcohol Treatment, December 1998
District 6	897	22
Roseburg		
District 7	678	28
Coos Bay Gold Beach		
District 8	1,727	99
Ashland Cave Junction Grants Pass Medford West Medford		
District 9	162	7
Condon The Dallas Hood River		
District 10	444	16
Bend Madras Prineville Redmond		
District 11	469	30
Klamath Falls Lakeview		
District 12	396	34
Hermiston Milton-Freewater Pendleton		
District 13	288	26
Baker City Enterprise John Day Lagrande		
District 14	200	20
Burns Ontario		
District 15	590	16
Milwaukie Oregon City		

Authorization For Release Of Information



Authorization for Release of Information

To Our Clients: We can serve you better if we are able to work with other agencies that know you and your family. By signing this form, you are giving permission for these organizations to release information about your situation.

This material is available in alternative formats including Braille, computer disk, large print and oral presentation, for persons that are visually impaired and meet the guidelines for the Americans with Disabilities Act.

Section A	Legal Name Last	First	MI	Date of Birth
	Child Legal Name Last	First	MI	Date of Birth
	Child Legal Name Last	First	MI	Date of Birth
	Child Legal Name Last	First	MI	Date of Birth

I authorize the following record holders; (individuals, schools, employer, or agencies)

CLIENT INITIAL	RECORD HOLDERS	HOW MUCH AND WHAT KIND OF RECORDS	MUTUAL EXCHANGE YES/NO

To release to: (If releasing to a team, list agency members on back of form)

CLIENT INITIAL	TO	PURPOSE	EXPIRATION DATE OR EVENT

I agree that the agencies and individuals listed above may share and exchange information about my family and my circumstances. Initial one: _____ Yes _____ No

I can cancel this authorization for release at any time, but I understand that the cancellation will not affect any information that was already released before the cancellation. I understand that information about my case is confidential and protected by state and federal law. I approve the release of this information. I understand what this agreement means. I am signing on my own and have not been pressured to do so.

Section D	Full Legal Signature or Mark of Client					Date
	Client	Parent	Guardian	Legal Custodian	Power of Attorney	
	Spouse	Adult Child	Other Family	Attorney	Caseworker	
	Full Signature of Worker				Initiating Agency	Date

To those receiving information under this authorization:

This information disclosed to you is protected by state and federal law. You are not authorized to release it to any agency or person not listed on this form without specific written consent of the person to whom it pertains unless authorized by other laws.

This is a true copy of the original authorization document.

Full Signature of Agency Staff Person making copies (HR 2100 page 1 (Rev. 10/98))

To release to:			
CLIENT INITIAL	TO	PURPOSE	EXPIRATION DATE OR EVENT
Section C			

Instructions

client to ask questions about the form and what it allows.

- Cannot read/Cannot write:** A client may substitute a signature with making a mark or by asking someone to sign on his/her behalf.
- This is a **Voluntary Form**. However, clients should be given accurate information on how the refusal to allow the release of information may adversely affect eligibility determination or coordination of services. If the client decides not to sign, consider referring the individual or family to a single service which may be able to help them without an exchange of information.
- Guardianship/Custody.** If the signer is a guardian, a copy of the guardianship paper must be attached when the request is sent. Similarly, if an agency has custody, and their representative signs, the custody order should be included.
- Duration.** The authorization is valid for one year unless otherwise specified.
- Family Records.** This release covers information about the person signing the form, minor children and information about the family he/she supplied for the record. It would not cover information supplied by other adult family members unless they also sign a release.
- Children.** Minors can consent to medical treatment at age 15; mental, emotional or chemical dependency treatment, at age 14. They may sign their own permission for release of information forms needed for such treatment.
- Revocation.** If the person later cancels this authorization, write "revoked" and the method and date of revocation boldly across the form. Date and initial it, and keep in the file. Federal regulations do not allow us to require that the revocation be in writing.
- Mail Requests.** If this form is being used to request information by mail, be specific about what you need. If you have a series of questions, use a cover letter. The more clear you are in your request, the more likely you are to receive a prompt and accurate response. Do not ask for information you do not need.
- Photocopying. Keep the original in the file** and send copies to other agencies. The person making the photocopies should sign each copy at the bottom of the first page certifying it as a true copy. The agency receiving the authorization should reject it if there is not an original signature by the person who made the copy.

Special Attention:

- Redisclosure.** Information received under this authorization should not be redisclosed to any party not identified on this form without specific written consent. Criminal penalties may apply to illegal disclosure. Federal regulations (42 CFR part 2) prohibit you from making any further disclosures of Alcohol and Drug information and state rules OAR 333-12-270, ORS 433.045 prohibit further disclosure of HIV/AIDS information, and statutes ORS 659.700-659.720 and OAR 333-24-0500 through 0560 prohibit further disclosure of Genetics information without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical information is not sufficient for this purpose.
- HIV/AIDS.** A general release is not sufficient. Identification of a specific individual, agency or facility is required including 3rd party payers, a specific purpose for the release and a specific time period are necessary.
- Genetics.** A general release is not sufficient for genetic test results but is sufficient for general historical information. OAR 333-024-0550 (Appendix 2) requires use of a specific genetic release form for disclosure or redisclosure. Provision of the specified form to the tested individual is required.

DAF 2100 (page 2) (Rev. 10/98)

Interfacing A&D Clients With Other JOBS Activities *

The following are descriptions of various treatment modalities and recommendations for client activities while in these different types of treatment services:

Detoxification (Detox): The client is toxic from regular, consistent use of alcohol or other drugs and needs 5-7 days of in-patient medical treatment before entering other treatment.

In-Patient Treatment (Residential): The client has a severe, chronic addiction and will be expected to be in-house for 1-6 months before stable in recovery. Usually the client enters directly from detox and has had a history of multiple out-patient treatment failures. Often this service is mandated by SCF or Corrections and can also be mandated by AFS/JOBS. JOBS activities, other than treatment are not appropriate for this client as they are confined to the treatment center.

Out-Patient Treatment: The client has an addiction problem but also has enough stability to remain in own housing and attend treatment group during the day or evening. Times are flexible and usually can be arranged to not conflict with networking, job search, or other JOBS activity. However, the client may need 2-4 weeks to stabilize prior to doing formal job search activities. The client could participate in computer or adult basic education classes as well as networking during this time unless it is in direct conflict with the treatment group times. For instance, ASAP's Women's Intensive Treatment groups are at 9:00 a.m. everyday downtown.

A general rule of thumb for addicted clients beginning out-patient treatment is 30-60 days in minimal activity other than treatment in order to stabilize. After that, most JOBS activities are appropriate and encouraged.

Methadone Maintenance: The client goes daily except Sunday to dose at one of three facilities in the area. Two programs are open at 5:00 a.m. or 6:00 a.m. for dosing and close around 1:00 p.m. to accommodate work schedules. CODA, the third program is open 8:00 a.m. to 5:00 p.m. After 90 days clean on methadone, the individual can go to "take out dosing" which means he/she will dose 3 times per week at the clinic and

take the dose for other days at home. Typically, a group session is required at least one time per week. Groups are available on Saturdays.

Generally, after an individual has been on methadone for 90 days, they are stable and ready for other activities. If you see an individual who has been on dosing for MORE THAN 6 MONTHS and is still dosing daily at the clinic, you are seeing an individual who is turning in positive urine samples which indicate the person is using other drugs as well as methadone. The case manager and the A&D assessment specialist must plan a very structured Employment Development Plan for this individual so he/she can move into recovery and become employable, or have the case closed for noncompliance.

*This informational sheet was developed by alcohol and drug abuse professionals in District 2 to assist case managers in balancing treatment and work-related activities when developing a self-sufficiency plan with a client in need of alcohol and/or drug treatment.

District Arrangements For The On-Site Presence Of Alcohol And Drug Abuse Professionals In The Welfare Office

Refer to Chapter 3, Section IV for further details of these arrangements.

District	Branch	Year On-Site Initiated	Hours Per Week	Staffing	Funding	Contract Mechanism
1	Astoria	1996	20	Contracted provider staff	TANF	AFS/OADAP state contract
	Tillamook	1996	4			
	St. Helen's	1997	4			
2	Albina	1992	40	Hired prime contractor staff	TANF	Through prime JOBS contractor
	East Portland		40			
	Gresham		15			
	Northeast Portland		12			
	Outer Southeast Portland		15			
	Southeast Portland		16			
	St. John's		24			
	Teen Parent Branch		33			
	West Portland		12			
	Beaverton Hillsboro Tigard		1992			
3	North Salem ^a	1992	24	Two professionals contracted from two local providers	TANF	AFS/OADAP state contract
4 ^b	Corvallis Albany Lebanon	1997	20 20 20	STEP-UP program comprised of AFS, JOBS and contracted provider staff	TANF funds; TANF reinvestment funds	AFS/OADAP state contract; and direct arrangements between AFS and local providers

^aThere are multiple branch offices in District 3, but the information gathered only applies to the North Salem office. This office handles over half of the total district caseload.

^bThe Newport office of District 4 is not shown. No information gathered.

Appendix D (continued)						
District	Branch	Year On-Site Initiated	Hours Per Week	Staffing	Funding	Contract Mechanism
5	Springfield Eugene West Eugene	1997	40 40 40	Contracted 3rd party staff	TANF	Through prime contractor to community-based organization (not a substance abuse service provider)
	Cottage Grove Florence	1997	20 20	Contracted 3rd party staff	TANF	Through prime contractor to community-based organization (not a substance abuse service provider)
6	Roseburg	1993	20	Contracted provider staff	TANF	Through prime contractor to local provider
7	Coos	N/A	40	Colocation of provider within same building	TANF	None necessary: Provider is self-supported through fees for assessments and treatment.
	Gold Beach	—	None	—	—	—
8	Grants Pass Cave Junction	1990 1990	20 20	Contracted provider staff	TANF	AFS/OADAP state contract
	Medford Ashland Rogue Family Center	1990	40 hrs across 3 offices			
9	Hood River Condon	—	Various part-time staff	Family Partnership Team comprised of AFS and contracted provider staff	TANF	Through prime contractor to local provider.
	The Dallas	1998	20	Contracted provider staff	TANF	Through prime contractor to local provider.
10	Bend Redmond La Pine Prineville Madras	1990	2-4 hrs per office	Contracted provider staff	TANF	AFS/OADAP state contract
11	Klamath Falls	1995	2 persons at 40 hrs each	Hired prime contractor staff	TANF	Through prime contractor
	Lakeview	—	None	—	—	—

Appendix D (continued)						
District	Branch	Year On-Site Initiated	Hours Per Week	Staffing	Funding	Contract Mechanism
12	Pendleton Hermiston Milton-Freewater	1994	5 30 5	Contracted provider staff	TANF	AFS/OADAP state contract
13	Baker City La Grande	N/A N/A	10 10	Contracted provider staff	TANF funds; TANF reinvestment funds	AFS/OADAP state contract; and direct arrangements between AFS and local providers
	John Day Enterprise	—	None None	—	—	—
14	Ontario	1997	About 20 hrs; ^c Team approach	Contracted provider staff	TANF	AFS/OADAP state contract
	Burns	1997	20-30	Contracted provider staff	TANF	Through prime JOBS contractor to local provider.
15	Oregon City Milwaukie	1991	48 hrs across offices	Contracted provider staff	TANF funds; TANF reinvestment funds	Through prime JOBS contractor to local provider.

N/A — Not Available

SOURCE: Case study interviews by Mathematica Policy Research, Inc.

Note: The arrangements indicated on this table were those in place at the time of telephone interviews conducted in September and October 1998.

^cHours on-site account only for the mental health/substance abuse professional that is part of the STEP-UP Team. There are additional hours for other members of the team.

Alcohol And Drug Upfront Services*

District and branch offices can arrange for the on-site delivery of these services by local alcohol and drug treatment providers through the contract mechanism established at the state level between the Division of Adult and Family Services and the Office of Alcohol and Drug Abuse Programs. See Chapter 3, Section IV for further details on this arrangement.

DEFINITIONS

CLIENT INFO/REFERRAL: Client information and referral (group) sessions. Services shall include but are not limited to the following:

- Provide information on issues related to alcohol and drug abuse in a group setting.
- Discuss with group how and where referrals are made for services and treatment.
- Provide information on the stages of addiction treatment, denial of addiction, and co-dependency.
- Assist clients to understand abuse/dependence behavior and how it interacts with everyday life, how addictive behavior affects gaining and maintaining a job, why alcohol and drug treatment is important, different types of treatment and what it will do for the client, myths and stereotypes of addiction, skill building in relapse prevention techniques, how families/significant others affect treatment, and motivating clients to utilize appropriate chemical dependency services.
- Provide services designed to approach and assist clients who are not aware of or are in denial that a chemical abuse problem exists or is a barrier to self sufficiency and employment.

STAFF INFO/REFERRAL: Staff information and referral (group) session and training on alcohol and drug issues. Services shall include but are not limited to the following:

- Provide information on pertinent issues in addiction treatment,

*Information provided by Adult and Family Services Division, Oregon Department of Human Resources

how addictive behavior manifests itself, denial and co-dependency as they relate to self sufficiency and obtaining employment.

- Chemical dependency impact on everyday life.
- How to identify a client with abuse/dependence issues.
- How to refer a client to alcohol and drug assessment and treatment using methods that will enhance client follow through with treatment.
- Tips and phraseology for talking with and identifying clients in need of services.
- Specific referral processes for each service/treatment provider and what happens when a client is in treatment.

A & D PRESCREENING: Alcohol and drug prescreening. Services shall include but are not limited to the following:

- A written survey/test administered to clients to determine the need for referral to an assessment to determine whether treatment is needed.

STAFF A & D CASES: Staffing client cases with alcohol and drug professional staff. Services shall include but are not limited to the following:

- Staffing with Division and JOBS staff on clients involved with alcohol and drug issues.
- Corroborate referrals and provide coordination in alcohol and drug treatment referrals for Division staff.

STAFF CONCILIATIONS: Conciliations. Services shall include but are not limited to the following:

- Meet with Division staff to discuss potential JOBS disqualifications in conciliations that are alcohol and drug related.
- Problem solving techniques and means to maintain client participation in JOBS.

MONITOR/COORDINATE A & D: Monitoring and coordination of clients in alcohol and drug treatment. Services shall include but are not limited to the following:

- Coordination of services to increase the efficiency of service delivery.
- Consultation with Division and JOBS Prime Contractor staff in the interest of the most appropriate services for clients.
- Monitor JOBS clients while in alcohol and drug treatment and coordinate with other JOBS components as needed.
- Facilitate the flow of information between alcohol and drug providers and Division/JOBS Prime Contractor staff.

LIFESKILLS A & D PRESENTATION: Life Skills alcohol and drug presentation. Services shall include but are not limited to the following:

- Provide information on issues related to alcohol and drug abuse in a group setting.
- Discuss with group how and where referrals are made for services and treatment.
- Provide information on the stages of addiction treatment, denial of addiction, and co-dependency.
- Assist clients to understand abuse/dependence behavior and how

alcohol and drugs interacts with everyday life, how addictive behavior affects gaining and maintaining a job, why alcohol and drug treatment is important, different types of treatment and what it will do for the client, myths and stereotypes of addiction, skill building in relapse prevention techniques, how families/significant other affect treatment, and motivating clients to utilize appropriate chemical dependency services.

A & D FOLLOW-UP: Follow-up for clients completing alcohol and drug treatment. Services shall include but are not limited to the following:

- Provide information to Division and JOBS Prime Contractor staff on services available following alcohol and drug treatment.
- Discuss with clients relapse prevention strategies.
- Meet with Division and JOBS Prime Contractor staff and client to develop an Employment Development Plan with a focus on developing and sustaining a fulfilling alcohol and drug free lifestyle.
- Procurement of additional resources and services for the individual client and connecting the client with those services.

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