

ALASKA LEGISLATURE COMMITTEE FILES 1997-1998 8672

9217 HOUSE JUDICIARY

THIS SEARCH	THIS DOCUMENT	GO TO
Next Hit	Forward	New Search
Prev Hit	Back	HomePage
Hit List	Best Sections	Help
	Doc Contents	

H.R.3734

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

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

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

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

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

(b) **EFFECTS ON ASSISTANCE AND BENEFITS FOR OTHERS**-

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

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

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

(d) **LIMITATIONS**-

(1) **STATE ELECTIONS**-

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

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

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

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

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

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

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

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

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

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

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

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

<i>THIS SEARCH</i>	<i>THIS DOCUMENT</i>	<i>GO TO</i>
Next Hit	<u>Forward</u>	<u>New Search</u>
Prev Hit	<u>Back</u>	<u>HomePage</u>
Hit List	<u>Best Sections</u>	<u>Help</u>
	<u>Doc Contents</u>	



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, DHMH/MCPA
JOSEPH E. DAVIS, DIRECTOR, DHMH/PSOA
THOMAS DAVIS, DIRECTOR, DHMH/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 FIP substance abuse treatment provisions, including the obligation to complete an initial health screen at the MCO; and has the individual sign a Consent for the Release of Confidential Alcohol and Drug Treatment Information form (Attachment D).

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

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

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

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

Forwarding Forms to the MCO

- ◆ Each local department has designated one person to act as a liaison between the MCOs in their jurisdiction and that local department. The MCO liaison (or his or her designee) is responsible for keeping controls on the consent forms and forwarding information to the MCOs. The MCO liaison or designee is also responsible for tracking information on compliance after a customer enrolls in a treatment program.
- ◆ After the case manager completes the application or redetermination, he or she files the record copy or copies of the consent form/s in the case record and gives the original consent form/s and other copies to the MCO liaison or designee.
- ◆ The MCO liaison or designee checks MMIS II to determine if the customer is enrolled in an MCO. If enrolled, the MCO liaison or designee writes the name of the MCO on the consent

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

- ◆ If the customer has not enrolled in an MCO, the MCO liaison or designee keeps the consent forms in a tickler file and reviews MMIS II each week until the customer enrolls. Once the individual enrolls and the MCO information is available on MMIS II, the MCO liaison forwards the original and copies of the consent forms to the appropriate MCO in the jurisdiction.
- ◆ The MCO liaison or designee batches and forwards these forms to the MCO weekly. A list of the Statewide MCO liaisons is attached (Attachment III).

PHASE II. DHMH/MCO - SCREENING/TREATMENT REFERRALS

New MCO Enrollees:

- ◆ Once the DSS authorizes MA, DHMH issues the MA card and provides the enrollment broker with a list of new TCA customers daily. Within five days of notification, the enrollment broker sends the customer an enrollment packet with a notification to choose an MCO. The packet includes a Health Risk Assessment (HRA) form to be completed when the customer enrolls. The customer has 21 days from the date of mailing to choose an MCO, except recipients in foster care or kinship care who have 30 days from the date of mailing. If a choice is not made within the specified time frame, DHMH assigns the customer to an MCO. DHMH provides the MCOs a list of new enrollees on a daily basis with TCA recipients identified. Access to customer's MCO enrollment status is available in MMIS II.
- ◆ When the MCO receives an HRA form, they evaluate the customer's need for immediate service. Individuals who are considered high risk (such as pregnant or post-partum substance abusing women) are scheduled for an initial health screen within 10 - 15 days of the MCO's receipt of the HRA form.
- ◆ If the MCO receives no HRA form or the HRA form indicates that the individual is not at risk, the MCO shall schedule the new enrollee for an initial health screen with the assigned Primary Care Physician (PCP) within 90 days of the individual's enrollment in the MCO.

All TCA Customers Effective July 1, 1997

- ◆ All Medicaid enrollees, including TCA adults and minor parents, who complete an initial health screen at the MCO are screened for substance abuse by the primary care provider (PCP) as part of that initial health screen.
- ◆ If the screen reveals substance abuse, the PCP refers the customer for a more comprehensive substance abuse assessment by a provider qualified to determine the appropriate level and

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

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

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

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

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 "P1" and issue an EBT card to that person.

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

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

NARRATE ALL CASE ACTIVITY.

INQUIRIES/FEEDBACK/SUGGESTIONS:

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

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

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

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

LA Case # _____

DSS Office: _____

I, _____ authorize the managed care
(Print name of adult or minor parent TCA applicant or recipient)

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

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

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

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

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

PROHIBITION OF REDISCLOSURE

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR 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 any alcohol or drug abuse treatment patient.

DEPARTMENT OF SOCIAL SERVICES

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

CUSTOMER NAME _____ MA CASE # _____

Managed Care Organization _____

_____ authorize.

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

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

- The results of substance abuse screening performed during the employability assessment at the DSS office are positive.
- I acknowledge that I have a substance abuse problem and request a referral for treatment.

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

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

Dated: _____

(Signature of adult or minor parent TCA applicant or recipient)

Prohibition of Redisclosure

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

LOCAL DEPARTMENT OF SOCIAL SERVICES
MANAGED CARE ORGANIZATION LIAISONS

LOCAL DEPARTMENT / DISTRICT OFFICE	NAME	PHONE# / FAX#
Allegheny County	Rozanne Lynch	(301) 777-2062
Anne Arundel County		
Baltimore County	Carole Ziegler Lisa Montford	(410) 847-2514 (410) 887-6204
Calvert County	Doris Freeland	(410) 535-8734
Caroline County	Rayshelle Robinson	(410) 479-5900
Carroll County	Phyllis Seipp	(410) 857-6214 FAX 857-6313
Cecil County	Dorothea Phillips	(410) 996-0656
Charles County	Mary Hazel	(301) 934-6641
Dorchester County	George Barnett	(410) 228-5100 ext. 201
Frederick County	Christine Bickle	(301) 694-2405
Garrett County	Linda Ashby	(301) 334-9461
HARFORD COUNTY Aberdeen Bel Air	Patricia Junchiewicz Sandra Watson	(410) 272-9081 (410) 836-4791
Howard County	Katherine Ward	(410) 872-2200 ext. 320
Kent County	Shirley Williams	(410) 778-0820
Montgomery County	Carol Pearson	(301) 468-4009
PRINCE GEORGE'S Camp Springs Hyattsville Palmer Park RISE Program	Bob Frere Jeffrey Niosi Janice Causey Joy Etukudu Lelia Moody	(301) 449-2552 (301) 449-2514 FAX 449-2558 (301) 422-5048 FAX 422-5097 (301) 341-2810 FAX 341-2819 (301) 386-5522 ext. 128 FAX 386-5533
Queen Anne's County	Beatrice Embry	(410) 758-5111
Saint Mary's County	Jennine Miller	(301) 475-4831 FAX 475-4799
Somerset County	Kathy Thomas	(410) 651-5346
Talbot County	Joyce Alderman	(410) 322-7802 FAX 820-7067
Washington County	Karen Worthington Ruth Fuller	(301) 739-8491 (301) 791-3464
Wicomico County	Robert Drudge	(410) 543-6814
Worcester County	Martha McGee	(410) 632-4525 FAX 632-3542
Baltimore City	Karen Matheson Janet Richardson	(410) 361-3920 (410) 361-6229 FAX 361-6254

SUBSTANCE ABUSE IDENTIFICATION AND TREATMENT NOTIFICATION

PATIENT NAME _____ MA CASE # _____

Local Department of Social Services/Office _____

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

- 1. After June 30, 1998, failed to appear for initial health screen appointment scheduled by MCO or PCP within 90 days of enrollment
 - 2. Substance abuse problem indicated by positive initial screen, follow-up diagnostic testing, or treatment
 - 3. Failed to keep appointment for comprehensive substance abuse assessment
 - 4. Comprehensive assessment indicates patient not in need of substance abuse treatment
 - 5. Patient referred to: _____ on _____ 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
- 4. Enrolled in treatment program
- 5. Not maintaining active attendance/participation
- 6. Successfully completed program

Admission date: _____

Discharge date: _____

Patient able to work? YES NO

(Signature of Treatment Provider) Date: _____



Which states test welfare recipients for substance abuse?

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

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

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

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

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

benefits.

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

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

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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-person" even though the marriage has been terminated by death or divorce.

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

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

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

i. The applicant/recipient;

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

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

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

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

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

2. Supplemental Security Income recipients, except for the purposes of receiving emergency assistance benefits;
3. Illegal aliens;
4. Other aliens who are not eligible aliens as defined in N.J.A.C. 10:90-2.10;
5. A person absent from the home who is incarcerated in a Federal, State, county or local corrective facility or under the custody of correctional authorities;
6. A person who is fleeing to avoid prosecution, custody or confinement after conviction, under the laws of the jurisdiction from which the person has fled, for a crime or an attempt to commit a crime which is a felony or a high misdemeanor under the laws of the jurisdiction from which the person has fled; or is violating a condition of probation or parole imposed under Federal or State law:
 - i. Under the laws of the State of New Jersey, a crime is defined at N.J.S.A. 2C:1-4(a) as "an indictable offense...for which a sentence of imprisonment in excess of 6 months is authorized."
 - ✓ 7. A person convicted on or after August 22, 1996 under Federal or State law of any offense which is classified as a felony, high misdemeanor or crime, under the laws of the jurisdiction involved and which has as an element the distribution, possession, or use of a controlled substance as defined in section 102 (6) of the Federal "Controlled Substances Act" (21 U.S.C. Section 802 (6)).
 - i. Under the laws of the State of New Jersey, a crime is defined at N.J.S.A. 2C:1-4(a) as "an indictable offense ... for which a sentence of imprisonment in excess of 6 months 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.

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

8. A person found, on or after August 22, 1996, to have willfully and knowingly fraudulently misrepresented his or her residence in order to obtain means-tested, public assistance benefits in two or more states or jurisdictions, shall be ineligible for benefits for a period of 10 years from the date of conviction in a Federal or State court.
 9. A person who, after July 1, 1997 and provided that the person has received written notice informing them of the WFNJ disqualification penalties, intentionally makes a false or misleading statement or misrepresents, conceals or withholds facts for the purpose of receiving benefits shall be ineligible for benefits for a period of six months for the first violation, 12 months for the second violation, and permanently for the third violation.
 10. In addition to 1 through 9 above, persons found eligible for or who are recipients of WFNJ/TANF, or who have been found ineligible for such programs due to voluntary refusal to comply with program requirements shall not be eligible for WFNJ/GA assistance.
- (b) WFNJ benefits shall not be payable for any month in which any individual in the assistance unit is participating in a strike. The individual who is on strike is ineligible for benefits; however, other members of the assistance unit remain eligible for benefits.
1. The term "strike" includes any strike or other concerted stoppage of work by employees (including a stoppage by reason of expiration of a collective bargaining agreement) and any concerted interruption of operations by employees.
 2. The term "participating in a strike" means an actual refusal, in concert with others, to provide services to one's employers.
 3. Examples of non-strikers who are eligible to participate in the program include, but are not limited to:
 - i. Employees whose workplace is closed by an employer in order to resist the demands of employees (for example, lockout);
 - ii. Employees unable to work as a result of striking employees (for example, truck drivers who are not working because striking pressmen prevent newspapers from being printed); or,
 - iii. Employees who are not part of the bargaining unit on strike who do not want to cross the picket line due to fear of personal injury.

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

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

SUBCHAPTER 2 NON-FINANCIAL ELIGIBILITY REQUIREMENTS**10:90-2.8 INDIVIDUALS INELIGIBLE FOR WFNJ TANF/GA****10:90-2.8(a)7 Drug Felons**

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

Cash assistance will be denied to any person convicted on or after August 22, 1986 of an offense which has as an element the distribution, possession or use of a controlled substance as defined in section 102(6) of the Federal "Controlled Substances Act" and the conviction was:

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

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

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

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

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

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

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

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

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

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

S:\working\2-Belfr1.doc

VFNJ-90
(New 7-97)

WORK FIRST NEW JERSEY DRUG TREATMENT REPORT FORM

AGENCY _____

CASE NUMBER _____ SS NUMBER _____

CLIENT NAME _____

Certification by Drug Treatment Facility

NAME OF TREATMENT CENTER _____

STATE OF NEW JERSEY LICENSED REGISTRATION NUMBER _____

ADDRESS _____

TELEPHONE NO. _____ CONTACT PERSON _____

DATE TREATMENT BEGAN _____

TREATMENT PROGRAM COMPLETED? YES NO IN PROGRESS

DATE TREATMENT CONCLUDED _____

TYPE OF DRUG PROBLEM _____

SUBSEQUENT TESTING DATE _____

RESULTS? POSITIVE NEGATIVE

SUBSEQUENT TESTING DATE _____

RESULTS? POSITIVE NEGATIVE

AUTHORIZED AGENCY REPRESENTATIVE SIGNATURE

I hereby certify that this report is true and accurate.

DATE

George V. Voinovich
Governor




Arnold R. Tompkins
Director

Ohio Department of Human Services

30 East Broad Street, Columbus, Ohio 43266-0423

To: Interested Parties

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

Date: October 9, 1996

Subject: Implementation of HB 167

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

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

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

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

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

attachments

CONSENT FOR RELEASE OF INFORMATION

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

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

Signature of Enrollee

Date

Signature of Witness

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 HMC. If you live in Butler, Cuyahoga, Franklin, Hamilton, Lucas, Montgomery or Summit counties and are on Healthy Start or ADC Medicaid, this information applies to you. The law says that you must be screened and if indicated assessed for the abuse of alcohol and other drugs while you are pregnant. If it is found that you may be abusing alcohol or other drugs during your pregnancy, you must go for treatment of your alcohol and drug abuse.

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

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

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

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

12. AOD Provider's Name		18. AOD Provider's Signature	
13. Address		19. AOD Provider's Certification/License No.	
14. Today's date	15. Fax no.	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 Certification/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 (OUHS 3501)**

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

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

- Item 1 **Enrollee's name:** Enter the enrollee's name as shown on the HMO card.
- Item 2 **Enrollee's Medicaid Billing Number:** Enter the 12 digit Medicaid billing number. You will find this number either on the enrollee's HMO card or you may get it from the HMO.
- Item 3 **PMSP's Name:** Enter the Prenatal Medical Service Provider's name.
- Item 4 **Address:** Enter the PMSP's street address, city, and state.
- Item 5 **Today's date:** Enter today's date.
- Item 6 **Fax no.:** Enter the PMSP's fax number.
- Item 7 **Phone no.:** Enter the PMSP's telephone number.
- Item 8 **PMSP's Signature:** Enter the signature of the Prenatal Medical Service Provider (PMSP).
- Item 9 **Scheduled date of the AOD assessment:** Enter the date the assessment for the suspected abuse of alcohol and other drugs has been scheduled for the enrollee, if needed.
- Item 10 **Date the Statement of Attendance was given to enrollee:** Enter the date the signed Statement of Attendance was given to the enrollee.
- Item 11 **Consent form statement:** Check "Yes" if the enrollee has signed a release of information form permitting the PMSP to share information regarding her need for assessment. Check "No" if the enrollee has not signed a release of information form.

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

- Item 12 **AOD Provider's Name:** Enter the name of the AOD provider who performed the AOD assessment.
- Item 13 **Address:** Enter the street address, city, and state of the AOD provider who performed the AOD assessment.
- Item 14 **Today's date:** Enter today's date.
- Item 15 **Fax no.:** Enter the fax number of the AOD provider who performed the AOD assessment.
- Item 16 **Phone no.:** Enter the telephone number of the AOD provider who will perform the AOD assessment.

- Item 17 **Enrollee Attendance:** Place a check by the appropriate line. If enrollee did attend the assessment, enter the date the assessment was performed.
- Item 18 **AOD Provider's Signature:** Enter the signature of the AOD provider who performed the AOD assessment. This signature verifies that the enrollee has signed a consent for release of information that permits the PMSP to share information regarding her need for treatment and that a consent form is attached.
- Item 19 **AOD Amassment Certification/License No.:** Enter the certification or license number of the AOD provider who performed the AOD assessment.
- Item 20 **Outcome:** Place a check by the appropriate line. *If follow-up is required and will be provided by an AOD provider other than the provider giving the assessment, complete the date and time of the scheduled treatment appointment and complete Items 21, 24, and 28.*
- Item 21 **Consent form statement:** Check "Yes" if the enrollee has signed a release of information form permitting the AOD provider to share information regarding her attendance at the assessment and her need for treatment. Check "No" if the enrollee has not signed a release of information form.
- Lines 22 - 30 are to be completed by AOD provider who performs any subsequent treatment. If the AOD provider who performs the treatment is the same as the AOD provider who performed the assessment, Items 21- 30 may be omitted.*
- Item 22 **AOD Provider's Name:** Enter the name of the AOD provider who performed the AOD treatment.
- Item 23 **Address:** Enter the street address, city, and state of the AOD provider who performed the AOD treatment.
- Item 24 **Today's date:** Enter today's date.
- Item 25 **Fax no.:** Enter the AOD provider's fax number
- Item 26 **Phone no.:** Enter the telephone number of the AOD provider who will perform the AOD treatment.
- Item 27 **Enrollee attendance:** Place a check by the appropriate line. If enrollee did attend the treatment, enter the date the initial treatment was performed.
- Item 28 **AOD Provider's Signature:** Enter the signature of the AOD provider who performed the AOD treatment. This signature verifies that the enrollee has signed a consent for release of information that permits the PMSP to share information regarding her need for treatment and that a consent form is attached.
- Item 29 **AOD Treatment Provider's Certification/License No.:** Enter the certification or license number of the AOD provider who performed the AOD treatment.
- Item 30 **Outcome:** Place a check by the appropriate line. If enrollee required further treatment and referral was made to a subsequent AOD treatment provider, enter the scheduled date for treatment

ODHS 3500 9/96

SCREENING INSTRUMENT

ALCOHOL AND OTHER DRUG ABUSE

Instructions for conducting the structured interview:

Interviewer

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

1. Begin by reading the Interviewer Statement (attached) to the enrollee and giving her the information sheet that explains the importance of this screening. Ask her if she has questions.
2. Ask each of the four (4) open-ended questions and note your professional observations. These questions are intentionally structured to be open-ended to prompt further discussion.
3. Refer to the Observation Checklist. Note your professional observations.
4. Based on your observations and discussion prompted by the screen and structured interview process, use your professional judgement to determine if the enrollee requires an assessment for possible alcohol and other drug abuse.
5. Talk to the enrollee about your observation and determination.
6. Document on the screening instrument your determination of a need for, or no need for, a referral for assessment.
7. Refer the enrollee to an alcohol or other drug provider for an assessment, if appropriate, by making the appointment for a clinical assessment.
8. Complete the bottom of the screening instrument including enrollee's name, signatures and date.
9. If a referral is made, complete the Statement of Attendance Form giving a copy to the enrollee and faxing a copy to the alcohol and other drug provider scheduled to perform the clinical assessment.

Glossary

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

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: _____

**TREATING HEART DISEASE
Examining the Alternatives**

OHIO STATE
Medical Journal
VOL. 81, NO. 2, February 1985

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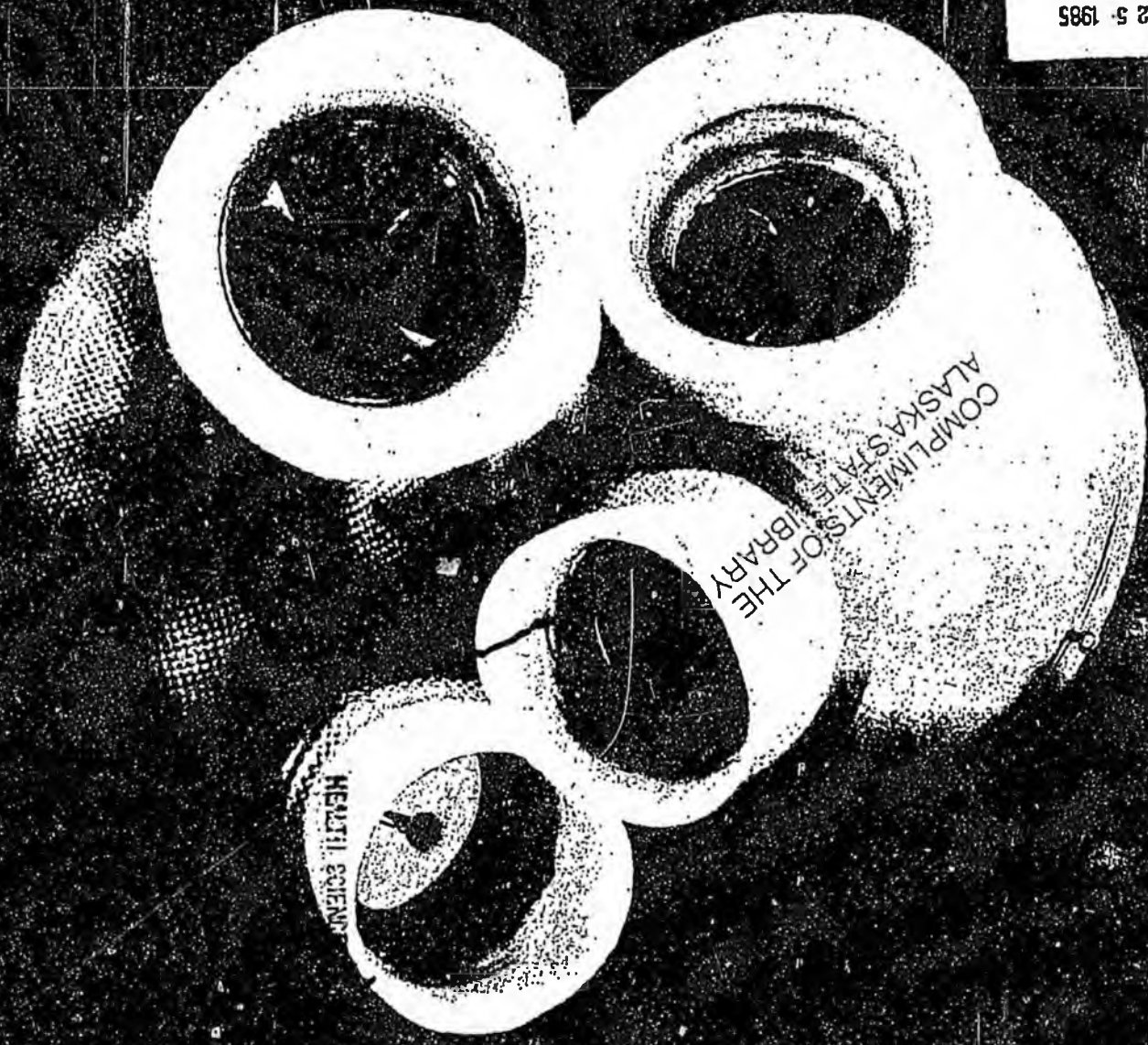
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Medical Dependency
eatable Disease

The AMA Interim Report
Minutes of the Meeting

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Second Opinion

The opinions expressed in this column are those of the author and do not necessarily reflect the opinion or views of the Ohio State Medical Journal or the Ohio State Medical Association.

Chemical Dependency: A Treatable Disease

By William J. Kennedy, MD

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

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

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

Our experience with third-party carriers continues to be equally distressing. In the past, their staff and consultants have had little

expertise in this field, and yet make significant decisions about treatment settings, modalities and length of treatment — all of which are decisions critically affecting treatment outcome in this very treatable disease.

One might assume that nothing of a constructive nature is

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

underway to address these concerns. In addition, competition in the field is clouding the issue of who in the health care profession is taking the lead in this important and critical area. It might be well to review what is happening in the field of chemical dependency and how physicians, like myself, are involved in this effort.

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

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

continued on page 79
77

Second Opinion

continued

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

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

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

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

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

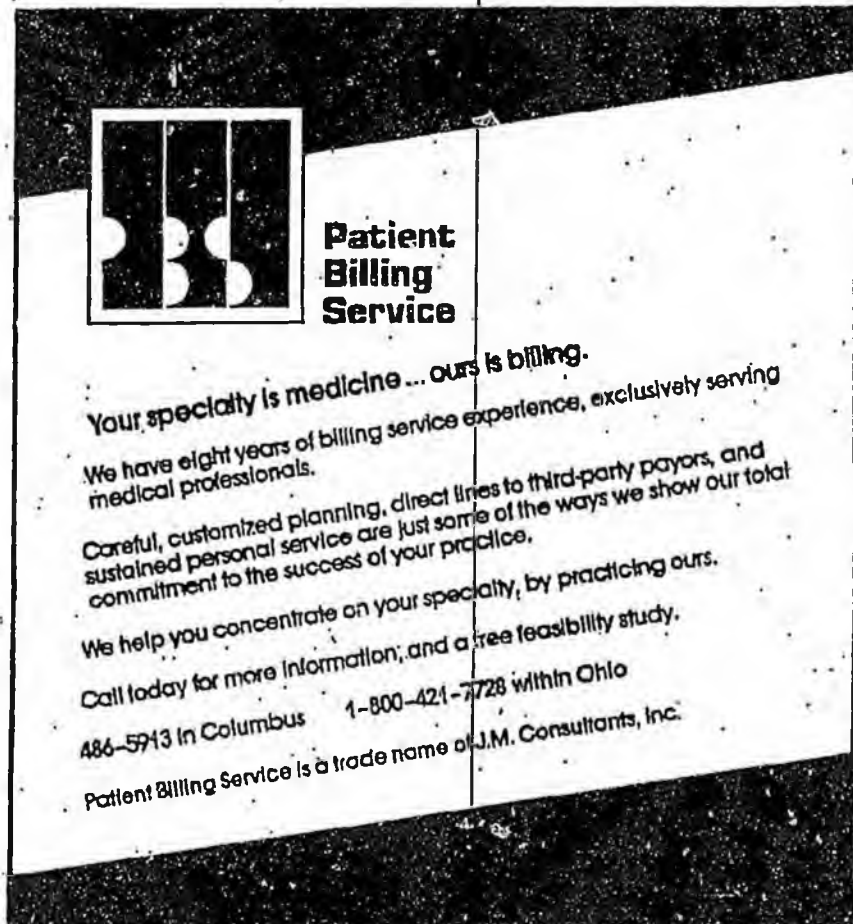
We are receiving strong support

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

Organized medicine has a vital role to play — first, in assisting this new field to obtain the credibility that it so desperately needs and that it has strived so hard to obtain; second, in bringing chemical dependency into the

mainstream of medicine. We need to rid it of the remaining vestiges of stigma as a moral issue, rather than a disease, to document its treatability and to recognize the successful methodology which is already in place. In short, chemical dependency should be viewed as any other life-threatening, treatable disease.

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



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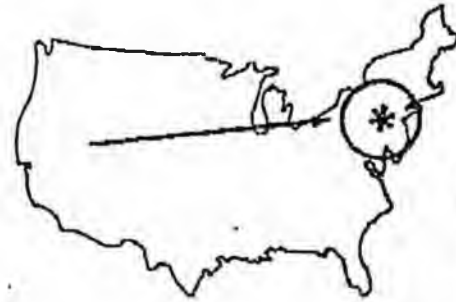
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Adapting the Chronic Disease Model in the Treatment of Dually Diagnosed Patients

FORT WASHINGTON, PENNSYLVANIA

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

MODELS OF TREATMENT IN THE DUAL-DIAGNOSES SETTING

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

Until recently, Malvern Institute has used the multidisciplinary treatment team model as the predominant

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

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

A significant drawback in this approach is the lack

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

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

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

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

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

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

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

THE DUAL-DIAGNOSIS MODEL

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

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

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

Adapting the Chronic Disease Model

65

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

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

THE CHRONIC DISEASE MODEL

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

is less neuropsychologically impaired and is less emotionally augmented, in other words, when they are less toxic from the effects of drugs and alcohol.

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

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

Neurocognitive Impairment

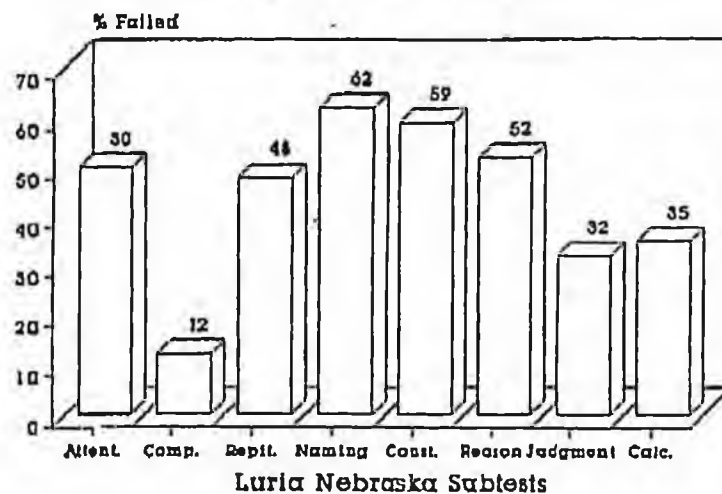


FIGURE 1. Study by Meek, Clerk, and Salana demonstrates the percentage of alcoholics who failed specific subtests of the Luria-Nebraska Neuropsychological Battery given in the first 10 days of treatment.

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

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

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

GOALS OF TREATMENT

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

1. *Education:* The education of the patient and the staff is one of the most important functions of the program. Therefore, it becomes important that the information meet the following criteria:
 - a. Everyone must be the recipient of the information; no secrets should be kept from the patients.
 - b. The information used is endorsed by the scientific community as the most accurate and up to date.
 - c. A significant part of the information should be a clear-cut explanation of the chronic disease model program. Patients are able to gauge their progress and hold the staff accountable to deliver their promise of treatment.
 - d. Because the major form of treatment of chemical dependence is still 12-step programs, the information should be heavily weighted on the practical use of these programs.
 - e. There should be a predictable and verifiable quantity of knowledge passed from the staff to the patients. Lectures entitled "The Disease of Addiction" must include information on tolerance, dependence, loss of control, and so on.

Staff should not lapse into stories such as "My Personal Recovery." When patients are halfway through treatment, they should be able to understand their treatment and recovery program well enough to begin to teach it to the newcomers.

2. *Self-diagnosis:* The next most important goal of treatment is that the patients must self-diagnose. In other words, all the material given to them is worthless if they cannot apply it to themselves. However, this is the work of the patient and his peers, not of the treatment staff. The primary treater in this model is the patient. The goal of the counselor is to educate and facilitate the patient's self-diagnosis, not to push him into self-recrimination or to provoke him into sobriety. It becomes very difficult for the staff members to project their issues onto the patient, partially because treatment is not issue-oriented and partially because there is little opportunity to do it. Therefore, patients are asked only to personalize the material that they have learned.
3. *Learn how to treat their illness:* Just as diabetics must learn to count calories, weigh food, and adjust dosages of insulin, addicts must learn to maintain their health and sobriety. Recovering addicts must learn to make lifestyle changes. They must learn what to avoid, new ways of dealing with stress, how to obtain a sponsor, how to fire a sponsor, and so on.
4. *Assumption of personal responsibility:* Compliance is not punished in this program. Compliance is simply the act of doing what you are told to do. In other treatment models, it is thought of as a deceptive maneuver on the part of the patient. In the chronic disease model, it is considered an important step in the patient's progress. Progress is measured by whether or not the patient meets certain behavioral learning objectives in the program. The staff does not engage in mind reading or accusing patients of impure thoughts and motives. It becomes the goal of the staff to remove all such impediments to the patient's progress. In this respect, the chronic disease model has been compared to the Montessori method. Patients are also expected to learn about their psychiatric diagnosis and to take personal responsibility for it. The patient's psychiatrist might then educate the patient about manic-depressive illness, for example, and how to do the self-care necessary for continued stabilization.

ROLES

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

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

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

after treatment. The focus is on the restoration of physical health through gradual increase in the level of physical activity. Self-care is taught along with the constructive use of leisure time.

THERAPEUTIC ACTIVITIES

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

These attributes are:

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

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

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

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

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

COMMUNITY MEETING

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

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

SMALL GROUPS

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

Groups operate out of one of four basic "modes." These modes are hostile, hopeless, hopeful expectation, and working. Obviously, the goal of the group and its facilitator is to help the group achieve a working mode. A group is in a working mode when its members are able to stick to the task at hand. Groups can fall into helplessness and hopelessness; they can become hostile and direct their hostility to the counselor or to one another. They can also enter hopeful

expectation mode, which on the surface appears to be positive activity. It is not activity that is based in reality, however.

The groups have one of four basic themes or tasks:

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

Adapting the Chronic Disease Model

69

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

INDIVIDUAL THERAPY

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

1. *Collect and assess a database.* This is a very important function in this model because some treatment must be deferred to the outpatient setting. It becomes very important to assess the aftercare needs of the patient and to make the appropriate referral.
2. *Develop, revise, and update individual treatment plans.* The plans are designed to educate, to relate learning to experience, and to bring about behavioral change. A detailed and relevant plan is made, and a copy is given to the patient.
3. *Provide cognitive and reality-oriented therapy.* It should be aimed at teaching patients helpful control of feelings. The emphasis should be on the prevention of regression. Therefore, patients are not encouraged into insight or expressive psychotherapy. "Conversion experiences" are not encouraged. The emphasis is on consistent and directed work and not self-castigation.
4. *Confront denial only by didactic methods.* There is nothing therapeutic about increasing the level of shame that an individual comes into treatment with because most of it is based on a moral understanding of addiction. It is very important that the staff model behavior that is consistent with that belief.
5. *Teach patients about defense mechanisms and how they are used to justify addictive behavior and to avoid treatment.* The more the behavior of questioning one's defenses is modeled for patients, the more they will do it. The more they are confronted forcefully, the more defensive they will become.
6. *Provide opportunity for patients to witness the use of defense mechanisms and to identify them.* Conflict, attitude, and behavior are never interpreted. The patients may make their own guesses

about what dynamics their defenses may conceal, but this should not be encouraged or validated by the staff.

7. *Provide the patient with all the information you learn about him or her.* Stick to basic data and facts. Avoid asking the patient to believe things that you cannot support with data. Patients should be given useful data in the same format as they are given data about their addiction.
8. *Self-disclose only when appropriate.* This means that therapists do not disclose personal information when it has no benefit for the patient. It also means that unresolved issues are not divulged.
9. *Develop appropriate aftercare, and motivate the patient to accept and follow it through.*
10. Teach the patient the effective use of 12-step groups.

LECTURES

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

DIET

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

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

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

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

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

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

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

feed them a diet that eliminates free sugar and caffeine and is low in fat.

CONCLUDING REMARKS

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

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United States General Accounting Office

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

FOSTER CARE

Parental Drug Abuse Has Alarming Impact on Young Children



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Relations.

GA 113

546-D

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

Results in Brief

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

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

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

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

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

Background

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

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

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

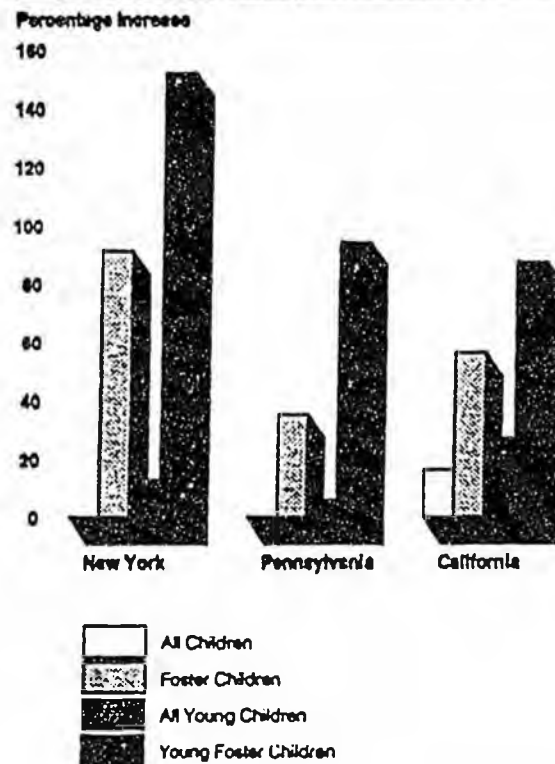
However, we previously reported that median costs associated with newborn medical care for infants known to be prenatally drug-exposed were approximately \$1,100 to \$4,100 higher (in 1989 dollars) than for other infants. Further, an HHS study provides an example of Medicaid costs in California from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

More Young Children in Foster Care

The foster care populations in the states reviewed increased dramatically between 1986 and 1991, with the number of young foster children increasing at a faster rate. The total foster care population in these states increased 68 percent while the number of young foster children increased 110 percent. During the same years, the total number of young children in these states increased 19 percent, indicating that a greater percentage of all young children in these states entered foster care in 1991 than entered previously. (See fig. 1 and tables II.1-II.4 in app. II.)

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

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



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

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

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

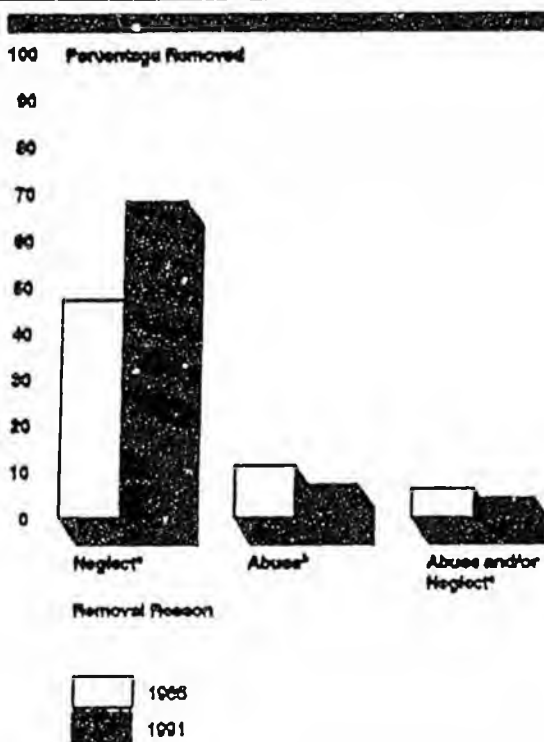
Sources: California and New York—state databases; Pennsylvania—aggregated state data; except "All Children and All Young Children"—Bureau of the Census midyear estimates.

Neglectful or Absent Parents Triggered Most Removals From Home

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

such as physical abuse, accounted for a large portion of the entries of young children into foster care in either year. For example, all types of abuse accounted for 11 percent of the removals of young children in 1988 and 7 percent in 1991. (See fig. 2 and table IL6 in app. II.)

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



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

*Includes removals due to neglect, caretaker absence or incapacity, relinquishment, and voluntary placements.

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

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

Source: State electronic databases.

Drug Abuse Further Impacts Troubled Families

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

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

Maternal Drug Abuse and Drug Exposed Children:
Understanding the Problem

U.S. Department of Health and Human Services

EXECUTIVE SUMMARY

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

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

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

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

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

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

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

- ◆ Prenatal drug exposure has significant, although not yet clearly defined, negative effects on the infant and developing child. Low birthweight and premature delivery are among the most serious. Parental drug use also puts children at increased risk of child neglect and abuse.
- ◆ Drug using women and their children are a particularly hard to reach population.
- ◆ Strained drug treatment and social service systems throughout the Nation currently either lack the capacity or appropriate family orientation to effectively serve this population.

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

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

- ◆ Conduct research in order to determine the nature and extent of maternal drug use; better understand the medical and developmental consequences of prenatal drug exposure on the fetus, infant, and developing child; and develop appropriate prevention and treatment approaches.
- ◆ Develop and disseminate effective interventions to:
 - Prevent drug use among women of childbearing age.
 - Treat drug addiction among women of childbearing age.
 - Prevent child abuse and neglect in families with substance abuse problems, and serve those children who have been abused or neglected because of their parents drug use.
 - Intervene with children who show or are at risk of developmental delays or other problems resulting at least in part from parental drug use.
- ◆ Continue to support drug treatment capacity by providing funds to States for prevention and treatment services.
- ◆ Improve the ability of the child welfare system to serve increased numbers of drug-exposed or drug-affected children and families.

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

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

Research on the Effects of Prenatal Drug Abuse

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

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

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

Preventing and Treating Drug Abuse in Pregnant and Parenting Women

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

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

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

Child Welfare Services for Drug Abusing Families

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

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

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

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

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

Legislative and Judicial Responses to Substance Abuse in Women

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

Financial Assistance Programs

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

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

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

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

Conclusions

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

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

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

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

INTRODUCTION

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- ◆ Conduct research in order to determine the nature and extent of maternal drug use; better understand the medical and developmental consequences of prenatal drug exposure on the fetus, infant, and developing child; and develop appropriate prevention and treatment approaches.
- ◆ Develop and disseminate effective interventions to:
 - Prevent drug use among women of childbearing age.
 - Treat drug addiction among women of childbearing age.
 - Prevent child abuse and neglect in families with substance abuse problems, and serve those children who have been abused or neglected because of their parents drug use.
 - Intervene with children who show or are at risk of developmental delays or other problems resulting at least in part from parental drug use.
- ◆ Continue to support treatment capacity by providing funds to States for prevention and treatment services.
- ◆ Improve the ability of the child welfare system to serve increased numbers of drug-exposed or drug-affected children and families.
- ◆ Provide medical insurance and disability income supports for eligible individuals and their children (including many with substance addictions). These programs enable many to receive treatment who might not otherwise.

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

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

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

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

Within the Public
Health Service (PHS)

Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA)
National Institute on Drug Abuse (NIDA)
National Institute on Alcohol Abuse and Alcoholism (NIAAA)
Office for Substance Abuse Prevention (OSAP)
Office for Treatment Improvement (OTI)
National Institute on Child Health and Human Development (NICHD)
Health Resources and Services Administration (HRSA)
Maternal and Child Health Bureau (MCHB)

Within the
Administration for
Children and Families
(ACF):

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

Elsewhere in HHS:

Health Care Financing Administration
Social Security Administration

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

CONGRESSIONAL UPDATE
104th Congress (1996)

WELFARE REFORM (9/18/96)

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

BACKGROUND:

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

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

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

The law takes affect on July 1, 1997.

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

WHAT YOU CAN DO:

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

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

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Florida considers welfare drug tests

Category: Category 1

Date: 25 Jan 1997

Time: 07:33:09

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Comments

(UPI Spotlight)

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

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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 Legis'ature 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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New Jersey Statute regulatory provisions

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 ¹or crime,
5 as appropriate,¹ under the laws of the jurisdiction involved and which
6 has as an element the possession, use, or distribution of a controlled
7 substance as defined in section 102(6) of the federal "Controlled
8 Substances Act" (21 U.S.C. §802 (6))¹; except that a person convicted
9 of any such offense which has as an element the possession or use only
10 of such a controlled substance may be eligible for benefits if the person
11 has successfully completed a drug treatment program approved by the
12 commissioner. Eligibility for benefits shall commence upon
13 completion of the drug treatment program, except that during the first
14 60 days after completion of the drug treatment program, the
15 commissioner shall provide for testing of the person to determine if the
16 person is free of any controlled substance. If the person is determined
17 to not be free of any controlled substance during the 60-day period,
18 the person's eligibility for benefits pursuant to this paragraph shall be
19 terminated. The commissioner, in consultation with the Commissioner
20 of Health and Senior Services, shall adopt regulations to carry out the
21 provisions of this paragraph, which shall include the criteria for
22 determining completion of a drug treatment program¹;

23 (8) a person found to have fraudulently misrepresented his
24 residence in order to obtain means-tested, ¹[federally funded]¹ public
25 benefits in two or more states ¹or jurisdictions¹, who shall be ineligible
26 for benefits for a period of 10 years from the date of conviction in a
27 federal or State court; or

28 (9) a person who intentionally makes a false or misleading
29 statement or misrepresents, conceals or withholds facts for the
30 purpose of receiving benefits, who shall be ineligible for benefits for
31 a period of six months for the first violation, 12 months for the second
32 violation, and permanently for the third violation.

33 c. A person who makes a false statement with the intent to qualify
34 for benefits and by reason thereof receives benefits for which the
35 person is not eligible is guilty of a crime of the fourth degree.

36

37 6. (New section) a. The signing of an application for benefits
38 under the Work First New Jersey program shall constitute an
39 assignment of any child support rights pursuant to ¹[45 CFR 232.11]
40 Title IV-D¹ on behalf of individual assistance unit members to the

2. Supplemental Security Income recipients, except for the purposes of receiving emergency assistance benefits;
3. Illegal aliens;
4. Other aliens who are not eligible aliens as defined in N.J.A.C. 10:90-2.10;
5. A person absent from the home who is incarcerated in a Federal, State, county or local corrective facility or under the custody of correctional authorities;
6. A person who is fleeing to avoid prosecution, custody or confinement after conviction, under the laws of the jurisdiction from which the person has fled, for a crime or an attempt to commit a crime which is a felony or a high misdemeanor under the laws of the jurisdiction from which the person has fled; or is violating a condition of probation or parole imposed under Federal or State law;
 - i. Under the laws of the State of New Jersey, a crime is defined at N.J.S.A. 2C:1-4(a) as "an indictable offense...for which a sentence of imprisonment in excess of 6 months is authorized."
7. A person convicted on or after August 22, 1996 under Federal or State law of any offense which is classified as a felony, high misdemeanor or crime, under the laws of the jurisdiction involved and which has as an element the distribution, possession, or use of a controlled substance as defined in section 102 (6) of the Federal "Controlled Substances Act" (21 U.S.C. Section 802 (6)).
 - i. Under the laws of the State of New Jersey, a crime is defined at N.J.S.A. 2C:1-4(a) as "an indictable offense ... for which a sentence of imprisonment in excess of 6 months is authorized."
 - ii. A person convicted on or after August 22, 1996 of any such offense which has as an element the possession or use only of such a controlled substance may be eligible for benefits if the person has successfully completed a drug abuse treatment program licensed by the State of New Jersey Department of Health and Senior Services (DHSS), at the conclusion of which the person is certified drug free by an authorized program representative.
 - (1) Eligibility for benefits shall commence upon successful completion of the established requirements of the DHSS licensed drug treatment program.
 - (2) During the first 60 days after successful completion of the drug treatment program or at the time of application or case redetermination, it must be determined, via testing by an entity designated by DFD, that the person is free of any non-prescribed controlled substance. If the person is determined not to be free of any controlled substance during, or at the conclusion of, the 60 day period, the person's eligibility for benefits shall be terminated immediately.

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

- (1) An applicant who is a parent-person may apply for WFNJ/TANF benefits for a child(ren) and him or herself as a needy parent-person.
- (2) Non-needy caretakers and/or parent persons shall also be eligible to apply for WFNJ/TANF benefits for the children in their care.

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

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

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

1. The WFNJ/GA assistance unit shall be comprised of one or more persons. In most cases, it will consist of a single individual, 18 years of age or over, or a couple without dependent children. In room and board or residential treatment situations, each person is an eligible unit of one. In all other situations, the eligible assistance unit shall consist of:
 - i. The applicant/recipient;
 - ii. The spouse of the applicant/recipient who lives in the home unless the spouse is receiving SSI or public assistance through another program; or,
 - iii. The person with whom the applicant/recipient lives as a couple (but only if there was a previous history or current history of support) unless such person is receiving SSI or public assistance through another program.

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

- (a) The following persons shall not be eligible for assistance and shall not be considered to be members of the WFNJ/TANF or WFNJ/GA assistance units:
 1. Non-needy caretakers, except that the eligibility of a dependent child shall not be affected by the income or resources of a non-needy caretaker;

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

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

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

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

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

1. The term "strike" includes any strike or other concerted stoppage of work by employees (including a stoppage by reason of expiration of a collective bargaining agreement) and any concerted interruption of operations by employees.
2. The term "participating in a strike" means an actual refusal, in concert with others, to provide services to one's employers.
3. Examples of non-strikers who are eligible to participate in the program include, but are not limited to:
 - i. Employees whose workplace is closed by an employer in order to resist the demands of employees (for example, lockout);
 - ii. Employees unable to work as a result of striking employees (for example, truck drivers who are not working because striking pressmen prevent newspapers from being printed); or,
 - iii. Employees who are not part of the bargaining unit on strike who do not want to cross the picket line due to fear of personal injury.

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

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

Kansas Department of Social and Rehabilitation Services
Rochelle Chronister, Secretary

MEMORANDUM

To: EPS Chiefs
From: *Gem* Gemmie Hubbell and *A. O'Donovan* Andrew O'Donovan
Date: November 1, 1996
Subject: AODAT Implementation

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

I. Background

Key barriers to ending dependence on public assistance are the health and social problems associated with the abuse of and dependence on alcohol and other drugs. ~~House~~ 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.

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.

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

EPS?
Employment
Preparation Services

CAGE -
Screening
device

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.

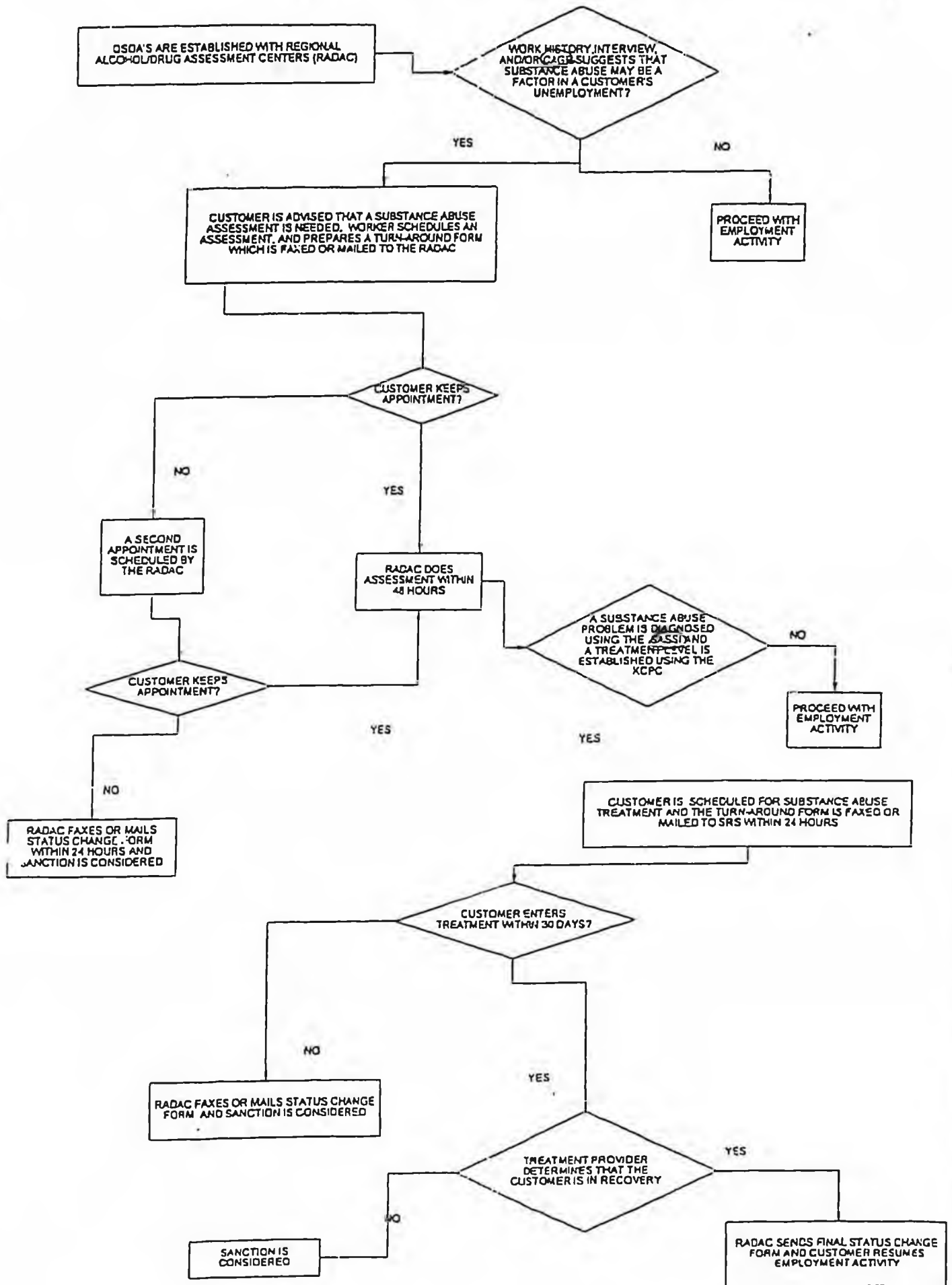
E. Effective Date

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 ___

KGPC** SHOWS CLIENT NEEDS LEVEL _____ TREATMENT SERVICES (SEE BELOW)

LEVELS 1 & 2 = OUTPATIENT SERVICES - HOURS WEEKLY _____

LEVEL 3 (24 HOUR TREATMENT) = SOCIAL DETOXIFICATION OR RESIDENTIAL TREATMENT - DAYS _____

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

RADAC EMPLOYEE _____

TELEPHONE NUMBER _____

RADAC REGION _____

DATE _____

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

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

STATUS CHANGE FORM

Alcohol and Other Drug Assessment and Treatment Project

SRS INFORMATION

 WORKER'S NAME TELEPHONE NUMBER

 AREA OFFICE ADDRESS

 CITY AND ZIP

 DIVISION--(SEE BELOW)

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

 CLIENT NAME KSCARES ID NUMBER

REGIONAL ALCOHOL/DRUG ASSESSMENT CENTER (RADAC) STATUS CHANGES

ADAS UNIQUE IDENTIFICATION NUMBER _____

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

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

RADAC REGION _____

 RADAC EMPLOYEE TELEPHONE NUMBER

 DATE

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

AODAT COMMENTS, QUESTIONS, AND ANSWERS

1. Would like teleconference or some type of training on this prior to implementation since we have not used either CAGE or SASSI. 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 chief's meeting, interviewers rarely just ask the CAGE questions point-blank straight from the card. The questions should be (and in many areas already are) integrated into current assessment practice. Current EPS interviewing and assessment procedures and techniques that look at strengths and barriers should produce accurate referrals.

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

Yes.

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

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

4. How is the treatment funded?

Through ADAS.

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

No.

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

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

5. Are MOST participants included in this plan?

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

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

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

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

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

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

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

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

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

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

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

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.