THE CALWORKS PROJECT:
Overcoming Mental Health, Domestic Violence and Alcohol and Other Drug Barriers to Employment

April, 2000

SIX COUNTY SURVEY RESULTS

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INTRODUCTION

Background

Welfare reform heightened the importance of addressing alcohol and other drugs (AOD), mental health (MH), and domestic violence (DV) issues within the AFDC/TANF population.

Under the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996, adults receiving TANF cash assistance (the old AFDC) were faced with a new environment. No longer was cash assistance guaranteed without time restrictions. Each participant had an 18-24 month limit per episode on welfare and a total limit of five years. And each participant had to engage in a set number of hours of work-related activity in order to receive cash assistance.

While estimates of the prevalence of alcohol and other drugs (AOD), mental health (MH), and domestic violence (DV) issues within the TANF population vary, there is general consensus that the rates are higher than in the general population and affect a substantial minority of TANF participants.. These issues can create barriers to TANF participants' ability to meet the work activity requirements and to become steadily employed at a level that allows them to be self sufficient within the time limits.

In recognition of the special problems that would be faced by TANF participants with DV issues, the PRWORA included a Family Violence Option (FVO) which allowed states to exempt survivors of DV from certain of the new TANF rules that might endanger their safety. California adopted the FVO and developed implementation guidelines for counties.

California's implementation legislation of TANF is called CalWORKs (California Work Opportunity and Responsibility to Kids). In it the Legislature created a special allocation that was to be used to address the AOD and MH problems of CalWORKs participants when these problems were barriers to employment. The legislation required the county Departments of Social Services (DSS) to enter into contracts or MOUs with the county MH system and with the county AOD system and/or private providers in order to obtain assessments of and services for participants with real or suspected AOD and MH barriers to employment. Because the county DSS was directed to work with the county MH system (and in our six counties the DSS chose to work with the county AOD system), the models for identifying and serving participants with AOD and MH barriers to employment reflected an "interagency collaboration" approach.

The CalWORKs Project is designed to gather and disseminate information about a) the impacts of AOD, MH, and DV issues on CalWORKs participants ability to become self sufficient and b) how best to identify and serve CalWORKs participants with these barriers. The California Institute for Mental Health (CIMH) obtained a grant from the Wellness Foundation in 1997 to determine how California might identify participants with these issues and to recommend benefits and services that would address the identified needs. It quickly became apparent that

there were no “tried and true” methods to identify participants with these issues and that there were few models of successful services for this population anywhere in the country.

The CalWORKs legislation devolved most of the decisions about the structure and implementation of welfare reform to the counties. This included decisions about how to organize the effort to identify and serve participants with AOD, MH, or DV barriers to employment. The focus of CIMH work thus moved to the county level where AOD, MH and DSS directors began asking for assistance in how to set up their programs to identify and serve this population.

The CalWORKs Project is a collaborative effort under the auspices of the California Mental Health Directors Association (CMHDA), County Alcohol and Drug Program Administrators Association of California (CADPAAC), and the County Welfare Directors Association (CWDA). All three of the Associations endorsed the Project and have assisted the Project in obtaining funding from the counties. The CalWORKs Project is overseen by the Joint Committee which has representation from all three of these Associations.

The CalWORKs project at the staff level is a collaboration of three organizations:

- California Institute for Mental Health (CIMH)
- Children and Family Futures (CFF)
- Family Violence Prevention Fund (FVPF)

Funding for the CalWORKs Project has been received from the following sources:

- The Wellness Foundation
- The Packard Foundation
- The National Institute of Justice
- SAMSHA
- Voluntary contributions from California counties.

What is included in this report

One of the methods we used to obtain information from each of the six counties was surveys. This report presents the results of the surveys in detail. The key points are summarized in the primary report.[1] The survey instrument design, data collection and data analysis were conducted by Joan Meisel, Ph.D. and Daniel Chandler, Ph.D., consultants to the CalWORKs Project.

Surveys of DSS Staff

Questionnaires were filled out by 793 DSS eligibility workers and 340 employment counselors in five of the six counties (Alameda was not included in this part of the study). Questionnaires were also filled out by 174 eligibility supervisors and 44 employment counselor supervisors in

[1] The CalWORKs Project Six County Case Study: Overcoming Mental Health, Domestic Violence, And Alcohol And Other Drug Barriers To Employment. Available on the web at: www.CIMH.org

the same five counties. Response rates varied by county and are described in Appendix A. The surveys queried staff about the impacts of welfare reform on their jobs; the amount and helpfulness of training received on AOD, MH, and DV issues and procedures for identification and referral; how comfortable and prepared they felt to deal with AOD, MH, and DV issues with their participants; the number of referrals they had made in the last three months; their satisfaction with certain parts of the identification and referral process; and whether their participants who had completed services had been helped. Many staff provided useful perspectives in the comments they made on the surveys.

Surveys of Providers of AOD, MH, DV Services

Surveys were completed by AOD and MH providers on 397 clients who had completed services. These clients were sampled from 41 providers. The providers themselves were selected because of serving large numbers of CalWORKs clients. Counties participating were Kern, Los Angeles, Shasta and Stanislaus. DV information on 79 clients came from 13 providers in Los Angeles and the CalWORKs provider from Stanislaus. The sample comprised the most recent discharges, in rough proportion to the total number of discharges during FY 1998-99 (when known). Providers were asked to fill in demographic and service information and rate the amount of change in the client on selected dimensions during the course of services; the reasons for the service episode ending; and the collaboration with CalWORKs staff, if any.

Surveys of Clients of AOD, MH, DV Services

We also surveyed 591 current clients of AOD, MH and DV services in the same four counties. The four counties provided Project staff with lists of open client episodes in the summer and fall of 1999. The same providers as above were sampled in roughly proportionate numbers to the numbers of clients they were serving and asked to distribute the surveys to clients as they came in for services. Clients were encouraged to complete the forms, seal them, and put them in a box on the receptionist's desk.

Part A: METHODOLOGY

Survey Design

In March of 1999 the CalWORKs Project Group met with representatives of the six study counties. Focus groups spent time discussing sampling, survey content and potential difficulties. Project staff developed survey forms for each of the domains above based on issues having arisen in site visits and on the literature. These were sent to each county for comment and then revised, sometimes several times. The final survey forms also were tailored to each county's nomenclature and staffing patterns.

Sample design

In Appendix A we present the detailed sampling method and response rates for each type of survey in each county. Here we sketch the broad outlines of the sampling process.

Sampling proportions vary for the different types of survey forms and by county. Counties shared our desire for a representative sample. However, they also had concerns about workload and logistics. In some cases we adjusted sampling to balance these concerns.

In one of the five counties we did not survey at all. Alameda, at the time of the sampling, was not able to involve DSS workers in the identification and referral of persons needing AOD/MH/DV services. Because of this, the county's referrals started very slowly. We did not feel it would be useful at that point to profile that system's AOD/MH/DV service recipients, and there was no reason to survey DSS workers. Since then outreach workers have been hired and have been generating referrals (see Part II of report). Monterey County was the last we surveyed, and we judged that we would have insufficient time to sample and survey the AOD/MH/DV clients and providers (a process that took from two and a half to seven months in each county). Therefore, only DSS surveys were completed for Monterey.

We attempted to include all DSS eligibility workers, employment counselors, eligibility worker supervisors and employment counselor supervisors.[2] Generating information from AOD/MH/DV clients and service records was very much more difficult than obtaining information from DSS staff. Our sample included both CalWORKs recipients who were receiving services as part of a welfare to work plan and those who were receiving services that were not part of a plan. This meant that service recipients were spread throughout the MH, AOD and DV service providers. Even in Stanislaus, the county with most "control" over the CalWORKs process, only 40 to 50 percent of all CalWORKs clients were seen by the designated CalWORKs behavioral health team. After reviewing print-outs showing the number of CalWORKs clients at each provider, we worked with each county to choose a sample that balanced the burden imposed on county staff and program staff with the need to be representative. In general, two considerations should be kept in mind: our sample is from larger providers, usually with 10 or more CalWORKs clients;

[2] Because of the large number of offices in the two regions in Los Angeles, eligibility workers were sampled. The other categories were intended to be a complete census.

and the actual number of clients or charts sampled was designed to give a large enough sample for analysis but is not equally proportionate to the size of the caseload in each county. Appendix A provides the sampling proportions and Appendix B demonstrates the effects on standard errors and totals of using statistics from the sample as opposed to those estimated for the population.

Client satisfaction forms were filled out by current clients. Staff filled out forms on discharged clients (and those in methadone programs on a long-term basis). These forms were complicated enough that they required referring to a chart and hence were time-consuming.

Return rates for the client satisfaction and review of services forms ranged from very high to relatively low, by county and by type of service. In two counties, the domestic violence agency was not able to complete the surveying. Because of both the lack of true representative sampling and the varying return rates, caution should be used in interpreting findings for the satisfaction and discharged client forms. Large percentage differences between counties are likely to reflect true variation in practice, but smaller differences may reflect sampling variation.

Comparisons between different types of surveys and between counties

We designed the survey forms so that there would be many common questions among the four types of DSS respondent and among the AOD, MH and DV respondents. However, the sampling approach for the different surveys varies to some extent as does the attrition rate.[3]Therefore, some caution is necessary in making direct comparison even when the question asked was identical. Likewise, comparisons among counties are valid only to the extent that the sampling was representative in each.

The "total" presented in the report and in the following tables is an average of all responses *in the survey sample*. While the DSS survey sample sizes reflect accurately the number of respondents in a county, the AOD/MH/DV sampling proportions differ by county. We have not weighted the responses according to the number of persons they represent. In other words, the "total" reflects our overall sample but not necessarily the combined population in the six counties—unless there is little difference between sampling groups, in which case the Sample Total and Population Estimate will also be very close..(See Appendix B for a demonstration of the difference.)

Statistical Significance

Measures of statistical significance are appropriate where the sampling is representative. Statistical significance tells us the likelihood that the differences between counties or groups that we find are not simply due to sampling variation. However, statistical significance reflects sample size. For eligibility workers the sample size of 793 is large enough that virtually all of the cross-tabulations by county are statistically significant even though some of the differences do not have much substantive significance. In presenting the results significance is mentioned only when it seems important to confirm a notable substantive difference. "Significant" is taken to mean that there is only a five percent chance that a difference between groups as large as the one observed in the *sample* could have arisen through random processes if there were in fact no

[3] Appendix B shows the effect of adjusting for these sampling characteristics. In general, the point estimates for the county sampling groups are accurate, but the "margin of error" depends on sample size in each county.

group difference in the *population*. Our usual focus is on the difference in percentages for different groups, a conventional measure of effect size.

PART B: DEPARTMENT OF SOCIAL SERVICES

SURVEY RESULTS

Eligibility workers and employment counselors were asked similar sets of questions. Employment counselor supervisors and eligibility worker supervisors were asked a more limited set of questions on the same issues. Generally we present tables on the eligibility workers and employment counselors and fill in supplementary information from the supervisor forms. The tables focus on between county differences while the "total" for the sample is discussed in the text.

CalWORKs contextual issues

Overall climate of welfare reform.

Eligibility workers. Eligibility workers were asked three questions that, together, give a good picture of how DSS staff are adapting to welfare reform. The questions ask whether the respondent agrees that: morale is high, that CalWORKs brought no significant changes, that many participants do not believe time limits will affect them, and that the office has a more positive orientation toward CalWORKs participants since welfare reform. Table 1 below shows the percent who agree with these statements, by county. Overall only 24 percent agreed that morale is high but 46 percent felt their office had a more positive orientation toward cash aid participants. Workers felt there had been significant changes for them (only 14 percent said there had not been) but two-thirds felt that many CalWORKs participants did not think time limits (the most important provision of the welfare reform law) would affect them.

Counties varied[4] in their responses to these questions. Monterey had the lowest percentage agreeing that morale was high (17 percent) and Shasta the highest (38 percent). Los Angeles workers were three or more times as likely to say nothing had changed since welfare reform as were workers in other counties. Monterey staff were least likely to agree that participants have not fully grasped the impact of time limits. (Whether this reflects staff attitudes or participant beliefs is not known.) Finally, Stanislaus stood out as having a much lower percentage (30 percent) of staff who believe there is a more positive orientation toward cash aid recipients now.

[4] Differences were statistically significant for each question.

Table 1: Percent of Eligibility Workers who Agree with Four Statements

Percent Who Agree:	Kern (N=110[5]) Percent	Los Angeles (N=394) Percent	Monterey (N=87) Percent	Shasta (N=45) Percent	Stanislaus (N=128) Percent
Morale at my office is high	21	25	17	38	21
Nothing much has really changed with CalWORKs	7	21	3	5	6
Many participants do not believe time limits will affect them	75	66	58	71	70
Our office has a more positive orientation toward participants now	47	48	53	58	30

The different Los Angeles offices showed little uniformity on these issues. For example, agreement on high morale ranged from 7 to 38 percent, agreement on there having been no change ranged from 13 to 32 percent, and agreement that the office had a more positive orientation to participants ranged from 35 to 88 percent. Thus, it seems that the impact of welfare reform on DSS office climate varies greatly by office in Los Angeles. In the other counties data are not broken out by office.

<u>Employment counselors.</u> Table 2 shows how employment counselors answered the same four questions:

- Overall employment counselors rated their morale as higher than eligibility workers (42 percent agreed morale was high vs. 24 percent among eligibility workers). However, this reflected great disparities by county, with Kern and Los Angeles around fifty percent and Monterey and Shasta under 20 percent.

- Almost the same percentage of employment counselors as eligibility workers (16 vs. 14 percent) felt there had been little change since CalWORKs. The highest percentage saying there was little change was in Stanislaus (24 percent).

- A virtually identical 74 percent of employment counselors and eligibility workers agreed many participants do not think time limits will affect them. Monterey's high of 100 percent was substantially higher than the 69 percent of Los Angeles.

[5] Numbers vary slightly from question to question (for each county). The percentage is of those answering each question.

- Overall 57 percent of employment counselors agreed that their offices have a more positive orientation toward participants since CalWORKs (21 percent disagreed and 22 percent were not sure). This is somewhat higher than the 46 percent reported in agreement by eligibility workers. There were not major differences by county, and in particular Stanislaus (which had relatively few eligibility workers saying there was a more positive orientation was the highest ranked of the employment counselors).

Table 3: Percent of Employment Counselors who Agree with Four Statements

Percent Who Agree:	Kern (N=63[6]) Percent	Los Angeles (N=168) Percent	Monterey (N=19) Percent	Shasta (N=28) Percent	Stanislaus (N=52) Percent
Morale at my office is high	55.6	48.8	15.8	19.2	32.1
Nothing much has really changed with CalWORKs	7.9	17.5	21.0	15.1	24.1
Many participants do not believe time limits will affect them	73.0	68.9	100.0	81.1	78.6
Our office has a more positive orientation toward participants now	46.0	62.2	63.2	50.0	60.7

<u>Eligibility worker supervisors.</u> Overall ratings (in Table 3) for morale are identical (25 percent) to the ratings given by eligibility workers, lending credibility to the reports of both groups. Only in Shasta (7 of 7) is morale felt to be high by more than 25 percent of the supervisors. While 57 percent agree overall that the attitude toward participants is more positive under CalWORKs, Shasta again stands out with 100 percent. The overall figures are very similar to those among eligibility workers and employment counselors regarding agreement that "nothing much has really changed" (only 18 percent agree) and that many participants do not think time limits will affect them (67 percent).

[6] Numbers vary slightly from question to question (for each county). The percentage is of those answering each question.

Table 3: Percent of Eligibility Worker Supervisors who Agree with Four Statements

Percent Who Agree:	Kern (N=18[7]) Percent	Los Angeles (N=106) Percent	Monterey (N=16) Percent	Shasta (N=7) Percent	Stanislaus (N=17)
Morale at my office is high	22.2	22.6	25.0	100	11.8
Nothing much has really changed with CalWORKs	10.0	21.2	16.7	0	17.6
Many participants do not believe time limits will affect them	75.0	63.8	53.3	100	76.5
Our office has a more positive orientation toward participants now	70.0	53.8	50	100	52.9

Employment worker supervisors. Supervisors of employment workers (Table 4) are slightly more likely to say morale is high and even less likely to say that nothing much has changed with CalWORKs.

Table 4: Percent of Employment Counselor Supervisors who Agree with Four Statements

Percent Who Agree:	Kern (N=7[8]) Percent	Los Angeles (N=21) Percent	Monterey (N=4) Percent	Shasta (N=5) Percent	Total (N=40)[9]
Morale at my office is high	57.1	47.6	50	40	48.7
Nothing much has really changed with CalWORKs	14.3	4.55	25	0	7.50
Many participants do not believe time limits will affect them	71.4	60.9	50	80.0	65.9
Our office has a more positive orientation toward participants now	71.4	60.9	100	50	63.2

[7] Numbers vary slightly from question to question. The percentage is of those answering each question.
[8] Numbers vary slightly from question to question. The percentage is of those answering each question.
[9] Stanislaus's two supervisors are included in the total though they are not presented separately since they represent only 11 percent of all the employment supervisors.

Staff turnover.

Eligibility workers. A rough measure of staff turnover is given by answers to whether the respondent had also worked as an eligibility worker prior to the implementation of CalWORKs—roughly in January of 1998. Overall, in October of 1999, 28 percent said they had not. Although this is a substantial amount of turnover the continuity of staff in these jobs is even more impressive. Counties varied a good deal on this dimension, however. Shasta had the least turnover (14 percent), followed by Monterey (16 percent), Los Angeles (29 percent), Stanislaus (30 percent) and Kern (36 percent). In offices in Los Angeles it ranged between six percent and 44 percent.

From the standpoint of a recipient of services, then, the chances are high (more than 3 out of 5) that the worker they deal was an eligibility worker under the AFDC system. This has its advantages—primarily continuity and knowing the ropes—as well as the possible disadvantage that attitudes generated in the context of AFDC might be carried over to CalWORKs.

Employment counselors. Turnover since the start of CalWORKs among employment counselors is quite a bit higher than among eligibility workers (56 percent vs. 28 percent). It ranged from a low of 28 percent for Shasta to a high of 63 percent for Kern (which contracted much of this function out). However, Los Angeles and Stanislaus also had similarly high rates.

Effect of welfare reform on workers' jobs.

Eligibility workers. Four questions probed the effect of welfare reform on workers' caseloads, amount expected to do with each participant, the complexity of rules and regulations, and interest in the job. Only those staff who had worked in eligibility prior to welfare reform as well as currently were asked to respond.

Overall 55 percent of staff said their caseloads had increased, 85 percent said they were expected to do more with each case, 92 percent said the complexity and number of regulations they were required to know increased, and (in partial compensation) 37 percent said their interest in the job increased. Based on these percentages welfare reform has been a very significant burden on most eligibility workers.

Staff in all counties reported much increased workloads, as shown in Table 5. However, Shasta stands out to some extent as having less of a caseload increase. And Stanislaus stands out as having the greatest increased burden in each domain with the least increased interest.

Table 5: Eligibility workers—increased workload/interest in job

Percent Who Say Increased:	Kern (N=63 [10]) Percent	Los Angeles (N=225) Percent	Monterey (N=70) Percent	Shasta (N=36) Percent	Stanislaus (N=81) Percent
Caseload	52	54	50	14	84
Amount to do per case	92	78	82	84	99
Complexity/number of regulations	100	88	88	95	99
My interest in job	32	44	35	35	22

Employment counselors. Overall 54 percent of employment counselors who had been employment counselors since before CalWORKs said their caseload had increased (ranging from 95 percent in Stanislaus to 41 percent in LA). This was identical to the eligibility worker increase.

The amount employment counselors have to do per case was rated as having increased by 72.5 percent overall—100 percent in Monterey down to 45 percent in Kern (see Table 6). The burden of having to understand more or more complex rules and policies was said to have increased by 81 percent overall (Los Angeles, Monterey and Stanislaus were around 90 percent; in Kern it was only 57 percent). Finally, the “compensatory” interest in the job averaged 31 percent saying it had increased since CalWORKs. In Monterey this was a substantial 50 percent and in Stanislaus a small 10 percent. Essentially, these figures differed little overall from those of eligibility workers. Both groups reported higher caseloads, more to do, and more to know. Around a third of each group felt their interest in the job had increased. The sometimes substantial variation between counties indicates that workload and interest in the job are strongly affected by local climate and decisions. However, because of the high rate of turnover the number of respondents was quite small, which could also contribute to the variability.

[10] Number responding the each question varies slightly.

Table 6: Employment counselors—Increased workload/interest in job

Percent Who Say Increased:	Kern (N=22) Percent	Los Angeles (N=59) Percent	Monterey (N=13) Percent	Shasta (N=21) Percent	Stanislaus (N=21) Percent
Caseload	45.4	40.7	53.8	61.9	95.2
Amount to do per case	45.4	80.	100.0	85.7	50.0
Complexity/number of regulations	56.6	87.9	92.3	90.5	70.0
My interest in job	31.8	36.8	50.0	23.8	10.0

DSS staff training in AOD/MH/DV issues

Amount of training received about AOD/MH/DV issues.

Eligibility workers. Each county DSS provided or arranged for training of eligibility workers regarding AOD/MH/DV issues. The mean amount of training per worker was 5.8 hours for AOD, 5.5 hours for MH and 6.7 hours for DV.[11]

Table 7: Eligibility Workers—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
Domestic Violence	4.4	5.2	17.5	3.2	7.7
Mental Health	2.6	5.1	18.2	1.4	2.3

Table 7 shows that for each type of training Monterey staff report receiving far more hours than any other county.[12] Shasta and Stanislaus were, in general, much lower than the other counties. However, two counties were not consistent in the amount of training staff reported receiving in the different issues. Kern had a lower amount of mental health training than it did AOD or DV and Stanislaus had substantially more DV than AOD or MH.

Although statistically significant due a large N, the differences between offices in Los Angeles appear to be relatively minor. Ranging, for example, from three to six hours for AOD.

[11] These differences are not statistically significant.
[12] These differences between counties are statistically significant (95% confidence level) for each issue.

Employment counselors. On average employment counselors received about an hour more of training in AOD/MH/DV, respectively (6.9 for AOD, 6.6 for MH and 7.4 for DV).

Table 8: Employment Counselors—Mean hours of training by issue and county

Type of training:	Kern (N=62[13])	Los Angeles (N-168)	Monterey (N=17)	Shasta (N=27)	Stanislaus (N=54)
Alcohol and Other Drugs	1.9	7.6	21.2	4.3	10.5
Domestic Violence	2.5	7.1	18.7	7.7	12.3
Mental Health	3.1	7.5	15.7	3.4	10.3

Substantial amounts of training for employment counselors was received in all three areas in Los Angeles, Monterey and Stanislaus; far less was received in Kern and Shasta (see Table 8).

Helpfulness of the training.

Eligibility workers. For each of the issue areas about 75 percent of those who received the training found it moderately or very helpful; only 3 to 5 percent said it was not at all useful. Consistently across the issue areas, however, Los Angeles reported greater degrees of helpfulness. (As with other issues in the survey, the generally positive stance of Los Angeles may to some extent reflect sample selection bias.) Stanislaus was relatively low on each of the areas and Shasta was low on MH and AOD. It is noteworthy that of all the counties Stanislaus, which had the most intensive DV training (next to Monterey), rated the training as least helpful (see Table 9). These differences seem to reflect discernible differences in the quality of the training being provided. Different offices in Los Angeles showed minimal variability in their ratings.

Table 9: Percent eligibility workers finding training moderately or very helpful, by county

Issue	Kern (N=86[14]) Percent	Los Angeles (N=291) Percent	Monterey (N=68) Percent	Shasta (N=33) Percent	Stanislaus (N=99) Percent
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

Employment counselors. Overall 82 percent of the employment counselors reported the AOD training was moderately or very helpful. The helpfulness corresponded generally with the number of hours. Thus, at the extremes, Kern staff received a total of two hours AOD training

[13] N varies slightly on each issue.
[14] N varies slightly on each issue.

and 72 percent rated it as very or moderately helpful; Monterey staff received 21 hours and 90 percent rated it very or moderately helpful. Ratings on MH and DV training were similar overall. The highest score on DV training was in Shasta, seemingly reflecting high quality training in that county (as it was also rated highly by eligibility workers).[15]

Table 10: Percent employment workers finding training moderately or very helpful, by county

Issue	Kern (N=47[16]) Percent	Los Angeles (N=148) Percent	Monterey (N=19) Percent	Shasta (N=26) Percent	Stanislaus (N=46) Percent
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

Initial contacts: identification of those with service needs

This section deals with a number of capacities and activities of eligibility workers and employment counselors. They include the capacity to identify those with AOD/MH/DV needs, the capacity to discuss AOD/MH/DV issues and services, and comfort with talking with clients about their AOD/MH/DV needs. We also present responses about the extent to which AOD/MH/DV information is distributed to all CalWORKs clients and the extent to which standardized screening questions are employed to identify those with AOD/MH/DV issues.

Identification of those with AOD/MH/DV issues.

Eligibility workers. Overall, 38 percent of eligibility staff report that it is not part of their job to identify recipients with AOD/MH/DV issues or else they report being only a little or not at all prepared to identify recipients. The percentages for MH and DV are 40 and 36, respectively. The remainder, roughly 60 percent, report they are "moderately" or "very" prepared to identify recipients with these issues.

There are a few differences by county (see Table 11): Stanislaus staff feel the least prepared for each issue. And despite the much greater amount of training Monterey staff received they do not appear to feel more prepared to identify participants needing services than do staff in Kern, LA, or Shasta. Similarly, despite more training in DV, Stanislaus staff reported being less prepared to identify that issue. In Los Angeles two of the offices were quite out of sync with the rest, reporting being much less prepared to identify these issues.

[15] Only the domestic violence ratings by county were statistically significant.
[16] N varies slightly on each issue.

More generally, do more hours of training yield higher ratings of preparedness to identify? The answer is a qualified yes. The biggest difference seems to be between those who received no training and those who got some. For example, among those with zero hours of AOD training, only 37 percent felt very or moderately prepared to identify. This contrasts with 68 percent among those with one to eight hours of training and 81 percent for those with over eight hours.

Table 11: Percentage of eligibility workers who do not think identifying participants with AOD/MH/DV problems is part of their job or who are not at all or little prepared to identify such participants

Percent Who Think Not Their Job, or Not At All or Little Prepared	Kern (N=111[17]) Percent	Los Angeles (N=418) Percent	Monterey (N=89) Percent	Shasta (N=45) Percent	Stanislaus (N=130) Percent
Alcohol and Other Drugs	34.2	36.4	34.8	37.8	47.7
Mental Health	34.2	38.0	39.3	51.1	50.8
Domestic Violence	28.8	34.4	36.0	35.6	44.6

The figures in Table 11 indicate from less than a third to over half of the eligibility workers are ill-prepared to identify AOD/MH/DV problems and would need additional training or orientation in order to be able to do so.

Employment counselors. For each of the three issues areas about 27 percent did not feel moderately or very prepared to identify persons with problems. Monterey employment counselors, who received the most training, felt least poorly prepared (Table 12). The high quality of the DV training in Shasta appears to be reflected in the Shasta employment counselors' scores here (lower is better).

[17] N varies slightly on each issue.(for each county).

Table 12: Percentage of employment counselors who do not think identifying participants with AOD/MH/DV problems is part of their job or who are not at all or little prepared to identify such participants

Percent Who Think Not Their Job, or Not At All or Little Prepared	Kern (N=66[18]) Percent	Los Angeles (N=171) Percent	Monterey (N=19) Percent	Shasta (N=29) Percent	Stanislaus (N=51) Percent
Alcohol and Other Drugs	36.4	24.6	10.5	20.7	29.4
Mental Health	34.8	22.4	21.1	27.6	39.2
Domestic Violence	33.8	24.4	15.8	13.8	35.3

Screening performed for all CalWORKs recipients

Eligibility worker supervisors. Eligibility and employment counselor supervisors were asked whether the staff they supervise "screen every CalWORKs participant" for AOD/MH/DV issues. Screening was defined as always asking a specific set of questions or giving participants a form to fill out that asks such questions. Overall, 57 percent of the supervisors said they do screen every participant for AOD and for MH and 61 percent said they screen for DV. County differences are substantial, with Kern and Monterey staff agreeing 60 to 70 percent of the time that this is done and only about one third of Monterey, Shasta and Stanislaus staff agreeing. The virtually identical ratings for AOD, MH and DV seem to indicate that staff are reporting what they see as universal policy. But the difference among staff make it clear that the nature of this policy is not well-agreed upon (see Table 13).

Table 13: Percentage of eligibility worker supervisors who say every participant is screened for AOD/MH/DV using standardized set of questions

Percent Who Think Not Their Job, or Not At All or Little Prepared	Kern (N=20[19]) Percent	Los Angeles (N=96) Percent	Monterey (N=16) Percent	Shasta (745) Percent	Stanislaus (N=17) Percent
Alcohol and Other Drugs	70.0	64.6	31.2	28.6	29.4
Mental Health	70.0	61.1	63.6	28.6	29.4
Domestic Violence	70	70.8	37.5	28.6	29.4

[18] N varies slightly on each issue.(for each county).
[19] N varies slightly on each issue.

Employment counselor supervisors. Overall, 86 percent of supervisors said their staff always screen for AOD issues, 81 percent screen for MH and 83 percent screen for DV. However, this varied greatly among counties, with all counselors in Kern and Los Angeles saying everyone is screened, while in two counties there was disagreement (Stanislaus was excluded due to small sample). These ratings were consistent for AOD, MH and DV. (Table not shown.)

Staff preparedness to tell participants about AOD/MH/DV policies and services.

Eligibility workers. Overall, 40 percent of eligibility staff report that it is not part of their job to tell recipients about AOD policies/services or else they report being only a little or not at all prepared to tell. The percentages for MH and DV are 41 and 37, respectively. Roughly 60 percent, therefore, said they are "moderately" or "very" prepared to tell participants about AOD/MH/DV policies and services. These figures are very similar to those presented above regarding being prepared to identify clients with AOD/MH/DV issues.

There are fairly striking differences among counties on this dimension, particularly with regard to domestic violence where Kern and Shasta are around 25 percent not prepared to tell about AOD/MH/DV while in Monterey and Shasta it is about 45 percent suggesting the additional training for eligibility workers did not pay off. The differences among LA offices are both substantively and statistically significant, ranging from 27 to 61 percent not prepared for AOD, to 20 to 62 percent for DV, and 29 to 65 percent for MH (see Table 14).

Table 14: Percentage of eligibility workers who do not think telling participants about AOD/MH/DV policies and services is part of their job or who are not at all or little prepared to talk to participants about policies and services

Percent Who Think Not Their Job, or Not At All or Little Prepared	Kern (N=111[20]) Percent	Los Angeles (N=418) Percent	Monterey (N=89) Percent	Shasta (N=45) Percent	Stanislaus (N=130) Percent
Alcohol and Other Drugs	37.3	37.3	44.3	37.8	48.4
Mental Health	36.0	38.5	46.6	42.2	49.6
Domestic Violence	26.4	37.0	43.8	24.4	46.5

Employment counselors. A somewhat lower percentage of employment counselors do not feel prepared to explain policies and services regarding AOD/MH/DV than feel poorly prepared to identify participants with problems: about 21 percent compared to 28 percent. There was substantial variability between counties, however. For example, only 5 percent of Monterey staff did not feel moderately or very prepared to talk to participants about DV while 40 percent of Kern staff felt poorly prepared or did not think it was their job. Again, the Shasta training in DV

[20] N varies slightly on each issue.

was good enough so that only 3 percent of the employment counselors did not feel prepared to talk about DV(see Table 15).

Table 15: Percentage of employment counselors who do not think telling participants about AOD/MH/DV policies and services is part of their job or who are not at all or little prepared to talk to participants about policies and services

Percent Who Think Not Their Job, or Not At All or Little Prepared	Kern (N=66[21]) Percent	Los Angeles (N=170) Percent	Monterey (N=19) Percent	Shasta (N=29) Percent	Stanislaus (N=59) Percent
Alcohol and Other Drugs	34.8	18.2	5.26	10.3	21.6
Mental Health	31.8	17.6	5.26	10.3	25.5
Domestic Violence	39.4	19.0	5.26	3.45	19.6

Universal distribution of oral or written material on AOD/MH/DV issues

Eligibility worker supervisors. The questionnaire for supervisors asked if written and oral information about AOD/MH/DV issues is given to *every* CalWORKs participant. It appears that the answer to this question is linked to office practice rather than universal county practice. Overall about 60 percent said yes to both oral and written material for each issue area. As seen below in Table 16 there is very little difference between the issues, which is somewhat surprising because of the universal requirement that the DV option be explained. It is conceivable, however, that this explanation would be presented without contextual information about DV itself or available services. Shasta again stands out as a county with wide agreement that such information is disseminated. Stanislaus, in contrast, has wide agreement that such information is not disseminated.

[21] N varies slightly on each issue.

Table 16: Percentage of eligibility worker supervisors who say oral and/or written material about AOD/MH/DV is given to *every* participant

Percent Who Think Not Their Job, or Not At All or Little Prepared	Kern (N=16[22]) Percent	Los Angeles (N=80) Percent	Monterey (N=17) Percent	Shasta (N=7) Percent	Stanislaus (N=17) Percent
Alcohol and Other Drugs					
Oral	50	72.5	47.1	85.7	17.6
Written	57.9	71.9	27.8	80	11.8
Mental Health					
Oral	43.8	70.4	41.2	85.7	17.6
Written	52.6	70.1	38.9	80	11.8
Domestic Violence					
Oral	50	77.5	47.1	83.3	17.6
Written	66.7	72.8	27.8	83.3	11.8

Employment counselor supervisors. The reports for AOD, MH and DV are very similar in each county. Only Los Angeles staff report consistently that both written and oral information is given each participant. Kern consistently 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. Again, although the numbers per county are very small these are issues of policy that should be reported similarly be all management staff. And in all except for Stanislaus County we had either all or a high proportion of employment counselor supervisors. (Table is not shown.)

Staff feelings of comfort in discussing issues participants might have with AOD/MH/DV.

Eligibility workers. Overall, 36 percent felt that it is not part of their job to discuss AOD issues with participants or said that they were only a little or not at all comfortable doing so. For DV the figure was somewhat lower, 32 percent, and for mental health slightly higher, 39 percent. The remainder said they were “moderately” or “very” comfortable in discussing these issues.

Counties were roughly the same on these dimensions (there was less variability than on the two previous measures); see Table 17. However, Stanislaus staff were high on all three and Shasta staff were high on mental health. So while overall around one third were uncomfortable, in some

[22] N varies slightly on each issue.

instances it was closer to half. The LA offices were widely disparate on all three measures; for example, they ranged from 25 percent to 61 percent lacking comfort regarding AOD.

Table 17: Percentage of eligibility workers who do not think talking to participants about AOD/MH/DV is part of their job or who are not at all or only a little comfortable doing so

Percent Who Think Not Their Job, or Not At All or Little Prepared	Kern (N=111[23]) Percent	Los Angeles (N=418) Percent	Monterey (N=89) Percent	Shasta (N=45) Percent	Stanislaus (N=130) Percent
Alcohol and Other Drugs	32.7	34.7	31.0	37.8	44.4
Mental Health	31.8	38.1	32.2	48.9	48.8
Domestic Violence	24.8	32.4	28.4	33.3	41.3

Employment counselors. About 23 percent of employment counselors did not think it was their job to talk with participants about AOD/MH/DV or felt only a little or not at all comfortable in doing so. Most remarkable is the report from Monterey staff: none of them did not think it was their job to talk about these problems or felt less than moderately comfortable doing so. The extensive Monterey training paid off in feelings of comfort.[24]

Table 18: Percentage of eligibility workers who do not think talking to participants about AOD/MH/DV is part of their job or who are not at all or only a little comfortable doing so

Percent Who Think Not Their Job, or Not At All or Little Prepared	Kern (N=66[25]) Percent	Los Angeles (N=169) Percent	Monterey (N=19) Percent	Shasta (N=29) Percent	Stanislaus (N=52) Percent
Alcohol and Other Drugs	24.2	25.4	0	24.1	19.2
Mental Health	22.7	23.1	0	31.0	28.8
Domestic Violence	29.2	23.8	0	27.6	25

Relationship of staff feelings of preparedness to hours of training.

Eligibility workers. Each of these dimensions—preparedness to identify, to talk about policies and services, and comfort in talking about AOD/MH/DV issues—is related to the amount of

[23] N varies slightly on each issue.
[24] Nonetheless, none of these county differences for AOD/MH or DV were statistically significant.
[25] N varies slightly on each issue.

training received. The pattern is shown for AOD below in Table 19. Fifty eight percent of staff without any training lack preparedness to identify persons with AOD issues while only 19 percent of those with over eight hours of training lack preparedness. However, there is little difference between those with only one or two hours of training and those with three to eight.

For AOD, staff feelings of preparedness are enhanced substantially by even a small amount of training but to make a large difference requires more than eight hours of training. For DV (table not shown), there was still a big difference between no training and some, but there was little advantage shown in having more than eight hours. This may also be related to the quality of the training. MH falls in between AOD and DV with regard to the effect of more than eight hours of training.

Table 19: Percentage of eligibility workers who *lack* preparedness for dealing with AOD issues, by hours of training.

Type of Preparedness		1 or 2 Hours	3-8 Hours	Over 8 Hours	Total N=708
Identify persons with issues	58.4	32.6	30.9	18.9	37.5
Prepared to discuss policy and services	63.0	36.8	30.0	26.0	39.7
Comfortable talking about AOD	49.2	35.7	31.1	18.6	35.6

Employment counselors. There is a steady increase in preparedness to deal with AOD/MH/DV issues as the number of hours of training goes up. As with the eligibility workers, the most striking jumps occur from zero to one or two hours and then again for the over 8 hours category. (See Table 20 below.) The difference between those with zero and those with over 8 hours of training is even more pronounced for MH and DV (tables not shown).

Table 20: Percentage of employment counselors who *lack* preparedness for dealing with AOD issues, by hours of training.

Type of Preparedness	Zero Hours	1 or 2 Hours	3-8 Hours	Over 8 Hours	Total N=319[26]
Identify persons with issues	43.2	34.2	21.7	15.6	26.3
Prepared to discuss policy and services	38.6	21.9	18.2	9.4	20.1
Comfortable talking about AOD	36.4	27.4	19.7	14.1	22.6

Referrals to AOD/MH/DV assessment and services

A critical issues is how many referrals are made to AOD/MH/DV providers for assessment and/or services. This section looks both at the number of the referrals and at a variety of determinants: staff perception that it is part of their job to make referrals; the helpfulness of training; the comfort staff have in discussing AOD/MH/DV issues; and the amount of training received.

Staff belief that making AOD/MH/DV referrals is part of their job.

Eligibility workers. To the best of our knowledge, administrators in each county have defined the job of eligibility worker so as to include the task of making referrals for AOD/MH/DV issues. In Los Angeles the referrals are made to a specialized eligibility worker who in turn refers to clinical assessors. In each of the other counties, referrals are made directly for assessments by eligibility workers.

Nonetheless some eligibility workers in each county reported either that making AOD/MH/DV referrals for services or assessment was not part of their jobs or that they were uncertain if it was. Overall, only 76 percent of the eligibility workers believed making referrals was definitely part of their job; 10 percent were not sure; and 14 percent believed it was not. Kern and Monterey had the highest percentage who believed it was part of their job, Shasta and Stanislaus the lowest percentage (see Table 21). A low rate of referrals for AOD/MH/DV assessment is not surprising if as many as 35 percent of staff do not see it as part of their responsibilities.

[26] N varies by 1 for DV and MH.

Table 21: Eligibility worker views on whether making AOD/MH/DV referrals for assessment or services is part of their job

Percent Who Agree:	Kern (N=109) Percent	Los Angeles (N=390) Percent	Monterey (N=89) Percent	Shasta (N=44) Percent	Stanislaus (N=126) Percent
Make Referrals	87.2	73.8	88.8	63.6	69.8
Do Not Make Referrals	5.50	16.7	2.25	25	15.1
Not Sure	7.34	9.49	8.99	11.4	15.1

In two Los Angeles offices only 43 percent and 49 percent of the respondents said making referrals was part of their job; the other office reports were over 75 percent.

At least 90 percent of supervisors of eligibility workers in all counties except Los Angeles agree that making referrals is part of the job of the staff they supervise. In Los Angeles only 67 percent agree.

Employment counselors and employment counselor supervisors. Employment counselors are much clearer overall than are eligibility workers that it *is* their job to make referrals (95 percent vs. 76 percent). (See Table 22.) Los Angeles employment counselors were least certain. Employment counselor supervisors reported 100 percent agreement that making referrals was part of the job of the staff they supervise—with the exception of Los Angeles (83 percent agreed).

Table 22: Employment counselor views on whether making AOD/MH/DV referrals for assessment or services is part of their job

Percent Who Agree:	Kern (N=66) Percent	Los Angeles (N=165) Percent	Monterey (N=19 Percent	Shasta (N=29) Percent	Stanislaus (N=152) Percent
Make Referrals	100.0	90.9	100.0	96.5	96.2
Do Not Make Referrals	0	7.3	0	3.5	1.9
Not Sure	0	1.8	0	0	1.9

Number of referrals made for AOD/MH/DV assessment or services during previous three months.

Eligibility workers. Those workers who indicated that making referrals is part of their job were asked how many they had made in the previous three months. Overall 50 percent did not make

any referrals at all. Presumably those who said making referrals is not part of their job or those who were uncertain also did not make referrals. That was another 180 persons. So of the 758 persons making some response regarding making referrals, 492 or 65 percent made no referrals during the previous three months.

With respect to the site differences in Los Angeles there is a paradox. Two of the offices have consistently been low in the tables above regarding whether they were prepared to identify or talk with persons having AOD/MH/DV issues. However, one of these has only 41 percent with no referrals while the two offices whose staff were more prepared and comfortable had 60 percent making no referrals.

Overall, twenty-six percent of those who said making referrals was part of their job made one or two referrals, 17 percent made three to five and 7 percent made more than five referrals. However, there were a few persons (all in Los Angeles) who reported making 15 to 70 referrals. In fact, 623 of 1132 (55 percent) referrals were made by the top 63 of the eligibility workers. These 63 people, while 20 percent of those making referrals, are actually only 8 percent of all eligibility workers. These figures seem to indicate that the potential exists for high rates of identification and referral by eligibility workers at the same time they underline how low or non-existent the rate is for most.

Table 23 below shows the overall numbers of referrals made and the pattern among counties.

Table 23: Number of eligibility worker referrals made for AOD/MH/DV assessment or service in previous three months

Number of Referrals	Kern (N=98) Percent	Los Angeles (N=312) Percent	Monterey (N=79) Percent	Shasta (N=36) Percent	Stanislaus (N=96) Percent	Total (N=621) Percent
No Referrals	45.9	51.3	49.4	63.9	46.9	50.2
One or Two	37.8	23.4	25.3	22.2	24.0	25.9
Three to Five	12.2	17.6	16.5	11.1	20.8	16.7
Over Five	4.1	7.7	8.9	2.8	8.3	7.1
TOTAL	100.0	100.0	100.0	100.0	100.0	100.0

Shasta had the highest percentage of workers making no referrals (despite outstationed mental health and AOD workers who are very accessible). The other counties appear largely similar to each other. Table 24 below shows the average number of referrals made by eligibility workers in each county. Not surprisingly (because of the higher percentage with no referrals) Shasta has the lowest average. However, the range is considerable, with Los Angeles and Stanislaus being considerably higher than the other counties. The high average number of referrals in Stanislaus is surprising considering the relatively lower preparedness reported by Stanislaus respondents.

Table 24: Mean number of referrals per eligibility worker, by county

County	Mean Referrals (N=621)
Kern	1.3
Los Angeles	2.1
Monterey	1.6
Shasta	0.8
Stanislaus	2.0
TOTAL	1.8

Eligibility worker supervisors. The survey form for supervisors of eligibility workers asked them to tell how many staff they supervise and how many referrals those staff made in the past three months[27]. On average, supervisors manage 6.2 eligibility who made an average of 6.3 (median 3) referrals in the three months, or just about exactly one per eligibility worker. Thus supervisors estimate referrals at about half the rate that workers report. In contrast to the reports of eligibility workers themselves, Kern ranked higher than the other counties in average number of referrals per eligibility worker (1.2)

Employment counselors. In theory, employment counselors know their clients better and are more likely to see job-related indicators that there might be an AOD/MH/DV problem. Thus they should be making more referrals than are eligibility workers. The data from the survey support this notion. Overall, employment counselors made an average of five referrals for AOD/MH/DV within the previous three months compared to the 1.8 of eligibility workers.

A total of 274 employment counselors reported making 1572 referrals. The most active 20 percent made 813 or 52 percent of the referrals.

As seen in Table 25, in Monterey, Shasta and Stanislaus there were no employment counselors who did not make at least one referral; but in Kern and Los Angeles those making no referrals exceeded 15 percent. In Los Angeles only 10 percent made more than five referrals compared to Monterey, Shasta and Stanislaus where over 55 percent made more than five referrals. The average number of referrals by county, shown in Table 26, reflects these percentage differences.

Table 25: Number of employment counselor referrals made for AOD/MH/DV assessment or service in previous three months

[27] For Los Angeles it asks whether referrals are made to the specialized eligibility workers who handle such cases. Only a few of the supervisors answering the questionnaire supervise specialized eligibility workers.

Number of Referrals	Kern (N=65) Percent	Los Angeles (N=154) Percent	Monterey (N=19) Percent	Shasta (N=28) Percent	Stanislaus (N=50) Percent	Total (N=316) Percent
No Referrals	16.9	20.1	0	0	0	13.3
One or Two	29.2	35.7	21.1	10.7	10	27.2
Three to Five	24.6	34.4	21.1	32.1	28.0	30.4
Over Five	29.2	9.74	57.9	57.1	62.0	29.1
TOTAL	100	100	100	100	100	100

Table 26: Mean number of referrals per employment counselors, by county

County	Mean Referrals (N=316)
Kern	4.36
Los Angeles	3.07
Monterey	8.68
Shasta	7.89
Stanislaus	8.60
TOTAL	4.97

Employment counselor supervisors. The survey form for supervisors of employment staff asked them to tell how many staff they supervise and how many referrals those staff made in the past three months. On average, supervisors manage 6 employment counselors who made an average of 17 referrals in the three months, or a little less than three per staff person. This is substantially less than employment counselors themselves report (mean of five). Here too, in contrast to the reports of employment counselors themselves, Kern ranked considerably higher than the other counties in average number of referrals per counselor (6.0).

Relative importance of eligibility workers and employment counselors referrals.

While employment counselors are much more likely to make a least one referral and to make a higher number on average if making at least one, there are far more eligibility workers. Below we show the relative importance of eligibility workers and employment counselors referrals

based on the average numbers referred by each type overall extrapolated to the actual number of eligibility workers and employment counselors in the five counties.[28] Overall, the extrapolated number of referrals favors eligibility workers: 3860 in three months vs. 2318 for employment counselors. However, the ratio varies considerably by county, being most extreme in Los Angeles. Though the accuracy of these figures is suspect[29], they do point out the importance of not relegating all identification to employment counselors alone.

Table 27: Eligibility worker referrals per three month period, extrapolated from reported referrals and by county

	Average referrals per worker	Total number of workers	Extrapolated referrals
Kern	1.31	338	443
Los Angeles (two regions)	2.11	1354	2857
Monterey	1.63	94	153
Shasta	0.83	47	39
Stanislaus	1.96	188	368
TOTAL			3860

[28] These numbers are shown in Appendix A. In Los Angeles we include only two of the six districts.

[29] We do not have accurate numbers of actual referrals for all the counties but these figures seem considerably in excess of what is probable. The eligibility workers and employment counselors supervisor estimates, which were about half that of the eligibility workers and employment counselors are probably more accurate.

Table 28: Employment counselor referrals per three month period, extrapolated from reported referrals and by county

	Average referrals per worker	Total number of workers	Extrapolated referrals
Kern	4.36	104	453
Los Angeles (two regions)	3.07	255	783
Monterey	8.68	23	200
Shasta	7.89	30	237
Stanislaus	8.60	75	645
TOTAL			2318

Hours of training as a determinant of number of referrals made.

Eligibility workers. In principle the amount of training staff receive is related to their skills and motivation for making referrals. Thus there should be a relationship between hours of training and number of referrals made.

Because we collected information on total referrals made rather than by issue area, we also converted training received to total hours.

Since 50 percent of those who said making referrals was part of their job had made none in the previous three months, we used logistic regression to determine whether knowing the number of hours of training a person received helped us predict whether they made zero or one or more referrals. The result was that prediction was improved—but only a small amount.[30]

Table 29 below helps us refine this finding, however. For two categories there is an apparently large effect: workers who received *no* training were much less likely to make any referrals and workers with a lot of training (over 30 hours combined for AOD/MH/DV) were very likely to make some referrals. Only 36 percent of those with no training made any referrals while 66 percent of those with over 30 total hours of training made referrals. For more than none but less than 30 hours there was little apparent relationship. Based on comments made on the survey forms, it seems likely that many of those who had more than 30 hours of training received it on their own initiative or as part of other programs. For example, a fair number had gone through domestic violence training with a non-profit DV agency. Thus, to some extent the greater number of referrals for persons with high hours of training reflects interest and motivation as well as the effects of training.

The relatively big difference between those receiving no training and those receiving one to 20 hours, however, would argue for the value of continually available training for new staff. (Of

[30] Although the result was statistically significant, the pseudo R2 was less than 1 percent and the area under the ROC curve was only .54, very little different from the .50 that would be found if there were not a relationship.

those not receiving training 53 percent reported not having been eligibility workers when CalWORKs started.) As we saw above, staff turnover (particularly in some counties and some offices) is relatively high.

Table 29: Whether referrals were made, by hours of training received

Number of Referrals	Hours of training					
	Zero (N=87)	**1-5 (N=120)**	**6-10 (N=111)**	**11-20 (N=124)**	**21-30 (N=111)**	**Over 30 (N=68)**
One or More	35.6	48.3	48.6	49.2	54.1	66.2
No Referrals	64.4	51.7	51.4	50.8	45.9	33.8
Total	100.0	100.0	100.0	100.0	100.0	100.0

A second approach is to look at the average number of referrals made once the threshold of at least one referral is overcome. Below we present data on persons who made at least one referral in order to be able to separate out the threshold effect from the effect of training on those who do make referrals. Here we see a very different pattern. Those with no training *if they made any referrals* made on average just as many as those with over 30 hours of training. In fact the differences between amounts of training are relatively small (it is not statistically significant) when the threshold effect is removed. There was not a statistical interaction with county.[31]

Table 30: Mean number of referrals per eligibility worker *if* at least one referral was made, by hours of training received

Hours of training	Number of Staff	Mean Referrals
Zero	31	3.4
1 to 5	58	2.9
6 to 10	54	3.3
11 to 20	61	4.4
21 to 30	60	4.3
Over 30	45	3.3
TOTAL	309	3.7

[31] ANOVA and ANOVA with interaction of County and Category of training hours with number of referrals as dependent variable.

In summary, any amount of training has a strong effect on getting workers to make at least one referral. Likewise a lot of training produces another major step up in the rate at which at least one referral is made. However, for those who *do* make at least one referral the amount of training has little relationship to the number of referrals made.

Employment counselors. Because relatively few employment counselors did not make any referrals at all we focus here only on whether hours of training is related to the mean number of referrals. There is a progression in number of referrals per amount of training hours. Those with no training hours referred an average of 1.2 clients in the three month period. Those with over 30 referred 6.8. As with eligibility workers, the biggest jumps are between zero and any hours of training and 30 to over 30.[32] (See Table 31.)

Table 31: Mean number of referrals per employment counselor, by hours of training received

Hours of training	Number of Staff	Mean Referrals
Zero	10	1.20
1 to 5	52	4.10
6 to 10	62	4.43
11 to 20	62	5.76
21 to 30	67	4.52
Over 30	53	6.85
TOTAL	316	4.97

Relationship of helpfulness of the training to number of referrals made.

Eligibility workers. A rough measure of the quality of training is the extent to which staff said training was helpful. The helpfulness of all three kinds of training were aggregated to create a total "helpfulness" score for the training the person received. However, this score was not associated (statistically or substantively) with either the likelihood of making zero rather than one or more referrals or with the average number of referrals made (among those who made at least one).

Employment counselors. There was a small (but statistically significant) trend toward an increasing number of referrals based on how helpful employment counselors rated the training (Table 32; Maximum rating of 12; those not trained were excluded.)

[32] These differences are statistically significant. In particular the difference between zero and over 30 hours of training is highly significant even when corrected for multiple tests (Scheffe).

Table 32: Mean number of referrals per employment counselor, by rating of helpfulness of training

Combined Rating of Comfort	Number of Staff	Mean Referrals
2-4	33	4.5
6-8	66	3.74
9-11	112	5.4
12	85	6.3
TOTAL	296	5.0

Comfort with discussing AOD/MH/DV issues as a determinant of number of referrals made.

Eligibility workers. Another potential determinant of the whether referrals are made and the number is how comfortable workers feel discussing AOD/MH/DV issues with participants. The comfort ratings for AOD, DV and MH were combined to make a scale, which was then divided into the categories shown in Table 33 below. The maximum score was 12 ("Very" comfortable for all three issues). There was no apparent effect of comfort on the likelihood that at least one referral would be made. Table 34shows the number of referrals made, if any, by comfort rating. Although there is a trend apparent—more referrals if more comfortable—it is due to a few outliers and is not statistically significant.[33]

Table 33: Whether referrals were made, by sum of self-rated comfort in discussing DV, AOD and MH

Number of Referrals	1-3 (N=46)	**4-6 (N=112)**	**7-9 (N=236)**	**10 -12 (N=174)**
One or More	50.0	47.3	52.1	48.3
No Referrals	50.0	53.7	47.9	51.7
Total	100.0	100.0	100.0	100.0

[33] Neither table was statistically significant.

Table 34: Mean number of referrals per eligibility worker *if* at least one referral was made, by rating of comfort in discussing AOD/MH/DV issues

Combined Rating of Comfort	Number of Staff	Mean Referrals
1 to 3	23	2.7
4 to 6	53	3.0
7 to 9	123	3.3
10 to 12	84	4.7
TOTAL	283	3.7

Employment counselors. As seen in Table 35, the effects of comfort were stronger among employment counselors. There is a very considerable mean difference of almost four referrals between the lowest category of comfort and the highest.[34]

Table 35: Mean number of referrals per employment counselor, by rating of comfort in discussing AOD/MH/DV issues

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

[34] The trend is statistically significant.

Co-location of AOD/MH/DV staff as an aid to identification and referral

Availability of co-located AOD/MH/DV staff.

Eligibility workers. The survey form asked whether AOD/MH/DV staff were co-located or spend time in the respondent's office. The question was phrased as an either/or option so co-location of any type of worker would have counted. Overall, 61 percent said that there was someone co-located or spending time in the office; 21 percent said there was not and 17 percent were not sure. This latter category might suggest need for more orientation of staff to assessment and referral arrangements.

There were significant differences by county (Table 36), with about half of Shasta and Los Angeles respondents reporting co-location or on-site time. In some cases we know that co-located staff do exist, so either a "no" or "not sure" indicates a need for orientation. This is particularly true in Shasta and Stanislaus. Arrangements in Los Angeles vary by office. In Monterey and Kern co-location exists but varies in intensity by office.

Table 36: Eligibility worker views on whether staff from AOD, MH or DV agency is co-located or spends time in their office

Percent Who Agree:	Kern (N=103) Percent	Los Angeles (N=360) Percent	Monterey (N=86) Percent	Shasta (N=44) Percent	Stanislaus (N=120) Percent
Co-located or spend time	71.8	52.2	82.6	50.0	69.2
Not co-located or time	19.4	26.1	4.6	45.5	11.7
No Sure	8.7	21.7	12.8	4.5	19.1
TOTAL	100	100	100	100	100

Employment counselors. Employment counselors are considerably more certain in Monterey, Shasta and Stanislaus than were eligibility workers that there are co-located staff. In Kern the employment counselors and eligibility workers answer this question the same way. In Los Angeles the employment counselors were much more definite in saying that co-location or on-site services did not happen (Table 37).

Table 37: Employment counselor views on whether staff from AOD, MH or DV agency is co-located or spends time in their office

Percent Who Agree:	Kern (N=65) Percent	Los Angeles (N=162) Percent	Monterey (N=19) Percent	Shasta (N=29) Percent	Stanislaus (N=52) Percent
Co-located or spend time	73.8	49.4	94.7	96.6	86.5
Not co-located or time	24.6	44.4	5.3	3.4	7.7
Not Sure	1.5	6.2	0	0	5.8
TOTAL	100	100	100	100	100

Helpfulness of having co-located or on-site staff.

Eligibility workers. Those respondents who reported that co-located or on-site staff existed were asked how helpful they were in providing information, handling crises, or making it easier to make referrals. Overall 53 percent said "very helpful," another quarter said "moderately helpful" and the remaining quarter said "a little" or "not at all" helpful. There were only minor differences in county responses on this question, with somewhat more variability among Los Angeles offices. (Table not shown.)

Employment counselors. Forty-eight percent of the employment counselors said the co-located or on-site staff were "very" helpful and a total of 80 percent said they were "very" or "moderately" helpful; 13 percent felt they were only a little helpful and 6 percent not at all helpful. Although not statistically significant there were fairly large differences by county. In one county, Shasta, 96 percent of the employment counselors said the co-located staff were very or moderately helpful; next was Monterey at 89 percent; then Stanislaus at 83 percent, Kern at 78 percent and Los Angeles at 76 percent. (Table not shown.)

How well the referral and assessment processes work

Satisfaction with the referral and assessment process

Employment counselors. Employment counselors, but not eligibility workers, were asked a number of other questions. The first were about how satisfied they were with the referral process, the timeliness of assessments, and feedback about the results of assessments. Overall, 73 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. Those who were "very" satisfied in these domains dropped from 34 percent to 17 percent to 11 percent (see Table 38).

Table 38: Employment counselor satisfaction with referral and assessment process, by county

Percent Very or Moderately Satisfied:	Kern (N=61) Percent	Los Angeles (N=146) Percent	Monterey (N=18) Percent	Shasta (N=28) Percent	Stanislaus (N=49) Percent
Ease of referrals	78.7	58.9	83.3	100	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

County satisfaction varies widely on each dimension. With regard to ease of referrals Los Angeles, which has been revising its referral process, ranks relatively low and Shasta stands out—all 28 of the employment counselors were moderately or very satisfied. The county-by-county disparity widens for timeliness, however. With only 38 percent of Kern employment counselors being satisfied in contrast to the 85 percent in Shasta. The percentage satisfied in Kern drops to 27 for feedback, but is no more than 50 percent in Los Angeles, Monterey and Stanislaus. These figures indicate serious difficulties with timeliness and feedback of information to employment counselors.

Employment counselors were asked to explain any problems. Fully forty percent responded, most mentioning serious problems. A total of 162 comments were made by 112 respondents. They were distributed as below:

Table 39: Comments made by employment counselors on referral process

	Number	Percent
No feedback from AOD/MH/DV providers	54	33.3
Lack of communication amongst workers	24	14.8
Disorganization across agencies	21	12.9
Time factors, especially delay in getting assessment and services	45	27.8
Other	18	11.1
TOTAL	162	100.0

It is important to note that categories 1-4 are all intertwined in one way or another. For example, here is a statement that reflects all of the themes.

“There is too much paper work to make referrals which takes too much time. There is little or no feedback concerning clients, and if they are attending treatment there are no treatment plans. There is disorganization and lack of communication between DSS and behavioral health.”

Below we summarize the major points made under each of these themes and then provide a significant number of the actual comments so that the tenor and detail come through.

No Feed Back

The main issues are:

1. Length of time it takes to get feedback, often over a month
2. Sometimes no feedback is received at all
3. Feedback is vague or inaccurate

The most common problems that occur because the length of time it takes to get feedback or problems because of no feedback consist of:

- Workers are unable to keep track of participants.
- Case workers spend many hours tracking activities of participants
- Workers can not place participants until they receive feedback.
- Participant may of stopped going and the worker is not informed
- Workers cannot issue bus passes for participants if they do not know what is going on.

Lack of communication among all workers involved

Major themes are:

1. There is little or no communication
2. There are communication problems between participants and AOD/MH/DV assessors
3. Communication within the office is not adequate
4. Narratives are not accurate

Problems that exist because of lack of communication:

- The EC needs timely up dates in order to successfully do his/her job
- EC may be unaware of participant being sent to a provider
- Never find out what program a client goes into or if they complete it and/or make progress.

Feedback and communication could be under the same category but were separated rather than have one very large category. The difference between the two is that feedback applies to feedback from a referral as compared to communication which is coming from statements that

specifically talk about the communication problems that exist among workers in the environment.

Disorganization across agencies

1. MH workers sometimes do not show up for appointments
2. Many times when trying to make a referral can't get through to anyone
3. Cant find proper paperwork
4. No immediate help available
5. Can't reach client because phone number is not written on referral
6. Regulations are unclear and disorganized

1. The major consequence of a lack of organization is that when clients are willing to get help it is important to have proper paperwork and immediate help available. As one worker said:

   "When making referrals to agencies there is no one to take referral making it necessary to call at a later date, which is not OK for a DV person"

Time factors and delay

1. Referrals take too long
2. Waiting time for an appointment is too long
3. Workers spend too much time tracking down participants
4. Paper work takes too long

Many complained that everything about this process takes too long. The most serious problem is that participants need help now; if they have to wait 2-4 weeks they sometimes change their minds.

Other

1. A few said services were good
2. Some said failure of is fault of the participant
3. Some have not made referrals
4. Some just started working and could not comment

Sample of comments

EAP: Behavioral Health person not always available and not always accessible when needed. Too many levels to go through, too much time to access appropriate substance abuse service providers. Domestic violence social worker: only one available; and not al

Lack of support groups for mental health issues which are barriers to employment, but do not constitute "mental illness" or AOD problems. For example: a support group for young single parents and grieving workshops for those who have suffered loss and had no opportunity to process that loss, etc.

We never get feedback on how many hours per week client sees Behavioral Health Team or if they are progressing. It takes way too long to get medical form (CA61) back listing duration of illness or other

There is no feedback on actual assessments unless we request at a later time. Very little communication.

very glad to have Behavioral Health Team available to us. We couldn't make it without them.

difficulty of meeting with one member of the team: "Never around." I do not receive feedback or know whether assessments are timely I'm not sure if I should (or need) to know.

The waiting time for an appointment is too long. We need more staff. We also need Spanish speaking staff.

Lack of feedback (reports) and/or not knowing what's going on in a case and how to support their clinical plan.

In order for me to follow WTW regs and reform, I need to know in a lot of cases why a specific result was reached. It is necessary to my job of classifying the case and helping client with resources, etc. As of now I get very little info. From B.H.S. and am frustrated - I can't help client and remain responsible for client not meeting current regs.

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 on to what to expect when I next see them for a different concern. Loss of communication is the biggest problem.

Too much paperwork to make referrals. Little or no feedback concerning clients, and if they are attending treatment. No treatment plans. Lack of communication with BHS and CSP workers.

Getting feedback on progress of participants. Even such info as meetings w/times and schedules so that we may issue bus passes for transportation.

As utilization of these programs increases, so does the period of time that a participant has to wait for assessment. It can take 2-4 weeks to get an initial assessment appt. BHS has been very good about responding in crisis situations or for case conferences very quickly.

The participant may have stopped going, and we are not informed in a timely manner.

Can't make the client appear or follow through.

Evaluation not thoroughly completed at all times. Sometimes you can see that there is an obvious problem with the customers and the assessment results indicate that no services are needed.

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

Provider has failed to notify case worker of schedule, results, etc. As a result the case worker spends many hours tracking activities of participants.

When making referrals to agencies some say there are fees participants must pay, thus hindering process. Also there is no one to take the referrals making it necessary to call at a later date and referral must be mailed back to participant. DV participants are not able to come to office, therefore referrals are hard to do. Regulations as to DV compliance with GAIN not clear.

Unnecessary differentiation between assessors and regular service providers.

I got a call 8/99 telling me a participant I enrolled 3/99 had not attended MH since 3/99. I had a PT enrolled who stated the Dr. had missed every scheduled appt.

Once you refer PT to any, you loose the PT. After many calls, you receive the results with 1 or 2 hours of treatment per week. DA!! We have to have PTs in a program for 32-35 hours/week.

It's hard to make referral to DV because providers seem not to understand what Gain workers are talking about

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.

The staffs were rude, untrained and lack of knowledge. No feedback from assessor after participant was referred to designated clinic. I was told only the assessor can call in to check the status of Cain participant. Is this true?

Too many no shows; Appt. are usually made 3 or more weeks later; GSW sends out appointment letter and calls PT a day or two before appt to remind him of appt; 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.

SA: Can't get the people to answer the phone to make the referral. It takes days of calling. Trouble finding out progress exactly what my participant needs to participate (transportation and childcare? how much?) MH: It takes a few days to get first appt. then it's scheduled about 10 days later. Then participant needs to be referred to another agency that's another couple of weeks. Then if I'm lucky I'll get the results in a week or 2 (it takes about 6 weeks for me to know that we are going to service PT for MH). Then I have to find out how much transportation and childcare. I never find out if they want school or anything else. DV: You call and they see PT tomorrow. Now DV is in office on Tues and Thurs. I get results right away. It still takes time to see about counseling, etc.

I am very satisfied with the ways of making referrals and feedback of results when the referral is to the MH worker outstationed in our office. The difficulty here is the time lag from date of referral to date of appointment. Referrals for DV have been excruciatingly painful.--No one available to take referral, unfamiliarity with referral process, and continual phone calls to obtain results. Similarly for MH referrals

to the MH worker outstationed in the Pasadena office. Referrals for SA are mixed.--Sometimes it works very smoothly and sometimes not. I think the difficulty arose when the provider was in process of moving.

Providers are rarely available (even co-located workers who are supposed to be on site for walk-ins) and unwilling to provide information on a timely fashion. Coop-case management is nearly impossible for lack of cooperation and communication.

It takes awhile for assessments. Not to mention, I feel there are plenty of CalWORKs participants who do not need mental health treatment but are referred anyhow. This makes it very difficult to refer or assess individuals who are much in need of these services. Also, we only have a mental health dept. I am not sure DV & AOD are met and dealt with as well as they need to be.

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.

Just telling the participants to go to a "window" at the Dept of Human Services is too impersonal. It tends to only increase anxiety of attending Mental Health Services.

Counselors have trouble contacting our clients, but we are not informed. Referral forms have no space for client's phone number. Counselors cal us and say they can't call clients.

Results are returned later than 2 weeks, mostly one month or never. Client's program schedule is not given.

The contractor is not responsive in providing show/no show information. Generally it takes well over 30 days to get a behavioral health report.

Employment counselor supervisors. Seventy three percent of the supervisors said that they were moderately or very satisfied with ease of referral (exactly the same percentage as the employment counselors reported). Supervisors in two counties, Los Angeles and Monterey were considerably less satisfied than in the other counties.

A very similar pattern by county, was seen in the rating for timeliness of assessments—for which 70 percent overall said they were very or moderately satisfied.

Finally, only 56 percent overall were very or moderately satisfied with feed back about assessments and services. Only Monterey and Stanislaus were predominantly positive about the way feedback is handled.

Supervisors were also asked to comment if any part of the process was not satisfactory. Here is a sampling of these comments.

It is hard to find an appropriate provider near our geographical area.

Sometimes the assessments are very slow coming in and the worker has to call and fax materials several times in order to get an assessment.

Delay of assessors returning the result of assessment and amount of time needed. Also delay in returning phone calls to workers.

We don't get the result back from MH worker. I referred so far 3 PTs, but have not received anything back from MH worker.

Clients are given appointments which they don't keep and get lost through lack of follow-up.

We've experienced some confusion with procedures. This includes a formal vehicle for communication between ETW/EW and BHT members. How often, what information, expectations etc, but we are working through these issues. Also experience difficulty with getting people to admit problem then seek or take help offered.

BHT wants all our info but is not willing to share back. They are lax about letting us know when clients fail to keep appointments or if progress is being made.

Feedback has been slow and quite often the information provided is too vague which makes it difficult for staff to make decisions re: the client's participation.

Too many waivers for participants. Some folks have had lots of time and don't need more. They need to do something.

The prevalence of AOD/MH/DV issues and the extent they are addressed in welfare-to-work plans

Employment counselor and employment counselor supervisor estimates of persons in their caseload for whom AOD/MH/DV is a barrier to employment

Employment counselors. There is no agreement on the number of persons in the CalWORKs population who have AOD/MH/DV problems that constitute a barrier to employment. Although there are a variety of estimates for MH, AOD and DV prevalence, there is relatively little consistency between estimates. This lack of consistency is exacerbated when the additional stipulation is made that these problems constitute a barrier to employment. In addition, there are a number of studies that seem to show there can be wide local variation. For all these reasons it is not possible to compare employment counselors' estimates with a "gold standard." However, it is helpful to see the range of estimates and to compare the estimates of prevalence with employment counselors' estimates of how many have AOD/MH/DV services in their welfare to work plan (the basic CalWORKs "contract").

Table 40 shows statistics summarizing employment counselor estimates. The range is very wide (1 to 100 percent for each category). The mean for each estimate is skewed by a relatively few very high estimates. The median is a more accurate representation. The last two columns are the 75th and 90th percentiles. Two facts stand out:

- Employment counselors do not as a group think that there is a huge percentage of AOD/MH/DV cases in their caseloads. For mental health the median is 6.5 percent and 75 percent of the estimates are below 15 percent while 90 percent are below 30 percent. For AOD the median is 10 percent and 75 percent of the estimates are below 25 percent with 90 percent below 49 percent. For domestic violence the median is 5 percent and 75 percent of the estimates are below 10 percent with 90 percent below 30 percent.

- In each case the estimates of those whose problems have been identified and services built-into the welfare to work plan are very considerably lower than those believed to have the conditions to an extent sufficient to be a barrier. Thus employment counselors clearly do not think that all those with AOD/MH/DV barriers to employment are being served.

Table 40: Employment counselor estimates of percent of persons with AOD/MH/DV issues in their caseloads and percent in which these issues are addressed in the participants' welfare to work plans, in percents

Variable	Number Responding	Mean	Median	Upper 75th %tile	Upper 90th %tile
MH caseload %	288	12.4	6.5	15	30
MH W-to-W %	259	7.2	3	10	15
AOD caseload %	277	16.3	10	25	49
AOD W-to-W %	250	7.4	2	10	20
DV caseload %	279	10.1	5	10	30
DV W-to-W %	252	5.4	1	5	10

Finally, in Table 41, we show the median estimate for each issue, by county.

Table 41: Employment counselor median percent of persons with AOD/MH/DV issues in their caseloads and median percent in which these issues are addressed in the participants' welfare to work plans, in percents by county

Percent Who Agree:	Kern (N=62[35]) Median	Los Angeles (N=138) Median	Monterey (N=16) Median	Shasta (N=27) Median	Stanislaus (N=45) Median
MH caseload %	5	4	17.5	20	10
MH W-to-W %	2	2	10	5	5
AOD caseload %	5	3	31.5	30	20
AOD W-to-W %	1	1	10	5.5	10
DV caseload %	2	2	20	11	10
DV W-to-W %	0	1	5	5	5

There is also considerable variation by county. In general the larger counties tend to estimate much lower percentages of participants with barriers than do those in smaller counties. Workers

[35] Number varies slightly for the six different estimates.

in Monterey, for example, estimate about ten times the percentage that workers in Los Angeles do.

Employment counselor supervisors. Supervisors of employment staff estimate the prevalence of AOD issues slightly lower (median of 6.5 percent). In other respects their estimates are very similar to those of employment counselors for both the overall prevalence and the percent with welfare to work plans. Again, about one half of those who are judged to have an AOD/MH/DV issue as a barrier are thought to have it as a part of the welfare to work plan. Monterey supervisors are consistently much higher in their estimates for the prevalence of all three issues than supervisors in the other four counties. We wonder if this may have to do with the much more extensive training they received—which may mean they are answering partially based on the literature rather than their own experience.

Eligibility worker supervisors. Supervisors of eligibility staff were asked only the first question—the percentage of the caseload having AOD/MH/DV issues. The median percentage they estimated was 10 for AOD and DV and 5 for MH. However, the median for AOD was pulled down by the 7 for Los Angeles; in each of the other counties it was between 15 and 20 percent. For MH and DV county estimates were fairly consistent.

The usefulness of AOD/MH/DV services

Employment counselor and their supervisors' judgements of how useful the AOD/MH/DV services have been for those who completed treatment specified in the welfare to work plan

Employment counselors. Overall 82 percent of the approximately 185 employment counselors who were aware of the outcome of mental health or alcohol and other drug services for some of their clients felt that the services had been Very, Quite, or Somewhat helpful. For domestic violence 85 percent felt they were at least somewhat helpful (Table 42).

Table 42: Employment counselor ratings of usefulness of the AOD/MH/DV services participants received, if services were completed

Percent Very, Quite, Somewhat useful:	Kern (N=30[36]) Percent	Los Angeles (N=83) Percent	Monterey (N=15) Percent	Shasta (N=22) Percent	Stanislaus (N=37) Percent
AOD	66.7	85.5	80	90.9	78.4
MH	69.7	81.7	86.7	90.9	86.1
DV	68	86.4	93.3	95.0	84.2

[36] Numbers vary slightly by category.

There may be a response set involved in these answers since there is very little difference noted in most cases between AOD, MH and DV. Kern employment counselors are consistently lower in rating services useful than employment counselors in other counties. Domestic violence in Monterey and Shasta are ranked particularly high.

Employment counselors were also asked to explain if services have not generally been quite helpful. Eighty-seven counselors made a total of 106 comments about whether AOD/MH/DV services had seemed to be helpful to clients who completed them. Not all the comments were "on track" with the question.

Table 43: Comments made by employment counselors on whether treatment helped clients who have completed it

	Number	Percent
Clients do not complete services or follow-up	26	24.5
These services are useful	12	11.3
Services need improvement	17	16.0
Time factors (time to referral, paperwork time, feedback time)	40	37.7
Other	11	10.4
TOTAL	106	100.0

Below are explanations of the categories comments were grouped into.

Clients do not complete the program

1. Many stated that participants do not complete the program and when they do complete the program they usually go back to the same environment which, brings out old behavior. Old behavior usually means drugs and alcohol. Also many DV participants go back to an abusive spouse.

2. If program itself has been completed they usually do not do follow-ups that are planned

These services are useful

1. Many employment counselors stated that these services have been useful to their client

2. Many said these services offer participants resources that they need and some are using these resources to better their lives.

The following statement made by a worker capsulizes categories 1 and 2:

"In my caseload the majority of clients don't complete their treatment plan. However, the ones who do complete the program, it seems to have helped quite a bit"

Services need to be improved

1. More staff are needed
2. More training is needed
3. One on one counseling and other specific services are needed
4. Professionals on-site are needed
5. Spanish speakers would improve services for Spanish minorities

Time factors/communication/feedback

c. Takes too long for an appointment
d. Paper work takes too long
e. Feedback takes too long
f. Communication among parties involved is inadequate
g. No feedback or feedback is not adequate

Other

1. People who couldn't answer the question because they were new employees/ and or the question did not apply.
2. Negative statements about participants

Sample of responses

Here is a representative sample of responses.

> In my caseload the majority of clients don't complete their treatment plan. The ones that do complete, it seems to have helped them quite a bit.
>
> The BHT in our area does not have the time for intensive counseling. She is stretched too thin. Also, getting those referred to participate in group sessions has been very difficult.
>
> Many participants are monolingual or are limited English proficient, and lack of services/bilingual professionals for these groups of participants. No visible efforts from the county to hire bilingual workers to serve some minority groups. The same regulations applied to everybody did not seem to work.

When the customers get into the program that they need most do fine for awhile and then they just give up. The drugs and alcohol are so powerful and addicting that it seems the drugs and alcohol win out in so many instances.

Usually the participant quits somewhere in it. If participant stays in treatment it helps them but they still return to their environment of friends, etc. that have a greater influence of the outcome as time goes by.

It's hard to say Once they complete program, I don't receive feedback regarding how they did. Of the few that have completed, I have not seen a significant improvement in their performance.

If at all possible, we need one on one counselors. All of these issues are very personal and many clients do not want to discuss these issues in a group as we do now. They end up dropping out rather than participating, or if they do participate, some feel the issues they have are not being addressed. We have a questionnaire clients fill out. If the client feels the issue keeps them from keeping a job, is due to drug use, and they check a box that they were a victim of domestic violence years ago, why do they need to go to domestic violence counseling if they are not in a domestic violence situation now.

Majority of the participants fail to follow through with regular * activities once treatment is completed.

The services are useful because, I believe it opens the door for those who might not otherwise have access to these services.

Not sure because there is very little feedback after PT has been placed.

MH, SA, DV agencies that county has contracted are not familiar with GAIN program and work requirements. At what point are participants exempt from GAIN activities? Home calls are necessary for many of these cases and not available. Most of these agencies don't take referrals in a timely manner and people answering phones don't know GAIN agency.

No one I have referred has completed the SA, MH, DV program. We are unable to effectively assess PTs in the short interview time we have. People often are in denial about MH or SA problems, particularly if they are in a reinforcing environment. They need a group meeting or confrontation to increase awareness.

Some participants want to stick with their doctors rather than being sent to assessment. Participants with MH/SA/DV problems should be given liberty to chose their own doctor. If they want to stay with their doctor, they should be allowed. By this way, we can win the support of participants with SA/MH/DV problems.

According to my participants, these services do offer some relief but not as much as they would like.

I have had only 1 participant complete her MH services. She was initially well-motivated to get on with her life. Not one of my other participants has completed or come up with an expressible plan for her/his future.

It's very difficult but not impossible to "supervise" a person with SA, MH, or DV with the limited time a GSW has to deal with them.

Region should assign special unit to handle these SA/MH/DV cases because most of the time the services providers are hard to reach, especially the doctors, as well as these kinds of PTs. If it is

necessary, the member of the special unit can make out field visit so the DPSS even can provide better service to the PT.

The participants tend to keep rescheduling initial appointment and drop out altogether and do not communicate with GSW. They prefer their own MH provider.

Services have been helpful, but we have some persons that fail to keep appointments. EW has to constantly reschedule these persons, some are very ill but are not receiving SSI?

Participants do not complete programs and/or providers do not provide information to caseworkers; co-op case mgt. nearly impossible.

No communication with mental health case managers. I have used phone and email. 90% of time no response. Don't even know if they really have my participant. Too many transfers of cases.

Initial service on MH and AOD is satisfactory. The problem is the subsequent follow-up.

No updates. Don't hear from mental health case managers. Participants are under the assumption that they do not have to show for scheduled appointments.

Very little communication between MH etc. workers and ECs. Somehow get the impression ECs and SECs etc don't actually "count" - MH etc pros seem to have much different goals/attitudes than ECs. Time limits, number of participant hours, general accountability not apparent prevalent in MH. ECs are forced to recognize and deal with those issues.

Clients don't show for appointments. I've never had a client receive these services and get a job, get off cash aid, etc.

Very little feedback is given by mental health or the clients. However, most clients that have received these services haven't become self sufficient through employment and their behavior returns within a year.

Employment counselor supervisors. Many supervisors did not feel they could answer the questions regarding the usefulness of completed AOD, MH or DV services for CalWORKs participants. Overall, of the 27 of 44 who did respond, 93 percent rated AOD services as somewhat, quite or very helpful; 82 percent rated MH at this level; and 96 percent rated DV at this level.

Comments volunteered by DSS staff

At the end of each survey form was an open-ended question asking respondents to “please tell us anything else that you think is important about the implementation of CalWORKs in your county as it relates to AOD/MH/DV issues.” In selecting from the ____ comments staff made we have tried to reflect to some degree the number of comments on a particular issue (such as the difficulties in the feedback process). We have otherwise picked the comments that seemed most useful to managers and policy-makers interested in how the programs are working and how they

might be improved. Before each set of comments we show a table summarizing the main categories of response.

Table 44: Eligibility Worker Comments: 168 workers (of 793) made 181 comments

	Number	Percent
Caseloads too big; overworked	35	19.3
More AOD/MH/DV training, orientation needed for both staff and participants	71	39.2
Misuse of benefits common by participants	5	2.8
Rules are too rigid to help people	12	6.6
CalWORKs and AOD/MH/DV programs are helpful	21	11.6
Other	37	20.4
TOTAL	181	100.0

Eligibility worker comments.

I like my job - wish I had less cases, to have more time with my participant. I believe both parents should look for work, not just one. ET has too many duties to be successful!

Our cases should be decreased in order for us to do a better job and for less errors to occur. We are always rushing with each client to finish all the work we are required to do, that we don't have the time to view our clients more carefully or answer their questions like we should. If we spent more time with each client we could recognize their needs more.

I think we need more training in all of these areas. These are three of the biggest 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 help and make referrals.

I think mental health gives clients way too many Cal Worker exemptions! Clients need to work, period. A lot of people function in everyday lives with going to work and dealing with their diseases - why shouldn't Cal Worker recipients? Makes sense huh?

I was receiving public assistance prior to becoming employed at DHS and I think CalWORKs is too easy. I didn't get the $225 & 1/2 deductions so I found that I needed to work because I was going nowhere on welfare. I also didn't have community connections paying child care. And I had to purchase my own bus pass because my 4 kids and I rode

the bus every day. The system is too easy to stay on it. From experience: make it harder!

Along with the CW changes and time limits, this department at Human Services has decided to make us generic workers again which consists of working all 3 programs, CW, food stamps, and Medi-Cal. There has been an overabundant amount of regulations changes in all 3 programs and have caused an overly impossibility to complete these tasks for a Eligibility Worker II II or III. and on top of this DHS has also required that we take 2 intakes appointments a day along with our ongoing appointments. Very impossible situation.

I have found my clients to be somewhat concerned about their aid stopping - they talk about this with each other. I see coworkers who can at last see that their efforts are not in vain. As far as MH/AOD/DV, the guidelines are a definite plus and following the guidelines does away with abuse. My coworkers who are there to assist in MH/AOD/DV are very professional and very knowledgeable. I still do see some abuse - but more importantly I see an end to the abuse because of time limits. Furthermore, I see another end to the abuse through quality control.

More work for same pay - trying to make us social workers without compensation - give us the workload of the others that receive fewer cases without the deadline and morale may go up.

Too much confusion, no logic. No future thought. They change something one day and change it again the next day. Administration does not plan well for the consequences of actions. They do not realize if this, then that. Morale is at al all time low. check how many eligibility techs are on anti-depressants; how many nervous breakdowns among employees.

A few clients are using their MH/AOD/DV issues to avoid the work involvement. I have had more than one client inform me that they have applied for SSI/SSP so they can stay on aid and not have to work.

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.

I feel most workers in the dept. of human services have very negative attitudes about clients and their situations. Some workers will bend over backwards for clients but most can care less!!

It seems that the training we receive is on the how to identify part. With MH/SA/DV issues we need more training in how to handle these identified part.

We have more tasks and need to learn more but our caseloads don't decrease. Now more than ever administration seems to care less about us. The focus is on the participants. We resent that. Our morale is lower than ever. How can we possibly sympathize with the participants when our working conditions are making us ill?

This is a good service to provide for participants. Cal Works is the best thing to happen to the welfare system.

The increase of requirements, as for example school attendance verification, had increased the amount of time EWs must work on every case.

I found that many participants are very interested to know where to go if they have domestic violence problems. This is something that is helping many participants. Thanks to t he people who made this possible. I am very interested to know more and willing to help those people with this kind of problems.

More participants are open with DV and SA than usual, because they feel that someone out there does care about their feelings and situations.

We need to have better training or more hours for MH/SA/DV issues. We also should have a professional in our office to handle these participants in a better and safe manner.

They should have a specialized person in District Office to see the participant right away if needed to be referred.

There is a need for specialized staff handling these cases and there is a need for resources.

Currently, services for MH/SA/DV are not available to participants who are not legal residents. Sometimes there are participants who are in need of these services, especially for domestic violence, but the specialized workers refuse such referrals if the participants are not eligible for Cal Works for themselves, even if their children are eligible for Cal Works. Such services should be provided to all of our participants in Cal Works in order to protect the children involved, regardless of their parents' eligibility to the program (Cal Works). As long as participants have a case open why not provide a better and safe environment for those children? Also, current information about services are only in English. I am enclosing forms that need to be translated into other languages in order to inform our participants.

Cal Works 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.

Need more training.

Need forms in Spanish. What if any services do the undocumented parents qualify for?

Constant training on a yearly basis regarding these issues.

Although removing the individual from these environments is important, I feel it is not enough. These individuals need to be monitored so that they do not go back to these particular lifestyles. Often these people do not have the support they need to free themselves, which would result in them being independent.

Most participants get upset if you ask them about SA, DV, MH.

There are things that should be left to experts.

Our office likes to pretend morale is high. We are always informed by our Director and Deputies we are not to say anything to visitors in our office. I don't know why they have clients sign affidavits. They lie anyways. If you give them a time limit to send something in and they fail to, you suspend the case, they file for a fair hearing, and win. So why take a negative action on a case. Everything has loopholes for the clients to get around. Our administrators don't support us and neither does the system.

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

Nothing has changed since Cal Works was implemented in Los Angeles County.

People with SA/MH/DV problems will rarely identify themselves as having any problem at all. They deny there is any problem at all if you ask, even when it is obvious and there is nothing we as EWs can do to help them. This is very frustrating to the point where you don't like asking the question because if the answer is yes, the participants become angry and defensive. Then there is a breakdown of trust and the participants are wary of us.

MH/SA pertain more to medical records and thus more private and confidential, reserved to well trained professional in these fields. Remember most of the eligibility workers do not have a college degree and.. The job does not require a BA to be hired! Expertise and well founded knowledge on these matters require specialized training, not just a couple hours of general information. Applications for aid do not clearly ask the applicant to state specific problems with substance use, abuse, mental dysfunctions, etc.

Cal Works is a great program but eligibility staff should also have a great program in our office to lift morale, so that we may serve the public better.

What I've observed the program lacks is the networking and communication needed between agencies regarding status of participants and continuous follow-up.

From my experience some participants are taking advantage of DV priority services. Not participants who are referred by DV shelters but participants off the street who claim DV so they can get monies to get new housing. Once they have their new place they terminate their case. There is no once in a lifetime homeless if all they have to say I'm a DV participant.

It would help if most people realized that the program is there to help them.

I think it has been a very effective program! There is always room for improvement but it's a step in the right direction.

I think we should be trained a lot more in the areas listed: Substance abuse; Mental health. I also think we should be taught how to be prepared to handle violent participants and become more knowledgeable about domestic violence and steps that can be taken to protect the victims.

Case loads should be decreased so that GAIN service workers can counsel more on

individual basis.

If supportive services were designed to help clients, it's doing a poor job. Example: A client in need of these services talks to Intake EW. He or she is sent immediately to Support Services EW to repeat her (his) problem. The client is then referred to GAIN worker to repeat her story. The GAIN worker refers the client to clinical assessment (if he can find them). How many times should a person repeat a troublesome situation?

This is a children's services department issue and should be handled by that department. Clients have no respect for eligibility workers and take what we say, do lightly. This issue needs a person with authority and that's children's services workers.

Supportive services provide and impact many families in a great positive way - giving participants the financial help they so desperately come seeking but also gives hope in their emotional distress. Cal Works has increased the EWs responsibilities giving them many more roles to play as part of their jobs therefore an increase of pay would serve as a good incentive to motivate and to help the worker to do their job in the best possible way.

There has been improvements in the personal lifestyles of several participants I have come in contact with, and they are excited about what the future will bring. I feel that the participants are learning from these programs.

There is no quality in your job when there is so much to do. Clients deserve more time for explanations about CalWORKs program, and welfare reforms changes. What's government's concern: Quality or Quantity?

I feel as being in part responsible for the successes and failures of our customers' progress and acceptance of CalWORKs, it is very important that we have consistent and updated resources available for these issues. Recently I encountered a situation of severe domestic violence with one of my customers and spent a good 1/5-2 hours compiling information, resources and referrals for her. Per one EAP worker I was told this referral would need to be made through the domestic violence unit. Which I had no idea we had. I was given the name of the DV counselor from our EAP worker but he did not have the number to contact her. Fortunately I was able to get the number from a CWES worker. I feel it is critical (especially now) that all departments work very closely together and all have access to available resources.

Our unit was mostly unaware that there is an EAP person here in ____City for a few hours a week.

It all happened too fast for me.

We need more training on these areas. Don't mix the 3 topics together. For each topic have a 1 day or 2 day training. And have experienced people teaching the class.

CalWORKs has changed the way I see our clients. Before I used to see them as subjects, part of my work. Now with CalWORKs, I have a different outlook. I'm more sensitive to their problems and aware of their needs. I see our clients more as human beings than just work. I think CalWORKs is giving the client another chance to get on their feet, to really improve their lifestyle.

We received training but the amount of training was inadequate because 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 given since then.

Many clients do not want to get help, especially for AOD problems. Methamphetamine use is horribly common and seen even as normal in this area, and there is no way to mandate people seek treatment. If they truly don't want to change, mandating treatment will be ineffective. Many of the clients who need MH services are not CalWORKs clients. They either never had children or they have lost custody due to their problems.

Too many rules or edicts are handed down by the legislature, which are unclear or show very little understanding in how we do our jobs. They need more direct feedback from workers who know what will work and what will not.

There are many generational clients in ____ Co. We should treat this as a MH issue. The children and young adults need to know there is a better way of life and how to achieve it. Even if their parents are not capable of securing employment, they should be required to do any job for a paycheck so the children will grow up seeing this as a way of life. Methamphetamine is a major factor in Shasta Co. Many clients will not give it up. This does not mean they cannot work a conventional job. Maybe we can come up with some type of self employment work they can do.

The 2 biggest barriers to self-sufficiency in ___ Co are DV and AOD. While __ Co. has zero tolerance for DV, and lots of support for DV victims, the legislation does not support agencies with regard to AOD. We have rampant drug abuse here, but CW clients are not mandated to participate in AOD rehab, etc. When clients won't even admit AOD problems, we cannot force them to face up to it. Mandatory drug testing for CW as a condition of eligibility would really help these clients begin recovery.

I have personal experience with drug and alcohol abuse and domestic violence. I have also volunteered at al alcohol and drug recovery center in the past. I don't feel that many workers have a deep concern for clients with abuse problems. Some workers even seem to have an attitude of contempt for the clients in need of help/I think a great deal more training is need to give workers a better idea of the barriers addicted clients face. Perhaps to even spend a day at the detox or women's refuge.

Honestly - we have so much work, so much to learn that I haven't had time to think on what is important. And I am not just complaining about the work or the case load size. It is just a lot a worker has to do and learn and remember - too many programs! for one worker.

There are many positive changes that have come about because of Stan Works. Our goal is to lead our customers to self sufficiency.

The BHS Dept we have here is excellent. During the course of my employment I have been able to refer clients and start them on a path of self awareness and life style changes sooner than I thought was possible.

Since each case needs more attention than before CalWORKs, our workload has

increased even if the numbers don't show increases. We are generic workers, so we have also been impacted by Medi-Cal changes (1931[b]) and Food Stamp changes (ABAWD, drug felon). Our casework has increased tremendously. HELP!

The same problem as always exists, the participants must want help in order for us to truly be helpful.

Most workers don't understand or want to understand the issues around AOD, DV and MH. I don't think it's because they aren't caring, it's just that with the work load and all the complex changes they don't have time to look for signs, unless they are blatant.

I think it is totally unfair to the children for an adult to be denied based on a previous felony. The check is decreased, the food stamps decreased, but the same amount of people in the home. Guess who pays most for these decreases?? These decreases will leave more children homeless!! Hungry!! The vouchers could be used in these cases, to be sure that the drug user can't use the money for drugs. Not enough drug programs in this county, especially affordable ones!!

Treat the participants like humans.

As an EW, referrals to BHS leaves me feeling stupid and inadequate. We do not use the same tools as ECs and BHS does not comprehend the difference between the two jobs.

I can see an increase in employment soon after WTW activities. I think BHS is a great asset but I feel they need to better schedule their on call persons so someone is available for intake situations.

As an eligibility worker I was told I wouldn't deal with certain issues as they were to be handled by EC's. But I have found that because there are limited EC's and the number of cases they are receiving, I've had to deal with referrals, services, and counseling for customers I think this is a disservice to them and internally for staff.

Because we re generic it is very frustrating to interview an applicant requesting AD, MH or DV issues and not be able to refer them to services because they are TANF for these reasons, they can't deal with WTW and aren't encouraged to seek solutions to their barriers. We need more family decision meetings for TANF families with sanctions.

If we are expected to do the job and all that it entails correctly and efficiently then we need reduced caseloads and more training. We can't be expected to have hundreds of cases, budget processing deadlines (usually have about 15 days in a month to process all change budgets, see customers, make referrals, add/delete customers, monitor school/work activities, vaccinations, on and on and on and on and be top notch social workers to boot!

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!

Welfare as we know it should be totally done away with, because it sucks!

I feel people don't understand addiction and are uncomfortable discussing it. I am a recovering person, and it is clear to me that there are a lot of gross misunderstandings of the dynamics of addiction for the individual and for the family.

Mental health issues are still a major problem.

More customers drug usage and mental problems are coming out. More interaction and intervention have happened. We are finding that children are not in school due to drug usage by parents, etc.

Eligibility supervisor comments.

Development of case management procedures for the BEST units has been unbelievable slow. Especially considering that we had advance notice of 2+ years. This has greatly impacted morale. Staff who were motivated and interested at that time (years ago) have since given up hope and desire to be part of that program change. This is a great loss to the department. as yet, no clear reason for the delay in developing these procedures. Why is that? Appears to staff that it is due to lack of support and interest from administration. Other things get rushed through and developed quickly, why not BEST procedure? Why the apathy? Who's to blame or responsible? I for one have given up hope and lost heart. Sad situation.

I think in South County we have a real problem with transportation. In order to allow us to help with SA/MH/DV issues we need to be able to provide reliable transportation to our customers.

Caseloads need to be decreased in order for EWs to have time to better communicate with customers.

We have had lots of excellent training with regard to these subjects, however, we do not, at the eligibility level, do assessments as are being alluded to in this questionnaire.

Problems are yet to happen. Once people start losing cash aid. Are we tracking the effects on local community?

2A: EAP: 15, plus 3 from me. PDM Case Manager-Benefits; 3: Ongoing only; 5: GA caseloads PDM & others

More education needed for staff to recognize issues and referral assistance to help those in emergency.

These issues are being addressed more than they ever have been before by our agency due to the collaboration with Behavioral Health Services. We may not be reaching every individual but we are reaching a large population and making a positive impact on families

Our eligibility workers are aware of available services, and when a need is suspected - they do orally explain the services and often try to make arrangements on behalf of the

customer. We have on site Behavioral Health staff whom we can speak to about specific cases and they are very receptive to helping us and the customer. The only negative to having these services is that they are only available to Stan Works customers. This excludes undocumented immigrants and those receiving only Medi-Cal or NAFS. Sometimes the undocumented parent of Stan Works children may need services, but we've been told they aren't part of the group covered by our BHS team, because they themselves aren't StanWORKs. I've experienced this twice in recent months in my workers' cases (I supervise a Spanish bilingual unit whose families are all Spanish speaking only).

On the old JA2's on the last page where they ask the screening questions for referrals to CHDP and WIC there used to be some questions asking if the person wanted information and or referral for drug counseling, emotional problems, etc. This was always nice lead in for asking about issues that clients might be dealing with. Would it be possible to get the state to add a few screening questions to the Saws 2A?

It seems that the implementation of CalWORKs here as it relates to MH/AOD/DV issues relates more to EC's than to EWs. EC's seem to be able to make these referrals more a part of their jobs. They have lower caseloads and more time to refer. Only so much you can do in an 8 hr day. Sad. Clients lose out. no fault of EWs.

We still don't spend enough time on these issues. We are still basically paper pushers.

More advertisement needed to reach participants. Using other means - telecommunication; such as audio and video forms, television. And newspapers and magazines.

MH/SA/DV services should be available to all CalWORKs participants regardless their immigration status, as long as they have children that are born in US.

This survey really did not pertain to the medical unit because our participants are rarely in the district office. The recertifications are taken by the R&R unit and all of this information is sent out by the R&R unit. When a participant comes into the district office they are informed of the various programs.

There should be a task force to screen SA-MA-DV prior to the eligibility staff having contact with the participant.

Give us training on how to handle a situation or questions such as procedures; do's and don'ts. We know what MHI SA & DV is; give us scenarios on case situations, a place or # where to call in emergencies.

Very good program. Keep the program.

People are aware that they are not alone, and there's help for them and their children and have some kind of comfort.

At the certification or redetermination interview the participants must be interviewed privately like intake to deliver the information regarding MH/SA/DV to the participants in a better constructive way. If one unit specialized in supp. Yvs. Would be in charge of the recertification procedure we would have a much better result of self declaration.

The following is needed: 1) More specialized training for supportive services workers; 2) Lower caseload for SS workers; 3) More workers; 4) Orientation for new Cal Works participants. Should include a video explaining all the benefits of seeking supportive services to overcome barriers to employment.

It really elevates the self-confidence and independence within the Cal Works participants!

The lack of adequate mental health care is the major problem in the U.S. The people who abuse substance and involves domestic violence are having problems with mental health. Yet the problem has been neglected for a long time. In our society the most people are ignorant about mental health, and medical institutions ignore the problem. May be because it is too costly. In the meantime those people who suffer from mental illness or mental incapacity are forced to live with a stigma. The solution for the problem is to educate the public that mental illness is like any other illness, it is treatable. And medical care for mentally ill people must be accessible, not only for Cal Works participants but everybody in our society.

It is a step in the right direction. However, some participants distrust the system to disclose such personal issues to a government agency. I see this happening in the Hispanic population. In my years as part of the EW staff, I have learned that a high percent of Hispanics fear a government agency. I also believe a high % of domestic abuse exists.

In my opinion this way of referencing pts to gain to be treated of any of the above definitions is being very successful I have seen myself pts improving a lot.

Staff needs extensive training in mental health. It has never been scheduled before in this office. It has been given to General Relief staff, but not to Cal Works staff.

It is very important that we continue to screen every participant that has mental health, domestic violence, and substance abuse and refers to the specialized worker for help which can save the children's lives and it can help the participant to change for better life and self support in the future.

Good services available for area participants through Cal Works.

Cal Works and GAIN basically do the same job. In evaluating and determining eligibility for Cal Works and job seeking, because the participants find employment by themselves.

The assigned worker for approve section for this type of services has a limited guidance on referring participants to seek counseling. Basic responsibility is to refer participants and issue R & R form. More than likely the participant does not contact any agency, the domestic worker and eligibility worker need training on how to approach and refer a participant in a manner of sensitivity on this matter.

As much as I agree that these problems exist, and as much as I promote the programs that benefit this population, I think we need to focus not on the end result of the misbehaviors, but rather in a preventing plan. Our children in grammar schools could be a good starting point. Videos, presentations and real life testimonies may push our young population mentality to be proactive to avoid that kind of consequences. Suffering, punishment and consequences need to be known to our children along with alternative

programs that create a proper ground for them to develop into positive and productive citizens.

It requires eligibility staff referral in which to help the participants.

Need to get transportation for undocumented persons. Participants who are DV; shelters will not pick up at DPSS offices.

There needs to be more training on recognizing different barriers for our clients. However, this will not be of any use to our workers as long as caseloads remain high and they continue to have to do manual processing for programs that our automated system should be able to do.

It is very difficult to counsel someone who is having problems in the areas mentioned when you don't have an educated background in those areas. If a client brings up during an interview that they are having problems in one or all areas, we should be able to send them to a Social Worker who has done counseling in those areas.

Employment counselor comments.

Table 45: Eighty-one employment counselors made 88 general comments

	Number	Percent
AOD/MH/DV services are good, but could be better if	22	25.0
More training	23	26.1
More staff	18	20.4
Better communication	15	17.0
Other	10	11.4
TOTAL	88	100.0

Employment counselor supervisors

I'm glad these services are available for the participants. I imagine it is a very good program and opportunity to cut down on any barriers present. Good idea!

We need to be more serious on these issues.

The need to implement these referrals in a more efficient manner by the providers for the interest of the participants instead of for the political interest.

Having BHT team located in our building has being a positive CalWORKs change. They are there and can intervene in crisis situations, can meet with or schedule appointments w/client versus the old way where we had to send them across town to Mental health. If client went across town to Mental Health there could be a several hour wait and often group was all that was available. The one on one services are appreciated by the participants and seem to have positive results.

I believe that there are too many people involved in the case management of our clients. Each agency/organization has its own goals/outcomes and the clients' needs have been pushed aside. CalWORKs is no longer about helping the clients - it is about other things.

Inadequate services for the Vietnamese speaking population.

Summary of DSS survey findings

1. There is substantial variation by county, and even more variation within the offices represented in LA.
2. There is substantial continuity in most counties of eligibility and employment staff. LA shows high variability between offices. Has positive and negative aspects for identification and serving AOD/MH/DV clients.
3. Increased demands on eligibility workers and employment counselors make it unlikely that they will have much time to devote to identification.
   a. Caseloads have gone up
   b. Work per case has gone up
   c. Complexity of rules and regulations has increased
4. Results confirm the county assumption that training is important for identification and referral of persons with AOD/MH/DV issues. Three aspects of the amount of training are important:
   a. There is an appreciable gain in feeling that training was helpful and in comfort at discussing AOD/MH/DV issues with large amounts of training. Large amounts of training are also associated with high levels of referrals.
   b. Persons with NO training are much less likely to feel prepared or comfortable in dealing with AOD/MH/DV issues and much less likely to make any referrals (especially true for eligibility workers).
   c. Between zero and large amounts of training there is little effect on preparedness, feeling comfortable, or number of referrals made.
5. Although not measured directly, it appears that in some counties training was of very high quality and hence was judged to be much more useful by staff. Conversely fairly large amounts of training in at least one county backfired, causing staff to rate helpfulness and preparedness very low.
6. Eligibility workers and employment counselors indicate that AOD/MH/DV issues affect a significant but not an overwhelming percentage of CalWORKs recipients and that substantially more of these persons could be identified and referred.
   a. Median percentages of AOD/MH/DV are estimated to be 5 to 10 percent
   b. However, staff recognize that more cases exist than are addressed
   c. A small proportion of both eligibility workers and employment counselors makes a large proportion of the referrals. If all employment counselors made as many referrals as the most active 20 percent do, there would be 260 percent as many referrals as currently.
7. Informing CalWORKs participants about AOD/MH/DV issues and services is far from uniform. Overall, there is wide diversity among counties as to whether each client receives oral or written material about AOD/MH/DV. This varies by whether it is AOD, DV or MH that is of concern.
8. Approximately a quarter of eligibility workers either say that components of the identification and referral process are not their job or they indicate they are poorly prepared to carry them out. (Components are identification, telling about AOD/MH/DV, and being comfortable discussing AOD/MH/DV issues with CalWORKs participants, and actually making referrals). While

employment counselors are only somewhat less likely to be ready and prepared to carry out the first three, they are much more likely (95%) to recognize that making referrals is part of their job.

9. CalWORKs staff are generally positive about the existence of, availability of, and helpfulness of AOD/MH/DV staff but a great many point to poor communication (particularly lack of feedback about persons receiving AOD/MH/DV services) and uncoordinated actions by staff from different agencies concerned with the same case.
10. Co-located staff are viewed as helpful by about 75 percent of staff.
11. Except in Los Angeles the referral process is regarded as fairly accessible.
12. Feedback from AOD/MH/DV staff to DSS staff about assessments is frequently missing or untimely.

Part C: AOD/MH/DV CLIENT VIEWS

CLIENT SATISFACTION SURVEY

Interpreting the client survey data

At the time participants in this study filled out a survey form they were all a) receiving TANF and eligible for CalWORKs and b) receiving services from a mental health, alcohol and other drugs or domestic violence provider. However, not all of them had welfare to work plans that included the AOD/MH/DV services they were receiving. That is, they may have entered AOD/MH/DV services without a CalWORKs referral.

The representativeness of the samples in each county is addressed in Appendix A. The table below shows the size of the sampling groups used in analysis of the client survey.

Table 46: Sampling groups used for analysis

	N	Percent
Kern AOD/MH	80	13.5
LA AOD	176	29.8
LA DV	59	9.9
LA MH	119	20.1
Shasta AOD	31	5.2
Shasta MH	29	4.9
Stanislaus AOD/MH	77	13.0
Stanislaus DV	20	3.4
TOTAL	591	100.0

Within these groups, the subgroup percentages shown in the following tables can be considered to be largely representative of the populations they represent. In general, though, it is safest to assume the "total" column, reflects only the 593 people in the sample itself.[37] We also use

[37] If sampling proportions were known with certainty, sampling weights could be constructed to permit us to generalize from the sample to the overall population in the four counties. However, some of the sampling proportions are unknowable (e.g. number of women in DV programs who are CalWORKs eligible). If there is little variability by sampling group the total can be presumed to represent the overall population. If variability is high, however, it does not. For example, if Los Angeles AOD clients reported much higher or lower scores than other sampling units, then averaging them could be misleading since each LA client in the sample may represent many

statistical modeling (ordinal multiple logistic regression) to artificially "hold constant" the sampling group, age, race and time in the program.[38]

The division into AOD vs. MH is based on the client categorization of the types of problems for which they are receiving services; the program itself was not identified on the surveys for confidentiality reasons. In some cases we provide an extra table which does break out responses into AOD, MH and DV. In doing so 27 cases in which it was impossible to judge whether the case/program was primarily AOD or MH are omitted.

How helpful are the services?

Helpful overall. All the survey respondents were asked if the services they were receiving were helpful. Table 47 shows the responses. The "helped a lot" category varies somewhat by response group, with Stanislaus MH/AOD and LA MH being at least 25 percentage points lower than the other groups.[39] However, if the "helped a lot" and "helped a moderate amount" are considered together all show over 75 percent who feel they were helped at least moderately. In many of the groups it is over 90 percent. Shasta MH and Shasta AOD stood out for their high marks. As an interpretive caution, "client satisfaction" surveys typically find that persons with a diagnosis of depression report much lower scores. According to the MIS information supplied by Shasta, Kern, and Stanislaus programs between 24 and 53 percent of the CalWORKs eligible MH clients served had depression-related primary diagnoses.

Table 47: Have the services you received here helped you deal with your situation or problems?

	Kern N=79	LA AOD N=166	LA DV N=54	LA MH N=116	Shasta AOD N=30	Shasta MH N=29	Stanislaus N=77	Stanislaus DV N =19	total N=570
Helped a lot	68.4	72.3	68.5	39.7	83.3	86.2	42.9	68.4	61.9
Moderate help	21.5	18.1	25.9	35.3	10	13.8	33.8	15.8	24.2
Little, none, worse	10.1	9.64	5.56	25	6.67	0	23.4	15.8	13.9
Total	100	100	100	100	100	100	100	100	100

more cases that do cases in other sample units. See Appendix B for an exploration of the difference between the sample and projected population estimates (limited to sampling groups for which we have population data). There is actually an advantage in not weighting the sample in the totals in that were we to do so Kern and Los Angeles would swamp the other sites, even though we include only two of the six districts in LA.

[38] The tests of statistical significance we use presume either random sampling (or that sampling weights are known and used). Since this is not entirely true, a report of statistical significance is simply a further indication of substantively important differences that are clearly apparent from the tables themselves. It tells us that differences that large are unlikely to have arisen by chance (there is only a 5 percent likelihood)—but there may have been sampling related bias that caused the differences.

[39] In ordered logistic regression these groups were statistically significantly different from the others.

Applying the principle that the total and cross-tabulations may be looked at where differences between the sampling groups are not large we see that a total of 62 percent say the services have helped a lot, and 86 percent say they have helped at least moderately. Only 4 clients out of 570 said they thought they were worse off as a result of the services. The multivariate modeling in this case corresponds closely with the raw data. For example, the percentage who say services helped a lot is 61.9 in the raw data and with sampling group, age, sex and how long in the program held constant it was 62.8.

Holding "sampling group" and the other variables constant, we find that those who had been in service at least six months reported moderately higher degrees of having been helped than those in services a lesser time and there was a statistically significant but relatively small tendency for Latino/Hispanic persons to rate helpfulness lower.[40]

We also broke out the AOD and MH programs in Stanislaus and Kern in order to see if helpfulness varied systematically by the type of program.[41] See Table 48.

Table 48: "Have the services you received here helped you deal with your situation or problems?" by AOD and MH programs

	Kern AOD N=25	Kern MH N=38	LA AOD N=166	LA MH N=116	Shasta AOD N=30	Shasta MH N=29	Stanislaus AOD N=26	Stanislaus MH N =42	total N=472
Helped a lot	84.0	57.9	72.3	39.7	83.3	86.2	34.6	47.6	61.0
Moderate help	16.0	28.9	18.1	35.3	10.0	13.8	34.6	33.3	24.6
Little, none, worse	0	13.2	9.64	25	6.67	0	30.8	19.0	14.4
Total		100	100	100	100	100	100	100	100

In multivariate analysis, not only was difference by program/county very significant, but an important ethnic difference was revealed. The "Other" respondents (who were primarily Asian and Pacific Islander) in AOD and MH programs reported low rates of being helped "a lot:" only 56 percent for AOD and 31 percent for MH.

Table 49 shows overall ratings of helpfulness by AOD, MH and DV program type. On average, 71 percent of the AOD program respondents report that the services received helped "A lot" versus 45 percent for the MH respondents and 68 percent of the DV respondents[42] The difference

[40] These differences were statistically significant in a ordered logistic model with sample group, age, race, and time in the program as the explanatory variables.
[41] Since we did not have program names on the forms (for confidentiality), we identified as AOD forms all those in which the client said they received Only AOD services or AOD AND DV. We dropped the few cases where all three or AOD and MH were received since we could not determine for sure what kind of program it was. We followed the same procedure for determining which were responses from mental health programs in Kern and Stanislaus. The drawback to this procedure is the loss of 28 cases which we were unable to categorize by program.
[42] This is highly statistically significant.

for those saying they were helped a lot *or* received moderate help is not so great: 89 percent for AOD vs. 79 for MH vs. 91 for DV respondents.

Table 49: "Have the services you received here helped you deal with your situation or problems?" by AOD, MH and DV totals

	AOD Program Respondents N Percent	MH Program Respondents N Percent	DV Program Respondents N Percent
Helped a lot	175 70.9	88 44.9	50 68.5
Moderate help	46 18.6	66 33.7	17 23.3
Little, none, worse	26 10.5	42 21.4	6 8.2
total	247 100	196 100	73 100

Services helpful regarding employment. A second question asked specifically if clients thought they "have a better chance of getting or keeping a good job" because of the services they got at the program. Table _ shows the responses to this question cross-tabulated by sampling groups. The overall responses show clients to be optimistic about their chances improving as a result of services. Fifty percent think their chances will be much improved while another 26 percent think their chances will be somewhat improved. Shasta County's 100 percent reporting much or some improvement stands out but is not statistically significant. However, we see the same pattern as with helpfulness overall in that both Stanislaus AOD/MH and Los Angeles MH clients rate their chances relatively low; as did Stanislaus DV respondents as well. See Table 50. As above, while age is unrelated to perceived job chances, persons of Hispanic background rate their chances lower than members of other racial/ethnic groups and those with over six months of services rate them higher than persons with less service.

Table 50: Respondent view of whether job chances are better due to services

Chances	Kern N=80	LA AOD N=174	LA DV N=57	LA MH N=116	Shasta AOD N=31	Shasta MH N=29	Stanislaus N=74	Stanislaus DV N =20	total N=581
Much better	61.3	60.3	57.9	32.8	67.7	72.4	23.0	40	50.3
Somewhat better	22.5	25.3	31.6	22.4	16.1	27.6	37.8	25	26.2
Little or no better	16.2	14.4	10.5	44.8	16.1	0	39.2	35	23.6
Total	100	100	100	100	100	100	100	100	100

As in overall helpfulness, AOD program respondents in our sample said their services were helpful in increasing employment chances to a much greater extent than MH program respondents. This is shown in the summary in Table 51: 86 percent of AOD respondents said their chances were some or much better compared to 57 percent of MH respondents and 83 percent of DV respondents.

Table 51: "Do you think you have a better chance of getting or keeping a good job because of the services you have gotten here," by AOD, MH and DV totals

	AOD Program Respondents N (Percent)	MH Program Respondents N (Percent)	DV Program Respondents N (Percent)
Much better chances	157 (61.3)	61 (31.6)	41 (53.2)
Somewhat better	63 (24.6)	50 (25.9)	23 (29.9)
Little better or same	36 (14.1)	82 (42.5)	13 (16.9)
total	256 (100.0)	193 (100.0)	77 (100.0)

How satisfied are clients with their services?

Client satisfaction surveys usually contain the three questions we asked respondents: how much do they trust the staff person they work with most, would they recommend the program to a friend, and how satisfied overall are they with the services they have received. Satisfaction survey responses from persons still receiving services tend to be artificially high, but obtaining responses from persons no longer receiving services (a more desirable sample) was logistically far beyond our capability. The research component of the Project will measure this for a sample of clients in Kern and Stanislaus.

<u>Trust staff member work with most.</u> Among the sample groups those who say they trust the staff member they work with most "very much" ranges from 57 percent (Stanislaus AOD/MH) to 81 percent (Los Angeles DV). Overall only nine percent respond that they trust "little" or "not at all." Shasta mental health is again maxed out at 100 percent who trust very much or somewhat. Stanislaus AOD/MH and Los Angeles MH are significantly lower than the other sampling units. (See Table 52.) Age, race and length of time in the program are statistically unrelated to trust.

Table 52: Percent trusting staff member work with most

	Kern N=78	LA AOD N=167	LA DV N=58	LA MH N=116	Shasta AOD N=31	Shasta MH N=29	Stanislaus AOD/MH N=77	Stanislaus DV N =19	total N=575
Very much	78.2	68.3	81.0	56.9	71.0	79.3	57.1	68.4	67.8
Somewhat	16.7	24.6	15.5	25	22.6	20.7	31.2	21.1	23.1
Little or none	5.13	7.19	3.45	18.1	6.45	0	11.7	10.5	9.04
Total	100	100	100	100	100	100	100	100	100

Recommend program to a friend. The range of those who definitely would recommend the program to a friend goes from 50 percent (for LA MH, the only statistically different group) to 84 percent (for LA DV). Hardly any respondents would not recommend the program (3 percent in the statistical model). (See Table 53.) Those in the program over six months are significantly more likely to definitely recommend it to a friend.

Table 53: Percent who would recommend program to a friend

	Kern N=80	LA AOD N=176	LA DV N=58	LA MH N=116	Shasta AOD N=31	Shasta MH N=29	Stanislaus AOD/MH N=76	Stanislaus DV N =20	total N=586
Definitely recommend	78.8	75.0	84.5	50	74.2	79.3	63.2	70	70.0
Probably recommend	18.8	19.9	13.8	42.2	22.6	20.7	34.2	30	25.9
Would not recommend	2.50	5.11	1.72	7.76	3.23	0	2.63	0	4.10
Total	100	100	100	100	100	100	100	100	100

Overall satisfaction with services. The range of clients saying they are very satisfied with their services overall is from 42 percent (Stanislaus AOD/MH) to 83 percent (Los Angeles DV). These two programs were statistically significantly different from the others.[43] (See Table 54.) The statistically adjusted percentage who are "unsatisfied" is only 4 percent. Age, race, and length of service are not significant predictors of satisfaction.

As with help received overall and specifically regarding employment, respondents in AOD programs are considerably more satisfied than are respondents in MH programs. For example, 70 percent of AOD respondents were very satisfied vs. 50 percent of MH respondents.

[43] Actually each category is compared to a reference category, which in this case is Kern AOD/MH, rather than to all other categories.

Table 54: Overall satisfaction with services, percentages in each sampling group

	Kern AOD/MH N=80	LA AOD N=175	LA DV N=59	LA MH N=117	Shasta AOD N=31	Shasta MH N=29	Stanislaus AOD/MH N=77	Stanislaus DV N =20	total N=588
Very satisfied	76.2	69.7	83.1	48.7	80.6	75.9	41.6	60	64.6
Somewhat satisfied	22.5	25.1	15.3	44.4	12.9	24.1	45.5	40	30.1
Unsatisfied	1.2	5.1	1.69	6.8	6.4	0	13.0	0	5.3
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

Table 55 shows the information for Kern and Stanislaus, broken out by AOD vs. MH.

Table 55: Overall satisfaction broken out for AOD and MH in Kern and Stanislaus

	Kern AOD N=25	Kern MH N=38	Stanislaus AOD N=26	Stanislaus AOD N=42
Very satisfied	92	65.8	42.3	38.1
Somewhat satisfied	8	34.2	42.3	47.6
Unsatisfied	0	0	15.4	14.3
Total	100.0	100.0	100.0	100.0

To what extent do clients perceive themselves as receiving services for more than one type of AOD/MH/DV issue?

One issue which is discussed frequently among treatment professionals in county AOD/MH/DV programs is the extent to which clients have more than one type of issue that requires services. Epidemiological studies show, for example, high percentages of persons with AOD also having mental health problems and vice versa.[44] Likewise, survivors of domestic violence are often left with a residue of mental health or AOD problems.[45] We did not test the overlap in clients in DV programs, but in both AOD and MH programs in LA and Shasta we asked clients to indicate which types of problems they were receiving services for. The results are shown in Table 56 below.

[44] A study of a very relevant California sample is: Jessup, M., Editor. (1996). Coexisting Mental Illness and Alcohol and Other Drug Dependencies in Pregnant and Parenting Women. Journal of Psychoactive Drugs, 28(4).
[45] See, for example, Browne, A., & Bassuk, S. (1997). Intimate Violence in the Lives of Homeless and Poor Housed Women: Prevalence and Patterns in an Ethnically Diverse Sample. *American Journal of Orthopsychiatry, 67*(2), 26-29.

Of clients in an AOD program, 63 percent say they receive only AOD services. Surprisingly 8 percent say they are only receiving MH services[46] and 2 percent that they are receiving only DV services. The remaining 17percent say they are receiving a combination of services of one type or another.

Of clients in a MH program, a much higher percentage of 85 say they receive only MH services. Another three percent say they receive only DV services and none that they receive only AOD services. The remaining 12 percent say they receive a combination of services.

While client perception is not a substitute for an interdisciplinary assessment and treatment plan, it does show the extent to which clients are currently receiving services for more than one issue. Presumably were more comprehensive services available in all service sites the percentage having multiple issues being addressed would be higher.

Table 56: Client reports of services they receive, by AOD or MH program

Type of service respondents report receiving	AOD Program N=207 Percent	MH Program N=148 Percent	Total N=355 Percent
MH Only	8.2	84.9	41.1
AOD Only	63.6	0	36.4
AOD and MH	11.3	7.5	9.7
AOD and DV	7.2	0	4.1
DV only	1.5	2.7	2.
AOD and DV and MH	6.1	1.4	4.1
MH and DV	2.0	3.4	2.6
total	100.0	100.0	100.0

Effects of multiple issues. Overall 84 percent of the sample said they were receiving services for one issue, 12 percent for two and 4 percent for three. Holding the sampling groups constant we tested whether persons who said they were receiving services for more than one type of issue felt that the services were less helpful overall and in terms of job chances. In neither case was there any apparent relationship of helpfulness with number of issues.

How are clients linked to CalWORKs?

- All of the clients in this sample had Medi-Cal eligibility codes that indicate they were eligible for CalWORKs. There are a variety of reasons—client reasons, provider reasons and system reasons—that clients might or might not have the services they were receiving written in as part of their CalWORKs welfare-to-work plan.

[46] These are not clients from Stanislaus or Kern who were classified based on their responses but are rather clients whose program type was known.

- They may or may not have been referred to AOD/MH/DV services through the county DSS; and

- The service worker may or may not help clients coordinate with DSS.

- In addition, services available through CalWORKs are likely to be services needed by persons attending AOD/MH/DV programs—things such as child care and transportation.

In sum, there are a variety of ways in which these clients *might* be linked to CalWORKs and DSS staff. Our goal was to discover the extent of these linkages.

Source of referral. Respondents were asked "Who told you about this program?" Four of the response categories were available to all respondents; one was asked only of AOD or MH clients. ("A court, probation officer, parole officer or the child welfare told me to come.") Tables 57 and 58 show the source of referral for AOD/MH and for DV separately.

Table 57: Referral source, by AOD and MH programs

	Kern AOD N=25	Kern MH N=38	LA AOD N=176	LA MH N=116	Shasta AOD N=31	Shasta MH N=29	Stanislaus AOD N=26	Stanislaus MH N =42	total N=472
Came on own	32	15.8	34.7	15.5	29.0	62.1	23.1	23.8	28.2
Welfare	8	42.1	9.7	56.9	3.23	37.9	53.8	19.0	28.0
Law enforcement, CPS	36.0	0	21.0	6.03	54.8	0	19.2	9.52	16.4
Friend, family	20	28.9	24.4	13.8	3.2	0	3.8	31.0	18.6
Someone else	4	13.2	10.2	7.76	9.7	0	0	16.7	8.90
Total	100	100	100	100	100	100	100	100	100

Table 57 above makes it very clear that the source of referral for AOD clients and MH is quite different. Overall in the sample, 33 percent of AOD respondents said they were self referred vs. 23 percent of MH respondents. Comparable figures for welfare are 13 and 45 percent, for law enforcement or CPS 26 and 5 percent and for family, friends or health provider 19 vs. 18 percent. Thus, AOD clients are much less likely to be referred through welfare than are MH clients but more likely to self-refer or be referred by law enforcement or CPS.

For both AOD and MH respondents, helpfulness was rated lower if referral source was welfare. For example, 74 percent of AOD respondents rated services as very helpful if they were a self-referral but only 50 percent did if referred by welfare. For MH the corresponding figures are 77 and 43 percent.

Table 58: Sources of referral to DV programs

	LA DV N=58	Stanislaus DV N=20	total N=78
Came on own	31.0	10.0	25.6
Welfare referred	20.7	65.0	32.1
Friend, family, heal provider	22.4	20.0	21.8
Someone else	25.9	5.0	20.5
Total	100.0	100.0	100.0

The sources of DV referral for the LA programs and Stanislaus are very different. Two thirds of the Stanislaus referrals are from the welfare department vs. one fifth in Los Angeles. This difference reflects the fact that the DV sample in Stanislaus was drawn entirely from the Behavioral Health Services team that includes DV staff and services. In Los Angeles the sample included all CalWORKs eligible persons. The figures above are actually most interesting because they show a relatively low proportion of DV clients are reaching the programs through the welfare department—though still higher than among AOD clients.

Program staff assistance in dealing with CalWORKs. On the survey form respondents could report how much help they received in dealing with the "CalWORKs program (welfare department)" or they could check that "Staff here did not have anything to do with the welfare department." See Table 59. The highest percentage of receiving "a lot" of help was recorded in Los Angeles DV programs and the lowest in the Stanislaus AOD/MH programs. We expected AOD programs to show lower amounts of help because so many clients have entered "through the back door." And indeed relatively high percentages in the AOD programs (and in Stanislaus AOD/MH programs) say that staff had nothing to do with the welfare department. However, AOD programs *also* show relatively high amounts of help. So it may be that AOD programs are somewhat less likely to get involved, but are very active when they do.

Table 59: How much program staff help respondents deal with welfare department

Amount of help	Kern AOD/MH N=761	LA AOD N=134	LA DV N=58	LA MH N=88	Shasta AOD N=24	Shasta MH N=29	Stanislaus AOD/MH N=58	Stanislaus DV N =20	total N=472
Helped a lot	59.0	38.1	63.8	20.5	37.5	48.3	13.8	45.0	38.6
Helped moderate amount	26.2	20.9	22.4	28.4	20.8	44.8	24.1	30.0	25.4
Helped a little	1.64	17.9	8.6	31.8	12.5	6.9	20.7	15.0	16.5
Did not have anything to do with welfare dept.	13.1	23.1	5.1	19.3	29.2	0	41.4	10	19.5
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0.	100.0	100.0

CalWORKs related service needs. CalWORKs offers participants a broad array of services in support of finding employment. Some of these services also are useful in helping clients of AOD/MH/DV programs use their services, for example, the expanded transportation and child care services.

AOD and MH program respondents were asked whether it was difficult for them to get to the program in order to receive services. (See Table 60.) Possible causes of any difficulty were transportation, child care, getting off from work or inconvenient hours. Those who felt the question was relevant to their situation were given three choices as to degree of difficulty in getting to the program. In Shasta MH 89 percent said there were no difficulties; in contrast only 40 percent of clients in Stanislaus AOD/MH programs said there were no difficulties. It is difficult to know how to interpret these differences, though, since the percentage who say it is *very* hard to come is relatively low in each sample group. We presume that some of these difficulties are ones that could be helped through CalWORKs support services.

Table 60: MH and AOD client reports of difficulty getting to their program

	Kern N=76	LA AOD N=120	LA MH N=97	Shasta AOD N=24	Shasta MH N=9	Stanislaus AOD/MH N=73	total N=399
Not hard to come	65.8	65	44.3	83.3	88.9	39.7	57.1
Somewhat hard to come	27.6	28.3	47.4	12.5	11.1	49.3	35.3
Very hard to come	6.6	6.6	8.2	4.2	0	11.0	7.5
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0

All of the respondents were asked more directly, however, whether they are getting the CalWORKs related services they need. Table 61 below shows the percentage in each sampling group who say they do not get CalWORKs services. The range (excluding Shasta MH) is 12 percent to 26 percent (in Los Angeles MH programs).

This table and the one above, showing reported difficulty of getting to treatment programs, give an approximate idea of the magnitude of the group that might benefit be being “hooked up” with CalWORKs—assuming that there are not other factors that make this inadvisable for any given individual in treatment.

Table 61: Respondents who report not receiving CalWORKs services

	Kern AOD/MH N=65	LA AOD N=142	LA DV N=59	LA MH N=92	Shasta AOD N=24	Shasta MH N=29	Stanislaus AOD/MH N=62	Stanislaus DV N =20	total N=493
Do not get CalWORKs services	16.9	28.9	11.9	26.1	12.5	0	24.2	5	20.7

The remaining respondents rated the extent to which they are getting all the services they need through CalWORKs. While there is a good deal of variation between sampling units it appears that over two thirds (of those for whom the question is relevant) are receiving most or all of the CalWORKs related services they need. DV program respondents scored lowest.

Table 62: How many of needed CalWORKs services respondents report getting

Services received	Kern AOD/MH N=4	LA AOD N=101	LA DV N=52	LA MH N=68	Shasta AOD N=21	Shasta MH N=29	Stanislaus AOD/MH N=47	Stanislaus DV N =19	total N=391
Get all or most services needed	81.5	75.4	66.1	68.5	83.3	89.7	72.6	65.0	74.2
Get some services needed	20.4	22.8	21.2	23.5	14.3	10.3	19.1	10.5	19.9
Get very few services needed	1.8	11.9	17.3	19.1	4.76	0	17.0	26.3	12.5
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

<u>Services in and out of the welfare to work plan.</u> AOD and MH respondents were asked directly whether their services were part of their welfare to work plan. DV clients were asked if they have any waivers in their welfare to work plan because of choosing the Family Violence Option.

The questions of MH and AOD respondents were designed as linked screening questions. In Table 63 below the first row indicates the number and percent of all 381AOD/MH respondents who definitely said they receive cash aid from the welfare department.[47] Percentages are quite similar across sampling groups. The second line of data show the number and percentage of clients who have definitely signed a welfare-to-work plan with the denominator being the overall group. The third row shows the number and percent who definitely say that the services being received definitely count toward the welfare to work plan work activity hours. Again the denominator is the entire group. Overall 167 of the 381 or 44 percent, said yes. The final row shows the percentage of the total number in the sampling group whose treatment time definitely counts toward their work activity hours. Of the 381, 108 said their services definitely counted toward work activity requirements—28 percent.

There are substantial differences between sample groups on both the question relating to signing the welfare to work plan and whether treatment hours count for activity hours. Overall it appears that only 123 out of 381 (32 percent) are certain that they have a welfare to work plan and that

[47] Shasta is excluded as that form contained a misprint that did not guide clients to the right questions.

their treatment hours count toward their work activity requirements. Respondents in AOD programs seem much less likely to have signed a plan and have it count toward the work activity hours. Again, we do not know how much of this lack of participation is client choice, provider choice or the consequences of management choices. And the large number of “not sure” responses (not shown) raises questions both about the validity of these numbers and the processes which leave CalWORKs participants so unsure of their status.

Table 63: MH and AOD client reports of links to welfare-to-work plan[48] : Percentages are of total N in the heading

	Kern AOD N=21 Percent	Kern MH N=36 Percent	LA AOD N=158 Percent	LA MH N=109 Percent	Stanislaus AOD N=19 Percent	StanislausMH N=38 Percent	total N=381 Percent
Definitely get cash aid	42.9	86.1	77.2	70.6	89.5	78.9	75.1
Definitely signed welfare to work plan	28.6	61.1	39.2	45.9	68.4	36.8	43.8
Tx hours definitely count on plan	23.8	50.0	20.9	34.9	36.8	18.4	28.3

DV respondent knowledge of and use of Family Violence Option. About half of the respondents (Table 64) in DV programs report that a CalWORKs staff person had told them about the Family Violence Option. Another 40 percent said no 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. In Table 65 we see a slightly smaller percentage of respondents (46 percent) say they have obtained a waiver, 29 percent have not, and a very high 24 percent do not know!

Table 64: CalWORKs tell about Family Violence Option

	N	Percent
Yes	42	51.9
No	32	39.5
Not sure	7	8.64
TOTAL	81	100.0

[48] The Shasta version of the form had a typographical error that sent respondents to the wrong question, so they did not answer this series. Because of missing values at each stage of the linked questions it is not possible to

Table 65: Have Family Violence waiver in plan

	N	Percent
Yes	37	46.8
No	23	29.1
Not sure	19	24.1
TOTAL	79	100.0

DV as a determinant of applying for cash aid. One of the reasons for the Legislature having enacted the Family Violence Option is the belief that welfare has served as a source of income and respite for women who have left their abusing partners and are attempting to become self-sufficient. In our sample of respondents in domestic violence agencies equal numbers reported that the DV situation was *entirely* the cause of applying for cash aid and that it had *nothing* to do with the decision. Another 24 percent said it had at least a little to do with the decision. (Table 65.)

Table 66: How domestic violence situation contributed to applying for case aid

	N	Percent
Only decided to apply for cash aid due to DV situation	29	37.2
DV situation affected decision somewhat	14	17.9
DV situation affected decision a little	5	6.43-
DV situation did not affect decision	30	38.5
TOTAL	78	100.0

DV respondents comfort level in talking with CalWORKs staff. Seventy five percent of the DV respondents were somewhat or very comfortable discussing their domestic violence situation with staff at CalWORKs. (See Table 67.) Another 15 percent said they do not discuss it and five percent were uncomfortable with such discussions. Respondents reported being slightly more comfortable with discussions if they had been referred by welfare.

Table 67: Comfort level in discussing DV situation with CalWORKs staff

	N	Percent
Very comfortable	32	40.5
Somewhat comfortable	27	34.2
Somewhat uncomfortable	3	3.8
Very uncomfortable	2	2.5
Do not discuss DV situation with CalWORKs staff	15	19.0
TOTAL	79	100.0

CLIENT COMMENTS

A total of 159 clients took the opportunity to write comments at the end of the survey. We had information available to cross-tabulate the type of comments with whether the client was primarily AOD, MH or DV. However, we have included many of the comments below because the general categories do not capture the nuance and detail of the comments themselves.

Table 68: Categories into which client comments fall, by AOD/MH/DV status

Codes	AOD N=82 Percent	DV N=39 Percent	MH N=35 Percent	Total N=156 Percent
1. Program is good or helpful (general comment) or counselor is helpful	32.9	38.5	25.7	32.7
2. Services have been helpful with drug and alcohol problems/domestic violence problems	9.76	15.4	5.71	10.3
3. Services have helped participants feel better about themselves or that they have more options or more positive attitude	11.0	7.69	14.3	10.9
4. Services have helped with childcare/work/transportation/referrals	7.32	2.56	2.86	5.13
5. Program is not for everyone and/or services are not good	8.54	20.5	22.9	14.7
6. Concerned that educational opportunities are not part of CalWORKs	2.44	0	8.57	3.21
7. Lack of information about or assistance is needed regarding childcare, transportation, or AOD/MH/DV programs.	13.4	10.3	8.57	11.5
8. Other	14.6	5.13	11.4	11.5
TOTAL	100.0	100.0	100.0	100.0

AOD Respondents

I definitely recommend this program that is trying to get their life together after having a very bad drug problem. As far as I am concerned it's the only way of dealing with and realistically coping with heroin habit that means jail hospital or the graveyard.

I think this is an excellent program.

I'm satisfied the way it is!

I feel that this program works if you want it to work. It helped me to start thinking in a different way.

The program has really helped me a lot.

I got my job through WTW program, being on methadone has helped me keep my job, stay clean, get a home, I otherwise could not have done on my own. I do wish my [time] here did count for my work activity hours. I just got laid off and have to go through it all over again now. Thank you.

Genesis is good in that there's such a short wait to get on Methadone program, 2-3 wks. StanWORKs is totally useless to me in that my medical condition prohibits me severely from all the employment advantages.

I wish I could receive some money to help with childcare. It costs me $375 a month. I only get $327 in my check.

I enjoy these groups and I am very grateful for all the help CalWORKs has given me.

I can't wait until I go to work.

This program is a lot more detailed than I thought. It helps with a lot more issues than just drug and alcohol.

Right now I am being deferred until my son is 6 months old to do the CalWORKs program.

Stepping Stones has helped me to see that there is a better life, and I feel self-confident that I can be a productive member of society.

With the short time I've been here I've gained a lot. I'm finding myself.

The services here are saving my life! And I love all the staff and because of this program I'm getting my two daughters back. I get the strength from my higher power and I'm willing to do what it takes one day at a time!

This program is helping me to see a lot of things I wasn't able to see before.

I received excellent benefits from CalWORKs and it has helped me tremendously. I really appreciate everything.

Day treatment needs to be more timely and consistent. Walk the talk type of issue.

I enjoy here coming for our sessions counseling it helps very much indeed to talk to someone it brings out a lot of tension stress etc

I recently went to a CalWORKs court appeal because they screwed it up. I won.

I have been in the ___ program and ____ Works for the past 7 months. I am very satisfied. I am now going to a vocational school and I must say that this is the start of my life with my kids again. Thank you!

I feel that I have tools to work being in this society and also as long as I have god on my side, nothing could go wrong. Life is not peaches and cream.

The services here are wonderful, they explain exactly what it is that's the problem. The problem is drugs. I have to stay clean no matter what. My program ___ helps a great deal. Future limitations are withstanding (?). I take one day at a time and pray.

The services I am receiving here have helped me a great deal. In many situations I go through in my life, and I am very grateful for this program.

___ program is a wonderful behavior modification establishment. Since I have been attending their Day Treatment classes I have new tools to use when I am under emotional strain. I am really very pleased for ___ and their technique.

___ is a very good program to teach you how to learn and live life on life term, it has job placement after 6 months of therapy. It is very beneficial for your future.

We should learn about this program and use the tools we need in order to be productive people to put back (in the service, society) that was so freely giving to us. Training in good jobs where we may have good careers. Not just jobs where we make enough money to help someone else.

This program makes me feel safe to tell the truth about who I am and find out what help I really need Thank you God for ___.

Welfare reform is a very good program, I think. Because it is helping a lot of women go to work and learn to support their children and themselves.

___ has helped me out a lot and showed me how to live my life the right way and to be a mother.

The services I have and am currently receiving have given me a better comprehension of my disease and the reality of problems which I have run from for a very long time. I've received therapy in groups as well as from outside sources due to referrals from this program. I'm continuing to listen to suggestions and recommendations from staff and my peers realizing I have options and choices. Understanding of my spirituality and knowing that keeping God first and me second and doing His will and not my own.

___ has covered a lot of issues and needs I need to acquire to help me through life. But I would like job training, and job placement.

Would like to find out how to get JPTA funding for desired career. I need input on how to go about.

What type of child care they have for us that don't have transportation, do they have child care that pick children up from home.

If I don't get services here I wouldn't be a good mom or a good student. I also would be jail, dead, or on heroin living on streets.

My counselor is a bitch.

People at social services and workers and this program want me to make appointments all at the same time of day and yell at me.

My counselor is a good person but I do not need to be here. I need to get a job.

My treatment is very good but overly demanding. Once employed, the demands will be extremely difficult to meet considering there will be NO time allowed to spend with children, i.e. cooking, cleaning, laundry, general parenting.

I was seeing someone who was not helping me with my therapy I asked to be changed to another therapist but I did not get the results I felt I should of gotten but a week or two later I got a phone call from my therapist telling me she was leaving and I would get a new therapist in about a month I was upset that I was going to have to wait to get a new therapist because I was coming every week. It took about 2 weeks and I got a phone call and got a new therapist. She has helped me I've only seen her twice but she is helping me to reach my goals. I feel that if possible we should be able to be seen by someone who is helping us in every way possible to meet our goals.

You need a career not just a job that you still need to get welfare to maintain. It's all about money!

I hope they get more therapists that stay longer.

I feel that groups are very helpful and I really like the new one that started a couple of weeks ago with ___, she is very caring, understands and makes me feel like I have a chance to get a job, and I will be able to do things. She gives me confidence and doesn't pressure anyone. I feel the world would be a better place if we had more people like her she really wants to help us.

Would like more info. Wish the front reception was more friendly. They just started to be friendly because of this survey.

Yo no estoy satisfecha porque nesesito medicina porque nesesito no puedo dormir no como tengo mucho dolor de cabeza y toda lagspina dorsal. Y nesesito ayuda. Gracias

MH Respondents

It's helped a lot. I feel better about myself and my situation. Things are looking up.

They listened to what I had to say and based my plan on that.

More time to study if going to school, they should count this time study time is hard to come by when you have 6 children under the age of 8 yrs old.

The staff here don't just talk to you, they encourage you to talk and they listen, letting you have a big part of figuring our your own problems.

I think a person like myself needs more intense help or they will never be on their feet.

All the services I have received through ___ have had very positive results. I am very grateful to all the wonderful people that have helped me in the past several months. Especially, ___, the services have really helped my son who is diagnosed ADHD. I can't say enough about his counselor who has done so much for us. He's a blessing in our lives. He's the best!

Estoy contenta con los servicios que otorgan y me siento contenta con venir aqui.

I've felt better about myself and the way I feel on medications.

I'm very appreciative for the help and support I've received from staff and classmates.

The instructors are wonderful here at ___. I am totally grateful because of these people and their knowledge. I believe my recovery will be a success.

Because of my condition, I am unable to do the total 26 hours a week as needed for keeping my grant. I am a full time student and physically and mentally cannot do all the hours, consequently I am losing my TANF grant.

It don't work for everyone

I'm very depressed and scared. It is hard for me to function normally. I need assistance in moving out of state to get away from my abuser. I'm not comfortable with groups.

Welfare reform stinks; not meant to catch some people. I'm afraid of losing services. I don't have education to get a good job and don't know how I will take care of my kids. I was helped with this survey by my case worker.

I was wondering if I started AFDC in 6/94 'til present, when would my cash aid stop. I would like to know so that way I'll be prepared.

It's helping me understand myself and my depressed state and guides me on how to cope with things and have hope for the future.

Tri City in Pomona has been very helpful in recognizing my dysfunction. Gasoline voucher would be very helpful since I have to budget for insurance (car) and registration renewal.

Espero ver como esta la relacion entre mis hijor y 11o en el futuro para desidir conprar casa junto con alguno do mis hijas claro despuer

Like services here couldn't do without them. But wish there were more staff. Ii don't know where I'd be without these services. I'd probably be dead by now. I only get $137/mo. It's not enough.

With my mental health problem I've been excused from the Gain program however there is a Voc Rehab here at the mental health institute that for some reason I think I would feel more safe and secure with their counselors here because of my problem mentally. I do want to work, I think it would bring up

my self esteem, self worth, and me as a person in general, it's just that I guess to get back in the way of life after all these years I suppose it will take a little time and a lot of help.

I came here and I've really been helped out as far as emotional difficulties I'm going through.

Bueno tengo unjigo sordo y el tiene 24 anos y al ala edad de 18 anos de dejaronde darme ayuda y no tengo ni medicl para el por que yo seque el necesita al el no le dantrajo por ser sordo osi le dan abusan de el desriminan

The doctors are good. They have a lot of cases and it's hard to get seen on time, sometimes your appointments would be months apart and the sessions don't last that long. But eventually they get the job done.

DV Respondents

I know that I haven't been attending often, but I do believe that this program can work for me. And help me get back on the right road to recovery, meaning my situation regarding domestic violence. Thank you ___ for being there for me.

Well, I've seen (target) vouchers given to other clients and me denied, I've been given wrong information about transitional housing, furniture, housing problems that pay 1st mo. rent. I was given mandatory rules to keep if I looked for a job and a home, and I see others do things without being told anything or refused to take their kids with them. I feel I was discriminated and not liked but it's OK because I'm moving on.

The welfare office employees are intimidating and act as though the benefits (cash aid, food stamps, etc) are coming straight from their house or pocket. But I thank the Domestic Violence program and their staff, at ___. They try to help and listen to my issues.

This program has helped me a great deal, and I'm glad I came because my problems have improved.

The ___ has helped me and my girls tremendously. If it had not been for the ladies here to help me through my situation I might still be in a violent relationship. They are providing me with so much support that I'm feeling that I have more power and control of myself and my children. I am very happy that House of Ruth is here for me because I wouldn't know where I would be. Please whatever you do make sure this place stays here so other women have a place to go.

I feel ___ has really empowered me.

Mr. ____ at DPSS has been very supportive and understanding. I have learned so much.

I am grateful for the help I've been given.

This program is a godsend .I am extremely grateful this program exists. I had no knowledge prior. This program is so necessary and a great service to humankind experiencing the horrible realities of DV.

I just started the program but I'm planning in working go to school and get out of the program. I really feel good about the program in helping us to work and go ahead in life without the program. I think that by just helping me with the child care is enough so I am really thankful.

With any program their basic motto is "If you don't know, we won't tell you!: And that is the basic problem I have with CalWORKs and many other programs. Give people all the information on all programs that are offered to give people a choice of what they really need so that they can make it work for them.

I feel that I have more options now.

Thanks to CalWORKs I could support my family.

Me pare se que el programa de CalWORKs esta muy bien. Me aguda muncho especialmente por mis ninos, que pagan por el quidado de elloys mientras que yo trabaja! Gracias!

This program is a perfect opportunity for women that are involved in a domestic dispute. There are so many women who are scared to address certain issues. And CalWORKs gives them a chance to open up and let go of their problems. And to address them instead of keeping them bottled up inside. We all have problems and issues that we need to deal with.

The counselors are very good thank you for everything.

The class could be more user friendly. Easy access to a restroom is needed. Women from domestic violence situations often have physical problems also. Softer chairs would help. Pain does not help in recovery.

I think if you're 5 to 10 minutes late you still should be able to get into class, because when I miss class, I feel bad all day feels like I missed something important, which I did. Thank you.

I was in a DV relationship on and off for 3-5 yrs. I left but always went back since this class I've been gone for good, and continue to come for support. I left for good and have a much better life (emotionally) now. I think this class is great.

The domestic violence classes are very meaningful and helpful. I had a very good experience with the workers here. They really care about the situation you're in. They're a lot of issues that you may have and not be comfortable to share with, but the counselors here are very professional and help you through your fears. I enjoy coming here. They (the counselors) have made it easy for us to share our fears or whatever feelings and experiences we have had. Because now, when the class is over, I feel I have some tools to work with that could help prevent me from getting into domestic violence situations.

___ is awesome. I've seen changes in a lot of people. It helps the self-esteem. Not just mine yet. I look forward to coming to group. That's all I look forward to.

I am pleased with my group counselor ___. At first I wouldn't open up but once I did - I felt more at ease. ___ has helped me understand that wanting my very ill mother to pass on and quit suffering is not a selfish feeling.

This program is awesome.. The instructor has been most beneficial in my recovery beginning and it is my hopes to recover completely. ___ is a wonderful program. Complaints: my eligibility worker was completely rude. My ride on the bus to come to class is gruesome due to area is abuser's home.

I was on time for my 1st group. Did not hear my name. Missed it because I could not get help to find out where it was. I have things I have not been able to talk about. Made appt's and missed them, felt

awful because I needed it so, and have found myself putting it off. I need a one on one with someone I trust. I feel this is holding me back!

Summary of client views survey findings

1. Most AOD/MH/DV service recipients are satisfied with their services
   - Services help overall
   - Services help with employment
   - Specific aspects of the service, such as relation to main staff person, are satisfactory.
2. Many AOD/MH/DV service recipients say they have not received important services that are available from CalWORKs.
3. Some of the missing services may affect the clients' capacity to continue to get AOD/MH/DV services (such as child care and transpiration).
4. Many CalWORKs recipients report AOD/MH/DV program staff are helpful to them in dealing with welfare. AOD programs have fewer clients saying that staff are involved with welfare, but when they are the help provided is rated very highly.
5. AOD clients are much less likely to be referred through welfare than are MH clients but more likely to self-refer or be referred by law enforcement or CPS.
6. For both AOD and MH respondents, helpfulness of the program was rated lower if referral source was welfare.
7. Among DV clients, the decision to apply for cash aid was due to or influenced by the DV situation for about three fourths of the clients.

PART D: CLIENT SERVICE RECORD AND STAFF INFORMATION

AOD AND MH SAMPLES

Treatment and service histories were sampled the same way satisfaction was with two exceptions:

- Only cases that were discharged were selected[49]; except that
- A sample of open cases of methadone clinic clients was included since persons on methadone are unlikely to be discharged.[50]

The staff person who had worked most closely with the client was asked to fill out an extensive form that included both objective information from the chart or service record and subjective judgements about the effects of the services. As with the satisfaction surveys, sampling was of all cash aid recipients receiving MH, AOD or DV services—there was no requirement that the client have a welfare-to-work plan that included AOD/MH/DV services.

Although some of the questions on the DV form mirrored those on the AOD/MH form, many were different. So for the most part we present the information for these subgroups separately.

Clients were classified as to whether they were "AOD" or "MH" based on a two-step process. 1) If clients were in a program specifically designed for MH or AOD they received the designation of that program. Some of these clients might well have both kinds of issues. 2) If the program served both types of clients—as did the CalWORKs specialized services in Kern, Shasta and Stanislaus—clients were classified by diagnosis and the "problems" staff indicated clients had. If both AOD and MH issues were mentioned, the presence of alcohol or drug *dependence* was used to decide. In a few cases where there was co-occurrence of alcohol or drug *abuse* plus a mental health diagnosis, the decision was made based on severity of the MH diagnosis or other comments made by the staff filling out the form.

Table 69 below shows the number of cases of each type in each county. Fully 64 percent of the cases are from Los Angeles and therefore the LA cases dominate the "total" percentages. However, since Los Angeles had 87 percent of all the TANF cases in these four counties it may

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[49] Agencies were given a list of discharged clients who met study criteria. They were instructed to record information for the most recent discharges (N depending on the size of the program).

[50] The methadone sample comprised 17 percent of all AOD and MH cases. They are excluded from analysis of outcome after discharge. Since this group is be definition "successful" their scores tend to be higher on positive outcomes than the AOD group overall.

actually be somewhat underrepresented in these overall percentages. As in the tables above, most attention should be paid to the comparative percentages.

There were 233 AOD cases served in 38 different programs (in some cases there were multiple programs in one agency) and 164 MH cases served in 55 programs.

Table 69: AOD/MH case records by sampling groups

	N	Percent
Kern AOD	41	10.3
Kern MH	26	6.5
LA AOD	150	37.8
LA MH	105	26.4
Shasta AOD	9	2.3
Shasta MH	15	3.8
Stan AOD	33	8.3
Stan MH	18	4.5
TOTAL	397	100.0

DESCRIPTION OF THE SAMPLE

Demographic factors.

Demographic factors such as age, race and education may themselves have an impact on the likelihood that CalWORKs recipients will obtain steady employment. When combined with AOD/MH/DV issues the barriers can be even more difficult to over come.

Age. Only 12 percent of cases under 25 and only 8 percent are over 48.

Table 70: Age of persons receiving AOD/MH services in discharged case sample

AGE	Kern AOD N=38	Kern MH N=25	LA AOD N=145	LA MH N=98	Shasta AOD N=7	Shasta MH N=14	Stanislaus AOD N=33	Stanislaus MH N =12	total N=372
18-24	7.9	4.00	12.4	12.2	28.6	21.4	15.2	8.3	12.1
25-36	50.0	48.0	48.3	35.7	57.1	57.1	27.3	58.3	44.1
37-48	34.2	28.0	32.4	41.8	14.3	21.4	54.5	33.3	36.0
Over 48	7.9	20.0	6.90	10.2	0	0	3.0	0	7.8
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

Gender. Not surprisingly 90 percent of the cases are female, with each sampling group having 78 percent or higher except for Kern, which had only 67 percent female. The highest percentage of females was in Los Angeles, 97 percent for MH and 95 percent for AOD.

Race/ethnicity. African American and Caucasian cases each made up one third of the overall sample with Hispanics comprising 27 percent and the remainder widely distributed between other ethnic groups. However, the distribution by sampling group is widely disparate as shown in Table 70 (with the small "other" category dropped for clarity). Clients sampled in Los Angeles were far more likely to be African American than in any other program, while a number of programs had 75 to 93 percent Caucasian. Shasta was the only county with a percentage of Hispanics lower than 23 percent.

Table 70: Race/ethnicity of discharged clients, by sampling group

	Kern AOD N=39	Kern MH N=24	LA AOD N=144	LA MH N=97	Shasta AOD N=9	Shasta MH N=14	Stanislaus AOD N=30	Stanislaus MH N =17	total N=372
African Am	0	16.7	52.1	51.5	0	0	6.67	11.8	35.6
Caucasian	74.4	54.2	17.4	13.4	88.9	92.9	70	64.7	35.6
Hispanic	25.6	29.2	30.6	35.1	11.1	7.14	23.3	23.5	28.9
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

Information on educational attainment was missing for almost 20 percent of the cases. Forty-three percent of those whom we know about did not finish high school or get a GED. This ranged from 37 percent for LA AOD to 57 percent for Kern.[51] For those with non-missing information, 18 percent overall are over age 36 *and* have no diploma. Almost a third of Kern's MH client sample fit this description.

Demographic factors as barriers to employment. Each of the factors discussed so far—race, age, sex, and education—can differentially affect chances of getting employment. Persons of color face discrimination[52], persons over age 35 are less likely to be hired for the entry level positions usually available to welfare recipients, women face pay differentials and are shunted to lower status positions,[53] and those without a high school diploma are often not considered by

[51] Virtually the only study to have looked at AOD/MH/DV barriers and traditional barriers to employment found that not having finished high school severely impacted having found work one year later in a random sample of recipients (40 percent with this barrier found work vs. 64 percent without it). In addition, while only 12.7 percent of women over 18 (current population survey) do not have a high school diploma 30.1 percent of this Michigan sample did not have a high school diploma. This is, of course, in itself considerably lower than all the programs in our sample.
[52] Danziger says: "Employer audit studies demonstrate that African-Americans and Latinos are less likely to receive job offers than are whites with comparable credentials (Turner et al., 1991 …Almost half of African-American women in a Los Angeles survey report having experienced job-related discrimination (Bobo, 1995)."
[53] *Explaining Trends In The Gender Wage Gap.* June 1998.A Report by The Council of Economic Advisers. http://www.whitehouse.gov/WH/EOP/CEA/html/gendergap.html

employers even for entry level.[54] Table 71 below shows the number and percentage of AOD/MH/DV services recipients in our sample who have one, two, three or four of these barriers. Only 4 persons (one percent) of the sample had none of the barriers, 18 percent had only one, 40 percent had two, 32 percent had three, and 10 percent had all four barriers. From the table it is clear that Los Angeles AOD and MH are heavily skewed toward three and four barriers: LA MH has 58 percent and LA AOD 49 percent with three or four barriers. In general, persons in mental health programs are somewhat more likely than those in AOD programs to have these demographic barriers.

Table 71: Number of persons in sample with one to four demographic barriers, by sampling group

Demographic barriers	Kern AOD N=41	Kern MH N=26	LA AOD N=150	LA MH N=105	Shasta AOD N=9	Shasta MH N=15	Stanislaus AOD N=33	Stanislaus MH N =18	total N=397
Zero or one	46.3	23.1	10.0	4.8	66.7	53.3	33.3	22.2	18.6
Two	26.8	42.3	40.7	37.1	22.2	46.7	45.5	66.7	39.8
Three or four	26.8	34.6	49.3	58.1	11.1	0	21.2	11.1	41.6
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

Clinical descriptors.

Problem or diagnosis. Staff were asked to describe the “client’s problem,” circling all that were relevant from a list. Note that the question did not specify that the problem had been addressed in the service plan. In addition staff specified DSM-IV diagnoses for many cases. However, this is not a requirement of most AOD programs so specific diagnoses are limited primarily to mental health cases. Table 72 shows the frequency of problems in rank order. Non-psychotic mental health problems such as depression, anxiety and panic ranked first followed by drug dependence, drug abuse, alcohol abuse and alcohol dependence. Domestic violence ranked just above severe mental illness and minor non-diagnosable disorders.

54 Danziger: “Holzer (1996) surveyed 3200 employers about entry-level jobs available to workers without a college degree and reported that most jobs required credentials (high school diploma, work experience, references) that many recipients do not have.”

Table 72: Problem being assessed/treated (not unduplicated)

Problem	N	Percent
Depression, anxiety, panic, PTSD, phobia and other non-psychotic	196	49.4
Drug dependence	172	43.3
Drug abuse	127	32.0
Alcohol abuse	75	18.9
Alcohol dependence	54	13.6
Domestic violence	49	12.3
Severe Mental Illness	31	7.8
Parenting skills and other non-diagnoses	25	6.2

In order to see sampling group differences we group all mental health issues together and all substance abuse issues together.[55] What we see is that, as expected, programs classified as AOD have as clients virtually 100 percent with AOD abuse or dependence. However, the mental health programs have roughly a third with AOD abuse or dependence as well. Conversely, the programs classified as mental health have virtually 100 percent with MH problems but also around 20 percent who have AOD abuse or dependence. Finally, while a majority of sampling groups have about 10 percent of the cases in the sample who have DV as an issue, it is a very large 46 percent in Shasta's MH cases and is quite low in the LA MH and Shasta AOD groups (Shasta, of course, having a very small N).

[55] This breakdown is not entirely "clean" because of the way that cases were classed into sampling groups. In Kern, Stanislaus and Shasta primary problem (as described above) was used in some cases where the program name or type was not sufficient to categorize. Thus we would expect very high rates of AOD in the sampling groups labeled AOD; and we would likewise expect very high rates of MH in the programs labeled MH. What is of interest is the extent to which clients have both types of problems and thus "cross" program types. Please note that, again, these percentages do not sum to one hundred because the same client may have (and many do) more than one type of problem.

Table 73: Percentages having AOD abuse or dependence, MH diagnosis, or DV issue, by sampling group

	Kern AOD N=41	Kern MH N=26	LA AOD N=150	LA MH N=105	Shasta AOD N=9	Shasta MH N=15	Stanislaus AOD N=33	Stanislaus MH N =18	total N=397
AOD abuse and/or dependence	100	34.6	98.0	35.2	100	33.3	97.0	27.8	71.8
MH diagnosis	53.7	100	25.3	96.2	22.2	93.3	18.2	100	57.2
DV problem	9.76	7.69	18.0	5.71	0	46.7	3.03	11.1	12.3

Principal drug used. The survey asked staff to fill in the primary substance of abuse/dependence at admission. A total of 256 cases (64 percent of the whole sample) had a primary drug listed. Heroin and other opiates were ranked first along with cocaine, followed in order by amphetamines (and methamphetamines), alcohol and polydrug abuse. (See Table 74.)

Table 74: Primary substance of abuse/dependence

	Number	Percent
Heroin/Opiates	61	23.8
Cocaine	61	23.8
Amphetamine	45	17.6
Alcohol	37	14.4
Polysubstance	27	10.5
Marijuana	18	7.0
PCP	7	2.7
Total	256	100.0

Multiple AOD/MH/DV problems. Another way to get a sense of the multiple problems confronting many clients is to make a frequency distribution of the number of problems each case has. This procedure has the advantage of adding to 100 percent of the sample, as well. Table 75 shows that less than half have only one problem, over a third have two, and the remaining 20 percent have three or more issues.

Table 76 shows the percentage with one, two or three-to-five by sampling group. There are significant differences with Stanislaus AOD and MH programs each having over 70 percent with only one problem compared to Kern and LA AOD and Shasta MH where a third or less have one

problem. Conversely, it is Kern AOD, LA AOD and Stanislaus MH that have over 20 percent with three problems or more.

Table 75: Number of concurrent problems

Diagnosis or problem	N=397	Percent
One	171	43.1
Two	147	37.0
Three	53	13.3
Four	21	5.3
Five	4	1.0
Six	1	0.2

Table 76: Number of concurrent problems by sampling group

	Kern AOD N=41	Kern MH N=26	LA AOD N=150	LA MH N=105	Shasta AOD N=9	Shasta MH N=15	Stanislaus AOD N=33	Stanislaus MH N =18	total N=397
One problem	31.7	46.2	30	54.3	44.4	20	72.7	72.2	43.1
Two problems	41.5	46.2	40.7	33.3	44.4	66.7	21.2	5.6	37.0
Three or more problems	26.8	7.7	29.3	12.4	11.1	13.3	6.1	22.2	19.9
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

Global Assessment of Functioning scores at intake. Mental health programs, and some AOD programs, assign DSM-IV diagnoses, a part of which includes an overall assessment of how well the person being assessed is functioning in social roles and/or how much symptoms interfere with that functioning.

The scale goes from 1 to 100, with scores over 70 indicating essentially normal functioning or situational problems. Here are the descriptions of the categories into which most members of our sample fell.

> 70-61 Some mild symptoms (e.g., depressed mood and mild insomnia) OR some difficulty in social, occupational, or school functioning (e.g., occasional truancy, or theft within the household), but generally functioning pretty well, has some meaningful interpersonal relationships.
>
> 60-51 Moderate symptoms (e.g., flat affect and circumstantial speech, occasional panic attacks) OR moderate difficulty in social, occupational, or school function (e.g., few friends, conflicts with peers or co-workers).
>
> 50-41 Serious symptoms (e.g., suicidal ideation, severe obsessional rituals, frequent shoplifting) OR any serious impairment in social, occupational, or school functioning (e.g., no friends, unable to keep a job).

40-31 Some impairment in reality testing or communication (e.g., speech is at times illogical, obscure, or irrelevant) OR major impairment in several areas, such as work or school, family relations, judgment, thinking, or mood (e.g., depressed man avoids friends, neglects family, and is unable to work; child frequently beats up younger children, is defiant at home, and is failing at school).

30-21 Behavior is considerably influenced by delusions or hallucinations OR serious impairment in communication or judgment (e.g., sometimes incoherent, acts grossly inappropriately, suicidal preoccupation) OR inability to function in almost all areas. (e.g., stays in bed all day; no job, home, friends).

Of the 397 persons in the sample 242, or 61 percent, received a GAF rating at intake. As shown in Table 77, only seven percent exceeded a score of 60 and only five percent were lower than 30. Fully 45 percent, however, were classed as having serious rather than moderate impairment in job or social life and another 21 percent had serious impairment in more than one domain. Thus, two thirds have serious or very serious impairment in social functioning (or equally serious and disruptive symptoms).

Table 77: Initial Global Assessment of Functioning rating

Diagnosis or problem	N=242	Percent
61 and over Mild problems if any	16	6.6
51-60 Moderate difficulty in job or social	55	22.7
41-50 Serious impairment in job or social areas	109	45.0
31-40 Unable to function in several areas	50	20.7
21-30 Unable to function in most areas	12	5.0

When (in Table 78) we exclude the small number (11 percent) with extremely severe or only mild impairment, there are large differences by sampling group—although caution should be used since the groups are quite small. In general, the mental health programs have a higher concentration with serious impairment (rather than moderate or unable to function). The Los Angeles AOD program stands out due to the high proportion of clients with seriously impaired functioning in several areas. Overall, however, there was not a statistical association between GAF entry score and whether it was primarily an AOD or MH case.

Demographic factors are associated with lower GAF scores. First, age is linearly associated with persons under 25 having a mean entry GAF score of 55 while those over 48 have a mean score of 41. Females had a (not quite statistically significant) lower average score than males (47 vs. 51). African Americans (average of 43) were significantly lower than Caucasians (49) or Hispanics

(50). High school graduation, however, had no association with GAF scores. Nor were duration of episode or number of prior episodes associated with entry GAF.[56]

Table 78: Initial Global Assessment of Functioning rating (over 60 and under 30 excluded), by sampling groups

	Kern AOD N=20	Kern MH N=23	LA AOD N=21	LA MH N=85	Shasta AOD N=6	Shasta MH N=11	Stanislaus AOD N=30	Stanislaus MH N =15	total N=214
51-60 Moderate difficulty in job or social	60	21.7	19.0	20	0	42.9	16.7	40	25.7
41-50 Serious impairment in job or social areas	30	47.8	33.3	44.7	100	57.1	80	60	50.9
31-40 Unable to function in several areas	10	30.4	47.6	35.3	0	0	3.33	0	23.4

Service patterns

Source of referral. Overall 23 percent of referrals came directly from CalWORKs and another 8 percent from MH/AOD assessors linked to CalWORKs. These two sources are combined as "CalWORKs" in Table 79, which shows source of referral for each sampling group

Table 79: Source of referral, by sampling groups

	Kern AOD N=41	Kern MH N=25	LA AOD N=148	LA MH N=105	Shasta AOD N=9	Shasta MH N=15	Stanislaus AOD N=33	Stanislaus MH N =18	total N=394
CalWORKs	43.9	64.0	6.76	39.0	44.4	60.0	63.6	22.2	31.2
Court or CPS mandate	14.6	0	45.9	10.5	44.4	0	0	5.6	22.8
Self Referred	34.1	16.0	31.1	23.8	11.1	6.7	21.2	22.2	25.9
Other	7.3	20.0	16.2	26.7	0	33.3	15.2	50.0	20.1
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

[56] Significance tests were applied both to the individual tables and in a multivariate analysis.

Referral by court or CPS mandate is much higher for the LA and Shasta AOD programs (45 percent) than in other sampling groups, while referrals from CalWORKs are very low in the LA AOD group (7 percent). Stanislaus AOD joins the MH programs with a comparatively high percentage of referrals from CalWORKs .

Prior service episodes. Staff were asked to record prior number of service episodes. These varied widely by sampling group. In general AOD programs tended to be higher than MH programs, but the Kern AOD and MH programs were very much higher than any others (Kern AOD=mean of 9.2; Kern MH=mean of 7.6 vs. overall mean of 2.3). Table 80 shows these differences. The biggest percentage of cases in the sample had had no previous episodes (45percent) while 18 percent had over three previous admissions. In about 15 percent of the cases this information was missing. The programs with a high percentage of clients new to the system were Shasta (AOD and MH) and Stanislaus MH.

Table 80: Percent with zero, one to three, or more than three prior service episodes

	Kern AOD N=32	Kern MH N=16	LA AOD N=127	LA MH N=81	Shasta AOD N=9	Shasta MH N=15	Stanislaus AOD N=28	Stanislaus MH N =10	total N=318
Zero	21.9	18.8	48.0	50.6	77.8	73.3	21.4	70	45.0
One to three	25	31.2	40.2	39.5	22.2	26.7	46.4	30.0	37.1
Over three	53.1	50	11.8	9.88	0	0	32.1	0	17.9
Total	100	100	100	100	100	100	100	100	100

Duration of service episodes (excluding persons in methadone maintenance). Although all of the cases were discharged, the duration of the treatment episode was extremely variable. Episodes were measured from the time of entering service until the last actual service was rendered.[57] Overall 22 percent had episodes of up to 30 days, while approximately equal proportions had episodes of 31 to 90 days (19 percent), three months to six months (21 percent), and six months to one year (25 percent). Twelve percent had episodes that had lasted over a year. The sampling groups reflected different proportions of these episode lengths. Most strikingly, more than half of the Shasta County cases were 30 days or less.[58] LA AOD had the highest percentage of persons in treatment over a year (16 percent). It is important to remember these distributions as we look at some of the measures of the impact of services.

[57] We asked staff to record month and year of initial visit an d last visit. If the month and year were the same they were counted as having received between 1 and 30 days of service.
[58] This probably reflects the Shasta approach to sampling, which was not based on a systematic sample of providers having CalWORKs eligible—as it was in Kern, Stanislaus, and LA.

Table 81: Duration of treatment episode for AOD/MH services, by sampling group

	Kern AOD N=25	Kern MH N=24	LA AOD N=109	LA MH N=97	Shasta AOD N=9	Shasta MH N=14	Stanislaus AOD N=15	Stanislaus MH N =18	total N=311
1 to 30 days	8	12.5	11.9	27.8	66.7	64.3	40.0	16.7	22.2
31 to 90 days	28.0	29.2	16.5	17.5	22.2	14.3	33.3	11.1	19.3
3 to 6 months	20	20.8	25.7	17.5	11.1	14.3	26.7	33.3	21.9
6 months to one year	36	25	29.4	24.7	0	7.14	0	27.8	24.8
Over a year	8	12.5	16.5	12.4	0	0	0	11.1	11.9
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

Child placed out of home. Particularly for persons who are dependent on or abuse alcohol or other drugs the involvement of child welfare is a possibility, with the out of home placement of the child or children a frequent outcome. Overall, staff said that a total of 22 percent of the cases had out of home placements. However, that result is heavily influenced by the Los Angeles AOD program's 42 percent. None of the other programs reported more than 17 percent. Of the LA AOD cases with children placed out of home, 58 percent were referred by the courts or CPS.

The high percentage in Los Angeles who have children placed out of home strong underlines the need there for close coordination between CalWORKs, designated AOD/MH/DV providers and child welfare services.

Services part of welfare-to-work plan. Overall, for 34 percent of the sample, services received were definitely part of the CalWORKs welfare to work plan; in 51 percent of the cases they were not, and the staff rater was unsure in 15 percent. As is seen in Table 82 the differences in the sampling groups are fairly extreme, with the percentage with services in the plan ranging from the 64 percent in Kern's MH program to 7 percent in Shasta's.

Table 82: Services received were part of CalWORKs welfare-to-work plan, by sampling groups

	Kern AOD N=41	Kern MH N=25	LA AOD N=148	LA MH N=1054	Shasta AOD N=9	Shasta MH N=15	Stanislaus AOD N=33	Stanislaus MH N =18	total N=393
Part of CalWORKs plan	39.0	64.0	29.7	30.8	22.2	6.67	57.6	16.7	33.8
Not part of plan	51.2	32.0	54.1	50	33.3	73.3	36.4	72.2	50.9
Not sure	9.76	4.00	16.2	19.2	44.4	20	6.06	11.1	15.3
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

AOD/MH/DV staff rating of contact with CalWORKs staff. Respondents were asked if they had any contact with any CalWORKs staff about or on behalf of the client. Only 91 staff said that they had. This is only 23 percent of the sample overall. For those cases who definitely received

services as part of a CalWORKs plan 60 percent also contained a staff report of having had contact with CalWORKs staff.

Staff were asked to rate four items: how knowledgeable the CalWORKs staff were about AOD/MH/DV issues, how knowledgeable they were about AOD/MH/DV services, how responsive the CalWORKs staff were to the client's needs, and to what extent they had a collaborative attitude.

Table 83 shows the answers given by the 90 staff who did have contact with CalWORKs workers regarding a client. For each of the four collaboration issues CalWORKs staff were rated as adequate in 80 percent or more of the cases. Knowledge about AOD/MH/DV issues was lowest rated and responsiveness to client need rated best.

Table 83 : AOD/MH staff rating of collaboration with CalWORKs staff

Rating of extent CalWORKs staff were:	Very Good	Adequate	Poor	Total
	Percent	Percent	Percent	N=89
Knowledgeable about AOD/MH/DV *issues*	23.6	58.4	18.0	100.0
Knowledgeable about AOD/MH/DV *services*	30.7	51.3	18.2	100.0
Responsive to clients' needs	39.3	41.6	19.0	100.0
Collaborative attitude	34.8	49.4	15.7	100.0

Participation of clients in scheduled treatment. Staff were asked to rate each client's participation in either scheduled outpatient services or, if a residential program, scheduled in-house services. To be sure we were not including clients who came only for assessment or very short periods we restricted this analysis to episodes of 30 days or more. Overall, participation of 20 percent of the clients was rated "very good" during their treatment episode and 38 percent was rated "good." Another 27 percent were rated "poor" (sporadic participation) and 14 percent were rated "minimal" (rare participation). The number of cases was too small for comparison by sampling group, but Los Angeles AOD cases stood out with 73 percent having "very good" or "good" participation (the mean was 58 percent).

Reason for termination of services.[59] Information on the reason for discharge was available for 320 clients (it did not apply to methadone clients). Table 85 shows that the single largest group is those who left because they met their treatment goals: it comprises 24 percent of the total. Two other categories involve client termination before meeting goals, a combined total of 34 percent. Provider termination or referral accounted for another 23 percent, and inability to locate the

[59] We considered limiting this analysis also to those with at least a month of service, but the percentages changed little with that restriction and the smaller N did not permit sample group comparisons.

client and other causes amounted to the final 18 percent. These categories were regrouped for the sampling group comparison.

Table 84: Reason for termination of services

Reason	Number	Percent
Met goals	78	24.4
Client ended before goals met	55	17.2
Client stopped, refused contact	54	16.9
Referred to another provider	42	13.1
Provider terminated	34	10.6
Client could not be located	30	9.4
Other or not known	27	8.4
Total	320	100.0

As seen in Table 85 , while the overall percentage of terminations due to meeting treatment goals was 24 percent, in some sampling groups it was considerably higher (particularly Los Angeles AOD at 40 percent) while in several mental health groups the percentage was as low as 9 percent (Los Angeles mental health).

Table_: Reason for termination, by sampling groups

Reason for termination	Kern AOD N=25	Kern MH N=25	LA AOD N=111	LA MH N=105	Shasta AOD N=9	Shasta MH N=12	Stanislaus AOD N=18	Stanislaus MH N =15	total N=320
Treatment goals met	32.0	12.0	40.5	8.6	0	25	38.9	20.0	24.4
Client terminated	40	44.0	39.6	45.7	66.7	16.7	55.6	53.3	43.4
Other	28.0	44.0	19.8	45.7	33.3	58.3	5.56	26.7	32.2
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

Service outcomes

Typically outcomes of AOD and MH services relate to the presenting problem: substance abuse/dependence or psychiatric symptoms. We have some evidence of improvement in these areas. However, the ultimate outcomes for CalWORKs recipients receiving AOD/MH/DV services relate to improved ability to find and retain employment and improved situations for the

recipients' children. We have asked AOD and MH staff about these outcomes regarding the clients in our sample. Since the ratings are based on information that may range from extremely reliable to much less so there is some built-in uncertainty about much they would be reflected in actual employment data (if we had it).

Global Assessment of Functioning (GAF) ratings. The most quantitative measure of improvement as a result of treatment is change in the Global Assessment of Functioning scale from admission to discharge. In general, the scale is thought to have a fairly high degree of validity but reliability may not be good unless staff are trained to criterion (which rarely happens). GAF scale change is also a function of the entry level GAF, as large improvements are much more likely to occur when the starting point is low. For example, a person dependent on alcohol or other drugs is likely to show a very large improvement if abstinent when discharged. However, as noted above most of the GAF scores are from MH clients, since GAF is rarely a required data element in AOD programs.

Overall, as shown in Table 86, 62 percent of the 208 clients with both admit and discharge GAF rating showed no change in Global Assessment of Functioning level from intake to discharge. Another 3 percent showed negative change. Nineteen percent changed between one and ten points and the remaining 15 percent changed more than ten points. Essentially, then, a positive outcome occurred in about a third of the cases where we have ratings. Among the 158 clients who were in the program at least a month—thus taking out any assessment only or early drop-outs— results were somewhat better: 60 percent had negative change or no change, 22 percent improved 1 to 10 points and 18 percent improved over 10 points. AOD clients improved an average of 8.9 points compared to the 2.7 of mental health clients, a strong statistically significant result.

Table 86: Change in Global Assessment of Functioning score from admit to discharge

Amount of change	Number	Percent
Over 20 point increase	14	6.7
11 to 20 point increase	17	8.2
1 to 10 point increase	40	19.2
No change	130	62.5
1-10 negative change	7	3.4
Total	208	100.0

Parenting ability/risk to child. The survey form asked staff to asses "the client's ability to meet the needs of her/his children at the time of the most recent visit"—the most recent visit being the last visit before discharge. This rating was based on one used in child abuse assessment.[60] Of the

[60] Olsen, LJ, Allen, D., & Azzi-Lessing, L. (1996). Assessing Risk in Families Affected by Substance Abuse. Child Abuse & Neglect, 20(9), 833-842.

385 respondents who answered the question, 27 percent said that they did not have enough information to judge reliably. Interestingly, this percentage only went down to 23 percent when persons with episodes of less than a month were excluded. The ratings in Table 87 exclude those who were unable to judge. Overall, 12.5 percent were judged as deficient or unsafe in their parenting abilities, 22 percent were inconsistent (still a matter for concern) and 69 percent were rated as good or very good at meeting the needs of their children. [61] A comparison between AOD and MH clients showed only minor differences.

Table 87: Staff ratings of client ability to meet needs of children

Amount of change	Number	Percent
Very high (Fully meeting emotional and physical needs.)	26	9.3
Good (Meeting basic needs. Coping.)	157	55.9
Inconsistent (Basic needs not met consistently, parent feels overwhelmed.)	63	22.4
Deficient (Severely diminished parenting abilities lead to high risk conditions.)	21	7.5
Unsafe (Safety was threatened so CPS referral was made OR child already removed from home.)	14	5.0
Total	281	100.0

Change during treatment. Staff were asked to rate the amount of change the client experience in several domains key to success in CalWORKs. They were also given a "Not applicable" and "Can't judge" category to help rule out clients for whom treatment was too short to appropriately measure improvements due to treatment. The domains rated are:

- Capacity to deal constructively with major life problems
- Substance abuse problems
- Mental health/emotional problems
- Ability to manage daily life tasks
- Parenting ability
- Capacity to look for, find and retain a job
- Self-confidence and positive attitude about the future.

[61] Interestingly, ratings of clients who had a child placed out of home were not very different. Only 16 percent were rated as Deficient or Unsafe compared to the 12.5 percent in the sample overall.

Ratings from the seven items were combined into a scale of multi-dimensional improvement.[62] The scale is more easily used to test differences between variables of interest. Table 88 shows the sampling groups (minus Shasta which had too few cases for statistical analysis). The most change was registered in Stanislaus, particularly with AOD clients. The least change was reported by Kern AOD staff. It should be remembered that raters were not trained, so some of the differences seen may simply reflect different ways of interpreting the points on the scale.

Table 88: Combined improvement score by sampling groups, the scores range from a low of 1 to a high of 4.

	Number of cases	Mean	Median
Stan AOD	24	2.9	3
LA AOD	142	2.8	3
Stan MH	17	2.8	3
Kern MH	22	2.5	2.3
Kern AOD	36	2.4	2.3
LA MH	82	2.3	2

In general, AOD clients were rated as having shown significantly more improvement than mental health clients (2.7 vs. 2.4 mean scores). Improvement was also significantly greater for high school graduates than non-graduates, but ethnicity, age and sex were not associated with the amount of improvement.[63]

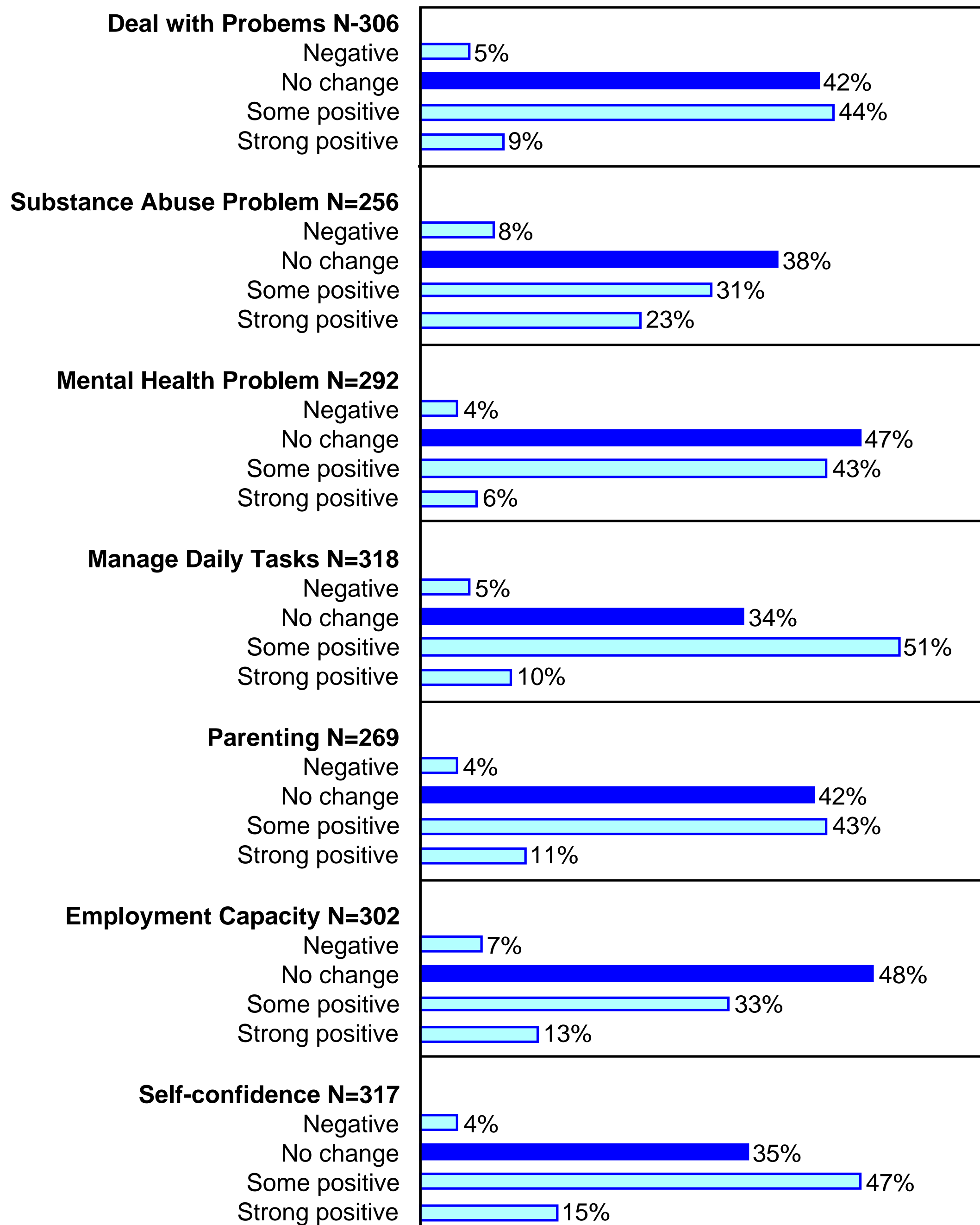
Figure 1 presents the data separately for all seven items, in this order, from the top :On the graph, "No change" has been made darker to make it easier to compare domains. Overall, the "negative change" category was selected in four to eight percent of the cases for the different domains. "No change" ranged from 34 percent (managing daily tasks) to 47 percent (mental health problems). Some positive and strong positive change together ranged from 46 percent (employment skills) to 62 percent (self-confidence). The greatest amount of strong positive change was registered for AOD problems.

Thus overall more than half of the clients were rated as having made positive change in six of the seven domains.

[62] The items are ordinal but treated as interval scaled. The scale had a internal reliability (coefficent Alpha) of 0. 946.

[63] Multivariate regression model with scale score as dependent variable and age, sex, ethnicity, high school graduation and type of problem (AOD or MH) as independent variables.

Figure 1: Amount of change made by AOD/MH clients during course of treatment (no change is highlighted to aid in comparison)



DOMESTIC VIOLENCE SAMPLE

Staff in domestic violence agencies in two counties, Los Angeles and Stanislaus, supplied information about discharged DV clients. In Stanislaus it proved impossible to track the TANF status of DV program participants other than in the integrated Behavioral Health Services team co-located at the welfare department. Thus the sample of 21 clients are all women who were served by the DV counselor on the team. Since the counselor also worked for the local shelter one day a week, many of the clients also received services from The Haven Women's Center.

In Los Angeles a variety of programs was sampled; a total of 58 forms on discharged clients were received from 11 programs. In addition, when it seemed appropriate we have added as a separate group (for contrast) the clients served in AOD and MH programs who were recorded as having domestic violence issues. There were 45 clients from 20 different programs.[64] Thirty of these clients were primarily AOD, 15 primarily MH. More detail on the sampling is contained in Appendix A.

Given the different sampling methods for each group—Stanislaus DV, Los Angeles DV, and DV cases from AOD/MH programs—we present results separately for each. While we create a "total" column for all 124 cases this figure needs to be interpreted cautiously. It is broadly representative of women receiving cash assistance through CalWORKs who have domestic violence issues because it includes information from women chosen randomly from 32 programs in four counties. However, it is not a probability sample of CalWORKs recipients with DV issues in these counties.

DESCRIPTION OF THE SAMPLE

Demographic factors.

Age. The mean age across all 126 cases was 30.9 years, with only small variations by sampling group. The distribution was broader in the AOD/MH and the LA DV samples than in Stanislaus DV, however, as Stanislaus DV was concentrated almost entirely in the 25-36 year old range. Table _ shows the age distribution by sampling group. The DV agency sample had a higher percentage of younger members (20 percent vs. 12 percent) than the AOD/MH group.

[64] 47 cases had DV checked as an "issue" but two of them were men in AOD programs. It seemed safest to assume they were perpetrators rather than victims of abuse. However, based on the comment of a staff rater it appears one of the other cases was a man (sex was not asked in the DV survey): "Cal Works should also be aware the men can be victims, also."

Table 89: Age distribution of DV discharged clients, by sampling group

	AOD/MH N=44 Percent	LA DV N=55 Percent	Stanislaus DV N=21 Percent	Total N=120 Percent
18-24	18.2	27.3	4.8	20.0
25-36	56.8	45.5	90.5	57.5
37-48	22.7	27.3	4.8	21.7
Over 48	2.3	0	0	0.8
TOTAL	100.0	100.0	100.0	100.0

Race/ethnicity. The Los Angeles DV sample had the lowest proportion of Caucasians, followed by the AOD/MH group and the Stanislaus DV sample.

Table 90: Race/ethnicity of DV discharged clients, by sampling group

	AOD/MH N=45 Percent	LA DV N=58 Percent	Stanislaus DV N=21 Percent	Total N=124 Percent
African American	33.3	29.3	4.8	26.6
Caucasian	37.8	24.1	52.4	33.9
Latino, Hispanic	24.0	43.1	33.3	34.7
Other	4.4	3.4	9.5	4.8
TOTAL	100.0	100.0	100.0	100.0

High school graduation. The Stanislaus DV group was much less likely to have graduated from high school or gotten a GED than the other two sampling groups. But those graduating was no higher than 60 percent for any of the groups.

Table 91: High school graduation or GED, by sampling group

	AOD/MH N=44 Percent	LA DV N=58 Percent	Stanislaus DV N=21 Percent	Total N=123 Percent
Graduated or GED	56.8	60.3	33.3	54.5
Did not graduate	40.9	31.0	66.7	40.7
Not sure	2.3	8.6	0	4.9
TOTAL	100.0	100.0	100.0	100.0

Service patterns

Source of referral. All but one of the 21 Stanislaus sample members were referred through the welfare department directly. Of the 58 Los Angeles group members, 36 percent were referred through welfare and the remainder through other channels. More detailed information is available on the AOD/MH group members. A total of 24 percent were referred through CalWORKs or CalWORKs AOD/MH assessors while 47 percent came through court or CPS mandate. Because of the different sampling and question wording, it is very difficult to compare the overall AOD/MH sample with the DV sample.

Duration of service. Overall percentages in the duration of service category are similar to those of the AOD/MH sample, with a somewhat larger group in the three to six months category. The LA DV sample, however, is considerably more likely than the other two sampling groups to have service episodes of 30 days or less and 30 to 60 days, presumably because many in this sample group were in temporary shelters.

Table 92: Service duration of discharged clients, by sampling group

	AOD/MH N=42 Percent	LA DV N=54 Percent	Stanislaus DV N=21 Percent	Total N=117 Percent
1 to 30 days	11.9	29.6	4.8	18.8
31 to 90 days	19.0	27.8	9.5	21.4
3 to 6 months	21.4	20.4	61.9	28.2
6 months to one year	35.7	22.2	23.8	27.4
Over a year	11.9	0	0	4.3
TOTAL	100.0	100.0	100.0	100.0

Services received. Only the clients who were served by DV agencies are reported here. Of 79 clients, 76 received counseling/support or case management. All but three of these received related services such as legal help, advocacy, employment or AOD/MH services as well. Twenty-five of the 79 received shelter services. Only one of these did not also receive counseling or related services as well. Two clients received only legal services.

Child placed out of home. There is a substantial and statistically significant difference between the sampling groups with respect to the percentage having a child or children placed out of home through child welfare services. Of the AOD/MH sample, 39 percent had a child placed out of home compared to 12 percent in the LA DV sample and 10 percent in the Stanislaus DV sample. The high percentage of out of home placements in the AOD/MH sample is predominantly from Los Angeles AOD programs.

Services part of welfare-to-work plan. This question was asked in somewhat different form in the DV and the AOD/MH samples. In the DV sample the questions was whether services "here"

were part of the client's welfare-to-work plan. The answer possibilities were Yes, No, Not Sure, and "Client was exempt from welfare to work while receiving our services under the Domestic Violence Option." The AOD/MH response categories did not mention the DV option.

Virtually all of the sampling group members in Los Angeles and Stanislaus DV programs are either exempt due to the DV option (61 percent in LA and 71 percent in Stanislaus) or have DV services as part of the welfare-to- work plan. Something over a third of the AOD/MH clients have services (AOD or MH at least) as part of their welfare to work plan, but we do not know what percent might be exempt due to the DV option.

Table 93: Services were part of welfare-to-work plan

	AOD/MH N=45 Percent	LA DV N=57 Percent	Stanislaus DV N=21 Percent
Yes	37.8	36.8	28.6
No	55.6	1.7	0
Not sure	6.67	0	0
Exempt due to DV Option	NA	61.4	71.4
TOTAL	100.0	100.0	100.0

Service staff rating of contact with CalWORKs staff. Respondents were asked whether they had any contact with CalWORKs staff about or on behalf of the client. In Los Angeles 72 percent of the DV staff replied yes to this question as did 70 percent in Stanislaus. The figure for the staff rating DV clients in AOD/MH programs was a much lower 32 percent.

DV staff were asked four DV specific questions regarding their rating of their CalWORKs colleagues. Since there were not comparable questions on the AOD/MH survey with regards to DV, only the DV samples are shown.

There is a large and statistically significant difference between the Stanislaus and Los Angeles samples on knowledge of the DV option, with Stanislaus not rating any CalWORKs' staff knowledge about the DV Option as "very good" in comparison with the 49 percent of LA staff who rated their CalWORKs colleagues' knowledge "very good.." (See Table 94.)

Table 94: DV staff rating of CalWORKs staff knowledge of the Domestic Violence Option

	LA DV N=41 Percent	Stanislaus DV N=24 Percent	Total N=55 Percent
Very good	48.8	0	36.4
Adequate	36.6	57.1	41.8
Poor	14.6	42.9	21.8
TOTAL	100.0	100.0	100.0

The differences shown in Table 95 indicate that in the vast majority of contacts around clients with CalWORKs staff Los Angeles DV staff found their colleagues responsive while Stanislaus staff ratings were significantly lower.

Table 95: DV staff rating of CalWORKs colleagues' responsiveness to client needs

	LA DV N=41 Percent	Stanislaus DV N=14 Percent	Total N=55 Percent
Very good	43.9	7.14	34.5
Adequate	39.0	78.6	49.1
Poor	17.1	14.3	16.4
TOTAL	100.0	100.0	100.0

Stanislaus staff ratings (in Table 96) of their CalWORKs colleagues' knowledge about domestic violence is considerably lower than that of the staff in Los Angeles (but not statistically significant).

Table 96: DV staff rating of CalWORKs colleagues' knowledge about domestic violence

	LA DV N=42 Percent	Stanislaus DV N=14 Percent	Total N=56 Percent
Very good	40.5	7.14	32.1
Adequate	45.2	64.3	50
Poor	14.3	28.6	17.9
TOTAL	100.0	100.0	100.0

The "collaborative attitude" of CalWORKs staff is rated almost as low in Stanislaus though rather high in Los Angeles. (See Table 97.)
It should be noted that only 14 ratings are involved in the Stanislaus data. Were the pattern not so strongly evidenced it would not be worthy of note.

Table 97: DV staff rating of CalWORKs staff collaborative attitude

	LA DV N=41 Percent	Stanislaus DV N=14 Percent	Total N=55 Percent
Very good	46.3	14.3	38.2
Adequate	39.0	71.4	47.3
Poor	14.6	14.3	14.5
TOTAL	100.0	100.0	100.0

Reason for terminating services. DV agency staff also described the reasons for which women had terminated services. These categories did not generally coincide with those of the question asked of AOD/DV staff regarding termination. As seen in Table 98, 48 percent of the Stanislaus clients terminated because they and their provider agreed service goals were met. In Los Angeles this was only 21 percent. In Los Angeles the percentage of clients who stopped without explanation was also higher (37 percent vs. 14 percent). These differences are statistically significant. Among the AOD/MH cases, termination because goals were met was 33 percent.

Table 98: Reason for termination of services

	LA DV N=48 Percent	Stanislaus DV N=21 Percent	Total N=69 Percent
Goals were met	20.8	47.6	29.0
Client terminated even though goals not met	12.5	28.6	17.4
Client stopped coming without explanation	37.5	14.3	30.4
Other or not known	29.2	9.52	23.2
TOTAL	100.0	100.0	100.0

Service outcomes for DV clients

<u>Change during services.</u> Staff were asked to rate "change in the client's total circumstances in these areas during the course of services even though this can be affected by factors outside [provider or] client's control, such as the behavior of the abuser." Four of the eight domains rated were also rated by the AOD/MH staff, so ratings exist for all three sampling groups. Results for the other four are presented for Los Angeles and Stanislaus only.

Overall about 60 percent of the women were rated as having made at least some positive change during services. Strong positive change occurred in 12 to 21 percent of cases. Large differences by sample group were apparent. Over 90 percent of Stanislaus clients were rated as having made positive change versus 64 percent in Los Angeles and 47 percent in the AOD/MH sample. It should be remembered that women in the latter group had at least one MH or AOD issue as well as the DV issue. These differences were statistically significant as well.

Table 99: Change during services in capacity to deal constructively with major life problems

	AOD/MH N=40 Percent	LA DV N=56 Percent	Stanislaus DV N=16 Percent	Total N=112 Percent
Strong positive change	17.5	21.4	12.5	18.8
Some positive change	30	42.9	81.2	43.8
No change	50	28.6	6.25	33.0
Negative change	2.5	7.1	0	4.5
TOTAL	100.0	100.0	100.0	100.0

Interestingly, from the standpoint of our focus on CalWORKs, fewer staff were able to rate the client's changes with respect to capacity to find and keep a job, particularly in Stanislaus where only eight of 21 were rated. Some positive change was recorded for 50 percent overall, with relatively small and statistically insignificant differences between sampling groups.

Table 100: Change during services in capacity to find and keep a job

	AOD/MH N=39 Percent	LA DV N=50 Percent	Stanislaus DV N=8 Percent	Total N=97 Percent
Strong positive change	15.4	12.0	0	12.4
Some positive change	30.8	40	62.5	38.1
No change	48.7	42.0	37.5	44.3
Negative change	5.13	6.00	0	5.15
TOTAL	100.0	100.0	100.0	100.0

Table 101: Change during services in capacity to manage daily life tasks

	AOD/MH N=41 Percent	LA DV N=54 Percent	Stanislaus DV N=16 Percent	Total N=111 Percent
Strong positive change	9.8	27.8	25.0	20.7
Some positive change	51.2	44.4	62.5	49.5
No change	34.1	25.9	12.5	27.0
Negative change	4.9	1.8	0	2.7
TOTAL	100.0	100.0	100.0	100.0

Ability to manage daily life tasks was rated as showing some positive change overall by 70 percent of the staff. Although not quite significant,[65] the percentage with at least some positive change ranged from 61 among the AOD/DV group to 72 in Los Angeles and 87 in Stanislaus.

The last of the four ratings made on all three sample groups was of client's self confidence and positive attitude about the future. Most of the clients were rated (115 of 124). Overall 72 percent showed at least some change, with Los Angeles clients being rated highest on *strong* positive change. However, overall differences were not statistically significant.[66]

[65] Ratings were dichotomized as at least some positive vs. other to avoid empty cells.
[66] Ratings were dichotomized as at least some positive vs. other to avoid empty cells.

Table 102: Change during services in self-confidence and positive attitude about the future

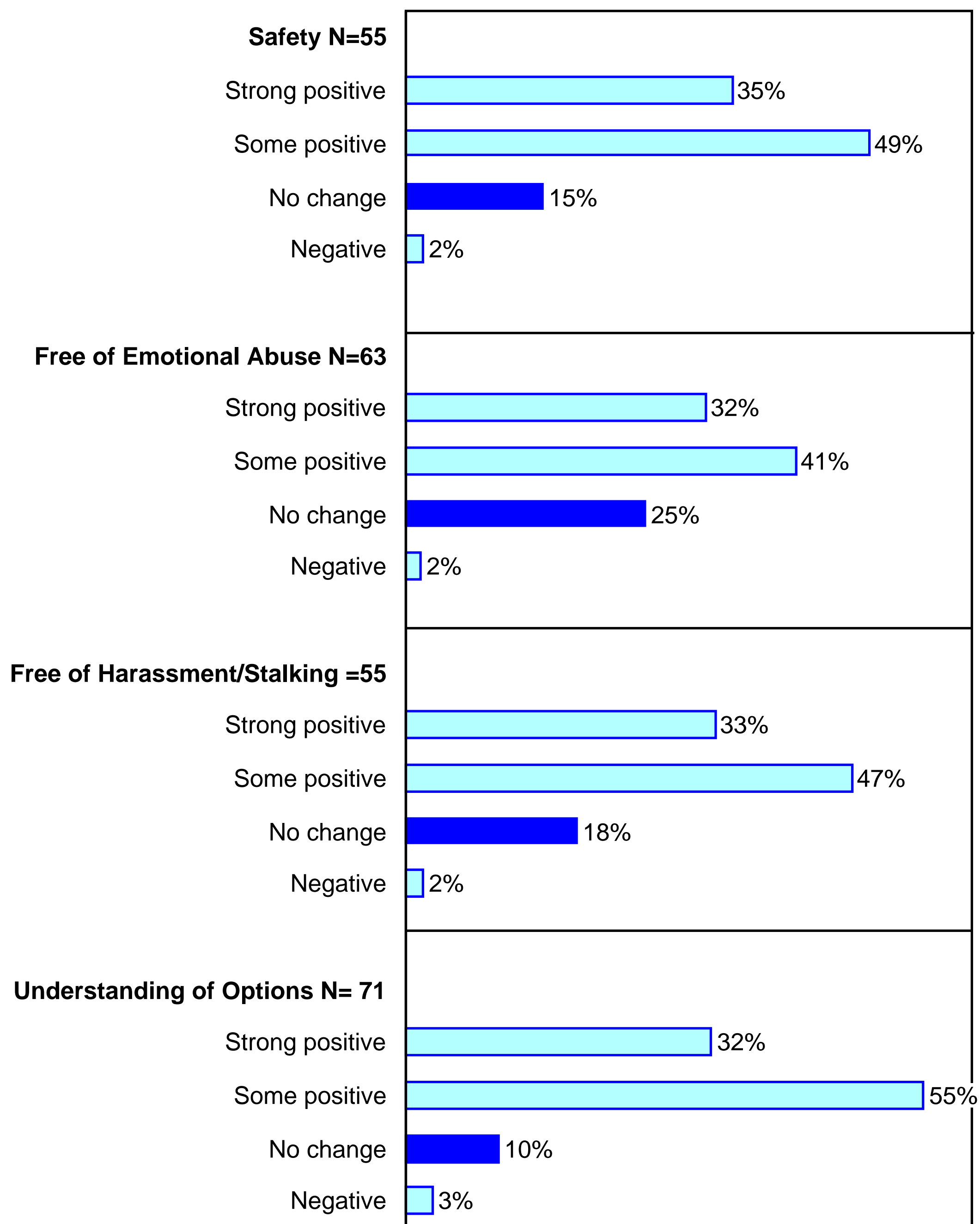
	AOD/MH N=41 Percent	LA DV N=56 Percent	Stanislaus DV N=18 Percent	Total N=115 Percent
Strong positive change	19.5	28.6	16.7	23.5
Some positive change	41.5	50.0	61.1	48.7
No change	29.3	16.1	16.7	20.9
Negative change	9.8	5.4	5.6	7.0
TOTAL	100.0	100.0	100.0	100.0

DV specific change. The four remaining items were more specific to the DV issues that might have brought a woman to a DV provider. Staff only rated change on those issues that were relevant for a particular woman. The issues were.

- Client's safety.
- Client's freedom from emotional abuse.
- Client's freedom from harassment or stalking.
- Client's understanding of all her options in regard to her relationship with her abuser.

Each of these domains is of extreme importance, but safety is preeminent—and is the reason for the DV Option. Unfortunately, in 21 percent of the cases the rater was unable to judge change in safety level; only six of the Stanislaus clients could be rated. A similar pattern was found with all of the items except understanding of options. Therefore the Los Angeles and Stanislaus cases are aggregated and the four outcomes presented graphically in Figure 2 on the next page. As above, the "no change" bar is highlighted to serve as a reference. We see that negative ratings are very small—two to three percent—and that the no change bar is 25 percent or less (much lower than in the AOD/MH sample). Seventy three to 87 percent had positive changes on these dimensions.

Figure 2: Rating of change, DV agency cases only



Summary of discharged client survey findings

1. Virtually all AOD/MH/DV service recipients face multiple barriers to finding and retaining employment.

    - Demographic barriers: race, age, sex, and education

    - Multiple diagnoses (only 43% have only one problem)

    - Frequently, more than one AOD, MH or DV type of issue.

2. A substantial number of AOD/MH clients have children placed out of home (22% overall, predominantly in LA AOD). The high percentage in Los Angeles who have children placed out of home strongly underlines the need there for close coordination between CalWORKs, designated AOD/MH/DV providers and child welfare services.

3. GAF scores at admission show 70 percent of MH clients (some AOD) have serious rather than only moderate or mild impairments.

4. AOD/MH/DV staff generally (around 80 percent) are positive abut several dimensions of their relationship with CalWORKs staff.

    - Collegiality

    - Sensitivity to client needs

    - Knowledge about AOD/MH/DV and AOD/MH/DV services

5. DV staff are similarly positive in Los Angeles but rated CalWORKs staff low in Stanislaus.

6. Approximately 40 percent of the AOD/MH clients were judged to have had poor or minimal participation in the program.

7. Only about 25 percent of the AOD/MH clients terminated services because they had achieved their treatment goals. However, in some sampling groups it was considerably higher (particularly Los Angeles AOD at 40 percent) while in several mental health groups the percentage was as low as 9 percent (Los Angeles mental health). The percentage of DV clients completing their planned goals ranged from 20 (in Los Angeles) to 47 percent (in Stanislaus).

8. Client capacity to meet the emotional and physical needs of their children was rated by staff as good or better for most AOD/MH clients but deficient or unsafe in 12 percent of the cases.

9. For mental health clients the change in GAF score from entrance to exit measures treatment effect in a rough way. For about two thirds of the clients no positive change was recorded.

10. Staff rated AOD/MH client change on seven critical dimensions:

   - Capacity to deal constructively with major life problems
   - Ability to manage daily life tasks
   - Capacity to look for, find and retain a job
   - Self-confidence and positive attitude about the future.
   - Substance abuse problems
   - Mental health/emotional problems
   - Parenting ability

   For AOD/MH clients "some positive" and "strong positive" change together ranged from a low of 46 percent (employment skills) to 62 percent (self-confidence).

   DV clients were rated on the first four of these dimensions. Their positive scores ranged from 53 percent (employment skills) to 82 percent (self confidence).

11. DV clients also were rated on four dimensions specific to DV:

   - Client's safety.
   - Client's freedom from emotional abuse.
   - Client's freedom from harassment or stalking.
   - Client's understanding of all her options in regard to her relationship with her abuser.

   Positive change was recorded for 73 to 87 percent of the DV clients, depending on the dimension.

APPENDIX A: SAMPLING AND ATTRITION

Introduction

Scope. The sampling design for this study was complex. In each county up to eleven groups had to be sampled:

- DSS Eligibility Worker (a census except in Los Angeles)
- DSS Eligibility Supervisor (a census rather than a sample)
- DSS Employment Counselor (a census rather than a sample)
- DSS Employment Supervisor (a census rather than a sample)
- Discharged mental health clients (which we tried to make proportionate to the number of direct CalWORKs cases and the number of “back door” or indirect CalWORKs cases)
- Discharged AOD clients (with separate sample for methadone maintenance; we also tried to make the sample proportionate to the number of direct CalWORKs cases and the number of “back door” or indirect CalWORKs cases)
- Current mental health clients (satisfaction survey) (which we tried to make proportionate to the number of direct CalWORKs cases and the number of “back door” or indirect CalWORKs cases)
- Current AOD clients (satisfaction survey) (which we tried to make proportionate to the number of direct CalWORKs cases and the number of “back door” or indirect CalWORKs cases)
- Discharged DV clients
- Current DV clients (satisfaction survey)

Sources of error. In conducting each of these surveys we tried to balance needs for representative sampling and low attrition with the needs to protect staff from excessive demands. The demands were felt by line level staff who had to fill out forms and by supervisors and program directors who had to arrange time and logistics to make it possible. We are grateful to all of the staff who participated!

The strengths and weaknesses of the sampling can be seen more clearly if we discuss four types of error that occurred to greater and lesser degree. Error in surveys is inevitable even though we try to minimize it. If we are not able to specify the degree of error we at least try to recognize it so that we may attempt to account for it in how strongly we present conclusions.

- Coverage error: When a sample does not include all elements of a population of interest it is termed coverage error. In this study there were several sources of coverage error. First, although a study of six counties only five welfare departments were surveyed, for reasons explained below. Second, AOD and MH data were solicited in only four of the counties. Third, although DV agency participation was solicited in four counties, in only two were the agencies able to participate. Finally, in sampling AOD and MH clients we chose for logistic reasons to sample only clients in larger providers (having ten or more CalWORKs clients), so if clients attending services in small providers are systematically different our sample design does not reveal it.

- Sampling error: All sample-based surveys involve some sampling error (margin of error). It is the error that occurs because no matter how chosen a subgroup will not be identical to the population. The most important factor in sampling error is sample size. In most of the surveys the sample size was considerable (the DV sample was smallest). However, since much of our interest is in the differences between counties, what really counts is the sample size in each county. As shown below, these ranged considerably in the different surveys.

  In some of the surveys we did not know the size of the population (for example, DV agency service recipients who are CalWORKs eligible), so the sampling proportion is finite but unknown. In addition the sampling proportion, when known, differed somewhat by county as we tried to include a higher proportion in small counties where the population was itself not large.

- Bias. Survey instruments themselves may create bias in the way in which they ask questions or even the order in which questions are asked. Bias may occur due to misunderstanding about the sponsorship of the study (in this case, some clients obviously thought the agency where they received services was the sponsor). We attempted to minimize this source of error by multiple revisions of the survey instruments in consultation with county representatives.

- Attrition error. If not everyone who is selected for the sample returns the survey form, bias may occur. Usually people who do not return surveys differ in some relevant way from those who do. For example, we were not able to keep track of which clients refused to answer the satisfaction survey. It is possible that the more successful or favorably disposed clients were more likely to answer. In addition, we provided all the welfare staff with individual return envelopes as a way of assuring anonymity. In some counties these were not used, but in others they were—which made it very difficult for those administering the study to assure a high response rate. Finally, the survey form to be filled out by staff regarding discharged AOD and MH clients was perceived (correctly) as quite burdensome, so attrition on this form was significant. Below we show the sample size and response rate for each of the surveys.

Special considerations for different surveys

DSS surveys

There were four types of county social service workers surveyed: eligibility workers, eligibility worker supervisors, employment counselors and employment counselor supervisors. In Shasta, Stanislaus, Monterey, and Kern it was practical to survey all of the staff in these categories. In

Kern, however, we surveyed the main office in Bakersfield and then randomly selected three outlying offices out of six.

Even the two districts chosen in Los Angeles were too large for a complete sample of eligibility workers, so workers in the largest (over 200 eligibility workers) office and one small office in each of the two regions were selected, with the small office selected randomly. Unfortunately due to communication problems between the Project staff and LA DPSS staff this sampling design was not carried out. Instead, surveys were sent to all of the offices in each region. Since, the number of surveys had been calculated based on a sample, there were not enough surveys for each worker. Therefore the surveys were distributed in each site to a subsample of the staff. We do not have information on how staff were chosen to be respondents at the different sites. It seems highly likely, however, that the responses from Los Angeles represent two kinds of selection bias: a) at each site the staff more knowledgeable or interested in AOD/MH/DV are likely to have been the persons filling out and returning the forms and b) the return rate by site varied, and it is likely that the ratings of sites with low return rates would be lower than those with high return rates. It was not possible to directly check either of these possibilities.

All AOD/MH/DV forms.

We used cluster sampling for all of the AOD forms, obtaining from the AOD, MH or DV MIS system in each county the number of CalWORKs eligible clients being seen in each program. Usually we picked programs with more than 10 eligible clients, but it depended in part on the size of the county and the distribution across programs.[67] Our intent was to achieve a reasonable sample size and not burden any single provider with too many forms to fill out. AOD programs, particularly in Los Angeles, were difficult to sample because reliable numbers regarding CalWORKs eligibles were not available. We ended up focusing on those providers that county administrators believed would have the most CalWORKs eligible. We attempted to make the sample representative of different types of providers as well (perinatal, methadone, intensive outpatient, residential).

AOD and MH client satisfaction forms.

The clients selected to be surveyed were to be the first X (10 to 30) persons who had appointments and were eligible for CalWORKs. Sites received written instructions on how to select the sample. The number of surveys filled out by clients with open cases was designed to match the number of surveys filled out at that provider by staff for discharged clients. We do not have information from each agency regarding how closely they were able to adhere to the guidelines. We know that Shasta MH sampled only from intake units.

AOD/MH/DV client histories from charts and staff report.

Once providers were chosen, as described above, we asked each provider to choose from a MIS list or (if MIS list not available) make a list of recent discharges of CalWORKs eligible clients,

[67] In Los Angeles, for example, mental health providers were checked for the number of closed CalWORKs eligible. Then the four largest providers in each of two regions (SPAs) were selected with samples ranging from six to 25 depending on the number of cases. Open cases were drawn from the 11 largest providers (closed cases). They were invited to a meeting; 9 came and forms were distributed proportionate to the number of cases each had.

and to choose the 10 (or whatever the sampling number was) most recent for record review. Some of the questions, however, required that the person filling out the form knew the client well, and that proviso was apparently not always possible to meet.

DV client surveys and histories.

All four of the counties from whom we requested AOD and MH information also had one or more DV agencies that served CalWORKs clients. They did not, generally, however, keep track of or know which of their clients met this description. So we did not have a clear idea of the size of the population we were sampling. Agencies were asked to sample in the same way AOD/MH programs were: consecutive appointments for the client survey and the most recent X number of discharges. In Stanislaus the only clients for whom CalWORKs eligibility was known were those seen through the integrated behavioral health team, i.e. the special CalWORKs clinicians. So it is really only a sample of those hooked up with CalWORKs not of those who could be but are not—a group the LA agencies included. In Shasta the DV agency participated minimally (two client surveys) and in Kern the DV agency was unable to participate at all.

Sample[68] sizes and response rates

Kern County[69]

	Returned	Sampled	Percent Returned	Population	Each survey respondent represents how many in population
Eligibility Worker	111	284	39.1	338	3.04
Eligibility Supervisor	21	40	52.5	45	2.14
Employment Counselor	66	104	63.5	104	1.57
Employment Supervisor	7	21	33.3	21	33.33
Behavioral Health AOD Discharge	41	46	89.1	164	4.00
Behavioral Health MH Discharge	26	114	22.8	493[70]	18.96
Behavioral Health AOD Satisfaction (Open cases)	25[71]	46	54.34	396	15.84
Behavioral Health MH Satisfaction (Open cases)	55	114	48.24	1184	21.52

[68] Samples vary by type of survey and county. The population for discharged clients was, when possible, the number discharged in the FY 1998-99 year. Open clients was those open at the time of the survey: September/October of 1999.

[69] The domestic violence program did not participate. There were an additional eight discharge forms and 15 satisfaction forms returned too late to be used.

[70] The Kern MIS reported 2237 persons had been served (open and closed) during FY 98-99. Since they reported 1580 were open at the end of the year, that would indicate 657 discharged clients. The AOD amount is assumed to be (like that for open clients, one fourth of the total).

[71] There were 79 returned surveys that indicated AOD or MH services. There were 25 AOD and 38 MH surveys but 11 showed both MH and AOD services being received and it was impossible to determine which system they belonged in. Another 6 did not indicate either. We have assigned these cases to MH. This is a reasonable assumption because the main CalWORKs program is in Mental Health but explicitly serves persons with a dual diagnosis; it also fits the sampling proportions.

Stanislaus County

	Returned	Sampled	Percent	Population[72]	Each survey respondent represents how many in population
Eligibility Worker	130	188	69.1	188	1.45
Eligibility Supervisor	18	18	100.0	18	1.00
Employment Counselor	54	75	72.0	75	1.39
Employment Supervisor	2	17	11.8	17	8.5
Behavioral Health Discharge: MH	18	40	45.0	772	42.89
Behavioral Health Discharge: AOD	33	45	73.3	470	14.24
Behavioral Health Satisfaction: MH	51	65	78.5	197	3.86
Behavioral Health Satisfaction: AOD	26	45	57.8	60	2.31
DV Discharge	21	21	100.0	118[73]	5.62
DV Satisfaction	21	21	100.0	50	2.38

[72] The population for DV cases in Stanislaus and Los Angeles was only cases in which the woman was receiving services as part of the Welfare To Work Plan. The number of CalWORKs clients receiving DV services without it being in the WTW plan is unknown.
[73] Cases served in 1998-1999.

Los Angeles County (These figures are for the two of the six service regions that were in our study.)

	Returned	Sampled	Percent	Population	Each survey respondent represents how many in population
Eligibility Worker[74]	426	1354	31.5	1354	3.18
Eligibility Supervisor	110	157	70.1	157	1.43
Employment Counselor	172	255	67.5	255	1.48
Employment Supervisor	26	37	70.3	37	1.42
MH Discharge	105	150	70.0	690[75]	6.57
MH Satisfaction	119	212	56.1	Unknown[76]	NA
AOD Discharge	114	150	76.0	Unknown	NA
AOD Satisfaction	176	237	74.3	Unknown	NA
Methadone Discharge	36	40	90.0	Unknown	NA
DV Discharge	58	150[77]	38.7%	Unknown[78]	NA
DV Satisfaction	59	170[65]	34.7%	708	12.00

[74] The sampling instructions (one large and one randomly selected small program in each SPA) were not followed for eligibility worker, so we are uncertain how the forms were distributed. We believe they were distributed to each office but are uncertain of what procedure was used. The total sample size is the total number of eligibility workers in the two SPAs.
[75] Discharged cases from 9/1/98 to 8/31/99
[76] There were 240 open direct CalWORKs cases as of 8/31/99. However, a comparable figure was never generated for the 30/35 or indirect CalWORKs cases.
[77] Because there was no list of CalWORKs eligible in DV programs from which to draw a sample, this number of surveys was distributed to the DV agencies. This represents the maximum size of the sample; the number of eligibles found by staff may have been smaller.
[78] No estimate was generated. In part this was a conceptual issue with some providers saying no cases are ever "closed" as woman might return at any time.

Los Angeles Eligibility Worker Returns by Office[79]

	Returned	Population	Percent	Each survey respondent represents how many in population
Compton	4	215	1.9	53.75
Exposition Park	60	92	65.2	1.53
Florence	50	86	58.1	1.72
Metro Family	39	115	33.9	2.95
Paramount	26	88	29.5	3.38
El Monte	31	209	14.8	6.74
Pasadena	50	110	45.5	2.20
Pomona	43	220	19.5	5.11
San Gabriel	109	127	85.8	1.16
Unidentified	6	NA	NA	NA
TOTAL	418	1262	33.1	NA

Shasta County[80]

	Returned	Sampled	Percent	Population	Each survey respondent represents how many in population
Eligibility Worker	45	47	95.7%	47	1.04
Eligibility Supervisor	7	9	77.8%	9	1.29
Employment Counselor	29	30	96.7%	30	1.03
Employment Supervisor	5	5	100.0%	5	1.00
MH Discharge	9	30	30.0%	206	22.89
MH Satisfaction	29	30	96.7%	Unknown	NA
AOD Discharge	15	30	50.0%	243	16.20
AOD Satisfaction	31	30	103.3%	Unknown	NA

[79] For analysis Compton, Paramount and the unidentified six cases were grouped as "other" so that each group was over 30.
[80] Two DV satisfaction forms were also returned.

Monterey County

	Returned	Sampled	Percent	Population	Each survey respondent represents how many in population
Eligibility Worker	89	94	94.7%	94	1.06
Eligibility Supervisor	19	20	95.0%	20	1.05
Employment Counselor	20	23	87.0%	23	1.15
Employment Supervisor	4	4	100.0%	4	1.00

APPENDIX B: PROJECTED POPULATION TOTALS

As we have pointed out in the report, the "total" column in tables refers specifically to the aggregate in the *sample.* Because the number of cases in the sample and the sampling proportions are different in each county, and often for each survey, one cannot simply assume that the "total" in the sample accurately represents the aggregate in the five (or four) counties. And in some sense it is not desirable to have the totals reflect the population since that means that the large counties (especially Los Angeles and Kern) could swamp all the rest. The sample total is a better representation of the variability within the five (or four) counties. Ideally we could have presented both the sample total and the population total. However, missing information about the population for several groups (and in different counties) made that impossible. Below we have calculated point estimates and confidence intervals for some of the key issues for both sample and population—limited to the groups for which we have information about the sampling proportion.[81] This exercise helps us see the difference between the two interpretations of the "total" as well as revealing the effect of the sampling proportions on the accuracy (margin of error) of the survey.

As noted above in Appendix A, there are other potential sources of error that could affect both types of total. One that we did not discuss—but which is relevant here—is the accuracy of the MIS counts of open and discharged AOD and MH cases. Based on our experience in working with the county MIS departments there may be miscounts in the population figures we are using here to determine sampling weights.

Eligibility Workers: The sample of the eligibility workers was quite close to the population except in Los Angeles and Kern, where each sampled case represented about three persons. Total hours of training is a dimension on which counties varied quite dramatically. Although the point estimates are the same for each county, the standard errors for each county except Los Angeles are smaller when using the sampling weights so that the confidence interval is smaller. The Los Angeles confidence interval is very broad because each of the offices in the two regions was included as a separate stratum. Differences between counties are not statistically significant in either analysis. However, the point estimate of the total is 16.7 using the sample total and 14.9 using the weighted total (11 percent less). In essence, the larger sampling weights in Kern and Los Angeles caused those counties to "outweigh" the smaller counties.

[81] Calculations were performed using the complex survey programming in *STATA 6.0.*

Total hours of training: Unweighted sample

County	N	Mean	Std. Error	95% Lower	Upper
Kern	111	11.1	3.6	3.9	18.2
LA	418	14.3	0.6	13.1	15.6
Monterey	89	48.0	9.1	29.9	66.1
Stanislaus	130	11.2	1.3	8.6	13.7
Shasta	45	5.8	0.8	4.2	7.4
TOTAL	793	16.7	1.3	14.2	19.2

Total hours of training: Weighted estimate of population

County	Population	Mean	Std. Error	95% Lower	Upper
Kern	337	11.1	2.9	5.3	16.9
LA	1329	14.4	1.4	11.7	17.2
Monterey	94	48.0	2.1	43.9	52.1
Stanislaus	188	11.2	.7	9.7	12.6
Shasta	47	5.8	.2	5.5	6.1
TOTAL	1996	14.9	1.1	12.8	17.0

The table below—in which the weighted and unweighted percentages are the same but the Sample and Population totals are different—illustrates the point made earlier that when the counties do not differ much the weighted and unweighted estimates are likely to quite similar. In this case the percentage of eligibility workers disagreeing with the statement that morale is higher is 61.4 percent in the sample and 58.9 in the weighted population estimate, a relatively small difference.

Morale higher now than before CalWORKs?

Point Estimates of Proportions, by County and Sample Total and Population Total

	Kern (N=110) Percent	Los Angeles (N=394) Percent	Monterey (N=87) Percent	Shasta (N=45) Percent	Stanislaus (N=128) Percent	Sample Total (N=593) Percent	Population Total (N=1912) Percent
Agree	20.9	25.1	17.2	37.8	21.1	23.7	23.9
Disagree	67.3	53.6	74.7	62.2	71.1	61.4	58.9
Don't Know	11.8	21.3	8.05	0	7.81	14.9	17.2
Total	100.0	100.0	100.01	100.0	100.01	100.0	100.0

Client Satisfaction: Only two counties had information about the population for both the AOD and MH population of open CalWORKs cases being sampled: Kern and Stanislaus. The table

below shows the answers to the question of how helpful services are overall. The Sample Total and Population Total are both given; the point estimates for the subpopulations are the same in weighted and unweighted versions.

Client Satisfaction: MH and AOD in Stanislaus and Kern Counties

How much did AOD or MH services help?

Point Estimates of Proportions, by County and Sample Total and Population Total

	Kern AOD (N=25) Percent	Kern MH (N=38) Percent	Stanislaus AOD (N=26) Percent	Stanislaus MH (N =42) Percent	Sample Total (N=131) Percent	Population total (N=1,436) Percent
Helped a lot	84.0	57.9	34.6	47.6	55.0	63.0
Moderate help	16.0	28.9	34.6	33.3	29.0	26.1
Little, none, worse	0	13.2	30.8	19.0	16.0	10.9
Total	100.0	100.0	100.0	100.0	100.0	100.0

In the table above the point estimates for the sampling groups within and across counties are the same in the weighted and unweighted estimates. However, in Kern each AOD respondent represented 16 cases and each MH respondent 22 cases. In Stanislaus these figures were 2 and 4. So the Population Total estimate gives much more weight to the Kern respondents—many more of whom reported being helped a lot. Thus in this case—where sampling proportions vary considerably and where percentages across sampling groups are not similar—the percentage for those helped a lot is 55 in the sample vs. 63 in the population. If our interest is whether they were helped *either* a moderate amount or a lot, then the percentages are 84 for the sample and 89 in the population. Again, the sample total better represents the county differences; the population total is calculated over the entire population.

In some cases we reported information aggregated by MH vs. AOD rather than using the actual sampling groups. In such tables the MH and AOD subtotals are also different for the sample and the population total. For example, if the table above is aggregated by AOD and MH, in the sample we find that 84 percent of both the MH and AOD respondents reported being helped moderately or a lot. In the population, these point estimates were 86 for MH and 96 for AOD. This discrepancy in AOD percentages is due to the fact that Kern cases were much more heavily weighted and there were none who were not at least moderately satisfied.

Discharged client survey. Sampling proportions for the survey forms filled out by staff on discharged clients were available for both the AOD and MH samples in Kern, Stanislaus and Shasta and for the MH sample in Los Angeles. Only AOD in Los Angeles is missing.

For this survey we had information on the number of forms returned from each provider. Since the providers themselves were the primary sampling units the surveys forms from each provider

represent a “cluster.” This information was included when estimating the weighted standard errors for the counties and the Population Total.

Discharged Cases: MH and AOD in Stanislaus, Kern and Shasta Counties; MH in Los Angeles

Age: Unweighted sample

	Mean	Std.Error	95% Low	95% High
Kern AOD	36.4	1.4	33.5	39.4
Kern MH	38.2	2.2	33.6	42.7
LA MH	36.1	0.9	34.3	38.0
Shasta AOD	31.1	3.7	22.1	40.2
Shasta MH	31.7	1.9	27.6	35.8
Stanislaus AOD	35.5	1.3	32.8	38.2
Stanislaus MH	33.0	1.9	28.7	37.3
TOTAL	35.7	0.6	34.5	36.9

Age: Weighted estimate of population

	Mean	Std.Error	95% Low	95% High
Kern AOD	36.4	3.1	30.0	42.9
Kern MH	38.0	1.2	35.6	40.5
LA MH	35.8	1.5	32.8	38.8
Shasta AOD	31.1	4.0	22.8	39.5
Shasta MH	31.7	1.1	29.4	34.0
Stanislaus AOD	35.3	4.8	25.5	45.2
Stanislaus MH	33.0	1.8	29.3	36.7
TOTAL	34.9	1.0	32.8	37.0

As can be seen above, the point estimates for client age for the county sampling groups are changed a small amount by including the information about the clusters of clients in each provider. None of the differences by sampling group in either table are statistically significant. The standard errors for the county sampling groups are affected differently so that the confidence intervals in the weighted and unweighted versions are narrower when weighted in some groups and broader in others. The point estimate for the total is quite similar for the sample (35.7) and the weighted population estimate (34.9). The confidence interval for the weighted population estimate is considerably broader, however.

Participation in the program while there

Program Participation Rating: Unweighted Sample

	Kern AOD (N=40)′ Percent	Kern MH (N=25) Percent	LA MH (N=102) Percent	Shasta AOD (N=8) Percent	Shasta MH (N=14) Percent	Stanislaus AOD (N=32) Percent	Stanislaus MH (N =17) Percent	Sample Total N=238 (Percent)
Good/very good	52.5	32.0	36.3	12.5	71.4	50	52.9	42.9
Poor/minimal	47.5	68	63.7	87.5	28.6	50	47.1	57.1
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

Program Participation Rating: Weighted Estimate of Population

	Kern AOD (N=40)′ Percent	Kern MH (N=23) Percent	LA MH (N=99) Percent	Shasta AOD (N=8) Percent	Shasta MH (N=14) Percent	Stanislaus AOD (N=32) Percent	Stanislaus MH (N =17) Percent	Population Total N=233 (Percent)
Good/very good	52.5	29.2	35.3	12.5	71.4	51.6	52.9	45.2
Poor/minimal	47.5	70.8	64.6	87.5	28.6	48.4	47.1	54.8
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

The two tables above demonstrate the effect of the sample design effects on both the point estimates in each county sampling group and in the total. Small differences in the point estimates in sampling groups are found, for example in the Kern MH and Stanislaus AOD groups. Both tables show statistically significant differences between sampling groups.[82] Despite fairly large differences between the sampling groups (range of 12 percent to 71 percent), the Sample Total of 43 percent "good/very good" is close to the Population Total of 45 percent.

Summary:

The complex sample design used had a number of effects. In the calculations shown above we have compared point estimates by sampling group and in total when the unweighted cases in each county sampling group were used with when sampling weights were applied and cluster sampling (choosing cases by choosing providers) was adjusted for. There are several conclusions:

- Point estimates for counties are the same or very close in both unadjusted and adjusted estimates.

[82] The unweighted chi-square for the sample is 13.58 with 6 df, p = 0.0347. The weighted Pearson test for the weighted and design-adjusted estimate of the population is F(5. 26, 126. 34) =3. 7835, = 0. 0027.

- The adjusted and unadjusted point estimate of the “totals” do differ to some extent, most notably for eligibility workers. The adjustment tends to bring the total much closer to the estimates for Los Angeles and Kern, since each case in those counties represents a larger number of unsurveyed persons than in the other smaller counties.
- Statistical significance of the difference between county sampling groups was not notably different with the two types of estimates.
- As suggested above, when the percentages in each county sampling group are roughly similar the adjusted and unadjusted totals are also similar.