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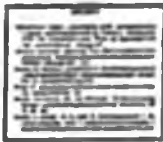
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Explore

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 to children should carefully consider parental childhood characteristics. *J. Am. Acad. Child Adolesc. Psychiatry*, 1997, 36(4):495-502. **Key Words:** substance abuse, psychopathology, risk factors.

Full Text: COPYRIGHT 1997 American Academy of Child and Adolescent Psychiatry. More than 6 million children in the United States are living with a parent with a substance use disorder (SUD) (Kumpfer and DeMars, 1986). While it is generally acknowledged that being the child of a parent with a SUD increases liability for a range 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 anxiety and

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 (Dobrenwend et al., 1992), HR families had lower SES by Hollingshead two-factor index (Hollingshead, 1990) than LAR families (35 [+ or -] 12 versus 45 [+ 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 ($[\chi^2]_{sup.2} = 4.6$, $p =$ 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 Schizophrenia 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 interviewer, 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 their 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 ($[\chi^2] = 16.64$, 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 243 correct negative predictions, 4 correct positive predictions, 34 incorrect negative predictions, and 2 incorrect positive predictions.

DISCUSSION

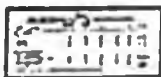
Epidemiological, clinical, and adoption studies have suggested that there are several pathways leading to [TABULAR DATA FOR TABLE 4 OMITTED] SUD. Cadoret and colleagues (1995) have presented evidence for a pathway that begins with ASPD in the biological parent, proceeds through adoptee CD and ASPD, and 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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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 (IHPP) 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

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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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 effect on July 1, 1997.

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

(c) 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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Florida considers welfare drug tests

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(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 Amall 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?

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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.

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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@csj.org.

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Kansas Department of Social and Rehabilitation Services
Rochelle Chronister, Secretary

MEMORANDUM

To: EPS Chiefs

Date: November 1, 1996

From: *Carrie Hubbell* and Andrew O'Donovan *A.O.*

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

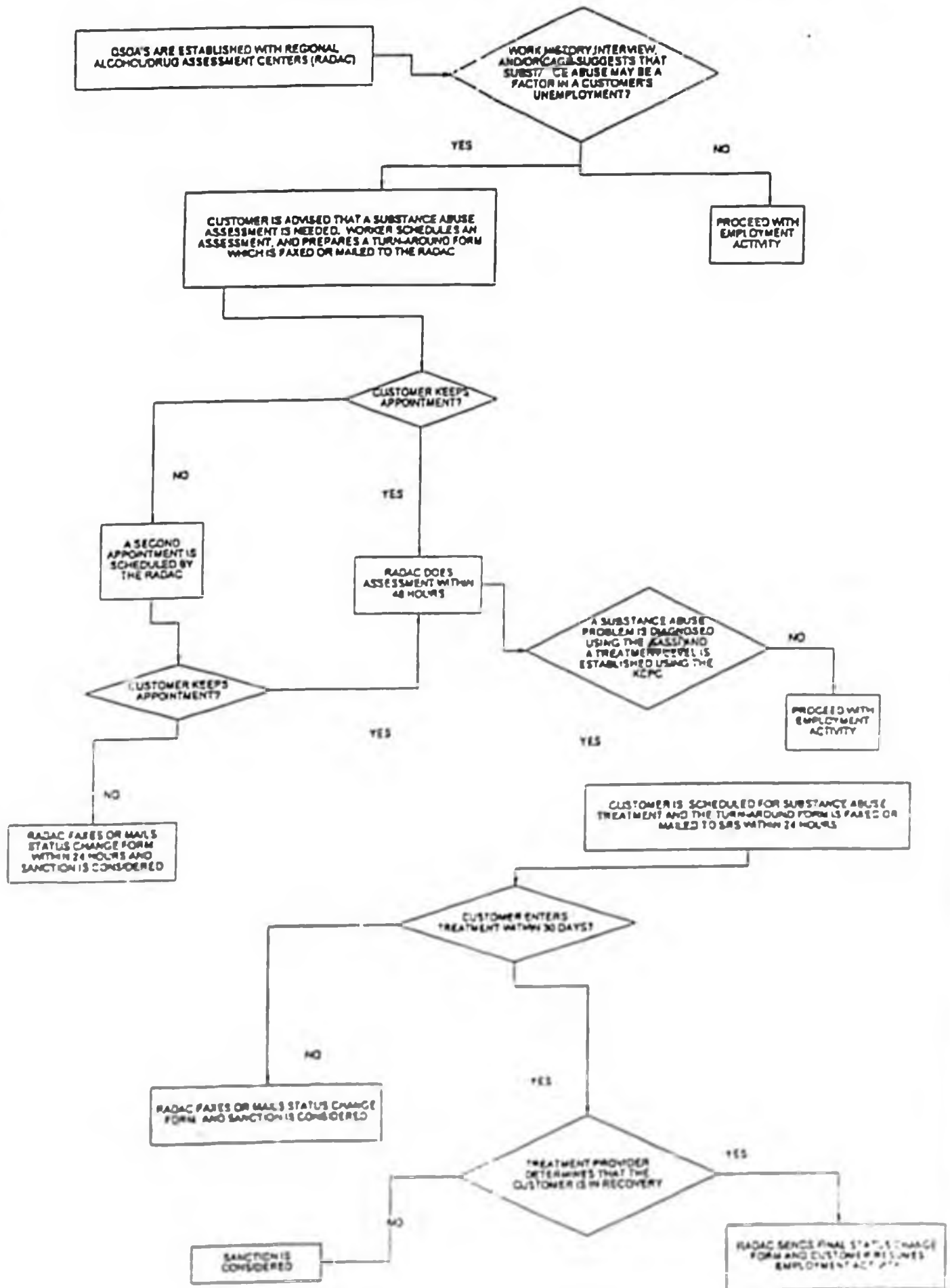
Implementation begins effective November 1, 1996 using the information contained in this memo and the attached flow-chart.

cc: IM Chiefs
Area Directors
Janet Schalansky

PROVIDING ASSISTANCE TO CUSTOMERS FOR WHOM SUBSTANCE ABUSE

CONTRIBUTES TO UNEMPLOYMENT

CAGE



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 EMPLOYER _____ 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) EPSYANWORK (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. IMEPS 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 chiefs 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 JCBS 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 11(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/ta.

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 constitutes 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.



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 E. Mahon
KEVIN MAHON, EXECUTIVE DIRECTOR, FIA
JOSEPH MILLSTONE, DIRECTOR, DHMB/MCPA
JOSEPH E. DAVIS, DIRECTOR, DHMB/PSOA
THOMAS DAVIS, DIRECTOR, DHMB/ADA

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.

ACTION REQUIRED: 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

Face to Face Interview:

◆ 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.

- ▶ Informs all adult and minor parent TCA applicants and recipients about the FDP 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 forms 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

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

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

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 .IMS 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.

REMEMBER: 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.

CARES 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, enter on the individual's DEM1 screen in the HOSPITAL field:
 - ▶ "SA1" - when the individual is enrolled in the treatment program.

- ▶ "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 "PI" 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

**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 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 REDISCULOSURE

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). 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 acts of alcohol or drug abuse treatment patients.

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 _____

authorize

(Print name of adult or minor parent TCA applicant or recipient)

I authorize 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 |
|---|--|---|
| Wegans County | Rosanne Lynch | (301) 777-2063 |
| Anne Arundel County | | |
| Baltimore County | Carole Ziegler Lisa Montford | (410) 887-2514 (410) 887-6204 |
| Calvert County | Doris Freedland | (410) 535-8731 |
| Carroll County | Ryanne Robinson | (410) 479-5900 |
| Carroll County | Phyllis Sripp | (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. 301 |
| Frederick County | Christine Rickle | (301) 694-2405 |
| Garrett County | Linda Ashby | (301) 334-9461 |
| HARFORD COUNTY Aberdeen Bel Air | Patricia Juchiewicz Sandra Watson | (410) 272-9081 (410) 336-4791 |
| Howard County | Katherine Ward | (410) 872-4200 ext. 310 |
| 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 Free Jeffrey Nimi Janice Causey Joy Etakudu Lela Moody | (401) 449-2562 (301) 449-2514 FAX 449-2558 (301) 422-5049 FAX 422-5097 (301) 341-2810 FAX 341-2819 (301) 386-5522 ext. 125 FAX 386-5533 |
| Queen Anne's County | Beatrice Embry | (410) 758-5111 |
| Saint Mary's County | Jennine Miller | (301) 475-1831 FAX 475-4799 |
| Summit County | Kathy Thomas | (410) 651-6346 |
| Talbot County | Joyce Alderman | (410) 822-7802 FAX 820-7067 |
| Washington County | Karen Workington Beth Fuller | (301) 739-8493 (301) 791-3464 |
| Wicomico County | Robert Drudge | (410) 543-6814 |
| Worcester County | Martha McGee | (410) 632-4325 FAX 632-3542 |
| Baltimore City | Karen Matheson Janet Richardson | (410) 361-3920 (410) 361-4229 FAX 361-4254 |

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 _____ Date
(substance abuse treatment program)

(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 5. Not maintaining active attendance/participation
- 4. Enrolled in treatment program 6. Successfully completed program

Admission date: _____

Discharge date _____

Patient able to work? YES NO

(Signature of Treatment Provider) Date

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 child(ren) 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/CA assistance unit is as follows:

i. The WFNJ/CA 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.

✓ 19:00-2.8 Individuals ineligible for WFNJ TANF/CA

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

i. 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 as N.J.S.A. 2C:1-6(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 132 (c) of the Federal "Controlled Substances Act" (21 U.S.C. Section 802 (c)).
 - i. Under the laws of the State of New Jersey, a crime is defined as N.J.S.A. 2C:1-6(a) as "an indictable offense ... for which a sentence of imprisonment in excess of 6 months is authorized."
8. 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 DTD, 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 WPNJ 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 WPNJ/TANF, or who have been found ineligible for such programs due to voluntary refusal to comply with program requirements shall not be eligible for WPNJ/OA assistance.

(b) WPNJ 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 employer.

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 WPNJ/OA

(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)/recipient(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 will not adversely affect the individual's Medicaid eligibility.

5/20/97 10:55 AM doc

VFNJ.00
(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 LICENSE () 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

A15 (IR)

6

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 'or crime,
5 as appropriate,' 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))'; 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';

23 (8) a person found to have fraudulently misrepresented his
24 residence in order to obtain means-tested, '[federally funded]' public
25 benefits in two or more states 'or jurisdictions', 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 '[45 CFR 232.11]
40 Title IV-D' 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 103 (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:

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*
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 refile 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

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 Certificate/License No. | |
| 14. Today's date | 15. Fax no. | 20. Outcome: <input type="checkbox"/> No follow-up required. <input type="checkbox"/> Follow-up required and enrollee will return to this practice for treatment. <input type="checkbox"/> Follow-up required and referral has been made to the provider listed below on ____/____/____ at ____ (Date) (Time) | |
| | 16. Phone no. | | |
| 17. Enrollee Attendance: <input type="checkbox"/> Enrollee attended assessment on ____/____/____ <input type="checkbox"/> 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 Certificate/License No. | |
| 24. Today's date | 25. Fax no. | 30. Outcome: <input type="checkbox"/> No follow-up required. <input type="checkbox"/> Follow-up required and enrollee will return to this practice for treatment. <input type="checkbox"/> Follow-up required and referral has been made to the provider listed below on ____/____/____ at ____ (Date) (Time) | |
| | 26. Phone no. | | |
| 27. Enrollee Attendance: <input type="checkbox"/> Enrollee attended assessment on ____/____/____ | | | |

**INSTRUCTIONS FOR COMPLETION OF
THE STATEMENT OF ATTENDANCE FORM (OHHS 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 JS00996

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

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: _____

SUBSTANCE ABUSE AND RECEIPT OF WELFARE

Background

Recent research indicates that between 10 and 20 percent of welfare recipients have a substance abuse problem. About 5 percent of recipients have substance abuse problems severe enough to substantially limit their day-to-day functioning. Anecdotal evidence suggests the problem may be more widespread among long-term recipients. 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. Because welfare reform initiatives require most welfare recipients to work or participate in employment programs states are faced with the challenge of identifying policies that effectively address substance abuse issues among welfare recipients and still promote and support family self-sufficiency.

The Value of Assessment and Treatment

Forty-five states have elected not to require drug testing as a factor of eligibility. In the few states that have opted for testing the tests are used to monitor compliance in assigned drug treatment programs rather than to serve as a catalyst for sanctions. Several factors contribute to the decision not to use drug testing as an eligibility criteria and help explain why states generally have used testing to monitor compliance with treatment rather than as a eligibility screening tool.

- The high cost associated with testing (at least \$20 per drug, rising to as much as \$70 with confirmation testing);
- The testing does not typically address alcohol abuse;
- The questionable reliability of any one test;
- The unresolved 4th Amendment legal issues around search and seizure; and,
- The contradiction inherent in excluding families whose members test positive from assistance they need to achieve self-sufficiency.

Experience from other states indicates that screening and assessing welfare recipients for substance abuse and providing counseling and treatment services better support family stability and self-sufficiency efforts than penalizing people who test positive for drug use. States such as Oregon, Utah, and Ohio use client interview instruments to determine which recipients should be referred for further diagnosis and treatment.

There are reliable instruments for identifying substance abuse which can be addressed with special service strategies. A variety of well-tested paper assessments can screen for alcohol and drug problems and are in use by welfare offices (e.g. Substance Abuse Self Screening Inventory (SASSI), Short Michigan Alcoholism Screening Test (SMAST), and Addiction Severity Index (ASI). The "CAGE" test consists of only four questions and can be integrated into a standard welfare intake process. Experts recommend against universal drug (urine) testing as not cost beneficial and recognize that other screening techniques facilitate early recognition and treatment. Some states are using outpatient treatment approaches to help clients more quickly obtain

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employment. When necessary, outpatient treatment is continued to promote and support job retention.

Researchers agree that drug treatment is cost-effective and results in reduced drug use, reduced criminal justice involvement, and increased employability. Data reported by states using treatment programs shows rather consistent results. Minnesota found a 64% increase in employment among welfare 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. Generally, states actively pursuing treatment programs see about a one-third drop in drug use, nearly a 60% increase in employment, and roughly a \$6 drop 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.

The Role of Sanctions

State and local experience shows that families with substance abuse problems can participate in welfare-to-work programs but participation often develops incrementally, beginning with small steps and becoming more comprehensive over time. A key issue in working with such families is the appropriate use 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 indicates that sanctioning the entire family has detrimental affects on family stability.

Utah found that many of those being sanctioned for noncompliance in its work program had previously undetected problems including substance abuse. Because of the possible negative impacts on children, Utah decided that full family sanctions were not appropriate for such families and now requires an extensive review process before sanctions are imposed.

The Alaska Model

The Divisions of Public Assistance and Alcohol and Drug Abuse will develop a pilot project to test a service model using screening, assessment and referral to treatment programs to address substance abuse among welfare recipients. Currently, the divisions are researching methods and tools for universal substance abuse screening as part of initial employability assessments. Staff are reviewing the feasibility of out-stationing alcohol/drug abuse counselors in local welfare offices to facilitate the identification of recipients in need of treatment services and to provide immediate counseling. These workers could also assist in the supervision of other staff working with difficult cases and train case managers and eligibility technicians to conduct effective screenings that identify substance abuse problems.

As needed, the initial screening would be followed by in-depth assessments to determine the appropriate counseling or treatment programs for clients substance abuse problems that impair their ability to obtain and sustain employment. Depending on the availability of treatment programs, clients determined to have substance abuse problems will be required to attend

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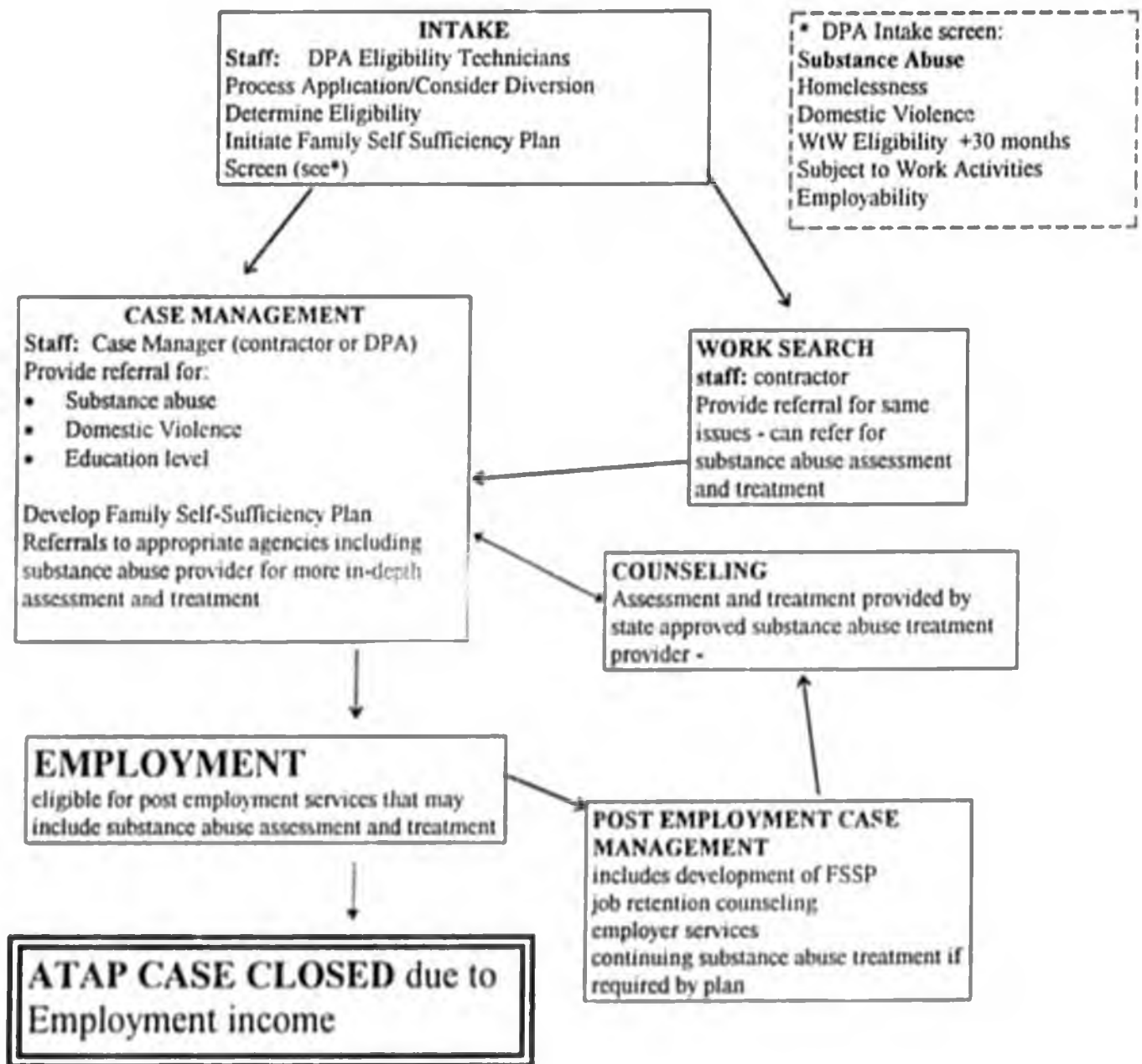
treatment, with the type of treatment varying in length and intensity. Treatment will be combined with other self-sufficiency activities such as work, education, or training.. Periodic drug-testing may be employed as an element of specific treatment programs. In all cases, the use of substance abuse screening, assessments or testing is intended to assist the client overcome dependencies and barriers to achieving self-sufficiency.

The use of penalties to encourage compliance with substance abuse treatment is part of Division of Public Assistance (DPA) policy. DPA is authorized to assign Temporary Assistance recipients to drug counseling and treatment when assessment indicates a substance abuse issue and to include these activities as a requirement of the Family Self-Sufficiency Plan (FSSP). Individuals who do not comply with the conditions of the FSSP are subject to sanctions and compliance is required in order to lift the sanction.

SERVICE MODEL

Screening, Assessment and Referral

- Universal screening for all ATAP applicants for indications of substance abuse barriers to employment
- Case managers are responsible for including substance abuse assessment and treatment as part the family self-sufficiency plan (FSSP) developed between the case manager and ATAP clients.
- Referral to state approved substance abuse treatment provider for in-depth assessment and treatment plan can occur anytime during a families participation in the ATAP program.
- Substance abuse treatment providers must notify the ATAP client's case manager if the client does not participate in assessment or comply with treatment regime.
- ATAP participants will be sanctioned for failure to participate in any substance abuse treatment activity indicated on their family self-sufficiency plan.



**DEPARTMENT OF HEALTH & SOCIAL SERVICES
DIVISION OF PUBLIC ASSISTANCE**

ATAP FAMILY SELF-SUFFICIENCY PLAN

Participant Name: _____ Date of plan: _____

Date of birth: _____ ID number: _____ Case number: _____

I understand that the purpose of this plan is to help my family earn income and support ourselves so we no longer need support from the Alaska Temporary Assistance Program (ATAP). I expect my family to be able to reach this goal by _____. I understand that I must participate in work activities and/or other activities when assigned by the Division of Public Assistance (DPA) or its agent.

I understand that my family cannot receive more than a total of 60 months of ATAP cash assistance (including benefits from a similar program in another state) unless DPA determines that I am exempt from this time limit.

| | |
|-----------------------------|----------------------------|
| Short Term Employment Goal: | Long Term Employment Goal: |
| | |

Steps Needed to Achieve Self-Sufficiency

Work Activities

- Employment: ___ Full time ___ Part time
- Job Search
- Volunteer Work Experience
- Job Sampling
- On-the-Job Training
- Job Readiness
-

Education/Training

- High school diploma
- GED
- ESL
- Literacy improvement
- Job skills training
- Employment counseling
-

Other activities

- Life Skills instruction
- Parenting skills workshop
- Establish paternity
- Help CSED locate absent parent
- Get a child support order in place
- Substance abuse assessment/ treatment
-

Self-sufficiency activity plan

| Start date | Activity/hrs per week | Who will do it? | Milestone and/or review date |
|------------|-----------------------|-----------------|------------------------------|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

Services needed to accomplish the plan

| Service | Who will arrange for it? | Who will provide it? | Who will pay for it? |
|---------|--------------------------|----------------------|----------------------|
| | | | |
| | | | |
| | | | |
| | | | |

Work requirement status:

_____ I am required to participate in work activities as assigned by DPA or its agent. Work activities to which I may be assigned include employment, job search, volunteer work experience, job sampling, on-the-job training, job readiness instruction, education, or job training.

_____ Even though I am exempt from work requirements until _____, DPA or its agent may require me to do certain other activities which will prepare me and my family to become self-sufficient.

Changes to this plan:

I understand that I must contact my caseworker if I want to make any changes to this plan.

I agree to contact my caseworker no later than _____ to set a review appointment for my Family Self Sufficiency Plan . This appointment will be:

_____ in person at _____ or _____ by telephone with my caseworker.

I agree to keep to this appointment and participate in the review.

Additional information: _____

Release of Information: I authorize DPA or its agents to exchange information about me with welfare-to-work contractors and grantees, education providers, medical and social service organizations, training agencies, worksites and employers I am involved with in order to monitor and evaluate my participation in Family Self-Sufficiency Plan activities and to assist me in achieving employment and self-sufficiency.

I understand that my family may lose some or all of our ATAP benefits, food stamps, and Medicaid if I fail to complete work activities or other activities directly related to my ability to work, such as screening and treatment for substance abuse, planning for and obtaining reliable transportation, and securing stable housing.

Participant Signature: _____

Date: _____

Participant Signature: _____

Date: _____

Caseworker Signature: _____

Date: _____

Family Self-Sufficiency Plan Attachment

Participant Name: _____ Date of plan: _____

ID number: _____ Case number: _____

Self-sufficiency activity plan

| Start date | Activity/hrs per week | Who will do it? | Milestone and/or review date |
|------------|-----------------------|-----------------|------------------------------|
| | | | |
| | | | |
| | | | |
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Services needed to accomplish the plan

| Service | Who will arrange for it? | Who will provide it? | Who will pay for it? |
|---------|--------------------------|----------------------|----------------------|
| | | | |
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ALASKA TEMPORARY ASSISTANCE PROGRAM

Employment Planning Information

Instructions: A separate information form must be completed by each adult 18 years or older in the household and each minor child who doesn't have a high school diploma or GED and who is not attending secondary school.

Date Completed: _____

SSN #: _____ / _____ / _____

Name: _____

Are you a U.S. citizen? Yes No

If no, Permit Number _____ Expiration Date _____

EDUCATION/TRAINING/SKILLS & ABILITIES

1. Date last attended school: _____ Circle Highest Grade Completed: 1 2 3 4 5 6 7 8 9 10 11 12 GED

If you have not completed high school or a GED, why did you leave school?

If you have attended college: How many years? _____ Major/subject area: _____

Did you receive a degree? (circle one) AA BA/BS MA/MS Other (specify) _____ What year? _____

2. List any training or certificates earned:

| Type of Training | School or Training Facility | City/State | Month/Year | Certificate/License |
|------------------|-----------------------------|------------|------------|---------------------|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

3. Current student? Yes No Where? _____

4. Do you have a valid Alaska Driver's License? Yes No If yes, ADL #: _____
Driving Limitations? _____

5. Veteran? Yes No Dates of Service: _____ to _____ Branch of Service: _____
Type of Discharge: Disabled Veteran Honorable Dishonorable General
Do you have a service-connected disability? Yes No

6. Do you have any medical problems that limit the types of work you can do? Yes No
If yes, do you have proof from a licensed medical provider? Yes No

7. List equipment, machinery, and tools you can operate: _____

8. Do you have a resume? Yes No If yes, please attach a copy of your resume.

9. List all the jobs you have had, beginning with your most recent job. Don't forget to include self-employment, part-time jobs and volunteer work.

Job Title: _____ Employer: _____

Address: _____ Phone: () _____

Dates of Employment: _____ Hrs/Week: _____ Pay per hour: _____

Duties and Skills Used: _____

Reason for Leaving: _____

Job Title: _____ Employer: _____

Address: _____ Phone: () _____

Dates of Employment: _____ Hrs/Week: _____ Pay per hour: _____

Duties and Skills Used: _____

Reason for Leaving: _____

Job Title: _____ Employer: _____

Address: _____ Phone: () _____

Dates of Employment: _____ Hrs/Week: _____ Pay per hour: _____

Duties and Skills Used: _____

Reason for Leaving: _____

Job Title: _____ Employer: _____

Address: _____ Phone: () _____

Dates of Employment: _____ Hrs/Week: _____ Pay per hour: _____

Duties and Skills Used: _____

Reason for Leaving: _____

PLANNING FOR SELF SUFFICIENCY

1. What plans do you have to get off of public assistance?

2. Are you now working? Yes No If yes, where? _____ How many hours per week? _____

3. If you are not working, how long have you been unemployed? _____

4. How can we help you find a job, or help you keep the job you have? _____

5. If you need these things for work or training, do you have them?:

| | | | |
|--|--|--|--|
| Transportation | Child Care | Clothing | Other: _____ |
| Yes <input type="checkbox"/> No <input type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> |

What plans do you have for child care while you work? _____

Do you have a vehicle? Yes No car insurance? Yes No another way to get around? Yes No

Comments: _____

6. Do you need help with any of these? (Check items that apply to you and comment below)

- | | | |
|---|---|---|
| <input type="checkbox"/> Pregnancy/Pre-natal care | <input type="checkbox"/> Family/Child Problems | <input type="checkbox"/> Vision Problems |
| <input type="checkbox"/> Family Planning | <input type="checkbox"/> Divorce/Child Custody Issues | <input type="checkbox"/> Dental Care Needs |
| <input type="checkbox"/> Housing | <input type="checkbox"/> Getting/Paying Child Support | <input type="checkbox"/> Hearing Problems |
| <input type="checkbox"/> Drug/Alcohol Problems | <input type="checkbox"/> Legal Problems | <input type="checkbox"/> Trouble with English |
| <input type="checkbox"/> Mental Health Issues | <input type="checkbox"/> Health Problems | <input type="checkbox"/> Difficulty Reading/Writing |
| <input type="checkbox"/> Other areas where you may need assistance. | | |

Comments: _____

7. Are there other things that might keep you from going to work? Yes No

Explain: _____

8. Have you been convicted of a crime other than a traffic violation? Yes No

Explain: _____

9. Are you on probation or parole? Yes No If yes, give the name and phone number of your probation/parole officer:

10. Is any other agency helping you with work and family problems? Yes No

If yes, please list the agency, contact person, and phone number:

EMPLOYMENT GOALS:

1. Based on your work history, what kind of employment are you seeking? Are you Qualified? Amount of Experience

1st Choice: _____ Yes No Months: _____

2nd Choice: _____ Yes No Months: _____

2. If **NOT** qualified, how can you become qualified? _____

3. Do you know of any job openings in this line of work? Yes No

Where? _____

4. Are you willing to move in order to obtain employment? Yes No

5. Are you willing to accept employment in a remote site? Yes No

6. Are you registered with the Alaska Employment Service? Yes No

7. Would your past employers give you a reference? Yes No

Signature

Date completed



National Conference of State Legislatures
Drug Testing and Public Assistance
Dana Reichert January 1997

Changes in federal law grant states considerable flexibility to determine for themselves the types of to operate. Even before federal reforms, states developed different approaches that mandate personal responsibility in their effort to reform welfare. One of these approaches requires welfare recipients to remain substance free. Many states, including Kansas, Maine, Michigan, Oregon, Pennsylvania and South Carolina require recipients with substance abuse problems receive treatment as a condition of receiving cash benefits.

Maryland, Minnesota, New Jersey, New York, Pennsylvania and South Carolina take one step further and require that individuals submit to random drug tests. Kansas specifies that recipients with substance abuse problems may have to submit to drug testing. Michigan's program requires recipients to submit to drug testing if their treatment program requires testing. To date, Michigan does not have knowledge of any participants who have had to submit to the test. Maryland mandates health screenings to determine substance abuse problems, including drug testing. Recipients must submit to the screenings as a condition of eligibility.

South Carolina has the longest running drug testing program for welfare recipients. Under the South Carolina provision, recipients who have been determined to have a substance abuse problem or a conviction relation to alcohol or controlled substance will be required to participate in random testing as a part of their eligibility maintenance. Individuals who give birth to a child determined within 24 hours of birth to be suffering from the effects of maternal substance abuse will be denied assistance, unless the individual submits to drug testing and treatment program. Refusal to participate in either the drug test or a treatment program will result in removal from the cash assistance program.

At the time of application, case managers will hope to identify individuals who have, or are at risk of becoming chemically dependent. Such a person must undergo an evaluation to determine whether or not a substance abuse treatment program is necessary. If the evaluation determines a treatment program is necessary, a recipient must comply with guidelines of the treatment program or be declared ineligible to receive further assistance from the AFDC program. Treatment program fees will be paid by a recipient's Medicaid benefits. Upon completion of the prescribed program, a recipient must agree to undergo random substance abuse testing to demonstrate that they have remained drug-free while on the AFDC program. Failure to participate in the random testing will result in cancellation from the program.

If a recipient feels that determination of a substance abuse problem, or prescribed treatment is incorrect, or should be re-evaluated, they may undergo the process of appeal by requesting a fair hearing. Particulars of the fair hearing process are set forth by the guidelines of the AFDC.

program. While undergoing the appeal process, the recipient will not be subject to cancellation of benefits for refusal to participate in prescribed programs.

South Carolina implemented its program on October 1, 1996 and has only referred very small numbers of recipients to treatment programs. Recent inter-agency meetings have raised questions whether or not case managers are doing an effective job of referring recipients to treatment. Although this data is very preliminary, South Carolina has increased its efforts to successfully screen and detect individuals who might benefit from treatment. The general sense is that substance abuse is perhaps not impacting recipients to the extent originally thought.

Pennsylvania's program is on a similar track, allowing drug testing for recipients who participate in a treatment program if testing is part of the program. To date, Pennsylvania has not been actively pursuing enforcement of this particular policy, feeling it more important to concentrate on treating substance abuse problems rather than testing for them.

in determining eligibility and payment amounts for Aid to Families with Dependent Children.

South Carolina

Part V

Parental Responsibility

No increase in welfare with increase in number of children

SECTION 1. To encourage parents to plan for security and assume responsibility for their children, there must be no incremental increase in AFDC benefits to a family as a result of a child born to that parent ten or more months after the family begins to receive AFDC. This section does not apply if the department establishes that the child was conceived as a result of rape or incest. The State may provide benefits to a child born after ten months in the form of vouchers that may be used only to pay for particular goods and services specified by the State as needed for the child's mother to participate in education training and employment related activities.

Eligibility denied on ground of alcohol or drug problem; treatment program required



SECTION 2. An AFDC recipient who, while receiving AFDC benefits, has been identified as requiring alcohol and other drug abuse treatment service or who has been convicted of an alcohol related offense or a controlled substance violation or gives birth to a child with evidence of the effects of maternal substance abuse and the child subsequently is shown to have a confirmed positive test performed on a suitable specimen within twenty-four hours of birth, is ineligible for AFDC assistance unless the recipient submits to random drug tests and/or participates in an alcohol or drug treatment program approved by the Department of Alcohol and Other Drug Abuse Services. Upon completion of the program, if a subsequent random test or subsequent conviction for a controlled substance violation or alcohol related offense occurs, the recipient is ineligible for AFDC benefits. Benefits may be reinstated at a later time upon reapplication, if the recipient first undergoes a conciliation assessment, including review and/or modification of the prescribed individual treatment program and agreement, and then agrees to comply with its terms and demonstrates compliance for a period of not less than sixty days. Testing of a child's specimen pursuant to this section must be conducted by a medical laboratory certified by the College of American Pathologists or the National Institute of Drug Abuse or Forensic Urine Drug Testing.