

The National Council on Alcoholism and Drug Dependence - NJ

CASASARD and the Work First New Jersey Substance Abuse Initiative

Women, Substance Abuse and TANF, How to Make the Difference!

June 2010


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BACKGROUND

- 1996 – Congress passed the Personal Responsibility Work Opportunity Reconciliation Act (PRWORA) – welfare became an employment directed, time-limited program which emphasized client accountability
- 1997 – The NJ Department of Human Services identified substance abuse as an employment barrier and formed a work group of state policy makers and researchers to design the Work First New Jersey Substance Abuse Initiative (SAI) for welfare recipients


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BACKGROUND

- 1998 – The Work First New Jersey Substance Abuse Initiative is implemented statewide
- 1999 – The CASASARD research evaluation is implemented in 2 counties to study Intensive Case Management for TANF women with substance abuse barriers to employment
- 2004 – System Coordination between Welfare and Child Welfare to maximize services to multi-system families
- 2009 – Behavioral Health Initiative (BHI) implemented in 7 counties to provide assessment and case management to welfare clients with primary mental health disorders

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Mission and Philosophy

Mission: The SAI has an active commitment to help welfare recipients eliminate drug and/or alcohol use as a barrier to employment through coordination of care among multiple agencies, client advocacy, and transitioning clients into the workforce.

Philosophy: The SAI adheres to a client-centered approach to addiction treatment. Clients are actively involved in the clinical decision making process and treatment planning. The SAI refers clients to the most appropriate and least restrictive level(s) of care that will meet all of the clients needs.

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SAI/SARD Program Design

1998 – Statewide Public Health/Managed Care Model:

- Substance abuse clinicians co-located in welfare offices to increase access and engagement
- Independent assessment and care coordination
- American Society of Addiction Medicine (ASAM) criteria, ASI - standardized assessment tool, DSM-IV-TR Diagnostic Impression
- Prior authorization of services, utilization management, fee-for-service reimbursement

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SAI/SARD Evaluation-CASASARD

- 1999 – 2-county (Essex and Atlantic) Substance Abuse Research Demonstration Project (CASASARD) to determine the cost-effectiveness of Intensive Case Management (ICM) services for Temporary Assistance for Needy Families (TANF) women
- Welfare-Reform Goals:
 - Work Readiness and Personal Responsibility
 - Treatment counts as a work activity

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SAI/SARD Program Design

- CC/CM assist with eliminating barriers to treatment such as housing, childcare, and transportation, by coordinating with welfare resources
- Treatment counts towards a mandatory welfare work activity
- SAI monitors client weekly attendance and UDS – attendance compliance or non-compliance is reported to welfare (not UDS)

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SAI/SARD Program Design

Interventions: Access & Retention

Outreach

- Clients are called or sent reminder letters for future assessment appointments or future treatment start dates
- Clients are called or sent letters when they miss assessment appointment
- Clients are called or sent letters when they drop out of treatment

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SAI/SARD Program Design

Interventions: Access & Retention

Treatment Agreements-Accountability

- Clients are required to sign agreement to attend treatment as scheduled and have negative UDS
- Failure to adhere to treatment agreement may result in welfare sanction and/or SAI case closure
- Clients are 100% responsible for their recovery decisions
- Set limits and hold clients accountable for their behaviors

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SAI/SARD Program Design

Interventions: Access & Retention

Motivational Interviewing

- Meet the client at their stage of recovery – empathy, collaboration
- Roll with the resistance to engage client in treatment
- Develop discrepancies – client should present arguments for change, change is motivated by the perceived discrepancy between current behavior and goals
- Support self-efficacy- client’s belief in possibility for change is the motivator

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Work Readiness Outcomes

Client Accountability & Limit Setting

- Weekly attendance and UDS are primary outcomes tracked for progress
- SAI case can be closed for non-compliance and client referred to welfare for sanction – parents behaviors assessed for “child risk/safety”
- NJ has a “duty to report” law – actively using non-compliant parents who refuse to re-engage in treatment are reported to child protective services
- SAI Methadone Policies

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Substance Abuse Research Demonstration:

CASASARD

National Center on Addictions and Substance Abuse at Columbia University (CASA)

Evidence Base Behind SAI

1999-2004

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Study Goals

- Will the intervention have good clinical outcomes?
- Will the intervention lead to self-sufficiency?
- Will the intervention be more cost-effective usual care?

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Study Design

- Randomized Study
- 3 Groups
 - Substance Abusers (SSN used to randomize)
 - Usual Care (UC)
 - Intensive Case Management (ICM)
 - Non-Users
 - Comparison

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Study Design and Interventions

Usual Care (UC)

- Screening in welfare office, clinical assessment, and feedback
- Referral to community substance abuse program based on ASAM level of care
- Low intensive care monitoring

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Study Design and Interventions

Intensive Case Management (ICM)

- Intensive Case Management with enhanced funding for ancillary services
 - Active outreach efforts
 - Assessment and linkage to needed wraparound services
 - Active coordination of treatment and employment training
 - Continuity of care, engagement and retention

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Study Design and Interventions

- Contingency Management (CM) Program
 - Incentives provided for completion of assessment
 - Incentives provided for treatment attendance and negative UDS.
- Implementation challenges and changes to (CM) post-research

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Client Profiles (N=452)

	Substance Abusers	Non-Substance Abusers
* p<.05, **p<.01,***p<.001,****p<.0001		
Age ****	36	28
Ethnicity *		
AA	95%	86%
Hispanic	3%	10%
Other	2%	4%
Years of Education	11.1	11.4
Years on Welfare****	12.0	5.8
Number of Children *	3.3	2.8

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Substance Abusing Client Profiles

- Moderate to Severe Substance Abuse Problems
- 70% using cocaine or heroin
- 8-10 years duration of problem
- 1/3 assigned to inpatient AOD treatment
- Many Other Barriers/Problems
- Mental Health Disorders (> 50%)
- Domestic Violence (38%)
- Low Job Skills (45%)
- Unstable Housing (50%)
- Health or Child's Health (23%)
- Criminal Justice Involvement (55%)

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Cross Systems Involvement

* p<.05, **p<.01,***p<.001,****p<.0001	Substance Abusers	Non-Substance Abusers
Ever Arrested****	56%	15%
Ever Incarcerated ****	25%	5%
Child Welfare Investigation (ever)****	84%	48%
Lived in an emergency shelter (past year)***	30%	18%
Long-term welfare recipient (> 5yrs)****	73%	36%
Prior substance abuse treatment****	70%	2%
Received emergency assistance (ever)	80%	64%

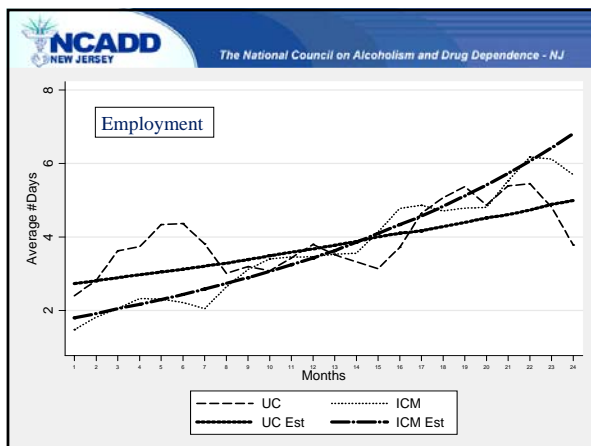
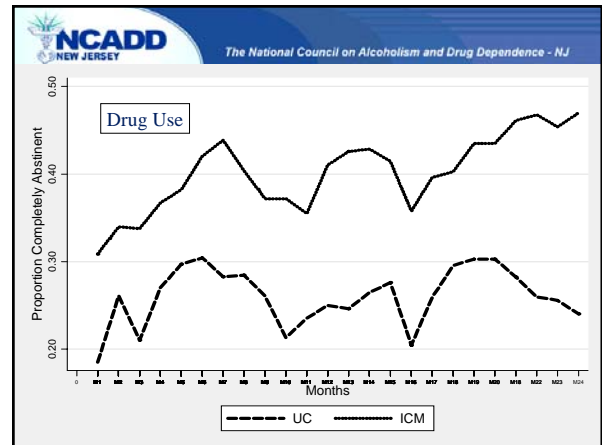
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INTERGENERATIONAL PROBLEMS

* p<.05, **p<.01,***p<.001,****p<.0001	Substance Abusers	Non-Substance Abusers
Parent(s) of TANF Client		
One or more parent with substance abuse problem***	71%	36%
Parent received welfare	53%	61%
Children (Age 12-17) of TANF Client		
Expelled or Suspended from School**	40%	11%
Having/Fathering Baby Prior to Age 18***	17%	0%
Arrested**	12%	4%

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SARD Lessons Learned

- Substance abusing mothers experienced problems across multiple domains & were involved in multiple systems
- Findings offer strong support for the SARD approach
 - Screening, assessment, and feedback in welfare office
 - Intensive case management and incentives

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SARD Lessons Learned

- High rates of child welfare involvement, drug use, domestic violence, maternal depression, and housing instability raise serious concerns about the safety and well being of 3-4 children in these families
- Next steps to improve outcomes
 - System coordination issues
 - Address parenting/child well-being

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POST-RESEARCH 2004

State and Local Collaboration: Welfare and Child Welfare

Expansion of SAI Case Management

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State and Local Collaboration

- New Jersey Department of Human Services' Division of Family Development (NJDHS-DFD) – state agency responsible for welfare
 - Work First New Jersey Substance Abuse Initiative (SAI)
- New Jersey Department of Children and Families' Division of Youth and Family Services (NJDCF-DYFS) – state agency responsible for child protective services
 - Child Protective Substance Abuse initiative (CPSAI)
- New Jersey Department of Human Services' Division of Addiction Services (NJDHS-DAS) – single state agency responsible for substance abuse planning and monitoring of treatment providers

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State and Local Collaboration

- 2004-2005 the NJDHS/DFD, NJDCF/DYFS and NJDHS/DAS developed a 12-county Systems Coordination (SC) process to:
 - Identify multi-system parents with substance use disorders
 - Increase their access, engagement and retention in treatment
 - Integrate service planning and case management across systems
 - Maximize funding streams and reduce duplication of effort
- The DFD-SAI and DYFS-CPSAI collaborate on the local level to refer DYFS-welfare parents to the SAI and DYFS-only parents to CPSAI
- DAS increased residential and outpatient treatment services for DYFS parents and children

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State and Local Collaboration

Shared Caseloads: 2004 NJ Data

- NJDCF-DYFS administrative data indicated a minimum of 31% of active DYFS cases were welfare
- NJDHS-DFD administrative data indicated a minimum of 25% of TANF cases were active DYFS
- CASASARD research data indicated 84% of TANF parents in the 2-county evaluation project had current or historic DYFS cases as an adult

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State and Local Collaboration

NJDCF-DYFS Linking Initiative

- NJDHS-DFD and NJDCF-DYFS MOU to fund SAI and CPSAI "Systems Coordinators" in 12 counties and share information
- Clients sign HIPAA and CFR 42 Part 2, "Release of Information" to allow communication among the multiple systems
 - DYFS, DFD, SAI, CPSAI, Treatment Agency, Courts, Probation, welfare
- Monthly Case-Conferencing Consortia in 12 counties to discuss and manage complex cases – participating agencies:
 - DYFS, DFD, SAI, CPSAI, Welfare, Treatment Providers
- SAI and CPSAI manage Family Drug Court Cases and attend weekly FDC sessions in Essex County with DYFS, DFD, Welfare

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Expansion of SAI Case Management

Research Based Expansion of Services:

- **Intensive Case Management Services** – More intensive case management with Essex and Camden TANF/GA DYFS clients; short-term monetary incentives, minimum of one face-to-face contact monthly, caseload in the 30s
- **Enhanced Care Coordination Services** – Case management with TANF/GA DYFS clients in 10 counties; no incentives, face-to-face contact when needed, caseloads between 40-50
- **Care Coordination Services** -Coordinating care for GA and TANF clients statewide (non-DYFS)

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Adapting ICM To Your Program

- Client outreach – reminder call prior to intake, client letter sent after multiple absences
- Collaboration and communication are key – engage other systems involved with the client
- Motivational Interviewing
- Multi-agency reciprocal ROI, meeting HIPAA and CFR 42 Part 2 regulations
- Multi-system interventions when needed

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Adapting ICM To Your Program

- ROI signed by clients to communicate with community partners and systems – frequent case conferences
- Client Advocacy – obtaining resources/services whenever possible (not advocating for clients to avoid the consequences of their behaviors)
- Treatment Agreements – participation, negative UDS, holding clients accountable
- Contingency Management Program – low-cost vouchers to reward success

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Adapting ICM To Your Program

- Reinforce the welfare-to-work program goals (and/or child welfare, court goals) with clients – collateral information improves treatment planning
- Include welfare-to-work outcomes and requirements in treatment plans and counseling sessions
 - work readiness skills, attendance, UDS results
- Balance support and setting limits with motivational interviewing
- Use client and program data to make service and service delivery decisions

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Future Trends

- Integration of Substance Abuse and Mental Health – NJ treatment providers offer COD services
- NJ now has DMHAS instead of two divisions
- Providers must be pro-active and plan for integration
- Funding tied to program and client outcomes

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Future Trends – NJDHS/DFD

- Integration of substance abuse and mental health
 - 2008-09 65% of SAI clients had co-occurring mental health
 - April 1, 2009, NCADD-NJ implemented the Behavioral Health Initiative (BHI) as a “pilot” in 7 Counties
- The BHI serves welfare recipients with primary Axis I mental health disorders that interfere with employability by providing access to treatment services and necessary supports – many BHI clients have substance use disorders

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Future Trends NJDHS/DFD

- BHI Care Coordinators assess, case manage and work collaboratively with community agencies to assist clients with moderate mental health disorders to become self-sufficient and gainfully employed
- BHI clients with serious, persistent mental health disorders are medically deferred from a traditional work activity and referred to NJ Legal Services Social Security Initiative to apply for SSI benefits
- BHI clients are referred to COD treatment providers

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In Conclusion

To Quote Nelson Mandela:

"Safety and security don't just happen, they are the result of collective consensus and public investment. We owe our children, the most vulnerable citizens in our society, a life free of violence and fear."

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Appendix – Program Data

SAI Client Flow Statistics Since 1998

- **88,561** welfare referrals to SAI
- **57,210** clients assessed (65% of total referrals)
- **51,547** assessed with a substance abuse problem
- **38,700** have entered treatment program

- 75% of assessed men and women with substance abuse as a barrier to employment have entered treatment

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Appendix – Program Data

- **14,182** GA/TANF DFYS referrals
- **10,344** DYFS clients assessed (73%)
- **9,475** assessed to have a substance abuse problem
- **7,202** have entered a treatment program.

-76% of assessed DYFS involved men and women with substance abuse as a barrier to employment have entered a treatment program.

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CHECKLIST

The factors listed below are behaviors that are associated with children being in danger of immediate or serious harm. Identify any that apply to children living in the household. Consider the vulnerability of each child living in the home. Remember, young children are particularly vulnerable, while older children with mental, emotional, physical disabilities or previously victimized often cannot protect themselves. In situations where some but not all of the children are affected, identify each child affected in the narrative. Finally, remember that a history of previous reports of child abuse or neglect are strongly associated with new incidents of child maltreatment.

- Caregiver leaves child alone who is not able to care for him/herself or caregiver leaves child with a person who is unwilling or unable to provide adequate care.
- Child is fearful of caregiver(s), other family members, or other people living in or having access to the home.
- The behavior of a child living in the home threatens immediate harm to himself or to others and the caregiver cannot control the behavior.
- Caregiver is verbally hostile when talking to or about the child and/or caregiver has extremely unrealistic expectations about the child's behavior.
- Violence among the adults living in or having access to the home seriously impairs the necessary supervision or care and/or physical safety of the child.
- Caregiver has caused serious harm to the child or has made a plausible threat to cause serious harm to the child.
- Caregiver has an unconvincing or illogical explanation for the child's injury or physical condition.
- Caregiver refuses access to the child, there is reason to believe that the family is about to flee, or the child's whereabouts can not be ascertained.
- Caregiver has not, cannot, or will not protect the child from potential serious harm, including harm from other persons living in or having access to the home.
- Caregiver is unable or unwilling to meet the child's immediate needs for supervision, shelter, food, clothing, medical or mental health care.
- Caregiver appears indifferent to child's safety or injuries or other health conditions that require immediate attention and concern.
- Child sexual abuse/exploitation is suspected and circumstances suggest that continued sexual abuse is an immediate concern.
- Physical conditions in the home are hazardous and immediately threaten child's safety (e.g. utilities shut off, environment is dirty, has odor, lacks electricity, working bathroom, heat or hot water, heated by gas stove or space heater, lives in abandoned building or other unsafe environment).
- Caregiver's behavior is violent or out of control, appears dazed, unsteady, slurred or confused speech, talks about hurting her/himself or others.
- Drug or alcohol use by caregiver or others living in or having access to home, places the child in immediate danger.
- Caregiver's involvement in criminal activity or criminal activity of others living in or having access to the home endangers the child.
- The physical or mental health or other mental limitations of caregiver or persons living in or having access to the home endanger the child.
- Client's financial situation has seriously worsened which endangers the safety or supervisory of the child, no visible means of financial support, or TANF cash grant or food stamps reduced or closed because of sanctions; unexplained losses in money, food stamps or EBT card.
- There is a pattern of homelessness or frequent changes in address which are not due to natural disaster.
- Caregiver has an unconvincing or illogical explanation for school age child not being in school or child has been expelled from school; child lacks immunizations necessary for school attendance.
- Child's clothes are dirty, unwashed, have an odor, clothing is inappropriate or insufficient.
- Other _____

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Client Name: _____ Name of Person Completing Checklist: _____ Date: _____

**National Council on Alcoholism and Drug Dependence (NCADD-NJ)
Interagency Consent To Release and Request Confidential Alcohol and Drug Information**

I, _____, Print Client Name and Date: _____

Authorize The National Council on Alcoholism and Drug Dependence Clinical Staff and the agencies authorized below to release information to and obtain information from all of the agencies checked and initiated below:

Check, complete, and date if not apply:

The _____ County Board of Social Services _____ Designee/Contact _____ (date initial)

The Division Of Youth and Family Services _____ Designee/Contact _____ (date initial)

_____ Name: (Address of other Treatment Provider that will allow information to and request information from NCADD-NJ) _____ (date initial)

_____ Name: (Address of other agency that will allow information to and request information from NCADD-NJ) _____ (date initial)

I authorize the following information to be released to and requested from these agencies:

<input type="checkbox"/> Welfare Information Name, Address, SSN, Telephone, Age, Care and Medical Number, Eligibility/Assistance Status, Benefits, Work Activity Status.	<input type="checkbox"/> Assessment Information Name, Assessment Dates, results, history, Date of Admission, Treatment and Service Plans, PAs, Programs, Attendance, Drug Test Results, Discharge Summary (date, type, status).
<input type="checkbox"/> DYFS Information Name, SSN, Case Status, Dates, Children Status.	<input type="checkbox"/> Employment Information Name, Case Status, Work Readiness and Participation.

The purpose of this authorized disclosure is to enable NCADD-NJ Clinical Staff to determine its eligibility for various benefits and services, assist and coordinate services, to establish a record of any progress and program of treatment, to authorize payment for and monitor services that I need, and to coordinate service planning with my Welfare, DYFS and Treatment Provider(s).

I understand that my records are processed under the federal regulations governing the confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and **Protected Health Information under the Health Insurance Portability and Accountability Act of 1996, 45 U.S.C. Section 17061, et. seq. and the regulations thereunder, including 45 CFR, Parts 160 and 164.** I understand that I may not use this information for any other purpose, except as set forth herein, or to collect data which has been obtained in relation to it. If my contacts are reviewed, I understand that the listed agencies will be notified and my eligibility for benefits and services may be affected. In any event, the correct information requires two (2) years from the date recorded on the release.

Name/Signature of Recipient (if recipient is a minor) _____ Date: _____

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NEW JERSEY DEPARTMENT OF HUMAN SERVICES (DHS)
Division of Youth and Family Services (DYFS) Confidentiality Agreement

The Division of Youth and Family Services (DYFS) is required to keep information about their current and former clients confidential. Therefore, individuals who do work for DYFS and who are either employees or non-employees (e.g. volunteers, students, interns, non-paid staff, provider agency staff, professionals, parents, foster grandparents, etc.) are required to maintain confidentiality of all current and former clients' information and case records. Types of information to be kept confidential include but are not limited to:

1. Names, listings of names, identifying data, addresses of current and former clients mentioned in the case records;
2. Past and present financial, social, medical, psychological, substance abuse, mental health and educational information about current and former clients mentioned in the case records;
3. Identification of services that agencies are providing to clients mentioned in the case record, including but not limited to protective services.

Only designated DYFS staff may approve the release of clients and/or clients' case records information, photographs, and/or case records under the following conditions:


1. When the information ~~data~~ relate to child abuse, the information may be released only in accordance with the specific exemptions that permit disclosure as set forth in N.J.S.A. 9:6-8, 10a, and/or CFR 42 Part 2 and/or HIPAA (Health Information Portability and Accessibility Act).
2. When the information ~~data~~ relate to child abuse, the information may be released only if the client or the parent/legal guardian of a minor client signs a release of information that permits disclosure as set forth in N.J.S.A. 9:6-8, 10a, and/or CFR 42 Part 2 and/or HIPAA (Health Information Portability and Accessibility Act).

It is a violation of state and/or federal law to disclose certain client information that (a) is not released in accordance with the specific exemptions that permit disclosure as set forth in N.J.S.A. 9:6-8, 10a, and/or CFR 42 Part 2 and/or HIPAA, or that (b) does not have the signed consent the client or the non-legal guardian of a minor client as set forth in N.J.S.A. 9:6-8, 10a, and/or CFR 42 Part 2 and/or HIPAA. Any person who releases or encourages the release of confidential information may be guilty of a misdemeanor which may result in a fine and/or imprisonment.

In addition to keeping client information confidential, all reports and publications written by or for the agency, and not approved by the DYFS for release must be kept confidential within the agency. By signing this form, I acknowledge that I have read this confidentiality statement, understand its content and agree to comply with it. I agree to maintain client confidentiality and the confidentiality of DHS and/or provider agency reports not approved for public release.

Print Name of DYFS Representative and Date	Print Name of Non-Employee and Date
Signature and Title	Signature and Title
Work Location(s)	Work Location(s)

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