

Issue Brief



Employment and Social Services Policy Studies
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Addressing Substance Abuse and Mental Health Problems under Welfare Reform: State Issues and Strategies

Background

Since the passage of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, states have dramatically reduced cash assistance caseloads and have placed substantial numbers of former welfare recipients into jobs. However, states still face challenges as they continue to implement welfare reform, including helping individuals with substance abuse and mental health problems successfully make the transition to work.

National figures on the prevalence of employment barriers among welfare recipients and low-income families are limited, though a majority of studies estimate that up to a third of current welfare recipients are substance abusers or have mental illnesses.¹ Studies of individuals with substance abuse and mental health problems found that more than half had “co-occurring disorders,” or two or more disorders at once (e.g., substance abuse and two mental health disorders).² Research also indicates that long-term welfare recipients are more likely than other recipients to display physical signs of problem drinking or report that they are depressed three to five days a week.³ Individual state estimates are even higher. A 1998 Oregon survey showed 50 percent of the state’s remaining Temporary Assistance for Needy Families (TANF) cases reported substance abuse problems and 75 percent reported slight to severe mental health conditions (e.g., post-traumatic stress disorder, severe anxiety, or depression). Addressing the needs of individuals with both problems is complicated, because the systems and funding streams for substance abuse and mental health are typically separate. (More information on co-occurring disorders can be found in *Understanding Health-Status Barriers that Hinder the Transition from Welfare to Work*, Sarah Callahan, NGA Center for Best Practices, 1999, at http://www.nga.org/center/divisions/1,1188,C_ISSUE_BRIEF^D_2402,00.html.)

Welfare reform’s time limits, work requirements, and sanction policies make finding solutions to substance abuse and mental health problems an urgent state need. This *Issue Brief* describes some of the strategies, programs, and policies that states can adopt, or are adopting, to help welfare recipients with substance abuse or mental health problems, such as:

- identifying individuals who have substance abuse or mental health problems by training caseworkers and co-locating trained specialists;

- helping individuals enter and follow through with treatment by improving access, monitoring participation, and providing wraparound support services;
- coordinating employment, substance abuse services, and mental health services that are supported with different funding streams, and building service delivery capacity; and
- determining appropriate combinations of work activities and treatment.

State Flexibility in Addressing Substance Abuse and Mental Health Barriers under Welfare Reform

States and localities have a variety of funding sources to provide treatment to individuals—including welfare recipients—with substance abuse and mental health problems including the state and local general funds, Medicaid, federally funded Substance Abuse Prevention and Treatment Block Grant and the Community Mental Health Services Block Grant. States may use also TANF, state maintenance of effort (MOE) monies under TANF, and Welfare-to-Work (WtW) funds to help welfare recipients overcome substance abuse and mental health barriers to employment. With the decline in welfare caseloads, some states have used funds previously spent on cash assistance to increase the capacity of the substance abuse and mental health systems to provide services to welfare recipients.

TANF and Maintenance of Effort (MOE) Funds

Final TANF regulations and other written guidance from the U.S. Department of Health and Human Services (HHS) indicate that federal TANF dollars may be used to fund a variety of *non-medical* services, supports, and employment-related activities for families with substance abuse and mental health problems.⁴ State MOE funds may be used for both *medical* and *non-medical* services and treatment. The HHS guidance provides a list, though by no means an exhaustive one, of allowable expenditures and explicitly encourages state creativity in developing TANF-funded services for this population. HHS guidelines include:

- using federal TANF or state MOE funds to provide *non-medical* substance abuse and mental health services, such as room and board costs at residential treatment programs, counseling, and peer support group services;
- using state MOE funds that have not been commingled with federal TANF funds to pay for *medical* services (i.e., treatment not covered by Medicaid) or to provide medical coverage for families that lack medical benefits.⁵

Other services and activities eligible for TANF and MOE funds include screening and assessment; client monitoring and case management; staff training; support services; and interagency coordination efforts. TANF and MOE funds can expand the capacity of the typically underfunded substance abuse and mental health systems to serve welfare recipients.

Welfare-to-Work (WtW) Grants

The WtW program, funded by the U.S. Department of Labor, provides both discretionary and formula grant monies to states to provide primarily postemployment services for hard-to-serve welfare recipients. TANF recipients are eligible for WtW-funded services if they have received

assistance for at least 30 months, if they are within 12 months of reaching their TANF time limit, or if they have exhausted their receipt of TANF due to time limits. TANF recipients with significant barriers to self-sufficiency (under criteria established by the Private Industry Council), individuals ages 18 to 25 who have “aged out” of foster care, and custodial parents with incomes below the poverty line are also eligible for WtW services. Seventeen WtW competitive grantee programs serve individuals with substance abuse problems, and several others involve the state or local mental health agency to address behavioral health barriers. (For more information and program descriptions, see <http://www.doleta.gov>.) Noncustodial parents are also a focus of WtW spending in several states and receive substance abuse treatment and other pre-and post-employment services to help them stabilize their employment situations.

Key State Challenges to Serving Low-income Individuals with Substance Abuse and Mental Health Barriers

Identifying Individuals with Substance Abuse and Mental Health Barriers

Accurately identifying individuals with substance abuse and mental health problems is difficult. Several states participating in an informal 1999 survey about the success rates of their screening tools experienced much lower levels of client disclosure than they had anticipated. States may experience low identification rates due to several factors.

- Recipients may believe that disclosure will result in losing their children to the child welfare system, their housing and other benefits, or their jobs.
- Caseworkers may not have received adequate training in detecting an individual’s substance abuse or mental health problem.
- Clients may deny the problem.
- Clients may lack awareness of available benefits and services, especially among those who were sanctioned off or diverted from TANF or who had their cases closed.

Most states have taken steps to identify low-income individuals who may have substance abuse and mental health problems and refer them to services. Initial screening is typically done through a written questionnaire; interview with a caseworker or substance abuse or mental health specialist; or combination of questionnaire and interview. Following an initial screen, some states refer clients to substance abuse or mental health specialists, who conduct a more rigorous and in-depth assessment using a battery of tests to determine the severity of the problem and appropriate services. As of early 2000, all states reported that they conduct client “assessments” (no distinction made between screening and more in-depth assessment) for substance abuse, and all but three said they do so for mental health problems.⁶

However, states continue to grapple with what constitutes an effective identification and referral process, who should conduct the screening and assessments and when they should occur. State practices vary widely. For example, states report using staff outside of the TANF agency (e.g., certified substance abuse or mental health counselors, domestic violence specialists, child welfare workers) to screen for substance abuse and mental health problems as often as they report using TANF caseworkers to conduct the screening. Nearly half (43 percent) of all states conduct

structured client interviews, and 16 percent of states administer forms and tools that must be completed independently by the client.⁷ While the trend is to conduct a formal client screen, some studies show that clients are actually less likely to disclose serious employment barriers in a government office than they would be in a less threatening environment.

Concerns about the reliability of caseworker screening and screening tools, and the correlation between substance abuse and child abuse and neglect led Michigan to enact mandatory drug-testing for every person applying for assistance. Under the state's proposal, individuals identified through the testing would receive treatment and supportive services such as transportation to get to treatment. Treatment would be available on a flexible basis to accommodate the schedules of those who are working. However, shortly after the pilot sites began, the state was sued by the American Civil Liberties Union and the court enjoined the state from conducting further mandatory testing.

States may want to consider some of the following strategies as they develop screening, assessment, and referral processes.

- **Use trained specialists to conduct assessments and develop treatment plans.** States tend to experience higher rates of identification if they follow an initial screen by a caseworker with an in-depth assessment by staff from the state Alcohol and Other Drug (AOD), or other agency, who are professionals in substance abuse and mental health issues. States that locate expert staff in TANF offices, other human services agencies, and one-stop career centers can quickly link individuals with substance abuse and mental health experts. This may reduce the lag time that often occurs between screening, assessment, and referral—a period when individuals are more likely to drop out of the process and forgo treatment and other services. The Kentucky Cabinet for Children and Families contracts with the University of Kentucky Women's Center to hire and supervise professionals with multidisciplinary expertise in substance abuse, mental health, domestic violence, and learning disabilities to conduct assessments and case management. (Contact: Sharon Perry, 502/564-3866.)

NORTH CAROLINA'S QUALIFIED SUBSTANCE ABUSE PROFESSIONALS

To address substance abuse-related barriers to work among TANF recipients, the North Carolina Department of Social Services (DSS), which administers the Work First program, established a working partnership with the Division of Mental Health, Developmental Disabilities and Substance Abuse (MH/DD/SA). While DSS was responsible for screening Work First clients for substance abuse problems, the Substance Abuse Services Section (SAS) of MH/DD/SA was given responsibility under a memorandum of agreement (MOA) to provide substance abuse assessment, referral, care coordination and treatment services for the Work First population. The state also required all county DSS offices to establish similar memorandums of agreement with all 39 Area MH/DD/SAS authorities.

Under the DSS-SAS partnership, screening is usually done at the county DSS office by a TANF caseworker but may also be completed by a Qualified Substance Abuse Professional (QSAP). Clients may then be referred to a QSAP for an assessment and, if necessary, referral for treatment. The QSAP may be located in a county DSS office or at one of the 39 local-area SAS authorities. The area SAS authorities are required to provide or coordinate substance abuse services for the Work First population, or to establish contracts with local treatment providers to do so. Throughout this process—assessment, referral, and treatment—the QSAP serves as the care coordinator and continues to work with the

- **Train TANF caseworkers and supervisors.** Even if specialists are located on site to conduct in-depth assessments, states may want to train TANF caseworkers and supervisors on general substance abuse and mental health issues and/or how to conduct an initial screen. Illinois uses co-located substance abuse clinicians to train local TANF staff to make referrals

for in-depth assessments. The training helps them understand addiction and relapse issues, recognize signs of substance abuse, and promote client confidentiality. (Contact: Teresa Tudor, 217/786-0115.) States may also want to train staff on co-occurring disorders, because the combination of substance abuse and mental health problems poses special challenges.

- **Develop aggressive outreach initiatives and opportunities for identification at other entry points.** Some individuals with substance abuse or mental health problems are leaving welfare for work, being diverted from cash assistance, or avoiding welfare offices altogether. Individuals who need but do not receive services are at greater risk of using homeless and domestic violence shelters, becoming involved with the criminal justice system, and relying services from other community and faith-based organizations. These trends, combined with the low disclosure rates experienced by welfare offices, build a strong case for conducting outreach strategies to link families with treatment.

Some strategies include providing opportunities for disclosure at other community “entry points”; making home visits to at-risk families; launching hotlines for client inquiries or emergencies; and using peer counselors, recovery coaches, and other staff to engage clients and motivate them to stick with treatment. The Street Outreach program in Oklahoma City, Oklahoma, uses former substance abusers with ties to their communities to recruit individuals with drug abuse problems into treatment. (Contact: Rick Cartwright, 405/232-0199.)

- **Take timing into consideration.** Substance abuse and mental health problems are sensitive in nature, and individuals with such barriers are more apt to disclose them to people with whom they feel comfortable. In addition to an initial screen at application, states may want to train staff who will work with clients at other points during the welfare-to-work process (e.g., job readiness coaches, adult basic education instructors, case managers) to identify substance abuse and mental health problems and refer clients to appropriate assessment services.
- **Investigate sanctioned cases.** Research indicates that welfare recipients who are sanctioned have more serious employment barriers, such as substance abuse or mental health problems, than other recipients.⁸ Kansas, New Jersey, and Utah are among the states that contact individuals who are not complying with TANF requirements, prior to sanctioning them, to discuss reasons for noncompliance and offer options for meeting the work requirement and engaging in treatment, if required. States may also want to pay special attention to welfare “cyclers,” who get jobs but are unable to keep them. Cycling is often an indication of problems such as substance abuse and mental illness. (Contacts: Kansas–Sandra Hazlett, 785/296-6750; New Jersey–Annette Riordan, 609/292-9686; Utah–Mary McConaughy, 801/468-0244.)

Helping Individuals Enter and Follow Through with Treatment Successfully

Once recipients with substance abuse or mental health barriers are identified, states face the further challenges of referring individuals to appropriate treatment and services and motivating them to complete the treatment regimen successfully. Besides the client fears described earlier, some individuals may fail to enter or complete treatment because of domestic violence; lack of transportation or child care; difficulties balancing employment, treatment, and family obligations

(which will be addressed in the following section); a general disinterest in engaging in treatment or complying with program requirements; and other reasons. Case managers (whether TANF caseworkers, specialists, or agency liaisons) can coordinate a streamlined treatment, aftercare, and discharge plan for individuals among multiple providers. Some other ways states can encourage individuals to follow through with treatment include the following.

Types of Substance Abuse and Mental Health Screening Tools

Substance Abuse⁹

States are using a variety of screening instruments to detect client substance abuse problems. Often caseworkers administer pen and paper screening instruments as part of an overall interview designed to create a profile of a recipient's problem. Most questionnaires take between 1 and 15 minutes to complete. Some of the most common tools include:

- **CAGE Questionnaire.** The CAGE is a 4-item questionnaire designed to screen for alcoholism. "CAGE" is an acronym for four questions pertaining to lifetime drinking behaviors. It can easily be adapted to screen for the use of illicit drugs as well.¹⁰
- **Substance Abuse Subtle Screening Inventory (SASSI).** The SASSI is a 78-item questionnaire designed to detect potential chemical dependency. It has eight subscales that can be used to detect defensiveness and other chemical dependency characteristics.
- **Michigan Alcoholism Screening Test (MAST).** The MAST is a 25-item questionnaire designed to quickly screen for lifetime alcohol-related problems and alcoholism. Shorter versions of the MAST are also available.
- **Alcohol Use Disorders Identification Test (AUDIT).** The AUDIT is a 10-item questionnaire designed to identify individuals whose alcohol use has become hazardous to their health. Three subscales assess amount and frequency of drinking, alcohol dependence, and problems caused by alcohol.

Mental Health¹¹

Many mental health screening and assessment tools are lengthy and must be administered by a trained mental health professional. Some tools that offer shorter versions and may not require extensive training include:

- **Beck Depression Inventory–Second Edition (BDI-II).** This is a 21-item self-report instrument for measuring the severity of depression. It assesses symptoms corresponding to criteria listed in the Diagnostic and Statistical Manual of Mental Disorders, 4th Edition (DSM-IV), the diagnostic tool used most often by mental health professionals.
- **HANDS Screening Tool.** This is a confidential 10-question screening test for depression that is available online at <http://www.depression-screening.org/>. Sponsored by the National Mental Health Association, it can be completed online or downloaded free of charge but cannot be distributed without permission.
- **Mini International Neuropsychiatric Interview (M.I.N.I.).** This is a shortened psychiatric interview based on the DSM-IV. It can be used by trained interviewers who are not mental health professionals.
- **SF-36 Health Survey.** This is a general health survey that includes a 5-item mental health scale. The tool not only identifies symptoms of mental health disorders, but also examines a client's ability to function in certain social roles.

- **Reduce wait times between screening, assessment, and referral.** Individuals with substance abuse or mental health problems often drop out of the treatment process if too much time elapses between their initial screen and followup steps toward treatment. States may want to establish time-saving protocols for scheduling in-depth assessments for clients who screen positive for potential substance abuse or mental health problems. Similar steps can be taken between the assessment and referral to treatment and other services. In Marion County, Indiana, the Divisions of Family and Children and Mental Health collaborate to provide a mental health therapist on site at two of the county's welfare offices. The therapist conducts assessments and individualized service planning, which minimizes wait times for recipients. (Contact: Matt Raibley, 317/232-2002.)
- **Monitor client's participation in treatment.** States can help individuals stay on the path to recovery by tracking their attendance in treatment activities and, if they are not attending, finding solutions to causes underlying their absence. For example, Wichita, Kansas, designates an AOD liaison to maintain contact with its regional alcohol and drug assessment centers and obtain reports on client follow-through with referral and treatment participation. The liaison reports the information to the TANF agency, and appropriate action is taken to ensure treatment compliance.¹² (Contact: Sandra Hazlett, 785/296-6750.)
- **Use peers to extol benefits of treatment.** Peers who successfully complete treatment can be used to encourage other clients to do the same. Former abusers or those with mental health conditions can assist in orientation and support activities by sharing experiences and offering advice. Tennessee's Sisters Program uses former substance abusers in a public-relations and support-group role for individuals living in public housing. In addition to peers, states can make personal connections by engaging other role models, such as church and community leaders. (Contact: Bettie Teasley, 615/313-6619.)
- **Ensure the availability of wraparound support services.** Individuals may not know the extent of their needs until they begin the treatment and recovery process. Therefore, states may want to ensure that individuals are able to secure necessary services at points other than initial intake. In addition to child care and transportation, health care coverage is particularly critical for this population. West Virginia, for example, requires its community behavioral health centers receiving Substance Abuse Prevention and Treatment block grant funds to provide child care for individuals in treatment. It also funds the centers to purchase vans to transport substance abusers to outpatient treatment appointments. (Contact: Mark Blankenship, 304/558-3877.)
- **Offer incentives and rewards.** Recognizing success and looking ahead to achieving next steps can help maintain momentum and motivation. Some states host awards banquets and post client pictures and accomplishments in offices and newsletters as inspiration for other individuals. States could also offer financial incentives or gift certificates to individuals who attend treatment regularly or achieve other welfare-to-work milestones.
- **Use the sanctioning process to identify clients needing additional services.** The welfare law allows states to sanction, deny benefits, to adults who do not comply with the work-participation and other requirements of the TANF program. This could include

noncompliance with a work activity or a treatment program if it is included as part of an individual's employment plan under TANF. States can use the sanction process as a way to identify barriers and help the individual address them before a sanction is actually imposed. Many states send violators "intent to sanction" notices as warning or undertake conciliation processes, allowing them to work intensely with families prior to sanctioning.¹³

- **Expand slots in residential treatment programs that allow children to remain with parents.** Research indicates that individuals needing residential substance abuse treatment are more likely to successfully complete the program if they are able to maintain regular contact with and the ability to care for their children. California's Center Point Women and Children's Program provides residential substance abuse treatment to 40 women and children at one time, and the average client does not have to wait for a treatment slot to open. Services are available for up to 12 months. The program is funded with the Substance Abuse and Mental Health Services Administration (SAMHSA) Pregnant and Postpartum Women and Children's program funds (65 percent) and match money raised by the program from foundations and state or local sources (35 percent). (Contact: Sushma Taylor, 415/459-2395.)

Types of Substance Abuse Treatment Programs¹⁴

- **Outpatient drug-free programs.** Offer individual and group counseling as well as an array of ancillary services.
- **Long-term residential programs.** Provide 6 months to 12 months of care and typically treat substance abusers with long histories of drug abuse, serious criminal involvement, or impaired social functioning.
- **Short-term residential programs.** Typically involve a 3-week to 6-week inpatient program followed by intensive outpatient therapy.
- **12-Step programs and methadone maintenance.** Many substance abuse treatment programs work with 12-Step programs, such as Alcoholics Anonymous (AA), during and after treatment. Methadone maintenance programs are targeted toward opiate users and offer medication to block the effects of opiate use and physical cravings for the drug.

Types of Mental Health Treatment Programs¹⁵

- **Partial hospitalization programs (PHPs).** Offer many of the intensive mental health services offered by institutional settings. Services typically include psychotherapy and medication management. Clients may attend a PHP anywhere from three hours to six hours a day, and up to five days a week.
- **Outpatient treatment.** Includes services such as individual or group therapy, marriage and couples counseling, family counseling, and medication management. The length of time a client receives outpatient care varies by treatment need and ability to cover costs of services.
- **Ancillary services.** Include nontherapeutic interventions, such as support groups that are facilitated by participants rather than a licensed clinician.

Determining Appropriate Combinations of Work Activities and Treatment

Individuals with substance abuse or mental health problems often have lower levels of education, less work experience, or both, than those without such problems. Individuals with less than a high school diploma are almost twice as likely as college graduates to report the use of illicit drugs.¹⁶

Another study found those diagnosed with major depression were 40 percent more likely to receive cash assistance than those without these symptoms.¹⁷ The extent to which substance abuse and mental health problems actually *cause* individuals to have lower levels of education and work experience is not clear. Nevertheless, determining what types of work activities are most appropriate for individuals with these barriers, whether or not to exempt them from work requirements or time limits, and how to effectively meet their treatment needs while they participate in work activities, are all issues states will need to address. Some treatment and work strategies that may be particularly effective for this population include the following.

- **Engage individuals in supported employment, part-time jobs, or other work experience.** Supported employment provides individuals with paid work experience, job development, and job search assistance in an intensely supervised environment. South Dakota's Department of Labor and the Humane Society of the Black Hills created a managed worksite offering training in keyboarding, cashiering concepts, customer service skills, basic auto maintenance, and life skills to low-skilled TANF recipients with multiple barriers as they transition to unsubsidized employment. (Contact: Bob Shaff, 605/773-2101.) Part-time employment, community service, and subsidized employment also count toward the federal TANF work-participation rate and may be more appropriate than other work activities for individuals who are less work-ready. States can design work schedules to accommodate participants' treatment needs.

SHIELDS FOR FAMILIES, INC.

(A CASAWORKS DEMONSTRATION SITE IN LOS ANGELES, CALIFORNIA)

CASAWORKS, administered by Columbia University's National Center on Addiction and Substance Abuse (CASA), oversees demonstration sites in 20 states that develop local programs for poor mothers who are long-term public assistance recipients and are also substance abusers. Every CASAWORKS site designs programs based on the needs of the community; however, all sites address drug treatment, parental training, and job skills development and placement. The sites bring together local employers, public and private service agencies, welfare departments, and other organizations providing substance abuse treatment, mental health services, literacy training, job training, and work experience and job placement services. Recipients of the services work with a single case manager, who integrates the services into a cohesive experience.

SHIELDS for Families, Inc., is a CASAWORKS site that serves recipients in the Compton and Watts communities in California. Integrating 15 programs, SHIELDS provides substance abuse, mental health, family preservation, vocational, youth, housing, and transportation services. A unique aspect of the program is Exodus, a nontraditional residential program housing families in an 86-unit apartment complex where on-site substance abuse treatment, child care, and youth services are provided. Also unique to the program is the integration of vocational and educational services with the existing substance abuse treatment program. Weekly conferences take place among a primary vocational case manager, a primary substance abuse treatment counselor, mental health staff, Department of Public Social Services staff, Department of Rehabilitation staff, a job development specialist, and representatives from other partners in the program. The program requires participants to obtain their high school diploma, fulfill job readiness activities, and complete a computer certification course. (Contact: Kathryn Icenhower or Sara Tienda, 323/242-5000.)

- **Enhance treatment programs to include a work component and other services.** States can also design treatment programs that provide participants with work or work readiness activities, as well as other ancillary services. For example, some treatment providers in New Jersey enhance their programs by including life skills training, job readiness activities, prevocational services, on-site dependent care, and transportation.¹⁸ New York’s Residential Treatment Training Program provides compressed job training for in-demand occupations at the same time and place as treatment. (Contact: Doug Bailey, 518/473-7213.)
- **Adjust outpatient treatment services to support work.** Individuals who do not require residential or institutionalized treatment are often referred to outpatient clinics that offer counseling services, emergency detoxification services, psychotherapy, and day treatment.¹⁹ States may want to consider ways to make such services more accessible to working individuals in recovery by offering services during evenings and on weekends.

Aligning Work and Time Limit Policies to Support Treatment

States can adopt policies around time limits and work participation that can facilitate the transition from welfare to work for individuals with substance abuse and mental health problems. While many individuals with substance abuse and mental health problems may be able to fully participate in work activities—receiving treatment or supports during non-work hours—others may benefit from participating in treatment full-time for some limited period or combining treatment and work.

States can count substance abuse and mental health treatment as “work activities.” Under TANF, states have only a limited ability to count substance abuse and mental health treatment as “work” for purposes of meeting the federal work-participation rate requirement. However, even if an activity is not considered work for the federal participation rate, states may include it among the allowable activities for the work requirement that the state imposes on individuals. Because states have had little difficulty in meeting the federal work-participation rate, many states have created a more expansive definition. Options include the following:

- **Consider treatment a “job readiness” activity for federal work requirements.** Substance abuse and mental health treatment activities most closely fit the federal TANF “work activity” categories of “job search and job readiness assistance.” The welfare law allows these activities to count as work for four consecutive weeks and up to six weeks total (12 weeks if the state’s unemployment rate is at least 50 percent higher than the national unemployment rate).
- **Count some or all time spent in treatment as a state work activity.** As of January 2000, 20 states reported that they count some portion of an individual’s time in treatment toward the state work requirement. Of those states, 10 require participation in treatment as a condition of TANF eligibility.²⁰

New Jersey uses a “Work Activities and Treatment Matrix” to determine what combinations of work and treatment case managers should suggest to clients. The matrix designates the specific work activities that recipients are able to engage in, based on the intensity of the substance abuse problem and the treatment they are receiving. Care coordinators work with

TANF caseworkers to incorporate work with treatment, and substance abuse treatment counts as an allowable state “work activity.”

- **Use MOE to serve individuals with barriers outside the TANF program.** States can serve TANF recipients who have more severe substance abuse and mental health problems with state MOE dollars in a separate state program. Using MOE in a separate state program means recipients are not included in the federal work-participation rate calculation and are not subject to the federal time limit. A state can then create a package of services and required activities that are appropriate to individuals’ circumstances. North Carolina is using state funds to stop the clock for substance-abusing recipients who are not yet ready for work.

States can exempt individuals with substance abuse or mental health problems from TANF work requirements or time limits on cash assistance. They may also grant these individuals temporary extensions to work requirements and time limits.

The TANF law provides that 20 percent of a state’s average monthly caseload may be exempted, due to “hardship,” from the federal 60-month time limit on cash assistance. States define what constitutes hardship and then determine who qualifies on an individual basis. For example, a state may want to define “hardship” as needing more time to complete treatment or reaching the time limit while the individual was still on a waiting list for treatment. States may exceed the 20-percent hardship limitation on exemptions by funding with state dollars, rather than federal TANF funds, the ongoing cash assistance to families that have reached the 60-month time limit.

Additional time on welfare, whether granted through an exemption or extension, should be used to address the recipient’s problems. States should also keep in mind that even families exempted from or given a temporary extension to the time limit ultimately lose benefits when their children “age out” of the system.

Coordinating Services and Improving Service Delivery

Key to keeping individuals with substance abuse or mental health problems participating in treatment and sustaining employment is ensuring that treatment and employment services are available and coordinated. This requires money, time, motivation, and a common vision among multiple agencies and providers. Service coordination has special implications for individuals with co-occurring disorders. If one disorder is treated, but not the other, treatment results may be nullified.²¹ Work requirements and time limits in the welfare law make coordinating services imperative if states want to help individuals with these barriers find work and leave welfare.

Some strategies for coordinating services include the following.

- **Provide cross-system case staffing and referral.** Designating a staff member or team to serve as an individual’s liaison to programs and services can help ensure that treatment and employment are coordinated, continuous, and attended by the individual. In Delaware, two “bridge agencies” work with clients with potential substance abuse or mental health problems who are referred from the TANF agency. These agencies provide further assessment and coordinate such supportive services as child care and transportation. (Contact: Rebecca Varella, Delaware Health and Social Services, 302/577-4450.)

- **Integrate data systems and program information.** Creating a link between a treatment provider, other agency data, and the welfare department, enables case managers to monitor attendance and client progress in treatment and work activities. States may also want to make directories of various programs and services, including the availability of these programs, available to the multiple partners serving individuals with substance abuse or mental health problems.
- **Partner with the department of vocational rehabilitation (VR).** Some states are also consulting with their VR departments regarding appropriate services for this population or are actually offering VR services to individuals with serious employment barriers. However, since the VR program is subject to an “order of selection,” a requirement to serve individuals with the most severe disabling conditions first, VR may be limited in its capacity to serve current or former welfare recipients with substance abuse or mental health problems. In some states, welfare, AOD, and other agencies contribute funds to help VR access additional federal matching funds and expand service capacity.²² Vermont developed a memorandum of understanding between TANF and vocational rehabilitation agencies to improve the referral process, provide cross-training of staff, and negotiate individualized employment plans that respect differences in agency policies.

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Endnotes

- ¹ Krista Olson and LaDonna Pavetti, *Personal and Family Challenges to the Successful Transition from Welfare to Work* (Washington, D.C.: Urban Institute, 1996).
- ² Substance Abuse and Mental Health Services Administration, National Advisory Council, “Improving Services for Individuals at Risk of, or with, Co-Occurring Substance-Related and Mental Health Disorders,” (Washington, D.C.: Substance Abuse and Mental Health Services Administration, April 1998).
- ³ Olson and Pavetti.
- ⁴ Preamble language, 64 FR 17840.
- ⁵ U.S. Department of Health and Human Services, Administration for Children and Families, *Helping Families Achieve Self-Sufficiency: A Guide on Funding Services for Children and Families through the TANF Program* (Washington, D.C., May 1999).
- ⁶ Gary Cyphers and Scott Brawley, “Charting Paths to Employment: A Study of State TANF Agencies’ Client Assessment Policies and Practices” (American Public Human Services Association presentation to NAWRS spell out NAWRS 40th Annual Workshop, insert place if known, August 2000).
- ⁷ Ibid.

- ⁸ Jan Kaplan, *The Use of Sanctions Under TANF* (Washington, D.C.: Welfare Information Network, April 1999).
- ⁹ Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment, *A Look at State Welfare Reform Efforts to Address Substance Abuse* (Rockville, Md.: Center for Substance Abuse Treatment, July 2000).
- ¹⁰ The CAGE questionnaire consists of the following four questions: 1) Have you ever felt the need to cut down on your using/doing? 2) Have you ever felt annoyed by remarks about your using/doing? 3) Have you ever felt guilty or remorseful about your using/doing? 4) Do you use/do the first chance you get as an "eye opener" to get going or calm down?
- ¹¹ Michelle K. Derr, Heather Hill, and LaDonna Pavetti, *Addressing Mental Health Problems Among TANF Recipients: A Guide for Program Administrators* (Washington, D.C.: Mathematica Policy Research, July 19, 2000).
- ¹² Gayle Hamilton and Susan Scrivener, *Promoting Participation: How to Increase Involvement in Welfare-to-Work Activities* (New York: MDRC spell out MDRC, September 1999).
- ¹³ Ibid.
- ¹⁴ Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment, *A Look at State Welfare Reform Efforts to Address Substance Abuse*.
- ¹⁵ Derr, Hill, and Pavetti.
- ¹⁶ Amy Johnson and Alicia Meckstroth, *Ancillary Services to Support Welfare to Work* (Washington, D.C.: Mathematica Policy Research, June 1998).
- ¹⁷ A.C. Leon and M.W. Weissman, *Analysis of NIMH's Existing Epidemiologic Catchment Area (ECA) Data on Depression and Other Affective Disorders in Welfare and Disabled Populations* (Washington, D.C.: U.S. Department of Health and Human Services, 1993). spell out authors' first names if known
- ¹⁸ Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment, *A Look at State Welfare Reform Efforts to Address Substance Abuse*.
- ¹⁹ The Annie E. Casey Foundation, "Improving the Identification and Referral Process Between the Welfare and Substance Abuse Systems: Meeting Summary" (Washington, D.C.: Health Systems Research, Inc., December 30, 1999).
- ²⁰ ACF/APHSA/NGA/NCSL/WIN State TANF Plan Database, January 2000.
- ²¹ U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration *Coordination of Alcohol, Drug Abuse, and Mental Health Services* (Rockville, Md.: Substance Abuse and Mental Health Services Administration, 1995).
- ²² Johnson and Meckstroth.