HB

434

HOUSE COMMITTEE REPORT

(7)
Date Referred to Committee: February 18, 1998 **FURTHER REFERRALS:** **Judiciary**

Date of Committee Action: 4/30/98

The HEALTH, EDUCATION AND SOCIAL SERVICES Committee considered: **HB 434**

HOUSE BILL NO. 434 **DRUG TESTING OF WELFARE RECIPIENTS**

"An Act requiring drug testing for applicants for and recipients of assistance under the Alaska temporary assistance program; and providing for an effective date."

recommends it be replaced with the following committee substitute CS HB434 (HES)

[ ] the same title
[X] a new title

[ ] additional referral to ____________ Committee
[ ] attached amendment(s)

ADOPTS: ____________ Letter of Intent

ATTACHES NEW FISCAL NOTE(s): (Dept)

[ ] fiscal note(s) ____________

[ ] zero fiscal note(s) ____________

APPROVES PREVIOUS: (Dept/Date)

[ ] fiscal note(s) ____________

[ ] zero fiscal note(s) ____________

SIGNING WITH RECOMMENDATIONS	DP	DNP	NR	AM
[illegible signature]	✓			
[illegible signature]			✓	
[signature] Con Bunde			✓	
Brian Porter [illegible]			✓	
[illegible signature]				✓
Tom Brice			✓	

CHAIR'S SIGNATURE [signature] Con Bunde

FISCAL NOTE

STATE OF ALASKA
1998 LEGISLATIVE SESSION

No: 2

..l Version: CSHB 434(HES)
(H) Publish Date: 5/2/98

Revision Date:
Title: Relating to assessment of ATAP recipients for the use of drugs and alcohol
Sponsor: Rokeberg
Requestor: House(HES)

Dept. Affected: Health and Social Services
BRU: Public Assistance
Component: ATAP
COMPONENT SERIAL NO. 220
See also (SN#):

Expenditures/Revenues: (Thousands of Dollars)

OPERATING	FY99	FY00	FY01	FY02	FY03	FY04
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS	(106.3)	(106.3)	(88.8)	(88.8)	(88.8)	(88.8)
MISCELLANEOUS						
TOTAL OPERATING	(106.3)	(106.3)	(88.8)	(88.8)	(88.8)	(88.8)
CAPITAL EXPENDITURES						
CHANGES IN REVENUES ( )						

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts	(53.2)	(53.2)	(44.4)	(44.4)	(44.4)	(44.4
1003 GF Match						
1004 GF	(53.1)	(53.1)	(44.4)	(44.4)	(44.4)	(44.4
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other (please specify)						
TOTAL	(106.3)	(106.3)	(88.8)	(88.8)	(88.8)	(88.8

POSITIONS:

FULL-TIME						
PART-TIME						
TEMPORARY						

Estimate of any current year (FY98) cost: $0.0

ANALYSIS: (Attach a separate page if necessary)

CSHB434 authorizes the Division of Public Assistance (DPA) to conduct screening of all ATAP applicants and recipients for substance and alcohol dependency. If the screening protocol indicates the applicant or recipient has a chemical or alcohol dependency the DPA may, as a condition of the family self-sufficiency plan (FSSP), refer the client for assessment and require the participant to comply with the conditions of the assessment as a par. of the FSSP.

The effects of this legislation on DPA relate primarily to the additional time necessary to screen clients and to provide follow-up case management services for ATAP participants who are referred to assessment and treatment. There will be some program savings generated by reductions in benefits for non-compliance.

5/1/98

Prepared by: Jim Nordlund (signed: C Ashenbrenner for)
Division: Division of Public Assistance
Phone: 465-2680
Date: 05/01/98

Approved by Commissioner: Karen Perdue, Commissioner
Agency: Department of Health & Social Services
Date: 5/1/98

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ANALYSIS (cont.):

Because the proposed legislation implies universal screening it is very likely that as a result of referrals there will be increased pressure on the existing infrastructure for providing assessments and treatment. In FY97, the Medicaid program spent approximately $2.6 million dollars to for assessment, in-patient and out-patient services to approximately 1200 individuals with chemical or alcohol dependencies. DPA estimates that approximately 400 ATAP participants may be referred each month for assessment.

Assumptions:

Approximately 1200 applicants and recipients will be screened each month.
By FY00 all on-going program participants will have been screened and only new applicants will be subject to screening.
Each month, approximately 40% of individuals (N=480 for FY99 and 00 and N=400 for FY01-04) will be referred to assessment.
Each month, approximately 5% of those referred to assessment (N=15) will fail to comply with this provision of the FSSP.
For the purposes of this fiscal note it is assumed that the average duration of a sanction is 1 month.
Caseloads will remain level from FY99 - FY04

Calculation:

FY99-00 Penalties
480 X .05 = 24 x $369 = $8.9 x 12 = $106.3

FY01-04 Penalties
400 x .05 = 20 x $7.4 = $7.4 x 12 = $88.8

0-LS0495\P.1
Lauterbach
5/4/98

AMENDMENT

By Repsesentative Norman Rokeberg

OFFERED IN THE HOUSE

TO: CSHB 434(HES)

1 Page 1, line 1, following "Act":
2 Insert "**relating to family self-sufficiency plans under the Alaska temporary**
3 **assistance program;**"

4 Page 1, following line 5:
5 Insert a new bill section to read:
6 "* Section 1. AS 47.27.030(a) is amended to read:
7 (a) A participant in the Alaska temporary assistance program shall cooperate
8 with the department, or its designee, to develop and sign a family self-sufficiency plan
9 that includes
10 (1) the steps the family will take towards the self-sufficiency of the
11 family;
12 (2) the self-sufficiency services the department will provide to assist
13 the family to attain self-sufficiency;
14 (3) specific benchmarks to indicate the steps toward successful
15 completion of the family plan;
16 (4) a statement that the family may be subject to **reduction or**
17 **elimination of benefits** [BENEFIT REDUCTIONS] or other sanctions if the family
18 fails to comply with the family plan; and
19 (5) a statement that describes the necessary conditions and the steps
20 that must be taken to renegotiate the terms of the family plan."

21 Page 1, line 6:
22 Delete "Section 1"
23 Insert "Sec. 2"

1 Renumber the following bill section accordingly.

ALASKA STATE LEGISLATURE
House of Representatives

COMMITTEE ASSIGNMENTS:

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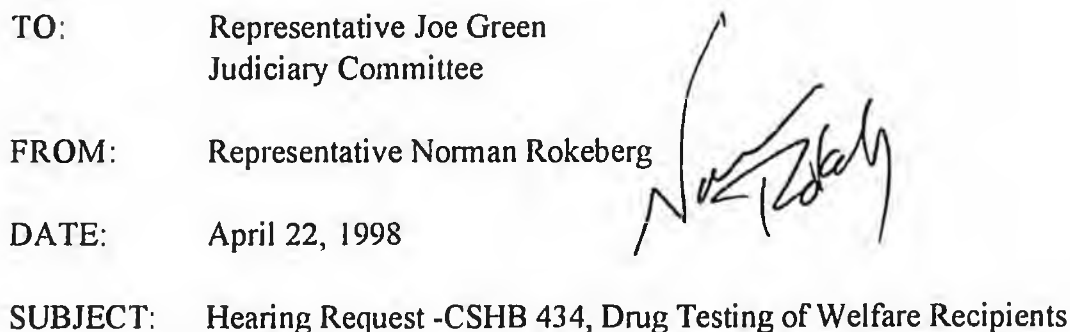
Representative Norman Rokeberg

MEMORANDUM



TO: Representative Joe Green
Judiciary Committee

FROM: Representative Norman Rokeberg

DATE: April 22, 1998

SUBJECT: Hearing Request -CSHB 434, Drug Testing of Welfare Recipients

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Consider this memorandum a request for a hearing on CSHB 434 pending referral from House HESS. I would appreciate a hearing being scheduled next week.

This bill provides the Division of Public Assistance and the Division of Alcoholism and Drug Abuse to screen ATAP participants for alcohol and substance abuse and require treatment for those participants who are found to have an alcohol or substance abuse problem

Attached is a committee packet which includes the following:

1. HESS Committee Substitute
2. Sponsor Statement
3. Sectional Analysis
4. Supporting Documentation

If you have any further question regarding this bill, please contact Mr. Randall Lorenz, on my staff at 465-4695. Thank you for your consideration.

Attachments

Alcoholism: Disease Or Addiction?

Editor's Note: As editor of Professional Counselor, *I am afforded the opportunity to work with many noted professionals in the addictions field and the creative freedom to bring together experts who may have different viewpoints on controversial topics.*

Only a few years ago, it would have been difficult to imagine having two of the most noted authorities on addictions and relapse prevention agree to a point/counterpoint on the question: Is alcoholism a disease? Today they acknowledge that, while their convictions may conflict in some ways, there is also much that they agree upon.

This debate highlights their common ground as well as their differences. It is offered in the spirit of cooperation between these two schools of knowledge, with the hope that by studying their perspectives, we can unite our efforts to decrease the devastating consequences of alcohol and drug addiction. As always, we welcome comments and feedback from our readers.

— Richard Fields, PhD

Top 10 reasons why alcoholism is an addiction but not a disease

By G. Alan Marlatt, PhD

The great debate continues. I'm not going to say that I don't think there is such a thing as alcoholism. It's a serious problem. There are people in my family who have died from it. I'm very concerned about this problem but I'm also a researcher and a scientist who is trying to figure out what alcoholism is.

I don't think it's a biological disease. To think of it just that way sets us up for certain problems. Well, what is it then?

I'm going to argue that it's an addiction. It has some overlap with disease and with behavior and habits, but we don't have the full answer yet of what addiction is. It's a very slippery animal and it has multiple causes. I don't want to say there are no biological issues here; of course there are. But there are also psychological, social, and spiritual issues that are important to this discussion.

(Continued to page 56)

G. Alan Marlatt (left) and Terence T. Gorski

Flawed disease definitions have hindered alcoholism treatment

By Terence T. Gorski, MA, NCAC II

To intelligently discuss the issue of whether alcoholism is a disease, you first have to define the disease. When talking about disease, people use three terms interchangeably: a disease; a disorder; and a syndrome.

Our working definition for use in this discussion involves three criteria:

- Does alcoholism constitute a clinical syndrome marked by an identifiable group of signs and symptoms?
- Is there a disorder present that is marked by structural or functional impairments related to the syndrome?
- Is there an etiology or cause of the syndrome that can be pinpointed or identified?

Let's address and answer the first question. Is alcoholism a syndrome? The answer to this is an absolutely unqualified "yes."

(Continued to page 16)

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You can distinguish alcoholism from other disorders. These signs and symptoms were originally identified before the turn of the century, and they've been studied and clarified ever since. Many researchers and leading professional organizations, including the American Medical Association and the American Psychiatric Association recognize these signs and symptoms.

"Here was a fundamental error inadvertently interjected into the consciousness of the chemical dependency field: that there is only one type of alcoholism."

Body of knowledge

The first modern-day medical researcher to study alcoholism, which at that time was termed "inebriety," was Dr. Benjamin Rush. His idea was that there was a syndrome of alcohol-related medical problems that he felt could best be described as a disease. His description of the symptoms was incomplete and quite primitive, but his inquiry started a process of medical examination of alcoholism as a disease.

Dr. Rush was acting against a moral model of alcoholism, which defined alcoholics as bad people, immoral sinners who needed to repent in order to get well. The framework of alcoholism as a disease was new and revolutionary.

This medical thinking culminated in the late '50s and early '60s with the research projects conducted at the Yale and Rutgers schools of alcohol studies. These studies resulted in a significant body of data that built a convincing argument that alcoholism was a disease. This body of knowledge was so compelling that the Congress of the United States created the National Institute of Alcohol Abuse and Alcoholism to nationally implement treatment programs based essentially upon this model. This work was summarized in the book, *The Disease Concept of Alcoholism*, by E.M. Jellinek, which was published in 1960.

The problem that I had all along in the field of addiction is that most people treating alcoholics never went back to this original source document, which very clearly presented an understanding of alcoholism and divided it into five subtypes:

- *Alpha* alcoholics are purely psychologically dependent but do not have physical dependence or damage. Jellinek was clear to assert that psychological dependency on alcohol alone did not constitute a disease state. Not all people with alcohol problems have the disease of alcoholism, some of them are alcohol abusers or problem drinkers who do not have the disease state.

- *Beta* alcoholics are socially and culturally heavy drinkers who were not physically addicted to the drug but suffered alcohol-related physical health problems, such as liver damage, in the absence of any pronounced signs of physical or psychological dependency. Beta alcoholism, Jellinek pointed out, is not of and by itself a disease, although the secondary damage to the organ system may be a disease.

- *Gamma* alcoholics exhibit progressive symptoms of both physical and psychological dependency upon alcohol. Looking retrospectively at chronic-stage alcoholism, this condition does progress and this research looked at retrospective studies only. Jellinek did view gamma alcoholism as a disease. In its end stages there was related organ-system damage, and he proposed an unknown "X factor" in terms of some function in the metabolism of the brain that created this disease state.

- *Delta* alcoholism characterizes someone physically and psychologically dependent on alcohol, but the intensity of their drinking does not increase—they drink the same amount every day. They are maintenance drinkers. Essentially, I think Jellinek was describing well controlled gamma alcoholism. He also considered delta alcoholism a disease.

- The *epsilon* alcoholic he described as the periodic alcoholic, who today we would call relapse-prone. This person has a period of sobriety, then relapses, has a binge, goes back into recovery, stays sober for a long time, then has another binge. This is a gamma alcoholic who has moved into incomplete or partial recovery and has become relapse-prone.

Gamma, delta and epsilon alcoholics represent the disease state. It's important to stress that, according to Jellinek's topology, only gamma alcoholism and its two related subtypes, delta and epsilon — the plateau drinker and the periodic binger — met the criteria for disease. The person who experienced physical consequences because of alcohol but with the absence of dependency did not, nor did the purely psychologically dependent drinker.

Damage done

Where did we lose Jellinek's topology? Where did the damage occur?

The damage occurred because of an extremely brilliant gentleman named Dr. Maxwell Glatt. Shortly after the publication of Jellinek's disease concept, Dr. Glatt was so taken with the description of gamma alcoholism that he took the symptoms, operationalized them and put them on a chart, which he dubbed the Jellinek Chart. Try and find the Jellinek Chart in any of Jellinek's published works. You won't, because Maxwell Glatt published it in the *British Journal of Addictions*.

He then proposed a course of recovery. What Dr. Glatt did was operationalize gamma alcoholism so well that everyone became hypnotized by it. Here was a fundamental error inadvertently interjected into the consciousness of the chemical dependency field: that there is only one type of alcoholism, gamma alcoholism; that it is chronic, progressive, and eventually fatal; that everyone who has any kind of alcohol problem has the disease; and that if you have mild, or early-stage alcoholism, the progression is inevitable.

This is a fundamental error that flawed the chemical dependency field and led to

(Continued to page 54)

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neglecting and failing to respond to the needs of non-addicted abusers and non-addicted problem drinkers. When these people came to us for help; we took two inexcusable positions that said, "Take treatment you don't need" or "Keep drinking until you get really sick, then come back." Both of these positions were stock and trade in many chemical dependency programs.

Dr. Glatt later published an extensive book on alcoholism that presented his full overview, but unfortunately that book never became as popular as his simple, easy-to-use Jellinek Chart.

Simultaneously, a gentleman named Mark Keller, operating under the auspices of the World Health Organization, put together a cross-cultural, international lexicon of terms involving diagnostic labels for alcoholism, basically confirming that the phenomenon of alcoholism — this thing called gamma alcoholism and the other type, the non-addicted abuser — is, in fact, a cross-cultural phenomenon.

Enter the Institute of Medicine, which was commissioned to give a report to Congress. When I read that particular document, I was rather shocked because I viewed it to be a biased document primarily developed by a committee that did not understand the work that was going on in disease-model programs; did not understand the evolution of where the leading-edge thinkers were going in this field; and who really diminished the importance, at that time, of the major treatment approach to alcoholism, namely Minnesota-model treatment and its emerging and developing forms. Evidence of this is the extremely limited number of pages devoted to explaining, understanding or referencing that model, while very small, obscure behavioral studies were given pages of credit and reference.

I was really concerned when I read this because I realized that if this document went unchallenged, it would become the blueprint for reshaping chemical dependency treatment in the nation. I expressed my concerns to the leaders in the alcohol and drug treatment industry. They put together a very weak, disorganized response and let it die; that became one of the most powerful, organizing public policy documents ever published.

"I have a hard time tolerating people who say, 'Here's this group of patients who have alcohol problems who definitely don't meet a disease profile; therefore, nobody does and we should throw out the disease model.' "

What we are seeing today is that the blueprint for the Institute of Medicine report is the game plan that is reorganizing service delivery for alcoholism and other drug dependency. Unfortunately, I believe it's a biased and flawed approach. It's partially correct, but it does not represent a higher-order model because biases were built in against very effective forms of treatment for very sick people. It's had, in my mind, some very dire consequences in terms of making treatment to certain subpopulations of alcoholics far less available than it was.

I think there is a broader base of treatment, but I also think there are people suffering from the disease of alcoholism who are not getting what they need publicly and privately. The document has backfired in many different ways.

Drawing the line

Let's look at it from a linear standpoint, where on one side is the non-addicted, infrequent abuser and on the other side of the line is the chronic, severely ill alcoholic. I don't know anyone who operates within a disease model of addiction who would contend that extremely mild forms of alcohol problems are a disease. They might say there are some factors that would indicate high risk, but the hardest-core disease advocate would never take a kid who got drunk for the first time and say, "You have a chronic, progressive, eventually fatal disease," and advise him to go into a long-term treatment program and never drink again.

At the other end of the line, there are some people with some very severe forms of alcoholism for whom not even the most hard-core behaviorists would say, "Gee, you don't have a disease. Your liver's falling out, you've got brain damage, you've got organ damage, you've been drinking a fifth a day for the last 12 years, you are nearly dead and in an intensive-care unit. Let's set up our little experimental drinking bar in your room and teach you how to drink in a controlled manner."

My point is, in the extreme positions there is a lot of concurrence. Would Dr. Marlatt agree that in the extreme latter scenario there are people who, in all practical senses, have the disease, and that there are people in the first scenario who, in all practical senses, don't — they're non-addictive abusers?

Where we've got the problem is the middle group. The key question is, where do we draw the line?

My basic principle is, I never knew anyone who died from abstinence. So, if in doubt, I say let's try abstinence. People with other biases say, "Well, controlled drinking is fine. If in doubt, put them on a control regimen. If it doesn't work, move toward abstinence."

The error I'd like to avoid in this discussion is what I call the "biased overgeneralization." As a disease-model advocate, I've had a lot of trouble with my colleagues who say, "Here are these people who definitely have a disease. Therefore, anyone with a drinking problem has a progressive, eventually fatal disease and should recover the way God intended him to recover, the way I did." That position is professionally untenable in my mind.

On the other hand, I have a hard time tolerating people who say, "Here's this

group of patients who have alcohol problems who definitely don't meet a disease profile; therefore, nobody does and we should throw out the disease model."

What I would like to see is a higher frame of reference capable of embodying and embracing both of these points of view. I am not going to argue that people with mild alcohol and drug problems have a disease. You can't win that argument because many of them probably don't at that point. But there is definitely a group of people who do. We must protect adequate services for this population. The key question is, how do we improve our diagnostic sophistication so that we can, in fact, get better at what we do?

When you look at the disease-model research you begin to find that the major subtypes of addiction are falling into three categories:

- *Primary alcoholism*: where alcoholism develops before any other psychiatric pathology. It has two subtypes; early onset, with people who seem to be more genetically and prenatally involved; and later onset, with people who are more environmentally influenced.
- *Secondary alcoholism*: where a psychopathology, primarily antisocial disorder or conduct disorders precede the development of addiction. There are two subsets of this; abuse disorders, and dependence disorders secondary to the psychopathology.
- *Reactive alcohol and drug abuse*: where a person drinks alcoholically and addictively in response to environmental stressors, such as Vietnam. When the person returns, the stressor is gone and they spontaneously stop or moderate their drinking.

When we're looking at the primary addiction, the newest research tells us this is a disease of the brain — specifically, a disease of brain-reward mechanisms. A person is born with a deficiency in brain-reward mechanisms, which creates a low-grade, agitated depression. When they find their drug of choice, their brain reacts by over-producing brain-reward chemicals, which produce a euphoria.

This feels so good that the person starts thinking about it a lot and develops an obsession with it. They feel an urge to do it, which is a compulsion, and this results in a craving. They have an innate, high tolerance. They're hangover-resistant, so they don't get very sick the next day.

"The disease model does not mediate against recovery."

During the '80s, the disease model brought more people into sobriety and recovery than any other approach to alcoholism or addiction treatment. The disease model does not mediate against recovery. One-third of the treatment programs were producing one-year recovery rates as high as 65 percent. They were effective. ■

Terence T. Gorski is a pioneer in the development of relapse prevention therapy. He is president of the CENAPS Corporation, a training and consulting firm in Homewood, Illinois, and the founder and clinical director of the Relapse Prevention Certification School, which conducts advanced training in the United States, Canada, and Europe. His books and articles have been published worldwide. He holds a bachelor of arts degree in psychology and sociology from Northwestern Illinois University and a master of arts degree from Webster University in St. Louis, Missouri. He is also a Nationally Certified Addiction Counselor and a Senior Certified Addiction Counselor.

FEEDBACK

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(Continued from page 17)

For example, let's look at cirrhosis of the liver. I have no argument as to whether cirrhosis is a disease. The question is whether the behavior that exacerbates cirrhosis — i.e., drinking — is itself a disease.

Studying susceptibility

Let's look at the definition of disease that has driven the disease model. In the introduction of *The (Alcoholic's Anonymous) Big Book*, Dr. Silkworth gives his definition of the origins of the disease model. He says:

"We believe . . . that the action of alcohol on these chronic alcoholics is a manifestation of an allergy. The phenomenon of craving is limited to this class and never occurs in the average temperate drinker. These allergic types can never safely use alcohol in any form at all and, once having formed the habit and found they cannot break it, once having lost their self-confidence . . . their problems pile up on them and become astonishingly difficult to solve."

"Relapse is the pivotal issue that determines whether the disease model works."

Although it doesn't necessarily have to be an allergy, (what he is proposing) is that only certain people are susceptible.

Later, in the opening paragraph of Chapter 4, it says: "In the preceding chapters you've learned something about alcoholism. We hope we have made it clear the distinction between the alcoholic and the non-alcoholic. If, when you honestly want to, you find you cannot quit entirely; or, if when drinking you have little control over the amount you take, you are probably alcoholic. If that be the case, you may be suffering from an illness which only a spiritual experience will conquer."

The interesting thing is that, yes, it's seen as a kind of disease there but the solution is a spiritual one, not a medical one.

Terry mentioned Jellinek's book, *The Disease Concept of Alcoholism*. Jellinek makes the case that maybe certain subtypes can be thought of as diseases, whereas others cannot. This book, probably more than any other, had the most impact in getting this model going.

Jellinek's key passage says: "The current majority opinion, to which the present writer subscribes, is that anomalous forms of the ingestion of narcotics and alcohol, such as drinking with loss of control and physical dependence, are caused by physiopathological processes and constitute diseases."

He defines loss of control this way: "Recovered alcoholics speak of loss of control to denote that stage in the development of their drinking history when the ingestion of alcoholic drink sets up a chain reaction, so that they're unable to adhere to their intention to have one or two drinks only and continue to ingest more and more, often with quite some difficulty, contrary to their volition."

As I read over this, I found this other sentence about relapse, which I hadn't noticed before. Jellinek says: "I must add that the occasion for relapse is a voluntary one and does not form a part of the disease process except perhaps in a psychopathological sense."

In other words, relapse is psychopathological and the disease is physiopathological. The uniform disease model that came out of this type of thinking is the definition I'm going to take issue with. Relapse is the pivotal issue that determines whether the disease model works.

Top 10

I therefore propose a sort of David Letterman Top 10 list of reasons why I don't believe that alcoholism is a disease:

10. Drinking is a risk behavior, not a disease. Both drinking and smoking can become addictive behaviors and leading causes of potentially fatal diseases like cirrhosis and cancer. The behavior is one

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thing, the disease consequence is another.

For example, when we look at a wide range of behavioral factors, approximately half of the 2,148,000 deaths in the United States in 1990 can be attributed to behavioral factors. Smoking, as we all know, is the number one killer; 400,000 a year are dying from tobacco-related causes. (In a recent study of mortality rates among alcoholics, it was reported that 60 percent of the mortality among alcoholics could be attributed to tobacco-related illnesses because of the high coincidence between smoking and drinking. Only 35 percent could be attributed to alcohol-related causes, such as cirrhosis).

Then we have diets and obesity as the leading cause of cardiovascular disease; HIV; microbial agents; toxic agents; firearms; motor vehicles; illicit drug overdoses; and more. These are all behaviors. At the Addictive Behaviors Research Center, where I'm working, we don't think that calling all these things "diseases that only certain people get" is very accurate.

9. Unlike biological disease, alcoholism can be eliminated or arrested by a voluntary decision made by the drinker.

This is the most optimistic thing about working with addiction problems. If you can create the right circumstances where the person can make a change, they can do it, and have done it, without necessarily having to turn themselves over to a doctor who treats them with some external agent like Antabuse or Naltrexone.

Decisions and cognitive factors are involved in the recovery process. It's a series of choices and decisions. There are forks in the road of recovery. Certainly there are decisions and choices that you get in the case of alcoholism that you probably don't get with most other diseases.

8. There is no official medical diagnosis of alcoholism, only degrees of alcohol abuse and alcohol dependence.

The *DSM-IV* model is basically a continuum model. When you bring all these definitions into it, you get more support from the continuum model than you do from the dichotomous, "either you have the disease or you don't have it" model.

"Decisions and cognitive factors are involved in the recovery process. It's a series of choices and decisions."

7. There is no single biological or genetic cause of alcoholism.

There are a lot of theories. It's not very specific anymore that it's just alcoholism. There seems to be a wide range of risk behaviors.

6. Effective treatments for alcoholism are almost always based on psychosocial, cognitive-behavioral or spiritual self-help groups, not on "medical treatments."

I'm on the advisory board for the National Institute for Drug Abuse, and the budget to try and find pharmacological interventions for, say, cocaine addiction, is incredible. A lot more money is going there than toward development of better psychosocial or behavioral programs.

5. Unlike with most diseases, many people resolve alcohol problems on their own, without treatment (e.g., maturing out, spontaneous remission).

We already know that most people who quit smoking did so on their own, even though nicotine addiction is very hard to overcome. Now we're finding the same is true with alcohol and other kinds of drug addictions. The number of people who resolve their problems on their own is quite large. This doesn't seem to fit with the progressive-disease model.

4. Loss-of-control drinking in alcoholics is triggered more by psychological factors (expectancy) than by the biological effects of alcohol.

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Jellinek's book talks about how one drink is sufficient to trigger this loss of control. We always thought it had more to do with what belief the person had about the alcohol, not just the physical effects. That led us to develop a placebo design study, where we could manipulate what alcoholics were actually given to drink and what they thought they were given.

What about when you don't think you're getting alcohol but you are? If it's a disease, that should trigger loss of control because the alcohol is in your blood, even though you don't know it. What about when you think you're getting alcohol but there's no alcohol in the drink? Do you get loss of control there? Yes, you do.

The study found that when the subjects were led to expect tonic, without vodka, they drank very little. If they expected vodka with their tonic, they drank a lot. It didn't matter whether they were actually getting alcohol or not. So we don't find that the mere presence of alcohol in the bloodstream is causing the loss of control. There has to be awareness of the psychological factors.

3. Belief in the disease model of alcoholism predicts greater relapse, according to a recent prospective treatment outcome study at the University of New Mexico, part of a project funded by NIAAA.

Researchers gave a single questionnaire to people who were in traditional 30-day, residential, inpatient Minnesota-model treatment. It said, "To what extent do you think alcoholism is a physical disease?" on a scale of one to seven, with one being "it is totally a disease" and seven being "no, it's not a disease, it's just a question of willpower." In predicting the magnitude of relapse, the time it took to relapse, and the amount of relapse, one of the biggest predictors was the belief in the disease model: the more they endorsed the physical disease model, the more they relapsed.

2. The "father" of the disease model of alcoholism, Benjamin Rush, MD, supported a continuum model of drinking, including moderate drinking (i.e., temperance equals moderation, not abstinence).

What is it?

Finally, if alcoholism is not a disease, what is it?

I think it's an addiction to alcohol. It's an addictive behavior that has biopsychosocial determinants. I would also consider it an affliction because it hurts and it causes problems, so it has biopsychosocial consequences and increases the risk of disease.

Some would think of it as an appetite habit disorder, something to do with the mechanisms of the brain and how they affect behavior. Even in those models, however, there is an emphasis on what people do and what the reward and consequences are that shape the behavior, as opposed to it being simply a biological disease process.

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I don't have a problem with that. The question is, what's causing it?

It's a behavior, an addictive behavior that has a lot of different governing factors and reward mechanisms; and it's a learned behavior, there is a lot of modeling going on, there is a lot of psychological attachment and expectancies.

You put all that together and you can't blame the victims because they have those problems or they lack willpower. It's because they've come under the influence of all these mixed factors. The good news is, you can get out of it. There are a lot of ways to fall off the wagon but there are a lot of ways you can get back on. I think the addictive model is more embracing than the more narrow disease model.

Addiction is the word I prefer. The disease model implies that it is entirely physiological. I don't think there is enough evidence to prove that people have a disease before they even start to drink.

Just because we are not saying that alcoholism or drug addiction is a disease does not mean that there aren't biological or genetic factors that increase the risk. But when you go out to the public and talk about alcoholism, most people think that it's a genetic disease, that you either have it or you don't. People are not used to thinking about polygenic determinations that increase the risk, about being raised in a certain kind of environment and upbringing, about whether their folks drank or not.

That's different from the all-or-nothing belief of "you either have it or you don't." ■

G. Alan Marlatt is professor of psychology and director of the Addictive Behaviors Research Center at the University of Washington, where he has been a faculty member since 1972. He received his doctorate in clinical psychology from Indiana University and has served on the faculties of the University of British Columbia and the University of Wisconsin. He is the author of more than 150 published journal articles and several books on addiction treatment, including *Relapse Prevention* (1985) and *Assessments of Addictive Behaviors* (1988). His research has been recognized with a MERIT Grant award from the National Institute of Alcohol Abuse and Alcoholism (1989); a Distinguished Psychologist Award from the Washington State Psychological Association (1990); and the Jellinek Memorial Award for Alcohol Studies (1990).

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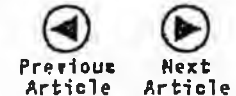

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Psychopathology in preadolescent sons of fathers with substance use disorders. *Duncan B. Clark; Howard B. Moss; Levent Kirisci; Ada C. Mezzich; Rebecca Miles; Peggy Ott.*

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Objective: While preadolescent children of parents with substance use disorders (SUDs) are known to have more behavior problems, depression, and anxiety than expected, psychiatric disorders in these children and their relationships with parental disorders have not been systematically investigated. This study compares the psychiatric disorders of preadolescent boys of fathers with and without SUDs and examines the relationships between offspring and parental psychopathology. Method: Fathers (i.e., probands) of boys 10 through 12 years old were recruited to represent families of boys with paternal SUD (high risk or HR: n = 113) and boys without paternal SUD (low average risk or LAR: n = 170). These boys (i.e., index cases) and their biological parents participated in structured diagnostic interviews, and diagnoses were determined by the best-estimate method. Results: Disruptive behavior disorders and anxiety disorders were more prevalent in HR than in LAR index cases. Logistic regression analyses examining the relationships between parental and index case psychopathology indicated that parental childhood psychiatric disorders were more strongly predictive of index case psychiatric disorders than parental adulthood psychiatric disorders, including SUDs. Conclusions: Inasmuch as HR boys had increased rates of disruptive behavior disorders and anxiety disorders, these disorders may be important targets for early intervention to prevent the development of SUD, as well as the morbidity associated with these disorders. Prevention efforts and studies of the transmission of liability for psychiatric disorders in children should carefully consider parental childhood characteristics. J. Am. Acad. Child Adolesc. Psychiatry, 1997, 36(4):495502. Key Words: substance abuse, psychopathology, risk factors.

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More than 6 million children in the United States are living with a parent with a substance use disorder (SUD) (Kumpfer and DeMarsh, 1986). While it is generally acknowledged that being the child of a parent with a SUD increases liability for a variety of adverse outcomes, there has been little systematic research with regard to the early development of psychiatric disorders in these high-risk children. Studies of adult children of parents with SUDs typically show that such offspring report more antisocial

behaviors, negative affect, and corresponding psychiatric disorders than control adults (Luthar et al., 1993; Sher, 1991; Sher et al., 1991). Previous studies have focused primarily on children of parents with alcohol use disorders (COAs) (e.g., Merikangas et al., 1994; Schuckit and Smith, 1996), and there are few studies of children and adolescents of parents with other SUDs (Wilens and Biederman, 1993). Given that SUDs often have an adolescent onset (Anthony and Heizer, 1991), studies focusing exclusively on preadolescence are more applicable to the development of prevention and early intervention programs. Previous research suggests the importance of considering two broad classes of psychiatric disorders, i.e., externalizing disorders, particularly disruptive behavior disorders including conduct disorder (CD), oppositional defiant disorder (ODD), and attention-deficit hyperactivity disorder (ADHD), and internalizing disorders, particularly mood disorders and anxiety disorders.

Disruptive Behavior Disorders

Disruptive behavior disorders (DBDs) have been the psychiatric disorders most commonly noted in children of parents with SUDs. In a study comparing COAs (aged 6 through 17 years) with children of psychiatrically healthy medical patients, Earls and colleagues (1988) found that COAs had elevated rates of ADHD and ODD compared with comparison children. On the other hand, Hill and colleagues (Hill and Hruska, 1992; Hill and Muka, 1996) have not found differences in DBDs between children (aged 8 through 18 years) of families with multigenerational alcoholism and children of families without alcoholism. These studies did not have sufficient samples of preadolescent children to present results stratified by age.

Questionnaire scores indicating elevated externalizing behavior problems in children of parents with alcohol use disorders and other SUDs have been noted in several studies. Preadolescent COAs, compared with control children, have shown higher rates of externalizing behavior problems (Aronson and Gilbert, 1963; Zucker and Fitzgerald, 1991). Wilens and colleagues (1995) found that children of parents with opioid dependence, compared with control children, had higher Externalizing subscale scores on the Child Behavior Checklist (CBCL) (Achenbach and Edelbrock, 1983). Gabriel and Shindledecker (1993) found that children of parents with opioid dependence showed higher levels of aggressivity than children of parents with alcohol dependence. Thus, children of parents with SUDs involving drugs other than alcohol may show different characteristics than COAs. Recent analyses from the Center for Education and Drug Abuse Research (CEDAR) have shown that CBCL Externalizing subscale scores are elevated in sons of SUD fathers compared with sons of control fathers (Moss et al., 1994, 1995). However, elevated indices on questionnaires do not necessarily indicate that psychopathology is severe enough to justify intervention.

Mood and Anxiety Disorders

While less studied than DBDs, children of SUD parents have also been found to have increased depression and anxiety symptoms and related diagnoses. Earls and colleagues (1988) noted an increased rate of depression and anxiety disorders in COAs compared with control children. In a study comparing 50 COAs with 48 children of psychiatrically healthy parents, Rolf and colleagues (1988) found increased depression symptoms by maternal and child report in COAs. Hill and Muka (1996) have found an increase in the rate of internalizing disorders (i.e., mood and anxiety disorders combined) in children

(aged 8 through 18 years) of families with multigenerational alcoholism and children of families without alcoholism. Wilens and colleagues (1995) found that children of parents with opioid dependence, compared with control children, had higher Internalizing subscale scores on the CBCL. In the CEDAR sample (Moss et al., 1995), sons of SUD fathers have higher CBCL Internalizing subscale scores than sons of control fathers on mother and teacher ratings.

Transmission

In families with paternal SUD, the mothers also often have SUD (Vanyukov et al., 1994). Steinhausen and colleagues (1984) noted trends toward CD being associated with paternal alcoholism and internalizing disorders being associated with maternal alcoholism. In the CEDAR sample, problem behaviors and internalizing symptoms were found to be most increased in children with bilineal parental SUD (Moss et al., 1994). Parents with SUD typically also have comorbid psychiatric disorders. As children of parents with SUD may show psychopathology similar to children of parents with other psychiatric disorders (Jacob and Leonard, 1986), consideration of comorbid psychopathology in parents needs to be included in examining possible transmission patterns. In the CEDAR sample, Moss and colleagues (1995) found that paternal aggression indices contributed to aggression among boys. Consideration of SUDs and other psychiatric disorders in both parents is therefore critical.

Study Aims

While a few studies have investigated dimensional measures of psychopathology in the preadolescent children of parents with SUDs, none has reported psychiatric diagnoses in these at-risk children. The relationship between parent and child psychiatric diagnoses has also not been investigated in this population. The two aims of this study were (1) to determine the psychiatric disorders differentiating preadolescent boys of fathers with and without SUDs, and (2) to determine the direction and magnitude of the relationships between index case psychiatric disorders and both paternal and maternal psychiatric disorders. The hypotheses of the study were that the preadolescent boys of SUD fathers would have increased prevalence rates of psychiatric disorders in all areas and that offspring psychiatric disorders would be associated with similar disorders in their parents as well as with parental SUDs.

METHOD

Subjects

The subjects were 283 boys 10 through 12 years old and their biological parents. Boys were identified and recruited by contacting their biological fathers through multiple sources, including substance abuse and other psychiatric treatment programs, social service agencies, newspaper and radio advertisements, and a sampling frame purchased from a marketing firm. After a complete description of the study to the parents and children, written informed consent was obtained. The study was approved by the Institutional Review Board of the University of Pittsburgh Medical Center.

The 283 index cases were classified into two groups based on paternal SUD history: (1) boys of fathers with SUD histories (high risk or HR: n = 113) and (2) boys of fathers

without SUD histories (how average risk or LAR: n = 170). One boy in each family was identified as the index case. Fathers (i.e., probands) were considered to have SUD histories if they met lifetime DSM-III-R criteria (American Psychiatric Association, 1987) for any substance abuse or dependence for substances other than nicotine, caffeine, or alcohol. The presence of other psychiatric disorders in SUD fathers was not an exclusionary factor. The fathers of boys in the LAR group did not meet DSM-III-R criteria for a lifetime history of any SUD, or any other major adulthood Axis I psychiatric disorder. (An exception was made for four probands with alcohol abuse prior to the age of 21 without lifetime histories of any other SUDs.) As described under "Results," this selection process led fathers without SUDs to have relatively fewer other psychiatric diagnoses than would be expected from a random community sample. Probands and index cases were excluded if they had chronic physical or mental disabilities which precluded full participation in the protocol. This sample includes subjects described in other cited articles from CEDAR (i.e., Moss et al., 1994, 1995) and adds subsequently assessed subjects.

As seen in Table 1, 91 (81%) of the SUD fathers had a substance dependence disorder other than alcohol dependence. With regard to the specific substances involved in dependencies, SUD fathers were characterized by cocaine dependence (n = 44, 39%), marijuana dependence (n = 42, 37%), opioid dependence (n = 25, 22%), and dependence on other substances (n = 26, 23%). Including alcohol dependence, 26 (23%) of SUD fathers had one type of substance dependence, 40 (35%) two, 15 (13%) three, and 22 (20%) four or more.

Families of HR and LAR boys were compared on demographic variables, index IQ, and parental IQ. While not different on index age (10.8 [+ or -] 0.9 versus 11.0 [+ or -] 0.9 years, for HR and LAR, respectively; t = 1.5, df = 281, p [greater than] .05), the HR index cases showed lower educational attainment than LAR index cases (4.3 [+ or -] 1.1 versus 4.6 [+ or -] 1.1; t = 2.7, df= 281, p [less than] .01). HR fathers were younger (38.5 [+ or -] 4.7) than LAR fathers (40.0 [+ or -] 5.0; F = 6.5, p [less than] .05). Consistent with other studies documenting an association between socioeconomic status (SES) and SUD in adults (Dohrenwend et al., 1992), HR families had lower SES by Hollingshead two-factor index (Hollingshead, 1990) than LAR families (35 [+ or -] 12 versus 45 4 [+ or -] 13; t = 6.2, df = 281, p [less than] .001). The index case IQ by WISC-III (Wechsler, 1991) was lower in HR than LAR index cases (104 [+ or -] 15 versus 114 [+ or -] 15; t = 5.7, df = 281, p [less than] .001). The IQs for parents were prorated from the Vocabulary, Digit Span, and Block Design subscales of the WAIS-R (Wechsler, 1981). Parental IQs were lower in HR than in LAR families (father: 101 [+ or -] 16 versus 113 [+ or -] 18; t = 5.9, df = 281, p [less than] .001; mother: 95 [+ or -] 15 versus 109 [+ or -] 17; t = 7.0, df = 281, p [less than] .001).

While index boys were included according to age, they were also characterized by Tanner stage. By pubic hair development, most boys were stage 1 (n = 57, 52%; n = 106, 63% for HR and LAR, respectively), with the remainder distributed among stage 2 (n = 42, 39%; n = 45, 27%), stage 3 (n = 9, 8%; n = 15, 9%), and stage 4 (n = 1, 1%; n = 3, 2%). The HR and LAR boys did not differ significantly on this measure ([[Chi].sup.2] = 4.6, p = not significant).

Procedures

These assessments are components of a research protocol implemented at CEDAR. The primary objective of this ongoing study is to use a prospective paradigm to understand the etiological pathways to SUD. Index cases and their parents participated in a 26-hour protocol, which included interviews, questionnaires, and laboratory tasks.

Recruitment

SUD fathers were identified and recruited primarily through substance abuse and other psychiatric treatment programs. Men in treatment programs who were the fathers of boys aged 10 through 12 years were informed that they may be eligible for the research program, and interested men were further informed and screened for inclusion and exclusion criteria. Fathers without SUD were identified and recruited as volunteers responding to newspaper and radio advertisements or through a sampling frame purchased from a marketing firm. Fathers recruited through community sources and subsequently found to meet diagnostic criteria for SUD were included in the SUD group. Fathers without SUD but with other major Axis I disorders were excluded.

Diagnostic Instruments

Parents. Father and mother diagnoses were made according to DSM-III-R, using data collected by several instruments. (DSM-III-R diagnostic criteria were used because this research was initiated prior to the availability of DSM-IV.) Information concerning SUDs was gathered by a structured interview developed for CEDAR, using sections of the Structured Clinical Interview for DSM-III-R (SCID) (Spitzer et al., 1988) and the Lifetime Alcohol Use Interview (Skinner, 1982), which was modified and expanded to assess other substances. Screening information was gathered on all classes of psychoactive substances, and detailed information was gathered on the more frequently used substances. CD and antisocial personality disorder (ASPD) were assessed by administering the SCID Personality Disorders Questionnaire (SCID-II) (Spitzer et al., 1987) and confirming the positive endorsements by interview. The validity of this method has been documented (Nussbaum and Rogers, 1992). Other psychiatric disorders were assessed by the SCID (Spitzer et al., 1988).

[TABULAR DATA FOR TABLE 1 OMITTED]

Index Cases. The child and one parent, typically the mother, completed a modified Schedule for Affective Disorders and Schizoophrenia for School-Age Children interview (Orvaschel et al., 1982) concerning the index child's psychiatric disorders. Mothers and teachers completed the CBCL and other questionnaires.

Diagnostic Procedure

The interviews were administered by graduate-level clinicians and were discussed in a consensus conference with two clinical psychologists or psychiatrists, the interviewers, and the evaluation coordinator. The consensus team reviewed all available information gathered in the assessment protocol, as well as psychiatric treatment records and teacher reports if available. Psychiatric diagnoses were then determined by the best-estimate diagnostic procedure (Leckman et al., 1982). Although data from each family member were gathered independently, discussions of subject characteristics with other family members and during case conferences resulted in the subject raters not being blind to the

recruitment and diagnostic characteristics of related family members.

Training of interviewers involved observation of several interviews with probands, index cases, and mothers, and joint interviews were practiced until greater than 90% agreement was reached with an experienced interviewer in all major areas. Interrater reliabilities for selected diagnoses by [Kappa] statistics for 22 probands were as follows: SUDs (other than alcohol), .94; alcohol use disorders, .96; DBDs, .88; separation anxiety disorder, .98; overanxious disorder, .87; major depression, .87.

Data Analyses

The HR and LAR groups were compared on index case and parental lifetime psychiatric disorders by Pearson [[Chi].sup.2] analyses. Test statistics were not completed for specific psychiatric diagnoses if the sample size was less than five in both cells. In cases in which the sample size in either cell was less than 12, the correction for continuity was used. For index cases, odds ratios were calculated with analyses controlled for differences between groups in index age, index education, SES, index IQ, mother IQ, and father IQ. Note that SES was calculated using raw scores of education and occupation for the head of household such that higher scores are interpreted as higher SES (Hollingshead, 1990).

Log-linear regression analyses were completed using parental psychiatric diagnoses to predict index case diagnoses. Regression equations were developed for the index case psychiatric diagnosis classes found to differ between groups. Parental psychiatric disorder variables included alcohol abuse, alcohol dependence, drug abuse, drug dependence, CD, ODD, ADHD, ASPD, mood disorders, childhood anxiety disorders, and adulthood anxiety disorders. For this procedure, SES, index IQ, father IQ, and mother IQ were forced to enter prior to parental psychiatric diagnoses. (The models were also examined with index age and index education entered as controlled variables. The results were not substantially changed with the addition of these variables.) A backward elimination method was used for other variables (Norusis, 1993). Backward elimination starts with all variables in the model, followed by evaluation of variables for entry and removal. The Wald statistic was used to select variables for removal. Variables were retained if heir removal was associated with a significant (p [less than] .05) decrement in variance explained. The contributions of variables to the regression are represented by the partial correlations (R) between the dependent variable and each of the independent variables. If the Wald statistic is less than 2, R is set to 0. Using the derived formula, the percentages of index cases classified correctly on the presence or absence of diagnoses were calculated.

RESULTS

Psychiatric Disorders in Index Cases

HR index cases showed higher rates than LAR index cases of several psychiatric disorders (Table 2). Significantly higher rates of DBDs overall, as well as CD and ODD specifically, were noted in the HR compared with the LAR index cases. Mood disorders were infrequent, and the rates were not significantly different between groups. Anxiety disorders overall were significantly more prevalent in the HR than the LAR sample.

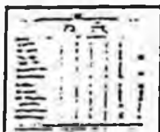
although neither overanxious disorder nor separation anxiety disorder separately showed significantly different rates. The proportion with any Axis I psychiatric disorder was higher in HR than in LAR index cases. The mean number of psychiatric diagnoses was [TABULAR DATA FOR TABLE 2 OMITTED] significantly higher in HR (1.60 [+ or -] 1.10) than in LAR index cases (1.27 [+ or -] 0.64; F = 8.59, p = .004).

Psychiatric Disorders in Parents

The psychiatric disorders identified in fathers and mothers are presented in Table 1. All diagnoses investigated were significantly more prevalent in the HR than in the LAR parents, with the exceptions of ADHD, ASPD, and major depression in mothers. As expected, the mean number of psychiatric diagnoses was significantly higher in the SUD fathers (5.40 [+ or -] 2.61) than in the fathers without SUD (1.14 [+ or -] 1.01; F = 464.39, p [less than] .001), as well as in the corresponding mothers (2.97 [+ or -] 2.26 versus 1.56 [+ or -] 0.36; F = 32.35,p [less than] .001).

Predicting Index Case Psychiatric Disorders From Parental Psychiatric Disorders

Logistic regression models were generated for index case DBDs and anxiety disorders. For index case DBDs, father childhood DBD was the most predictive variable (estimated coefficient = 1.22, p [less than] .001, r = .17, odds ratio = 3.4, 95% confidence interval = 1.7 to 6.9). Given the importance of these disorders, CD, ODD, and ADHD were used as separate predictors. Predictive parental psychiatric diagnoses included father CD, father ODD, mother drug dependence, and father alcohol abuse. The resulting equation (Table 3) correctly predicted 77% of cases (216/283), with a specificity of 94% (196/209) and a sensitivity of 31% (23/74), including 196 correct negative predictions, 23 correct positive predictions, 51 incorrect negative predictions, [TABULAR DATA FOR TABLE 3 OMITTED] and 13 incorrect positive predictions. Father DBD was highly associated with index DBD ([[Chi].sup.2] = 16.64, p [less than] .001). In cases in which the father had a history of DBDs, 31 of 69 index cases also had DBDs. In cases in which the father did not have a history of DBDs, 171 of 214 index cases also did not have DBDs.



For index case anxiety disorders (Table 4), predictive parental psychiatric diagnoses included mother childhood anxiety disorders and mother adulthood anxiety disorders. The resulting equation correctly predicted 88% of cases (248/283), with a specificity of 99% (243/245) and a sensitivity of 11% (4/38), including 2.43 correct negative predictions, 4 correct positive predictions, 34 incorrect negative predictions, and 2 incorrect positive predictions.

DISCUSSION

Epidemiological, clinical, and adoption studies have suggested that there are several pathways leading to [TABULAR DATA FOR TABLE 4 OMITTED] SUD. Cadoret and colleagues (1995) have presented evidence for a pathway that begins with ASPD in the biological parent, proceeds through adoptee CD and ASPD, and results in SUD. These results are consistent with Cadoret's hypothesis in indicating that fathers with SUDs transmit an increased vulnerability to DBDs in their sons. The pathway to SUD may, however, begin with childhood DBDs in the biological father. The logistic regression results indicate that the risks transmitted were more closely associated with the

chronologically distal childhood characteristics of the parents than with the proximal characteristics of the parents as adults. Paternal childhood CD and ODD each independently contributed to the liability for index DBD. Although the genetic or environmental nature of this transmission is not explicitly investigated here, this pattern of results is consistent with a genetic interpretation. Behavioral genetics studies have suggested that there is substantial heritability for behavioral dimensions involved in DBDs (Edelbrock et al., 1995). Childhood DBDs are also highly relevant to the genetics of nonalcohol SUDs, as the genetic correlation between childhood DBD symptoms and drug use disorder symptoms has been found to be higher than that between adulthood antisocial symptoms and drug use disorder symptoms (Grove et al., 1990). Genetic influences on delinquent behaviors may be more relevant for these middle-age children than would be the case at younger ages, when environmental influences predominate (Schmitz et al., 1995). Assortative mating may also contribute to parent - offspring correlations (Vanyukov et al., 1996). The modest proportion of the variance in index case DBD accounted for by paternal DBD and the low sensitivity of predictions, however, suggests that factors other than parental psychopathology are influential in the development of DBD.

Anxiety disorders may be another pathway leading to SUD (Clark and Neighbors, 1996; Clark and Sayette, 1993). Anxiety disorders were more prevalent in HR than in LAR index cases, although the association was relatively weak. In a finding parallel to that with DBD, maternal childhood anxiety disorder was the parental disorder most associated with index case childhood anxiety disorder. While studies have yielded less consistent results than for delinquent behavior, anxiety symptoms show significant heritability (Todd and Heath, 1996). As with DBD, the modest proportion of the variance in index case anxiety disorders accounted for by maternal anxiety disorders and the low sensitivity of predictions suggests that factors other than parental psychopathology are influential in the development of anxiety disorders. The possibility that anxiety disorders may increase risk for SUD remains somewhat controversial, primarily because retrospective reports may be contaminated by anxiety symptoms produced by intoxication and withdrawal (Clark and Neighbors, 1996; Schuckit and Hesselbrock, 1994). Prospective follow-up of these index cases and other similar research will determine whether or not childhood anxiety disorders confer risk for SUD.

There are several limitations to this study, including a lack of systematic information regarding possible sampling bias, the possible contamination of child rating characteristics by parental bias, and the lack of blind evaluators for diagnoses. Fathers were self-selected from several sources. The extent to which these fathers and their families are representative of the programs and communities from which they were drawn is not known, and sampling bias may have influenced the results. As mothers reported on themselves and their child, bias in the direction of perceived similarities may have been introduced (Simonoff et al., 1995). As evaluators were not blind to the characteristics of family members, bias may have been introduced into the diagnostic procedure. These findings may also be limited by the focus on suprathreshold disorders, as well as the relatively young age of the index cases. Depressive symptoms may, for example, emerge during adolescence in the high-risk group prior to the development of SUD.

The presence of psychiatric disorders in these children justifies intervention. In addition to reducing the morbidity associated with these disorders in childhood, the early identification and treatment of psychiatric disorders in high-risk children may be an effective strategy for the prevention of later SUD. Prospective research reveals that violence and violation of social norms, key features of CD, predict consumption of marijuana and other illicit substances in late adolescence (Boyle et al., 1992). CD has been noted to be an ideal target for prevention programs, particularly those involving parent training (Reid, 1993). Externalizing behavior disorder characteristics have been shown to be evident in children of SUD parents as early as 3 through 5 years old (Zucker and Fitzgerald, 1991), suggesting the importance of very early intervention for CD prevention. In addition, as a relatively small proportion of sons of SUD fathers had CD (8%), interventions could feasibly be targeted to this affected group.

Given the limitations of parents with SUD, it may be unrealistic to expect that these parents would be able to participate successfully in parent-training programs. Limited education and low SES, characteristics disproportionately present in this population, predict poor outcome in parent-training programs (Clark and Baker, 1983). Interventions involving multiple settings including the school are more promising (Reid, 1993). These results indicate that, while paternal SUD confers increased vulnerability to DBDs and anxiety disorders in offspring, the childhood characteristics of parents themselves are also important to consider when identifying children at risk for SUDs and other psychiatric disorders.

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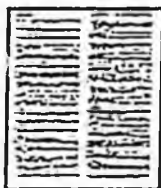

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Prenatal drug exposure: meeting the challenge. *Linda C. Sluder; Lloyd R. Kinnison; Dennis Cates.*

Abstract: Early childhood educators face an enormous challenge in children with prenatal drug exposure. These children present severe cognitive, social, behavioral and motor deficiencies that require special nurturing and encouragement from early childhood professionals. Among the approaches that research and experience have identified as the 'best practices' are a small learning area, self-directed exploration, adult intervention in cooperative play and work activities and an adjustment period to new activities. Community-based, family-centered approaches undertaken jointly with local and state agencies, focusing on caregiver training, counseling and parenting skills training are advised.

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Educators and child care providers today face a challenging new community of children identified as one of the fastest growing at-risk populations in America (Poulsen, 1992). These children have been labeled as "crack babies," "prenatal drug exposed," "peri-natal cocaine addicted" or "substance exposed infants and children" (Kinnison, Sluder & Cates, 1995, p. 35).

The mainstream media first identified such children in the early 1990s, focusing on demographic projections and associated statistical implications. The pressing issue now, however, is that these children have reached school age. As these children enter early childhood programs, educators must be prepared to nurture and encourage them.

Children with prenatal drug exposure exhibit a complex range of cognitive abilities and behaviors (Chasnoff, 1992; Howard, Beckwith, Rodning & Kropenske, 1989). Wright (1994) emphasizes that identifying specific traits is difficult, however, because prenatal exposure has diverse effects.

THE CASE OF TWO CHILDREN

Treavor

To the casual observer, Treavor appears to be a typical 5-year-old. He lives with his grandparents, who provide him with a caring and nurturing environment. His size is average for his age. Although his gross motor development appears to be age appropriate, he has some difficulty with fine motor tasks. In general, his physical

responses are spasmodic, limiting his ability to independently accomplish directed activities, such as placing wooden pegs into specific holes.

Psychoeducational test evaluations (e.g., measures of cognitive ability and adaptive behavior) indicate that Treavor functions in the severe-profound range of mental retardation. He becomes excited and distracted when individuals enter the learning environment, often soiling his diaper or outer clothing.

Treavor's receptive language is adequate to deal with simple tasks. He is able to follow basic verbal directions and participate, to some extent, in classroom activities. Treavor usually responds during group language activities with gestures and grunts or by showing recognition through directed eye movements. He is able to identify size ("big" and "little"), pictures of his immediate family, and his teacher and classmates when their names are given as prompts. Over the past year, the teacher noticed that Treavor improved in receptive language, attempts at expressive language, motor skills and attention span. Treavor attends a half-day early childhood program for disabled children.

Melissa

Melissa, a 2nd-grader, participates in a special education resource room one hour each day. She is small for her age, but otherwise displays no physical indications of prenatal drug exposure. While pregnant, Melissa's birth mother ingested alcohol, marijuana and various other drugs, including, possibly, cocaine. Melissa lives with adoptive parents in what appears to be a positive environment.

Melissa suffered from seizures at an early age, for which anticonvulsive medications were prescribed. Additionally, she takes Ritalin daily to help control her attention deficit disorder with hyperactivity and possible obsessive conduct disorder. A psychoeducational assessment indicates that Melissa's cognitive ability is above average. Her reading skills range from one to two standard deviations above the mean. Melissa's math achievement is on grade level and her written language skills are one standard deviation above the mean. Assessments indicate that she has average oral language development. In contrast to the assessment scores, Melissa's classroom teacher reports extreme variations in her daily academic performance.

Melissa's teachers maintain daily logs that illustrate her erratic behavior. Her teachers say that Melissa "tries hard, [is] inattentive, lacks small muscle control, [is] slow, in constant motion and has extremes in emotions." She appears to work best in a relatively small space and in one-on-one teaching situations.

In the regular classroom, she is compulsive - always giving an answer. She can also be mentally inflexible, needs constant redirection and has limited attention. Her regular education teacher is frustrated and has threatened to resign if Melissa is not removed from her classroom.

Melissa's medication has been invaluable. Without prescriptive intervention, her behavior is unpredictable. Consequently, she does not seem to have control of her actions. Records document that prior to taking her medication, Melissa had, among other things, threatened to beat her adoptive mother. After receiving treatment, Melissa was remorseful and expressed sorrow for such behavior.

COMPOUNDING ISSUES

Approximately 375,000 children are prenatally exposed to illicit drugs each year (Behrman, 1990; Feig, 1990). A rapidly growing proportion of these children are exposed to crack cocaine. Feig (1990) estimates that 30,000 to 50,000 "crack babies" are born each year.

A survey by the National Institute on Drug Abuse (1989) revealed that approximately 9 percent of all women of child-bearing age admitted to using illicit drugs. The number of women in this age group testing positive for drug use increased from 25 percent in 1972 to 40 percent in 1988. Other data indicate that prenatal drug use has remained at a consistent level ("Children of Cocaine: Facing New Issues," 1990). Women who use drugs while pregnant come from all socioeconomic and ethnic backgrounds (Feig, 1990; Weston, Ivins, Zuckerman, Jones & Lopez, 1989).

The severity of cognitive, social, behavioral and motor deficiencies are compounded by the multiple ingestion of tobacco, alcohol and combined drugs. Table 1 offers some behavioral characteristics that may be associated with prenatal drug exposure.

COMPLICATIONS

Motor Development

Although a small number of drug-exposed children exhibit gross motor difficulties, the influences on fine motor development are far more apparent. Researchers report that cocaine-exposed infants and toddlers often avoid eye contact and negatively respond to multiple stimuli (Zuckerman, Jones, La Rue & Lopez, 1990). Other studies suggest that these infants appear to have underdeveloped muscle tone and poor reflexes, and that their arms and hands may tremble when they reach for objects (Daberczak, Shaner, Senie & Kendal, 1988; Feig, 1990). Behrman (1990) suggests that such visual-perceptual and fine motor problems persist as these children mature. Van Dyke and Fox (1990) suggest that fetal exposure to various types of illicit drugs (e.g., cocaine or cocaine used with other drugs) may cause other developmental problems. These complications' characteristics may be similar to those of hyperactivity.

Cognitive Development

Many factors related to prenatal drug exposure directly and indirectly influence cognitive development. Drugs such as cocaine may force blood vessels in an expectant woman to constrict, reducing the blood flow and decreasing the amount of oxygen delivered to the fetus's brain (Woods & Plessinger, 1990). Bellisimo (1990) emphasizes that the "high" brought on by drug use may cause the fetus to suffer small strokes or seizures. These findings suggest that central nervous system damage and subsequent learning problems are possible.

Children prenatally exposed to drugs tend to perform more poorly on tests designed to measure concentration, group interaction and the ability to cope within an instructional environment, according to Viadero (1990). Further studies suggest that these children are

often disorganized, unstructured, irritable, less goal-directed and have problems processing information.

Language Development

Drug exposed infants and children are less likely to spontaneously vocalize or use gestures to communicate. In preschool, these children experience prolonged difficulty in articulating, identifying pictures and using expressive language (Chapman & Worthington, 1994).

Some children may have better success with receptive language (what is understood), as in Treavor's case. In this instance, receptive language may be superior to expressive language development. Treavor's behavior suggests he understands oral language, but cannot verbally communicate.

Affective-Behavioral Development

Children prenatally exposed to harmful substances may undergo a variety of emotional and behavioral swings, sometimes shifting rapidly from apathy to aggression. "A giggle becomes a scream, or a response to a question becomes an outburst" (Bellisimo, 1990, p. 25). Changes in environmental stimuli, such as visitors or minor disruptions in routines, may prompt the child to suddenly act uncontrollably. Melissa's behavior is characteristic of these extremes. It appears that prenatally drug exposed children commonly insist on addressing tasks in their own terms and persistently refuse to comply with requests.

These children interact poorly with others. Cocaine-exposed infants may become easily frustrated and throw temper tantrums when adults provide inconsistent directional cues (Bellisimo, 1990; Howard et al., 1989). Often, the children resist attachments to new adults or children. Some children actually avoid adult interactions.

Play Development

Howard, Beckwith, Rodning and Kropenske (1989) observed less representational play among drug exposed children. Instead, their play was characterized by randomly scattering toys, and then indiscriminately picking up and discarding them. These behaviors are in sharp contrast to children's typical play behavior.

Substance exposed infants and children often have difficulty initiating independent play activities. Consequently, they aimlessly wander through the learning environment. Many of these youngsters do not seem to have the necessary skills to spontaneously stack blocks or engage in representational play. They appear confused and unable to select a particular material for play or focus.

ACCEPTING THE CHILD

Children with suspected prenatal drug exposure need assurances from the adults in their lives. Educators who work with this population must understand the child's social, legal and educational needs. Unfortunately, accurate information about the extent of prenatal drug exposure is limited. Admitting that their child has been prenatally exposed to drugs places the mother or parents at risk for legal action. Moreover, as many states consider

prenatal drug exposure to be child abuse, admission of such activity will be rare.

Other issues also prevent parents from fully disclosing their drug use. Increased public awareness of the effects of prenatal drug exposure places the parent in a precarious situation. Many fear the reactions of their families, friends, the community and their children. Fetal alcohol children interviewed in Michael Dorris's The Broken Cord (1989) expressed difficulty understanding their disability and their parents' reasons for engaging in drug use.

Often, these children come from chaotic and dangerous home environments where the potential for continued drug abuse is high. Their mothers may be estranged from the family because of their drug use, which perpetuates a lack of support systems for both mother and child. Careful consideration and effort must be given to ensure that extensive time and opportunity are provided for these children to develop bonds with the family or other caregivers.

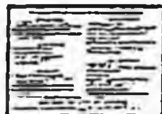
IMPLICATIONS AND SUGGESTIONS

Children who are exposed prenatally to illicit drugs present myriad challenges for early childhood professionals. The cognitive and behavior extremes associated with prenatal exposure precludes drawing up an explicit list of "best practices" or pedagogical approaches.

Compounding the problem is researchers' inability to systematically identify children who have been exposed to illicit drugs. Many research studies have samples that are too small with poorly defined subjects or no control groups (Chapman & Worthington, 1994). Other studies have been narrowly defined and use highly selective strategies, offering limited general application.

The following suggestions for early childhood professionals are based on the most current review of research and experience. Educators should pay special attention to the learning environment, ensuring that programs are predictable and restricting the number of nonessential people who enter and leave the environment. Howard et al. (1989) reported that a small room or learning area is superior to large, open areas.

Education professionals must carefully consider these children's unique learning styles when determining the classroom environment and teacher-to-student ratios. Daily routines must allow the children to engage in self-directed exploration. The educator or care provider, however, must always be aware that these children do not tend to engage in spontaneous activities. Adult intervention may be necessary to direct the child toward cooperative play and work opportunities.



Many potentially volatile situations can be diffused by alerting children to transitions and providing time to adjust to new activities. When a child is cognitively and emotionally involved with a special activity, adults can reduce children's frustration by providing notice that the activity is about to end. A statement such as "We have five more minutes left in math before lunch" will alert the child that the activity is closing.

CONCLUSION

Educators and care providers must be aware that children may exhibit multiple disabilities - including physical, medical, emotional, social and/or educational. A team of professionals should work together to focus on individual children's needs. Community-based, family-centered solutions should be emphasized, as should confidentiality.

Early childhood education and care providers need to establish close working relationships with local and state agencies. Joint efforts should promote specific caregiver training, substance abuse counseling, activities to raise mothers' self-esteem and training in basic parenting skills. These efforts may be university-based or associated with community and state agencies. Only through such collaborative efforts can substantial help be given to children with prenatal drug exposure.

Table 1

BEHAVIORAL INDICATORS OF PRENATAL DRUG EXPOSURE IN YOUNG CHILDREN

Motor Development

* Awkward eye and hand coordination

* Trembling arms and legs when reaching for objects

* Excessive fidgeting and/or hyperactivity

* Clumsy or immature use of tools such as spoons, crayons or small toys

Language Development

* Limited early vocalizations

* Prolonged articulation errors

* Difficulty in picture identification

* Problems following directions

* Limited vocabulary

Play Development

* Reluctance to initiate play activities

* Aimless wandering through the play area

* Inability to stack blocks

* Apparent confusion in some play situations

* Awkward understanding of and response to social cues

* Occasional aggressive behavior in group situations

Affective Development

* Avoidance of eye contact

* Low tolerance for change of environment or caregiver

* Difficulty in dealing with changes in routines

* Low ability to self-regulate own behavior

* Frequent limit testing

* Decreased response to verbal praise as a reinforcer

* Poor interactions with caregivers

* Increased frequency of temper tantrums

* Fearfulness of strangers

Cognitive Development

* Decreased imitative play

* Less pretend play or exploration of the environment

* Difficulty concentrating

* Disorganization

* Inability to structure work or play activities

* Diminished ability to stay on task

* Less goal-directed behavior

* Increasingly disruptive behavior

* Greater need for a more controlled learning environment

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Article A19137948

Substance Abuse and Welfare Reform Policy

by Julie Strawn

Background

According to the U.S. Department of Health and Human Services, research studies have found that between 10 and 20% of welfare recipients have a substance abuse problem, with about 5% of recipients affected enough to substantially limit their day-to-day functioning. Anecdotal evidence suggests the problem may be larger among long-term recipients. States have begun to grapple with the question of what policies to adopt toward welfare recipients with substance abuse problems as a result of efforts to require most welfare recipients to work or participate in employment programs. A recent Urban Institute study concludes that substance abuse has emerged as one of the primary personal or family barriers to employment among welfare recipients, together with physical disabilities, mental health problems, children's health or behavioral problems, domestic violence, housing instability, and low basic skills or learning disabilities. (Low basic skills is by far the most common of these barriers, and the one most associated with a recipient not working.)

The new federal welfare reform law gives states the option of testing recipients for illegal drugs and sanctioning those who test positive. The law also prohibits states from providing cash aid or food stamps to those convicted after August 22, 1996, of drug-related felony offenses, unless the state chooses to pass a law modifying this requirement or opting out of it entirely. There are no provisions regarding alcohol abuse. Beyond the substance abuse provisions, the new law's stringent work requirements and five-year time limit—and shorter limits in many states—will necessitate that states find ways to help recipients with substance abuse problems become more employable. Some states are developing short-term, outpatient treatment options that aim simply to help substance abusers function well enough to begin working in combination with longer-term, outpatient treatment. Outpatient treatment may not be enough, however, for severely affected families. States are likely to find that they need to expand treatment options for single parents who need residential care. Such recipients may be unlikely to enter residential treatment if the facility cannot accommodate their children, if adequate child care is not available, or if doing so means giving their children up to foster care.

Policy Issues

The role of drug testing in welfare reform. There are four key policy reasons for drug testing welfare recipients: 1) to identify recipients who need substance abuse treatment; 2) to monitor compliance with treatment; 3) to screen recipients on behalf of employers; and, 4) to try to reduce drug use by sanctioning welfare recipients who test positive. Weighed against these programmatic objectives are: the high cost of testing all welfare recipients (at least $20 per drug, rising to as much as $70 with confirmatory testing); the questionable reliability of any one test; unresolved 4th Amendment legal issues around search and seizure; and, the shortage of treatment in many areas, especially for residential settings for families. These factors help explain why states generally have used testing to monitor compliance with treatment rather than as a general screening tool. In addition, such testing typically does not address alcohol abuse. There are alternative ways to screen for alcohol and drug abuse problems. States such as Oregon, Utah, and Ohio use client interview instruments to determine which recipients should be referred for further diagnosis and treatment.

Substance abuse as a barrier to steady work. According to a recent Urban Institute study, welfare recipients with substance abuse problems are as likely to work as other recipients — 63% worked at some point in the current or previous year, compared to 58% of recipients without a substance abuse problem. These

recipients do seem less likely to work steadily, however, with only 15% working full-time, year-round, as compared to 22% of all recipients. Because job retention has become a much higher priority for welfare-to-work programs in the wake of welfare time limits, this finding that substance abuse hurts job retention may give states and localities a powerful reason to address treatment needs. In addition, as employers themselves increasingly require job applicants to undergo drug tests, even substance abusers who function well enough to work may find themselves unemployable if they cannot pass a drug test.

Effectiveness of drug treatment. There is a consensus among researchers that drug treatment is cost-effective and results in reduced drug use, reduced criminal justice involvement, and increased employability. State-reported treatment data shows rather consistent results across states for client outcomes post-treatment as compared to pre-treatment: about a one-third drop in drug use, nearly a 60% increase in employment, and roughly $6 in benefits for every dollar invested in treatment. Some states have also found a decreased need for foster care and child protective services as a result of treatment.

Many states do not have outcome data on welfare recipients specifically, but a few do. Minnesota found a 64% increase in employment among public aid recipients after treatment; a special Florida treatment program for pregnant or postpartum women and their children found a 76% increase in employment or school enrollment after treatment; and Ohio's data on welfare recipients who received treatment showed a substantial decline in the amount of work missed by recipients, a key finding given the need to improve job retention due to welfare time limits. Ohio also found a 15% reduction in welfare payments. The U.S. Department of Health and Human Services will soon release a study of treatment outcomes for welfare recipients in California showing that outcomes for them are comparable to outcomes found for all individuals in treatment.

Financing treatment for welfare recipients. States in the past have funded substance abuse treatment for welfare recipients in three ways: through the federal substance abuse block grant, through the Aid to Families With Dependent Children (AFDC) program, and through Medicaid. The block grant is by far the largest source of overall federal treatment funding, but anecdotal reports suggest that AFDC and Medicaid funds have played an important role in expanding residential treatment options for low-income, single parents with children. Medicaid funds can also support a range of outpatient services including screening services, counseling, detoxification, day treatment, and methadone maintenance.

It is unclear whether states can continue to fund substance abuse treatment under the new welfare program that replaced AFDC (the Temporary Assistance for Needy Families block grant or TANF), because TANF funds cannot be used to provide medical services. In addition, because federal TANF funds are capped, supporting treatment and other services through Medicaid is probably a better strategy because state treatment spending in that program will generate additional federal matching funds. Another advantage to funding treatment through Medicaid is that if a welfare recipient and her children are placed in a residential setting, states may be able to remove that family from the welfare rolls, deferring the parent from time limits and work requirements while treatment occurs. One key obstacle to funding residential treatment through Medicaid, however, is a federal regulation that prohibits Medicaid spending on services to individuals (between the ages of 21 and 65) in an "institution of mental diseases" (IMDs) with more than 16 beds. Medicaid treats nonhospital, residential treatment settings as IMDs. A 1992 survey of states by the Intergovernmental Health Policy Project (IHHP) found that states believe this IMD restriction prevents cost-effective provision of substance abuse treatment services under Medicaid. As a result, many states limit inpatient substance abuse coverage to short-term detoxification and emergency services provided by hospitals.

Requiring participation in welfare-to-work programs and the role of sanctions. State and local experience shows that it is feasible to require families with substance abuse problems to participate in welfare-to-work

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programs but that participation often develops incrementally, beginning with small steps and becoming more intensive over time. A key issue in working with such families is the appropriate role of sanctions. While studies have shown that sanctions are important for increasing participation by recipients in welfare-to-work programs, the experience of several states with full family sanctions suggests that families with serious, unaddressed problems are more likely to be sanctioned.

In particular, Utah found that many of those being sanctioned for noncompliance in its work program had previously undetected problems, with mental health problems four times greater among sanctioned families and substance abuse problems twice as high. Utah decided that full family sanctions were not appropriate for such families and now requires that there be an extensive review process before full family sanctions are imposed, including an interdisciplinary team staff review and a home visit. Because of the possible negative impacts on children of denying all benefits to very troubled families, states with full family sanction policies may want to explore the use of protective payments to third parties as an alternative for some families. States have experience in using such third party payments with recipients of federal disability aid who have substance abuse problems.

Research Findings

Little research has been conducted on what types of welfare policies are effective for addressing substance abuse issues among recipients. Utah is one of four states (with Kansas, Oregon, and South Carolina) that has a waiver to require substance abuse treatment as a condition of welfare receipt. An independent, rigorous evaluation of Utah's overall welfare-to-work program shows large increases in family income, large reductions in public aid, and a strikingly high level of participation by families in self-sufficiency activities. No separate results are available, however, for families with substance abuse problems.

The Urban Institute recently conducted case studies of eight welfare-to-work programs that have substantial experience in working with families who face multiple personal or family barriers to self-sufficiency, including substance abuse. Researchers drew five broad lessons from the case studies:

· Programs must be flexible, with a broad range of strategies and services to respond to the diverse circumstances of individual families.

· Special services to families with various personal and family challenges are not incompatible with a "work first" program strategy. For some families, these services can be short-term; in other cases, employment or community service may help families to gain confidence that helps them overcome other problems.

· Welfare-to-work programs must form partnerships with community agencies that provide substance abuse treatment, mental health counseling and specialized services for women in abusive situations in order to help some families become self-sufficient.

· Clients must develop trust in program staff. It is very important to hire staff who are committed to helping families change their lives by celebrating small successes and pushing them toward further progress.

· Programs must set clear expectations for participation, reinforced by financial penalties.

Innovative Practices

Like Utah, Oregon has a federal waiver to require compliance with substance abuse treatment as a

condition of receiving aid. (All states are free to implement such policies under TANF.) Oregon provides local offices with considerable latitude for deciding how to provide substance abuse services to recipients. Local offices have the option to test recipients for drugs but most have not elected to do so. In most local welfare or JOBS offices, mental health and/or alcohol/drug abuse counselors are outstationed to identify recipients in need of treatment services and to provide counseling.

Initially, local offices in Oregon only addressed substance abuse issues when such problems interfered with participation in work-related activities. Over time, however, Portland and other localities have instituted a broader substance abuse education component as part of their upfront employability and job search process for all applicants and recipients. This change developed in response to staff concerns that some recipients successfully completed employment and training programs only to fail an employer's drug test. The substance abuse education component does include substance abuse screening using the Substance Abuse Subtle Screening Test (SASSI), a pen-and-paper test that can be administered in groups or individually and takes only 15-20 minutes to complete. Clients with substance abuse problems can be mandated to treatment, with the type of treatment varying in length and intensity. Treatment is usually combined with other self-sufficiency activities such as work, education, or training.

Utah has hired trained counselors (generally social workers) for its local welfare offices who are responsible for families with the severest problems, including substance abuse. These workers also supervise other staff working with difficult cases and train eligibility and self-sufficiency staff to be able to identify these problems. In addition, there are on-site mental health and alcohol/drug abuse counselors in some of the local offices. Like Oregon, Utah has found that substance abuse problems tend not to surface right away but rather become apparent when a recipient is failing to comply with program participation requirements. Utah tries to maintain its principal program focus on employment, so much of its substance abuse treatment is short-term to allow recipients to quickly move on to work.

Two other states, South Carolina and Kansas, have federal waivers to require treatment as a condition of eligibility. These waivers were approved more recently than those in Oregon and Utah, however, and are just now being implemented. In addition, Wisconsin's pending waiver request for its Wisconsin Works proposal includes substance abuse treatment as one of the activities that recipients can be required to participate in as a condition of eligibility. Other states and localities are also trying new ways of working with families who have substance abuse problems. Ohio is field testing a screening instrument to be used in alcohol and drug abuse assessment of all welfare recipients. Sacramento County, California, is training some child welfare, public health, and employment and training staff to identify and intervene with substance abusing clients. It is unclear yet what welfare policies states will choose to adopt toward substance abusers under TANF; the final decisions on this will probably be made by legislatures early in 1997. Some states, such as Maryland and New York, are considering whether to test all welfare recipients for drug use in order to identify those who need treatment.

For More Information . . .

RESOURCE CONTACTS

The Legal Action Center, Washington, DC. Contact Gwen Rubinstein, Deputy Director of National Policy, (202) 544-5478.

National Association of State Alcohol and Drug Abuse Directors, Washington, DC. Contact Kathleen Sheehan, Director of Public Policy, (202) 293-0090.

National Center on Addiction and Substance Abuse (CASA), Columbia University, New York, NY.

Contact Mary Nakashian, (212) 541-5200.

Oregon Department of Human Resources, Salem, OR. Contact April Lackey, Field Service Section, (503) 945-6122.

Portland, OR, Steps to Success Program. Contact Christa Sprinkle, Coordinator, Mental Health/Alcohol and Drug Treatment Services, Steps to Success, Mount Hood Community College, (503) 256-0432.

The SASSI Institute (publisher of the SASSI substance abuse screening instrument), 4403 Trailbridge Road, Bloomington, IN, 47408. Call 1-800-726-0526 for SASSI information.

The Urban Institute, Washington, DC. Contact LaDonna Pavetti, Research Associate, (202) 857-8660.

U.S. Department of Health and Human Services, Office of the Asst. Secretary for Planning and Evaluation (ASPE), Washington, DC. Contact Laura Feig, Senior Policy Analyst, (202) 690-5938.

Utah Department of Human Services, Salt Lake City, UT Contact Connie Cowley, Program Specialist, (801) 538-4337.

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Administration (1994). Patterns of Substance Abuse and Substance-Related Impairment Among Participants in the Aid to Families with Dependent Children Program. Washington, DC: U.S. Department of Health and Human Services.

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Young, N.K. (forthcoming February 1997). Implementing Welfare Reform: Solutions to the Substance Abuse Problem. Washington, DC: Joint publication of Children and Family Futures and Drug Strategies.

H.R.3734

Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Enrolled Bill (Sent to President))

SEC. 115. DENIAL OF ASSISTANCE AND BENEFITS FOR CERTAIN DRUG-RELATED CONVICTIONS.

(a) IN GENERAL- An individual convicted (under Federal or State law) of any offense which is classified as a felony by the law of the jurisdiction involved and which has as an element the possession, use, or distribution of a controlled substance (as defined in section 102(6) of the Controlled Substances Act (21 U.S.C. 802(6))) shall not be eligible for--

(1) assistance under any State program funded under part A of title IV of the Social Security Act, or

(2) benefits under the food stamp program (as defined in section 3(h) of the Food Stamp Act of 1977) or any State program carried out under the Food Stamp Act of 1977.

(b) EFFECTS ON ASSISTANCE AND BENEFITS FOR OTHERS-

(1) PROGRAM OF TEMPORARY ASSISTANCE FOR NEEDY FAMILIES- The amount of assistance otherwise required to be provided under a State program funded under part A of title IV of the Social Security Act to the family members of an individual to whom subsection (a) applies shall be reduced by the amount which would have otherwise been made available to the individual under such part.

(2) BENEFITS UNDER THE FOOD STAMP ACT OF 1977- The amount of benefits otherwise required to be provided to a household under the food stamp program (as defined in section 3(h) of the Food Stamp Act of 1977), or any State program carried out under the Food Stamp Act of 1977, shall be determined by considering the individual to whom subsection (a) applies not to be a member of such household, except that the income and resources of the individual shall be considered to be income and resources of the household.

(c) ENFORCEMENT- A State that has not exercised its authority under subsection (d)(1)(A) shall require each individual applying for assistance or benefits referred to in subsection (a), during the application process, to state, in writing, whether the individual, or any member of the household of the individual, has been convicted of a crime described in subsection (a).

(d) LIMITATIONS-

(1) STATE ELECTIONS-

(A) OPT OUT- A State may, by specific reference in a law enacted after the date of

the enactment of this Act, exempt any or all individuals domiciled in the State from the application of subsection (a).

(B) LIMIT PERIOD OF PROHIBITION- A State may, by law enacted after the date of the enactment of this Act, limit the period for which subsection (a) shall apply to any or all individuals domiciled in the State.

(2) INAPPLICABILITY TO CONVICTIONS OCCURRING ON OR BEFORE ENACTMENT- Subsection (a) shall not apply to convictions occurring on or before the date of the enactment of this Act.

(e) DEFINITIONS OF STATE- For purposes of this section, the term 'State' has the meaning given it--

(1) in section 419(5) of the Social Security Act, when referring to assistance provided under a State program funded under part A of title IV of the Social Security Act, and

(2) in section 3(m) of the Food Stamp Act of 1977, when referring to the food stamp program (as defined in section 3(h) of the Food Stamp Act of 1977) or any State program carried out under the Food Stamp Act of 1977.

(f) RULE OF INTERPRETATION- Nothing in this section shall be construed to deny the following Federal benefits:

(1) Emergency medical services under title XIX of the Social Security Act.

(2) Short-term, noncash, in-kind emergency disaster relief.

(3)(A) Public health assistance for immunizations.

(B) Public health assistance for testing and treatment of communicable diseases if the Secretary of Health and Human Services determines that it is necessary to prevent the spread of such disease.

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Department of Human Resources
311 W. Saratoga St.
Baltimore, MD. 21201-3521

FIA ACTION TRANSMITTAL

Issuance Date: August 21, 1997

Effective Date: Upon Receipt

Control Number: 98-07

FROM:	KEVIN MAHON, EXECUTIVE DIRECTOR, FIA JOSEPH MILLSTONE, DIRECTOR, DHMH/MCPA JOSEPH E. DAVIS, DIRECTOR, DHMH/PSOA THOMAS DAVIS, DIRECTOR, DHMH/ADAA
RE:	FIP SUBSTANCE ABUSE TREATMENT PROVISIONS
PROGRAMS AFFECTED:	TEMPORARY CASH ASSISTANCE (TCA), FOOD STAMPS (FS), AND MEDICAL ASSISTANCE (MA)
ORIGINATING OFFICE:	OFFICE OF POLICY AND RESEARCH

SUMMARY: During its 1997 session, the Maryland General Assembly passed Senate Bill 499, The Welfare Innovation Act of 1997. Provisions of this bill set forth requirements for substance abuse screening and treatment for customers receiving Temporary Cash Assistance (TCA) benefits under the Family Investment Program.

Beginning July 1, 1997, Local Departments of Social Services (DSS) must add questions designed to identify substance abuse to the up-front job readiness assessment for all TCA adult and minor parent applicants and recipients. Local departments must also inform all adult and minor parent TCA applicants and recipients about the FIP substance abuse treatment provisions, including the customer's obligation to participate in an initial health screen with the Managed Care Organization (MCO). Customers must sign consent forms to allow the MCO or treatment provider to exchange information with the DSS about the customer's compliance with substance abuse screening and treatment (if treatment is necessary).

The MCO screens for substance abuse as part of a comprehensive health screen for TCA customers when they enroll in the MCO. If the initial health screen suggests a substance abuse problem, the MCO provider refers the individual for a comprehensive substance abuse assessment and notifies the DSS of the referral. The purpose of this assessment is to determine whether the individual really needs treatment, and if so, the appropriate level and intensity of treatment needed.

The MCO or substance abuse assessment provider notifies the DSS of the outcome of the assessment. When a substance abuse treatment provider receives the referral, it must notify the DSS of the individual's compliance with the recommended treatment program.

A customer with a substance abuse problem who complies with the FIP substance abuse treatment provisions is eligible for TCA benefits. The individual may be exempted from work requirements for a period of time as determined by the DSS. The DSS must remove customers who are not in compliance from the TCA grant and pay the remainder to a third party.

<u>**ACTION REQUIRED:**</u> The following procedure is effective for all TCA adult and minor parent applicants and recipients at their first redetermination after July 1, 1997. We recognize that it is paper intensive and may present administrative problems. There are very stringent federal regulations and requirements surrounding confidentiality for persons with substance abuse problems. Designing a system to meet these and the legislative requirements surrounding this policy has been a challenging task. We are committed to improving and automating this system to the fullest extent possible. We encourage your feedback on these procedures and suggestions on how to improve them.

PHASE I. DSS - NOTIFICATIONS / ASSESSMENT/ CONSENT FORMS

<u>**Face to Face Interview:**</u>

- At application or redetermination interview for TCA, the FIA Case Manager:

  - Completes an enhanced assessment on each TCA adult and minor parent applicant or recipient as part of the employment assessment. The local department shall add the following questions to its employment assessment instrument:

    1. *Do you feel or has anyone ever told you that you should cut down on your drinking or drug use?*
    2. *Have you ever tried to cut down or quit drinking or using other drugs?*
    3. *Has the use of alcohol or drugs caused problems in your life such as getting or keeping a job?*
    4. *Do you sometimes need a drink or drug first thing in the morning (an eye opener) to steady your nerves or get rid of a hangover?*

  A minor parent included in an adult caretaker relative's TCA application must be assessed using the same questions even if the minor parent is in school and would not otherwise be called in for an employment assessment. Local departments that require minor parents to sign a family responsibility plan may include the questions as part of the assessment for the plan. Local departments may use a more extensive substance abuse screening instrument, such as the MAST (Michigan Alcoholism Screening Test), as long as they screen each adult and minor parent.

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- Informs all adult and minor parent TCA applicants and recipients about the FIP substance abuse treatment provisions, including the obligation to complete an initial health screen at the MCO; and has the individual sign a **Consent for the Release of Confidential Alcohol and Drug Treatment Information** form (Attachment I).

- If the adult or minor parent TCA customer gives an affirmative answer to any of the substance abuse screen questions at the employment assessment, the individual discloses a substance abuse problem and requests a treatment referral, or the case manager otherwise has reason to believe a problem exists, the case manager must:

  - Determine if the individual should be referred for work activities. This must be done on a case by case basis based on established local department criteria. If the individual meets all other technical and financial eligibility criteria, certify the customer for a four month period. Four-month redeterminations allow case managers to follow-up on MCO treatment referrals.

  - Indicate the positive results of the screen on the **DSS Consent to Release Confidential Alcohol and Drug Screening Information** form (Attachment II) to notify the MCO. Unlike the **MCO Consent for the Release of Confidential Alcohol and Drug Treatment Information** form which must be signed by all adult and minor parent TCA applicants or recipients, only those TCA adults and minor parents whose screen suggests a substance abuse problem or who self disclose a substance abuse problem must sign the **DSS Consent to Release Confidential Alcohol and Drug Screening Information** form.

- Provided the customer meets all other technical and financial eligibility factors, issue the TCA within 30 days of the application and authorize Medical Assistance (MA). Forward the consent form/s to the MCO through the local department MCO Liaison.

Forwarding Forms to the MCO

- Each local department has designated one person to act as a liaison between the MCOs in their jurisdiction and that local department. The MCO liaison (or his or her designee) is responsible for keeping controls on the consent forms and forwarding information to the MCOs. The MCO liaison or designee is also responsible for tracking information on compliance after a customer enrolls in a treatment program.

- After the case manager completes the application or redetermination, he or she files the record copy or copies of the consent form/s in the case record and gives the original consent form/s and other copies to the MCO liaison or designee.

- The MCO liaison or designee checks MMIS II to determine if the customer is enrolled in an MCO. If enrolled, the MCO liaison or designee writes the name of the MCO on the consent

forms and forwards them to the appropriate MCO. Effective June 1997, the MMIS II reflects MCO enrollment information. DHMH updates this information daily.

- If the customer has not enrolled in an MCO, the MCO liaison or designee keeps the consent forms in a tickler file and reviews MMIS II each week until the customer enrolls. Once the individual enrolls and the MCO information is available on MMIS II, the MCO liaison forwards the original and copies of the consent forms to the appropriate MCO in the jurisdiction.

- The MCO liaison or designee batches and forwards these forms to the MCO weekly. A list of the Statewide MCO liaisons is attached (Attachment III).

PHASE II. DHMH /MCO - SCREENING/TREATMENT REFERRALS

New MCO Enrollees:

- Once the DSS authorizes MA, DHMH issues the MA card and provides the enrollment broker with a list of new TCA customers daily. Within five days of notification, the enrollment broker sends the customer an enrollment packet with a notification to choose an MCO. The packet includes a Health Risk Assessment (HRA) form to be completed when the customer enrolls. The customer has 21 days from the date of mailing to choose an MCO, except recipients in foster care or kinship care who have 30 days from the date of mailing. If a choice is not made within the specified time frame, DHMH assigns the customer to an MCO. DHMH provides the MCOs a list of new enrollees on a daily basis with TCA recipients identified. Access to customer's MCO enrollment status is available in MMIS II.

- When the MCO receives an HRA form, they evaluate the customer's need for immediate service. Individuals who are considered high risk (such as pregnant or post-partum substance abusing women) are scheduled for an initial health screen within 10 - 15 days of the MCO's receipt of the HRA form.

- If the MCO receives no HRA form or the HRA form indicates that the individual is not at risk, the MCO shall schedule the new enrollee for an initial health screen with the assigned Primary Care Physician (PCP) within 90 days of the individual's enrollment in the MCO.

All TCA Customers Effective July 1, 1997

- All Medicaid enrollees, including TCA adults and minor parents, who complete an initial health screen at the MCO are screened for substance abuse by the primary care provider (PCP) as part of that initial health screen.

- If the screen reveals substance abuse, the PCP refers the customer for a more comprehensive substance abuse assessment by a provider qualified to determine the appropriate level and

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intensity of care needed. If substance abuse treatment is needed based on this assessment, the PCP or the comprehensive substance abuse assessment provider authorized to make treatment referrals refers the customer to an appropriate substance abuse treatment provider:

- When the MCO receives an MCO Consent for the Release of Confidential Alcohol and Drug Treatment Information form, the PCP (or designee) completes **PART I - Identification and Treatment Referral of the Substance Abuse Identification and Treatment Notification** form (Attachment IV). The actual form is still being developed by DHR in conjunction with DHMH and the MCOs. The attached draft is a prototype; the final form may contain additional sections to accommodate comprehensive assessment alternatives. The PCP forwards the original of this form to the substance abuse treatment provider. The PCP also forwards, along with the referral to the substance abuse treatment provider, a page of the enrollee's carbonized MCO **Consent for the Release of Confidential Alcohol and Drug Treatment Information** form.

- The PCP (or designee) forwards the second copy of the **Substance Abuse Identification and Treatment Notification** form to the DSS MCO liaison within 30 days of the date he or she refers the individual to treatment services.

If the individual has a positive substance abuse screen at the initial health screening with the PCP but fails to show up for the comprehensive substance abuse assessment, the PCP (or designee) notifies the DSS. The PCP (or designee) must complete **PART I - Identification and Treatment Referral of the Substance Abuse Identification and Treatment Notification** form within 30 days of the of the individual's missed appointment for the comprehensive substance abuse assessment and forward it to the DSS MCO liaison.

♦ If the PCP completes an initial health screen before receiving consent form/s from the DSS, or the enrollee is exempted from the initial health screen as a preestablished patient of the PCP, and the adult or minor parent TCA recipient screens positive for substance use, the PCP shall refer the customer for a comprehensive substance abuse assessment. If the results of the assessment are positive, the PCP or the comprehensive substance abuse assessment provider authorized to make treatment referral shall refer the customer to the appropriate treatment service. Upon receipt of the consent forms, the PCP shall consult the individual's medical record, complete the **Substance Abuse Identification and Treatment Notification** form based on information in that medical record, and forward the forms to the treatment provider and the DSS as described above.

♦ If an adult or minor parent TCA recipient does not complete the initial health screen within 90 days of enrollment, and the MCO receives a **DSS Consent to Release Confidential Alcohol and Drug Screening Information** form indicating that the DSS assessment revealed substance abuse, or that the individual self disclosed a substance abuse problem and is requesting a treatment referral, the MCO shall attempt to administer substance abuse screening and refer the customer for a comprehensive substance abuse assessment. If the MCO is successful in its

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outreach efforts and refers the individual for appropriate treatment, they shall notify the DSS as above.

- When a substance abuse treatment provider receives a referral and consent form for a TCA adult or minor parent from an MCO/PCP, the treatment provider must complete **PART II - Compliance Notification of the Substance Abuse Identification and Treatment Notification** form to notify the DSS within 30 days if the individual:

  - Is the subject of a referral for substance abuse treatment.
  - Fails to schedule and appear for initial appointment within 30 days of date of referral, or, if no appointment available within 30 days of referral, patient fails to schedule and appear for first available appointment,
  - Is awaiting an available vacancy,
  - Is enrolled in the treatment program,
  - Is not maintaining active attendance/participation, or
  - Has successfully completed the treatment program.

PHASE III: DSS - COMPLIANCE

- When the DSS receives a **Substance Abuse Identification and Treatment Notification** form from the MCO with positive substance abuse identification of an adult or minor parent TCA recipient, and the individual was referred for treatment services, the case manager flags the case to expect the treatment provider copy of the form in 30 days.

- Upon receipt of the treatment provider copy of the form, the case manager reviews **Part II - Compliance Notification** of the form to decide if the individual meets FIP substance abuse treatment provisions.

- If the individual identified in need of substance abuse treatment meets FIP substance abuse treatment compliance the TCA grant continues as long as the individual meets other TCA eligibility requirements. The case manager may exempt the individual from work activities if determined necessary by the treatment provider. The individual is considered in compliance if he or she:

  - Is awaiting availability of a treatment vacancy,
  - Is actively enrolled in an Alcohol and Drug Abuse Administration (ADAA) defined treatment program, or
  - Has successfully completed the treatment program.

- Local department case managers must place all adult and minor parent TCA recipients identified as having a substance abuse problem into redetermination cycles of no longer than four months. At each subsequent redetermination, the case manager will review the case file for verification of the customer's compliance with FIP substance abuse treatment

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provisions. If there is no verification in the case record, the case manager and local department MCO liaison must secure it. Verification requires that the individual's case record include the **Substance Abuse Identification and Treatment Notification** form (**Part II only**) completed by the treatment provider indicating compliance with the FIP substance abuse treatment provisions until the substance abuse treatment provider discharges the individual.

- If the individual who is identified in need of substance abuse treatment does not comply, the case manager sends notification to inform the individual that he or she does not meet FIP substance abuse treatment provisions. The individual is out of compliance if he or she:
  - Fails to keep initial health screen appointment at the MCO (after June 30, 1998)
  - Had a positive substance abuse screen at the MCO and has not enrolled in available and appropriate treatment, or
  - Is not attending/participating as defined by ADAA to maintain active enrollment in the treatment program.

- If the case manager or customer cannot verify that the individual is in compliance after 30 days, the case manager must remove the individual from the TCA grant. The individual shall remain active on MA provided he or she continues to meet eligibility for the program. For FS purposes, phantom income rules apply.

- If the individual is also the TCA head of household, pay the remainder of the TCA benefit to a third party until the individual provides a **Substance Abuse Identification and Treatment Notification** form from the MCO or the treatment provider to verify that he or she is in compliance.

AIMS PROCEDURES:

When the **Substance Abuse Identification and Treatment Notification** form is received, complete the following procedures:

- To identify a case with an individual affected by the substance abuse treatment provisions, on the AIMS 2 form, beside the "**Good Cause**" field, enter the code "SA" (for substance abuse). Applicable codes for "SA" are as follows:
  - "**01**" - when the individual is enrolled in the treatment program.
  - "**02**" - when the individual is awaiting an available vacancy.
  - "**03**" - when the individual has successfully completed the treatment program.
  - "**04**" - when the individual fails to enroll in appropriate and available substance abuse treatment.
  - "**05**" - when the individual fails to maintain active enrollment in appropriate and available substance abuse treatment.

- "06" - when the individual fails to complete the initial MCO health screening within the time specified by DHMH regulation (CODE IS ENTERED, BUT SANCTIONING IS NOT APPLICABLE UNTIL AFTER 6/30/98).

When a customer does not comply with the substance abuse treatment provisions, remove the individual from the TCA grant as follows:

- On the **AIMS 2**, close the individual using the following codes:
  - **094** - when an individual fails to complete the initial MCO health screening within the time specified by DHMH regulations (NOT APPLICABLE UNTIL AFTER 6/30/98)
  - **095** - when an individual fails to enroll in appropriate and available substance abuse treatment
  - **096** - when an individual fails to maintain active enrollment in appropriate and available substance abuse treatment.
- If the non-compliant individual is also the head of household, add a third party payee by entering a **"Y"** on the **AIMS 2** in the alternate information field 14. On the **AIMS 2/3 C**, enter the representative payee's name.
- Subtract the new TCA benefit amount from the TCA amount received prior to the sanction. Enter the difference on the **AIMS 3** in the **Unearned Income** section as type F10.

REMINDER: Shorten the certification end date on the **AIMS 2** to four months for ALL cases that have at least one individual who is affected by the substance abuse treatment provisions (including those who are in compliance).

The sanctioned individual remains eligible for medical coverage provided he or she continues to meet eligibility for the program.

The case manager must close the household's medical assistance with the appropriate code on the DHMH 8000 form if a customer does not complete the TCA recertification process at 4 months.

NARRATE ALL CASE ACTIVITY.

<u>CARES PROCEDURES</u>:

When the **Substance Abuse Identification and Treatment Notification** form is received, complete the following procedures:

- To identify a case with an individual affected by the substance abuse treatment provisions, enter on the individual's **DEM1** screen in the **HOSPITAL** field:
  - **"SA1"** - when the individual is enrolled in the treatment program.

08-15-1997 08:22AM FROM DMU-SRT

- "SA2" - when the individual is awaiting an available vacancy.
- "SA3" - when the individual has successfully completed the treatment program.
- "SA4" - when the individual fails to enroll in appropriate and available substance abuse treatment.
- "SA5" - when the individual fails to maintain active enrollment in appropriate and available substance abuse treatment.
- "SA6" - when the individual fails to complete the initial MCO health screening within the time specified by DHMH regulation (CODE IS ENTERED, BUT SANCTIONING IS NOT APPLICABLE UNTIL AFTER 6/30/98).

When a customer does not comply with the substance abuse treatment provisions, remove the individual from the TCA grant as follows:

- Enter on the non-compliant individual's UINC screen the amount of the sanction (the difference between the amount of the grant for the household size with the individual and without) as:
  - "OA" (Other Countable, Cash Only) - The grant will then be in the correct amount for the sanctioning and still allow medical coverage.

    AND
  - "OF" (Other Countable, Food Stamps Only) - This will maintain the FS allotment at the level prior to the sanction.
  - Enter "OT" for the verification amount and "AC" for the frequency.

- On the CAFI screen, press PF13 and enter the appropriate text and COMAR citation:
  - For SA4 - "<INDIVIDUAL'S NAME> FAILED TO ENROLL IN APPROPRIATE AND AVAILABLE SUBSTANCE ABUSE TREATMENT. COMAR 07.03.03.15E(1)(b)."
  - For SA5 - "<INDIVIDUAL'S NAME> FAILED TO MAINTAIN ACTIVE ENROLLMENT IN APPROPRIATE AND AVAILABLE SUBSTANCE ABUSE TREATMENT. COMAR 07.03.03.15E(1)(c)."
  - For SA6 - "<INDIVIDUAL'S NAME> FAILED TO COMPLETE THE INITIAL MCO HEALTH SCREENING WITHIN THE TIME SPECIFIED BY DHMH REGULATION. COMAR 07.03.03.15E(1)(a)." (NOT APPLICABLE UNTIL AFTER 6/30/98.)

- If the non-compliant individual is also the head of household, add a third party payee to the AREP screen for TCA with Rep Type "P1" and issue an EBT card to that person.

REMINDER: Shorten the redet.end date to reflect the required four month certification period for ALL AUs that have an individual affected by the substance abuse treatment provisions (including those who are in compliance).

The sanctioned customer remains eligible for medical coverage provided he or she continues to meet eligibility for the program.

NARRATE ALL CASE ACTIVITY.

INQUIRIES/FEEDBACK/SUGGESTIONS:

Call or write: Phyliss J. Arrington, FIA Policy Specialist
Office of Policy and Research
311 W. Saratoga Street
Room # 642
Baltimore, MD 21201
(410) 767-7079

Call Joyce Westbrook on (410) 767-8735 for CARES / AIMS inquiries.

cc: DHR Executive Staff
DHMH Executive Staff
FIA Management Staff
FIA Trainers
Constituent Services
OIM Help Desk
CTF

ATTACHMENT I

CONSENT FOR THE RELEASE OF
CONFIDENTIAL ALCOHOL AND DRUG TREATMENT INFORMATION
by Managed Care Organizations to Departments of Social Services

LA Case # ____________________ DSS Office: ________________________________

I, ____ authorize the managed care
(Print name of adult or minor parent TCA applicant or recipient)
organization that I am or will be enrolled in ("the MCO"), a provider chosen by the MCO, and any provider that I may be referred to for substance abuse assessment or treatment, to report to the Department of Social Services ("DSS") office named above the information listed below, if it has this information about me:

- That I failed to appear for an initial appointment scheduled by my MCO within 90 days of enrollment. (This provision effective after June 30, 1998.)
- That my initial substance abuse screen, follow-up diagnostic testing or treatment by the MCO or one of its providers shows that I have a substance abuse problem;
- That I did not keep an appointment for a comprehensive substance abuse assessment ordered by the MCO or one of its providers;
- That a comprehensive substance abuse assessment indicates that I am not in need of substance abuse treatment.
- That the MCO or one of its providers has referred me for substance abuse treatment;
- That a substance abuse treatment provider has received my consent form and referral for treatment from the MCO or one of its providers;
- That I did not schedule or appear for my first appointment for substance abuse treatment because I:
  - did not schedule the first appointment within 15 days of referral; or
  - did not, within 15 days of the missed appointment, make a new appointment; or
  - did not appear for an appointment I made to make up for the missed appointment.
- That I am waiting for there to be room for me in the kind of substance abuse treatment program I was referred to;
- That I am enrolled in a substance abuse treatment program that I was referred to by my MCO;
- That I am not "actively enrolled" in a substance abuse treatment program (because I have not come to the program's sessions or appointments on a regular basis); and
- That I successfully completed the substance abuse treatment that I was referred to.

This release is necessary to comply with State law which requires that this information has to be reported to your local DSS office if you are going to receive Temporary Cash Assistance (TCA) benefits.

I understand that my records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and cannot be reported to anyone without my written consent unless those regulations provide otherwise. I also understand that I can cancel this consent at any time, but the cancellation will not apply to the past acts of someone who was covered by this consent at the time and relied on it: if I do cancel this consent, I could lose my TCA benefits. In any case, this consent will automatically be canceled when my TCA benefits end.

Dated: ____________ ____
(Signature of adult or minor parent TCA applicant or recipient)

PROHIBITION OF REDISCLOSURE

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part2). The federal rules prohibit any further disclosure of this information unless expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse treatment patient.

______________________ DEPARTMENT OF SOCIAL SERVICES

CONSENT TO RELEASE CONFIDENTIAL ALCOHOL AND DRUG SCREENING INFORMATION TO COMPLY WITH THE WELFARE INNOVATION ACT OF 1997

CUSTOMER NAME______________________ **MA CASE #**______________

Managed Care Organization______________________________________

I, ____ authorize.
(Print name of adult or minor parent TCA applicant or recipient)

the Department of Social Services (DSS) to disclose to the Managed Care Organization specified above, in which I am enrolled, the following information:

☐ The results of substance abuse screening performed during the employability assessment at the DSS office are positive.

☐ I acknowledge that I have a substance abuse problem and request a referral for treatment.

The purpose of the disclosure authorized herein is to comply with the State law requiring disclosure of this information in order to receive Temporary Cash Assistance benefits under the Family Investment Program.

I understand that my records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, that if I revoke my consent, I may lose my Temporary Cash Assistance benefits, and that in any event this consent expires automatically upon my termination from the Temporary Cash Assistance Program.

Dated:______________ ______________________________________
(Signature of adult or minor parent TCA applicant or recipient)

Prohibition of Redisclosure

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug treatment patient.

LOCAL DEPARTMENT OF SOCIAL SERVICES
MANAGED CARE ORGANIZATION LIAISONS

LOCAL DEPARTMENT / DISTRICT OFFICE	NAME	PHONE# / FAX#
Allegany County	Roxanne Lynch	(301) 777-2062
Anne Arundel County		
Baltimore County	Carole Ziegler Lisa Montford	(410) 887-2314 (410) 887-6204
Calvert County	Doris Freeland	(410) 535-8734
Caroline County	Rayshelle Robinson	(410) 479-5900
Carroll County	Phyllis Seipp	(410) 857-6214 FAX 857-6313
Cecil County	Dorothea Phillips	(410) 996-0656
Charles County	Mary Hazel	(301) 934-6641
Dorchester County	George Barnett	(410) 228-5100 ext. 201
Frederick County	Christine Bickle	(301) 694-2405
Garrett County	Linda Ashby	(301) 334-9461
HARFORD COUNTY Aberdeen Bel Air	 Patricia Junchiewicz Sandra Watson	 (410) 272-9081 (410) 836-4791
Howard County	Katherine Ward	(410) 872-4200 ext.320
Kent County	Shirley Williams	(410) 778-0820
Montgomery County	Carol Pearson	(301) 468-4009
PRINCE GEORGE'S Camp Springs Hyattsville Palmer Park RISE Program	 Bob Frere Jeffrey Ntoi Janice Causey Joy Etukudo Lelia Moody	 (301) 449-2552 (301) 449-2514 FAX 449-2558 (301) 422-5048 FAX 422-5097 (301) 341-2810 FAX 341-2819 (301) 386-5522 ext.128 FAX 386-5533
Queen Anne's County	Beatrice Embry	(410) 758-5111
Saint Mary's County	Jennine Miller	(301) 475-4831 FAX 475-4799
Somerset County	Kathy Thomas	(410) 651-5346
Talbot County	Joyce Alderman	(410) 822-7802 FAX 820-7067
Washington County	Karen Worthington Ruth Fuller	(301) 739-8491 (301) 791-3464
Wicomico County	Robert Drudge	(410) 543-6814
Worcester County	Martha McGee	(410) 632-4525 FAX 632-3542
Baltimore City	Karen Matheson Janet Richardson	(410) 361-3920 (410) 361-6229 FAX 361-6254

SUBSTANCE ABUSE IDENTIFICATION AND TREATMENT NOTIFICATION

PATIENT NAME____________________________ MA CASE #____________________

Local Department of Social Services/Office______________________________________

PART I - IDENTIFICATION & TREATMENT REFERRAL (To be completed by MCO or PCP)

☐ 1. After June 30, 1998, failed to appear for initial health screen appointment scheduled by MCO or PCP within 90 days of enrollment

☐ 2. Substance abuse problem indicated by positive initial screen, follow-up diagnostic testing, or treatment

☐ 3. Failed to keep appointment for comprehensive substance abuse assessment

☐ 4. Comprehensive assessment indicates patient not in need of substance abuse treatment

☐ 5. Patient referred to:______________________________ on______________
(substance abuse treatment program) Date

____
(Signature of MCO/PCP Designee)

PART II - COMPLIANCE NOTIFICATION (To be completed by substance abuse treatment provider)

☐ 1. Date treatment provider received consent form and referral from MCO/PCP______________

☐ 2. Patient failed to schedule or appear for initial appointment by:
– not scheduling an initial appointment within 15 days of referral;
– not appearing for scheduled initial appointment and then not rescheduling within 15 days of the missed appointment; or
– not appearing for a rescheduled missed initial appointment

☐ 3. Awaiting available vacancy

☐ 4. Enrolled in treatment program

☐ 5. Not maintaining active attendance/participation

☐ 6. Successfully completed program

*Admission date;*____________________ *Discharge date*____________________

Patient able to work? ☐ YES ☐ NO

____
(Signature of Treatment Provider) Date

Inquiry LINE

Which states test welfare recipients for substance abuse?

The Personal Responsibility and Work Responsibility Act of 1996 (P.L. 104-193) allows states to test Temporary Assistance for Needy Families applicants for drug use. So far, Kansas, Louisiana, Maryland, Michigan, New Jersey and New York have enacted legislation to screen TANF recipients.

Kansas House Bill 2423, enacted in 1996, established a pilot project for alcohol and drug screening within the KanWork Program. Employment Preparation Services case managers interview all participants. If screening indicates substance abuse, participants are referred to Regional Alcohol and Drug Assessment centers. Further drug screening, assessment and treatment are mandatory. Those who do not cooperate are subject to sanctions and work program penalties.

Maryland implemented similar drug screening for participants of Temporary Cash Assistance under the Family Investment Program. Local departments of Social Service ask applicants standard questions to detect abuse. Participants also must submit to an initial health screening by a managed care organization. Any substance abuse detected is assessed.

Under New York's former Home Relief welfare plan, counties in New York could test applicants if there was a reason to believe that unemployment was due to substance abuse. The recently enacted Safety Net program screens all applicants and refers those who have substance abuse problems to professionals for assessment and mandatory treatment. Recipients with substance abuse problems are eligible only for noncash benefits.

Recipients of WorkFirst New Jersey who have been convicted of distributing, possessing or using controlled substances are ineligible for benefits. WorkFirst recipients convicted of possession or use of drugs may be eligible for benefits upon successfully completing a substance abuse treatment program. After 60 days of treatment, these recipients must submit to drug tests. If the test indicates drug use, benefits are immediately terminated and the recipient must complete another treatment program and test "drug free" for 60 days to become eligible for benefits.

Ohio passed HB 167 in 1996 to require pregnant women on Healthy Start or Medicaid enrolled in managed care to submit to drug screening. The screening is conducted at the earliest prenatal visit and throughout the pregnancy. The screening instrument is conducted by Medicaid service providers or doctors. Treatment is mandated if there is an indication of substance abuse. — *Mary Bone, SIC manager*

For further detailed information on this issue, contact the States Information Center. The SIC provides an inquiry and reference service to the states. Our staff responds to information requests from state government officials and staff on a variety of issues. The SIC provides confidential responses to constituent inquiries within 48 hours. You can contact the SIC directly at (606) 244-8253, or email at sic@csg.org.

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- Learn more about persons you have interviewed than they have told you.
- Learn complete employment history of the applicant.
- Find missing persons and learn how to discover the true background of anyone.

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16600 Sprague Road • P.O. Box 30339 • Cleveland, OH 44130

New Jersey Dept. of Human Services
Div. of Family Development

siblings (2nd degree), great-grandparents (3rd degree), uncles or aunts (3rd degree), nephews or nieces (3rd degree), great-great grandparents (4th degree), great-uncles or aunts (4th degree), first cousins (4th degree), great-great-great grandparents (5th degree), great-great uncles or aunts (5th degree), or first cousins once removed (5th degree). (A first cousin once removed is the child of a person's first cousin.)

(1) An applicant who is a parent-person may apply for WFNJ/TANF benefits for a child(ren) and him or herself as a needy parent-person.

(2) Non-needy caretakers and/or parent persons shall also be eligible to apply for WFNJ/TANF benefits for the children in their care.

ii. Spouses of any persons named in the above groups may be considered "parent-persons" even though the marriage has been terminated by death or divorce.

iii. Under New Jersey law, relatives of persons who adopt children become legally related to such adopted children to the same extent that they are related to natural children of the adopting parent.

(b) Composition of the eligible WFNJ/GA assistance unit is as follows:

1. The WFNJ/GA assistance unit shall be comprised of one or more persons. In most cases, it will consist of a single individual, 18 years of age or over, or a couple without dependent children. In room and board or residential treatment situations, each person is an eligible unit of one. In all other situations, the eligible assistance unit shall consist of:

i. The applicant/recipient;

ii. The spouse of the applicant/recipient who lives in the home unless the spouse is receiving SSI or public assistance through another program; or,

iii. The person with whom the applicant/recipient lives as a couple (but only if there was a previous history or current history of support) unless such person is receiving SSI or public assistance through another program.

10:90-2.8 Individuals ineligible for WFNJ TANF/GA

(a) The following persons shall not be eligible for assistance and shall not be considered to be members of the WFNJ/TANF or WFNJ/GA assistance units:

1. Non-needy caretakers, except that the eligibility of a dependent child shall not be affected by the income or resources of a non-needy caretaker;

2. Supplemental Security Income recipients, except for the purposes of receiving emergency assistance benefits;

3. Illegal aliens;

4. Other aliens who are not eligible aliens as defined in N.J.A.C. 10:90-2.10;

5. A person absent from the home who is incarcerated in a Federal, State, county or local corrective facility or under the custody of correctional authorities;

6. A person who is fleeing to avoid prosecution, custody or confinement after conviction, under the laws of the jurisdiction from which the person has fled, for a crime or an attempt to commit a crime which is a felony or a high misdemeanor under the laws of the jurisdiction from which the person has fled; or is violating a condition of probation or parole imposed under Federal or State law;

   i. Under the laws of the State of New Jersey, a crime is defined at N.J.S.A. 2C:1-4(a) as "an indictable offense...for which a sentence of imprisonment in excess of 6 months is authorized."

7. A person convicted on or after August 22, 1996 under Federal or State law of any offense which is classified as a felony, high misdemeanor or crime, under the laws of the jurisdiction involved and which has as an element the distribution, possession, or use of a controlled substance as defined in section 102 (6) of the Federal "Controlled Substances Act" (21 U.S.C. Section 802 (6)).

   i. Under the laws of the State of New Jersey, a crime is defined at N.J.S.A. 2C:1-4(a) as "an indictable offense ... for which a sentence of imprisonment in excess of 6 months i. authorized."

   ii. A person convicted on or after August 22, 1996 o any such offense which has as an element the possession or use only of such a controlled substance may be eligible for benefits if the person has successfully completed a drug abuse treatment program licensed by the State of New Jersey Department of Health and Senior Services (DHSS), at the conclusion of which the person is certified drug free by an authorized program representative.

      (1) Eligibility for benefits shall commence upon successful completion of the established requirements of the DHSS licensed drug treatment program.

      (2) During the first 60 days after successful completion of the drug treatment program or at the time of application or case redetermination, it must be determined, via testing by an entity designated by DFD, that the person is free of any non-prescribed controlled substance. If the person is determined not to be free of any controlled substance during, or at the conclusion of, the 60 day period, the person's eligibility for benefits shall be terminated immediately.

(A) Benefits cannot be granted or reinstated until the person completes another drug treatment program, and remains drug free for a minimum of 60 days and is determined via testing to be free of any non-prescribed controlled substance.

8. A person found, on or after August 22, 1996, to have willfully and knowingly fraudulently misrepresented his or her residence in order to obtain means-tested, public assistance benefits in two or more states or jurisdictions, shall be ineligible for benefits for a period of 10 years from the date of conviction in a Federal or State court.

9. A person who, after July 1, 1997 and provided that the person has received written notice informing them of the WFNJ disqualification penalties, intentionally makes a false or misleading statement or misrepresents, conceals or withholds facts for the purpose of receiving benefits shall be ineligible for benefits for a period of six months for the first violation, 12 months for the second violation, and permanently for the third violation.

10. In addition to 1 through 9 above, persons found eligible for or who are recipients of WFNJ/TANF, or who have been found ineligible for such programs due to voluntary refusal to comply with program requirements shall not be eligible for WFNJ/GA assistance.

(b) WFNJ benefits shall not be payable for any month in which any individual in the assistance unit is participating in a strike. The individual who is on strike is ineligible for benefits; however, other members of the assistance unit remain eligible for benefits.

1. The term "strike" includes any strike or other concerted stoppage of work by employees (including a stoppage by reason of expiration of a collective bargaining agreement) and any concerted interruption of operations by employees.

2. The term "participating in a strike" means an actual refusal, in concert with others, to provide services to one's employers.

3. Examples of non-strikers who are eligible to participate in the program include, but are not limited to:

i. Employees whose workplace is closed by an employer in order to resist the demands of employees (for example, lockout);

ii. Employees unable to work as a result of striking employees (for example, truck drivers who are not working because striking pressmen prevent newspapers from being printed); or,

iii. Employees who are not part of the bargaining unit on strike who do not want to cross the picket line due to fear of personal injury.

10:90-2.9 Definition of employable/unemployable persons in WFNJ/GA

(a) Definition of employable/unemployable persons for determination of payment level:

SUBCHAPTER 2 NON-FINANCIAL ELIGIBILITY REQUIREMENTS

10:90-2.8 INDIVIDUALS INELIGIBLE FOR WFNJ TANF/GA
10:90-2.8(a)7 Drug Felons

Cross-references: DFD Instruction No.97-1-10
DFD Instruction No.97-3-8

Cash assistance will be denied to any person convicted on or after August 22, 1996 of an offense which has as an element the distribution, possession or use of a controlled substance as defined in section 102(6) of the Federal "Controlled Substances Act" and the conviction was:

a. in the case of a conviction or convictions under the laws of the State of New Jersey, of an offense defined as a crime under N.J.S.A 2C:1-4(a) (in general, for New Jersey, a crime is defined as an offense that is indictable and that carries the potential for a sentence of imprisonment in excess of six months); or

b. in the case of a conviction or convictions under Federal law or the laws of another State, of an offense classified as a felony or crime, as appropriate, in the jurisdiction involved.

A person convicted only of possession or use of a controlled substance may be determined eligible for benefits if he/she successfully completes a drug treatment program licensed by the New Jersey Department of Health and Senior Services (NJDHSS). (A listing of NJDHSS *licensed* drug treatment programs follows this section). However, such recipient must test drug free during the following 60-day period after completion of the program or public assistance benefits will be terminated. If the recipient does not test drug free and is terminated from WFNJ, in order to reapply and be determined eligible, the client must complete another *licensed* drug treatment program and test drug free for a period of sixty days before eligibility for WFNJ/TANF/GA can be established. Therefore, in order to begin or continue receiving WFNJ benefits, the individual must submit to drug testing by a DFD approved entity that must certify that the individual is drug free.

Benefits may be issued during the first 60 days after completion of the drug treatment program or at the time of application or redetermination as appropriate if the drug treatment program has already been completed by the individual, but it must be determined through testing that the individual is drug free. Failure of the drug test will result in termination of WFNJ benefits.

DFD does not yet have a drug testing entity in place. Therefore, in the interim, applicants and recipients who have completed a NJDHSS licensed drug treatment program who are otherwise eligible may be granted WFNJ benefits.

Pending the establishment of the drug testing procedures, county/municipal agencies should maintain a listing of all such individuals, so that when the testing procedure is in place, such individuals can be referred for drug testing.

The applicant/recipient must be given the Work First New Jersey Drug Treatment Report Form to take to the NJDHSS licensed center where he/she is completing or has completed the drug treatment program for documentation and verification. This completed form is to be retained in the case record file.

An Affidavit of Work First New Jersey Non-Criminality must be completed by the assistance unit applicant(s)/recipients(s) at time of application and redetermination. This self-declaration form must be attached to the application/redetermination form and retained in the case record.

If the applicant/recipient is unsure of his/her or any assistance unit member's status with respect to the statements on the affidavit, the worker should, *after the applicant/recipient signs the form, have the client note the uncertainty of their status on the form.* The agency shall forward a copy of this type of completed affidavit to their DFD field representative for follow up.

Please note that for Food Stamp purposes only, questions regarding the above provisions are already included in the PA-1J and the PA-1J(A). These forms will be modified in the future to reflect the applicability of these provisions to both WFNJ and the Food Stamp Program.

Ineligibility for cash assistance as a result of the provisions related to drug convictions willl not adversely affect the individual's Medicaid eligibility.

S:\working\2-8elig1.doc

WFNJ-30
(Now 7-97)

WORK FIRST NEW JERSEY DRUG TREATMENT REPORT FORM

AGENCY ______________________________

CASE NUMBER ____________ SS NUMBER ____________

CLIENT NAME ______________________________

____

Certification by Drug Treatment Facility

____

NAME OF TREATMENT CENTER ______________________________

STATE OF NEW JERSEY LICENSED REGISTRATION NUMBER ____________

ADDRESS ______________________________

____

TELEPHONE NO. ____________ CONTACT PERSON ____________

DATE TREATMENT BEGAN ______________________________

TREATMENT PROGRAM COMPLETED? YES NO IN PROGRESS

DATE TREATMENT CONCLUDED ______________________________

TYPE OF DRUG PROBLEM ______________________________

SUBSEQUENT TESTING DATE ______________________________

RESULTS? POSITIVE NEGATIVE

SUBSEQUENT TESTING DATE ______________________________

RESULTS? POSITIVE NEGATIVE

____

____

AUTHORIZED AGENCY REPRESENTATIVE SIGNATURE

I hereby certify that this report is true and accurate

____

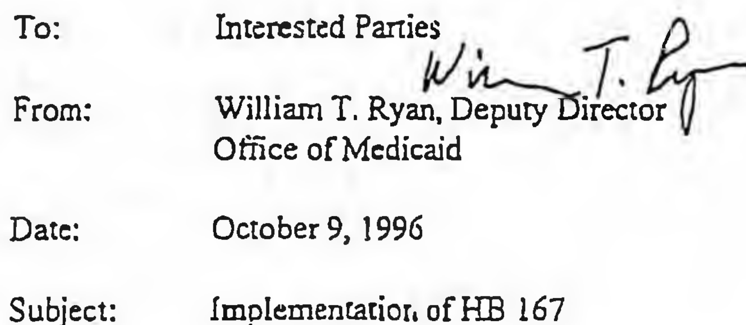
DATE

George V. Voinovich
Governor

Arnold R. Tompkins
Director

Ohio Department of Human Services

30 East Broad Street, Columbus, Ohio 43266-0423



To: Interested Parties

From: William T. Ryan, Deputy Director
Office of Medicaid

Date: October 9, 1996

Subject: Implementation of HB 167

On October 1, 1996, the drug screening provisions of HB 167 became effective. These provisions have been broadly shared with stakeholders, and through this sharing process we have received valuable input that has helped shape how these provisions are implemented. The implementation strategy continues to evolve as we attempt to be responsive to local needs.

As I send this to you today, ODHS has approved rules to implement these statutory provisions for drug screening. The Department recently received significant legislative input concerning the effective date for the implementation of sanctions for noncompliance with the drug screening/treatment provisions. The Department will soon issue a transmittal that will accompany a refiling of the sanctions rule that delays the implementation date of the sanctioning provisions.

While implementation of the sanction process is delayed, other requirements referenced in the rules remain in effect. These include screening, referral, assessment, treatment, and reporting activities. The Department intends to modify only the sanction process at this time.

The changes in the sanctioning provisions have required modifications in the materials and forms many of you received at the September drug screening training sessions. Revised forms, including the prescribed screening instrument, statement of attendance, and PMSP consent for release of information, are attached. These revised forms and accompanying instructions replace any earlier versions that you received.

I appreciate your interest and continuing attention to the implementation of the drug screening provisions of HB 167. Staff from the department of Human Services, Alcohol and Drug Addiction Services, and Health look forward to working with you to ensure that Ohio's pregnant ADC and Healthy Start women and their infants are healthy and drug-free.

attachments

CONSENT FOR RELEASE OF INFORMATION

I __(name of enrollee)__ authorize __(PMSP)__ to release the following information and records held by __(PMSP)__ to __(AOD)__ for the purpose of assessment by the __(AOD)__ as to whether I need alcohol or other drug rehabilitation services. It has been explained to me that release of this information is required by Ohio law in order to comply with section 5111.017 of the Revised Code. This section of the Revised Code applies to pregnant women living in a county where they are required to enroll in a managed care program. I understand that this statute requires me to cooperate in being assessed regarding a possible need to receive treatment for alcohol or other drugs. The following information and records are to be released:

____
____
____
____
____
____

I understood that this release can be used only for the purpose of providing information for this assessment. This release will expire no later then twelve months from the date of your signature below.

______________________________ Signature of Enrollee

______________________________ Date

______________________________ Signature of Witness

ODHS 3501 (10/96)

STATEMENT OF ATTENDANCE AT AOD ASSESSMENT/TREATMENT

IMPORTANT INFORMATION FOR PREGNANT WOMEN

If you use alcohol or other drugs while you are pregnant, you and your unborn baby could both have serious health problems. The State of Ohio wants to do everything possible to help assure that both you and your baby are healthy. So, there is now a law in Ohio (Ohio Revised Code 5111.017) for pregnant women on Healthy Start or ADC Medicaid who live in a county where they must enroll in an HMO. If you live in Butler, Cuyahoga, Franklin, Hamilton, Lucas, Montgomery or Summit counties and are on Healthy Start or ADC Medicaid, this information applies to you. The law says that you must be screened and if indicated assessed for the abuse of alcohol and other drugs while you are pregnant. If it is found that you may be abusing alcohol or other drugs during your pregnancy, you must go for treatment of your alcohol and drug abuse.

1. Enrollee's name	2. Enrollee's Medicaid Billing Number

TO BE COMPLETED BY THE PMSP (Prenatal Medical Service Provider):

3. PMSP's Name		8. PMSP's Signature
4. Address		9. Scheduled date of the AOD assessment ___/___/___
5. Today's date	6. Fax No.	10. Date the Statement of Attendance was given to enrollee
	7. Phone No.	
11. The enrollee has signed a release of information form that permits the PMSP to share information regarding her need for assessment. Consent form is attached. (Check one.)		Yes / No

TO BE COMPLETED BY THE AOD PROVIDER WHO PERFORMED THE ASSESSMENT:

12. AOD Provider's Name		18. AOD Provider's Signature
13. Address		19. AOD Provider's Certification/License No.
14. Today's date	15. Fax no.	
	16. Phone no.	20. Outcome: [ ] No follow-up required. [ ] Follow-up required and enrollee will return to this practice for treatment. [ ] Follow-up required and referral has been made to the provider listed below on ___/___/___ at ______. (Date) (Time)
17. Enrollee Attendance: [ ] Enrollee attended assessment on ___/___/___. [ ] Enrollee did not attend assessment.		
21. The enrollee has signed a release of information form that permits the AOD provider to share information regarding her need for treatment. Consent form is attached. (Check one.)		Yes / No

TO BE COMPLETED BY THE AOD PROVIDER WHO PERFORMED THE ASSESSMENT:

22. AOD Provider's Name		28. AOD Provider's Signature
23. Address		29. AOD Provider's Certification/License No.
24. Today's date	25. Fax no.	
	26. Phone no.	30. Outcome: [ ] No follow-up required. [ ] Follow-up required and enrollee will return to this practice for treatment. [ ] Follow-up required and referral has been made to the provider listed below on ___/___/___ at ______. (Date) (Time)
27. Enrollee Attendance: [ ] Enrollee attended assessment on ___/___/___		

INSTRUCTIONS FOR COMPLETION OF THE STATEMENT OF ATTENDANCE FORM (ODHS 3501)

The completed form must be reviewed with the enrollee. A copy of this form and educational material explaining the adverse affects of alcohol and other drugs on pregnant women must be given to the enrollee.

Items 1 - 13 and item 16 are to be completed by the Prenatal Medical Service Provider.

Item 1 **Enrollee's name:** Enter the enrollee's name as shown on the HMO card.

Item 2 **Enrollee's Medicaid Billing Number:** Enter the 12 digit Medicaid billing number. You will find this number either on the enrollee's HMO card or you may get it from the HMO.

Item 3 **PMSP's Name:** Enter the Prenatal Medical Service Provider's name.

Item 4 **Address:** Enter the PMSP's street address, city, and state.

Item 5 **Today's date:** Enter today's date.

Item 6 **Fax no.:** Enter the PMSP's fax number.

Item 7 **Phone no.:** Enter the PMSP's telephone number.

Item 8 **PMSP's Signature:** Enter the signature of the Prenatal Medical Service Provider (PMSP).

Item 9 **Scheduled date of the AOD assessment:** Enter the date the assessment for the suspected abuse of alcohol and other drugs has been scheduled for the enrollee, if needed.

Item 10 **Date the Statement of Attendance was given to enrollee:** Enter the date the signed Statement of Attendance was given to the enrollee.

Item 11 **Consent form statement:** Check "Yes" if the enrollee has signed a release of information form permitting the PMSP to share information regarding her need for assessment. Check "No" if the enrollee has not signed a release of information form.

Any items not already completed in Items 12 - 21 are to be completed by the AOD provider who performed the assessment.

Item 12 **AOD Provider's Name:** Enter the name of the AOD provider who performed the AOD assessment.

Item 13 **Address:** Enter the street address, city, and state of the AOD provider who performed the AOD assessment.

Item 14 **Today's date:** Enter today's date.

Item 15 **Fax no.:** Enter the fax number of the AOD provider who performed the AOD assessment.

Item 16 **Phone no.:** Enter the telephone number of the AOD provider who will perform the AOD assessment.

Item 17 **Enrollee Attendance:** Place a check by the appropriate line. If enrollee did attend the assessment, enter the date the assessment was performed.

Item 18 **AOD Provider's Signature:** Enter the signature of the AOD provider who performed the AOD assessment. This signature verifies that the enrollee has signed a consent for release of information that permits the PMSP to share information regarding her need for treatment and that a consent form is attached.

Item 19 **AOD Amassment Certification/License No.:** Enter the certification or license number of the AOD provider who performed the AOD assessment.

Item 20 **Outcome:** Place a check by the appropriate line. *If follow-up is required and will be provided by an AOD provider other than the provider giving the assessment, complete the date and time of the scheduled treatment appointment and complete Items 21, 24, and 28.*

Item 21 **Consent form statement:** Check "Yes" if the enrollee has signed a release of information form permitting the AOD provider to share information regarding her attendance at the assessment and her need for treatment. Check "No" if the enrollee has not signed a release of information form.

Lines 22 - 30 are to be completed by AOD provider who performs any subsequent treatment. If the AOD provider who performs the treatment is the same as the AOD provider who performed the assessment, Items 21- 30 may be omitted.

Item 22 **AOD Provider's Name:** Enter the name of the AOD provider who performed the AOD treatment.

Item 23 **Address:** Enter the street address, city, and state of the AOD provider who performed the AOD treatment.

Item 24 **Today's date:** Enter today's date.

Item 25 **Fax no.:** Enter the AOD provider's fax number

Item 26 **Phone no.:** Enter the telephone number of the AOD provider who will perform the AOD treatment.

Item 27 **Enrollee attendance:** Place a check by the appropriate line. If enrollee did attend the treatment, enter the date the initial treatment was performed.

Item 28 **AOD Provider's Signature:** Enter the signature of the AOD provider who performed the AOD treatment. This signature verifies that the enrollee has signed a consent for release of information that permits the PMSP to share information regarding her need for treatment and that a consent form is attached.

Item 29 **AOD Treatment Provider's Certification/License No.:** Enter the certification or license number of the AOD provider who performed the AOD treatment.

Item 30 **Outcome:** Place a check by the appropriate line. If enrollee required further treatment and referral was made to a subsequent AOD treatment provider, enter the scheduled date for treatment

ODHS 3500 9/96

SCREENING INSTRUMENT

ALCOHOL AND OTHER DRUG ABUSE

Instructions for conducting the structured interview:

Interviewer

The screening instrument is designed to be used as part of a structured interview with all pregnant women on ADC or Healthy Start Medicaid, enrolled in an HMO in a mandatory enrollment county. The interview will be conducted at the earliest possible prenatal visit and also at subsequent visits if, in the Prenatal Medicaid Service Provider's (PMSP) professional judgement, such screening is indicated. The instrument can be administered by PCPs, ob-gyns and other providers permitted by state law to provide prenatal medical care and who are rendering services as an MCP subcontractor. In addition, other licensed or certified health care practitioners who are under the general supervision of a subcontracting PMSP may administer the screen.

1. Begin by reading the Interviewer Statement (attached) to the enrollee and giving her the information sheet that explains the importance of this screening. Ask her if she has questions.

2. Ask each of the four (4) open-ended questions and note your professional observations. These questions are intentionally structured to be open-ended to prompt further discussion.

3. Refer to the Observation Checklist. Note your professional observations.

4. Based on your observations and discussion prompted by the screen and structured interview process, use your professional judgement to determine if the enrollee requires an assessment for possible alcohol and other drug abuse.

5. Talk to the enrollee about your observation and determination.

6. Document on the screening instrument your determination of a need for, or no need for, a referral for assessment.

7. Refer the enrollee to an alcohol or other drug provider for an assessment, if appropriate, by making the appointment for a clinical assessment.

8. Complete the bottom of the screening instrument including enrollee's name, signatures and date.

9. If a referral is made, complete the Statement of Attendance Form giving a copy to the enrollee and faxing a copy to the alcohol and other drug provider scheduled to perform the clinical assessment.

Glossary

Alcohol or Other Drug Abuse- Abuse of one or more of the following mood altering

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SCREENING INSTRUMENT

ALCOHOL AND OTHER DRUG ABUSE

Interviewer Statement

There is now a law in Ohio (Ohio Revised Code 5111.017) for pregnant women on ADC or Healthy Start Medicaid who live in a county where they must enroll in an HMO. This law says that any woman in this group must be screened for the abuse of alcohol and other drugs while she is pregnant. Based on the results of your screen, or in the judgement of your Prenatal Medical Services Provider (PMSP), you could be referred to an alcohol and other drug treatment provider for an assessment and treatment, if needed. I am giving you an information sheet that explains why this screening is important. Do you have any questions?

I am going to ask you a few questions about your use of alcohol and other drugs (including prescription drugs). This does not include the use of tobacco products. Based on your answers to these questions, we may refer you to get a complete assessment.

1. Have you ever felt you have used too much alcohol or other drugs?
   Comments:

2. Have you ever tried to cut down or quit drinking or using other drugs?
   Comments:

3. Has the use of alcohol or other drugs caused problems in your life?
   Comments:

4. Have you used any alcohol or other drugs that may cause you concern now that you are pregnant?
   If yes, what are you concerned about?

Observation Checklist

The following signs and symptoms may indicate alcohol and other drug abuse problems in the enrollee being screened; note if observed:

- Needle track marks
- Skin abscesses, cigarette burns, or nicotine stains
- Tremors (shaking and twitching of hands and eyelids)
- Unclear speech: slurred, incoherent, or too rapid
- Runny nose, sniffing
- Unsteady gait: staggering, off balance
- Dilated (enlarged) or constricted (pinpoint) pupils
- Smell of alcohol or marijuana on breath
- "Nodding out" (dozing or falling asleep)
- Burns on the inside of the lips (from freebasing cocaine)
- Perspiring
- Bruising
- Scratching
- Swollen hands or feet
- Inability to focus
- Irritability, agitation
- Depressed mood

Referral Made Yes No (circle one)

Enrollee Name: ______________________________

PMSP Signature: ______________________________

____
(PMSP Name-stamp, print or type)

Interviewer Signature: (if different from PMSP) ______________________________

Date: ______________________________

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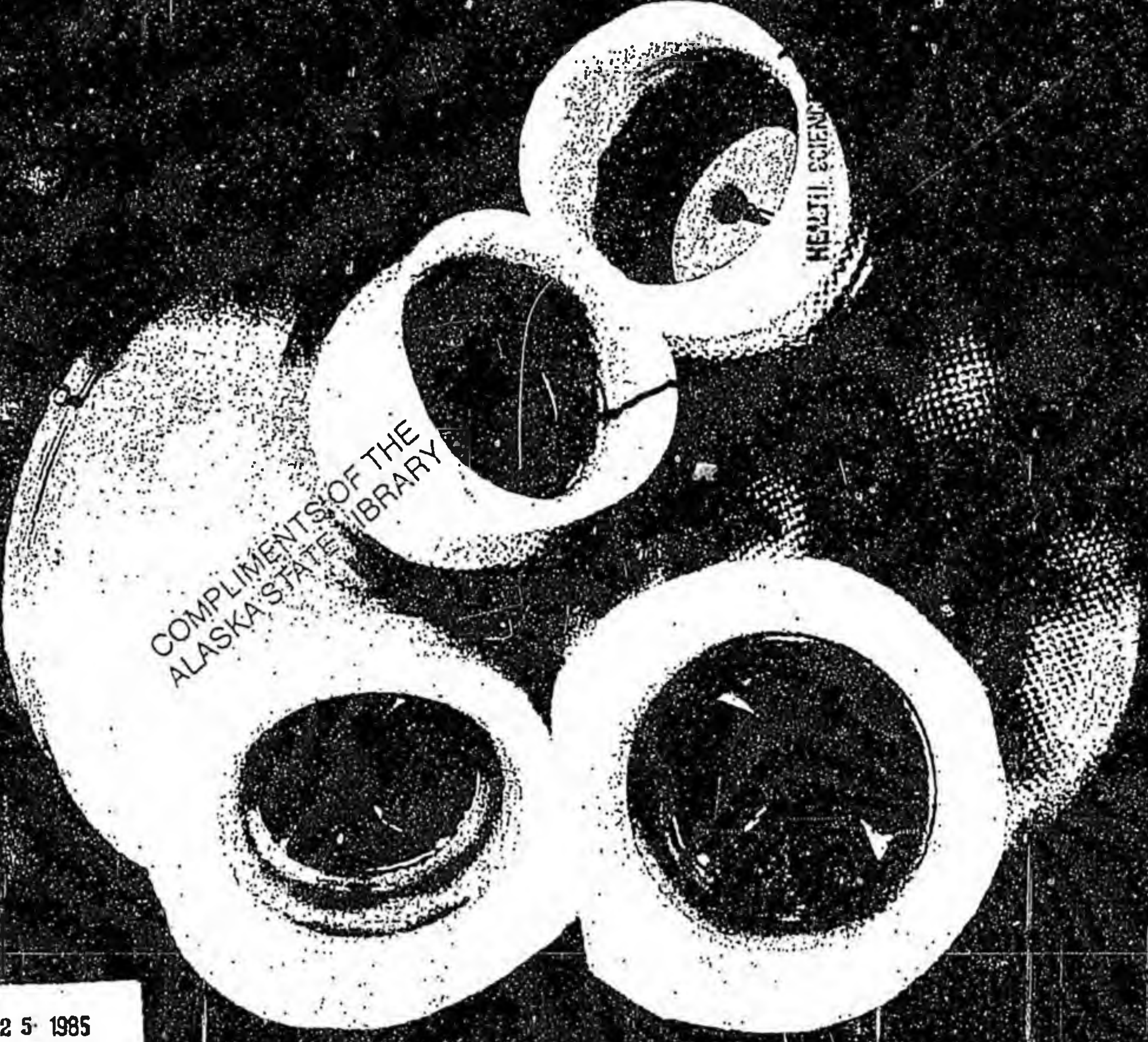
THE Ohio STATE Medical Journal
VOL. 81, NO. 2, February 1985

TREATING HEART DISEASE
Examining the Alternatives



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...mical Dependency
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The AMA Interim Report
Minutes of the Meeting

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Second Opinion

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Chemical Dependency: A Treatable Disease

By William J. Kennedy, MD

As a full-time addictionologist, I have many concerns about the role of organized medicine in the field of chemical dependency. A number of us working in this new field also have concerns for what we perceive to be vital areas: appropriateness of therapy, recognizable authorities in the field for consultations with courts, legislators and third-party carriers, recognized teaching resources for medical schools, etc.

Those of us working in the field have great concern for the continued inappropriate care offered by otherwise qualified medical practitioners. A recent American Medical Association (AMA) poll indicates that only 21% of physicians recognize alcoholism as a primary disease; 17% continue to see it as a psychiatric problem, while 57% see it as some kind of behavioral problem. Only 27% felt competent to treat alcoholism; 45% did not feel competent, and 26% had very mixed feelings.

This poll unfortunately demonstrates where we are in treating the nation's number one health problem.

Our experience with third-party carriers continues to be equally distressing. In the past, their staff and consultants have had little expertise in this field, and yet make significant decisions about treatment settings, modalities and length of treatment, — all of which are decisions critically affecting treatment outcome in this very treatable disease.

One might assume that nothing of a constructive nature is underway to address these concerns. In addition, competition in the field is clouding the issue of who in the health care profession is taking the lead in this important and critical area. It might be well to review what is happening in the field of chemical dependency and how physicians, like myself, are involved in this effort.

A recent poll indicates that only 21% of physicians recognize alcoholism as a primary disease . . . and only 27% felt competent to treat it.

In the last few years, largely due to the stimulus generated by a group of recovering physicians, some significant steps have been made. In 1982, the State of California passed a law requiring medical directors of alcohol and drug programs be certified as specialists in the field of chemical dependency. In 1982, a group of us from around the nation, field tested an examination for the California Society for the Treatment of Alcoholism and other Drug Dependencies. In November, 1984, 115 physicians were examined and 101 were passed and certified as specialists in the field of chemical dependency.

Also, in October, 1982, the American Academy of Addictionology was founded, largely due to the leadership of Dr. G. Douglas Talbott. Under its sponsorship and with the support of the AMA, the two historic KROC Ranch Conferences came about. The first conference brought together all the diverse medical groups interested in the field of chemical dependency: the AMA, the California Society for the Treatment of Alcoholism and Other Chemical Dependencies, the American Medical Society on Alcoholism, the Association of

continued on page 79

Second Opinion

continued

Medical Educators and Researchers in Substance Abuse, the American Psychiatric Association, the National Institute of Drug Abuse, the National Institute of Alcohol and Alcohol Abuse, the National Institute of Health and others.

Out of these meetings, a consensus report was formulated, recognizing that there is a special body of knowledge applicable to the field of chemical dependency, and those who are familiar with this body of knowledge should be identified as specialists in this new and distinct discipline.

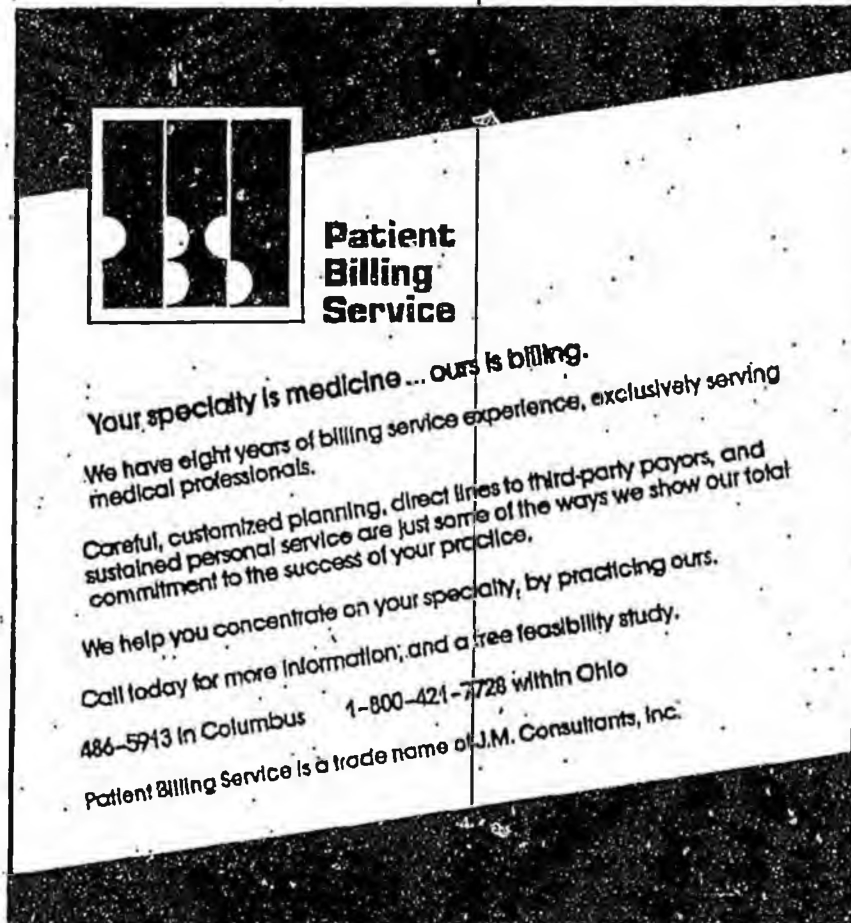
The second KROC Ranch Conference delegated to the American Medical Society on Alcoholism and Other Drugs the responsibility of implementing a credentialing and certification process, as well as developing fellowship or residency training programs.

Following the second conference, the American Medical Society on Alcoholism and Other Drugs accepted this charge and implemented this by appointing a number of us to a committee to continue developing a certification process, as well as fellowship training programs. Many of the members of these committees come from the medical teaching field, as well as having practical experience in the treatment of chemical dependency.

In addition, I was recently appointed to an AMA committee to review the terminology used in the chemical dependency field, and also hopefully remove chemical dependency from the psychiatric category in the DSM 3 as well as the current international classification. This issue is already being tested in the courts.

We are receiving strong support in our efforts from the AMA, and hopefully within a few years medicine will have a new recognized specialty in the field of Addictionology. This new field is obviously long overdue, when 85% of all chemically dependent people receive no treatment at all for their disease.

Organized medicine has a vital role to play — first, in assisting this new field to obtain the credibility that it so desperately needs and that it has strived so hard to obtain; second, in bringing chemical dependency into the mainstream of medicine. We need to rid it of the remaining vestiges of stigma as a moral issue, rather than a disease, to document its treatability and to recognize the successful methodology which is already in place. In short, chemical dependency should be viewed as any other life-threatening, treatable disease.



Dr. Kennedy is program director for the Alcohol Rehabilitation Unit of Licking Memorial Hospital in Newark and is a member of the OSMA Committee on Impaired Physicians.

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IN THE SPOTLIGHT

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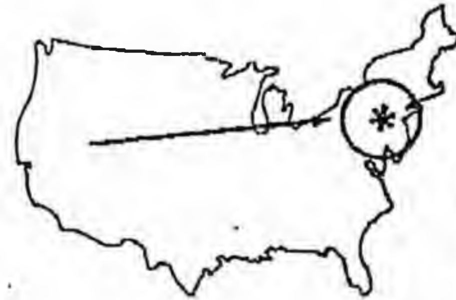

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Adapting the Chronic Disease Model in the Treatment of Dually Diagnosed Patients

FORT WASHINGTON, PENNSYLVANIA

Abstract—*This article suggests that while the focal point of inpatient treatment in the field of addiction should continue to be abstinence and 12-step programs, there should be considerable modification of the process of treatment. Many of the present inpatient psychiatric hospitals that treat addiction seem to be largely unaware of the biochemistry and physiology of early recovery. A model of treatment is proposed that takes into account the neurocognitive impairment and emotional augmentation that is present in early recovery. The focus of active treatment in this program is the treatment of the addictive process. The psychiatric diagnosis is managed through supportive psychotherapy and/or education if appropriate. Active treatment of the psychiatric diagnosis is deferred to outpatient treatment.*

MODELS OF TREATMENT IN THE DUAL-DIAGNOSES SETTING

MALVERN INSTITUTE is a 35-bed residential treatment center in Malvern, Pennsylvania. The staff of the Malvern Institute has been treating chemically dependent patients since 1946 and dually diagnosed patients since 1981. In the Delaware Valley, dual diagnosis treatment is usually done in psychiatric hospitals. In that respect, Malvern Institute occupies a unique treatment niche. Patients who are floridly psychotic or suicidal are treated at Malvern Institute after their psychiatric conditions have stabilized.

Until recently, Malvern Institute has used the multidisciplinary treatment team model as the predominant treatment mode. This is a common approach in facilities that treat dually diagnosed patients. In these facilities, addiction is seen as the end result of multiple etiologies. In this model, it is important to expeditiously treat any condition that may have contributed to the evolution of this disease in the first 30 days of treatment.

Psychiatrists, psychologists, nurses, counselors, social workers, recreation, art, and movement therapists are employed, when available, by the facility. Each discipline views the addicted individual from a slightly different professional perspective. The input of these disciplines is then woven together into a patchwork program. These programs frequently recommend sobriety, 12-step programs, and mental health. Although this approach has been somewhat successful, there are inconsistencies in the treatment based on the training and talent of the members of the team.

A significant drawback in this approach is the lack

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of any built-in mechanism to define and enforce role and task boundaries with the staff. Our observations of the actual day-to-day working of this model indicated that there were great discrepancies between the actual work done by the disciplines and the work that was reported by them in case conference. For example, although counselors reported that they were working on first step issues, direct observation indicated that they were working on issues of personality development and attitude. Psychiatrists strongly asserted that they were reinforcing the program, when they were frequently using insight therapy. Nursing staff would confront and interpret behavior, believing themselves to be ego supportive.

As this kind of disjointed treatment continues, the patient community will begin to perceive such treatment as poor and inconsistent. If they confront the staff, they are told that they are acting like addicts. If the patients accept an interpretation of this nature and surrender to the treatment program, they have the approval of the staff. If they do not, they are continually told that they are an addictive community and approval is withheld.

It is also not unusual to see this model hybridized within the therapeutic treatment community model. Staff and patients are seen as equal participants in the treatment community. In this case, the staff may be in a position that is equally as perilous as that of the patients. They may both be subjected to a nonvoluntary group process. This process usually tends to be neither therapeutic nor supportive, but frequently seeks to influence thought and attitude. By the very nature of a therapeutic community, it runs, day-to-day, on the basis of a belief system. This system may have very little to do with the treatment of addiction. The long-term effect of this approach may push the staff into behaving like an alcoholic family. The staff behavior then shapes the community behavior.

Admittedly, this is worst-case scenario. These problems do not always occur. The success of these styles of treatment depend on the experience and quality of a core membership of the staff. Although a facility may enjoy tremendous initial success, these systems tend to deteriorate as members of this core elite move on to other places and positions.

The difficulty of maintaining a therapeutic environment with dually diagnosed patients is further compounded by the regressive pull that these patients exert on the staff. This pull comes from their tremendous needs and endless issues. Staff may frequently feel overwhelmed when using a style of counseling that is issue-oriented in its approach. In addition, this treatment approach suggests that if addiction is a disease, it is a disease of personality disorder. Recent research suggests strongly that addiction is a genetic, biochemical, and physiologic event, making the latter approach inaccurate, somewhat judgmental, and moralistic.

Wishing to avoid some of these pitfalls, the clinical administrative staff at Malvern Institute sought a treatment model that would do the following:

1. Keep both staff and patients on the primary task, that is, treatment of addiction, and help to prevent the inevitable regressions that seem to accompany many other models.
2. Keep the wisdom and structural support of AA and NA while using treatment methods and information based on the most up-to-date research on addiction.
3. Set realistic treatment goals that take into consideration the weakened and debilitated condition of the patients early in sobriety and not expect more of them than they can do. Studies show that as many as two thirds of patients entering a residential treatment center may have a significant level of neuropsychological impairment, with clinical presentation running the gamut from inability to set priorities to difficulty in learning new information. Frequently, patients remain in a sate of prolonged withdrawal. As a result, they may be emotionally augmented for the length of their inpatient stay. *Augmentation* refers to a clinical state of increased emotional arousal secondary to withdrawal. Any treatment method used should be extremely simple (cognitively concrete), highly logical, and nonprovocative.
4. Give patients a clear message of personal responsibility for the treatment of their illness.

THE DUAL-DIAGNOSIS MODEL

The dual diagnosis model as used here refers to a model that sees addiction as a disease, but allows for the existence and treatment of a concurrent psychiatric illness. There are several advantages to this model.

1. Both disease processes are considered primary.
2. Both require treatment.
3. They coexist without attributing etiology to each other.
4. Substance abuse must stop in order to diagnose and treat the psychiatric illness.
5. If the patient is proven not to have a psychiatric illness, this exclusion permits a shift of focus to the disease model of treatment.
6. Allowing for two separate etiologies decreases denial and splitting within the staff.

The most important feature of this model is that it does not compel the treatment team to attribute etiology of the addiction to the psychiatric illness. This permits patients and staff to continue to view addiction as a primary disease requiring abstinence. The accurate diagnosis and subsequent treatment of the psychiatric illness also requires abstinence. This clear separation of both diseases suggests that we should not combine substance abuse treatment with psychodynamic therapy in the context of the same program. When we do

this, the spoken or unspoken message to the patient is that the two illnesses are somehow magically woven together. We are left with the embarrassingly impossible task of explaining how a genetic and physiologically distinct disease has been caused by a psychiatric disorder.

Once having committed to this model, however, it became obvious that while it permits clarity it does not suggest a method or mode of treatment. The advantage of combining the dual diagnosis model with the chronic disease model is that it gives us a methodology by which we can treat two separate chronic illnesses within the context of the same program.

THE CHRONIC DISEASE MODEL

The chronic disease model of treatment was developed and written about extensively by Ron Rogers and Scot McMillin. They have produced books describing the treatment philosophy, group process, and family involvement inherently implied in this model. The model is based on the seminal work, *Under the Influence*, written by Milam. It is distinguished from other therapies by several key features. Its most important accomplishment is the direct and focused treatment of the disease of addiction. Most multidisciplinary treatment team models and therapeutic treatment community models attempt to treat the issues that emanate from the addiction, that is, negative attitude, intergenerational family conflict, grief issues, sexual abuse, and so on. These matters certainly are important and may even have a direct bearing on an individual's recovery. They are better dealt with when the individual is less neuropsychologically impaired and is less emotionally augmented, in other words, when they are less toxic from the effects of drugs and alcohol.

Alcoholism and drug addiction are marked by two distinct phases of symptomatology. The first phase includes symptoms of intoxication that range from slurred speech, to explosive behavior, to delusion and hallucination. Less well known are the symptoms of withdrawal. There are those symptoms that occur immediately after cessation of alcohol and drug use and those that occur after prolonged abstinence. Acute withdrawal can last up to 7 days. It can result in loss of reality testing, convulsions, and death. It can certainly mimic almost any of the common axis-1 disorders.

The second and less well-known phase is the protracted withdrawal syndrome. This makes its appearance after the cessation of acute withdrawal and can last up to 2 years. In the past, it has been most frequently described within the context of the social sciences and has been mistaken for the emergence of preexisting psychiatric and emotional disorders. Data gathered by computerized axial tomography and electroencephalography strongly suggest cortical damage from long-term alcohol ingestion. In alcohol treatment centers using the Luria-Nebraska Neuropsychological Battery, as many as two-thirds of alcoholics entering treatment have been shown to have significant cognitive impairment (see Figure 1). This impairment begins to show improvement by the time of discharge in many of the patients. Vaillant's comprehensive review of large numbers of alcoholics revealed that many of the alcoholics who were studied demonstrated a wide variety of psychological and behavioral disturbances

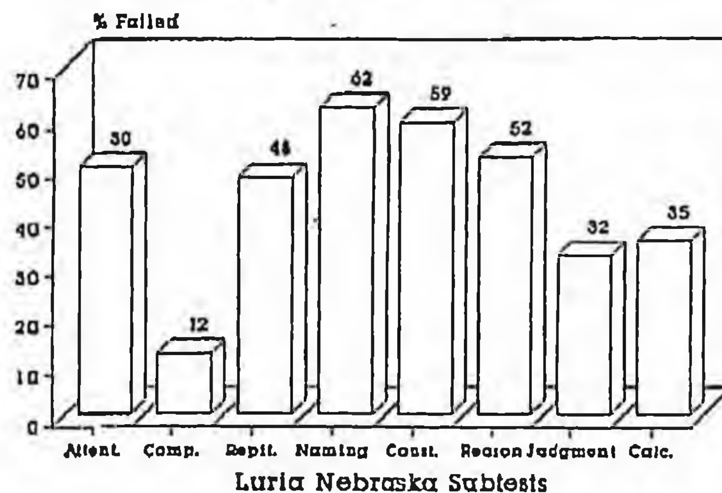

FIGURE 1. Study by Meek, Clark, and Solana demonstrates the percentage of alcoholics who failed specific subtests of the Luria-Nebraska Neuropsychological Battery given in the first 10 days of treatment.

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that were not present before the onset of their disease. This strongly suggests that there is great physiologic disturbance that occurs as a direct result of the substance abuse and extends well past the period of acute withdrawal.

Obviously then, patients in early recovery are going to suffer from the effects of this protracted withdrawal. They will be easily confused, show disturbances of memory, and over-react to stress. They may be unable to attend, concentrate, conceptualize, and prioritize. All too often, these difficulties are interpreted as having Axis I or Axis II significance. They are then either medicated or confronted inappropriately. This knowledge should have far-reaching implications for the rehabilitation centers and intensive outpatient clinics that treat these patients.

The chronic disease model treats addictions in a direct and focused manner that assumes a disease with central nervous system sequelae. Program material repeats every 21 days so that patients repeat their first week. The program uses task groups that occur in appropriate sequence with the lectures. All of the work is then related to one of the four primary goals of treatment. Information deemed to be strategic and important for treatment is cycled to repeat in various lectures and at appropriate times.

GOALS OF TREATMENT

Once the patient's physical and emotional conditions are stabilized, programmatic goals of treatment can be met.

1. *Education:* The education of the patient and the staff is one of the most important functions of the program. Therefore, it becomes important that the information meet the following criteria:
   a. Everyone must be the recipient of the information; no secrets should be kept from the patients.
   b. The information used is endorsed by the scientific community as the most accurate and up to date.
   c. A significant part of the information should be a clear-cut explanation of the chronic disease model program. Patients are able to gauge their progress and hold the staff accountable to deliver their promise of treatment.
   d. Because the major form of treatment of chemical dependence is still 12-step programs, the information should be heavily weighted on the practical use of these programs.
   e. There should be a predictable and verifiable quantity of knowledge passed from the staff to the patients. Lectures entitled "The Disease of Addiction" must include information on tolerance, dependence, loss of control, and so on. Staff should not lapse into stories such as "My Personal Recovery." When patients are halfway through treatment, they should be able to understand their treatment and recovery program well enough to begin to teach it to the newcomers.
2. *Self-diagnosis:* The next most important goal of treatment is that the patients must self-diagnose. In other words, all the material given to them is worthless if they cannot apply it to themselves. However, this is the work of the patient and his peers, not of the treatment staff. The primary treater in this model is the patient. The goal of the counselor is to educate and facilitate the patient's self-diagnosis, not to push him into self-recrimination or to provoke him into sobriety. It becomes very difficult for the staff members to project their issues onto the patient, partially because treatment is not issue-oriented and partially because there is little opportunity to do it. Therefore, patients are asked only to personalize the material that they have learned.
3. *Learn how to treat their illness:* Just as diabetics must learn to count calories, weigh food, and adjust dosages of insulin, addicts must learn to maintain their health and sobriety. Recovering addicts must learn to make lifestyle changes. They must learn what to avoid, new ways of dealing with stress, how to obtain a sponsor, how to fire a sponsor, and so on.
4. *Assumption of personal responsibility:* Compliance is not punished in this program. Compliance is simply the act of doing what you are told to do. In other treatment models, it is thought of as a deceptive maneuver on the part of the patient. In the chronic disease model, it is considered an important step in the patient's progress. Progress is measured by whether or not the patient meets certain behavioral learning objectives in the program. The staff does not engage in mind reading or accusing patients of impure thoughts and motives. It becomes the goal of the staff to remove all such impediments to the patient's progress. In this respect, the chronic disease model has been compared to the Montessori method. Patients are also expected to learn about their psychiatric diagnosis and to take personal responsibility for it. The patient's psychiatrist might then educate the patient about manic-depressive illness, for example, and how to do the self-care necessary for continued stabilization.

ROLES

Role boundaries are very important in this model, and staff members are expected not to stray from their defined positions and delineated tasks. The patients also know the task and role expectations. The patients have

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the right to remind staff members about program boundaries and to exercise that right with healthy exuberance. This encourages patients to begin to take charge of their lives while they are still in treatment, and this promotes skill building.

1. *Counselors* educate the patients, facilitate groups and community meetings. They set up back-to-work conferences. They also educate families and lead multiple family discussion groups. They counsel They do not do interpersonal group therapy or individual therapy in a group setting.
2. The *addictionist* develops individual detoxification protocols and oversees the medical care of the patient. His primary goal is to stabilize the patient medically and apprise the patient of his condition. He will explain laboratory tests to the patients and relate results to their disease. He may also do individual counseling. In addition, the addictionist may help develop drug-free programs for the maintenance of chronic pain syndromes when appropriate.
3. It is the *psychiatrist's* job to diagnose and treat mental and emotional instabilities in a manner that is responsible and consistent with the goals of a chemical dependence treatment center.
   a. Before psychiatric medications are given, the patient must demonstrate *DSM-III-R* criteria for that illness before the onset of the addiction, or they must have maintained their symptoms for a period of 3 weeks after detoxification.
   b. Diagnoses such as borderline personality disorder are not medicated. We strongly believe that personality disorders cannot usually be accurately diagnosed in the first 4 weeks of treatment because of the complications of protracted withdrawal.
   c. The psychiatrist should continually assess the level of cognitive impairment of the patient and help to ease his adjustment to the program.
   d. Supportive therapy is provided when indicated. The goal of this therapy approach is to reinforce the patient's participation in the program and to help reduce the use of primitive ego defenses and acting out behavior.
   e. The psychiatrist must also educate the patient about the psychiatric illness and the responsible care of that illness.
4. *Nursing staff* help to maintain the program boundaries 24 hours a day and are extremely important to the ongoing integrity of the program. They take part in patient education through lectures and the explanation of laboratory tests. They also help the dietitian and the kitchen staff in educating the patients in the proper nutrition of recovery.
5. *Recreational staff* consult with the physician to help the patients develop a realistic and healthy exercise regiment that they will be more likely to continue after treatment. The focus is on the restoration of physical health through gradual increase in the level of physical activity. Self-care is taught along with the constructive use of leisure time.

THERAPEUTIC ACTIVITIES

Because the most important goal is to teach addicts to be responsible for their own care, it makes sense to approximate the individual's aftercare environment as closely as possible within the treatment setting. They would then be better able to use this environment after treatment because they would have some experience negotiating it. One might think of the clinical milieu as attempting to replicate the successful and unique attributes of a 12-step program.

These attributes are:

1. Alcoholics are not treated by professionals in 12-step programs. They are treated by each other. This is an experience that should then be replicated in group, community, and milieu therapy.
2. The basic character of 12-step programs is that they are homogeneous. They are made up of individuals who are addicted and have similar life experiences. No one goes to an AA meeting for therapy for an emotional disorder. People may go, however, to stay sober in the face of many emotional problems. They are then likely to see their therapist to deal with their emotional issues. Meetings are also positive in tenor, supportive in nature, and task oriented.
3. There are traditions that are passed on that are unchangeable. Some are written, and some are passed on by word of mouth from the older members to the newcomers. They prevent the group from being subverted by circumstance and individuals. This ensures that the primary task of the maintenance of sobriety continues within the 12-step program.
4. In addition to the following 12 traditions, each group develops its own character and mores.
5. Leadership is passed on so that no one individual becomes more important than the fellowship or the group.

The style of group process most often used in rehabilitation settings is the short-term Yalom group, wh[illegible] does not meet the aforementioned criteria. In th[illegible] groups, patient's issues, many of which vary from patient to patient, are worked on one at a time. Differences and not similarities are stressed in group. The counselor frequently sets the agenda for what issues will be declared to be "crucial" to the patient's sobriety. These "choices" may reveal more about the counselor than they do about the patient.

The group process used in the chronic disease model is based on the group style of Lord Wilfred Bion. The groups have specific tasks, and the role of

the counselor is merely to keep the group or the community on task.The primary task of the group or the community is always the treatment of the addiction.

The psychiatric diagnosis is not treated by the group or the community. It is treated by the psychiatrist. It is the job of all staff members to make their primary investment in the maintenance and continued life of the program. In that spirit, the primary task must always be preserved. Therefore, anything such as a psychiatric diagnosis, that prevents the individual from attending to the primary task is actively treated. In that respect, the psychiatrist helps the patient by managing the psychiatric illness, whereas the patient attends to the primary task of treating his or her addiction.

COMMUNITY MEETING

The community meets daily lead by its officers. After the groups elect their leaders, those group leaders are eligible to be elected to office by the community. Leadership is passed on each week. The primary task of this meeting is the same as for every activity. The patients call the meeting to order and then read the community rules and boundaries (program rules). They will solve problems that develop within the community that are not specifically covered in the program rules. One community may have to solve the problem of how its members will help each other adhere to a 10-min telephone limitation, whereas another community may have to solve the problem of getting its members to therapeutic activities on time.

Community meeting is generally facilitated by only one staff member. This staff member may assist the community by clarifying a problem or refocusing the community. It is important that the facilitator work to empower the group and not determine it by solving its problems for them.

SMALL GROUPS

Groups occur daily at Malvern Institute. The groups are task oriented, and they are facilitated. Individual and interpersonal therapy is not done in the context of the group as it is with the Yalom model. All of the groups are focused on some aspect of addiction and recovery. They must fulfill one of the four basic goals of treatment and are coordinated with the lectures given that day.

Groups operate out of one of four basic "modes." These modes are hostile, hopeless, hopeful expectation, and working. Obviously, the goal of the group and its facilitator is to help the group achieve a working mode. A group is in a working mode when its members are able to stick to the task at hand. Groups can fall into helplessness and hopelessness; they can become hostile and direct their hostility to the counselor or to one another. They can also enter hopeful expectation mode, which on the surface appears to be positive activity. It is not activity that is based in reality, however.

The groups have one of four basic themes or tasks:

1. *Defense mechanism groups* occur twice a week. They dovetail with the lectures that define defense mechanisms and detail their use in the service of the addiction. Patients are given examples to watch on videotapes to further identify these mechanisms of denial. They will then participate in a group in which they relate the use of these defenses to themselves. The patients discuss how these defenses are used to avoid self-diagnosis. They discuss how to change this behavior. Acting out in the community may be discussed in the defense mechanism group so that the patients can relate this to their avoidance of treatment. It serves as a way of using peer interaction to keep community behavior under control. Confrontation is always done didactically. Patient are taught to confront in this manner, directly and by example.
2. *Step groups* occur once each week and go sequentially through the first three steps. These groups emphasize maintenance of sobriety. They are related to the educational lectures. For example, step 1 emphasizes how the disease process leads to powerlessness through the mechanisms of tolerance and withdrawal. Unmanageability stresses the problems stemming from the disease, such as legal problems, family problems, and so on. The need for abstinence and working the steps is emphasized. Step 2 stresses the importance of the group, AA, and reality testing. Step 3 stresses the group and why willpower does not work and what it means to turn one's will over.
3. The *education group* is the third type of task group. This group stresses familiarity with the present week's lecture material. Again, the group stresses relating the material to the individual members. They also must identify educationally weak areas in the group. This ensures that all of the members of a given community receive the information that is needed to self-diagnose. There is, of course, a certain amount of new learning that takes place with each new member as the group attempts to diagnose or determine what information an individual is missing and to develop ways in which the patient may make good on those deficits.
4. The *treatment plan group* is another type of group. This is the only group that may on occasion address a patient's self-defeating behavior and attempt to prescribe alternative behaviors that are more consistent with active treatment. Again, this is patient-led and patient-determined. Clients are expected to follow the guidelines of treatment planning and to develop goals and objectives.

Counselors are rotated through the different groups

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so that no group identifies itself as belonging to a particular individual or vice versa. The counselor can make an intervention if the group is having trouble with the task, but he or she must first determine what mode the group is in and must address all of his or her comments to the group as a whole and never to individuals. This prevents projective identification with the group and further prevents acting out countertransference. The advantage of this kind of disciplined therapeutic interaction to dually diagnosed patients is obvious. Emotional turmoil and patient acting out is greatly decreased. Patients with Axis I diagnoses that could not tolerate more "invasive" or "penetrating" group techniques are generally able to tolerate these groups.

INDIVIDUAL THERAPY

The individual therapist has 10 major tasks in this model of treatment.

1. *Collect and assess a database.* This is a very important function in this model because some treatment must be deferred to the outpatient setting. It becomes very important to assess the aftercare needs of the patient and to make the appropriate referral.
2. *Develop, revise, and update individual treatment plans.* The plans are designed to educate, to relate learning to experience, and to bring about behavioral change. A detailed and relevant plan is made, and a copy is given to the patient.
3. *Provide cognitive and reality-oriented therapy.* It should be aimed at teaching patients helpful control of feelings. The emphasis should be on the prevention of regression. Therefore, patients are not encouraged into insight or expressive psychotherapy. "Conversion experiences" are not encouraged. The emphasis is on consistent and directed work and not self-castigation.
4. *Confront denial only by didactic methods.* There is nothing therapeutic about increasing the level of shame that an individual comes into treatment with because most of it is based on a moral understanding of addiction. It is very important that the staff model behavior that is consistent with that belief.
5. *Teach patients about defense mechanisms and how they are used to justify addictive behavior and to avoid treatment.* The more the behavior of questioning one's defenses is modeled for patients, the more they will do it. The more they are confronted forcefully, the more defensive they will become.
6. *Provide opportunity for patients to witness the use of defense mechanisms and to identify them.* Conflict, attitude, and behavior are never interpreted. The patients may make their own guesses about what dynamics their defenses may conceal, but this should not be encouraged or validated by the staff.
7. *Provide the patient with all the information you learn about him or her.* Stick to basic data and facts. Avoid asking the patient to believe things that you cannot support with data. Patients should be given useful data in the same format as they are given data about their addiction.
8. *Self-disclose only when appropriate.* This means that therapists do not disclose personal information when it has no benefit for the patient. It also means that unresolved issues are not divulged.
9. *Develop appropriate aftercare, and motivate the patient to accept and follow it through.*
10. Teach the patient the effective use of 12-step groups.

LECTURES

The topics of lectures are chosen on the basis of what patients need to know about addiction and the normal recovery process. They also need information about the basics of self-care. In the case of addicts, that means teaching them a practical working knowledge of 12-step groups and sober living skills. Lectures must be outlined well enough that anyone can take over the lecture and cover the important points. Topics are presented in a logical manner and are coordinated with the day's activities. Therefore, if a lecturer is absent on a given day, someone else must be able to step in and cover that topic. It must be covered point by point.

DIET

It is with some trepidation that I place diet under the heading of therapeutic activities. It is still fashionable in medical circles to state that if a person eats three well-balanced meals a day that person will get all the necessary nutrition. However, addicts are people who have run up a tremendous debt with reality. They are vitamin and mineral depleted by the time they come into treatment. They frequently attempt to digest and absorb food with a compromised digestive tract.

In addition, there is some evidence to suggest that an addict's need for protein, or the amino acids that are the building blocks of protein, are increased. The protracted withdrawal syndrome occurs out of a deficiency of neurotransmitters. Serotonin, for example, relies heavily on the amino acid tryptophan for its synthesis. It does not cross the blood-brain barrier itself; therefore, one of the few ways of increasing serotonin is to increase the amount of tryptophan delivered to the brain. Theoretically, at least, diet should be important to the process of recovery.

This, of course, does not even begin to cover the topic of diet for general food health. Typical rehabil-

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itation food is high in caffeine, simple sugars, fats, and cholesterol. The theory is that recovering people need "hearty fare" and tasty food (usually high in fat) to keep their minds on treatment. I have been dismayed by the fact that middle-aged men, who have some risk of heart attack, experience increases in their blood lipid and cholesterol levels in their second week of treatment, not as a consequence of recovery but because of the diet that they were fed.

Caffeine is not a benign drug in the hands of active addicts and recovering individuals. In an addiction, it was all too often used to stimulant-load an individual who was lethargic and exhausted from alcohol and drugs. This kind of stimulant loading always incurs a debt to be payed later in neurotransmitter depletion.

Simple sugars have similar effects on people in recovery. Although chocolates may temporarily decrease a craving for alcohol, there is a "high" that occurs after eating and then a rebound depression state. This "low" feeling state is often accompanied by a recurrence of craving.

Sugar and caffeine loading also increase stress in an organism. Recovering people are particularly sensitive to stress. We believe that these eating habits have a very direct and negative effect on the protracted withdrawal syndrome and measurably increase the difficulty of recovery. Therefore, we not only teach diet and recovery to individuals in our program, we also feed them a diet that eliminates free sugar and caffeine and is low in fat.

CONCLUDING REMARKS

This model of treatment does not trivialize the many important issues of the recovering addict. It merely prioritizes the sequence of treatment to match the recovering patient's physiology and limitations. Many issues are deferred for outpatient treatment. The strength of this model lies in its restraint. The staff must place most of its energy into the maintenance of the program itself, which helps to prevent acting out of codependent and countertransference issues. In other words, it helps to prevent the staff members from acting on inappropriate thoughts, feelings, and attitudes from their own past that would be harmful to the patients and impede their progress. Its success with dually diagnosed patients suggests that those who treat the addict early in recovery have an obligation to remember and practice the first rule of Medicine: "First do no harm."

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United States General Accounting Office

Report to the Chairman, Subcommittee on Human Resources, Committee on Ways and Means House of Representatives

FOSTER CARE

Parental Drug Abuse Has Alarming Impact on Young Children

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for a substantial portion of each state's young foster children in 1991: 44 percent in California, 81 percent in New York and 29 percent in Pennsylvania.

Results in Brief

The 1991 population of young foster children is significantly different from the 1986 population in the locations reviewed in a variety of ways: the 1991 population size is much larger, more of these children entered foster care due to some form of neglect, their biological parents are more likely to abuse drugs, these children have more health-related problems and are at high risk for further problems due to prenatal drug exposure,[3] and they are more likely to be eligible for federal maintenance payments.

The number of young foster children increased at almost twice the rate of the general foster care population. Neglect and caretaker absence prompted an estimated 68 percent of removals, up from 47 percent in 1986. We estimate that families where at least one parent was a drug abuser increased from 52 percent to 78 percent. An increasing percentage of children had serious health-related problems in 1991 and most of them were prenatally exposed to drugs. Specifically, an estimated 58 percent of young foster children had serious health-related problems in 1991 compared with 43 percent in 1986. Those at high risk for problems due to prenatal drug exposure increased from 29 percent to 62 percent over this period. Cocaine was the most prevalent drug children were prenatally exposed to in both years; documented prenatal cocaine exposure increased from 17 percent to 55 percent between 1986 and 1991. A larger percentage of young foster children qualified for federal maintenance payments in 1991 than previously. At the same time, the growing number of young foster children increased overall maintenance expenditures, compounding their financial impact on government. Federal and state governments in these three states alone spent over $2 billion in 1992 to maintain foster children of all ages.

These changes have implications for federal foster care and health care programs. Both federal and state expenditures have felt the impact of the growth in the number of young foster children and the decline in their overall level of health. Further, two broad service needs overlap foster and health care programs. First, drug abuse treatment programs for biological mothers and pregnant women are needed to reduce the risks associated with prenatal drug exposure and the likelihood that children will be

[3]We included alcohol abuse in our definition of drug abuse. However, the documented incidence of alcohol use was low, about 6 percent in 1991 and 3 percent in 1986.

removed from their families. Second, services to address the health and developmental needs of drug-exposed children are needed to treat their problems. While few alternatives to foster care currently exist for many of these families, meeting both of these service needs should increase the possibility that such families can be reunified and leave the foster care system. However, drug abuse, to the extent it continues to occur, will remain a hidden contributor to the costs of various federal programs.

Background

While the federal, state, and county governments and foster parents share responsibility for providing care and services to foster children, the Department of Health and Human Services (HHS) is responsible for the management and oversight of federal programs benefiting foster children. The programs are authorized primarily by the Social Security Act. The act, in part, authorizes expenditures to (1) maintain foster children who are eligible under the Aid to Families with Dependent Children (AFDC) program, (2) assist states in providing child welfare services, and (3) provide medical care. Primarily, HHS establishes federal regulations and monitors states' compliance with them for children placed in federally funded foster care and other programs under the act and administers federal funding for them.

Federal expenditures for the administration and maintenance of AFDC-eligible foster children are authorized under title IV-E of the Social Security Act. Those expenditures increased from about $637 million in 1986 to over $2.2 billion nationwide in 1992. The federal portion of foster care maintenance costs varies by state and is linked to a state's Medicaid matching rate. The federal portion ranges from 50 percent to 83 percent of the maintenance cost for AFDC-eligible foster children; states or counties are responsible for the full cost of maintaining foster children who are not eligible for AFDC benefits. Thus, payments to foster parents for the care of an AFDC-eligible foster child are comprised of federal, state, and in some cases county monies.

In addition to maintenance funds under title IV-E, federal funds authorized in other titles of the Social Security Act may be used to provide medical and other needed services to foster children. States may participate in programs such as title IV-B, federal matching grants for various child welfare services; title XIX, Medicaid, for medical services for foster children; and, title XX, block grants for a wide array of social services for children. Data were unavailable to estimate the additional federal, state, and county expenditures for these other services for foster children.

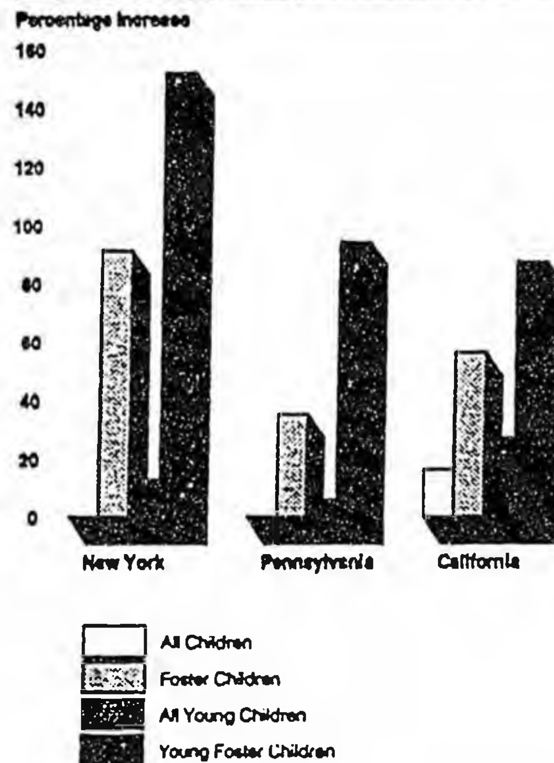
However, we previously reported that median costs associated with newborn medical care for infants known to be prenatally drug-exposed were approximately $1,100 to $4,100 higher (in 1989 dollars) than for other infants. Further, an HHS study provides an example of Medicaid costs in California from 1986 to 1988 for children from birth to 24 months of age. HHS reported a 2-year average Medicaid expenditure of $1,551 for children who were not identified as being prenatally exposed to drugs compared to $2,285 for those who were known to be exposed.[4] Further, medical expenses for drug-exposed foster children from birth to 12 months of age were 62 percent greater than the medical expenses for drug-exposed children who were not in foster care.

More Young Children in Foster Care

The foster care populations in the states reviewed increased dramatically between 1986 and 1991, with the number of young foster children increasing at a faster rate. The total foster care population in these states increased 66 percent while the number of young foster children increased 110 percent. During the same years, the total number of young children in these states increased 19 percent, indicating that a greater percentage of all young children in these states entered foster care in 1991 than entered previously. (See fig. 1 and tables II.1-II.4 in app. II.)

[4] *An Exploratory Analysis of the Medicaid Expenditures of Substance Exposed Children Under 2 Years of Age in California*, Office of the Assistant Secretary for Planning and Evaluation and Health Care Financing Administration, HHS (1993) (study prepared by SysteMetrics, a division of MEDSTAT Systems, Inc., Cambridge, Mass.). The average was calculated for all children receiving Medicaid benefits in California, not just foster children. It also excluded costs for the federally mandated Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services and delivery services at birth. However, we believe that this is a reasonable minimum estimate of average costs for foster children as well.

Figure 1: Increase in Foster Care and Child Populations in Three States Between 1986 and 1991



Note: Part of New York's increase in foster children is due to the provisions of the New York Supreme Court case, Eugene F., which required all foster children placed with relatives to be included in foster care caseloads and eligible for services.

Pennsylvania's count of "Young Foster Children" consists of all foster children under age 5, as its aggregate data did not break out children under age 3.

California and New York foster children counts represent all children in foster care at any time during the review year; Pennsylvania data for foster children represent year-end counts, as comparable data were not available.

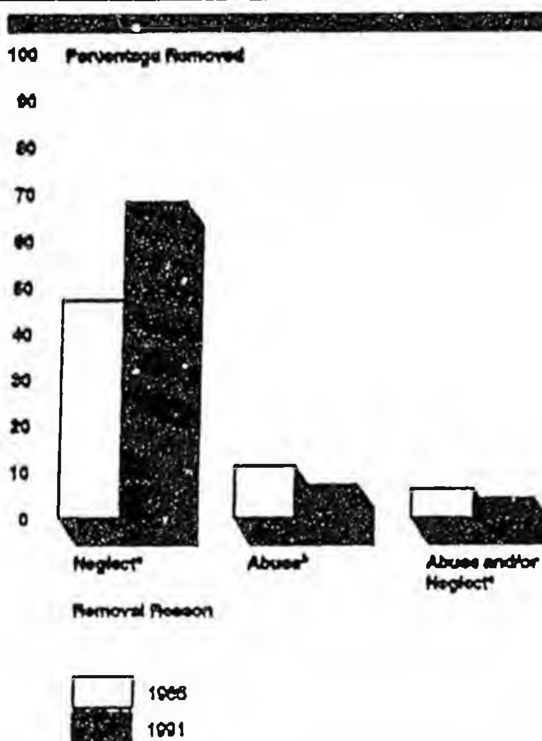
Sources: California and New York—state databases; Pennsylvania—aggregated state data; except "All Children and All Young Children"—Bureau of the Census midyear estimates.

Neglectful or Absent Parents Triggered Most Removals From Home

Neglect and caretaker absence or incapacity were the primary reasons why young children were removed from their families in both California and New York, the states where data were available. Together, these reasons accounted for approximately 47 percent and 68 percent of the removals in 1986 and 1991, respectively. No other reasons for removals,

such as physical abuse, accounted for a large portion of the entries of young children into foster care in either year. For example, all types of abuse accounted for 11 percent of the removals of young children in 1986 and 7 percent in 1991. (See fig. 2 and table II.6 in app. II.)

Figure 2: Reasons for Removal of Young Children From Home in California and New York



Note: There were other reasons for removals that did not account for significant portions of total removals. In addition, some cases only show broad service program categories, such as "court ordered placement;" others are listed as unknown or error.

[a]Includes removals due to neglect, caretaker absence or incapacity, relinquishment, and voluntary placements.

[b]Consists of physical, sexual, and emotional abuse.

[c]Consists of New York data only. This state uses up to two reasons for removal, thus, abuse and/or neglect can be cited. Further, the definitions of some reasons for removal, such as Health/Safety, refer to abuse and/or neglect.

Source: State electronic databases.

Drug Abuse Further Impacts Troubled Families

To better describe the parents' situation around the time their children were removed from home, we reviewed random samples of case files for certain difficulties that families face in the three locations reviewed. Of these situations, estimated increases in the number of parents who abused drugs or had other children in foster care are significant between 1986 and 1991. Fully 78 percent of the young foster children reviewed had at least one parent who was abusing drugs or alcohol in 1991 compared with 52 percent in 1986. Families with other children in foster care increased from 68 percent to 79 percent. Further, families with no other children decreased from an estimated 18 percent to 11 percent during this time.

Families in 1991 had additional serious problems in common with their counterparts in 1986 in the three locations. For example, the percentage of young foster children who came from families with at least one parent absent was high in both years, estimated at about 70 percent. In addition, over 27 percent of the young foster children in these years came from families where both parents were absent from the home around the time of the child's removal, according to our estimates. (See fig. 3 and table II.7 in app. II.)

Maternal Drug Abuse and Drug Exposed Children: Understanding the Problem

U.S. Department of Health and Human Services

EXECUTIVE SUMMARY

Drug abuse is a serious problem in the United States. In particular, the expanding popularity and highly addictive properties of crack cocaine have generated considerable concern at the local and national levels. With large numbers of women using illicit substances during pregnancy, Federal, State, and local policy makers and service providers are struggling to define how best to address the growing problem of infants exposed to drugs.

Analysis of NIDA's most recent National Household Survey on Drug Use (1991) indicates that the use of cocaine by women of childbearing age is still high. Of the approximately 59.2 million women in the childbearing age group (15 - 44 years), over 4.5 million are estimated to have used illicit drugs in the past month. Especially alarming is the fact that about 601,000 women in this age group appear to be current users of cocaine. There is, however, no accurate estimate of how many of these women are pregnant.

There are several overlapping populations of concern when one talks about maternal drug use. From the broadest perspective, the population of concern is women of childbearing age who use or are at high risk of using drugs, and their children. Of particular concern are pregnant substance abusers, mothers currently using drugs, children exposed to drugs in-utero, and children residing in drug using households.

This paper was written as a step toward defining the problem of maternal drug use and prenatal drug exposure for the U.S. Department of Health and Human Services (HHS) and its component agencies. Its authors include representatives from the variety of HHS agencies which have an interest in this issue. This paper is not intended to serve as a definitive analysis of the problem. However, we hope that it will help inform the field on varying aspects of the problem and the strategies which are evolving to help in its solution.

The discussion includes descriptions of the nature and extent of the problem of maternal drug-abuse and the prevalence of drug-exposed children; research on substance abusing women and their children; drug treatment and prevention services for mothers; child welfare and legal issues relating to drug abusing women and their children; and Medicaid and Social Security financing for this population. The paper concludes with observations about the nature of maternal drug abuse and effective strategies for intervention.

This paper does not address the emerging issue of the long term developmental needs of drug-exposed children. While research is underway to document possible implications for child development of parental drug use before and after birth, as well to develop appropriate interventions for affected children, such work has not yet produced sufficient consensus for a comprehensive discussion. It is clear, however, that drug-exposed children display a wide range of ability levels and that only a small proportion display serious, long term impairment. Materials under development both within HHS and the Department of Education will address this issue in the coming months and years.

Problem

Drug abuse among pregnant women and women of childbearing age is a complex and growing problem with several important inter-related components.

- Prenatal drug exposure has significant, although not yet clearly defined, negative effects on the infant and developing child. Low birthweight and premature delivery are among the most serious. Parental drug use also puts children at increased risk of child neglect and abuse.

- Drug using women and their children are a particularly hard to reach population.

- Strained drug treatment and social service systems throughout the Nation currently either lack the capacity or appropriate family orientation to effectively serve this population.

Strategy

Service providers are finding the needs of drug-exposed families so extensive that no one agency can address them all. Instead, the agencies must work together and pool their expertise and resources to serve these families most effectively.

HHS efforts regarding this population are focused on the following objectives:

- Conduct research in order to determine the nature and extent of maternal drug use; better understand the medical and developmental consequences of prenatal drug exposure on the fetus, infant, and developing child; and develop appropriate prevention and treatment approaches.

- Develop and disseminate effective interventions to:

  - Prevent drug use among women of childbearing age.

  - Treat drug addiction among women of childbearing age.

  - Prevent child abuse and neglect in families with substance abuse problems, and serve those children who have been abused or neglected because of their parents drug use.

  - Intervene with children who show or are at risk of developmental delays or other problems resulting at least in part from parental drug use.

- Continue to support drug treatment capacity by providing funds to States for prevention and treatment services.

- Improve the ability of the child welfare system to serve increased numbers of drug-exposed or drug-affected children and families.

- Provide medical insurance and disability income supports for eligible individuals (including many with substance addictions) and their children. These programs enable many to receive treatment who might not otherwise.

A number of offices within HHS play vital roles in carrying out the objectives described above. Detailed descriptions of specific programmatic efforts of each agency with respect to this population may be found in the companion document to this piece, "Maternal Drug Abuse and Drug-exposed Children: A Compendium of HHS Activities".

Research on the Effects of Prenatal Drug Abuse

The challenge to research is to design instruments and develop the methodologies to determine the nature, extent, and consequences of maternal drug abuse; enhance our understanding of the basic mechanisms of action of drugs and their effects when they cross the placenta; and to evelop and test new treatment and prevention strategies which address the myriad of problems facing drug abusing women and their children. In addition, more research is needed on the effects of paternal drug abuse on children.

To determine the incidence and prevalence of maternal drug abuse and its developmental, psychological, and physical effects, NIDA is supporting research to develop and improve approaches for identifying pregnant women and neonates at risk; provide estimates of the prevalence of drug use during pregnancy and the number of infants exposed to drugs during pregnancy; and determine the effects of drug exposure on a variety of outcome measures. Research on the optimal combination of treatment and other services, as well as settings in which such services are provided will permit us to make recommendations regarding model treatment strategies and options for providing such services. NIDA's basic research program is increasing the understanding of the effects of drug abuse on mothers and their offspring and laying the foundation for the development of medications appropriate to this population.

There has been little information on effects of paternal drug abuse on children until recently. One animal study has demonstrated a relationship between ingestion of morphine and alteration in normal development of offspring, and observed that these effects were long-term in nature. This research hints at the potential harmful effects of a father's drug use on his children.

Preventing and Treating Drug Abuse in Pregnant and Parenting Women

The many negative health and social consequences of substance abuse for a woman and her children demand that such abuse be prevented to the extent possible and treated in those for whom prevention is too late or unsuccessful. The challenge for HHS and for State, local, and private agencies supporting prevention and treatment activities has been to tailor appropriate and effective prevention messages and treatment strategies for high risk groups.

At the Federal level, HHS is working to develop, document, and disseminate effective models of substance abuse prevention and treatment.

Drug addiction is a chronic, relapsing disorder that is frequently accompanied by a host of medical, psychological, and sociological problems. The incidence of addiction-related health, mental health, social and emotional disorders is especially high in drug dependent women (as opposed to men), who typically are without family and community support systems or economic resources, and whose own family histories often include abuse and/or addiction. Treatment programs are often unprepared to meet the particular needs of women with children, including child care and development, parenting skills training and child abuse and neglect prevention, and addressing the consequences of addicted women's frequent histories of abuse as children and other domestic violence.

Child Welfare Services for Drug Abusing Families

The number of drug-exposed infants and children of drug abusers entering the child welfare system is creating a new set of demands that have yet to be properly addressed. Parental substance abuse significantly increases the risk of neglect, physical abuse, and sexual abuse.

During the 36 months between June 1987 and June 1989 the American Public Welfare Association estimates that the number of children in foster care in the U.S. increased approximately 29 percent, to 360,000 children. The States of California and New York were together responsible for 55 percent of this increase.

Assessment of the risks to the child is particularly complex and difficult in situations of illegal drug use. Intensive family service programs often will not accept drug involved families. The mother may deny drug use due to distrust of the child welfare authorities. In addition, child welfare caseworkers often doubt that promises of sobriety can be maintained.

Despite these uncertainties, most of the substance-exposed infants and children of drug users do not go into foster care placement. In New York, only about one-third of the substance exposed infants go into foster care immediately, and in a 1990 GAO study only 1,200 of the 4,000 infants reported to be born substance exposed were placed in foster care.

Many child welfare professionals are unfamiliar with the special care needs of drug-exposed children and do not have adequate preparation or resources to handle such a large proportion of high-risk cases. In-service training and staff education on drug effects, treatment, infant-parent interaction, and high-risk mother-infant pairs are essential supports for professionals and para professionals serving these children and their families.

Legislative and Judicial Responses to Substance Abuse in Women

For the most part, drug-exposed children are being served by the public child welfare system and the family courts, rather than the criminal justice system. However, a few States have begun to prosecute pregnant women as drug dealers, drug abusers, or as child abusers under criminal statutes. Some States have also enacted legislation to require reports of perinatal drug abuse to child protective service agencies, or similar authorities. Although, child welfare agencies adhere to a philosophy of preserving family unity, they frequently make out-of-home foster care placements to protect the child. Federal statutes require that States make "reasonable efforts" to rehabilitate and reunite the family, i.e., to provide services to the family, in order to qualify for certain Federal funds. When it is not possible to reunite the family, State laws govern the termination of parental rights and adoption. Federal legislation also provides fiscal support for adoption of children with special needs, which may apply to some drug-exposed children.

Financial Assistance Programs

The Medicaid program, administered by the Health Care Financing Administration (HCFA) is a Federal-State entitlement program that pays for the health care of certain categorically eligible low income individuals. For eligible individuals, States must provide, at a minimum, needed inpatient and outpatient hospital services, rural health clinic services, physician services, nurse midwife services, services in Federally qualified health centers, and EPSDT services for children under 21 years of age. Within the above categories, States can choose to offer a variety of alcohol and drug treatment services, for instance detoxification, outpatient day treatment, or methadone maintenance. Whether or not individual States cover such services depends on how they define services under the mandatory categories and whether they set limits on the amount of services available to an individual under Medicaid. At present, Medicaid does not pay for treatment of drug addiction or mental illness in residential treatment facilities of larger than 16 beds. HCFA is, however, sponsoring a series of waiver demonstrations allowing several States to experiment with the option of allowing such services for pregnant substance abusing women.

Mothers and children with substance addictions or substance-related disabilities may be eligible for payments and medical coverage under two disability programs administered by the Social Security Administration. These are the Social Security Disability Insurance (SSDI) and the Supplemental Security Income (SSI) programs. While the disability eligibility criteria for the two programs are similar, SSDI requires the recipient to obtain insured status, which is accomplished by working for a certain period of time in a job covered by Social Security. SSI is a needs-based program that does not require insured status. Minor dependents of SSDI beneficiaries are eligible for benefits based on their dependent status. Children of SSI recipients only receive benefits if they are disabled themselves.

Under both the SSDI and SSI programs, the mother must have a medically determinable physical or mental impairment that has kept, or is expected to

keep, her from working for at least 12 months, or is expected to result in death. The impairment must be demonstrated by medically acceptable diagnostic techniques–signs, symptoms and laboratory findings. In addition, a child can qualify for SSI disability payments in his or her own right, even if the parent is not disabled, if a child manifests a substantial reduction in ability to function independently, appropriately, and effectively in an age-appropriate manner because of a medically determinable impairment. Recently published childhood disability regulations include medical listings for psychoactive substance dependence disorders in children for the first time.

Conclusions

Drug using mothers and their children have multidisciplinary needs and will require the coordinated provision of services from a number of service systems and disciplines. Service providers who work with these families stress that cooperation, collaboration, and communication among the agencies and programs who see these families is essential.

Substance abuse by pregnant women and women with children is a problem of extreme concern to the U.S. Department of Health and Human Services and its component agencies. In this document we attempt to outline an understanding of this problem and a strategy toward its solution. In particular, we emphasize the following:

- Maternal drug abuse is a complex, multifaceted problem.
- It is possible to provide effective services to this population.
- Women and children have particular characteristics and needs which must be accounted for in service design.
- Maternal drug abusers have complex needs which cannot be solved with short-term interventions. Severely addicted women in particular may need long-term interventions at varying degrees of intensiveness over the course of their recovery.

The varied agencies within HHS are committed to working together to address the problem of maternal drug use and the needs of drug-exposed children. As has been described above, substantial progress has been made in understanding the nature of the problem and developing strategies to address the needs of this population. By conducting research, developing and disseminating effective interventions, supporting State and local service capacity, and through medical and disability insurance payments for eligible individuals, HHS carries out its commitment to healing and strengthening families affected by maternal substance abuse.

INTRODUCTION

PURPOSE

Drug abuse is a serious problem in the United States. The low cost of crack cocaine coupled with its highly addictive properties are especially troublesome. Substance abuse by women of childbearing age, particularly during pregnancy and during the early years of child rearing, has resulted in increasing numbers of children coming to public attention for their protection. Federal, State and local policy makers and service providers are struggling to define how best to address the growing problem of infants exposed to drugs and mothers unable to provide proper care and nurturance for their young.

This paper draws from the perspective of various programs from within the Department of Human Services which have responsibilities concerning drug using mothers and their children. It is not a definitive analysis of the problem. However, we hope that it will help inform the field on varying aspects of the problem and the strategies which are evolving to help in its solution.

This paper is one of several products generated by the Sub-Group on Substance Abusing Women and Their Children of the Department's Ad Hoc Drug Policy Group. Its companion piece, "Maternal Drug Abuse and Drug-exposed Children: A Compendium of HHS Activities," details the variety of efforts the Department has underway which relate to these populations. Taken together, we anticipate that these pieces, and others the group may decide to produce in the future, can represent a coherent vision of this Departments involvement in addressing the needs of substance abusing women and their children, and in preventing the future abuse of drugs by women of childbearing age.

The discussion which follows includes descriptions of the nature and extent of the problem of maternal drug abuse and the prevalence of drug-exposed children; research on substance abusing women and their children; drug treatment and prevention services for mothers; child welfare and legal issues relating to drug abusing women and their children; and Medicaid and Social Security financing for this population. The paper concludes with observations about the nature of maternal drug abuse and effective service strategies for this population.

This paper does not address the emerging issue of the long term developmental needs of drug-exposed children. While research is underway to document possible implications for child development of parental drug use before and after birth, as well to develop appropriate interventions for affected children, such work has not yet produced sufficient consensus for a comprehensive discussion. It is clear, however, that drug-exposed children display a wide range of ability levels and that only a small proportion display serious, long term impairment. Materials under development both within HHS and the Department of Education will address this issue in the coming months and years.

urine for drugs and collection of data on the infants birth weight and length of stay in the hospital. Data will be available in 1992-1993.

Problem

The problem of maternal drug use has several inter-related components. While described here in broad terms, later discussions provide more detail about specific aspects of the problem and approaches toward its solution. Throughout these discussions it must be remembered that polydrug use (the use of more than one drug) is the norm among drug abusing women. Most will use alcohol and marijuana in addition to cocaine, for instance, and therefore talking about a crack user or a cocaine exposed infant, for instance, is in many cases misleading.

There are several overlapping populations of concern when one talks about maternal drug use. From the broadest perspective the population of concern is women of childbearing age who use or are at high risk of using drugs, and their children. Of particular concern are pregnant substance abusers, mothers currently using drugs, children exposed to drugs in-utero, and children residing in drug-using households.

Prenatal drug exposure has significant, although not yet clearly defined, negative effects on the infant and developing child. Details remain unclear, however, in part because effects are dependent on the specific drug as well as on the amount used, duration of use, and timing of exposure during pregnancy. In addition to direct biological effects, parental drug related behavior can have negative consequences for children independent of direct drug exposure (e.g., increased risk of child abuse or neglect).

Drug using women and their children are a particularly hard to reach population. In addition to the general denial associated with drug use, initial reports indicate that fear o' hild protection agencies may discourage some maternal drug abusers from seeking treatment or other services. In addition, poor and minority women are disproportionately represented among substance abusing mothers (at least among those identified through public systems) and face the same under service that these populations face regarding most health care services.

Strained drug treatment and social service systems throughout the Nation currently lack either the capacity or appropriate family orientation to effectively serve this population. As will be discussed in more detail later, child welfare caseloads in many parts of the Nation are far beyond levels allowing adequate services and supervision. In addition, drug treatment programs are rarely operated with a family foct s, undermining the possibility of effective treatment for pregnant women or women with children.

HHS considers and treats addiction as a disease. Nonetheless, it is critical to remind those contemplating drug use, drug users who have not yet become addicted, and those who are struggling to recover from addiction that they have responsibility for the course of their lives. For such individuals,

establishing personal responsibility and a commitment to a healthy lifestyle is a vital part of preventinn and recovery.

Strategy

The issue of maternal drug abuse is complex and extremely emotional. Service providers are finding the needs of these families so extensive that no one agency can address them all. Instead the agencies must work together and pool their expertise to serve these families most effectively.

HHS efforts regarding this population are focused on the following objectives:

- Conduct research in order to determine the nature and extent of maternal drug use; better understand the medical and developmental consequences of prenatal drug exposure on the fetus, infant, and developing child; and develop appropriate prevention and treatment approaches.

- Develop and disseminate effective interventions to:

  - Prevent drug use among women of childbearing age.

  - Treat drug addiction among women of childbearing age.

  - Prevent child abuse and neglect in families with substance abuse problems, and serve those children who have been abused or neglected because of their parents drug use.

  - Intervene with children who show or are at risk of developmental delays or other problems resulting at least in part from parental drug use.

- Continue to support treatment capacity by providing funds to States for prevention and reatment services.

- Improve the ability of the child welfare system to serve increased numbers of drug-exposed or drug-affected children and families.

- Provide medical insurance and disability income supports for eligible individuals and their children (including many with substance addictions). These programs enable many to receive treatment who might not otherwise.

These goals are consistent with Secretary Sullivans Goals and Program Directions for HHS. (For a full discussion of Goals and Program Directions see The FY1991-FY1992 HHS Program Directions Plan.)

The importance which the Department places on the objectives outlined above is consistent with the President's special emphasis, and top priority placed in the National Drug Control Strategy, on addressing the issues associated with substance abusing women. The Administration will continue to foster access

to and expansion and improvement of treatment services for pregnant women and their children.

A number of offices within HHS play vital roles in carrying out the objectives described above. These are listed immediately below and include components of the Public Health Service (which oversees the health side of the Department's activities), the Administration for Children and Families which oversees the Department's human services activities, as well as the Health Care Financing and Social Security Administrations. Detailed descriptions of specific programmatic efforts of each agency with respect to this population may be found in the companion document to this piece, "Maternal Drug Abuse and Drug-exposed Children: A Compendium of HHS Activities."

Within the Public Health Service (PHS)

Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA)
- National Institute on Drug Abuse (NIDA)
- National Institute on Alcohol Abuse and Alcoholism (NIAAA)
- Office for Substance Abuse Prevention (OSAP)
- Office for Treatment Improvement (OTI)

National Institute on Child Health and Human Development (NICHD)

Health Resources and Services Administration (HRSA)
- Maternal and Child Health Bureau (MCHB)

Within the Administration for Children and Families (ACF):

Administration on Children, Youth and Families (ACYF)
Administration for Native Americans (ANA)
Administration on Developmental Disabilities (ADD)

Elsewhere in HHS:

Health Care Financing Administration
Social Security Administration

The efforts of these various agencies come together in order to carry out the goals of better understanding the conditions and service needs of drug abusing mothers and their children, developing effective interventions to meet those needs, and financing services for those in need.

CONGRESSIONAL UPDATE
104th Congress (1996)

WELFARE REFORM (9/18/96)

Legislation to reform the country's welfare system, formally known as the "Personal Responsibility and Work Opportunity Reconciliation Act of 1996," was recently signed into law by President Clinton. The law does not include any alcohol or other drug treatment provisions or requirements for beneficiaries.

BACKGROUND:

The welfare reform law is comprehensive legislation that ends entitlements and sets up block grant programs that give states wide latitude in providing assistance to needy families. States will be required to develop a plan on how they will spend the block grant and submit that plan to the federal government for approval. Even though substance abuse treatment was not specifically covered in the law, states will be able to include treatment requirements for benefit recipients if they chose to.

There is ample evidence that treatment plays a positive role in getting people off welfare and into jobs. The National Association of State Alcohol and Drug Abuse Directors (NASADAD) issued a report in August that concludes "the evidence from across the country is clear: treatment for alcohol and other drug problems is a critical component of welfare reform efforts and is a successful strategy to end welfare dependency and to increase employment-related outcomes." The report Alcohol and Other Drug Treatment: Policy Choices in Welfare Reform has been sent to all state substance abuse directors and is available from NASADAD for your use as well. If you are interested in obtaining a copy for $10, please call NASADAD at 202/783-6868.

At least two states are already incorporating drug testing into their welfare plans. A county in Florida is requiring individuals to pass a drug test before given social services (apparently without offering access to treatment if needed). South Carolina appears to be the first state to require drug testing with treatment made available to those who need it. Social service benefits would continue as long as an individual remains in treatment.

The law takes affect on July 1, 1997.

If you have further questions about this legislation, please contact our Public Policy Office via e-mail: publicpolicy@ncadd.org.

WHAT YOU CAN DO:

1) Become involved in the process of developing your state's new welfare plan as soon as possible.

** Contact your state's alcohol and drug abuse director, welfare commissioner, governor and your state legislators. ALL of these people will be involved with developing your state's welfare plan, and it is imperative that they have the information they need to include treatment as an integral part of the plan.

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Florida considers welfare drug tests

Category: Category 1
Date: 25 Jan 1997
Time: 07:33:09
Remote Name: 127.0.0.1
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Comments

(UPI Spotlight)

TALLAHASSEE, Fla., Jan. 24 (UPI) - A Florida legislator has introduced a bill (Friday) that would force welfare recipients to pass drug tests or lose their benefits. State Rep. Joe Arnall says abusing drugs is an unacceptable lifestyle and should not be subsidized by taxpayers. Question: Do you feel this bill is an infringement of rights?

Governor will seek welfare drug tests

Engler also supports more aid for poor kids

January 26, 1998

BY DAWSON BELL
Free Press Staff Writer

LANSING -- Gov. John Engler will take a carrot-and-stick approach to continuing efforts to reform welfare in 1998, expanding health care coverage for poor children while calling for a ban on benefits to recipients who fail drug tests.

The drug ban, dubbed Operation Zero Tolerance in echo of the governor's Project Zero efforts to put welfare recipients to work, would be enacted on a pilot basis in selected areas. Those who test positive for illegal substances would be referred to drug treatment programs; if they don't show up and complete treatment, benefits would be denied.

Aides said Engler eventually would like to have all welfare applicants subject to drug testing.

Details of the proposal have not been completed. And advocates for the poor said the program would have to be carefully crafted to be effective and to avoid violating individual rights.

But advance copies of the governor's text on the proposal indicate an initial emphasis on tough talk.

"Zero tolerance means just that -- zero tolerance. No abuse. No excuse," the text reads.

"The purpose ...is not to be harsh for the sake of being harsh. The aim is to send a signal."

Engler, scheduled to deliver his eighth State of the State address Thursday, will ask the Legislature for authorization to begin the drug

testing after running through a lengthy list of accomplishments in human services and improvements in the quality of life for poor people.

Among them:

Seven straight years of decline in the infant mortality rate.

45 consecutive months of decline in the welfare rolls.

Michigan as one of only five states to register a decline in the poverty rate.

80,000 previously uninsured children receiving health coverage through the Healthy Kids initiative.

Engler also plans to announce Thursday the expansion of health-care coverage for poor people, under a state-federal program that will make low-cost insurance available to "virtually 100 percent" of the state's children.

Engler spokesman John Truscott said the administration is unsure how much the drug testing and treatment program would cost, and does not have an estimate on the number of welfare recipients with substance abuse problems.

"We believe it is higher than the general population ...and is one of the reasons that people fall into poverty," he said.

The pilot programs would give welfare administrators a clearer picture of the problem, Truscott said.

A national study released last year indicated that the rate of drug use among welfare recipients is not substantially higher than that among non-recipients.

Advocates for the poor said drug testing and treatment can nevertheless be beneficial if administered carefully.

Demetra Nightingale, director of welfare and training research at the Urban Institute in Washington, D.C., said her agency found, in focus groups of recipients, a recognition that drug abuse was a problem.

"Drug testing is increasingly common in the workplace. In a way, it helps people prepare,"

Nightingale said. "But the important question is what happens after the test. You have to be sure there are treatment programs. You have to be sure (sanctions) are not administered arbitrarily."

Civil rights groups occasionally have objected to drug testing programs as an invasion of privacy.

Richard Lobenthal of the American Civil Liberties Union of Michigan said Sunday there is a danger that drug testing will be aimed at people without political power regardless of whether a real problem exists. But it is possible to conduct drug testing without violating the law -- "in which case we wouldn't have a problem with it," he said.

State Rep. Sharon Gire, D-Clinton Township, a member of the House Human Services Committee, said she suspects the number of welfare recipients with drug problems is relatively small. And drug testing and treatment may be more expensive than the governor realizes, she said.

"But we'll have to wait to see the details to make any judgments."

Engler's other welfare initiative in 1998 will involve strengthening the state's enforcement of child-support orders. Although Michigan has a relatively high level of success in collecting child support, improved computerization should be in place by spring to augment it, he will suggest.

Staff writer Dawson Bell can be reached at 1-313-222-6609.

MORE MICHIGAN STORIES

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New Jersey statute regulatory provisions

1 jurisdiction from which the person has fled; or is violating a condition
2 of probation or parole imposed under federal or State law;
3 (7) a person convicted on or after August 22, 1996 under federal
4 or State law of any offense which is classified as a felony [1]or crime,
5 as appropriate,[1] under the laws of the jurisdiction involved and which
6 has as an element the possession, use, or distribution of a controlled
7 substance as defined in section 102(6) of the federal "Controlled
8 Substances Act" (21 U.S.C.§802 (6))[1]; except that a person convicted
9 of any such offense which has as an element the possession or use only
10 of such a controlled substance may be eligible for benefits if the person
11 has successfully completed a drug treatment program approved by the
12 commissioner. Eligibility for benefits shall commence upon
13 completion of the drug treatment program, except that during the first
14 60 days after completion of the drug treatment program, the
15 commissioner shall provide for testing of the person to determine if the
16 person is free of any controlled substance. If the person is determined
17 to not be free of any controlled substance during the 60-day period,
18 the person's eligibility for benefits pursuant to this paragraph shall be
19 terminated. The commissioner, in consultation with the Commissioner
20 of Health and Senior Services, shall adopt regulations to carry out the
21 provisions of this paragraph, which shall include the criteria for
22 determining completion of a drug treatment program[1];
23 (8) a person found to have fraudulently misrepresented his
24 residence in order to obtain means-tested, [1][federally funded][1] public
25 benefits in two or more states [1]or jurisdictions[1], who shall be ineligible
26 for benefits for a period of 10 years from the date of conviction in a
27 federal or State court; or
28 (9) a person who intentionally makes a false or misleading
29 statement or misrepresents, conceals or withholds facts for the
30 purpose of receiving benefits, who shall be ineligible for benefits for
31 a period of six months for the first violation, 12 months for the second
32 violation, and permanently for the third violation.
33 c. A person who makes a false statement with the intent to qualify
34 for benefits and by reason thereof receives benefits for which the
35 person is not eligible is guilty of a crime of the fourth degree.
36
37 6. (New section) a. The signing of an application for benefits
38 under the Work First New Jersey program shall constitute an
39 assignment of any child support rights pursuant to [1][45 CFR 232.11]
40 Title IV-D[1] on behalf of individual assistance unit members to the

2. Supplemental Security Income recipients, except for the purposes of receiving emergency assistance benefits;

3. Illegal aliens;

4. Other aliens who are not eligible aliens as defined in N.J.A.C. 10:90-2.10;

5. A person absent from the home who is incarcerated in a Federal, State, county or local corrective facility or under the custody of correctional authorities;

6. A person who is fleeing to avoid prosecution, custody or confinement after conviction, under the laws of the jurisdiction from which the person has fled, for a crime or an attempt to commit a crime which is a felony or a high misdemeanor under the laws of the jurisdiction from which the person has fled; or is violating a condition of probation or parole imposed under Federal or State law;

   i. Under the laws of the State of New Jersey, a crime is defined at N.J.S.A. 2C:1-4(a) as "an indictable offense...for which a sentence of imprisonment in excess of 6 months is authorized."

7. A person convicted on or after August 22, 1996 under Federal or State law of any offense which is classified as a felony, high misdemeanor or crime, under the laws of the jurisdiction involved and which has as an element the distribution, possession, or use of a controlled substance as defined in section 102 (6) of the Federal "Controlled Substances Act" (21 U.S.C. Section 802 (6)).

   i. Under the laws of the State of New Jersey, a crime is defined at N.J.S.A. 2C:1-4(a) as "an indictable offense ... for which a sentence of imprisonment in excess of 6 months is authorized."

   ii. A person convicted on or after August 22, 1996 of any such offense which has as an element the possession or use only of such a controlled substance may be eligible for benefits if the person has successfully completed a drug abuse treatment program licensed by the State of New Jersey Department of Health and Senior Services (DHSS), at the conclusion of which the person is certified drug free by an authorized program representative.

      (1) Eligibility for benefits shall commence upon successful completion of the established requirements of the DHSS licensed drug treatment program.

      (2) During the first 60 days after successful completion of the drug treatment program or at the time of application or case redetermination, it must be determined, via testing by an entity designated by DFD, that the person is free of any non-prescribed controlled substance. If the person is determined not to be free of any controlled substance during, or at the conclusion of, the 60 day period, the person's eligibility for benefits shall be terminated immediately.

siblings (2nd degree), great-grandparents (3rd degree), uncles or aunts (3rd degree), nephews or nieces (3rd degree), great-great grandparents (4th degree), great-uncles or aunts (4th degree), first cousins (4th degree), great-great-great grandparents (5th degree), great-great uncles or aunts (5th degree), or first cousins once removed (5th degree). (A first cousin once removed is the child of a person's first cousin.)

(1) An applicant who is a parent-person may apply for WFNJ/TANF benefits for a child(ren) and him or herself as a needy parent-person.

(2) Non-needy caretakers and/or parent persons shall also be eligible to apply for WFNJ/TANF benefits for the children in their care.

ii. Spouses of any persons named in the above groups may be considered "parent-persons" even though the marriage has been terminated by death or divorce.

iii. Under New Jersey law, relatives of persons who adopt children become legally related to such adopted children to the same extent that they are related to natural children of the adopting parent.

(b) Composition of the eligible WFNJ/GA assistance unit is as follows:

1. The WFNJ/GA assistance unit shall be comprised of one or more persons. In most cases, it will consist of a single individual, 18 years of age or over, or a couple without dependent children. In room and board or residential treatment situations, each person is an eligible unit of one. In all other situations, the eligible assistance unit shall consist of:

i. The applicant/recipient;

ii. The spouse of the applicant/recipient who lives in the home unless the spouse is receiving SSI or public assistance through another program; or,

iii. The person with whom the applicant/recipient lives as a couple (but only if there was a previous history or current history of support) unless such person is receiving SSI or public assistance through another program.

10:90-2.8 Individuals ineligible for WFNJ TANF/GA

(a) The following persons shall not be eligible for assistance and shall not be considered to be members of the WFNJ/TANF or WFNJ/GA assistance units:

1. Non-needy caretakers, except that the eligibility of a dependent child shall not be affected by the income or resources of a non-needy caretaker;

(A) Benefits cannot be granted or reinstated until the person completes another drug treatment program, and remains drug free for a minimum of 60 days and is determined via testing to be free of any non-prescribed controlled substance.

8. A person found, on or after August 22, 1996, to have willfully and knowingly fraudulently misrepresented his or her residence in order to obtain means-tested, public assistance benefits in two or more states or jurisdictions, shall be ineligible for benefits for a period of 10 years from the date of conviction in a Federal or State court.

9. A person who, after July 1, 1997 and provided that the person has received written notice informing them of the WFNJ disqualification penalties, intentionally makes a false or misleading statement or misrepresents, conceals or withholds facts for the purpose of receiving benefits shall be ineligible for benefits for a period of six months for the first violation, 12 months for the second violation, and permanently for the third violation.

10. In addition to 1 through 9 above, persons found eligible for or who are recipients of WFNJ/TANF, or who have been found ineligible for such programs due to voluntary refusal to comply with program requirements shall not be eligible for WFNJ/GA assistance.

(b) WFNJ benefits shall not be payable for any month in which any individual in the assistance unit is participating in a strike. The individual who is on strike is ineligible for benefits; however, other members of the assistance unit remain eligible for benefits.

1. The term "strike" includes any strike or other concerted stoppage of work by employees (including a stoppage by reason of expiration of a collective bargaining agreement) and any concerted interruption of operations by employees.

2. The term "participating in a strike" means an actual refusal, in concert with others, to provide services to one's employers.

3. Examples of non-strikers who are eligible to participate in the program include, but are not limited to:

i. Employees whose workplace is closed by an employer in order to resist the demands of employees (for example, lockout);

ii. Employees unable to work as a result of striking employees (for example, truck drivers who are not working because striking pressmen prevent newspapers from being printed); or,

iii. Employees who are not part of the bargaining unit on strike who do not want to cross the picket line due to fear of personal injury.

10:90-2.9 Definition of employable/unemployable persons in WFNJ/GA

(a) Definition of employable/unemployable persons for determination of payment level:

Kansas Department of Social and Rehabilitation Services
Rochelle Chronister, Secretary

MEMORANDUM

To: EPS Chiefs
From: Connie Hubbell and Andrew O'Donovan

Date: November 1, 1996
Subject: AODAT Implementation

IMPLEMENTATION PLAN
ALCOHOL AND OTHER DRUG ASSESSMENT AND TREATMENT (AODAT)

I. Background

Key barriers to ending dependence on public assistance are the health and social problems associated with the abuse of and dependence on alcohol and other drugs. House Bill 2423, enacted by the 1996 Kansas Legislature, established "a pilot project of alcohol and drug screening within the KanWork Program". The 1996 federal Personal Responsibility and Work Opportunity Act established the basis for allowing mandatory alcohol and drug screening and assessment for public assistance recipients. This legislation facilitated the development of the following plan which outlines new policy and procedures on the statewide implementation of substance abuse screening and treatment for EPS participants. Alcohol and other drug screening assessment and treatment (AODAT) is a mandatory component for EPS participants who meet the criteria for referral. Referred participants are subject to work program penalties upon non-compliance with the component.

EPS? Employment Preparation Services

II. New Policy

EPS casemanagers will refer an EPS participant to the Regional Alcohol and Drug Assessment Center (RADAC) with the SRS/RADAC turnaround form if the participant meets at least one of the following criteria during the current period of participation:

1. A positive outcome from administering the CAGE.
2. Well-documented incidence of intoxication while in the SRS office.
3. Dismissal from employment or any EPS activity for substance abuse related causes.
4. Any substance abuse related legal problems (such as DUI).
5. Participant admission or medical diagnosis that an alcohol-and/or drug-related problem with abuse or dependency exists.

CAGE - screening device

Once referred, RADAC will be responsible for determining and reporting non-compliance and status changes with any assessment or treatment activities on the Status Change

form.

EPS Case Managers should assign participants who are in outpatient treatment for less than 20 hours per week to additional appropriate components.

If an EPS participant has been discharged from treatment (in-patient or out-patient) during the current participation period and the participant is subsequently identified as needing a referral to RADAC, the participant would be referred to RADAC again. RADAC will determine compliance.

III. Procedures

A. Referrals and Coordination

Referrals to the RADAC will be made by telephone by the case manager and followed-up through use of the attached SRS/RADAC turnaround form. Good coordination will be required between the RADAC and SRS. Areas are encouraged to assign a liaison to handle coordination and communication issues as they arise. All areas must have a Qualified Service Organization Agreement with the RADAC on file. A copy of this agreement is attached.

C. Activity Assignment

Participants will be assigned to the AOD (Alcohol and Other Drug) component "AOD" will be an available KsCares component November 1, 1996. AOD Assignments should be made in conjunction with other EPS activities when the AOD hours are less than 20 hours per week. The number of hours per week that the participant is initially assigned for AOD activities will be included on the turnaround form by the RADAC. Changes in treatment hours will be noted by RADAC staff on the Status Change form. EPS participants in AOD activities are eligible for all component support services.

D. Status, Non-compliance and Penalties

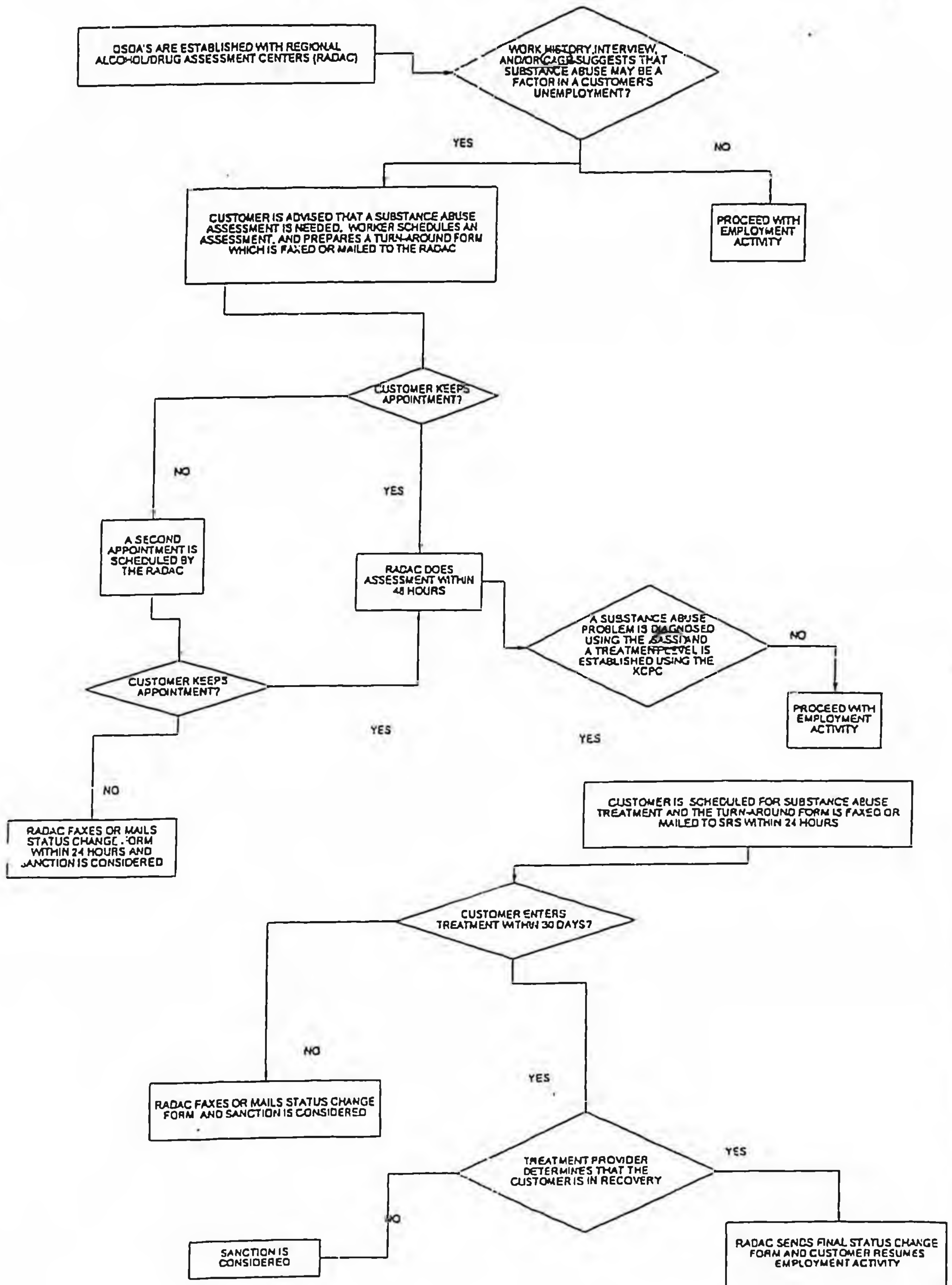
The RADAC will be responsible for determining and reporting non-compliance and status changes with any assessment or treatment activities. The EPS Case Manager will be responsible for determining penalties and good cause. The RADAC will send a Status Change form to the EPS Case Manager when treatment hours change and whenever the participant exits the AOD program. The RADAC will note whether or not the individual was in compliance at the time of exit.

E. Effective Date

Implementation begins effective November 1. 1996 using the information contained in this memo and the attached flow-chart.

cc: IM Chiefs
Area Directors
Janet Schalansky

VIDING ASSISTANCE TO CUSTOMERS FOR WHOM SUBSTANC… CONTRIBUTES TO UNEMPLOYMENT



QUALIFIED SERVICE ORGANIZATION AGREEMENT

THE SRS OFFICE AT______________________________
TOWN NAME

AND

____
NAME OF SERVICE PROVIDER

HEREBY ENTER INTO A QUALIFIED SERVICE ORGANIZATION AGREEMENT WHEREBY THE SRS OFFICE WILL PROVIDE THE NAME AND OTHER IDENTIFYING INFORMATION OF INDIVIDUALS TO BE ASSESSED OR TREATED FOR SUBSTANCE ABUSE.

FURTHERMORE THE SRS OFFICE:

(1) ACKNOWLEDGES THAT IN RECEIVING, STORING, PROCESSING, OR OTHERWISE DEALING WITH ANY INFORMATION FROM THE SERVICE PROVIDER ABOUT THE PATIENTS IN THE PROGRAM, IT IS FULLY BOUND BY THE PROVISIONS OF THE FEDERAL REGULATIONS GOVERNING CONFIDENTIALITY OF ALCOHOL AND DRUG ABUSE PATIENT RECORDS, 41 CFR PART 2; AND

(2) UNDERTAKES TO RESIST IN JUDICIAL PROCEEDINGS ANY EFFORT TO OBTAIN ACCESS TO INFORMATION PERTAINING TO PATIENTS OTHER WISE THAN AS EXPRESSLY PROVIDED FOR IN THE FEDERAL CONFIDENTIALITY REGULATIONS, 42 CFI PART 2.

EXECUTED THIS _______DAY OF _________199___

_______________________________ SRS EMPLOYEE

_______________________________ PROGRAM DIRECTOR

TURN-AROUND FORM

SRS REFERRAL FOR ALCOHOL AND OTHER DRUG TREATMENT AND ASSESSMENT

WORKER'S NAME ____________ DATE ____________

AREA OFFICE ____________ ADDRESS ____________ PHONE ____________

CITY AND ZIP ____________

DIVISION: ____ (1) CHILDREN & FAMILY SERVICES (2) EPS/KANWORK (3) INCOME MAINTENANCE (4) REHABILITATION SERVICES (5) OTHER

CLIENT NAME ____________ KSCARES ID NUMBER ____________

ADDRESS ____________ CITY ____________ ZIP ____________ TELEPHONE NUMBER ____________

RADAC ASSESSMENT DATE ____________

I understand that failure to attend an alcohol and other drug assessment appointment and/or comply with further assessment and/or treatment activities without good cause will result in a work program penalty and loss of assistance. Further, I authorize the release of referral and status change information as may be required for program administration.

PARTICIPANT SIGNATURE ____________

REGIONAL ALCOHOL/DRUG ASSESSMENT CENTER (RADAC) REPLY

ADAS UNIQUE IDENTIFICATION NUMBER ____________

SASSI* SHOWS CLIENT NEEDS SUBSTANCE ABUSE TREATMENT YES____ NO____

KCPC** SHOWS CLIENT NEEDS LEVEL ________ TREATMENT SERVICES (SEE BELOW)

LEVELS 1 & 2 = OUTPATIENT SERVICES –HOURS WEEKLY______

LEVEL 3 (24 HOUR TREATMENT)= SOCIAL DETOXIFICATION OR RESIDENTIAL TREATMENT–DAYS______

CLIENT'S CONTINUED STAY NEEDS WILL BE REVIEWED ON ____________ DATE

RADAC EMPLOYEE ____________ TELEPHONE NUMBER ____________

RADAC REGION ________ DATE ____________

* SUBSTANCE ABUSE SUBTLE SCREENING INVENTORY
** KANSAS CLIENT PLACEMENT CRITERIA

CONFIDENTIAL - This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal Regulation (42 CFR Part 2) prohibits you from making any further disclosure of it without specific written consent of the person to whom it pertains. A general authorization for release of medical or other information is NOT sufficient for this purpose.

STATUS CHANGE FORM

Alcohol and Other Drug Assessment and Treatment Project

SRS INFORMATION

WORKER'S NAME ______________________ TELEPHONE NUMBER ______________

AREA OFFICE ______________ ADDRESS ______________________

CITY AND ZIP ______________________

DIVISION–(SEE BELOW) ______________

CHILDREN & FAMILY SERVICES (1) EPS/KANWORK (2) INCOME MAINTENANCE (3)
REHABILITATION SERVICES (4) OTHER (5)

CLIENT NAME ______________________ KSCARES ID NUMBER ______________

REGIONAL ALCOHOL/DRUG ASSESSMENT CENTER (RADAC) STATUS CHANGES

ADAS UNIQUE IDENTIFICATION NUMBER ______________

NON COMPLIANCE		COMPLIANCE	
DID NOT COME FOR APPOINTMENT		DISCHARGED TO LEVEL	
DID NOT ENTER TREATMENT		HOURS PER WEEK	
LEFT WITHOUT COMPLETING TREATMENT		EFFECTIVE DATE	

CLIENT'S CONTINUED STAY NEEDS WILL BE REVIEWED ON ______________
DATE

RADAC REGION ________

RADAC EMPLOYEE ______________________ TELEPHONE NUMBER ______________

DATE ______________

CONFIDENTIAL - This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal Regulation (42 CFR Part 2) prohibits you from making any further disclosure of it without specific written consent of the person to whom it pertains. A general authorization for release of medical or other information is NOT sufficient for this purpose.

AODAT COMMENTS, QUESTIONS, AND ANSWERS

1. Would like teleconference or some type of training on this prior to implementation since we have not used either CAGE or SASSI. IM/EPS staff need training on how to effectively administer the CAGE; I am afraid that they will just ask the questions on the card; we need to have training, or more info on a list of questions that can be asked to get the same results.

   There will be a teleconference scheduled as soon as possible but not before the implementation date. In-service training may be available through the RADAC to help with interviewing and assessment. As noted at the last chief's meeting, interviewers rarely just ask the CAGE questions point-blank straight from the card. The questions should be (and in many areas already are) integrated into current assessment practice. Current EPS interviewing and assessment procedures and techniques that look at strengths and barriers should produce accurate referrals.

2. Have the RADAC referral agencies had the opportunity for input on this?

   Yes.

3. Are the referrals to AODAT eligible for medical transportation or KanWork transportation reimbursement? We're concerned about the distance that persons will need to travel to RADAC. Is the intent of the statement "EPS participants in AOD activities are eligible for all JOBS support services" to allow us to use AOD as the component and issue a $25. transportation allowance? Could we also offer to pay for Child Care for screening and related appointments (if a treatment plan is required)?

   The draft implementation memo stated: "EPS participants in AOD activities are eligible for all JOBS support services." This has been changed to say "EPS participants in AOD activities are eligible for all component support services." This includes transportation, child care, and special services allowances. We will research medical transportation eligibility.

4. How is the treatment funded?

   Through ADAS.

   Does the client need a medical card to access the services of RADAC?

   No.

   Most of our clients are assessed as applicants and therefore do not have medical cards for up to a month after assessment.

   Our referrals will most likely meet the ADAS low income- level payment guidelines and services will be free.

5. Are MOST participants included in this plan?

   Yes. The memo states: "Alcohol and other drug screening assessment and treatment (AODAT) is a mandatory component for EPS participants who meet the criteria for referral." This is confusing because the beginning of the memo quotes directly from the bill regarding KanWork participants.

6. We have concerns about liability. Section II (2.)—"well documented incidence of intoxication while in the SRS Office." Using this as an example, what would constitute effective "documentation"?

Would we have more than one person note the odor of alcohol, then require RADAC screening, and if the person failed to cooperate, impose a penalty? Would this hold up in an appeal?

In further discussion of this issue, we would advise that documentation include the observations of more than one person if this is the only grounds for referral.

7. We're considering adding the CAGE questions to our standard assessment questionnaire. We already ask a general alcohol/drug question but will expand it with the CAGE questions.

8. We plan to contact RADAC to ask that one of their staff meet with us to coordinate the close communication that will be required to make this all work.

9. Will this assessment be required for applicant job search? or can it be done at the 3 week assessment?

   This assessment should be completed whenever appropriate and needed to make a determination of employability and/or component placement.

10. Need further clarification on the use of the turnaround document and if the info on the document can be released in an appeal situation.

    The turnaround and status change documents should be treated as you would a medical statement - as third party documentation. With the participants release signed on the turnaround form they can be used in an appeal situation.

11. I would suggest that the turnaround document have some type of release of information statement signed by client, and that statement could also indicate that failure to follow thru with the RADAC level of treatment will result in penalty for cash/fs.

    A release of information and a non-compliance statement for the participant to sign has been added to the turnaround document.

12. Turnaround form also needs name, address and phone number of the client referred.

    These have been added.

13. A clarification on "probable cause" for administering the test would be helpful.

    We have consulted with our Legal staff and are assured that the policy and procedures outlined in the implementation memo are adequate. We are confident that case managers will be able to make this assessment and document appropriately using current assessment practice and the five referral criteria.

14. Do you want the CAGE done on all participants, or just those with probable cause?

    The CAGE questions should be part of the strengths and barriers assessment battery and asked when the case manager believes it is appropriate.

15. You mentioned that RADAC makes decision on non-compliance. Will that be consistent throughout the state?

    Yes.

    What are their guidelines?

RADAC guidelines for non-compliance are similar to guidelines of other providers of component activity: not showing up for appointments; leaving treatment program before discharge; inappropriate behavior, etc.

What consitutes good cause for non-compliance?

Good cause is determined by the EPS case manager and includes reasons such as lack of transportation, child care, etc.

16. If a client is referred for treatment and is complying, does that count towards countable work activities?

No, not unless they are involved in some type of treatment related work program such as reintegration or a halfway house. Further clarification will be provided as the project develops.

Will a code be added to the system to identify the activity to place the client?

Yes, "AOD".

or is it NP?

No.

An explanation of what you want coded on the system would also be helpful.

Information should be added in the same way you would add information for any component with dates, participation hours, etc.