

Contract No.: 282-98-0021  
MPR Reference No.: 8528-100

**Addressing Substance  
Abuse Problems Among  
TANF Recipients:  
A Guide for Program  
Administrators**

*Final Report*

*July 19, 2000*

*Gretchen Kirby  
Jacquelyn Anderson*

**MATHEMATICA**  
Policy Research, Inc.

# Contents

<i>Acknowledgments</i> .....	v
<i>Preface</i> .....	vii
<b>Section I</b>	
Understanding the Substance Abuse Problem.....	1
Prevalence of Substance Abuse Among Welfare Recipients .....	1
The Benefits of Addressing Substance Abuse Problems .....	3
<b>Section II</b>	
Identifying Welfare Recipients with Substance Abuse Problems .....	7
Decisions in Developing a Screening Process in the TANF Program .....	7
Assessment: The First Step in Treatment .....	13
<b>Section III</b>	
Treating Substance Abuse .....	15
Connecting Clients with Treatment .....	15
Substance Abuse Treatment Options .....	15
Treatment Outcomes and Expectations .....	16
Service Delivery Issues .....	17
Funding for Substance Abuse Treatment.....	19
<b>Section IV</b>	
Integrating Treatment into a Work-Focused Welfare Program.....	23
Policy and Programmatic Decisions .....	23
Coordinating Welfare and Substance Abuse Treatment Services .....	26

<i>References</i> .....	31
<i>Appendix A</i> .....	35
<i>Appendix B</i> .....	41

# Acknowledgments

The authors express their appreciation to the Administration for Children and Families (ACF) of the U.S. Department of Health and Human Services for providing the impetus and resources to create this report for state and local program administrators. We particularly thank our project officer, Yvonne Howard, for her guidance throughout the preparation of this report. We also thank Ann Burek and Elaine Richman at ACF and Sharon Amatetti at the Center for Substance Abuse Treatment at SAMHSA for reviewing a draft of the report. Their recommendations were extremely helpful in clarifying the finer policy points and in providing additional information for the report.

At Mathematica Policy Research, LaDonna Pavetti was the project director. Embry Howell provided insightful comments and suggestions on a draft of the report. Pam Sutton provided editorial assistance, Donna Dorsey provided secretarial and production support, and Daryl Hall designed the report.

# Preface

The Personal Responsibility and Work Opportunity Reconciliation (PRWORA) Act of 1996 places a premium on cash-assistance recipients' efforts to work and holds recipients and state programs accountable for increasing self-sufficiency. The work requirements and time limits under the Temporary Assistance to Needy Families (TANF) system provide little room for work exemptions and create an incentive to explore the needs of “harder-to-serve” populations—including those with substance abuse problems—so that they, too, may move into work and be assisted on a path toward self-sufficiency. TANF program administrators who hope to meet future work-participation requirements and prevent significant time-limit exemptions may want to start making policy and programmatic choices now to better prepare this population for work in the long run.

This guide provides TANF program administrators and staff with information to help devise a strategy for identifying and addressing the needs of recipients with substance abuse problems. The guide has four sections:

- **Section I: Understanding the Substance-Abuse Problem.** Discusses the prevalence of substance abuse among welfare recipients and the benefits of addressing these problems in the context of the welfare program.
- **Section II: Identifying Welfare Recipients with Substance-Abuse Problems.** Presents a series of decision points for developing a process to identify TANF recipients with substance-abuse problems.
- **Section III: Treating Substance Abuse.** Provides background information on treatment-related issues such as treatment options, outcomes, expectations and service delivery as well as the resources available for treatment.
- **Section IV: Integrating Treatment into a Work-Focused Welfare Program.** Outlines the policy and programmatic decisions for integrating an approach to treatment into the welfare program and discusses the points to consider when coordinating welfare and treatment services.

Additional organizations and resources that can provide greater detail on the concepts and decisions outlined in this report are described throughout the text and in the resource section in Appendix A.

## **SECTION I**

# Understanding the Substance Abuse Problem

State TANF program administrators generally agree that substance abuse is a significant barrier to work for many welfare recipients (Center on Addiction and Substance Abuse, 1999). However, the extent of the problem remains somewhat illusive. This section discusses the prevalence of substance abuse problems among welfare recipients and outlines some of the benefits of addressing these problems in a work-focused welfare program.

## **PREVALENCE OF SUBSTANCE ABUSE AMONG WELFARE RECIPIENTS**

National and state-level studies provide a wide range of estimates of the prevalence of alcohol- and drug-abuse problems among welfare recipients. Prevalence estimates vary based on the definition of substance abuse and the subpopulation studied. Some studies use a broad definition of substance use while others measure the proportion of welfare recipients with an addiction to alcohol or other drugs. In addition, because most of these studies were conducted before welfare reform, these estimates may understate the problem. The prevalence of substance abuse among the welfare population is likely to be higher as the welfare rolls decrease because individuals with fewer barriers to employment are likely to leave the rolls more quickly.

### **About one in five welfare recipients abuses drugs and/or alcohol.**

National estimates of the welfare population that abuse alcohol or other drugs range from 11 percent to 27 percent. Estimates of substance abuse prevalence among welfare recipients are affected by differences in defining alcohol and drug use and abuse.

Using a relatively narrow definition of substance abuse, the U.S. Department of Health and Human Services (DHHS) found that 10.5 percent of AFDC recipients age 15 and older reported illicit drug use in the past month (1994). In a similar study, DHHS found that 10.6 percent of female adults in AFDC households had “some impairment” involving alcohol or other drugs—enough to warrant treatment along with work activities (1994).

The Center on Addiction and Substance Abuse (CASA) used a broad definition for the abuse of alcohol and other drugs in examining data from the National Household Survey on Drug Abuse. CASA estimated

that in 1991, 27 percent of females over the age of 14 receiving AFDC were abusing alcohol or other drugs. The Center found that younger women were affected more often by substance abuse problems; estimates showed that 37 percent of women between the ages of 18 and 24 receiving AFDC had alcohol or drug problems, defined as binge drinking two or more times or any use of illicit drugs during the last year (1994).

**About 1 in 20 welfare recipients is dependent on alcohol or drugs, making it difficult to hold regular employment.**

DHHS estimated that 5.2 percent of adults in AFDC households are dependent on alcohol or other drugs (1994). This group will be in greater need of services to help them overcome their dependence and become self-sufficient. DHHS defines dependence as an impairment significant enough to preclude participation in work activities. Other studies define dependence in terms of behaviors like tolerance, withdrawal and a desire but inability to stop use. Applying this definition of dependence to data from the 1992 National Longitudinal Alcohol Epidemiologic Survey, one study estimated that 7.6 percent of AFDC recipients were dependent on alcohol and 3.6 were dependent on other drugs (Grant and Dawson 1996).<sup>1</sup>

**Substance abuse problems are more common in the welfare population than in the general population.**

While the vast majority of alcohol and drug users are not public-assistance recipients, studies have shown that the prevalence of alcohol and drug problems among women receiving welfare is higher than among the general population. CASA estimates that mothers over age 14 receiving AFDC are about three times as likely to be abusing alcohol or other drugs than other women—27 percent compared with 9 percent (1994). However, these data do not suggest a causal relationship between substance abuse and welfare receipt; rather, they reflect the fact that people

**For more information on prevalence, refer to:**

Johnson, A. and Meckstroth, A. “Ancillary Services to Support Welfare to Work.” Mathematica Policy Research. Prepared for the Office of Human Services Policy, Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services. July 1998. <http://aspe.hhs.gov/hsp/hspwelfare.htm> (under “Welfare-to-Work” heading).

Young, N.K. “Alcohol and Other Drug Treatment: Policy Choices in Welfare Reform.” National Association of State Alcohol and Drug Abuse Directors. Prepared for the Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration. 1996. <http://www.nasdad.org/publica1.htm> to order, or call 202-293-0090.

U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation. “Patterns of Substance Use and Substance-Related Impairment Among Participants in the Aid to Families with Dependent Children Program (AFDC).” December 1994. <http://aspe.hhs.gov/hsp/hspwelfare.htm> (under “Hard-to-Serve Populations” heading).

The National Center on Addiction and Substance Abuse at Columbia University. “Substance Abuse and Women on Welfare.” June 1994. <http://www.casacolumbia.org/publications1456/publications.htm>.

at risk for greater levels of substance abuse are generally overrepresented in the welfare population.

## **THE BENEFITS OF ADDRESSING SUBSTANCE ABUSE PROBLEMS**

Substance abuse can be a serious barrier to work and is often a cause or a manifestation of other obstacles such as mental-health problems and domestic violence. Identifying alcohol and drug problems among welfare recipients can help welfare programs address substance abuse as a barrier to work as well as uncover other problems that may impede self-sufficiency. Furthermore, identifying and treating parental substance abuse can create a healthier environment for children.

### **Individuals with substance abuse problems are less likely to be steadily employed, but those who pursue treatment may fare better at work, earn more and require less assistance.**

Substance abuse can interfere with the ability to find and keep a job. One study found that women receiving AFDC were more likely to be unemployed if they had used drugs in the past month—30 percent were unemployed compared with 21 percent among all females in AFDC households (DHHS 1994). Another study found that welfare recipients with substance abuse problems are as likely to work as those without substance abuse problems but are less likely to be steadily employed. Only 15 percent of welfare recipients with substance abuse problems were employed full-time, year-round compared with 22 percent of all welfare recipients (Olson and Pavetti 1996).

Other studies show that investments in substance abuse treatment can improve employment and earnings among individuals who seek treatment. A five-year national study by the Center for Substance Abuse Treatment (1997) found a 19 percent increase in employment among people who completed treatment and an 11 percent decrease in the number of clients who received welfare after receiving treatment. A sample of individuals who completed four or more months of residential treatment in California in the early 1990s experienced a 30 percent increase in employment, compared with their level of work before treatment. This study also found a 22 percent decrease in welfare participation among those who received welfare before treatment (Gerstein et al. 1997). An Oregon study also found that the earnings of individuals who participated in a publicly funded alcohol and drug treatment program were 65 percent higher than individuals who did not participate (Finigan 1996).

Over time, increases in employment can help TANF programs meet their own work participation goals by improving outcomes for people who otherwise may not have, or may have only minimally, participated in the labor force.

### **Identifying substance abuse problems may uncover other problems that case managers must be prepared to address when helping a client become employed and self-sufficient**

Mental health issues and domestic violence are more common among

*TANF recipients with drug or alcohol addiction will need more intensive treatment and support services.*

individuals with substance abuse problems. Finding and keeping employment is harder for people with these co-existing barriers. The National Institute of Mental Health (NIMH) estimates that 52 percent of adults with a lifelong history of alcohol abuse or dependence also have a lifelong mental disorder (Callahan 1999). Studies also show that a large number of women with substance abuse problems have been physically or sexually abused. Up to 75 percent of women in treatment have reported sexual or physical abuse (Nelson-Zlupko et al. 1995).

### **Addressing substance abuse can create a healthier environment for children.**

Parental substance abuse impairs the health and development of children. About 60 percent to 80 percent of parents in the child welfare system have substance abuse problems (Young and Gardner 1998). Moreover, children of substance-abusing parents are more likely to develop alcohol or drug problems later in life. Addressing substance abuse problems can help improve the outcomes for these children.

### **Treatment saves public and social service systems money.**

Two frequently cited state studies indicate that investments in substance abuse treatment “pay off” because of the savings produced in other public and social services such as the criminal justice system, child welfare, health care services, and food stamps and other public assistance programs. In Oregon, researchers estimated that each dollar spent on substance abuse treatment saved \$5.60 in direct public costs (Finigan 1996). A California study estimated savings of about \$7 for every \$1 in treatment (Gerstein et al. 1997). A follow-up study focused solely on welfare recipients with children who received treatment found savings of \$2.50 for every \$1 in treatment. The lower ratio is partly explained by the lower crime rates among welfare mothers compared with the larger population of people needing treatment.

#### **For more information on client outcomes and state cost-effectiveness studies, refer to:**

Young, N. K. “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. Washington, DC: National Association of State Alcohol and Drug Abuse Directors, 1996.

Young, N. “Invest in Treatment for Alcohol and Other Drug Problems: It Pays.” Washington, DC: National Association of State Alcohol and Drug Abuse Directors, 1994.

Both of the above reports are available from the National Association of State Alcohol and Drug Abuse Directors. <http://www.nasadad.org/publical.htm> to order or call 202-293-0090.

See also Gerstein, et al. “Alcohol and Other Drug Treatment for Parents and Welfare Recipients: Outcomes, Costs, and Benefits.” U.S. Department of Health and Human Services. January 1997. <http://aspe.hhs.gov/hsp/hspwelfare.htm> (under “Hard-to Serve Populations”).

Some savings will accrue directly to the welfare system by addressing substance abuse. However, the benefit-to-cost ratio for investing TANF funds in treatment approaches will be lower if benefits are measured only for the TANF program. From a broader perspective, greater opportunities exist for cross-system collaboration in the current TANF environment that stresses work requirements and places a time limit on cash assistance. With findings such as these, there are strong arguments for collaborating with the treatment, child welfare and other social service systems to build healthier families who can work toward self-sufficiency.

### **NOTES**

1. These groups are not mutually exclusive. AFDC recipients who are dependent on alcohol and drugs would be counted in both groups.

## **SECTION II**

# Identifying Welfare Recipients with Substance Abuse Problems

The first step in addressing welfare recipients' alcohol and substance abuse problems is identifying the problems. This process can identify clients with substance abuse problems that could impede their progress toward self-sufficiency. The identification process also can determine which clients show early signs of alcohol and substance abuse that might otherwise go undetected. Both are valuable functions, with the former as a treatment approach and the latter as a prevention mechanism.

Generally, identifying and diagnosing an actual or potential substance abuse problem involves two steps: screening and assessment. These terms often are lumped together under the broad heading of "screening and assessment," but they accomplish different things, usually at different points in the process. Screening instruments are first-level detection devices that quickly determine whether signs of a substance abuse problem are present. Assessments serve a higher level function by gathering the more detailed information on an individual's substance use that is needed to form a diagnosis for specific treatment.

This section discusses the decisions TANF program administrators and staff must make to implement a screening process. These decisions include the program's purpose in screening clients, which TANF recipients to screen, when to screen, what screening instrument and method to use, who will conduct the screen, and how to pay for screening.

Screening instruments are not perfect and have not been tested for use with the TANF population. The use of screening instruments does not in itself constitute a comprehensive system for identifying clients with substance abuse problems. Programs must also carefully consider staffing structures and training programs that can complement the use of any screening procedures. These issues are addressed throughout this section.

## **DECISIONS IN DEVELOPING A SCREENING PROCESS IN THE TANF PROGRAM**

### **The Purpose for Screening**

According to the Legal Action Center, as of February 1999, 31 states had plans to screen all or some TANF recipients for alcohol and drug problems. However, screening is just one part of the process of addressing clients' alcohol and drug problems. State and local programs should

*In identifying and diagnosing substance abuse, screening means detection, and assessment means patient evaluation and diagnosis.*

determine what they hope to achieve through screening and consider the other components in the process that will support these purposes. There are four main purposes for screening:

1. To provide a rough estimate of the extent of substance abuse among the TANF population
2. To identify individuals at risk of substance abuse
3. To identify individuals who need treatment
4. To identify individuals for possible work deferral or accommodation, or for participation in alternative activities

Deciding on a purpose or multiple purposes will inform other decisions around screening and follow-up. For example, if a program decides that screening will identify people who need treatment, then the program must also take steps to ensure that these individuals can obtain treatment.

### Which TANF Recipients to Screen and When to Screen

TANF programs can screen all recipients for alcohol and drug abuse (broad screens) or just certain clients (targeted screens), such as those who appear to show signs of a substance abuse problem.

If a program intends to screen all recipients, this screening generally occurs early in the TANF process during intake and orientation activities. Targeted screening can occur at any point during an individual's participation in the TANF program.

Deciding whom and when to screen is tied to the purpose of screening. A broader approach to screening is more likely to uncover a population with a range of use, abuse, and dependence issues, while targeted screening will focus more heavily on the population whose alcohol or drug problems will hurt their ability to work or participate in other required TANF activities. (Refer to the Decision Matrix below.)

**Program Tip:**

One district in Oregon screens all TANF recipients within two weeks of application as part of a two-hour addictions awareness class.

**Decision Matrix: Relationships between the Purpose of Screening, Whom to Screen, and When to Screen**

Purpose of Screening	Whom to Screen	When to Screen
To provide a rough estimate of the extent of substance abuse among the TANF population	Broad; all TANF recipients	Early in the TANF process and on-going
To identify individuals at risk of substance abuse	Broad; all TANF recipients	Early in the TANF process and on-going
To identify individuals who need substance-abuse treatment	Broad or targeted	On an as-needed basis any point in the TANF process
To identify individuals for work deferral or accommodation	Broad or targeted	Early in the TANF process and on-going

## Advantages to Screening Early in the TANF Process

There are three main advantages to screening early in the TANF process. First, since clients face work requirements and time limits on benefits, the earlier a potential problem is identified, the sooner a client can work toward increased self-sufficiency. Second, in work-first TANF programs, which emphasize up-front requirements such as job searches, early screening can identify clients with substance abuse problems that would interfere with their efforts to meet those requirements. Third, when a goal of a TANF program is a better substance abuse prevention program, early screening can identify clients with minor issues that could become abuse problems if left unchecked.

## Advantages to Targeted Screening throughout the TANF Process

There are two primary advantages to conduct targeted screening throughout the TANF process. First, continual targeted screening identifies only clients whose abuse or dependence interferes with their ability to work or meet other program requirements and who must undergo treatment to move toward self-sufficiency. The TANF program does not intervene with clients who can succeed in work or work-related activities. Second, some administrators and staff may believe that broad screening implies a distrust of clients. With targeted screens, all clients are not required to “prove” their independence from drugs and alcohol.

In addition, continual screening is critical even to TANF programs that conduct initial, broad screens of all applicants. Since no screening tool is perfect, some clients with substance abuse problems might not be immediately detected. In addition, some clients may develop problems after they enter the program. Clients need multiple opportunities for self-disclosure for programs to effectively address their needs.

## General Lessons on Screening

Regardless of whether broad or targeted screening is used, TANF programs can increase the effectiveness of screening and minimize clients’ discomfort by following a few simple suggestions from clinicians and TANF programs with screening experience:

- **Maintain a positive, supportive approach; limit the impression that screening is meant to be punitive.** Screening instruments rely on self-reported data that can be influenced by a person’s denial or fear of consequences. A simple screening instrument may produce better results if an individual does not feel threatened. Administrators of any screening instrument should tell clients that the information will be used to help them and their families, not to punish them.
- **Treat clients with dignity and respect.** Many people, particularly women, who are addicted to alcohol and/or drugs suffer from low self-esteem. The less intimidating screening is, the greater the likelihood that clients will view it positively and feel more inclined to pursue treatment, if warranted. In addition, if the approach to screening is positive and respectful, it can decrease clients’ animosity to-

## Considerations Based on the Americans with Disabilities Act (ADA) of 1990

The ADA requires public agencies to provide people with disabilities the same opportunity to obtain benefits and services as anyone else. Programs cannot impose different eligibility standards or procedures and must make reasonable accommodations for people with disabilities when providing services. Under the ADA, alcohol addiction is a disability, but addiction to illicit drugs is not.

The law’s focus on consistent services suggests that broad-based screening of all clients is the safest approach. However, targeted screening is not pre-empted under the ADA. TANF programs should be cautious in selecting certain individuals for screening over others with ADA considerations in mind.

For further information on the ADA, refer to: Civil Rights Laws and Welfare Reform. Office of Civils Rights, U. S. Department of Health and Human Services. <http://www.hhs.gov/progorg/ocr>

ward the process and potentially minimize the legal complaints that could result.

- **Try to avoid having clients feel singled out, particularly for targeted screens.** When broad screens are used, make it clear to clients that everyone is subject to the same process. When targeted screens are conducted, use a positive approach in explaining that the questions are designed to better assist the client through the TANF program. It is not necessary to disclose that the client is suspected of alcohol or drug abuse.

### Screening Instruments

TANF programs can choose from among several screening instruments. While some are commonly used (see Table 1), there is no one recommended or perfect instrument for the welfare population that is made up predominantly of women.

There are, however, some important characteristics to consider when selecting a screening instrument, such as:

- Degree of sensitivity (ability to detect a broad range of potential substance abuse problems)
- Brevity
- Ease in administration
- Cost to administer, particularly if large numbers of individuals are to be screened
- Cultural sensitivity (although instruments are not widely tested on this attribute)

*“A good screening instrument may be viewed as beginning a process that leads to intervention or early assessment.”*

—The Center for Substance Abuse Prevention, 1993

#### **For more information on identifying substance abuse, refer to or contact:**

Local substance abuse treatment providers

“Identifying Substance Abuse Among TANF Eligible Families.” Technical Assistance Publication (TAP), Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration, forthcoming Fall 2000. Copies will be available through the National Clearinghouse for Alcohol and Drug Information, 1-800-729-6686. This publication will include a discussion of instruments and methods to use to identify substance abuse among the TANF population.

“Simple Screening Instruments for Outreach for Alcohol and Other Drug Abuse and Infectious Diseases.” Treatment Improvement Protocol (TIP) Series No. 11, Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration, 1994. Call 1-800-729-6686 to order at no charge from the National Clearinghouse for Alcohol and Drug Information. This publication presents a screening instrument developed by the CSAT that encompasses a spectrum of signs and symptoms for substance abuse disorders.

“Maternal Substance Use Assessment Methods Reference Manual: A Review of Screening and Clinical Assessment Instruments for Examining Maternal Use of Alcohol, Tobacco, and Other Drugs.” Center for Substance Abuse Prevention, Substance Abuse and Mental Health Services Administration, 1993. SAMHSA no longer distributes this publication, but it may be available from your local library. This publication provides a review and brief abstracts on 22 screening instruments and 18 clinical assessment instruments.

**Table 1. Matrix Review of Some Common Screening Instruments**

<b>Screening Instrument</b>	<b>Substance Assessed</b>	<b>Number of Items on Instrument</b>	<b>Staff Training Required?</b>	<b>Method of Administration</b>	<b>Developed for Pregnant Women/ Mothers</b>	<b>Easily Adaptable for Pregnant Women/ Mothers</b>	<b>Targets Early-Stage Problem Use</b>	<b>Targets Late-Stage Problem Use</b>
CAGE	Alcohol	4	No	Self-administered	No	Yes	Yes	Yes
Drug Use Screening Inventory (DUSI)	Alcohol and other drugs	149	No	Self-administered	No	Yes	Yes	Yes
Michigan Alcoholism Screening Test (MAST)	Alcohol	25	No	Self-administered	No	No	No	Yes
Substance Abuse Subtle Screening Instrument (SASSI)	Alcohol, tobacco, drugs	78	Yes	Self-administered	No	No	Yes	Yes

Source: Excerpted from "Maternal Substance Use Assessment Methods Reference Manual: A Review of Screening and Clinical Assessment Instruments for Examining Maternal Use of Alcohol, Tobacco, and Other Drugs." Center for Substance Abuse Prevention, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services. 1993.

**For more information on drug testing, refer to or contact:**

Gaber, Paula. "Drug Testing of AFDC Recipients." The Center for Law and Social Policy, July 1996. <http://www/clasp.org> or call 202-328-5140.

The Legal Action Center. Contact Gwen Rubinstein at 202-544-5478.

## Drug Testing as a Screening Tool

Drug testing of TANF recipients is a controversial issue, raising both legal and moral arguments. While there may be several reasons for drug testing, this discussion focuses only on its use as a screening tool to identify which clients should be referred to substance abuse treatment.

In this context, programs may want to consider how the characteristics of screening tools apply to drug testing (typically through urine samples). For example, programs should consider that while drug tests provide a great deal of information about specific drug use, they are not highly sensitive. Drug tests only detect recent drug use and do not typically detect alcohol use. Also, while drug tests take little time for the recipient, obtaining reliable results takes longer. Tests must be analyzed by licensed laboratories, and positive results should always be confirmed by a second, more accurate test. Other considerations include the complexity in administering drug tests and the costs of administration.

## Who Should Conduct the Screen

Screening can be conducted by a TANF case manager or a substance abuse clinician, either at the TANF office, a clinic, or treatment location. The decision on who should administer the screening instrument depends on the setting for screening and the complexity of the instrument and, therefore, on the level of training needed.

The decisions about which screening tool to use and who should administer the tool are related. If a TANF program can only use case managers to conduct screens, then it should select a tool and a setting appropriate for their level of training and comfort. If a program has greater flexibility on who can conduct the screen, it can consider a number of screening instruments and settings. For such programs, there are advantages to each approach.

A trained clinician will:

- Increase the screen's effectiveness as the first step in the treatment process through the clinician's ability to put clients at ease and to discuss issues and reactions that result from the screen.
- Free case managers from having to confront issues they may not be trained to handle.
- Save case managers time.
- Clarify the differences in the roles that case management and counseling staff play.

A case manager will:

- Probably save money.
- Make it simpler to incorporate screens into an existing intake process.
- Remove the conflict of interest that can occur if clinicians of local treatment providers conduct screens and make referrals to their own treatment programs.

### ProgramTip:

The Illinois Department of Human Services developed a training session entitled, "Assisting the Client—Putting the Assessment Pieces Together," to prepare nearly 3,000 workers to identify and screen TANF recipients for substance abuse problems and refer them to treatment as

Regardless of who administers the screen, it is critical that TANF case managers be trained on the basics of understanding substance abuse and observing signs of problems.

### How to Pay for Screening

While a number of resources can be tapped to cover screening costs, the most available source is likely federal or state TANF funds and Welfare-to-Work funds. Many states have additional TANF funds available for services, while other funding sources for substance abuse prevention and treatment are more limited. TANF and WtW funds can be used to pay for screenings done by the TANF program or for contracts with clinics or treatment providers to administer the screens.

### ASSESSMENT: THE FIRST STEP IN TREATMENT

Once a client is identified as having a potential substance abuse problem, the person should be referred for an in-depth assessment. Assessments, which evaluate clients and diagnose them for treatment, can be considered the first step in treatment. For this reason, while screening decisions must be initiated by TANF program administrators, most decisions involving assessments are made by substance abuse clinicians. For example, the assessment tool will be selected and administered by trained clinicians who are either contracted employees or on the TANF staff, or by off-site providers who have their own preferred instruments.

TANF administrators, however, may decide where assessments should be done—on-site by in-house or contracted clinical staff, or off-site at a treatment provider—and how to pay for them.

- **Where:** Many TANF programs are bringing trained clinical staff on-site to provide screening, assessments, and some counseling services. TANF programs that don't have such arrangements must develop internal systems for referring clients to local treatment providers for assessment.
- **Payment:** Typically, programs that have clinical staff on site cover payment arrangements through TANF funding, either federal or state MOE funds. While assessments are the first step in treatment, they do not necessarily constitute medical services and, if not, they may be paid for with federal TANF funds. State TANF MOE funds are not subject to the medical services restriction. The restriction on federal TANF funds for medical uses is discussed further in Section III under "Funding for Substance Abuse Treatment."

**Program Tip:**

In North Carolina, Qualified Substance Abuse Professionals are placed in every county Division of Social Services office. These positions are paid for by TANF block grant funds. Among their duties are conducting comprehensive assessments, including determining the level of care needed, referral to local treatment providers and follow-up.

## **SECTION III**

# Treating Substance Abuse

This section provides a foundation for understanding treatment and the implications for serving TANF clients with substance abuse problems. The section discusses the role of the TANF office in connecting clients with treatment as well as a number of treatment-related issues around treatment options, outcomes, expectations, and service delivery. The section also outlines the resources available for treatment. Specific understanding of the substance abuse treatment system in an area (e.g., access points and payment arrangements) can only be gained through close coordination with local treatment providers.

## **CONNECTING CLIENTS WITH TREATMENT**

Helping clients with substance abuse problems is a process that does not end with identification but continues through referral to and monitoring in treatment. The Legal Action Center recently found that while TANF programs are placing a greater emphasis on identifying recipients with substance abuse problems, the number of referrals to treatment programs they visited has not changed (1999).

Generally, TANF programs can refer recipients to local providers through:

- TANF case managers
- On-site clinical staff
- A managed-care “gatekeeper”

Programs should select the mechanism that works best with their staffing and treatment resources. If case managers provide the referrals, they must be fully informed and updated on all the options available to a client, and not simply rely on an informal list of programs that they are aware of. If on-site clinical staff perform this function, TANF administrators should address any potential conflicts of interest that may arise when contracted staff work for a particular treatment provider. If a managed-care organization is involved, a TANF staff member must ensure that the client contacts the organization in order to expedite treatment.

## **SUBSTANCE ABUSE TREATMENT OPTIONS**

There are three components to substance abuse treatment—services, settings, and therapeutic approaches.<sup>1</sup>

### **Program Tip:**

As part of Kentucky’s Targeted Assessment Project (TAP), assessment specialists placed in TANF offices are required to follow the clients through the system to make sure that services are provided.

- **Services:** What services are provided? Treatment services fall into seven main categories: assessment and diagnosis, detoxification, medication management, outpatient/ambulatory services, inpatient/residential services, counseling and case management, and aftercare.
- **Settings:** Where is the treatment delivered? Services can be delivered in a variety of settings, including hospitals, residential-care facilities, outpatient counseling centers, clinics or workplaces.
- **Therapeutic Approaches:** What approach to care is used? Approaches typically fall into three main categories: pharmacological treatment, psychological treatment, and social learning.

The combination of one item from each category constitutes a treatment modality. For example, a treatment modality might be outpatient care in a counseling center in combination with both psychological treatment, such as behavior modification, and social learning, such as a self-help group.

## TREATMENT OUTCOMES AND EXPECTATIONS

**Treatment of substance abuse takes time. Retention in treatment is critical, and success may not mean total abstinence from alcohol or drug use, particularly in the short term.**

Substance abuse is a chronic problem, not an acute one. One-time, short periods of treatment are not likely to result in abstinence. In fact, research indicates that people who remain in treatment longer have better results than those who participate in treatment only briefly (Kumpfer 1991). Studies suggest that the threshold for improved results ranges from three to six months of inpatient and outpatient treatment, respectively. Nonetheless, relapse is an experience that almost all recovering substance abusers experience at least once.

Retention in and compliance with treatment depends on a number of factors, including the individual, the treatment program, and the community and social environment. People with stable families, steady employment, and with other forms of social engagement have higher success rates than those who have fewer job opportunities, poor skills, and educational deficiencies, and who face other obstacles such as depression or difficult family or living situations.

The TANF program can support treatment by ensuring that program requirements do not put too much pressure on clients too early in their treatment. In addition, training of case managers on the cycles of use and abuse and the demands of treatment can lessen the discouragement and disillusionment case managers may feel when clients make slow progress in treatment or relapse, both of which are likely to occur.

**Substance abuse treatment is very individualized. No single treatment modality works for everyone, and individuals will have different degrees of success in different treatment approaches and settings.**

Relatively little is known about the effectiveness of different treatment modalities, and even less about treatment for pregnant women and mothers. There is a lack of research indicating that one treatment modal-

*“The single most important key to success is length of time in treatment.”*

—Children and Family Futures, and Drug Strategies, 1977, “Implementing Welfare Reform: Solutions to the Substance Abuse Problem.”

ity works best under certain circumstances and another under other circumstances. Given the differences in individuals' backgrounds, experiences and characteristics, it is difficult to predict what method will meet their needs, help keep them in treatment, and set them on a long-term path toward abstinence and improved life skills. However, assessment instruments can be used to match clients to their specific treatment needs as closely and effectively as possible.

**Treatment modalities vary in their intensity and whether they can be combined with work or work-related activities.**

Not every TANF client in need of substance abuse treatment will require the same degree of structure or intensity of services. Some clients will be able to balance treatment with other required TANF activities, while others will not. The demands of treatment will vary for each individual depending on the treatment's intensity. The Legal Action Center's recent report, "Steps to Success: Helping Women with Alcohol and Drug Problems Move from Welfare to Work" (see Appendix A), highlights a number of programs that have successfully integrated work and work preparation into their treatment approach.

## **SERVICE DELIVERY ISSUES**

**Women with children face unique barriers to treatment and need different treatment approaches than those developed for men.**

Research indicates that mothers of young children face several particular challenges that hinder their entry into substance abuse treatment. Among the most common barriers to treatment for women with children are:

- **Stigma:** Social norms and women's feelings of guilt and shame can produce a strong denial that a problem exists. This denial prevents women from seeking treatment and can strain interactions with healthcare or social service professionals who believe there is a problem.
- **Family Responsibilities:** Because women tend to be the primary caregivers for children, they are hesitant to enter treatment that cannot accommodate their children. In addition, other family members who rely on the woman may contribute to the denial that a problem exists.
- **Fears:** Women may distrust the social service system and may believe that if they seek treatment, they will face prosecution, or more frightening, may lose custody of their children during and possibly after their treatment.
- **Lack of Support:** Mothers with addictions are often poor, unemployed, without job skills, and isolated from social support systems. Participation in treatment requires some basic supports, such as child care, transportation and often housing.

Women generally turn to drugs or alcohol because of a traumatic event in their lives, such as physical or sexual abuse, or a significant disruption in their family life, such as the death of a loved one or a seri-

*“The availability of safe, alcohol- and drug-free affordable housing and childcare is an essential support for recovery.”*

—Center for Community Change, November 1999, “Tackling Substance Abuse.”

ous disability in the family. As a result, mental health issues often are connected with addictions in women, presenting another reason why women with children have special treatment needs. The suggested treatment components for women with children include:

- Nonconfrontational approaches
- Women-only groups
- Counseling for other issues
- Health screening, education, and prevention activities
- Involving family members
- Supportive services

TANF program staff can ease the entry into treatment by dispelling fears of “the system” and by creating a supportive environment. While the TANF program may have little influence over the approach and services that comprise treatment, the program can greatly assist by arranging for the supportive services that will help women obtain and remain in treatment.

**For more information on barriers to treatment for women and on recommended treatment components, refer to:**

Center for Substance Abuse Treatment. “Practical Approaches in the Treatment of Women Who Abuse Alcohol and Other Drugs.” Substance Abuse and Mental Health Services Administration. 1994. <http://www.health.org/catalog/index.htm> to order or call 1-800-729-6686.

Finkelstein, N. “Treatment Issues for Alcohol- and Drug-Dependent Pregnant and Parenting Women.” *Health & Social Work*, vol. 19, no. 1, February 1994.

Kumpfer, K. “Treatment Programs for Drug-Abusing Women.” *The Future of Children*, Spring 1991.

Nelson-Zlupko, L., Kauffman, E., and Morrison Dore, M. “Gender Differences in Drug Addiction and Treatment: Implications for Social Work Intervention with Substance-Abusing Women.” *Social Work*, vol. 40, no. 1, January 1995.

**Publicly funded treatment programs do not have the capacity to address the needs of all individuals with substance abuse problems, and there are shortages of programs for pregnant women and mothers in particular.**

The publicly funded treatment system is straining to address the needs of people who cannot pay for treatment. In 1994, about 3.6 million people had drug problems severe enough to warrant treatment (Woodward et al. 1997). Of these 3.6 million people, 1.7 million did not receive treatment. Approximately 1 million of the 1.7 million needed access to

publicly supported treatment. In addition to a general shortage in treatment capacity, programs specifically for women with children are particularly scarce.

TANF programs can consider providing supplemental funding to expand treatment services. Federal TANF funds can be used for up-front and counseling services to help keep individuals on a track toward treatment while they wait for an opening. Federal TANF funds can also help cover nonmedical costs associated with residential treatment to help such programs expand services. State TANF MOE funds can cover the costs of medical and nonmedical services (see the next section on funding).

### **Managed care can affect the choices of treatment programs that are available to clients as well as the level of treatment a client receives.**

Many Medicaid programs now require recipients to be enrolled in a managed care plan, which may restrict the type and amount of substance abuse services that are covered. The concern with managed care is that managed care organizations' strong emphasis on containing costs and offering financial incentives to providers to reduce specialty referrals, hospital admissions, and length of treatment may affect the quality and accessibility of services (NIMH 1999). In one study, managed care patients reported having substantially more trouble getting a knowledgeable provider, timely services, and admission to a hospital, and with knowing how to access treatment and services compared with those in fee-for-service arrangements (Hall and Beinecke 1998). However, other studies show that managed care may actually increase access to treatment or that there is no difference in the level of treatment compared to fee-for-service arrangements (Lurie et al. 1992; Mittler, Gold, and Lyons 1999). Overall, the research comparing patient outcomes and level of treatment in fee-for-service arrangements with managed care is mixed, and the results appear to be contingent more on the individual organization than the plan structure.

*As of July 1, 1998, 29 states had implemented or had received approval of waivers to run Medicaid managed care programs that cover substance abuse treatment (SAMHSA 1998).*

## **FUNDING FOR SUBSTANCE ABUSE TREATMENT**

Several federal and state funding sources cover medical and/or non-medical expenses for substance abuse treatment. Through creative thinking and strategic planning, state and local TANF administrators can use these funding streams to expand local treatment capacity and improve services to TANF recipients.

The most common federal funding sources include:

- **Substance Abuse Prevention and Treatment Block Grant:** This is the primary source of funding for public substance abuse treatment services. This capped block grant is funded at \$1.6 billion in Fiscal Year 2000 and is distributed by formula to each state's lead administering agency for substance abuse treatment and services. Block grant funds can be used for any project that supports prevention, treatment and rehabilitation among individuals with substance abuse problems. At least 20 percent of the funds must be used for substance abuse prevention services among those who do not have alcohol or drug problems.

*“Because mandatory and optional health care services under Medicaid do not explicitly mention substance abuse, many Medicaid programs do not offer extensive treatment services.”*

—Forum for State Health Policy Leadership, National Conference of State Legislatures, March 1999.

- **Targeted Capacity Expansion Program:** Additional grant funding to expand substance abuse treatment capacity is available by application through the Center for Substance Abuse Treatment (CSAT) of the Substance Abuse and Mental Health Services Administration (SAMHSA). This program is designed to address gaps in treatment capacity by supporting rapid and strategic responses to demands for substance abuse treatment services in communities with serious, emerging drug problems as well as communities with innovative solutions to unmet needs.
- **Medicaid:** The extent to which Medicaid covers substance abuse services varies significantly by state. Since Medicaid does not provide a specific benefit for substance abuse services, they are optional, leaving the range and level of services covered to the discretion of the states. However, all states are required to cover inpatient and outpatient hospital services (such as detoxification). States can also use Medicaid funds to pay for nonmedical services. Medicaid funds may not be used for inpatient treatment at an institution for mental disease (IMD) serving over 16 people between the ages of 22 and 64.

Other significant federal funding sources include TANF funds, Welfare-to-Work (WtW) funds and the Title XX Social Services Block Grant (SSBG). The main distinction among federal funding sources is whether they allow coverage for medical treatment. Although there is no specific definition of medical services in federal TANF rules, substance

**For more information on funding sources for substance abuse treatment, refer to:**

Administration for Children and Families. “Helping Families Achieve Self-Sufficiency: A Guide on Funding Services for Children and Families through the TANF Program.” U. S. Department of Health and Human Services, 1999. <http://www.dcf.dhhs.gov/programs/ofa>.

American Public Human Services Association (APHSA). “Federal Funding for Substance Abuse Treatment and Support Services: Sources and Uses.” January 1999. <http://www.aphsa.org/publicat/publicat.htm#books> to order, or call 202-682-0100.

Capitani, et al. “Understanding Funding Sources for Substance Abuse Treatment for Welfare Recipients.” Center for Substance Abuse Treatment (CSAT) Welfare Reform Technical Assistance Network. Caliber Associates. 1999. <http://www.calib.com/peerta/whatsnew/index.htm> or call 703-385-3200.

Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration. <http://www.ssamhsa.gov/csats> (see under “Grants”).

Johnson, P. “Substance Abuse Treatment Coverage in State Medicaid Programs.” Forum for State Health Policy Leadership. National Conference of State Legislatures. March 1999. Call 303-830-2200 to order a copy.

Legal Action Center. “Welfare Reform: How States Can Use TANF Funding to Pay for Alcohol and Drug Treatment.” September 1998. Call 202-544-5478 to receive a copy.

National Association of State Alcohol and Drug Abuse Directors. “State Resources and Services Related to Alcohol and Other Drug Problems, Fiscal Years 1996 and 1997: An Analysis of State Alcohol and Drug Abuse Profile (SADAP) Data.” November 1999. <http://www.nasadad.org/publica1.htm> to order or call 202-293-0090.

abuse treatment services that can be classified as “medical” are likely to include any service provided by a medical professional in a hospital or clinic. Some examples of medical services may include methadone maintenance, detoxification and inpatient or outpatient hospitalization. Services performed by anyone outside of the medical profession, such as a counselor, social worker or psychologist, may count as nonmedical services. Nonmedical substance abuse treatment services may include individual and group counseling, and case management and services that support treatment.

- **Federal TANF funds:** These funds can only be used for nonmedical services.
- **Welfare-to-Work (WtW) funds:** For clients participating in a job-readiness or work activity, WtW funds may cover non-medical substance abuse treatment if a recipient needs it to retain employment. However, WtW funds can be used for substance abuse treatment only if no other source is available. In addition, WtW funds must be used for recipients who have received TANF assistance for at least 30 months, are within 12 months of reaching their TANF time limit, or have exhausted their receipt of TANF due to time limits.<sup>2</sup>
- **Social Services Block Grant (SSBG or Title XX):** The SSBG can be used for non-medical substance abuse treatment services and initial detoxification of an alcoholic or drug-dependent individual. Funds cannot be used for medical services other than initial detoxification. Up to 10 percent of federal TANF funds can be transferred to the SSBG.

In addition to federal funds, state funds support the infrastructure for substance abuse treatment services. The lead agency that administers treatment services typically oversees any state funding. In fiscal year 1995, states provided nearly 40 percent of the total monies directed to treatment services (NASADAD 1997).

TANF programs also can use their TANF State Maintenance of Effort (MOE) funds to cover treatment. State MOE funds can be used for both medical and nonmedical substance abuse treatment services as long as they are not commingled with federal TANF funds. Expenditures on treatment services that are used to obtain federal Medicaid matching funds cannot be counted as MOE.

## NOTES

1. This discussion was adapted from “Implementing Welfare Reform: Solutions to the Substance Abuse Problem.” Drug Strategies. 1997.
2. WtW eligibility criteria changed with Title VIII of H.R. 3424 that contained the Welfare to Work and Child Support Amendments of 1999. WtW competitive grantees could begin using the new criteria as of January 1, 2000. Formula grantees began serving newly eligible individuals as of July 1, 2000, although federal formula funds were not expended for these purposes until October 1, 2000.

## SECTION IV

# Integrating Treatment into a Work-Focused Welfare Program

Combining substance abuse treatment into work-oriented TANF programs involves creating a policy and programmatic structure that facilitates the linking of the two, and working with the treatment community to set clear goals and responsibilities for treating recipients.

This section discusses the decisions that states and localities must make to accomplish this. The first section focuses on the policy and programmatic decisions that affect how easily treatment can be integrated into a larger welfare program. The second section focuses on issues to consider when coordinating with the treatment community.

## **POLICY AND PROGRAMMATIC DECISIONS**

### **Deciding Whether to Count Treatment as a Work Activity**

States and localities must determine whether substance abuse treatment will be considered part of a client's work requirement. Federal regulations limit which activities can count as work for participation rate purposes. Treatment can count as a work activity under the "job search and job readiness assistance" category, which is limited to four consecutive weeks and six weeks in total. As a result, most of the time that a client spends in treatment cannot help a state or locality meet federal work participation rates. But because few states are having difficulty meeting these general standards, states have room to define work activities more broadly to include treatment. Doing so brings both advantages and challenges.

#### *Advantages to Counting Treatment as a Work Activity*

The following are advantages to counting treatment as a work activity:

- **Clients can address their alcohol and drug problems while remaining accountable for some activity.** Individuals with serious alcohol and drug problems may not be ready to handle intensive work activities before or during treatment. Making treatment part of required activities allows these clients to seek help to lessen their barriers to employment and improve their well-being without diluting the message that assistance is contingent on increased personal responsibility.
- **Clients can participate in both treatment and work activities.** Many clients with substance abuse problems will not need to focus

*Currently, 29 states report that they count substance abuse treatment as a work activity, and another 31 provide some sort of deferral or exemption from work activities for clients with alcohol and drug problems.*

— Center on Addiction and Substance Abuse, 1999. "Building Bridges: States Respond to Substance Abuse and Welfare Reform."

solely on treatment but can combine treatment with job search or job readiness activities, or even work. Not having to exempt those clients from all work requirements allows case managers, treatment providers, and the clients to build a more balanced self-sufficiency plan.

- **Supportive services for treatment may be more readily obtained if treatment is considered a required activity.** In many TANF programs, receiving supportive services depends on a client's participation in work or in a work-related activity. If treatment does not count toward work requirements, it may be more difficult for clients to get the child care and transportation services they need to go to treatment.

#### *Challenges Involved in Counting Treatment as a Work Activity*

Counting treatment as a work activity poses the following challenges:

- **Case managers must monitor clients' attendance in and compliance with treatment.** When clients are exempt from work requirements to pursue treatment, case managers may feel less pressure to keep abreast of the clients' status. However, if clients are pursuing treatment as part of their self-sufficiency plan, case managers may be more specifically expected to track clients' progress and ensure that they keep up with their responsibilities, just as case managers do with clients in regular work activities.
- **Welfare reform has emphasized the importance of work, and some legislators and executives may not yet be ready to entertain a broader definition of work activity.** The welfare debate that led to PRWORA was clearly focused on work and as a result, the role of activities such as education and training was diminished in the final federal legislation. Similar legislative changes also occurred in many states. States that have made their programs work-oriented may be hesitant to officially expand the definition of work activity.

#### **Deciding Whether to Make Treatment Mandatory**

States and localities must decide whether to require recipients diagnosed with substance abuse problems to undergo treatment. Mandatory treatment would be enforced through sanctions. Sanctions could be used if a client fails to enroll in treatment, attend treatment sessions, or comply with treatment in other ways (e.g., failing a drug test used to monitor progress in treatment).

Some TANF administrators and staff may feel strongly that sanctions help make clients comply with treatment and set them on a course toward self-sufficiency. Many women with addictions are in denial, and mandatory treatment may help them begin recovery. However, forcing people into treatment before they are ready might not be effective, although some research on mandatory treatment in the criminal justice system indicates that it can be (Gostin 1991).

Other local offices may choose a different approach. Participation in treatment may not be required but strongly encouraged through man-

#### **Program Tip:**

Substance abuse clinicians in one district in Oregon developed a reference sheet for TANF case managers to use in understanding the time commitments that different treatment components demand. This sheet also gives general guidelines on when to require clients under treatment to work or participate in other activities.

dated work or work-related activities. Clients with significant substance abuse problems clearly need to address these problems so they can meet their TANF work obligations. But other clients will have more discretion, allowing them to work with case managers to determine the best activities for moving toward self-sufficiency. This approach gives clients freedom to address their substance abuse problem when they feel it is right for them, but it also carries the risk that the same clients will not necessarily seek treatment even if they need it. These clients may stumble several times in meeting work or work-related activities—and possibly face sanctions for noncompliance— before they pursue treatment.

### **Deciding Whether to Count Time in Treatment Toward the Benefit Time Limit**

Some states do not count the period spent in treatment toward the benefit time limit. Recovery from addiction is a slow process, and some recipients must address their substance abuse problems before they can adequately function in the working world. This policy allows them to stay in treatment longer if they need to and re-enroll if they relapse.

However, time in treatment does count toward the federal time limit. Therefore, states that exempt recipients from the time limit while they are in treatment must use state funds to pay for their benefits or count these recipients under the federal 20 percent exemption if they hit the 60-month federal time limit.

### **Deciding Which Supportive Services to Provide**

For recipients with alcohol problems, drug problems, and limited resources, participating in work activities and treatment can be a big hurdle to overcome. The day-to-day challenges of securing child care and transportation raise the bar even higher. Supportive services provided through the TANF program can ease these challenges. While treatment providers may offer some supportive services, funding is often extremely limited. TANF administrators and staff can work with providers to develop a package of services that will adequately support an individual on a path toward recovery and work. If TANF resources are also limited, local offices and case managers can look to community agencies and/or religious organizations for resources.

Three services—housing, child care and transportation—are essential to people with substance abuse problems, particularly women, and they should be addressed by the TANF program, providers, and community organizations, or some combination of the three.

- **Housing.** Safe, affordable housing in an alcohol- and drug-free environment is critical for recovering addicts. They may be less likely to relapse if they are removed from their former environments. For recipients dealing with domestic violence as well, safe housing away from an abusive partner is even more important.
- **Child Care.** Treatment programs that offer child care on-site or can cover child-care expenses are rare. Child care is essential for women in treatment and on welfare, who are often their children's primary caregiver and sole support.

- **Transportation.** Transportation that is both flexible and reliable will help clients, especially women, meet their treatment and work requirements.

## COORDINATING WELFARE AND SUBSTANCE ABUSE TREATMENT SERVICES

Combining work activities and treatment requires coordination between the welfare office and the treatment community. Welfare programs that have successfully integrated work-based programs and treatment have created unified service plans for their clients by working closely with treatment providers to coordinate responsibilities, structure programs, and train staff. This coordination allows the welfare office to benefit from the treatment community's expertise and helps align the goals of the welfare office and the treatment community.

There are several questions that program administrators and staff should ask when coordinating with the treatment community to develop a service plan for recipients:

- Are the goals of the welfare office congruent with the goals of the treatment community? Do staff in both systems understand the program strategy?
- Do TANF case managers and treatment professionals understand their roles and responsibilities? Do case managers understand the treatment system? Do treatment professionals understand the welfare system, and the work requirements and time limits faced by recipients?
- Will the screening, prevention, and treatment services be provided at the welfare office or by the treatment provider?

In coordinating the welfare and treatment systems, programs must decide how to build an effective relationship with the treatment community, how to train welfare and treatment staff, whether to place treatment staff in the welfare office, and how to address confidentiality issues.

### Cultivating an Effective Relationship with the Treatment Community

Open communication and good relations between the welfare office and the treatment community are among the most important components of creating an effective treatment program for welfare recipients. These qualities can be cultivated from the beginning, integrating the treatment community's expertise into the program planning and uniting what have traditionally been two separate systems. Here are ways to build an effective working relationship with the treatment community:

- **Creating a shared vision at the state level helps cultivate relationships between the welfare office and the local treatment community.** Collaboration between state welfare and treatment organizations will make it easier for local areas to coordinate services. If state-level coordination is not feasible, then state support of treatment initiatives is another way to help local areas.

#### Program Tip:

In Oregon, the Adult and Family Services Division encourages local-level collaboration and communication by establishing Community Partnership Teams. These teams, consisting of six people with community-organizing experience, provide technical assistance to localities that are building partnerships among different service systems.

- **The welfare office and the treatment community should understand each other's goals.** While the welfare office hopes to help a client find a job and become self-sufficient, treatment providers will be more focused on keeping clients off alcohol or drugs. The different goals may lead to different approaches in serving welfare recipients. But understanding each other's goals will help the welfare office and the treatment community coordinate their services so that their goals are pursued concurrently.
- **The responsibilities of the welfare office and the treatment community should be clearly defined.** Because both welfare and treatment staff will be working with the same client, the responsibilities of each staff person must be well-defined. If they are not, the result can be confusion, and conflict between welfare and treatment staff members who may want to pursue different strategies for a client.

### Training the Welfare and Treatment Staff

Cross-training treatment professionals and TANF case managers helps them understand their counterparts' processes and goals, and helps delineate each staff member's responsibilities. Case managers will gain insights about substance abuse and the barriers to work that clients, particularly women, with alcohol and drug problems face. Case managers also would learn how to identify a possible substance abuse problem. Treatment professionals will learn more about the TANF office's goals and what the program requires from recipients. Cross-training can also clarify the roles of case managers and treatment professionals, which will help their relationship run smoothly.

*Although cross-training is beneficial, only eight of 47 states responding to a survey use it to help integrate the two systems.*

—Center on Addiction and Substance Abuse, 1999

#### **For more information on approaches to training for TANF program staff, contact:**

Fred Munson or Shawn Clark, Office of Alcohol and Drug Abuse Programs, Oregon Department of Human Resources, 3414 Cherry Ave., N.E., Suite 100, Salem, OR 97303-4984. Phone: 503-373-1650, ext. 234. Fax: 503-373-7348. Email: f.munson@state.or.us and sclark@state.or.us.

Michael Lawler, Director, Center for Human Services, University of California, Davis, 1632 DaVinci Court, Davis, CA 95616. Phone: 530-757-8643. Fax: 530-754-5104. Email: mjlawler@ucdavis.edu. Web site: [www.humanservices.ucdavis.edu](http://www.humanservices.ucdavis.edu).

### Co-Locating Treatment Staff in the Welfare Office

Co-locating certified alcohol and drug professionals in the welfare office may be the most effective way to integrate treatment into a work-based welfare program. Having a treatment professional conduct substance abuse awareness classes, screening, and referrals at the welfare office a day or two a week can make the services more seamless. On-site treatment professionals also can be a resource for case managers. However, localities should carefully consider the benefits and drawbacks to

co-location before making a decision. The benefits of co-location include the following:

- **A more seamless service system that can help to facilitate communication between case managers and treatment providers.** If treatment professionals are located on site, clients can obtain assessment and prevention services at a single location. Case managers will also have more opportunity to coordinate their efforts with treatment professionals who are in the welfare office.
- **Treatment professionals who can serve as a resource for case managers when drug and alcohol issues surface among their clients.** This can help take pressure off case managers who may have little training in handling substance abuse problems. Case managers can refer to the treatment professionals if they suspect a substance abuse problem or if a client is in denial and refuses to address the problem.
- **A program that can be more focused on clients' substance abuse problems because of the presence of treatment professionals in the welfare office.** Those problems are less likely to remain unaddressed if treatment professionals are regularly in the welfare office.

In addition to these benefits, co-location also poses the following challenges:

- **It may create a conflict of interest.** If treatment professionals conduct prevention and screening services for the welfare office, they may be more likely to refer people to their organization rather than distributing clients evenly among treatment providers. Having case managers conduct the screening reduces this problem.
- **It is likely to cost more than having case managers conduct substance abuse screening and make referrals.** Localities may not want to pay for having treatment professionals on-site. Co-location

### Program Tip:

In Kentucky, officials believe that the presence of assessment specialists [in the welfare office] to conduct screening, assessment, referral, and follow-up services allows case managers to focus more fully on their case management responsibilities and will produce improved results in connecting clients to treatment programs.

—*Alcoholism and Drug Abuse Weekly*, May 2000.

### For more information on integrating treatment into a work-based welfare program, refer to:

“A Look at State Welfare Reform Efforts to Address Substance Abuse.” Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration. Forthcoming Fall 2000. Copies will be available through the National Clearinghouse for Alcohol and Drug Information, 1-800-729-6686.

“Building Bridges: States Respond to Substance Abuse and Welfare Reform.” Center on Addiction and Substance Abuse at Columbia University. Prepared with the American Public Human Service Association. August 1999. <http://www.aphsa.org/publicat/publicat.htm> or <http://www.casa.columbia.org/publications1456/publications.htm>.

“Integrating Alcohol and Drug Treatment into a Work-Oriented Welfare Program: Lessons from Oregon.” Mathematica Policy Research, 1999. <http://www.mathematica-mpr.com>.

“Steps to Success: Helping Women with Alcohol and Drug Problems Move from Welfare to Work.” Legal Action Center, 1999. To order, call 202-544-5478

also may not make sense for programs with small caseloads; there may not be enough clients to justify the cost.

### **Confidentiality Issues Related to Integrating Treatment into the Welfare Program**

Under federal confidentiality law (42 U.S.C. §290dd-2) and regulations (42 CFR Part 2), substance abuse treatment providers generally cannot provide information to the welfare office about a client's diagnosis, referral, treatment services, and attendance without the client's valid written consent.

Federal confidentiality law applies to the following (CSAT, 1999):

- **Information on a formal diagnosis or treatment services.** Treatment providers may not share any formal diagnosis of a substance abuse problem, referral to treatment, or treatment services without the client's written consent. This also applies to alcohol and drug professionals employed by the welfare office; in this case, information may not be shared with other welfare staff without written consent. Therefore, without a client's consent form, case managers cannot determine whether the person needs treatment.
- **Information on treatment program attendance.** Treatment providers also may not share information on a client's attendance without the person's written consent. Therefore, without a consent form, case managers cannot determine whether clients are meeting their treatment requirements.

Federal confidentiality law does not apply to the following (CSAT, 1999):

- **Information from a substance abuse screen.** Many welfare offices administer screens to determine if a client is at risk of having a substance abuse problem. Because screening tools are not diagnostic instruments, information from these screens is not covered under the federal confidentiality law and may be shared without written consent.

### **Creating a client consent form can effectively address confidentiality concerns.**

Treatment providers and the welfare office can work together to maintain the confidentiality of client information. They should develop a client consent form that lists the treatment and welfare program staff involved in a client's case planning and specifies what information the programs will share.

According to federal regulations (42 CFR §2.31), a consent form must contain the following (CSAT, 1999):

- Name of the program disclosing the information
- Name of the individual(s) receiving the information
- Name of the patient
- Purpose of the disclosure

- What information will be disclosed
- Date, event and condition of expiration
- Date and the patient's signature
- A statement that the patient can revoke consent at any time.

A sample form created and used by the Oregon Department of Human Resources appears in Appendix B.

**For more information on confidentiality, refer to:**

“Welfare Reform and Substance Abuse Treatment Confidentiality: General Guidance for Reconciling Need to Know and Privacy.” Center for Substance Abuse Treatment, SAMHSA. November 1999. To order a free copy, contact the National Clearinghouse for Alcohol and Drug Information (NCADI) at 1-800-729-6686.

“Yellow Pages: Handbook for Confidentiality in Social Service Collaborations.” Oregon Department of Human Resources. October 1998. <http://www.hr.state.or.us/news/pubsgeneral.html>.

The Legal Action Center provides regional or on-site training, or telephone technical assistance on the confidentiality law at no cost to states. This training, provided through a contract with the Center for Substance Abuse Treatment (CSAT), must be requested through a State Technical Assistance and Training Request Form signed by the state substance abuse agency director. To obtain this form, contact Gayle Saunders at CSAT at 301-443-0318, or go to <http://www.treatment.org>, under the Treatment Improvement Exchange Program.

## **APPENDIX A**

# Resources

### **SOURCES FOR PROGRAM TIPS AND HIGHLIGHTS**

The program examples throughout this report are adapted from the following three publications:

*“Building Bridges: States Respond to Substance Abuse and Welfare Reform.”* The National Center on Addiction and Substance Abuse at Columbia University and the American Public Human Services Association. 1999.

This report presents findings from a two-year substance-abuse and welfare-reform survey conducted in 50 states and the District of Columbia. Key government officials in 12 states were interviewed, and five comprehensive state case studies with front-line workers and administrators were done. The study discusses what works and what does not in states’ efforts to address substance-abuse problems under the new TANF requirements. Copies are available on-line at <http://www.casacolumbia.org/publications1456/publications.htm>

*“Integrating Alcohol and Drug Treatment into a Work-Oriented Welfare Program: Lessons from Oregon.”* Mathematica Policy Research. 1999.

Oregon has developed an innovative approach to integrating treatment into its work-focused welfare program. This report presents key decisions, challenges, and lessons from Oregon’s experience. Copies are available on-line at [www.mathematica-mpr.com](http://www.mathematica-mpr.com), or by calling 202-484-9220.

*“Steps to Success: Helping Women with Alcohol and Drug Problems Move from Welfare to Work.”* Legal Action Center. 1999.

This publication profiles 20 model treatment programs in California, Florida, Illinois, Maine, Maryland, New York, and Ohio that use an array of treatment, health, social, educational, and employment training services to help women on welfare with substance-abuse problems, and their families. Copies are available by calling 202-544-5478.

### **OTHER PUBLICATIONS**

*“A Look at State Welfare Reform Efforts to Address Substance Abuse.”*

Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration. Forthcoming Fall 2000.

This case study report describes efforts in the states of Colorado, Delaware, Kansas, New Jersey, North Carolina, Ohio, Oregon, and Utah to address substance abuse as part of welfare reform. Copies will be available through the National Clearinghouse for Alcohol and Drug Information, 1-800-729-6686.

*“Alcohol and Other Drug Treatment: Policy Choices in Welfare Reform.”* Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment and the National Association of State Alcohol and Drug Abuse Directors, Inc. 1996.

This report presents findings from several studies on the incidence of substance abuse among the welfare population, clients’ use of treatment services, and the results of treatment as determined by state-based studies. It concludes with an examination of the issues from a policy perspective and potential approaches to recipients’ substance-abuse problems. Copies can be ordered on-line at <http://www.nasadad.org/publica1.htm>, or by calling 202-293-0090.

*“Ancillary Services to Support Welfare to Work.”* Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services. July 1998.

This publication offers background information, research findings, and innovative approaches to employment barriers including substance abuse, mental-health issues, special child-care needs, and inadequate transportation. Each section explains an employment barrier, describes the need for services based on research reports, presents a framework for addressing the barrier, and provides examples of program models. Copies are available on-line at <http://aspe.hhs.gov/hsp/hspwelfare.htm>

*“A Field Guide to CASAWORKS for Families: A Treatment and Training Program for Substance-Abusing Women on Welfare and Their Families.”* Volumes I (Policy and Planning) and Volume II (Service Delivery). The National Center on Addiction and Substance Abuse at Columbia University. 1998.

In January 1999, the center launched CASAWORKS for Families, a three-year demonstration project to help welfare mothers who are addicts achieve self-sufficiency. In a single concentrated course, CASAWORKS combines treatment, literacy and job training, parenting and social skills, violence prevention, health care, family services, and a gradual move to work. The program is being tested at 11 sites in nine states, including New York and California, and will serve more than 1,100 women and their children. The field guides are being used in the pilot sites but can help other locations in their planning. Copies are available by calling 212-841-5200.

*“Identifying Substance Abuse Among TANF Eligible Families.”* Technical Assistance Publication (TAP). Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration. Forthcoming Fall 2000.

This publication in SAMSHA's TAP series presents guidance in three areas: (1) instruments and identifiers to use in identifying substance abuse, (2) outreach and marketing methods to engage clients with substance abuse problems, and (3) organizational cultures that can make systems more responsive to client needs. Copies will be available through the National Clearinghouse for Alcohol and Drug Information, 1-800-729-6686.

*“Practical Approaches in the Treatment of Women Who Abuse Alcohol and Other Drugs.”* Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration. 1994.

Designed for health care administrators and professionals, treatment practitioners, and other social service providers, this manual offers guidelines for more effectively using existing resources for programs that address women's specific needs. Copies are available by calling the National Clearinghouse for Alcohol and Drug Information at 1-800-729-6686.

## **ORGANIZATIONS WITH INFORMATION ON SUBSTANCE ABUSE TREATMENT AND WELFARE REFORM**

### **American Public Human Services Association**

810 First Street, N.E.  
Suite 500  
Washington, DC 20002-4267  
202-682-0100  
[www.aphsa.org](http://www.aphsa.org)

### **Center for Best Practices, National Governors' Association**

Hall of States  
444 North Capitol Street  
Washington, DC 20001-1512  
202-624-5300  
[www.nga.org](http://www.nga.org)

### **The Center for Law and Social Policy**

1616 P Street, N.W.  
Suite 150  
Washington, DC 20036  
202-328-5140  
[www.clasp.org](http://www.clasp.org)

### **Center for Substance Abuse Prevention Substance Abuse and Mental Health Services Administration**

301-443-0365  
[www.samhsa.gov/csap/index.htm](http://www.samhsa.gov/csap/index.htm)

**Center for Substance Abuse Treatment  
Substance Abuse and Mental Health Services Administration**  
301-443-5700

*www.samhsa.gov/csat/csat.htm*

Refer to: CSAT Treatment Improvement Protocols (TIPs) at *www.treatment.org/Externals/tips.html*. These publications provide “best practices” treatment guidelines.

CSAT Technical Assistance Publications (TAPs) at *www.treatment.org/TAPS/*. These publications, manuals, and guides offer practical responses to emerging issues in the treatment field.

**The Legal Action Center**

236 Massachusetts Avenue, N.E.

Suite 505

Washington, DC 20002

202-544-5478

*http://www.lac.org*

or

153 Waverly Place

New York, NY 10014

1-800-223-4044

Various resources including:

“Key Provisions of TANF Final Rule Affecting Welfare Recipients with Alcohol and Drug Problems.” (May 27, 1999)

“Effects of Welfare Reform on Women with Drug and Alcohol Problems.” (September 18, 1996)

“Welfare Reform: Implementing Drug Felony Conviction Provisions.” (December 6, 1996)

**National Association of State Alcohol and Drug Abuse Directors**

808 17<sup>th</sup> Street, N.W.

Suite 410

Washington, DC 20006

202-293-0090

*www.nasadad.org*

**The National Center on Addiction and Substance Abuse (CASA) at  
Columbia University**

19<sup>th</sup> Floor

633 Third Avenue

New York, NY 10019-6706

212-841-5200

*www.casacolumbia.org*

**National Clearinghouse for Alcohol and Drug Information**

1-800-729-6686

[www.health.org](http://www.health.org)

Refer to the web site's "Women" category for specific information on treatment for women: [www.health.org/pubs/catalog/women.htm](http://www.health.org/pubs/catalog/women.htm).

**National Evaluation Data Services (NEDS), Caliber Associates**

10530 Rosehaven Street

Suite 400

Fairfax, VA 22030

703-385-3200

[neds.calib.com/products/index.cfm](http://neds.calib.com/products/index.cfm)

Scientific analyses of treatment topics

**Office of the Assistant Secretary for Planning and Evaluation  
U.S. Department of Health and Human Services**

Refer to the "Human Services Policy" category on web site:

[aspe.hhs.gov/hsp/hspwelfare.htm](http://aspe.hhs.gov/hsp/hspwelfare.htm)

**Welfare Information Network (WIN)**

1000 Vermont Avenue, N.W.

Suite 600

Washington, DC 20005

202-628-5790

Various resources including:

*Issue Notes*: "Substance Abuse and Welfare Reform Policy." January 1997.

"The Hard-to-Place: Understanding the Population and Strategies to Serve Them." March 1998.

*Resources for Welfare Decisions*: "Addressing Substance Abuse and Mental Health Barriers to Employment." November 1999.

*General*: WIN web site's "Hard-to-Place" category. Provides links to many of the publications noted in this report.

[www.welfareinfo.org/hard.htm](http://www.welfareinfo.org/hard.htm)

**APPENDIX B**

# 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)

Section B	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)

Section C	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	Date
	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 DHRS1100 (page 1 (Rev. 10/98))

## Appendix B (continued)

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.

OHF 2100 page 2 (Rev. 10/98)