REPORT OF THE
DEPARTMENT OF SOCIAL SERVICES

THE EFFECTIVENESS AND APPLICABILITY OF THE PROPOSED PLAN FOR SUBSTANCE ABUSE TREATMENT FOR RECIPIENTS OF PUBLIC ASSISTANCE

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

SENATE DOCUMENT NO. 19

COMMONWEALTH OF VIRGINIA
RICHMOND
2000

ATER ROW BUILDING
EAST BROAD STREET
RICHMOND, VIRGINIA 23219-1849

(804) 692-1944

FOR HEARING IMPAIRED
VOICE/TDD:
1-800-828-1120

COMMONWEALTH of VIRGINIA

DEPARTMENT OF SOCIAL SERVICES

Clarence H. Carter
Commissioner

December 15, 1999

TO: The Honorable James S. Gilmore, III

and

The General Assembly

The report contained herein is pursuant to Senate Joint Resolution 387 as approved by the 1999 General Assembly.

The Departments of Social Services; Mental Health, Mental Retardation and Substance Abuse; Medical Assistance Services; and Rehabilitative Services completed the attached report which reviewed the prevalence and implication of substance abuse among the recipients of Temporary Assistance to Needy Families (TANF), funding sources, and the status of treatment for TANF clients.

The report cost the Commonwealth $16,621 to complete. This amount includes the cost of a contract with the Institute for Public Policy Research in the Center for Public Administration and Policy at Virginia Tech to help analyze data and write part of the report. Staff from the four agencies spent 651 hours collecting and analyzing data and writing the remainder of the report.

Respectfully Submitted,

Clarence H. Carter
Commissioner

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EXECUTIVE SUMMARY

Overview

- Virginia's welfare reform efforts have led to an almost 50 percent reduction in families receiving Temporary Assistance to Needy Families (TANF), from 70,797 in June 1995 to 36,662 in June 1999. The 'work first' focus of welfare reform has been effective in moving many individuals into the competitive labor market and off welfare. TANF is administered by the Department of Social Services (DSS), with services delivered through 122 local departments of social services (LDSSs). The TANF employment program is called Virginia Initiative for Employment Not Welfare (VIEW). Once enrolled in VIEW, participants are limited to a maximum of 24 months of additional cash assistance.

- Many of the remaining TANF cases are considered hard-to-serve. Substance abuse is a factor, often intertwined with other employment barriers, including mental illness, learning disabilities, and domestic violence. Treatment of substance abuse, is critical to financial independence and family functioning, the core of welfare reform.

- The Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) administers publicly-funded treatment services through 40 community services boards (CSBs) that provide a range of mental health and substance abuse services including: emergency, inpatient detoxification, outpatient, day treatment, residential, and supportive services. However, not every CSB provides each of these services, and demand for some services exceeds capacity in many localities.

- In the fall of 1999, Governor James S. Gilmore, III announced the Substance Abuse Reduction Effort (SABRE) Project. The project will help eliminate drugs in neighborhoods, address needs of those caught in the downward spiral of dependence, prevent others from becoming drug-involved, and protect children. Screening and assessment for substance abuse, mandatory treatment, and prevention are among the components of this initiative.

- In 1998, DSS and DMHMRSAS developed a plan for substance abuse treatment for recipients of TANF.

- Senate Joint Resolution 387, approved by the 1999 General Assembly, requests an evaluation of the effectiveness and applicability of the proposed plan and current programs delivering substance abuse treatment to public assistance recipients.

- Five agencies -- the Departments of Social Services (DSS); Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS); Medical Assistance Services (DMAS); Rehabilitative Services (DRS); and Health (VDH) completed the study.

- The study reviewed the prevalence and implications of substance abuse among TANF and other social services populations, funding resources and the status of treatment. Other areas explored were policy changes and options for incentives to encourage participation in and completion of a treatment program.

Prevalence of Substance Abuse

- As of October 1, 1999, 31 CSBs estimated they were serving 630 TANF clients.

- Accurate assessments of prevalence are difficult. In Virginia, it is estimated that 7,225 TANF clients (at a point in time) may have substance abuse problems. Further work on incidence and prevalence is still needed. (See *Recommendation 1.)*

- Substance abuse and dependence play a significant role in other programs administered by DSS. Abuse or dependence on alcohol or other drugs is suspected as a key factor in the non-payment of child support by absent parents. Further, substance abuse is a known factor associated with the state's child welfare cases and placement of children into foster care. No estimate can be made on the impact of substance abuse on these populations without further study. *(See Recommendation 2.)*

Treatment Strategies

- While substance abuse treatment services have expanded, the effective screening and concurrent expansion of treatment capacity are essential to address the substance abuse problems of the TANF population. Both CSBs and LDSSs identified on-site clinicians in local social service agencies as an effective strategy to link TANF clients to treatment. *(See Recommendations 3, 4, 5, 6, 7, and 8.)*

- Treatment programs for the TANF population are most effective when they are built on a broad service model, including intensive case management and extensive services that are found in Project LINK, a DMHMRSAS model for addressing substance abuse among pregnant or postpartum women. Further, services need to address the unique needs of women and children, put safety first in instances of domestic violence, provide and coordinate services for co-occurring disorders, and offer concurrent treatment for children.

- Employment services are an important component because TANF clients are limited to 24 months of continued cash assistance once they enter VIEW. Research shows that integration of employment and vocational services into the treatment program has positive outcomes for both work and treatment. *(See Recommendation 9.)*

- Treatment strategies may be applicable at least in part to other populations, but more study is needed. *(See Recommendations 10 and 11.)*

Funding

- Both LDSSs and CSBs voiced particular concern over deficiencies in service capacity as TANF clients often cannot receive treatment services of the appropriate intensity or in a timely fashion.

- Some of the service gaps can be filled with DMHMRSAS' funding, additional coordination and innovative use of shared funding, as well as maximizing existing funds. *(See Recommendations 12 and 13.)*

- Service capacity for treatment and supportive services is an area that will continue to be explored as community partners get a better handle on the size of TANF population with substance abuse problems and the availability of resources to serve them. Evaluation is needed to determine outcomes, costs and cost offsets. *(See Recommendation 14.)*

Implementation of Short-Term Strategies

- DSS and DMHMRSAS deployed several approaches to further the development of local initiatives and planning for substance abuse services. Localities received information about effective models in addressing substance abuse among TANF recipients. Secondly, they have had the opportunity for multi-agency training. Finally, several localities received funds and technical assistance to develop or enhance LINK projects for the TANF population that will test and refine various components in the treatment model proposed in 1998. DRS has been a key partner in these initiatives.

- New programming is underway. Welfare to Work projects have funded new screening and treatment targeted for TANF clients and non-custodial parents. In addition, DSS has allocated $1.5 million for residential treatment that localities can access as needed for TANF clients and their children. While DMHMRSAS' new funding of over $11 million for substance abuse programs serves the general population, its designation of women and dependent children as a priority group should expand treatment resources available to TANF clients. These funds also make possible the expansion of DRS' specialized employment services.

- DSS has implemented several policy changes, and others are under consideration to more effectively address substance abuse as an employment barrier. *(See Recommendations 15 and 16.)*

- Expanded services have led to new partnerships at the state level and among Private Industry Councils, LDSS, DRS field offices and CSBs to address substance abuse issues. DMHMRSAS, DRS and DSS have also collaborated and developed a multi-agency action plan to address substance abuse issues as part of DSS' approach to addressing the needs of the hard to serve TANF population. *(See Appendix V for an outline of this plan.)*

- It is clear that agencies at both the state and local levels have made progress in pulling together to work with TANF clients who have substance abuse problems.

ACKNOWLEDGMENTS

Staff from the Departments of Social Services; Mental Health, Mental Retardation and Substance Abuse; Rehabilitative Services; Medical Assistance Services; and Health developed this report, with extensive involvement of other state agencies and local representatives.

Representatives of state and local agencies played an important role in clarifying issues and developing recommendations. Key individuals are identified below.

Department of Social Services
Barbara Cotter, Project leader
Zandra Relaford
Linda Nisbet
Mark Golden
Terry Corean
Tanya Simmons
Carol Baron

Department of Mental Health, Mental Retardation and Substance Abuse Services
Mellie Randall
Lewis E. Gallant, Ph.D

Department of Medical Assistance Services
Anita Cordill

Department of Rehabilitative Services
Mary Kaye Johnston

Department of Health
Catherine Bodkin

Local Representatives
Marion Teasley, Norfolk Social Services
Ginny Ferguson, Hanover Social Services
Downing Miller, Region Ten Community Services Board

In addition, the Department contracted with the Center for Public Administration and Policy at Virginia Tech for assistance with the research and writing of this report. The Virginia Tech staff members were Judy Moore and Pat Suarez.

I. Introduction

Study Mandate

- Senate Joint Resolution 387, approved by the 1999 General Assembly, requests an evaluation of the effectiveness and applicability of the proposed plan and current programs for substance abuse treatment for public assistance recipients.

- Four agencies – the Departments of Social Services (DSS); Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS); Medical Assistance Services (DMAS); and Rehabilitative Services (DRS) are to complete the evaluation.

- The four agencies are to make recommendations concerning:

  needs for long-term changes in substance abuse policies and Temporary Assistance for Needy Families (TANF) policy, including administrative policy changes;

  optional programs available to the state; and

  options for incentives to encourage participation in and completion of a treatment program.

- Further, the four agencies are to:

  report back on localities' progress in implementing the short-term strategies in substance abuse treatment;

  evaluate the need for substance abuse services for other populations and evaluate the LINK/TANF service model for future use with these other populations; and

  make recommendations for resources needed to address substance abuse issues.

- The study reviewed the prevalence and implication of substance abuse among the TANF and other social services populations, funding resources and the status of treatment for TANF clients. Also explored were policy and legislative changes and options for incentives to encourage participation in and completion of a treatment program.

- The study resolution can be found in Appendix I.

Background

- The TANF program evolved from the Aid to Families with Dependent Children (AFDC) program as a result of the federal Personal Responsibility and Work Opportunity Reconciliation Act, passed in 1996. Under TANF, states receive block grants to provide services and time-limited cash assistance to needy families.

- Virginia's welfare reform efforts, have led to almost a 50 percent reduction of TANF cases, from 70,797 families in June 1995, to 36,662 in June 1999. The 'work first' focus of welfare reform has been effective in moving many individuals into the competitive labor market and off welfare. In June 1999, 38 percent of the TANF caseload was participating in the Virginia Initiative for Employment Not Welfare (VIEW). Once enrolled in VIEW, participants are limited to a maximum of 24 months of additional cash assistance.[1]

- Many of the remaining TANF cases are considered "hard-to-serve". Substance abuse is a factor among the hard-to-serve, often intertwined with other employment barriers, including mental illness, learning disabilities, poor work history, low educational attainment, and domestic violence.

- In Virginia, publicly-funded substance abuse treatment services are administered by DMHMRSAS and provided through the 40 community services boards (CSBs) established by the *Code of Virginia,* § 37.1-194.

- CSBs provide a range of mental health and substance abuse services emergency, inpatient detoxification, outpatient, day treatment, residential, and supportive services. However, the *Code* only requires CSBs to provide emergency and outpatient services. Therefore, not every CSB provides every service, and the demand for some services exceeds the supply in many localities.

Current Efforts to Address the Problem

- In recognition of the importance and priority of addressing substance abuse and dependence across caseloads of many human service agencies, several major efforts are now underway:

  DMHMRSAS, in cooperation with DMAS, has completed a study on Medicaid coverage of substance abuse treatment.

  DSS, DMHMRSAS and DRS are engaged in several joint initiatives to address the needs of TANF recipients with substance abuse problems and other disabilities. These efforts will be covered in more detail in Section V.

  DSS is in the midst of a community planning process whereby local departments of social services can request additional funding to address needs of the hard-to-serve, including

[1]Within Virginia's TANF population are the VIEW and the VIEW-exempt case. Virginia exempts parents with children under 18 months, individuals with disabilities and others who are not able to work. Also exempt are non-parent caregivers who receive cash assistance only for the children.

those with substance abuse and dependency problems. This process and the progress made to date are discussed later in the report.

To enhance localities' ability to identify and treat substance abuse among the TANF population, a major cross-agency training plan has been developed. The details of this effort will be discussed in Section V.

Methodology

- Extensive secondary research was done on national studies and literature related to substance abuse and the TANF and child welfare populations, including incidence and outcomes of treatment. No research on this topic could be identified for non-custodial parents.

- To obtain the LDSS perspective, 840 surveys were distributed to all directors and a random sample of staff in local departments. Different instruments were sent to three populations: local directors (n=122), employment services/self-sufficiency workers (n=208), and eligibility and service workers (n=510). The overall response rate was 64 percent. For each sample, the response rates were: local directors (74 percent), employment services/self-sufficiency workers (67 percent), and eligibility and service workers (61 percent).

- To ascertain the CSB perspective, surveys were administered to the executive directors of the 40 CSBs in Virginia. Two instruments were used: one reporting the estimated number of TANF recipients receiving specific services on October 1, 1999; and the second collected information regarding collaborative efforts and service structures with local departments of social services. Thirty-one (78 percent) CSBs responded to the survey.

- Three Private Industry Councils (PICs), which offer services to non-custodial parents, provided information for the study.

Organization of the Report

- The following sections of this report will more specifically address the interest and issues outlined in SJR 387:

  Section II covers the incidence of substance abuse problems among clients of programs administered by DSS.

  Planned and ongoing treatment strategies are outlined in Section III.

  Section IV addresses funding streams.

  Section V details state and local agency initiatives and includes a discussion of administrative and policy issues to be resolved.

- Recommendations are included throughout the report.

II. Prevalence and Impact of Substance Abuse: TANF Recipients and Other Social Services Populations

Introduction

- This section will address the issue of prevalence among TANF clients and VIEW participants. It will also discuss substance abuse in child welfare programs and among non-custodial parents, as both have a close relationship with the TANF population. Also discussed is the impact of substance abuse on self-sufficiency and family functioning.

Virginia's Prevalence Estimates for VIEW

- Utilizing the conservative estimate of 20 percent, the prevalence of substance abuse would likely be 7,225 TANF clients at a point in time.[2]

- The employment services staff rated substance abuse as a somewhat serious to very serious problem for 83 percent of the TANF population.

- Because substance abuse or dependency often goes undetected or unacknowledged, it is possible that prevalence estimates of abuse and/or addiction are substantially understated.

- Thirty-one of the forty CSBs responding to the survey estimated that approximately 630 TANF recipients were receiving one or more substance abuse treatment services on October 1, 1999.

Recommendation 1. *By September 2001, DMHMRSAS and DSS will review and refine current estimates on the prevalence of substance abuse and accompanying disabilities and conditions (such as mental illness and domestic violence) among the TANF and VIEW population.*

Impact of Substance Abuse and Dependency on the TANF Caseload

- Substance abuse interferes with adequate parenting by:

  Impairing mental functioning, judgment, inhibitions and protective capacity.

  Interfering with the ability to respond consistently and sensitively to a child.

  Lowering the threshold of aggression.

[2]This estimate is based on 36,127 TANF cases in July 1999.

Using resources needed for food and clothing on alcohol or drugs.

Exposure to criminal activity that may compromise a child's safety or welfare

Neglecting a child's basic health care needs.

Leaving the parent emotionally and physically unavailable to care for the child.

Prevalence in the Child Welfare Caseload

- The data from numerous national studies suggest that 40 to 80 percent of families in the child welfare system have problems with alcohol and other controlled substances that contributed to abuse or neglect of their children.

- Substance abuse is a factor in an estimated 75 percent of all foster care placements.

- A General Accounting Office (GAO) study showed that 62 percent of young children (i.e., under three years of age) in foster care in New York City, Philadelphia, and Los Angeles were at high risk for serious health problems as a result of prenatal drug exposure.[3]

- No estimates of the prevalence of substance abuse are available for child protective services or foster care cases in Virginia. However, some information from a recent state study, as well as information from Virginia's localities, suggests the problem is serious.

Non-Custodial Parents

- Another group seriously affected by substance abuse and dependence is the non-custodial parents associated with TANF families. Substance abuse among this group contributes to joblessness, homelessness and incarceration. All these conditions are factors in the failure to pay regular child support. Lack of child support keeps families dependent on public assistance.

- Three PICs identified substance abuse as a potentially serious problem among non-custodial parents, but estimates of prevalence among the caseload varied widely, from five percent to 50 percent in Planning District One.

- Substance abuse among this population is reflected in a high absentee rate in training and work. It has an adverse effect on work performance, rapport with employers and family life.

Recommendation 2: By June 2001, DMHMRSAS and DSS should determine the incidence and prevalence of substance abuse in the child welfare and non-custodial parents related to the TANF population in Virginia. For child welfare this study should take place after the full implementation of the new child welfare information system and child welfare cases receiving TANF.

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[3]United States General Accounting Office. "Foster Care: Health Needs of Many Young Children are Unknown and Unmet," Letter Report, May 26, 1995, p. 7.

III. Treatment Strategies

Introduction

- Substance abuse is one of the key factors identified as a characteristic of hard-to-serve VIEW participants in the document "Virginia's Welfare Reform: Employment Strategies for the Hard-to-Serve" submitted in response to Item 404 (4c) of the 1999 Appropriation Act. The inclusion of substance abuse rests partly on the fact that this employment barrier often occurs with other barriers, especially psychological and psychiatric disabilities and domestic violence.

- An extensive service model is outlined in the document. This model can be adapted and expanded to include clients with substance abuse problems throughout the TANF caseload, as well as in other social services programs.

Screening and Assessment

- Effective screening and assessment are essential to identify and treat TANF clients with substance abuse problems.

- For TANF recipients, a two-step screening protocol, consisting of screening followed by assessment, will help identify clients with alcohol and drug problems. Recipients identified as having a substance abuse or dependence problem will then be referred for treatment.

- This process should occur at the earliest possible point, but no later than entry into the VIEW program, and should take into account safety issues for women in domestic violence situations, and other related issues such as mental health.

- Both CSBs and LDSSs identified training as critical to enhance LDSS staff skills to recognize signs of drug and alcohol abuse, and to help clients be receptive to assessment and treatment.

- Local health department staff and other human services personnel could be part of the screening team and, where appropriate, administer screening instruments and refer clients for an assessment.

- A general staff awareness of alcohol and other drug abuse and dependence and the potential value of treatment can significantly improve the effectiveness of screening. Further, LDSSs, CSBs and health professional should provide clients with information about how the agencies' services will benefit the recipient and the dependent children, identify barriers, both real and perceived, and work to address the barriers.

- Both CSBs and LDSSs identified the need for clinicians in the local social service agency to facilitate the screening and assessment processes and reach more clients who need substance abuse services.

Recommendation 3: By July 2000, LDSSs and community partners such as local health departments, with guidance from DMHMRSAS, will select and begin using standardized assessments instruments appropriate for each agency setting to determine the need for referral to substance abuse treatment. The assessment will occur at the earliest possible point in the client's entry into the agency's services. A standardized assessment and referral protocol between LDSSs, local health departments, other community providers, and CSBs will be in place.

Treatment for Substance Abuse and Dependency

- CSBs identified case management (60 percent) and outpatient treatment (48 percent) as the primary services provided to the 630 TANF clients receiving services on October 1, 1999. In addition, 10 percent received methadone maintenance; six percent received intensive to highly intensive residential services; and two percent or less received other treatment.

- Treatment is an essential component of the overall case management plan. Treatment at the appropriate level, intensity and duration will be the objective for TANF recipients whose abuse or dependence prevents them from holding a job or functioning in an acceptable manner.

- Treatment should be multi-dimensional, focusing on all aspects of life and social dimensions. A continuum of treatment services includes outpatient services, intensive outpatient treatment, detoxification and short-term residential services, long-term residential services, and short-term, community-based hospital care. Of critical importance is after-care follow-up and supportive service to discourage relapse. (See Appendix II, **Continuum of Substance Abuse Treatment Services.)**

- Treatment may be pharmacological, cognitive-behavioral, or a combination of the two, depending upon disease dynamics. Regardless of the treatment setting or approach, outcomes generally appear to be as much related to completion of the treatment program as treatment intensity or length.[4]

- For the TANF population, clinicians may need to use motivational counseling to engage a substance abusing or dependent individual into therapy.

- Immediate treatment (treatment on demand) needs to be available and accessible to maintain the momentum of individuals who have expressed willingness to seek help. Providing treatment on demand will require an analysis of local gaps in the continuum and capacity of

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[4]Thomas Wickizer, Jutta Joesch, Dario Longhi, Antoinette Krupski, and Kenneth Stark. Employment Outcomes of Indigent Clients Receiving Alcohol and Drug Treatment in Washington State, Substance Abuse and Mental Health Services Administration, April 1997, p. 6.

treatment services and strategies (e.g., through additional resources, restructuring etc.) to eliminate these gaps.

- Treatment approaches must address the full range of issues that TANF recipients are likely to present. These include mental health issues, low literacy levels, poor cognitive skills, domestic violence, problem solving skills, parenting, budgeting, and personal and child health and nutrition.

Recommendation 4: Cross-training will be offered for all community partners to facilitate the screening, assessment and treatment processes for substance abuse issues as well as other related issues such as mental health and domestic violence. These partners include LDSSs, CSBs, domestic violence service providers, DRS, and local health departments.

Treatment Programs for Women

- DSS' customers are predominantly women with children. Women who are substance abusing or dependent require specialized treatment to address issues critical to women achieving and maintaining sobriety and stability.

- Women sometimes are reticent to seek or accept treatment. Barriers to treatment include:

  Financial concerns, including loss of income or inability to pay for treatment or child care;

  Strong feelings of denial, guilt, and/or low-self esteem;

  Issue of prosecution or losing custody of children. While this is an issue for all levels of treatment, it is especially critical in the event of residential treatment;[5] and

  Lack of safety in domestic violence situations. Safety issues need to be addressed prior to beginning the treatment program, and safe approaches must be used during recovery that does not jeopardize lives.

- Women in rural areas often experience additional barriers, including geographic inaccessibility to treatment, a tradition of self-sufficiency, distrust of the process, a stronger sense of stigma, and a fatalistic attitude toward life.

- Important components of treatment for women include:

  Medical interventions.

  Addiction treatment and psychological counseling.

  Health education and prevention.

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[5]Legal Action Center. Steps to Success: Helping Women With Alcohol and Drug Problems to Move from Welfare to Work, Legal Action Center, May 1999, p. 14.

Parenting skills.

Other life skills.

Domestic violence services.

Other Social Services, such as child care, transportation, legal services, and housing.[6]

- The use of a staff mentor or community sponsor to work closely with clients in recovery or aftercare will be an important part of the client's treatment program. This will be part of the support necessary to help prevent relapse into active abuse.

- If an individual is referred for treatment by a drug court or other judicial proceedings, the court also can require participation in treatment and monitoring of progress.

Recommendation 5: By July 2000, LDSSs and CSBs, with other agencies, will evaluate where treatment capacity is lacking and should develop a plan that maximizes resources to provide timely, accessible treatment at the appropriate level that meets the special needs of the TANF population and includes concurrent treatment for children. Where feasible, substance abuse assessment and treatment services should be available on-site in LDSSs.

Recommendation 6: By December 2000, CSBs will develop or enhance integration of mental illness and substance abuse treatment for TANF clients with dual diagnoses (mental health and substance abuse), and CSBs, DRS, and LDSSs should develop the capacity for ongoing supportive employment and other services for these individuals.

Recommendation 7: By December 1999 and periodically thereafter, DSS, DMHMRSAS, VDH, and DRS will provide training in screening, assessment, and the treatment process to local agency personnel, appropriate for the functions of the respective agencies, that addresses the specific needs of the TANF population. The training curriculum will be jointly developed, based on research-based precepts and will promote increased understanding of the treatment and recovery issues of TANF clients.

Incentives and Rewards

- In the broadest sense, incentives include both inducements to motivate clients to participate in treatment as well as rewards for achieving milestones in their recovery. Providing incentives for welfare recipients with alcohol and drug problems to enter and stay in treatment will help them become ready for work, increase functional family behavior, and improve the long-term effect of the treatment.

- An important incentive to undergo treatment for substance abuse or dependence or avoid relapse is to prevent children from being removed from the home or to regain custody of them. The incorporation of parenting skills into the treatment protocol supports the success of this incentive. Beyond this, other incentives, as well as penalties, are currently being

[6]Ibid., p. 8.

developed to provide an effective mix of rewards, necessary supports, and leverage to encourage full participation in treatment. The approach is to:

Provide timely and accessible treatment.

Offer support services: child care during treatment hours (including 24-hour care for those in residential or detoxification care), transportation to meetings, affordable and safe housing – both residential and "bridge". While these are essential support services, they also provide an incentive by eliminating a hurdle to receiving treatment.

Where necessary, encourage participation in treatment by temporarily placing addicted clients in an inactive VIEW status, which temporarily stops the 24-month time limit clock.

Utilize VIEW policies and grant opportunities to provide other incentives to clients for participating in substance abuse treatment. Virginia localities are beginning to develop incentive structures. For example:

- ⇨ In 1998 the Highlands CSB, which serves Washington County, received a grant to pay for up to two months rent for clients who are fulfilling a treatment plan.
- ⇨ Region Ten CSB's LINK Program in Charlottesville provides supplies needed by mothers, such as diapers, as an incentive for participation.
- ⇨ The Norfolk CSB and LDSS are considering coupons for restaurant meals, personal services and other commodities, cosmetic and clothing allowances, and special recognition luncheons and ceremonies as part of the Norfolk Care Management Model, a new LINK project.

- Recipients who are willing to enter treatment should not be penalized if appropriate treatment or supportive services are not available. Sanctioning should be considered only for those recipients who refuse to enter available appropriate treatment.

Recommendation 8: During 2000, LDSSs and CSBs will collaborate to design a system of rewards and sanctions designed to encourage full participation in substance abuse treatment by TANF recipients. DSS and DMHMRSAS will actively promote best practices models that support successful completion of treatment, good clinical outcomes, and economic independence among TANF clients.

Treatment Availability

- At the community level, the CSB is the chief resource (sometimes the only resource) for treatment of substance abuse or addiction. Unfortunately, in many communities, individuals needing and seeking treatment cannot receive it because it is not available. Utilization of the various CSB services has remained relatively constant during the past five years, despite a growing demand.

- In response to the survey, both CSBs and LDSSs indicated a need for greater capacity at all levels of the treatment continuum.

  In many instances, the appropriate level of care, such as residential treatment, is not available, and individuals enter less intensive treatment that does not adequately address the severity of the alcohol or other drug dependence.

  In other instances, significant delays occur while the client moves up on a waiting list. Across the state, service gaps exist in both short-and long-term treatment modalities.

  Localities also voiced concern about deficiencies in support programs, such as aftercare and support groups for clients and family members. In general, localities viewed treatment as inadequate in scope and unavailable or inaccessible when needed.

  Additional service gaps include the paucity of substance abuse programs specializing in services for women, including the needs of current victims of domestic violence, and those that can accommodate child care needs.

- With improved screening and assessment and the need for immediate access to services, the systems in all partner agencies could quickly become overloaded.

Case Management

- Intensive case management is necessary to connect the participant with community resources to address the multiple issues accompanying abuse or dependence on alcohol or other drugs. These include: mental health issues, health care for self and children, domestic violence, involvement with criminal justice system, literacy problems, inadequate housing, and lack of child care.

- Elements of effective case management will include:

  Interdisciplinary approach to manage programs and engage in joint case planning. The support team should include the LDSS caseworker, substance abuse specialist, public health nurse, mental health specialist, employment specialist, and possibly housing specialist;

  An on-site substance abuse specialist, assigned to the LDSS office or the CSB or both. This position could also serve more than one area if the region or sub-region is defined as the catchment area and geographic considerations enable this. The specialist could provide screening, assessment, and limited treatment;

  Wrap-around support services including transportation, child care, coordination of health care, and affordable housing. Wrap-around services make the most efficient use of time spent in the treatment setting by locating multiple services in one place, eliminating the need for transportation time and resources; and

Well-trained workers and, as appropriate, smaller caseloads.

Specialized Employment Services and Relapse Prevention

- Employment services are an important component in the service model because TANF clients are limited to 24 months of continued cash assistance once they enter the VIEW program. Integration of employment and vocational services into the treatment program has positive outcomes for both work and treatment.

- Prevention of onset or relapse of substance abuse or dependence reduces factors that often result in child abuse and neglect, criminal behavior, prenatal exposure, at-risk sexual behavior and sexually-transmitted diseases, and a host of chronic physical and mental disorders.

Recommendation 9: During FY 2001, LDSSs, DRS and treatment providers will evaluate current capacity of vocational and work components that are integrated with substance abuse treatment, including relapse prevention services, and develop components as needed.

Services to Children Affected by Substance Abuse

- Intervention for children affected by prenatal exposure to substances is critical. In addition, children born to substance dependent mothers need intervention to ensure the proper stimulation, enhance opportunities for brain development, and support emotional health through bonding and attachment.[7]

- Children of substance abusers also need prevention programs. Two of the most frequent findings relating to the long-term effects of children living with substance-abusing parents are greater rates (with perhaps double the risk) of alcohol and drug abuse in adolescence and adulthood, and greater likelihood of trouble with the law. The long-term effects usually began to appear during the teen-age years.[8]

- A key to prevention and early intervention of substance abuse and dependence is involvement of family members, especially children. This is an area of concern in Virginia. A 1998 survey by the Virginia Community Prevention Network of 24 community service boards revealed that most CSBs focus treatment on the dependent adult, with little involvement of their children.

- The Governor's SABRE Project will also focus on prevention and encourage the use of locally based prevention programs that have a proven track record.

- In a similar vein, responses to the 1998 survey of local social services agencies identified a need for more prevention and early intervention services, including intervention for children affected by prenatal exposure to substances, support groups for parents to prevent relapse

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[7]Nancy K. Young, Sidney L. Gardner, and Kimberly Dennis. Responding to Alcohol and Other Drug Problems in Child Welfare: Weaving Together Practice and Policy, CWLA Press, Washington, D.C., 1998, p. 99.

[8]Virginia Department of Social Services, "Virginia Child Protection Newsletter," Spring 1998, p. 5.

into active substance dependence, support groups for children, and education programs in the public schools.

- Both CSBs and local social services agencies have identified the need for better interagency coordination and networking between child protective services and substance abuse and dependency programs.

Recommendation 10: By September 2001, DSS, VDH, and DMHMRSAS should explore the feasibility of adapting some or all of the substance abuse service model for use with the child welfare caseload. The feasibility analysis should include, at a minimum, how assessment for alcohol or drug abuse on the child welfare and foster care caseloads might be strengthened and made more uniform and how service linkages might be established and enhanced across child welfare and TANF programs to improve services to families and children.

Non-Custodial Parents

- The survey identified that non-custodial parents often did not divulge their substance abuse problem. For those who sought help, the services were not accessible, and, in some cases, families did not support participation in treatment.

Recommendation11: By September 2001, DMHMRSAS, DSS and community partners will study the service needs of the non-custodial parents related to the TANF population and, if appropriate, subsequently explore the feasibility of adapting some or all of the substance abuse service model for use with this population.

IV. Current and Potential Funding for Substance Abuse Treatment

Introduction

- This section covers current funding for treatment. Most funding flows through DMHMRSAS, but some comes from others in the human services family. The recent expansion of funding is highlighted along with new sources of federal funds that may be used for treatment.

DMHMRSAS' Funds

- The 40 CSBs, funded through DMHMRSAS, are the major source of treatment for substance abuse at the local level. Some CSBs contract with private and non-profit community organizations to provide treatment.

- A major source of funding for CSBs is the federal Substance Abuse Prevention and Treatment (SAPT) block grant. Other funds are provided by State General Funds and local government dollars. Funding available for substance abuse treatment for FY 1998 totaled $96,582,192.

- New treatment initiatives have been funded for the current fiscal year that begin to address resource gaps. Expanded funding is over $11 million, $8.2 million additional from the SAPT Block Grant and $3 million in General Funds.

- The SAPT Block Grant funds give priority to women with dependent children.

- Recent General Funds initiatives are expanding the continuum of treatment and providing important supportive services including:

  More case management and women's services, including continued funding of residential treatment for women with dependent children;

  Establishment of new regional perinatal centers based in Richmond, Tidewater and Roanoke;

  Additional intensive residential care (6 new programs), supervised care (6 new programs), and supported residential care (11 new programs); and

  Expansion of specialized employment services to 16 CSBs, from DRS as part of the Substance Abuse Vocational Rehabilitation Program.

Medicaid Coverage

- Federal law is explicit about one restriction to Medicaid funding, however: Medicaid will not reimburse for services to individuals between the ages of 22 and 64 in Institutions of Mental Disease (IMDs). An IMD is a hospital, nursing facility or other institution of more than 16 beds that provides diagnostic, treatment, and care of persons with mental disease, including substance abuse.

- Within the policy latitude provided, Virginia provides the following coverage for treatment of substance abuse.

  Virginia's Medicaid Plan, under the expanded prenatal service component of Baby Care, covers pregnant and postpartum women for substance abuse treatment. Reimbursement from Medicaid provides for once in a lifetime admission to residential treatment of day treatment during their pregnancy and up to 60 days postpartum. According to Medicaid claims data, 31 women have received these services (through five CSBs) since 1997.

  Medicaid also covers targeted case management for adults with serious mental illness, children with serious emotional disturbance or at risk of serious emotional disturbance. Additional outreach is needed to make sure that eligible individuals who need this service receive it.

- DMAS and the Virginia Department of Health (VDH) collaborate on the Maternal and Infant Care Coordination component of Baby Care, a VDH nurse visitation program for Medicaid-eligible high risk infants and mothers. It is available locally across the state, but limited in enrollment. The benefits of this type of program are discussed later in this section. DMAS is currently studying Baby Care, including ways to enhance collaboration.

Recommendation 12: DSS, DMHMRSAS and others will provide policy clarification and guidance to LDSSs, CSBs and others to encourage outreach to eligible "at risk" children requiring specialized case management services.

DSS' Funds: TANF and Welfare to Work

- Two funding sources for services and supports to TANF recipients with substance abuse problems are the TANF Block Grant and the Welfare-to-Work (WtW) Grant.

- The TANF Block Grant is made up of federal funds. In addition, the state is required to spend a certain amount of funds called Maintenance of Effort (MOE).

  TANF and related MOE funds offer significant flexibility for employment and other services. TANF can pay for most services required by those disabled by substance abuse, with the major exception of medical services.

The related MOE funds offer greater funding flexibility. If they are not mingled with TANF funds, they may be used to pay for medical care and other services not permitted by TANF or WtW funds.

From a technical perspective, TANF and MOE funds might also be used to pay for residential care prohibited from Medicaid funding, such as care in facilities with more than 16 beds.

- WtW funding is designed to supplement welfare reform efforts funded by TANF. Virginia's grant totals $16.5 million for FFY 1998 and $15.4 million for FFY 1999, with a two for one federal match.

Funding Provided by Other State Agencies

- Although DRS does not provide substance abuse treatment, vocational rehabilitation services are provided to eligible individuals with substance abuse disabilities. DRS and DMHMRSAS collaborate on providing specialized employment services at CSBs. This program is discussed in Section V.

- Other state agencies that administer funds related to substance abuse treatment or prevention services include the Departments of Criminal Justice Services, Education, Health, and Juvenile Justice. Many of these funding sources are directed toward prevention efforts in Virginia's public schools.[9] In addition, local public housing authorities are becoming more involved in substance abuse prevention and treatment to make housing environments safer.
- Appendix III lists the range of available federal funding sources for substance abuse services.

Potential Sources of Additional Funds

States increasingly have been using federal funding (through Title IV-E policy waivers) and private funding to provide services for families with alcohol or drug-dependent adults. Some of the funding has been used for adults on child welfare caseloads; however many of these adults also are current or former recipients of TANF.

Recommendation 13: By June 2000, state agencies will collaboratively provide a funding guide to localities that identifies what services may be purchased with particular funds. The guide will facilitate local development of funding plans to expand capacity for TANF and related populations. In addition, state agencies will explore the feasibility of accessing additional funds through federal waivers or private funding.

Cost Benefit

- Treatment is very effective for those with substance abuse and dependency problems, and well worth the cost.

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[9]Ibid., p. 20

- While treatment results generally appear very positive, GAO's 1998 study of treatment outcomes cautioned that the benefits of substance abuse treatment may be somewhat overstated. Some research projects rely on self-reports from clients to establish outcomes.[10] However, the failure of many studies to count foster care costs may balance out some of the potential inflation of study results.

- Substance abuse and dependence are very difficult to overcome. Relapses and multiple treatment episodes are common. CSAT determined that approximately one-third of the women completed a rehabilitation program on their first attempt and estimates that about one-half might complete a program on successive attempts. Nevertheless, because of the high cost of out-of-home care of children, significant cost-savings are accrued, even with these rates of success.[11]

Recommendation 14: By July 2000, DSS, DMHMRSAS and DMAS will develop and implement an evaluation to evaluate costs and outcomes, including cost offsets, of providing substance abuse services to the TANF population. It should be integrated with DSS' evaluation related to the TANF hard-to-serve population.

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[10]GAO, 1998, Op. Cit., p. 7.
[11]Nancy K. Young, *et. al.*, Loc. Cit.

V. Current and Future Actions to Address the Substance Abuse Issue

Introduction

- In 1998, DMHMRSAS and DSS proposed several long-term objectives to confront dependence on alcohol and other drugs in the TANF caseload. These strategies are to:

  Identify and provide appropriate level, intensity, and duration of substance abuse treatment for TANF recipients whose abuse or dependence clearly prevents them from obtaining and retaining work;

  Offer incentives and establish the needed leverage to encourage recipients to undergo and complete treatment;

  Offer intensive case management for recipients and their families with multiple problems, including substance abuse;

  Provide specialized employment services integrated with substance abuse treatment;

  Promote prevention and early intervention for TANF clients and their children.

- Successfully implementing these objectives requires a substantial commitment of effort, collaborative planning, and breaking of new ground among the involved agencies. Additional information is required about the substance abusing population itself, effective approaches to screening and treatment, and needed policy and resources.

- For this reason, short-term planning and programming have been developed and implementation has begun to provide answers required for longer-term efforts. These near-term activities also are needed to gain momentum in making the major changes needed for DSS and its partner agencies to work effectively with the TANF substance abuse population.

- This section of the report reviews the short-term strategies to which DMHMRSAS and DSS and its partner agencies committed in 1998. Progress toward implementing these strategies is noted. Also reviewed are policy and administrative issues that must be addressed as the overall plan for confronting substance abuse and dependency is put into place.

Expanded Planning and Programming

- Short-term initiatives focus on improving the capacity and quality of case management and treatment for TANF recipients with substance abuse and dependence problems. Progress in implementing these initiatives has been encouraging.

- DSS, DMHMRSAS, and DRS have deployed three approaches to further the development of local initiatives and planning:

  Providing localities with information about effective models in addressing substance abuse among TANF recipients;

  Offering multi-agency training at the local level on substance abuse and dependence, including screening instruments and treatment resources, as well as various service delivery issues; and

  Providing technical assistance for new local programs that test and refine the various components in the treatment model.

- The first objective is underway.

  From January to April 1999, the Commissioner of DSS met with all LDSSs directors to highlight the needs of the hard-to-serve TANF population (including substance abuse) and to encourage community planning to fully identify and address these needs.

  In July 1999, DSS sent a document to localities that discussed services strategies for the hard-to-serve population, including components of effective treatment for substance abuse.

  DSS, DRS, DMHMRSAS and other partners are developing more comprehensive documents on screening, service strategies and model programs that will be distributed to local affiliates by the end of 1999.

- The second objective has been launched with a plan for training and scheduling of important training events.

  The inaugural event was a series of seminars on screening, assessment, and collaborative treatment models at the Community Partners Conference in May 1999 to enhance local efforts on welfare reform.

  In November 1999 a workshop was conducted (across the state) on service design issues related to the integration of work programs and substance abuse treatment at the local level.

  A series of workshops on screening, assessment and treatment of substance abuse will be held during the winter of 1999 and 2000 that is geared to improving the ability of local agency staff to identify possible drug and alcohol problems among the various social services populations, and to intervene effectively. Training also will include administration of screening instruments and referral of clients for assessment and services.

The multi-agency training plan includes other events such as co-occurring problems of substance abuse and mental health, and domestic violence.

Participants in these events are: LDSSs' staff (directors, supervisors, line staff – eligibility, employment and services), CSBs' Substance Abuse directors and staff, DRS field staff, private industry councils' (PICs) staff, and domestic violence, health care and other providers.

- In addition, some localities have conducted training to increase LDSSs' staff awareness of substance abuse and facilitate their screening and referrals for this problem. As a VIEW-LINK pilot, Norfolk LDSS and CSB have held a series of sessions on different types of abuse and the screening process for all LDSS staff.

- The third objective of new programming is already providing information that will be needed for long-term planning. DMHMRSAS' initiatives were highlighted in the Funding section of this report. Other new programming includes the VIEW-LINK projects, Welfare to Work projects, and various other initiatives. Greater detail about these projects is included later in this chapter.

- The state agencies have developed an action plan, summarized in Appendix V, to implement these objectives. The plan highlights four important areas:

  Developing a shared vision and specifying the state policy framework to address the problem through March of 2000. This will be achieved through such strategies as guidance documents, training for different levels of staff, and the opportunity to request additional funding.

  Developing an approach to service integration by April 2000. Orientation to the approach will occur through the training and guidance documents mentioned above. Local social service agencies will be asked to define the service flow, including substance abuse services, for hard-to-serve participants in the VIEW program.

  Creating local office infrastructures to support integration of substance abuse services with existing operations; developing or connecting to the treatment system, implementing needed changes and expanding capacity.

  Identifying clients with substance abuse problems through screening and assessment, providing treatment, and offering specialized employment services and other supports.

DMHMRSAS' and CSBs' New Initiatives

- These initiatives were referenced in the Funding section and have been made possible by additional federal and state funds, effective FY 2000.

- The expansion of specialized employment services from DRS will enable the co-location of 18 additional DRS staff with clinical staff in 16 CSBs as part of a Substance Abuse

Vocational Rehabilitation program. This collaborative effort addresses job entry and work retention problems experienced by people with alcohol and other drug dependence problems. Expansion beyond the three current sites (Portsmouth, Charlottesville and Winchester) will benefit TANF clients, as well as other populations.

- A few CSBs, such as Region Ten in Charlottesville, have funded a substance abuse clinician to work with TANF recipients in the local social services agency.

VIEW- LINK Projects

- DSS, DRS, and DMHMRSAS have developed formal inter-agency agreements to provide treatment and employment services in several pilot sites for VIEW and other TANF clients who have substance abuse disabilities. Funds of $732,000 from the Governor's Discretionary Welfare-to-Work allocation are supporting these agreements. These resources have enabled the establishment of the VIEW-LINK projects in Norfolk and Richmond and expansion of the existing LINK Project in Roanoke City. As part of its effort, Norfolk has instituted policy and trained all agency staff to screen for substance abuse in all programs. Richmond and Roanoke have just completed the planning for their projects and are proceeding to hire staff.

- Project LINK, the model underlying the VIEW-LINK effort, has been a highly effective collaborative effort administered by community services boards in five (presently expanded to eight) localities.[12] This established model provides wrap-around services, as well as in-home counseling and case management, to help pregnant, postpartum, and at-risk women overcome substance abuse and dependence, as well as other problems. Collaborative teams at the management and staff levels support an interdisciplinary approach to case management, treatment and other services. While LINK traditionally has focused on perinatal women, the VIEW-LINK project will focus on all TANF recipients participating in, or headed for, the VIEW program.

- The VIEW- LINK model provides:

  Initial and ongoing assessments regarding clinical need and readiness for treatment;

  Oversight of the client's experience with a particular treatment service, its appropriateness, impact, length, and duration;

  Intensive case management and a point of contact for all services provided to the TANF/VIEW recipient;

  Wrap-around support services that include transportation, child care, affordable housing; and

[12]Localities are Charlottesville, Fredericksburg, Newport News, Norfolk, Petersburg, Richmond, Roanoke, and Virginia Beach.

Specialized employment services (by DRS), as a new component integrated into the treatment program.

- The VIEW-LINK initiative was originally intended as a short term effort. However, experience indicates that this model requires a fairly lengthy planning effort, unless the LINK program is already in place. In addition, VIEW-LINK requires a great deal of collaboration within the community, at both the management and staff levels. Current experience now indicates that a minimum of five months is required to plan and implement a new LINK site.

Projects Funded from Welfare to Work and TANF

- Fairfax County has been awarded $338,000 in competitive WtW funds for a project focused on hard-to-serve TANF clients with serious substance abuse problems. The project will run through June 2001, serving participants from Fairfax City and County, as well as Falls Church. Funding will support three substance abuse counselors to provide immediate access for on-site assessment, substance abuse therapy, linkage to community support systems, and assistance with job location and retention. All services will be coordinated through aggressive case management and active partnering with other local agencies and organizations.

- While the majority of LDSSs use referrals as their only method of obtaining substance abuse services for clients, over 28 LDSSs identified many diverse strategies either implemented or in development. Many communities are expanding screening, assessment, and treatment through the WtW funds allocated to the PICs' Service Delivery Areas, and some LDSSs are using existing TANF (VIEW) allocations to fund substance abuse services. Some initiatives focus on the child welfare population. See Appendix VI for a partial listing.

- The Southeastern Virginia Job Training Administration, a private industry council, has also entered into an agreement with each of the area's CSBs[13] for the screening of mental health and substance abuse problems, and provision of non-medical services. The funding for this project supports an on-site clinician for Virginia Beach.

- In Fall 1999, DSS allocated $1.5 million of TANF funds for residential care across the state. A central fund has been established to be accessed by any locality as the need arises. This fund helps to address a major resource gap and allows residential care to be offered to TANF clients who have the most serious problems with alcohol and other drug dependence.

Statewide Planning

- A statewide planning effort is underway to more fully assess needs among TANF clients and other populations, and promote the implementation of effective service models.

- Community planning was incorporated into DSS' Welfare Reform Phase II planning process. All LDSSs were asked to collaborate with community partners and to review their client

[13]The CSBs are in Virginia Beach, Norfolk, Portsmouth, and Western Tidewater (Isle of Wight and Suffolk).

needs and identify gaps. Where needed, LDSSs can request supplemental TANF funding to meet local needs. The funding priority of hard-to-serve TANF clients fits most clients who are abusing substances.

- The outcomes and decisions relative to the HJR 225 study will be relevant to the overall planning process.

Policy Issues

- DSS has taken a series of actions to support TANF clients' participation in substance abuse treatment and additional policies are being put in place or under study that will strengthen the process of identifying and treating substance abuse and dependence.

- DSS has implemented the following procedural changes:

  Effective July 1999, the LDSS employment services worker can temporarily place clients with substance abuse problems in an inactive VIEW status. This temporarily stops the 24-month 'clock' and gives clients time to begin the recovery process. The inactive VIEW status can last for up to 60 days.

  Effective July 1999, provision of treatment and supportive services can continue while the client is in a fixed period of sanction.

  LDSSs may use MOE funds to cover medical expenses related to substance abuse treatment.

  Effective January 2000, policy will permit the provision of transportation, child day care and other support services during treatment hours. These supports may include 24-hour care for those in residential care and "bridge" housing. While these are essential support services, they also provide incentives by eliminating barriers to treatment.

- In policy and other documents that guide the actions of LDSSs staff, DSS will be requesting the following:

  In the VIEW Plan due April 2000, LDSSs must specify their workflow for enhanced services to the hard-to-serve. Strategies for addressing alcohol and drug problems in this population would be part of a comprehensive approach that prepares these clients for the workforce.

  As part of this plan, LDSSs will have a system to screen the hard-to-serve for various barriers, including substance abuse. It is expected that screening for this problem, utilizing the standardized approach, would be managed by certified professionals.

- DSS is continuing to identify the need for policy enhancements and legislative changes. Currently the Department is evaluating the following options to enhancement current VIEW policies and procedures:

  Incorporating alcohol and drug treatment as part of the Personal Responsibility Agreement and service plan;

  Mandating treatment if the inactive status is used;

  Not imposing sanctions if the appropriate level of treatment or support services (for accessing treatment) are unavailable; and

  Requiring a substance abuse screening for any VIEW participant who fails to comply with a VIEW work activity and is sanctioned and optional use of a multi-disciplinary team to review the family situation.

Recommendation 15: On an ongoing basis, local social service agencies and their community partners will identify legislation, policies and procedures that interfere with effective service delivery and local coordination so that they may be addressed at the state level.

Recommendation 16: By July 2000, as services are being implemented statewide, DSS & other agencies will continue to identify and address the need for additional enhancements to the Code, policies and procedures that more effectively address substance abuse problems, as well as provide supplemental guidance to achieve the needed flexibility within TANF and VIEW programs. Further, relevant policies and practices of the child welfare, juvenile justice, family violence, health, and mental health and substance abuse treatment systems should be evaluated to detect barriers to collaboration. To the extent possible policies should be adapted to increase inter-agency effectiveness and optimal use of existing staffing and financial resources.

Summary

- It is clear that agencies at both the state and local levels have made progress in addressing the needs of TANF clients who have substance abuse problems. The development of effective screening programs and the concurrent development of treatment capacity is essential to address the substance abuse problems of the TANF population.

- Some of the service gaps can be filled with additional coordination and innovative use of shared funding. This is an area that will continue to be explored as partners in this effort know more about the specific treatment and support needs of the TANF and related population and the availability of substance abuse treatment resources to serve them.

APPENDICES

Appendix I

SENATE JOINT RESOLUTION NO. 387

Requesting the Department of Social Services, the Department of Mental Health, Mental Retardation and Substance Abuse Services, the Department of Medical Assistance Services, and the Department of Rehabilitative Services to evaluate the effectiveness and applicability of the proposed plan for substance abuse treatment for recipients of public assistance.

Agreed to by the Senate, February 22, 1999
Agreed to by the House of Delegates, February 18, 1999

WHEREAS, substance abuse is often at the root of crime, family violence, poverty, diminished physical and mental well-being, and lost productivity and income; and

WHEREAS, research shows that drug addiction is a highly treatable disease, although often one of the most stigmatized; and

WHEREAS, national studies have confirmed that appropriate treatment significantly reduces alcohol and other drug use, improves medical and social functioning, increases earnings through employment, and reduces drug-related crime and the risk of AIDS; and

WHEREAS, a study of treatment outcomes for welfare recipients in other states showed that the benefit to taxpayers exceeded costs by more than five or seven to one; and

WHEREAS, the Joint Subcommittee to Evaluate the Future Delivery of Publicly Funded Mental Health, Mental Retardation and Substance Abuse Services established a special subcommittee to examine the needs of those recipients of public assistance who have substance abuse problems and as a result are unable to maintain employment and therefore are at risk of having benefits expire; and

WHEREAS, it was this group of recipients, considered "hard-to-serve," that the subcommittee concentrated on in order to find a way to help them get treatment for their substance abuse problems, receive those needed services which would enable them to find and maintain a job, and to provide their families with the help they needed as well; and

WHEREAS, the desired outcomes of treatment for this population include (i) the reduction of welfare and addiction; (ii) that recipients with problems are motivated to participate in treatment; (iii) that recipients are able to maintain employment; (iv) that children and other family members receive prevention services, and (v) that treatment will provide benefits in reducing costs associated with health care and Medicaid, foster care and criminal justice; and

WHEREAS, the Departments of Social Services and Mental Health, Mental Retardation and Substance Abuse Services, along with the Community Services Boards, have developed several service strategies to accomplish this goal, including: (i) providing early

identification and treatment on demand that is at the appropriate level, intensity and duration; (ii) offering a continuum of services that address all barriers, including specialized employment services; (iii) treating barriers concurrent with involvement in work to the greatest extent possible; (iv) organizing treatment around the family, including temporary care of children whose parents require residential care; (v) offering "wrap-around" or "one-stop" support services, preferably community based; (vi) engaging multiple agencies to address all barriers and identifying multiple funding streams; and (vii) providing incentives to encourage participation in and completion of treatment; and

WHEREAS, with certain funds already available through Welfare to Work and Temporary Assistance to Needy Families (TANF), these departments have already begun to implement these programs and a community planning process will be implemented to further refine the resource needs for such a program;

WHEREAS, since the funding is already available for these services, it is imperative that the Departments embark on these new programs in an expeditious manner; now, therefore, be it

RESOLVED by the Senate, the House of Delegates concurring, That the Department of Social Services, the Department of Mental Health, Mental Retardation and Substance Abuse Services, the Department of Medical Assistance Services, and the Department of Rehabilitative Services be requested to evaluate the current program and make recommendations concerning identified needs for long-term changes in substance abuse policies and TANF policy, including administrative policy changes, optional programs available to the state, and options for incentives that encourage participation in and completion of a treatment program. In addition, the departments should report back on localities' progress in implementing the short-term strategies in substance abuse treatment, evaluate the need for substance abuse services for other populations and evaluate this model for future use, and make recommendations for future legislation and funding needs and other resources needed to address substance abuse issues.

All agencies of the Commonwealth shall provide assistance to the Departments for this study, upon request.

The Departments of Social Services, Mental Health, Mental Retardation and Substance Abuse Services, Medical Assistance Services, and Rehabilitative Services shall complete their work in time to submit their findings and recommendations to the Governor and the 2000 Session of the General Assembly as provided in the procedures of the Division of Legislative Automated Systems for the processing of legislative documents.

Appendix II

CONTINUUM OF SUBSTANCE ABUSE TREATMENT SERVICES

Outpatient Services
For clients who have maintained a significant period of sobriety, and who have achieved a level of stability, including vocational or educational involvement, safe and sober housing, stable family and social relationships, and significantly reduced criminal justice involvement.

- Ongoing assessment, including urinalysis
- Individual and group therapy for support
- Involvement of family and significant others
- Access to crisis counseling and maintenance psychiatric services
- Relapse prevention, including stress management
Medication Management
- Ongoing case management with related agencies, and to assess client's need for continued support/treatment

Intensive Outpatient Treatment
Provides treatment services two or more hours per day, two or more days per week.
For clients who have a relatively severe substance abuse problem but who live in a relatively safe and stable living environment, and lack the ability to structure time, access resources, or identify and solve problems successfully.

- Services provided in varying intensity and duration, according to client need.
- Case management for access to psychiatric services, housing issues, and immediate primary health care issues.
- Medication management
- Positive social culture and support system allows client to witness peer success and experience peer support.
- Individual and group counseling.
- Involvement of family and significant others.
- "Hands on" experience with problem solving skills in the context of overcoming addiction or dependence.
- Education about addiction and dependence
- Introduction to self-help groups, such as Alcoholics Anonymous or Narcotics Anonymous.
- Structure and accountability for client time.
- May provide childcare and parenting support
- Access to a wide variety of other community resources and supports, according to client's individual need.
- Discharge planning for the next step in treatment

Detoxification and short-term residential services
Provides a safe and stable environment with an intensive level of clinical oversight, with staff supervision 24 hours per day, 7 days per week, for a period up to 30 days. May include detoxification from alcohol or other drugs.

- Assessment of addiction and readiness for treatment
- Case management for access to psychiatric services, housing issues, and immediate primary health care issues
- Individual and group counseling
- Involvement of family and significant others
- Medication management
- Education about addiction and dependence
- Introduction to self-help groups
- Education and counseling about relapse prevention
- Discharge planning for the next step in treatment

Long-term residential services
Assumes that an assessment of addiction and readiness for treatment indicates that the individual would benefit from an intensive and long-term (60 days or more) investment in treatment. The individual has severe addiction and dependence problems, lacks safe housing, has often neglected primary health care needs, may have a secondary mental illness (e.g., depression or personality disorder), has problems controlling impulses, and has very poor problem identification and problem resolution skills.

- Highly structured and focused treatment experience in a closely supervised environment.
- Case management for access to psychiatric
- Involvement of family and significant others.
- Positive social culture and support system allows client to witness peer success and experience
- Education about addiction and dependence.
- Access to psychiatric assistance, including appropriate medications.
- Education and
- Access to primary health care.
- Direct supervised experience with life skills, such as nutrition, budgeting

services, housing issues, and immediate primary health care issues.
- Individual and group counseling.
- Medication management

peer support.
- "Hands on" experience with problem solving skills in the context of overcoming addiction or dependence.

counseling about relapse prevention.
- Access to primary health care
- Introduction to self-help groups

- May provide parenting classes and may have provisions for childcare.
- Discharge planning for the next step in treatment

Short-term community-based hospital care
For persons with acute physical problems related to severe addiction or dependence, who may also be experiencing acute mental health crises or acute physical illness, requiring 24 hour medical supervision and stabilization. This may be a resource developed on a regional basis.

- Acute detoxification.
- Physical assessment of health problems.

- Psychiatric assessment and stabilization of mental health crisis.

- Case management to involve significant others.
- Medication mgmt.

- Basic patient education about addiction and dependence.
- Discharge

Substance Abuse Residential Treatment Center for Women and Children
Population to be served could include substance addicted/dependent (A/D) women, pregnant A/D women, A/D post-partum women – with or without dependent children (regardless of custody status). This may be a resource developed on a regional or statewide basis.

Specialized Program Elements
- Early identification of women with substance abuse problems
- Residential Component for women
- Residential Component for Pregnant or post-partum women (Perinatal)
- Residential Component for women with young children (specialized child care)
- Welfare to work
- Training Campus (for professional workers)
- Aftercare services
- Programs for children

Involved Agencies (Potential)
- Social Services
- Rehabilitative Services
- Richmond _____ Housing Authority
- VCU/MCV
- Department of Health, Richmond/State
- Private Industry Council
- Faith Community
- Richmond Redevelopment and Housing Authority
- Social Agencies (YWCA, ALLCAP, Boys Club, etc.
- Criminal Justice Agencies (P&P, Drug Court, Sheriffs Office, Day Reporting)

Appendix III

Access to Treatment

Obstacles to Access	Factors Promoting Access
Not identifying individuals in need of treatment	Effective screening, assessment, training
Not reaching clients in locations where they Enter the system; e.g., courts	Satellite sites, systematic linkage, training
Long waiting periods for appropriate services	Services within 72 hours, depending on Severity of clinical need
Multiple steps, people and places needed to access services	Widely available and simplified intake processes
Arbitrary service limits	Individualized treatment plans
Automatic "fail-first" policies	Individualized, comprehensive assessment to guide appropriate placement
Geographic inaccessibility	Well-distributed sites located on Transportation lines
Resource-intensive review and appeal procedures	Highly efficient, publicly known utilization review processes
Excessive and clinically inappropriate exclusionary criteria	Restricted ability to exclude specified types of hours/days of operation
Cultural, gender, or ethnic sensitivities	Priority placed on cultural competence Development
Restrictive co-payments	Elimination of co-payments
Not known, timely, or objective appeal processes	Widely known, objective, timely appeals
Lack of transportation, child care	Transportation, child care available as Needed
Placement criteria that are non-standardized, financially-driven, and/or objectively applied	Placement criteria that are collaboratively developed, clinically driven, objective, and standardized

Source: "Purchasing Managed Care Services for Alcohol and Other Drug Treatment", Technical Assistance Publication Series 16, DHHS, Substance Abuse and Mental Health Sevices Administration

Appendix IV

Federal Funding for Substance Abuse Treatment and Support Services

Funding for Treatment
(both medical and non-medical)

Medicaid
TANF
TANF State Maintenance of Effort
Welfare to Work Formula Grant State MOE
Title IV-B, Social Security Act
Title XX-Social Services Block Grant
Ryan White Comprehensive AIDS Resources Emergency
Substance Abuse and Performance Partnership Block Grant

Non-Medical Treatment Only

TANF Federal Funds
Welfare to Work Formula and Competitive Grants
Title IV-B, Social Security Act –Child Welfare Formula Grants

Case Management

Title XX, Social Services Block Grant
TANF, TANF MOE
Welfare to Work Formula Grants to States, Competitive Grants
Ryan White Programs (HIV-Related)

Other Services

Substance Abuse and Mental Health Services Administration
Community Development Block Grant
Community Services Block Grant
Maternal and Child Health Care Block Grants

Source: American Public Human Services Association. "Federal Funding for substance Abuse Treatment and Support Services, 1989.

Appendix V

Schedule of Planned Activities To Address Substance Abuse Among TANF Clients

Time Frame	Multi-Agency Activities
April 1999-September 2000	**Community Planning**. LDSSs and local partners begin to determine the needs of their VIEW population, review existing resources, and identify unmet needs. Where gaps cannot be met through blending diverse funding (e.g., WtW, VIEW), LDSSs will submit proposals to DSS that address needs and document expected outcomes.
June 1999-December 2000	**Funding Local Projects.** On receipt of proposals from LDSSs, DSS review and approves funding for those that provide expanded services for TANF population, including substance abuse assessment and treatment and other services to address employment barriers.
November 1999-December 2000	**Training.** Begin initial multi-agency training with three statewide sessions focusing on integrating alcohol and drug treatment into VIEW, followed by a series of two-day sessions on screening and treatment and other topics as needed through at least 2000. Integrate with other training and encourage local training initiatives.
December 1999 – 2000	**Guidance**. In consultation with other state and local agencies, DSS will develop and distribute to LDSSs an enhanced guide on addressing substance abuse and dependence. Information will include the service model, screening tools and other information about the process. DSS and other state agencies will provide guidance and technical assistance to local social service agencies and other local organizations.
December 1999-2001	**Funding.** Through a DSS budgetary proposal, DSS is seeking additional funds to expand local capacity for critical services to address barriers associated with substance abuse and other problems, as well as provide more directed employment options. With its state partners and local service agencies, DSS will monitor the status of resources to address needs of the hard-to-serve TANF population.
January 2000 -	**Evaluation.** DSS will develop a full evaluation plan of the hard-to-serve initiatives, including substance abuse. This will include: development of baseline measures; a full process study that will inform the implementation process, identifying both facilitators and barriers to implementation; identification of measures of goal attainment/outcomes; and data collection and analysis strategies. By April 2000, DSS will implement the "hard-to-serve" initiative evaluation plan
By April 2000	**Local Client Flow.** LDSSs, with local partners, complete specification of the work flow for addressing substance abuse on the VIEW caseload. Work flow will reflect decisions with partners on structure of key processes and issues (e.g., screening, roles and responsibilities, professional requirements, location of functions, tools to use, referral processes, case management, payment for services). Variations of the state model will occur related to size and needs of the hard-to-serve caseload, effective service delivery strategies in area, local resources, and other factors. Organizational changes, workload issues, and training will be considered.
April – December 2000	**Community Gaps.** LDSSs, with community partners, will determine resources needed to provide the full continuum of services required for hard-to-serve VIEW and other populations and develop inter-agency plan to address gaps. Identify and promote new strategies to enhance coordination among major service providers for improvement of service delivery.
By July 2000	**Blending State Programs.** Along with other state agencies and organizations, review differing missions, objectives, policies and funding to identify linkages and potential resources (expertise, model programs, and funds) that could be tapped by localities in new ways. In addition, develop a resource guidebook that identifies effective local efforts to coordinate services and address the needs of the hard-to-serve.

Time Frame	Multi-Agency Activities
Jan-Dec 2000 By October 2000	**Other State Level Enhancements**. Expand efforts with DRS, DMHMRSAS, Health, DMAS to address substance abuse at state level, including consultation with local partners. Involve PICs and providers of services to victims of domestic violence where appropriate. **Seamless Services.** LDSSs and community partners will examine differing purposes and resources and determine how best to coordinate, blend and integrate programs and resources to address issues of substance abuse among TANF population. Evaluation should be carried out in terms of such operating issues as intake, assessment, service provision and program outcomes.

Appendix VI

Local Approaches in Addressing Substance Abuse

Local Agency	Initiative
Frederick County	Two Welfare-to-Work counselors on site
Radford	Staff training on substance abuse related issues along with staffing of SA cases
Roanoke City and Roanoke County	Partnership with Blue Ridge Community Services Project LINK. On-site personnel will assess TANF customers for SA and provide case management.
Norfolk	On pilot basis, there is an on-site SA counselor. Also, contract with YWCA to provide specialized employment services to clients in recovery.
Franklin City	Welfare-to-Work coordinator and referrals to DRS and Western Tidewater Mental Health
Mecklenburg	In addition to referrals to CSB, customers are brought before J&D judge and have treatment ordered
James City County	Maintains information library. Old Towne Medical Center screens VIEW customers for SA when needed for employment
Cumberland	Applied for grant to hire a therapist for services for one day per week
Gloucester	JEWEL program will assess barriers (including SA) and teach life skills
Mathews County	On-site family counseling funded in part through family preservation funds. Theses funds target assorted issues faced in "dysfunctional" households. Substance abuse is one of these issues.
Staunton/Augusta	Have applied for funds to provide assessment and treatment
Williamsburg	Department provides child care and respite for customers who have been referred to Community Services for substance abuse services. Social workers provide on-going case management
Hopewell	An in-depth assessment process is under development by the Employment Services Program.
Albemarle County	Accesses Welfare-to-Work program to provide counseling and connections with DRS
Newport News	Maintains a purchase of services agreement with local CSB for vocational services through a private service provider, Lassen House. Customers admitted to day treatment program as a result of screening are placed in inactive status. Once stable, customer is referred back to Employment Services.
Madison	Training and assessment tools have been requested from the CSB. Treatment and related services are provided through the Welfare-to-Work plan
Southampton County	Specific guidelines regarding substance abuse and Child Protective Services (CPS) have been developed. When substance abuse is suspected in CPS cases, customer is asked to submit to screening. Workers seek protective orders in cases where customer refuses to obtain screening.
Hampton	Developing partnership with CSB to provide training for workers
Brunswick	In addition to referrals to CSB, agency works with the court to use a counselor available through a local beer distributor
Alexandria	Memo of understanding on substance abuse that will provide on-site counselor on one day per week to see Alexandria Works! Customers
Bristol	Established CPS guidelines for drug screenings for customers
Fredericksburg	Uses Family Preservation and CSA funds to assist customers with substance abuse services when appropriate
Harrisonburg/ Rockingham	Developed TANF grant proposal to provide assessment and evaluation program
Richmond City	A VIEW-LINK site. In addition to referrals to CSB, requests for protective orders for treatment are sought in CPS and Foster Care cases. Sometimes treatment is paid for in these cases.
Chesterfield-Colonial Heights	Developing joint training with CSB
Patrick County	Have an agreement with local hospital for testing customers who agree to take the test.