CASASARD and the Work First New Jersey Substance Abuse Initiative

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

June 2010

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

NCADD-NJ WFNJ Care Coordination Services 1

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

NCADD-NJ WFNJ Care Coordination Services 2

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.

NCADD-NJ WFNJ Care Coordination Services 3

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

NCADD-NJ WFNJ Care Coordination Services 4

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

NCADD-NJ WFNJ Care Coordination Services 5
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)

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

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

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

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

Substance Abuse Research Demonstration: CASASARD

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

Evidence Base Behind SAI 1999-2004
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?

Study Design

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

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

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

Client Profiles (N=452)

<table>
<thead>
<tr>
<th></th>
<th>Substance Abusers</th>
<th>Non-Substance Abusers</th>
</tr>
</thead>
<tbody>
<tr>
<td>**Age ****</td>
<td>36</td>
<td>28</td>
</tr>
<tr>
<td>Ethnicity *</td>
<td></td>
<td></td>
</tr>
<tr>
<td>AA</td>
<td>95%</td>
<td>86%</td>
</tr>
<tr>
<td>Hispanic</td>
<td>3%</td>
<td>10%</td>
</tr>
<tr>
<td>Other</td>
<td>2%</td>
<td>4%</td>
</tr>
<tr>
<td>Years of Education</td>
<td>11.1</td>
<td>11.4</td>
</tr>
<tr>
<td>Years on Welfare ****</td>
<td>12.0</td>
<td>5.8</td>
</tr>
<tr>
<td>Number of Children *</td>
<td>3.3</td>
<td>2.8</td>
</tr>
</tbody>
</table>

*p<.05, **p<.01, ***p<.001, ****p<.0001
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%)

Cross Systems Involvement

<table>
<thead>
<tr>
<th></th>
<th>Substance Abusers</th>
<th>Non-Substance Abusers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ever Arrested***</td>
<td>56%</td>
<td>15%</td>
</tr>
<tr>
<td>Ever Incarcerated</td>
<td>25%</td>
<td>5%</td>
</tr>
<tr>
<td>Child Welfare Investigation (ever)****</td>
<td>84%</td>
<td>48%</td>
</tr>
<tr>
<td>Lived in an emergency shelter (past year)***</td>
<td>30%</td>
<td>18%</td>
</tr>
<tr>
<td>Long-term welfare recipient (&gt; 5yrs)****</td>
<td>73%</td>
<td>36%</td>
</tr>
<tr>
<td>Prior substance abuse treatment****</td>
<td>70%</td>
<td>2%</td>
</tr>
<tr>
<td>Received emergency assistance (ever)</td>
<td>80%</td>
<td>64%</td>
</tr>
</tbody>
</table>

INTERGENERATIONAL PROBLEMS

<table>
<thead>
<tr>
<th></th>
<th>Substance Abusers</th>
<th>Non-Substance Abusers</th>
</tr>
</thead>
<tbody>
<tr>
<td>One or more parent with substance abuse problem***</td>
<td>71%</td>
<td>36%</td>
</tr>
<tr>
<td>Parent received welfare</td>
<td>53%</td>
<td>61%</td>
</tr>
<tr>
<td>Expelled or Suspended from School**</td>
<td>40%</td>
<td>11%</td>
</tr>
<tr>
<td>Having/Fathering Baby Prior to Age 18***</td>
<td>17%</td>
<td>0%</td>
</tr>
<tr>
<td>Arrested**</td>
<td>12%</td>
<td>4%</td>
</tr>
</tbody>
</table>

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
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

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

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

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

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

State and Local Collaboration

POST-RESEARCH

2004 State and Local Collaboration:
Welfare and Child Welfare
Expansion of SAI Case Management
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)

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

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

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
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.”
The Division of Youth and Family Services (DYFS) is required to keep information about their current and former clients confidential. Therefore, individuals who work for DYFS and who are employees, 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 records; including but not limited to protective services.

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

1. When the information relates 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 does not 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. 30:4-24.3, Administrative Order 2:01, 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 parent/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

Work Location(s)

Contact Information

Annette Riordan, PsyD
New Jersey Department of Human Services – Division of Family Development
Transitional Services and Special Initiatives Unit
6 Quakerbridge Plaza P.O. 716
Maysville, NJ 08619
Tel: 609.631.4525 Fax: 609.631.4541
Email: annette.riordan@dhs.state.nj.us

Stacey Wolff, NCC, LPC, LCADC, ICADC
NCADD-NJ
360 Corporate Blvd.
Robbinsville, NJ 08691
Phone: 609.477.7004 Fax: 609.689.0595
Email: swolff@ncaddnj.org