CHAPTER II: IDENTIFICATION OF CALWORKS PARTICIPANTS WITH AOD/MH/DV BARRIERS TO EMPLOYMENT AND REFERRAL TO ASSESSMENT AND/OR SERVICES

Introduction

Identifying CalWORKs participants with AOD/MH/DV issues is a complex process that occurs differently in the six counties. This chapter explores the counties' approaches to identification of such individuals and the process of referral to assessment and/or services according to six elements of the overall process:

- ***Methods used to identify individuals in need of assistance –*** The two basic methods that have been used for identification are encouragement of self-disclosure and screening using a standardized instrument or set of questions.

- ***The role of training in the identification and referral process –*** The focus is primarily on the training about AOD, MH, DV issues provided to eligibility workers and employment counselors with some mention of training for the AOD, MH, and DV systems about CalWORKs. The relationship of training to referral rates is also explored.

- ***Settings in which identification efforts occur –*** Locations for identification include CalWORKs offices, other employment-related sites such as Job Clubs, community setting through active outreach, and AOD, MH, and DV programs which provide the "back door" way into CalWORKs.

- ***Structure and use of co-location –*** Co-location has been the organizational arrangement that has been most used to enhance the identification and referral efforts.

- ***Special issues regarding individuals who are exempt from Welfare-to-Work requirements and those who have been sanctioned for failure to comply with requirements –*** This section discusses identification issues for two particular TANF sub-populations – those who are exempt from CalWORKs Welfare-to-Work requirements and those who have been or are in the process of being sanctioned.

- ***Issues involved in making in-depth assessments of individuals identified as possibly needing AOD/MH/DV services –*** Assessment occurs once CalWORKs participants have been identified as having potential AOD, MH, or DV issues. The nature of the assessment process and the feedback of that information to the referrer are explored.

Throughout we describe practices based on our site visits and intersperse results from our surveys of welfare staff. Surveys of welfare staff were conducted in all case study counties except Alameda.

Methods Used to Identify Individuals in Need of Assistance

This section describes the two basic approaches used to identify TANF participants with AOD, MH, and DV issues – encouraging self-disclosure and screening. As described below we use the term "self-disclosure" broadly to cover identification that results from participants' revealing that they have an issue, for example in response to a social marketing effort or to informal questioning by a staff member, or in a group Job Club setting. It also covers identification that results from the observation of the participant's behavior that indicates that there might be an issue, e.g. signs or symptoms or failure in a Welfare-to-Work activity. The term "screening" is reserved for either formal screening instruments or the use of a routine set of questions asked of all CalWORKs participants at a particular point in the process.

Self-Disclosure

The most common approach to identification in the six case study counties has been the encouragement of self-disclosure of AOD, MH, and DV issues. The strategy of self-disclosure is based on the following assumptions:

- Show-up rates for follow-up assessment and treatment will be best when participants willingly acknowledge their AOD, MH, or DV issues.
- Most participants want to work and are willing to acknowledge barriers if they believe that they can get help for them.
- It was initially thought that AOD/MH/DV problems would be obvious when participants started working. In other cases workers could be trained in the recognition of signs and symptoms which could lead to a conversation and questioning that would result in self-disclosure.
- Many participants who received AFDC over several years were known by staff to have AOD/MH/DV difficulties, but there had not previously been a mandate to address these problems. In these cases, disclosure had already occurred.

Self-disclosure

County	Active Social Marketing	Presentations and Information About Services
Alameda	Planned	Medium
Kern	No	Medium
Los Angeles	No	Low [1]
Monterey	Yes	High
Shasta	No	High
Stanislaus	No	Low

[1] Since the last Project site visit, orientations about AOD, MH, and DV services are being provided in CalWORKs District Offices.

The counties vary in the amount of emphasis they put on self-disclosure and the ways in which they encourage it. The following are the approaches we have seen in the six counties:

- Social marketing through the use of posters and materials that encourage a positive view of obtaining assistance for problems

- Informing participants of the availability of services either through printed material in information packets, use of video-taped messages in waiting rooms, or presentations in orientations

- Building referral relationships with the staff who run the Job Club workshops. When such workshops run for four to five days there is a group bonding and a considerable amount of sharing of personal stories

- Encouraging employment counselors to spend enough time with participants (time permitting) to gain their trust and to follow-through on either signs and symptoms of problems or behavioral manifestations of AOD, MH, or DV issues

- Having a specially trained eligibility worker who takes over the application process if self-disclosure is made or thought likely (only in Los Angeles)

Information about AOD/MH/DV services is not getting to all TANF participants in a routine way. Data from the survey of supervisors of eligibility workers and employment counselors suggest that counties may not be maximizing their opportunities to provide participants with information about AOD, MH, and DV issues and services. The survey asked whether the workers they supervise give information about AOD, MH, or DV issues and services to all of their clients. The results for the eligibility worker supervisors show that such information is not being disseminated routinely. The results also suggest that each county's policy is similar whether the issue is MH, AOD, or DV, with greater variation across counties than across the three subject areas.

Percentage of Eligibility Worker Supervisors Who Say Oral and/or Written Material about AOD/MH/DV is Given to *Every* Participant, by County

Materials	County				
	Kern Percent	Los Angeles Percent	Monterey Percent	Shasta Percent	Stanislaus Percent
Alcohol and Other Drugs					
Oral	50	72	47	86	18
Written	58	72	28	80	12
Mental Health					
Oral	44	70	41	86	18
Written	53	70	39	80	12
Domestic Violence					
Oral	50	77	47	83	18
Written	67	73	28	83	12

The results from the employment counselor supervisors are similar. In only one county did employment counselor supervisors report consistently that both written and oral information is given to each participant. One county said that it is given orally but not in written form. In none of the other counties for either oral or written was there substantial agreement among supervisors and in no county did the percentage answering "yes" rise above 50 percent.

The results from those participants who had received DV services are consistent with the above results. Only about half of the respondents report that a CalWORKs staff person had told them about the Family Violence Option. Another 40 percent said they had not received such information, and 9 percent were unsure. The question is somewhat ambiguous since it says a person "told" them. It is possible that people received written information without it having been explained.

Results from DV Client Survey

Did CalWORKs Staff Tell You About FVO Option?	Number	Percent
Yes	42	51.9
No	32	39.5
Not sure	7	8.6
TOTAL	81	100.0

Although the numbers of supervisors reporting by county are very small, these are issues of policy and/or implementation worth pursuing. Either policy direction is not clear, or supervisors are honestly reporting that staff are not uniformly adhering to policies.

Issues for Consideration in Implementing a Self-disclosure Strategy:

- ☑ The change in orientation of CalWORKs to a "helping" program will take time; large bureaucracies do not change quickly. And, there is likely to be a further lag until "the word is on the street" about the change. In a number of welfare offices we visited, the physical environment still consists of barred windows, metal detectors, and armed guards. Under these circumstances, it will be hard for many participants to trust the system enough to self-disclose problems that may yield negative consequences for them. This is particularly the case with AOD where mothers fear the loss of their children.

- ☑ There needs to be some clear incentive for participants to disclose issues. Unless counties provide concrete information that they will waive (for some period of time) all work requirement hours for those participating in treatment, disclosing may just seem to mean attending services on *top* of the other requirements.

- ☑ Effective presentations that engage participants in the issue of the impacts of AOD, MH, and DV on their lives take more than the 2-3 minutes that is often allotted to this activity. This is particularly the case where participants are receiving a ream of other orientation information or are anxious about either qualifying for aid or what CalWORKs will mean in their lives.

- ☑ State regulations require that every CalWORKs applicant and recipient be given information about the Family Violence Option and the availability of services for DV issues. The design of an effective way to present this information and a system to track that the information is being routinely conveyed to TANF recipients should be a part of every CalWORKs program. Experience in our six counties indicates doing it well is more difficult than it seems.

- ☑ Policies for the distribution of information about AOD, MH, and DV issues and the availability of services need to be clear so that all eligibility workers and employment counselors know what they are expected to do. Supervisors need to be clear on the policies and must track the implementation of those policies.

Promising Practices for Encouraging Self-disclosure:

- ☑ Monterey has developed a campaign on the theme of "recovery is an opportunity of a lifetime" posters, and materials with this theme are widely visible in the welfare offices. It is being extended to a media campaign and a focus on neighborhoods with high percentages of CalWORKs recipients.

- ☑ Stanislaus is working toward a model of a combined welfare staff person who would handle all of a participant's needs, determining eligibility for any programs for which they qualify, as well as managing the employment part of the participant's program. While not yet fully implemented nor tested, the concept of having one person rather than several would enhance the quality of the relationship and make self-disclosure more likely. However, trust is not likely to result if the integrated functions result in a greater workload for staff.

- ☑ Stanislaus has an active community services program in which CalWORKs clients are assigned to work sites. The Department of Employment and Training and local community college managers of these placements work closely with the work site supervisors and are able to track the progress of participants. When problems arise, the program managers have the background information that allows them to confront participants about issues that have created barriers to their ability to sustain placements.

- ☑ One Los Angeles welfare office redecorated and reorganized so that it looked and felt like a Kaiser health office. Although the intent was to change the entire nature of the relationship with the "customer," it had the effect of increasing the trust necessary for self-disclosure.

Screening [2]

Screening for AOD/MH/DV issues follows a medical model of using simple, brief, inexpensive tests that indicate the need for further diagnostic work-up. Screening instruments have been developed for all three issues and have most often been used in medical settings, particularly among pregnant women and in emergency rooms. These instruments usually approach the sensitive issues of AOD, DV, and MH indirectly, for example, by asking how often someone felt guilty about their drinking. Ideally, instruments have been tested so that a "cut-point" score can be selected that optimizes the accuracy of the test for the population. Even if validated

[2] See the Introduction for a description of the meaning of "screening," "assessment," and "appraisal" as used in this report.

information on accuracy at different cut-points is not available, a standard set of questions can be considered a "screen" if it is administered to all participants and a referral is made on the basis of a standard scoring of the answers. The rationale for screening is as follows:

- It allows for earlier identification of problems. Participants are not forced to fail, further exacerbating their problems.

- It substitutes an "objective" instrument for eligibility worker judgment – judgments that workers often do not feel comfortable making.[3] In principle, the accuracy of such judgments is known (in practice it has differed more significantly among welfare recipients than in other populations).

Screening choices among the six counties – During the planning stages for the AOD and MH components of CalWORKs, many counties considered the implementation of some screening instrument. The County Welfare Directors Association requested from CIMH the development of screening instruments for AOD and MH that welfare staff could use to determine who should receive a more thorough assessment. Counties that decided to adopt a screening approach had to decide the following:

- What screening instrument to use

- When and in what setting to do the screening

- What the consequences of a positive screen would be

Following is a summary of the choices that the six case study counties made in regard to screening:

[3] Los Angeles Department of Public Social Services. Evaluating CalWORKs in Los Angeles: http://dpss.co.la.ca.us/calworks.c/evaluating calworks_rptl.htm

Screening

County	Content	How	When	Consequences
Alameda	One question	Written Form	▪ Application ▪ CalWORKs Orientation	Assessment not mandatory
Kern				
Los Angeles	Eight questions	Oral	▪ Eligibility worker at application and recertification ▪ GAIN worker at end of CalWORKs Orientation ▪ Education vocational assessor at vocational assessment [4]	Assessment mandatory
Monterey [5]	One question	Written	Appraisal	Assessment not mandatory
Shasta				
Stanislaus	▪ Multiple questions ▪ AOD testing when required by employer	▪ Written form ▪ Drug test	▪ After 4-week job search if not successful ▪ Before community service placement	▪ Assessment mandatory ▪ Assessment mandatory

Kern, Monterey, Shasta, and Stanislaus did not utilize screening instruments or processes at the front end of the Welfare-to-Work process. Stanislaus uses screening methods later in the process. It routinely administers an extensive screening form if a participant fails to obtain a job during the first four weeks of job search. Participants will be referred for drug testing if it is required by the employer. Many community service employers require drug testing prior to placement. A positive drug test results in an automatic referral for a mandatory assessment.

Alameda has a form that includes a question about whether there are reasons why the participant cannot work. There are boxes for MH and for AOD problems. The form is filled out by all new applicants and all participants in its CalWORKs Orientation. Welfare department social workers in some welfare offices attempt to make contact with anyone who has filled in either the MH or the AOD box. The participant is free to refuse such contact and to refuse to obtain an assessment that is recommended based on the screening question.

[4] CalWORKs participants in Los Angeles who do not have a job at the end of the Job Search are referred to an in-depth vocational assessment under a contract with the Los Angeles County Office of Education.

[5] Monterey utilizes the SASSI for AOD screening at any point in the process where an employment social worker, EAP staff, or DV social worker expects a problem. We do not include it in the table because its use is not routine.

The experience of the screening process in Los Angeles – Of the six counties, Los Angeles has relied the most heavily on screening. [6] The screening instrument consists of four MH and four AOD questions. [7] A "yes" answer to any of the MH questions results in a referral to an MH assessment. A "yes" answer to any of the AOD questions results in a referral to an AOD assessment. The person doing the screening can also make a referral based on observed behavior, or if the person self-declares a problem. Attendance at the assessment is mandatory. [8]

The screening process was initially conducted only by the employment counselors, but was expanded in May 1999 to occur at the time of initial eligibility determination, at entry into CalWORKs, and at annual recertification for CalWORKs. The intention was to identify participants needing support services as early in the process as possible so that their eligibility could be expedited allowing them to qualify earlier for CalWORKs and the support services that accompany enrollment in CalWORKs.

The employment counselor asks the screening questions during her meeting with the participant after a CalWORKs orientation. The Los Angeles August 1999 report on the implementation of CalWORKs [9] indicates that many DSS workers are uncomfortable asking screening questions. Furthermore, some believe that the questions can be insulting to the TANF participants and can interfere with their attempts to develop a trusting relationship.

We heard similar comments from some CalWORKs line staff that we interviewed:

- Participants feel defensive, like they are being accused.
- Ones in denial don't know how to deal with it.

The range of the percentage of participants showing positive on the screening ranged between 4.2 percent and 6.4 percent a month from November 1998 through August 1999. This percentage has remained roughly equivalent as the process has expanded from the roughly 2,500 – 4,000 new CalWORKs registrants monthly to the 8,000 – 10,000 new TANF applicants and new CalWORKs registrants since the process has been expanded. The ratio of MH to AOD positive screens over this time-period was 2.4 to one.

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[6] Los Angeles had implemented a universal screening process for AOD problems with the general relief population. This experience led to the early adoption in Los Angeles of a screening approach to similar problems in the CalWORKs population.

[7] The AOD portion of the screening instrument consisted of the four questions from the CAGE alcoholism screener adapted to include drugs. The AOD portion of the screening instrument was being expanded in late 1999. The mental health portion was not a standard screening instrument but one developed (but not validated) specifically for this role.

[8] Participants are required to attend assessments when referred for either an AOD or MH problem. But they are required to attend services only if it is an AOD service. They do not have to attend MH services to which they are referred.

[9] "Monitoring the Implementation of CalWORKs: Welfare Reform and Welfare Service Provision in Los Angeles County, 1998." Urban Research Division, Chief Administrative Office, County of Los Angeles, August 1999.

Issues for Consideration in Implementing Screening:

- ☑ Screening has yielded relatively low numbers of positives. In Los Angeles, approximately 5% of those screened are referred for an assessment. Positive answers have been particularly low for the AOD questions, about 1%. However, it is unclear how much of this low positive rate relates to the context in which the screening is done, including whether eligibility or employment counselors administer the screen.
- ☑ The screening can interfere with relationship building. Some of the employment counselors in Los Angeles, where the questions are asked at their first meeting with a client, feel that the questions interfere from the very start with their efforts to establish a co-operative relationship with the participant.
- ☑ The context and timing of the screening is crucial. No matter how good the questions, CalWORKs applicants will be reluctant to answer truthfully if they fear the consequences of their answers. This is particularly the case with AOD where women fear the loss of their children.
- ☑ Los Angeles is modifying its process to provide the participants with information about the availability of AOD and MH services prior to asking the screening questions in the hope of engendering more honest answers.
- ☑ Counties considering screening might also consider focus groups of CalWORKs recipients which would discuss what kinds of context might allay fears and make the use of the instrument(s) more valid.
- ☑ There is little work to date on the reliability or validity of screening instruments with this population or in the context of welfare reform. The CalWORKs Project research will provide validation of selected screening instruments, at least within a research context. The SASSI, a much longer instrument than the CAGE and one that also generates a score for "denial" of problems, is widely used in Oregon and other states – although it too has not been formally validated for this purpose.
- ☑ Screening instruments do exist for domestic violence (developed for use in emergency rooms), although none of the six counties used them. [10] Given the inconsistent dissemination of Family Violence Option information the "indirect" questions of a screening instrument could be useful in directing recipients to FVO specialists on the DSS staff.
- ☑ Screening instruments have frequently been used in other settings for identifying heavy drinkers (not necessarily those who are alcohol dependent). While not excluding such persons, none of the six counties specifically have focused on this population. Instead the assumption is usually made that the persons with AOD problems in CalWORKs will, like those already in the county-based service system, be persons who are dependent on alcohol or drugs.

[10] The Los Angeles DV community specifically recommended not using a screening instrument. Instead, each CalWORKs participant is given information about the FVO and DV services and asked to sign a form indicating that such information was given to her.

The Role of Training in the Identification and Referral Process

Variation in Training Emphasis among Study Counties

While all counties provided some training to their eligibility workers or employment counselors, the emphasis placed on it varied considerably. Policy discussions in 1997, prior to the implementation of CalWORKs, presented training of DSS staff as an alternative to using screening instruments. The belief was that if staff were well-trained, they would be able to either identify signs and symptoms of AOD, MH, and DV issues, and/or feel more comfortable in discussing the issues more informally with CalWORKs participants. Most counties thought that a major investment in training of DSS staff would assist either in better implementation of screening protocols and/or in promoting the broadly defined self-disclosure described in the previous section.

Counties varied in their initial training efforts in the following areas: [11]

- How much emphasis they placed on training in their overall identification strategy, and
- Who received the training

The following table indicates the overall emphasis the county placed on training and the amount of training designed to be given to employment counselors and eligibility workers. Those counties that trained DSS staff over a period of time concentrated first on employment counselors, believing that they were the more likely source of referrals. They then moved this training up in the process to include the eligibility workers.

[11] Most counties also offered training about the CalWORKs program to AOD/MH/DV management and providers. While we do not specify the content and hours of this training in this report, the Project believes that this has been a critical part of successful collaborations.

Emphasis on Training by County

County	Overall Emphasis	Who is Trained
Alameda	Low	▪ One-day training for employment counselors and social workers ▪ Training of eligibility workers has been a disputed issue with union ▪ DV training has been in planning stages for over a year
Kern	Moderate	▪ Half-day for DSS staff on AOD/MH; none mandatory for the staff of the private contract agency doing CalWORKs employment counselor functions ▪ 8-hour training on DV by local program
Los Angeles	High	▪ GAIN workers trained first; two-day training on AOD and MH ▪ Second training for all other staff (also a two-day training on AOD and MH); everyone covered by end of 1999 ▪ All staff get an additional 6-hour DV training
Monterey	High	▪ 36-hour training initially for employment workers ▪ Same training then given to eligibility workers
Shasta	Low	▪ Two trainings for DSS staff, each less than one hour in length ▪ Training focused on procedures for making referrals
Stanislaus	Moderate	▪ 18-hour AOD/MH/DV training for employment counselors and direct service providers ▪ 8-hour AOD/MH/DV training for eligibility workers

The following two tables present data from the surveys of eligibility workers and employment counselors, and thus represent an average of the amount of training that they remember having received. The number of hours is less than in the table above because some of the workers surveyed were hired after the training had been concluded. In general, employment counselors reported having received about one hour more training in each of the areas than eligibility workers, but there were substantial differences among the counties. Monterey County provided the most extensive training program for both eligibility workers and employment counselors. In a few counties a different reliance was placed on training for eligibility workers and employment counselors, reflecting in part their different expectations of who would be responsible for identification and referral. In Stanislaus, for example, the responsibility for identification and referral rested most clearly on the employment counselors and this group received more training than did the eligibility workers.

Eligibility Workers Responses on Staff Surveys
Mean Hours of Training by Issue and County

Type of Training	Kern	Los Angeles	Monterey	Shasta	Stanislaus
Alcohol and Other Drugs	4.7	5.2	17.0	1.6	2.2
Mental Health	2.6	5.1	18.2	1.4	2.3
Domestic Violence	4.4	5.2	17.5	3.2	7.7

Employment Counselors Responses on Surveys
Mean Hours of Training by Issue and County

Type of Training	Kern	Los Angeles	Monterey	Shasta	Stanislaus
Alcohol and Other Drugs	1.9	7.6	21.2	4.3	10.5
Mental Health	3.1	7.5	15.7	3.4	10.3
Domestic Violence	2.5	7.1	18.7	7.7	12.3

Staff Ratings of Training

In general, eligibility workers and employment counselors reported that the trainings were helpful. Similar percentages of eligibility workers and employment counselors rated the trainings as "very" or "moderately helpful" in Kern and Los Angeles, but in the other three counties the employment counselors rated the trainings as more helpful than did the eligibility workers. In Shasta and Stanislaus this could reflect the fact that the latter group received significantly more hours of training. In Monterey the reasons are less clear since both groups received roughly the same extensive number of hours of training. Los Angeles stands out across the two groups of workers as having the highest favorableness ratings on helpfulness of training.

Percent of Eligibility Workers Rating Training as Moderately or Very Helpful, by Issue and County

Issue	Kern	Los Angeles	Monterey	Shasta	Stanislaus
Alcohol and Other Drugs	74.3	84.5	70.8	52.9	54.8
Mental Health	77.9	82.8	66.2	45.5	55.6
Domestic Violence	78.6	86.3	67.1	77.5	61.5

Percent of Employment Counselors Rating Training as Moderately or Very Helpful

Issue	Kern	Los Angeles	Monterey	Shasta	Stanislaus
Alcohol and Other Drugs	72.3	85.8	89.5	80.8	78.3
Mental Health	79.3	87.0	94.7	87.0	70.2
Domestic Violence	78.9	84.8	89.5	89.7	85.7

Comments from eligibility workers – The final question on the eligibility survey asked for any other comments. A total of 168 eligibility workers provided 181 comments. The largest category – 39 percent – related to the need for additional training. The most common volunteered response from eligibility workers to a general question about "what else should we know" on the survey was that more training would be useful. Below is just a sample of the numerous comments about the desire among eligibility workers for more training on how to identify AOD, MH, and DV issues and what to do once these issues are identified:

> "I think we need more training in all these areas. These are three of the big issues affecting our clients and how they are dealing with life issues. We need to know how to recognize the signs and how to bring up the fact that they need services and make referrals."

> "Constant training on a yearly basis regarding these issues."

> "I attended all three classes at 8 hours a day. I feel more in-depth training can be useful to all levels of eligibility staff to better understand and be more knowledgeable about interviewing and dealing with MH/SA/DV applicants or participants."

> "We received training but the amount of training was inadequate because then there was no follow-up or refresher training. I went to wave-training 15 months ago and haven't had any exposure to the information since then."

Comments from employment counselors – Employment counselors also volunteered comments requesting additional training, but not in as great a number as with the eligibility workers. The same question on the employment counselor survey generated 88 responses from 81 respondents; 26 percent indicated a desire for additional training on AOD, MH, and/or DV issues. A few examples follow:

> "Not enough training. No specific guidelines on how to assist these problem participants."

"We need more training in these areas to best counsel our clients. Sometimes clients may ask what happens at the [AOD/MH] assessment or initial referral and following. The worker may not be able to let the client know…"

"I think more training in identifying possible persons with AOD/MH/DV barriers would be very helpful."

Impact of Training on Referrals

The biggest impact of the amount of training on the number of referrals that eligibility workers or employment counselors make occurs where there is either no training or a lot of training. The relationship between the amount of training and the number of referrals that the eligibility workers report making is complicated.

- Whether or not an eligibility worker makes any referrals is influenced by the amount of training, but the number of referrals made is not.

- Whether or not an eligibility worker reports making any referrals is considerably less likely (36 percent) if the eligibility worker reports having received no training; is much higher (66 percent) if the worker has received a lot of training (over 30 hours); but is little different (48 – 54 percent) within the middle range of hours of training (1 to 30 hours).

For employment counselors the biggest difference is again between those that received no training and those that received a lot. The mean number of reported referrals for those receiving no training is 1.2. For those with over 30 hours of training, the mean number of reported referrals is 6.8.

Issues to Consider in Implementing Training of DSS Staff

- ☑ How often the training will be given. The substantial turnover in DSS staff means that any training effort needs to be more than a one-time activity. Twenty-seven percent of eligibility workers, for example, said they had received no MH or AOD training and eighteen percent said they had received no DV training.

- ☑ The content of the training. Most counties have included what could be called AOD- or MH- or DV-101 information. Most have also had information on that county's policies and procedures for identifying these issues and for making referrals. Feedback from one county was that the more specific and action-oriented the information, the better.

- ☑ Many suspect that the prevalence of the issues covered in the training – particularly the DV – is relatively high within the DSS staff. It can be expected, therefore, that the training will evoke personal reactions within the DSS staff that the training must be able to be used to achieve a positive end.

- ☑ Training in DV is different from that for AOD/MH in some respects, as the primary focus of the training needs to be on the provisions of the Family Violence Option as set out by law and regulation. Contextual information about nature and prevalence of DV needs to relate both to the Family Violence Option and to women who choose not to pursue that option.

- ☑ Based on the results of our survey of eligibility workers, the provision of even a minimal amount of training for eligibility workers appears to increase the probability that the worker will make at least one referral. Similarly, the provision of at least some training for employment counselors increases the mean number of referrals. Beyond that, unless the county initiates a very comprehensive training program (more than 30 hours) it is unlikely (again based on the results of our survey) that either the probability of any referrals (for eligibility workers) or the mean number of referrals (for employment counselors) will increase.

- ☑ Counties should evaluate the usefulness of the training they offer. Based on the eligibility worker and employment counselor surveys, different trainings were rated as more or less helpful in different counties.

It appears as if the training plays the role of making eligibility workers feel both "more comfortable in talking to participants about AOD, MH, and DV issues" and "more prepared to talk to them about policies and procedures related to AOD, MH, and DV issues." The same pattern is found here – providing *any* training increases the proportion of eligibility workers who feel comfortable and prepared, but big increases do not come until very large amounts of training are provided.

Note, though, that a substantial proportion of those with high levels of training indicated it was obtained outside of the CalWORKs program – by volunteering at a DV shelter, for example. So high levels of training also indicate higher interest and motivation.

Promising Practices for Training

☑ Monterey County not only carefully planned an extensive training, it also conducted an evaluation of that training so that subsequent training efforts could be more useful to staff.

Settings in which Identification Efforts Occur

CalWORKs Offices and Personnel

Efforts for identifying CalWORKs participants with potential AOD, MH, or DV barriers to employment have concentrated on the eligibility and the employment counselor staff working in CalWORKs offices.[12] This seems logical on the face of it given that:

- Every CalWORKs recipient has an eligibility worker, and all CalWORKs Welfare-to-Work participants have an employment counselor
- The participants are required to have at least some regular contact with each type of worker, and
- Each type of worker is supposed to be tracking what happens with the participant's progress from Welfare-to-Work

It would appear, therefore, that focusing on these two parts of the CalWORKs system would be most likely to yield the largest payoff. As noted above, many hours of training have been

[12] The exception to this statement among the case study counties is Alameda. While referral relationships were developed with DSS, the union issues precluded as active a focus on DSS staff as in other counties.

devoted to increasing the knowledge of these staff about AOD, MH, and DV issues and procedures have been put in place in each county for how to identify and refer.

Employment counselors are generally clearer that the identification and referral to assessment or services of participants with AOD, MH, and DV issues is a part of their job than are eligibility workers. In only one county do more than 10 percent of the employment counselors report that either this is not part of their job, or they are unsure about whether or not it is. Eligibility workers, on the other hand, are less sure, with three counties having more than 25 percent responding that it either is not part of their job, or they are unsure whether or not it is.

Identification of AOD/MH/DV issues by employment counselors and eligibility workers – Our survey asked workers to estimate the number of referrals of CalWORKs participants to AOD/MH/DV assessments or services they had made in the last three months. A far higher percentage of employment counselors than eligibility workers reported having made at least one referral in the last three months (87% vs. 35%). Similarly, the average number of referrals made by employment counselors was higher at 5.0, compared with 3.7 for those eligibility workers who made any referrals.[13]

There were significant differences among the counties in the mean number of referrals reported by the eligibility workers and employment counselors over the last three months.

Mean Number of Referrals by Eligibility Worker and Employment Counselor, by County

County	Eligibility Workers Who Made Any Referrals		All Eligibility Workers		All Employment Counselors	
	N	Mean	N	Mean	N	Mean
Kern	53	2.4	98	1.3	65	4.4
Los Angeles	152	4.3	312	2.1	154	3.1
Monterey	40	3.2	79	1.6	19	8.7
Shasta	13	2.3	36	0.8	28	7.9
Stanislaus	51	3.7	96	1.9	50	8.6

A small proportion of both eligibility workers and employment counselors make a large proportion of the referrals – The top 20 percent of the eligibility workers and employment counselors in terms of number of referrals accounted for 52 percent and 55 percent of the referrals respectively of all referrals made by their group of workers. There are at least two potential implications of this finding:

[13] The mean number of referrals per eligibility worker including those who made no referrals is 1.8.

- The potential exists for high rates of identification and referral by eligibility workers and employment counselors should all become as comfortable and expert at identifying AOD, MH, and DV issues, and/or
- Some DSS workers are more skilled at this type of identification activity, and a fruitful strategy would be to identify who they are and give them a larger role in the identification process

Two major barriers to eligibility workers and employment counselors making more referrals are large caseloads, and not feeling comfortable or prepared to deal with these issues – A clear barrier to identification is the size of the caseloads and the increased amount of other work that has come with CalWORKs. Caseloads for both types of workers are very high in most counties[14] making it difficult for either the eligibility workers or the employment counselors to spend much time with the participant, or to track progress in any reliable or thorough fashion. Here are some comments from the survey:

> EW: "It is difficult to have time to deal with our clients on a one-to-one basis. Many of my clients have drug issues but I am unable to follow up on these clients."
>
> EW: "We are overwhelmed with the cases. We don't have enough time to give clients the information regarding AOD/MH/DV or give complete interviews to observe if there is anything else we could help them with."
>
> EW: "Most workers don't understand or want to understand the issues around AOD and MH. I don't think its because they aren't caring, it's just that with the workload and all the complex changes, they don't have the time to look for signs, unless they are blatant."
>
> EW: "We would be more helpful in implementing programs and referrals for our clients if we didn't have so many cases and other things to do. So their problems come last. We don't have time to care!"
>
> EC: "As an employment counselor I really don't get a lot of one-on-one interaction, even though the position implies I do."

A second factor in eligibility workers and employment counselors not making more referrals is that some eligibility workers and employment counselors do not feel prepared or comfortable with this part of their role, despite training. The amount of preparedness and comfort that

[14] RAND in its overall evaluation of CalWORKs notes that the welfare staff "workload has increased." Their findings confirm what respondents told us, that both the number of cases increased and the amount that needs to be done with each case increased. Jacob Klerman, Testimony to California State Health and Welfare Committee, December 8, 1999. County Boards of Supervisors have often denied staff increases on the grounds that caseloads have been declining rapidly, and that they do not wish to add more county employees in a program they see getting smaller over the years. Additionally, as noted by Klerman, even where new staff or contracts for outside staff were approved, the time delay in hiring or contracting did not relieve the workload of existing welfare department staff.

workers feel in dealing with AOD, MH, and DV issues appears to make a difference with the employment counselors in the number of referrals that they make, but this relationship is not as clear with eligibility workers.

Our staff survey asked a) how prepared the workers felt to identify participants with AOD, MH, or DV issues, b) how prepared they were to talk about AOD, MH, DV policies and services, and c) how comfortable they felt in talking about these issues with their clients. We combined these into one general scale of "preparedness and comfort" and found sizeable differences among employment counselors in the numbers of referrals made. The higher the rating on the scale, the more prepared and comfortable the staff was.

Mean Number of Referrals per Employment Counselor, by Rating of Preparedness and Comfort

Combined Rating of Preparedness and Comfort	Number of Staff	Mean Referrals
Rating from 2-5	19	2.2
Rating from 6-8	58	4.5
Rating from 9-11	128	4.8
Rating of 12	108	6.1
TOTAL	313	5.0

For eligibility workers there was not a relationship between whether or not *any* referrals were made, but there was a trend (not statistically significant) for a higher number of referrals to be made for those with higher Preparedness/Comfort self-rating.

System-level barriers to increasing referrals – Some system barriers to increasing referrals from eligibility workers and employment counselors (particularly for AOD issues) will take a longer time to address. TANF recipients have built up over many years a perception of welfare workers as not helpful. Traditionally, most of their interactions with eligibility workers were limited to rule-governed eligibility determinations that did not accommodate recognition of their particular situation or needs. Early referral information suggested that fewer CalWORKs clients were being referred for AOD than for MH issues. Anecdotal reports suggest that there is greater concern among those with AOD problems that disclosing their situation to an eligibility worker or employment counselor may put them at risk for loss of their children.

As part of this study we surveyed roughly 600 TANF clients who were receiving AOD, MH, and/or DV services, whether or not they were part of the county's "official" CalWORKs AOD/MH/DV program (see Chapter III for more details about the sampling and other results). These results suggested that within this sample, CalWORKs participants receiving AOD services were less likely to have been referred from welfare than were MH clients.

Self-Reported Sources of Referral to AOD and MH Programs, Percent in Each Category

	AOD (N=258) Percent	MH (N=225) Percent	Total (N=483) Percent
Came on own	32.6	23.1	28.2
Welfare referred	13.2	44.9	28.0
Court, probation, parole or CPS	26.4	4.9	16.4
Friend, family, or health provider	19.4	17.8	18.6
Someone else	8.5	9.3	8.9
TOTAL	100.0	100.0	100.0

Information about the source of DV referrals from a number of programs in Los Angeles suggests that most CalWORKs clients they are serving are not referred from welfare. They report 31 percent coming on their own, 21 percent being referred from welfare, 22 percent from a friend, family, or health care provider, and 26 percent from someone else.

Issues to Consider in Increasing the Number of Referrals from Eligibility Workers and Employment Counselors

- ☑ The critical step for eligibility workers to take is making the first referral. Based on our staff survey, roughly 40 percent of the eligibility workers either feel like identifying AOD/MH/DV issues is not part of their job or that they are "not at all" or "very little" prepared to do so. These percentages vary by county and type of issue, but there appear to be a substantial number of eligibility workers who won't make any referrals unless they are either given more training and/or given a clearer message about the importance of the activity.

- ☑ The level of preparedness/comfort varies among employment counselors with those feeling most prepared/comfortable reporting making more referrals. This suggests either increasing the activity to make them feel more prepared/comfortable and/or identifying those with high self-reported preparedness/comfort and giving them a larger role with participants more likely to have AOD, MH, or DV issues.

- ☑ Eligibility workers and employment counselors indicate that high caseloads make the identification and referral process more burdensome. Until caseloads can be reduced there may be limits to how much can be expected from eligibility workers and employment counselors despite all the training and their best intentions.

- ☑ Consideration should be given to adopting and *publicizing* a policy on the circumstances under which an AOD or DV issue will result in a referral to Child Protective Services (CPS). This is a potential way to reduce the distrust on the part of CalWORKs participants, so long as the policy focuses on the well being of the child as the basic criteria and as long as it is consistently followed.

- ☑ Despite all the best efforts, relying on eligibility workers and employment counselors for most AOD referrals may be problematic. Counties may want to explore the alternate routes into services discussed below especially for CalWORKs participants with AOD issues.

Other Sites Frequented by CalWORKs participants

Participants who are engaged in the CalWORKs process must spend a considerable amount of their time engaged in some work-related activity. Many of these settings have staff (or employers) who get to know the participant well or who at least have the responsibility for tracking the performance of the participant. To take advantage of these individuals as potential sources of referral requires the following:

- Identifying those parts of the CalWORKs process where the participant is most likely to either spend a lot of time or develop a relationship with some CalWORKs staff. Examples include the Job Clubs, One-Stops, and work activity placements.

- Doing outreach to these sites informing them of service availability, and

- Ensuring that access to services from these sources can be expedited

Issues to Consider in Doing Identification in Settings Frequented by CalWORKs Participants

☑ Implementing this strategy requires a review of the CalWORKs process from the perspective of the participant in order to identify those settings where the participant spends a fair amount of time. Someone at that setting then needs to receive sufficient training to be able to identify when the participant may be having difficulty because of an AOD, MH, or DV issue. Thus, the strategy requires an investment of resources if it is to be successful.

☑ This strategy also involves outreach to staff who may well be working on contract, as, for example, most of the instructors of Job Club orientation sessions are. This means adjusting contract goals from a narrow focus on training to a broader focus that includes concern with AOD/MH/DV barriers.

Promising Practice in Identifying AOD/MH/DV issues in Settings Frequented by CalWORKs Participants

☑ Stanislaus County has developed a community service component in which all CalWORKs participants who do not get a job are assigned. The community service program is run by a special unit within the Department of Employment and Training and the local community college. Caseworkers from these units become familiar with participants since they track their ongoing status within their community service placements. They are thus in a good position to identify participants who might have an AOD/MH/DV issue that is an obstacle to obtaining and maintaining a placement. These staff are encouraged to make referrals for assessments by the Behavioral Health Team.

Community Outreach Strategies of AOD/MH/DV Identification

One county – Alameda – has actively engaged in "case finding" in the community. Alameda developed its community outreach strategy in part because it was unable to implement the usual approach of relying on DSS eligibility workers and employment counselors. Unresolved union contract issues precluded the involvement of DSS staff in the kind of active identification and referral efforts that were initiated in the other five counties. Alameda County undertook two different community outreach strategies involving:

- A media campaign
- AOD and MH outreach staff

Alameda hired a public relations firm to plan a media campaign beginning in November 1999. A video tape that explains the CalWORKs process and the availability of AOD, MH, and DV services was produced and sent out to every sanctioned CalWORKs participant.

In the spring of 1999, Alameda Behavioral Health Care Services hired roughly 15 FTE AOD and MH staff who would make contact with organizations and settings in which CalWORKs participants were likely to spend time. Some staff are county employees and others are hired by contract agencies. Staff are culturally and linguistically quite diverse in keeping with the ethnic and linguistic makeup of the county.

Considerations in Developing an Outreach Effort

- ☑ In Alameda's case, lack of referrals meant funds for AOD and MH services were going unspent. But in the long run and in other counties such programs are likely to be expensive, so the results should be carefully monitored.
- ☑ Once participants are identified through such an outreach effort, they must have easy access to the system of services or the benefit of the outreach effort will not materialize. A direct "hotline" to a designated DSS staff member, such as one established for AOD providers in Kern, might be a necessary adjunct for outreach programs.
- ☑ The ability to make the linkage from the outreach worker to the regular service system will also be dependent on building participant trust. Sufficient time needs to be allotted for the outreach phase in order to ensure that the trust is established and can be transferred.

Promising Practice for Outreach

☑ AOD and MH outreach workers in Alameda have contacted the community-based organizations (CBOs) that have contracts to provide Job Clubs and work-related activities with CalWORKs participants. Alameda provides many of these services through CBOs because of their cultural and linguistic acceptability to many CalWORKs participants. The outreach workers have made these contacts because these agencies are likely to know the CalWORKs participants best.

"Back Door" Referrals from AOD/MH/DV Service Providers

The many barriers to identification in the context of the welfare system have led (particularly for AOD and DV) to increased efforts to identify CalWORKs recipients or potential recipients at treatment or service sites. In varying degrees, counties have encouraged AOD/MH/DV service providers to identify any of their clients who are CalWORKs or potential CalWORKs eligible to help them get their services incorporated into Welfare-to-Work Plans. There are two distinct aspects to this outreach depending on whether:

- The client is already a CalWORKs participant but either has no Welfare-to-Work plan[15] or does not have the services included in the Welfare-to-Work Plan
- The client is eligible for CalWORKs but is not a recipient

In the former, the issue is whether and how to have the participant have the services included in her WTW Plan. In the latter it is whether and how to have the person apply for CalWORKs.

Back door referrals involve a complex set of pros and cons dependent on whether one is a recipient, an AOD/MH/DV service provider, or a DSS administrator.

Another factor increasing the attention to back door referrals is the realization that many AOD and MH clients have difficulty navigating the CalWORKs system. Thus, AOD and MH providers are including in their service package assistance to clients in both gaining CalWORKs eligibility where needed and advocacy for them in acquiring all needed support services once they are eligible (see clients' viewpoint of this assistance).

[15] All CalWORKs recipients received at least a letter informing them of the CalWORKs requirements by January 1, 1999. However, in some counties during the study period a number of participants still had not been called in to meet with employment counselors and develop a Welfare-to-Work Plan or had not followed through with such appointments.

Two Variations of "Back Door" Clients

	Client Already on CalWORKs	Client Eligible But Not on CalWORKs
Issue	Having the services included in WTW plan	Having the client become a CalWORKs beneficiary
Fiscal incentive to DSS	Neutral	Negative because the county then has to pay for the cash benefit
Fiscal incentive to county AOD and MH departments	▪ Positive if required as part of contract with DSS ▪ Neutral otherwise	Positive
Fiscal incentive to individual service providers	▪ MH – neutral ▪ AOD – depends on contract with county ▪ DV – positive if required in contract	▪ MH – neutral ▪ AOD – depends on contract with county ▪ DV – positive
Other positive or negative incentives for individual provider	▪ Going through the paperwork and serving as an advocate with the DSS is a time-consuming task ▪ Providers do, however, appreciate the added services available – which can facilitate treatment success	▪ Negative: paperwork ▪ Positive: CalWORKs services can increase treatment success
Potential benefits to client	▪ Hours included in WTW hours ▪ Child care and transportation for services ▪ Good cause waivers for DV	▪ Assistance and/or advocacy with CalWORKs by AOD/MH/DV service provider ▪ All the CalWORKs services
Potential costs to clients	▪ Possible Child Protective Services (CPS) involvement ▪ Start the requirements and clock if don't already have a WTW Plan	Start clock on lifetime use when need may not be the highest

Issues to Consider in Developing "Back Door" Approaches

- ☑ Not every person receiving services for an AOD, MH, or DV issue is unable to work. Using the back door approach to identifying CalWORKs participants thus requires the separate step of making an assessment that the issue for which services are being given in fact constitutes a barrier to employment. This issue is handled inconsistently by service providers since there is little guidance available as to how to make these determinations.[16]

- ☑ Service providers need more information and training about CalWORKs if they are to provide their clients with accurate and useful information that will allow them to make educated decisions about whether to apply for CalWORKs and whether to have their services included in their WTW Plan.

- ☑ Some of the motivation for the back door approach was as a way to ensure that the CalWORKs allocation was expended, particularly in those counties where the funding agreement required that the services be included in the WTW Plan. With the increasing clarity that the CalWORKs funds can be used flexibly,[17] decisions on whether to include the services in the WTW Plan can be made on the basis of what is in the best interests of the particular client.

[16] See our Resource Guide for review of the scant literature on this issue, available on the CIMH web page, www.cimh.org

[17] See, for example, the State DSS All County Information notice No. I – 82-99, October 28, 1999, which says that funds can be used for "outreach and marketing of services" and "capacity building."

Promising Practices in Utilizing "Back Door" Identification

- ☑ In Los Angeles, eligibility workers are assigned to some of the large AOD programs and spend time at the site of these programs. This facilitates the co-ordination with DSS so that CalWORKs participants in treatment can get what they need from CalWORKs, and those not yet eligible for TANF can be assisted in the application process.
- ☑ The DV programs (in Los Angeles and in Alameda) provide an active advocacy role in assisting existing CalWORKs participants to obtain good cause waivers under the family violence option when this is appropriate. They also assist women in completing applications for CalWORKs.
- ☑ In Los Angeles, each county-operated and county-contracted MH clinic was given a list of their clients who had Medi-Cal aid codes that indicated that they were already receiving CalWORKs. The clinicians then raised the issue of whether or not the client wanted the treatment hours added to the WTW Plan. This allowed the clients to become better educated about the choice and its potential benefits and costs.
- ☑ The Kern County welfare department assigned a special staff member to handle all of the calls from AOD providers in order to facilitate the process.
- ☑ In Alameda County, providers have learned to contact particular DSS social workers who are in a position to facilitate whatever is needed from the DSS system.
- ☑ Los Angeles County issues Provider Directives so service provider agencies get consistent information on how to facilitate access to CalWORKs services for their participants. One Provider Directive includes guidelines and complete instructions for "back door" referrals.

Structure and Use of Co-location

Patterns of Staff Co-location

In an all-county survey (December 1998), co-location of AOD/MH/DV specialists at DSS offices was cited by the counties as the most promising approach to identifying CalWORKs

participants with AOD, MH or DV issues.[18] Co-location at DSS offices follows from the emphasis placed on obtaining referrals from eligibility workers and employment counselors. The basic functions that co-located AOD, MH, DV staff can provide that are likely to enhance referrals and/or improve show rates at assessments include the following:

- Being able to do assessments quickly, ideally at the very time someone appears, thus reducing "fall-out" in this step
- Directly intervening with and diverting persons having an emotional crisis at the welfare office
- Building trust and informal relationships with welfare staff
- Keeping welfare staff informed of policies and procedures relevant to AOD, MH, and DV issues
- Doing presentations to groups of CalWORKs participants during orientations, Job Clubs or workshops

Five of the six counties used AOD/MH/DV service staff co-located at DSS sites, but the functions of co-located staff did not follow a single pattern.

Not all of the counties had their co-located staff provide all of these functions. Kern, Monterey, and Shasta implemented the most comprehensive co-location efforts. The AOD and MH staff are located full-time at the DSS offices and have an expansive view of their roles. They make concerted efforts to integrate themselves into the DSS culture through both formal and informal connections. They make presentations about AOD and MH services to groups of CalWORKs participants at CalWORKs orientations. And they make themselves available to assist DSS workers in crisis situations that arise with CalWORKs participants. They also are used by DSS staff both formally (stress management classes) and informally (individual private contacts) to deal with their own AOD or MH issues.

[18] Statewide, 32 counties reported that they co-locate AOD and/or MH staff. Co-location was the most frequently mentioned "successful strategy" by counties for identifying AOD and MH issues. Ebener, P.J., & Klerman, J.A. (2000). *Welfare Reform in California: Results of the 1999 All-county Implementation Survey.* Santa Monica: RAND.

Co-location

County	AOD	MH	DV	Expansiveness of Role
Alameda	No	No [19]	Partial	Low
Kern	Yes	Yes	No [20]	High
Los Angeles	No	Yes	Partial	Low [21]
Monterey	Yes	Yes	Partial	High
Shasta	Yes	Yes	No	High
Stanislaus	Yes	Yes	Yes	Medium

Co-location at Stanislaus has most of these features – particularly full-time location at the central CSS location and outstations. But the general reliance on a more formal referral mechanism, a more stringent view about problems that are barriers to employment, greater physical distance between the welfare and the behavioral health offices, and the lack of presentations to groups of participants sets this county somewhat apart from the former three.

Co-location in Los Angeles occurred only with MH, and the role of the co-located staff was limited primarily to conducting scheduled assessments. Co-located MH staff provided some crisis intervention and training of DSS staff, but most interaction between the clinical assessors and the DPSS staff was about individual clients. Because of the indirect way appointments with the assessor were made (frequently a letter was mailed after the client had left the office), this arrangement did not maximize the benefits possible with co-location. Co-location of non-DSS staff at DSS locations in Alameda did not occur at all during the initial CalWORKs implementation.

Only one of the counties – Stanislaus – co-located DV specialists on-site on an almost full-time basis. Other counties attempted to have DV specialists on-site for a few hours a week or have someone available via beeper, but these arrangements proved difficult to sustain since the specialized help was not generally available when needed. Counties tried to at least set aside a private space in which participants with current DV issues could call the local DV program directly.

[19] Alameda has begun the co-location of MH staff since the last Project site visit.

[20] Effective January 2000, DV staff are co-located at DSS sites.

[21] Since the last Project site visit, AOD, MH, and DV providers have been given the responsibility to provide orientations to CalWORKs participants at welfare offices, refugee centers and Job Clubs.

Perception of Co-location among Staff

Surveyed eligibility workers and employment counselors indicated that co-location was useful, but the perceived usefulness varied by county. Of those eligibility workers who said they had either AOD, MH, or DV staff co-located at least some of the time, over half (53 percent) said that they found this "very helpful," with another quarter saying it was "moderately helpful." The overall figures were similar for employment counselors – 48 percent said it was "very helpful" and another 32 percent said it was "moderately helpful." There was some difference among the employment counselors in their ratings of usefulness across the counties with the highest ratings of usefulness in Shasta (96 percent) and the lowest in Los Angeles (76 percent).

Between 30 and 50 percent of the eligibility workers in two counties were unaware of co-located staff. In these instances they are unlikely to make use of the availability of such resources:

> "Our unit was mostly unaware that there is an (AOD/MH/DV) person here in ____ for a few hours a week."

In their comments on the survey, some eligibility workers suggested that having more AOD, MH, and DV specialists on site would be helpful:

> "CalWORKs mothers who are MH or SA are having a difficult time talking about their problems or asking if help is available for them. Maybe if a mental health worker was stationed here, they would be more willing to discuss MH/SA problems."

> "We should have a professional in our office to handle these participants [those with MH/SA/DV issues] in a better and in a safe manner."

> "They should have a specialized person in the District Office to see the participants if they need to be referred."

> "We have always been told not to get personally involved with our clients or their lives, but to only determine eligibility. Having a BHT on-site makes it a little easier to discuss issues with clients, especially at their renewal appointment."

Co-located staff were *not* included as a routine part of the application or re-determination process in any of the six counties. Inclusion of an AOD, MH, and/or DV specialist as a routine part of the application and/or re-determination process for all TANF participants would, of course, be a resource-intensive approach. But, given the anticipated prevalence of the disorders, the reduced caseloads, and the excess of funds, it would be feasible at least on a pilot basis.

Issues for Consideration in Implementing Co-location

- ☑ Full-time co-location can be expensive in counties where there are multiple welfare offices or where eligibility and employment staff are located in separate offices. Part-time co-location, as has been the case with all the DV co-location except Stanislaus, reduces the expansiveness and potential effectiveness of the role that the co-located staff can play. In small areas (such as rural areas with small centers of population) the advantages of co-location can be achieved by close working relationships without actually having staff present on a full-time basis at the welfare office.

- ☑ It can be difficult for the co-located staff to maintain an identity that is separate from the welfare staff. To the extent that participants view the welfare system as non-helpful and potentially punitive, this blended identity can work against disclosure. Careful thought should go into what to call and where to locate the co-located staff.

- ☑ Flexibility, very good people skills, and an outgoing personality (in addition to professional skills) are necessary for co-located staff to be maximally effective.

- ☑ Making sure that the DSS staff are aware of the presence of the co-located staff is essential to making the strategy effective.

Promising Practices for Co-location

- ☑ **Building relationships –** One Monterey EAP staff member made a point of having lunch with welfare staff to begin to develop personal relationships. Co-located EAP staff offered a series of stress reduction classes for welfare staff.

- ☑ **Engaging participants –** In Shasta the co-located staff spend their time with CalWORKs participants during Job Club engaging in a give-and-take conversation rather than just making a presentation about available services.

Special Issues Regarding CalWORKs Subpopulations

Two subsets of the TANF population – those that are exempt from CalWORKs Welfare-to-Work requirements and those who have been or are in the process of being sanctioned – are unlikely to have their AOD, MH, or DV issues identified unless special efforts are made to do so. And yet, there is some evidence that the prevalence of AOD, MH, and DV issues may be higher within these groups than within the rest of the TANF population.

Exempt Individuals

The most common reason for exemption in California is disability. While counties do not generally track the percentage of disabilities that are MH related, most think the number is small. Some counties have established special procedures whereby the MH staff working with the CalWORKs program review all requests for exemptions because of MH issues. While the vast majority of the disability exemptions result from physical disabilities, there is a significant overlap of these disabilities with AOD, MH, and DV issues that can complicate recovery from the physical disability.

Many counties are beginning to review the disability exemption caseload to determine whether the CalWORKs participants might qualify for SSI. Part of this process can include a review of potential AOD, MH, and DV issues.

For those CalWORKs participants who are exempt from Welfare-to-Work requirements and yet not eligible for SSI, options for receipt of services are limited. While a CalWORKs participant is exempt from WTW requirements, they are not eligible for the support services (through CalWORKs) such as AOD, MH, or DV services that might assist them to overcome the disability. There is nothing, however, that prevents a county from using its CalWORKs funds to provide these services if the participant voluntarily agrees to a WTW Plan. In such a case, however, the county could not insist that the participant utilize the services that were offered.

AOD/MH Involvement with Exemptions

County	Exemptions
Alameda	DSS social workers reviewing exemptions for SSI potential
Kern	Not yet looked at recipients exempt from WTW
Los Angeles	Exemptions granted based on any physician's statement
Monterey	Beginning to review exempt cases for potential SSI
Shasta	The BHT reviews all requests for exemptions and can grant 1-year exemptions for MH issues
Stanislaus	All MH, AOD, DV exemptions are reviewed by the Behavioral Health Services team

Promising Practices for Identifying AOD/MH/DV Issues in Exempt Population

- ☑ Alameda County DSS social workers are systematically reviewing the disability exempt caseload to determine both whether an SSI application is warranted, and whether the person is receiving services that are appropriate to the disability.
- ☑ Los Angeles County makes a routine referral to the Department of Rehabilitation on every medical exemption with a duration of over 30 days.

Sanctioned Individuals

Counties differ in the extent to which they have pursued sanctioning for participants' failure to abide by the CalWORKs' rules and requirements. Bothered by the high sanction rates, [22] some counties have developed special methods of finding out more about why families are being sanctioned and what the system can do to prevent so many sanctions. AOD or MH staff have been included in some of the outreach efforts to understand, prevent, and/or cure sanctions. Some counties include AOD/MH/DV expertise within a team as they try to learn more about the sanctioned population.

AOD/MH Involvement with Sanctions

County	Sanctions
Alameda	CBOs have been given lists of sanctioned cases to find and engage, but no specific AOD, MH, or DV involvement. A videotape about AOD/MH/DV services was mailed to 1500 first-time sanctioned clients
Kern	Behavioral Health has offered assistance, but not yet a part of sanctioning process
Los Angeles	Will be reviewing a sample of sanctioned cases; review to include potential AOD, MH, DV issues
Monterey	Will be using specialized workers to contact pre-sanction and sanctioned cases to determine if AOD/MH/DV issues are present and/or can be addressed and to make referrals to prevent sanctions or resolve sanction issues
Shasta	
Stanislaus [23]	DSS is piloting a family resource conference approach to sanctioned families; BHT is officially a part of that process

[22] RAND reports that the statewide sanction rate is high – 20 percent sanctioned and another roughly 13 percent in the sanctioning process. Ibid., Klerman, et al., 2000.

[23] After the Project's last site visit, Stanislaus began an Interdisciplinary Team including social workers, to engage sanctioned individuals.

Issues to consider in Developing Identification Approaches with Exempt and Sanctioned Populations

- ☑ **Exemptions:** Efforts to provide services to participants who have disability exemptions with AOD, MH, or DV services could be a long-term cost-effective strategy. As caseloads diminish, the number of participants who can be exempt will lessen. Efforts can be made to inform exempt participants of their eligibility through other sources of funding or through CalWORKs funding (which allows them access to child care and transportation for services) if they agree to a voluntary WTW Plan.
- ☑ **Sanctions:** Inclusion of AOD, MH, and DV specialists on teams that are attempting more vigorous intervention during the sanctioning process could assist in the identification of any of these issues that are making the resolution of the situation more difficult.

Promising Practice for Inclusion of AOD/MH/DV in Working with Sanctioned Population

- ☑ San Bernardino County did a home visit survey of a sample of sanctioned clients and found a high percentage could be brought into compliance. Many seemed to have AOD/MH/DV problems.

Assessment of Individuals Needing AOD/MH/DV Services

Characteristics of Assessment in the Six Study Counties

The assessment stage of the identification process varies on a number of dimensions:

- Where, when, and by whom the assessment is done, or the organizational structure that supports it
- Content of the assessment, and
- The purpose of the assessment:

  (a) To determine if there is a barrier to employment that would qualify for services

  (b) To establish a level of care

  (c) To make a referral to a specific service provider

  (d) To develop a treatment plan

All six counties established a process by which CalWORKs participants who were identified by DSS with potential AOD or MH problems would *first be assessed and then referred for services*. This structure was developed in part because of the expectation that very large numbers of participants would be referred, creating a need to either validate the referrals and/or narrow the funnel to meet existing resources. In the AOD system it was also expected that it would provide the mechanism for determining a level of care and for treatment planning. For AOD and MH such a structure was required by the CalWORKs legislation.

Four of the six counties created an organizational unit to which participants would be referred once an AOD or MH issue had been identified by DSS. Los Angeles County augmented already existing AOD Assessment Centers, but the MH Assessors represented a new function. Only Alameda County used an existing structure: its #800 ACCESS line used for all of its other AOD and MH referrals into the system.

The situation was different for DV:

- In four of the counties, referrals were made directly to local DV service agencies rather than to an intermediate assessment structure. (In Stanislaus the DV procedure paralleled that for AOD and MH; in Monterey, a county staff person was hired about one year into implementation to handle referrals.)
- In only one county was a county staff person involved directly in the assessment of DV issues.

Organizational Structure for Receiving Referrals

County	AOD	MH	DV
Alameda	Existing 800 number	Existing 800 number	Contract agency
Kern	County team	County team	Contract agency
Los Angeles	Contract agency	Contract employees [24]	Contract agency
Monterey	County team	County team	County employee and contract agency
Shasta	County team	County team	Contract agency
Stanislaus	County team	County team	Contract staff on county team

The drop-off in attendance at each stage of the process (referral to assessment and assessment to services) suggests that the fewer steps the better. Not all the counties keep information that allows us to determine what proportion of the referrals to assessment result in a completed assessment. But the preliminary figures from counties confirm suspicions that many fail to keep

[24] Since the last Project site visit, Los Angeles Department of Mental Health began direct referrals to service providers from DSS for non-English speaking monolingual participants.

assessment appointments. Achieving a higher than 70 percent show rate for assessments may be problematic. [25] Some examples follow:

- In Stanislaus, where the DV assessment occurs on-site, the show rates for assessments from August 1998 through March 1999 was 67 percent.
- In Shasta County, the overall percentage of completed assessments for AOD and MH was roughly 62 percent for July 1998 through April 1999.
- In Monterey County, the overall percentage of completed assessments by the behavioral health team was roughly 58 percent of referrals.
- In Los Angeles, the show rate for mandatory AOD assessments from April 1998 through May 1999 was 72 percent.

Since a separate assessment is expensive, time-consuming, and adds another hurdle for participants, it is critical that counties consider the *additional* purposes for the assessment (besides verifying that the participant qualifies for services) as they make decisions about who/where/when to do the assessment and what it should consist of. This is particularly the case where a high proportion of those assessed are referred to services.

AOD Assessments

County	Who	Where	When	What	Purpose
Alameda	AOD contract agencies	Contract agencies	After referral from ACCESS		Determine level of care & Tx provider
Kern	BHT AOD specialist or AOD contract provider	BHT or contract provider	After seen initially by co-located staff and discussed with BHT		Develop treatment plan
Los Angeles	AOD assessment centers	Assessment center	By appointment	ASI	Determine level of care and service provider
Monterey	Any EAP staff	Welfare office	Immediate or by appointment	ASI	Determine treatment plan
Shasta	BHT AOD specialist	Welfare office	Immediate or by appointment	ASI	Determine level of care and service provider
Stanislaus	BHS AOD specialist	Welfare office and other sites	By appointment	ASI, where feasible	Determine treatment plan

[25] A survey of all counties in late 1998 received responses from 34 counties. The show rates reported in that survey were somewhat higher than what we have found in the actual data from some of the six case study counties. The average show rate for AOD assessments was 71 percent (median of 78 percent) and for MH was 73 percent (median of 82 percent).

MH Assessments

County	Who	Where	When	What	Purpose
Alameda	MH network providers	Network provider	After referral from ACCESS		Determine level of care and Tx provider
Kern	BHS MH specialist or MH contract provider	BHS or contract provider	After seen initially by co-located staff and discussed with BHT	Regular Short Doyle Medi-Cal assessment	Develop treatment plan
Los Angeles	Individual MH contract assessors	Welfare offices	By appointment or immediately in crisis situations	Regular Medi-Cal assessment form	Determine service provider
Monterey	Any EAP staff	Welfare office	Immediate or by appointment	Regular Short Doyle Medi-Cal assessment	Determine treatment plan
Shasta	BHT MH specialist	Welfare office	Immediate or by appointment		Determine level of care and treatment plan
Stanislaus	BHS MH specialist	Welfare office and other sites	By appointment	Regular Medi-Cal assessment form	Determine treatment plan

DV Assessments

County	Who	Where	Purpose
Alameda	DV programs	DV programs	Determine service needs
Kern	DV program	DV program	Determine service needs
Los Angeles	DV programs	Welfare offices or DV programs	Determine service needs
Monterey	DV programs or DSS staff	DV programs or welfare office	Determine service needs and information for waiver
Shasta	DV program	DV program	Determine service needs
Stanislaus	BHS DV specialist	Welfare office and other sites	Determine service needs

Staff Perception of Assessment Processes

Employment counselors in the staff surveys were asked how satisfied they were with the referral process, the timeliness of assessments, and feedback about the results of assessments. Overall:

- Seventy-three percent were very or moderately satisfied with the ease of making referrals for assessments or services
- A smaller percentage, 58 percent, were very or moderately satisfied with the timeliness of the assessments, and
- Only 43 percent were very or moderately satisfied with the feedback they got from AOD/MH/DV professionals about assessments and/or services

County satisfaction varies widely on each dimension. With regard to ease of referrals, only one county has a satisfaction rate lower than 79 percent with one county having all its employment counselors satisfied. The county-by-county disparity widens for timeliness, with only 38 percent of employment counselors in one county being satisfied, contrasted with 85 percent in another. The percentage satisfied in one county drops to 27 percent for feedback, but is no more than 50 percent in three other counties. These figures indicate serious difficulties with timeliness and feedback of information to employment counselors.

Employment Counselor Satisfaction with Referral and Assessment Process, by County

Percent Very or Moderately Satisfied in:	Kern Percent	Los Angeles Percent	Monterey Percent	Shasta Percent	Stanislaus Percent
Ease of referrals	78.7	58.9	83.3	100.0	89.8
Timeliness of assessments	38.1	54.8	61.1	85.2	77.6
Feedback of results of assessment or services	27.0	42.0	42.1	67.9	52.0

Here are some examples of the kinds of comments on the employment counselor survey about timeliness of assessments and lack of feedback:

> "After the initial referral is made, I rarely hear back from the counselor to indicate the participant's condition or results of the assessment. It is crucial that I am made aware of the participant's condition so that I can be adequately prepared about what to expect when I next see them for a different concern. Loss of communication is the biggest problem."

"Results and/or feedback take far too long – weeks to months."

"In most instances setting up appointments for assessments can be a tedious process, prompting us to send the participants home and we end up making the appointments in their absence, resulting in conflicts."

"Too many no-shows. Appointments are usually made three or more weeks later. EC sends out appointment letter and calls participant a day or two before the appointment to remind him of appointment. Doesn't show or shows too late and is turned away. Go through process again. Doesn't show. Maybe phone interviews could be implemented for continual no-shows."

"Failure to return reports in a timely manner with estimated outcome of problem. It is almost impossible to do a WTW Plan and give participant positive outlook about becoming self-sufficient with no definite goal to work toward."

Issues to Consider in Implementing an Assessment Strategy

- ☑ The closer the assessment is to the referral from screening – both in terms of time and space – the more likely the participant is to attend and complete the assessment. Assessments that can be done on the spot are the most likely to be completed. Intermediate success comes from making an appointment with the assessor while the participant is there. The least likely to lead to completion is when the participant is informed in writing about an appointment that has been made for her at a specified time.
- ☑ There is a trade-off between ensuring the most appropriate level of service and creating an additional step in the process. Those systems that rely on a face-to-face assessment for the purposes of determining the appropriate level of care and/or the most appropriate service provider create an additional step between the identification of the issue and the entry into services. The decision may be most difficult to make in the AOD system where providers often offer only one service type (e.g., a residential program or a day treatment program), and service resources may be scarce. In this case, the decision may be made that doing an assessment in order to channel participants to the most appropriate level of care and to a specific provider is worth the potential drop-off in client show rates.
- ☑ The choice of who does the assessment depends on the uses to which the assessment will be put and how cross-trained assessors are. While the staff on the integrated interdisciplinary teams are generally alerted to the occurrence of other issues outside their specialty, only in Monterey do the same EAP staff routinely do both AOD and MH assessments. [26] In the other counties the relevant specialist staff is assigned to do the initial assessment according to what the most likely primary problem is based on the information from the referral source. If additional and/or more prominent issues arise during the initial assessment, then the participant is sent for another assessment.
- ☑ While this process ensures that the most trained staff are conducting the assessments, it does create an additional step for the participant. Again, the choice of whether or not this is worth the potential additional barrier to service entry depends on what use that assessment is put to within the overall system.
- ☑ Having good feedback mechanisms with the employment counselors who make referrals is necessary to maintain, let alone increase, the number of referrals. Unless assessments are conducted promptly after receiving a referral, and unless those making referrals are giving prompt and useful information about what is happening with the clients who have been referred, they will stop making referrals.

[26] The type of assessment and the level of training required to do the particular assessment depends on the overall structure and function of the initial assessment within that particular county. In Monterey, the EAP staff do not do a full assessment that would be required for treatment planning.

Promising Practices for Assessments

- ☑ The EAP workers in Monterey are cross-trained so that they can do both an AOD and a MH assessment. This allows for a single assessment appointment in instances where there may be multiple issues and allows a service referral or treatment plan that addresses the most critical issues first.

- ☑ The multidisciplinary teams in Kern and Stanislaus meet daily to discuss who will conduct the assessment for each referral and treatment plans for those needing services. When there is sufficient information from the referring source this allows for a targeting of the assessment to the most appropriate team member thus eliminating unnecessary steps.

Summary

Methods of Identification

Self-disclosure – Counties used social marketing, informing participants about services, encouraging CalWORKs staff to spend time with participants to build more trusting relationships, and having specially trained CalWORKs staff to deal with those with suspected AOD/MH/DV issues to encourage self-disclosure. Survey results from DSS supervisors suggest that policies to inform participants about AOD/MH/DV services are not uniformly implemented. This is of particular concern to DV where only about half of a set of participants receiving DV services said they had been told about the Family Violence Option by CalWORKs staff.

Screening – Of the six case study counties, only Los Angeles has made use of formal screening questions for AOD and MH with a required assessment if the screen is positive. Approximately five percent of those screened in Los Angeles answered "yes" to one of the questions, with MH positive screens roughly two and a half times more frequent than AOD.

Training of CalWORKs Staff

All six counties trained eligibility workers and employment counselors regarding AOD/MH/DV. The number of hours of training ranged from roughly two hours for each issue area in one county to nearly 20 hours for each issue area in another. In general, both eligibility workers and employment counselors reported that the trainings were helpful and that they would like more. The biggest impact of training on the number of referrals made by eligibility workers and employment counselors is between those who receive *any* training and those who receive none.

Settings in Which Identification Efforts Occur

CalWORKs offices and personnel – All six case study counties focused most prominently in their identification strategies on eligibility workers and employment counselors. Across the six counties surveyed, 87 percent of the employment counselors and 35 percent of the eligibility workers reported making at least one referral within the last three months. However, a small proportion of these workers made a large proportion of the referrals – the top 20 percent made roughly 50 percent of the referrals. Two major barriers to eligibility workers and employment counselors making more referrals are large caseloads and not feeling comfortable with or prepared to deal with AOD/MH/DV issues. For the employment counselors there is a direct relationship between the reported level of comfort and preparedness and the reported number of referrals.

Other sites frequented by CalWORKs participants – The chance of identification of an AOD/MH/DV barrier is enhanced where the staff has a lot of contact with CalWORKs participants, for example those who run Job Clubs, run training programs, or supervise work-sites. Enhancing referrals from these sources will require providing training in AOD/MH/DV issues for these staff and developing referral protocols. One county – Alameda – has actively engaged in "case finding" in the community. While Alameda's initiative is too new to evaluate, developing referral relationships with those who have contact with CalWORKs participants – such as health clinics, child care centers, WIC programs – appears to be a sensible strategy.

"Back door" referrals from AOD/MH/DV service providers – A majority of CalWORKs eligibles who are receiving AOD/MH/DV services do so without those services being a part of the participants' official Welfare-to-Work Plan. The six counties have made varying levels of effort to identify these individuals and the three issue systems (AOD, MH, and DV) face different barriers to doing so.

Structure and Use of Co-location

Five of the six case study counties used AOD, MH, and/or DV staff co-located at CalWORKs sites, but the function of the co-located staff did not follow a single pattern. The most expansive role for co-located staff involves full-time staff who attempt to integrate into CalWORKs culture, make routine presentations to groups of CalWORKs participants, make periodic presentations to CalWORKs staff, handle participant "emotional" crises, and do assessments immediately on-site. About three quarters of the surveyed eligibility workers and employment counselors who knew about the co-located staff indicated that their presence was helpful, but between 30 and 50 percent of the eligibility workers in two of the counties using co-location were unaware of co-located staff.

Special Issues Regarding Special CalWORKs Subpopulations

Exempt participants – Some of the case study counties are reviewing CalWORKs participants who are exempt from Welfare-to-Work requirements because of a disability for possible SSI eligibility and for receipt of services for AOD, MH, and DV issues. AOD/MH/DV services to

participants who are exempt from WTW are not currently reimbursable through the CalWORKs AOD or MH allocations, but other sources of funding are available.

Sanctioned participants – Some of the six case study counties are developing special efforts to intervene during the sanctioning process, or even after a sanction has been applied, to determine why the participant is not complying with CalWORKs requirements. Attempts at inclusion of AOD, MH, or DV expertise in these efforts are just beginning.

Assessment of Individuals Needing AOD/MH/DV Services

Characteristics of assessment in the six study counties – All six counties included a separate assessment step in the AOD and MH referral process. Four of the six created a separate organizational unit to conduct the CalWORKs AOD or MH assessments. Since drop-off in attendance rates at the assessment step ranged from 28 to 42 percent, each county needs to weigh the benefits of the separate assessment step against the likelihood of drop-off. The use of an intermediate assessment step is much less frequent within the DV system.

CalWORKs staff perception of assessment processes – While most employment counselors (73 percent) were very or moderately satisfied with the ease of making referrals, a smaller number (58 percent) were very or moderately satisfied with the timeliness of assessments, and only 43 percent were very or moderately satisfied with the feedback they got from AOD/MH/DV professionals about the assessments and/or services. Considerable work still needs to be done in making assessments more timely and in ensuring that the results are communicated back to the referral source.

Overall, the six study counties have made substantial progress at implementing their initial strategies for identification and referral based largely on the CalWORKs eligibility workers and employment counselors, and have at the same time broadened the scope of their efforts beyond this targeted referral source. The next chapter describes the counties' service systems for those CalWORKs participants who received AOD, MH, and/or DV services.