The CalWORKS Project: Overcoming Mental Health, Alcohol and Other Drugs and Domestic Violence Barriers to Employment

SIX COUNTY CASE STUDY

Moving Beyond Implementation to Identification and Service

Project Report #2
Fall 2001
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We continue to be impressed with the ingenuity and determination of the county and contract staff in all six counties who are committed to making CalWORKs an effective program for low-income adults and their children.

Generous funding for this Six County Case Study has been provided by the California Wellness Foundation, the David and Lucile Packard Foundation, and by voluntary payments from California counties. We also appreciate the ongoing guidance from the Joint CalWORKs Committee, a collaboration of the California Mental Health Directors Association, County Alcohol and Drug Program Administrators Association of California, and the County Welfare Directors Association.

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INTRODUCTION

The purpose of the CalWORKs Project is to gather and disseminate information about alcohol and other drug (AOD), mental health (MH), and domestic violence (DV) issues within the CalWORKs population.

The CalWORKs Project is a collaborative effort under the auspices of the California Mental Health Directors Association (CMHDA), County Alcohol and Drug Program Administrators Association of California (CADPAAC), and the County Welfare Directors Association (CWDA). The CalWORKs Project is overseen by the Joint CalWORKs Committee, which includes representatives from all three of these associations as well as representatives of domestic violence centers.

The CalWORKs Project at the staff level is a collaboration of three organizations: California Institute for Mental Health (CIMH), Children and Family Futures (CFF), and the Family Violence Prevention Fund (FVPF).

The CalWORKs Project is designed to gather and disseminate information about a) the impact of AOD, MH, and DV issues on CalWORKs participants’ ability to become self-sufficient, and b) how counties have implemented procedures to identify and serve CalWORKs participants having these barriers to employment.

The CalWORKs Project consists of four components:

- **Six County Case Study** - This study is gathering information on CalWORKs in six California counties: Alameda, Kern, Los Angeles, Monterey, Shasta, and Stanislaus.

- **Research** – Funded by a grant from the National Institutes of Justice, the Project is following 880 TANF participants in Kern and Stanislaus counties for a two-year period.

- **Technical Assistance** – Information derived from other Project activities is being shared with counties and others through regional forums, a web site, satellite broadcasts, newsletters, and presentations at conferences.

- **Policy** – Based on what is learned through other Project activities, policy recommendations are made to federal, state, and county-level policymakers.

This is the second report on the CalWORKs Project Six County Case Study.

The first report was issued in Spring 2000 and covered developments in the six counties through the end of 1999. This report contains information gathered during a last round of site visits (conducted from October – December, 2000) that focused on changes that had occurred during the 12 – 18
months since our last visit. Management Information System data on AOD and MH services received during FY 99-00 are also included in this report. The report contains information from other counties gathered during additional Project activities such as the regional forums.

Part I: MAJOR TRENDS

The first Case Study Report contained substantial contextual information about the six counties. Here we highlight some of the trends since that report.

*CalWORKs caseloads continue to decline, as do unemployment rates.*

The chart below shows the decline in CalWORKs caseloads from July 1998 through July 2000 in the six counties. The percentage decline over the two years was from 28% to 35% in Alameda, Monterey, Shasta, and Stanislaus counties. Kern (17%) and Los Angeles (14%) had more modest rates of decline. The number of adults in the CalWORKs caseload has declined even faster, since each year has seen an increase in the percentage of child-only cases. Child-only cases now range from 20% in Los Angeles up to 39% in Alameda. The decrease in numbers of adults is important, since it more accurately reflects the change in the Welfare-to-Work (WTW) caseload and the number potentially eligible for AOD, MH, and DV services.

<table>
<thead>
<tr>
<th>Change in CalWORKs Caseload¹ July 1998 – July 2000</th>
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<tr>
<td>July 1998</td>
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<tr>
<td>July 1999</td>
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<tr>
<td>July 2000</td>
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<tr>
<td>% Decline</td>
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Unemployment rates declined from CY 1998 to CY 1999 in all six counties. The decline continued into CY 2000 for Alameda and Los Angeles, but generally leveled off for the other four counties.

<table>
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<th>Unemployment Rates² CY 1998 - CY 2000</th>
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<tr>
<td>CY 1998</td>
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<td>CY 1999</td>
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<td>CY 2000</td>
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¹ Report CA 237, California State Department of Social Services.
Each of the six counties continues to improve its programs of identification and service for CalWORKs participants with AOD, MH, and DV issues.

Highlighted below are the one or two major events in each county. A table in Appendix I contains a fuller list of modifications and new developments in each of the counties.

- **Alameda:** The Behavioral Health Department got its full outreach team up and running, hired its full-time DV resource specialists, and instituted contracts for aggressive outreach to sanctioned families.

- **Kern:** The CalWORKs program instituted specialized employment coordinators for participants with AOD, MH, and DV issues; enhanced and formalized the DV component of the program; and used Incentive Funds for primary prevention children’s programs.

- **Los Angeles:** The Alcohol and Drug Program and the Department of Mental Health implemented coordinated AOD and MH community assessment services centers throughout the county; the CalWORKs program instituted pilot projects to screen for AOD and MH issues prior to contact with an eligibility worker and pilot projects to conduct home visits as part of the eligibility process.

- **Monterey:** The Behavioral Health Department centralized all of its CalWORKs clients under its special EAP program, started a Disability Assessment Unit that will review all requests for exemptions, and formalized its DV component.

- **Shasta:** An employee of the local DV agency joined the CalWORKs Behavioral Health Team, and CalWORKs AOD and MH services were extended outside the Redding area.

- **Stanislaus:** The CalWORKs program instituted an intensive interdisciplinary team service for participants who have been sanctioned, and procedures were changed to allow the Behavioral Health Services team to receive direct referrals from Employment and Training Services without going through the employment coordinator.

**A number of common themes emerged during this last round of site visits.**

Some of these themes are reflected in the above changes, while others are subtler in terms of changes in attitudes and approach. The most important of these are:

- **More efforts to identify AOD, MH, and DV issues early in the process:** Some counties took the initial approach of waiting for a participant to “fail” in some required WTW activity before they made a concerted effort to identify barriers. Counties have shifted, often on a pilot basis at first, to more comprehensive efforts to identify barriers as soon

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3 This approach is in keeping with the work-first philosophy that creates an expectation that all individuals can obtain employment until experience shows otherwise.
as participants enter the CalWORKs system. Some of these efforts are described in Chapter I.

- **More outreach:** Counties are moving more of their services out of welfare offices into the community. Both CalWORKs staff and some AOD/MH/DV staff are doing home visits, and some services are located at sites where CalWORKs participants spend their time, such as community colleges. Some examples of this are found in Chapters I and II.

- **An increase in the number of AOD, MH, and DV clients:** The numbers of clients being referred and the number in services have continued to increase as the systems and procedures are refined and the interagency collaborations deepen. Data on the number of clients served is presented in Chapter VI.

- **Awareness of a subset of AOD/MH/DV clients who have multiple barriers for whom the usual CalWORKs approach is unlikely to be effective:** Both CalWORKs staff and AOD/MH/DV providers agree that longer-term, more intensive services will be needed if this group is to attain any degree of self-sufficiency. Data from the counties’ Management Information Systems (presented in Chapter VI) substantiate the severity of disability of some of the CalWORKs participants receiving AOD, MH, and DV services.

- **Growth in DV service component:** All six counties now have organized approaches to the identification and referral of participants who have DV issues, and all are also contracting with private DV providers for services. The counties have differed in the speed with which these systems have been established and in the way they have structured their systems. The special challenges in creating a system of DV services for CalWORKs participants are described in Chapter III.

- **Greater focus on the needs of the children of AOD/MH/DV clients:** This manifests itself in numerous ways, including more referrals to the Children’s System of Care for MH services; some programs designed specifically for the children of CalWORKs parents receiving AOD/MH/DV services; and better coordination with the various child welfare programs. Some counties have used a portion of their Incentive Funds specifically for children’s services. Chapter V describes some of the developments in the services for children.

- **Greater focus on employment services:** The counties are devoting more attention to how to address the AOD, MH, and DV issues that directly impede employment. Some counties have incorporated specific vocational services into their AOD, MH, and DV programs, while others have formed closer alliances with vocational programs. Some examples of these efforts are found in Chapter IV.

- **Continuing challenge of the data systems:** Most counties continue to struggle with obtaining accurate and complete information on the numbers of CalWORKs participants referred for services and receiving services. This is particularly problematic when it
crosses department lines, and few counties are yet addressing outcomes of AOD, MH, or DV services. A county best practice in the area of evaluation is included in Chapter II.

**Part II: ORGANIZATION OF THE REPORT**

The first five chapters contain information about various components of the CalWORKs program relevant to participants with AOD, MH, or DV issues:

- Chapter I: Identification of AOD, MH, and DV Issues
- Chapter II: Services for Participants with AOD, MH, or DV Issues
- Chapter III: Special Considerations for Participants with DV Issues
- Chapter IV: Employment Services for Participants with AOD/MH/DV Issues
- Chapter V: Services for CalWORKs Children

These chapters are organized in a similar format. First we present a set of principles that underlie effective approaches in that program component. This is followed by a set of best practices and promising practices. We consider “best practices” to be those strategies that should be considered an essential part of any county’s CalWORKs AOD/MH/DV system. The “promising practices” category includes strategies that are being tried in one or another county and appear to have merit, but are not yet developed enough to be considered best practices. The judgment of the CalWORKs Project staff has played the largest role in distinguishing these two categories. The chapters end with a checklist that counties can use in assessing how their programs are doing.

The last chapter (Chapter VI) contains information from the Management Information Systems of the six case study counties about the numbers of participants receiving AOD and MH services, their demographic and clinical characteristics and the patterns of services they have received. The chapter contains a set of findings and implications.
Chapter I: IDENTIFICATION OF AOD, MH, AND DV ISSUES

This chapter covers strategies for identifying CalWORKs participants who have AOD, MH, or DV issues. It first describes four principles that should underlie any identification system. This is followed by four best practices that should be a part of any county’s system of identification. The next section describes four promising practices, which counties may want to explore. The final section is a checklist that will allow your county to assess how it is doing.

Rates of identification have increased in the case study counties, but still remain far below original expectations and below known prevalence of the three issues within the CalWORKs population. It is critical, however, to put this finding within the broader context of the general lack of identification of these issues within the general population. For example, most studies have found only 20 to 40 percent of persons with a Major Depression disorder receive any sort of treatment. Rates are even lower for low-income persons, those receiving Medicaid (Medi-Cal), and persons who are not white.

Part I: IDENTIFICATION PRINCIPLES

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<td>Recognize and address the barriers to identification</td>
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<td>Establish a trusting environment</td>
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<tr>
<td>Implement identification efforts in multiple ways at multiple times</td>
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<tr>
<td>Track the results of identification efforts</td>
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Principle A: Recognize the barriers to identification.

Major barriers to identification continue to exist. Listed below are the major hypotheses for why identification rates are low.4

➢ CalWORKs participants fear the consequences of having an AOD, MH, or DV issue known to the welfare system. The two most noted fears are of losing cash assistance and of losing parental rights. These fears appear greatest for participants with AOD issues and to a lesser, but still significant degree, with participants with DV issues.

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4 These are taken from another CalWORKs Project document – Screening Guide, April 2001 – available on the CIMH website www.cimh.org.
Front-line CalWORKs staff (eligibility workers and employment coordinators), as a whole, have neither the time nor the capacity or support to undertake the responsibility of identification.

- Very high caseloads (with greater complexity and responsibilities associated with each case) limit the time available to each client.

- Despite training, some continue to feel uncomfortable or unprepared to address these issues with their clients.

CalWORKs participants do not recognize the signs of these problems themselves and/or deny their impact on their lives and those of their children.

- Denial is widely acknowledged as an AOD issue, and treatment approaches incorporate awareness and enhancement of the stages of motivation for change.

- Persons who have been subject to long-term DV may accept part of the batterer’s view that there is nothing unusual about the situation.

- Chronic MH problems, such as depression and anxiety, may not be understood as mental health issues, but rather as normal responses to difficult lives.

CalWORKs participants may see no advantage to making known AOD/MH/DV problems they have.

- They may believe there is nothing available that can help them. This may result from prior bad experiences with the treatment and services systems or from simple lack of knowledge about potential benefits from services.

- They may lack the confidence to make a positive change. The difficulties may appear overwhelming and they may not feel they have the resources to become engaged in treatment or services.

Understanding these barriers helps in designing more effective identification methods.

**Principle B: Establish a trusting environment.**

All the identification methods rely essentially on the client’s willingness to self-disclose an issue. Most counties rely entirely on self-disclosure. It is easy to ascertain the intent of the screening instruments that are used by the few counties that utilize such tools. So, unless the participant feels it is in her best interest to disclose an issue, the efforts of the county are likely to be nonproductive.

Developing trust is not an easy task, particularly within what has been historically a rule-bound, and sometimes punitive, welfare system. CalWORKs participants must believe that disclosure of an
AOD/MH/DV issue will, at a minimum, not hurt them, and hopefully will lead to some positive consequences. Without this assurance, they are unlikely to disclose, and even if they do, they are unlikely to make it through the steps to receive services.

Having a private place in which a person can talk about issues which are very personal is a necessity. This is a dilemma for many welfare offices that are accustomed to open office environments with limited square footage. Without privacy, self-disclosure is unlikely.

The most important way to establish trust is to be helpful to the participant. Every time the “system” does something that the participant views as helpful, her trust in the system increases. Trying to obtain self-disclosure before the system has demonstrated its usefulness is unlikely to yield much.

**Principle C: Implement identification efforts in multiple ways at multiple times.**

There is no one right way or one right time to try to identify participants with AOD/MH/DV issues.

- The AOD/MH/DV issues ebb and flow within the lives of the participants so that an attempt that works at one time may not at another.

- Participants are different, so it only makes sense that they will respond differently to one staff person or setting. The more staff in different settings that are open to a self-disclosure the greater the chance of making a connection.

- CalWORKs participants face multiple demands and challenges. They may not be able to focus on AOD/MH/DV issues the first few times the issues are raised, but the more they hear about them, the more they may be able to process the information.

**Principle D: Track the results of identification efforts.**

As counties begin to try multiple identification methods at multiple points in the process, they will get a sense of what works and what doesn’t work in their particular system. By tracking the results of specific strategies, they are able to halt or modify certain approaches that do not work, rather than continuing to do something that uses resources and is not successful. This has led to an experimental attitude, where a new idea will be tried in a part of the program for a while and then either adopted system-wide, if it is successful, or ceased if it is not.
Los Angeles County has done a universal four-question AOD screening with all new applicants. As a pilot, they tried using a longer screening instrument in the same setting and found that it made no difference in terms of the number of positive screens.

They also tried a process in which a contract agency used a paraprofessional in recovery to conduct one-on-one interviews with all new applicants prior to their meeting with their eligibility workers. This increased the number of referrals for assessment and, so, is likely to be expanded.

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Part II: IDENTIFICATION BEST PRACTICES

This section highlights four best practices in the area of identification. Enough evidence has accumulated through the experiences of counties to suggest that these are minimum requirements for an effective system of identifying CalWORKs participants with AOD, MH, and DV issues.

Best Practices

- Co-location of AOD/MH/DV staff at welfare sites
- Presentations on AOD/MH/DV issues and services to CalWORKs participants
- Training of CalWORKs and AOD/MH/DV staff
- Enhancing back-door referrals

A: CO-LOCATION OF AOD/MH/DV STAFF AT WELFARE SITES

Co-location of AOD/MH/DV staff is essential to building relationships with welfare staff.

As noted in the first Six County Case Study Report, counties assumed that most of the identification of participant AOD, MH, and DV issues would occur at the welfare offices. We have all learned the limitations of this assumption:
Welfare staff caseloads are too large to allow much interaction with participants.

Many welfare staff are reluctant to discuss AOD/MH/DV issues because of lack of comfort and/or lack of feeling prepared to do so.

Participants are reluctant to disclose AOD/MH/DV issues to welfare staff, particularly before a relationship has been established.

And yet, the welfare office remains the linchpin of the CalWORKs system. It is the one place where all welfare participants must spend some time; and the participant’s Welfare-to-Work Plan, developed with her employment coordinator, is the key element in the participant’s interaction with the welfare system. Thus, the AOD/MH/DV component needs to have a strong presence in this welfare environment and culture.

The most successful approach to developing this presence is through the personal contact that occurs when an AOD/MH/DV staff person is present for enough time to build trusting relationships with the welfare staff. The welfare staff have the opportunity to learn about the AOD/MH/DV component of the program, and they learn who to ask if they have a question or a problem.

To be successful, co-located staff must have the personal and professional characteristics to be effective liaisons.

The job requires people who can work in a different culture without becoming frustrated or placing blame. They must be willing to learn the rules and regulations of the CalWORKs system so that they can be a point of translation for both the AOD/MH/DV and the welfare parts of the system. They must be able to take the initiative to form personal and professional connections, e.g., offering to do training or attend unit meetings or have lunch with CalWORKs staff. They must be able to respond to immediate crises, since the presence of back-up support increases the willingness of CalWORKs staff to deal with AOD/MH/DV issues.

The system structure must support the co-located staff’s role.

There are a few general principles that facilitate more effective co-location:

- The co-located staff should devote enough time on-site to become known to the welfare staff. When too many different staff share a co-location responsibility, the impact is reduced. If the co-located individuals are there to only do one thing, e.g., assessments, presentations at orientations, or job clubs, they don’t have the time to develop the range of relationships that make the co-location work.

- The co-located staff should have an official liaison role. One of the more useful functions of the staff is being helpful to the CalWORKs staff when they have a question or a concern about the AOD/MH/DV services to which their client has been referred. Being able to field those questions and give answers reinforces the usefulness of the person in the welfare setting.
This points to having specially designated, co-located AOD/MH/DV staff that work on CalWORKs rather than spreading the responsibility among a group of staff who have multiple other responsibilities. This should be the case whether the co-located staff are from the county or from a contracted AOD/MH/DV program.

*Alternatives need to be developed in cases where co-location is not feasible, e.g., in rural or low volume areas.*

Where low volumes make the stationing of an AOD/MH/DV staff at a welfare office not economically feasible, the same results can be obtained by having a staff person who is on-call to provide the same functions as co-located staff. The same issues apply here — the staff person should have the same characteristics as noted above and the system should provide the same support and structure as if the person were co-located. The smaller number of welfare staff in these low-volume areas allow the benefits of personal relationships and trust to develop with a designated AOD/MH/DV staff person in much the same way as co-location does in more urban areas.

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**COLLEGE HEALTH KERN COUNTY**

Kern County Behavioral Health Services contracts with College Health to provide AOD and MH service in four outlying areas of the county. The contract includes serving CalWORKs clients. In Lake Isabella, College Health staff make presentations to orientations and are on-call to come to the DHS office to screen cases. They can schedule same-day appointments for assessments where required. The small size of the community facilitates good relationships between the College Health staff and DHS.

*Contact: Joni Meachem  760-379-3412*

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**B: PRESENTATIONS ON AOD/MH/DV ISSUES AND SERVICES TO CALWORKS PARTICIPANTS**

*It is critical to view the CalWORKs process from the position of the participant.*

As professionals, we tend to see the world from our perspective. We create policies and practices intended to provide information to our clients and assume that the information will be fully absorbed by them. There is, of course, extensive evidence to suggest otherwise; but it is a common trap.
Each new applicant for CalWORKs receives a huge quantity of information about the program when s/he first applies for cash aid or when s/he undergoes a re-determination. There is information about the basics of the program, i.e., who qualifies and how much money one can expect to receive. There is information about other possible benefits, like Food Stamps and Medi-Cal. Then there are all the requirements of the program, including work activity hours, time limits, and conditions that qualify for exemptions. Finally, there is the information about support services, including transportation and childcare, as well as AOD/MH/DV services. All of this information is provided through individual and/or group orientation sessions that last from an hour to a full day depending on the process within each particular county. Information about AOD/MH/DV issues and services is often provided for the first time to CalWORKs participants in this type of situation.

**It is important to understand two things about the new CalWORKs applicants in this setting.**

- A new applicant may be under especially high stress because something has happened in her/his life that has led to the current application for cash assistance. This makes the processing of information all the more difficult.

- AOD/MH/DV issues are likely not at the top of the priorities for the applicant at the time at which s/he applies. It is likely that daily life needs, such as shelter and food for her/his family, are more critical at the moment than addressing issues that may have been long-standing in the person’s life.

Under these circumstances, it is unlikely that the applicant is going to process all of the information about the AOD/MH/DV issues and services that is presented to her or him. It is essential, therefore, to develop methods for highlighting the AOD/MH/DV information.

**Taking the time to present the information about AOD/MH/DV issues and services pays off in terms of numbers of participants who will self-disclose either at that time or later.**

Many counties are now using group orientation sessions — both at the time of application and prior to enrollment in Welfare-to-Work — as opportunities to present information about AOD/MH/DV issues and services. The amount of time devoted to this varies from ten or fifteen minutes to as much as an hour or an hour and a half. Most counties are now using specialized AOD/MH/DV staff — either co-located staff or staff from community programs — to make these presentations. Reports from staff who do these sessions suggest that longer, more interactive sessions are more likely to yield self-disclosure, as are ways of framing the issues in non-clinical terms. A supportive context that presents the information in a non-threatening fashion is more likely to be successful.
EAP FOCUS ON STRESS
MONTEREY COUNTY

An Employee Assistance Program (EAP) staff in Monterey does a 20-30 minute part of a four-hour orientation given to all new applicants and all participants at the time of re-determination. In that time, she is able to talk about the wide prevalence of stress, particularly for those living in difficult circumstances, to do a few exercises with the participants, and to briefly describe the EAP services. She also makes clear that EAP is distinct from DSS and that no referrals will be made to Child Protective Services (CPS) just because someone receives EAP services. The EAP staff also gives out a confidential telephone number. The staff that does this orientation believes it demystifies the EAP and fosters self-referral.

Contact: Cathy Gutierrez
831-796-3068

1736 FAMILY CRISIS CENTER HOUR-LONG SESSIONS
LOS ANGELES COUNTY

Los Angeles County contracts with community-based DV programs to provide services to CalWORKs clients. Part of the contract includes being available to provide information to CalWORKs participants about DV services. One of the DV organizations in Los Angeles — 1736 Family Crisis Center — conducts a one-hour session on DV in the GAIN Job Club. The DV staff person presents himself as separate from the GAIN program. He uses an interactive approach and reports that this is a setting that is conducive to self-disclosure. He notes, however, that the participants may not be interested in DV services at that time, but they have received the information in a way that they can respond to later, should the need arise.

Contact: Michael Chifalo
1736 Family Crisis Center
213-741-5050

Job club is a setting that is conducive to presentations.

The bonding that occurs among participants in this setting creates an atmosphere of greater safety. The structure of the job search process can make a large difference; if there is time set aside for discussion among the group, AOD/MH/DV issues are more likely to emerge.
REDESIGNED JOB SEARCH
MONTEREY COUNTY

In an attempt to provide a level of service which would help participants obtain jobs that they would keep, Monterey’s CWES redesigned their job search activity to include two full days of classes (on Mondays and Fridays), with job search occurring on the other three days. They utilize the “30 Ways to Shine” curriculum. The classroom sessions have generated substantial discussion and self-disclosure of AOD/MH/DV issues — so much so that the staff conducting the sessions is seeking assistance from the EAP to manage the stress of the CWES staff as well as the CalWORKs participants.

Contact: Deborah McAlahney, CWES
831-755-8488

C: TRAINING OF CALWORKS AND AOD/MH/DV STAFF

Training of CalWORKs staff in AOD/MH/DV issues and services enhances referrals.

The Six County Case Study Report (April 2000) presented data that eligibility workers who received some training in AOD/MH/DV were more likely to make a referral than those who did not, and that employment coordinators who received training made more referrals than those who received no training.

Training of CalWORKs staff in AOD/MH/DV issues needs to be done on a routine basis.

There is substantial turnover in the CalWORKs eligibility worker and employment coordinator roles. Unless training is done on a routine basis, there will be a sizable number of workers who have not been trained.

CalWORKs rules and regulations are numerous. Unless CalWORKs staff are reminded of the AOD/MH/DV issues, policies and procedures, they are likely to slip into the background. Also, policies and procedures change, so updated training is needed to keep everyone current.

AOD/MH/DV staff need training about CalWORKs.

The training should not be a one-way street. Dealing effectively with the CalWORKs system is an essential part of an effective AOD/MH/DV program for CalWORKs participants. Data from client surveys found that assistance in dealing with the CalWORKs bureaucracy was one of the benefits that clients found useful in their AOD/MH/DV programs.5 The CalWORKs rules and regulations are exceedingly complicated, so that AOD/MH/DV service providers should not be expected to

5 See the CalWORKs Project Six-County Case Study Report, April 2000, page 114.
master them all, but a basic understanding and clear direction on whom to call with questions is an absolute minimum requirement.

**AOD/MH/DV staff should receive some basic cross-training.**

Prevalence data shows substantial overlap in the three (AOD, MH, and DV) issues. In a random sample of CalWORKs single female heads of household, 21% in Kern County and 32% in Stanislaus County had at least two of the three issues. Counties have or are beginning to develop programs to serve clients who have more than one of these issues, but the large majority of CalWORKs clients who are served will be in programs that are directed at only one of the issues.

While some professionals have training in more than one issue, many know only a rudimentary amount about the other two issues. At a minimum, staff working in any AOD, MH, or DV program should be able to recognize the possible presence of the other two issues and know how to either provide services directly for that other issue, or make an appropriate referral.

This is particularly important for MH professionals, since more CalWORKs participants self-identify as having a MH than an AOD or DV issue. Many MH staff we interviewed noted that some clients would reveal an AOD issue once a trusting relationship had been developed. Programs must have clear guidelines for how such cases will be handled.

D: ENHANCING “BACK-DOOR” REFERRALS

**Many clients enter the system through the “back-door,” i.e., they are already receiving AOD/MH/DV services.**

A sizable number of CalWORKs participants appear first at an AOD/MH/DV service program rather than being referred to such a program from CalWORKs. All three service systems — AOD, MH and DV — have alternative sources of funding for such clients. The incentives to inquire about the welfare status of a client and to pursue having the client’s services included in her Welfare-to-Work (WTW) Plan vary by service system and county.

There are clear benefits to such clients in having their AOD, MH, and/or DV services included in their WTW Plan. At a minimum, the clients should be informed of the potential benefits and any risks from having the services in the WTW Plan. The ultimate decision on whether or not the CalWORKs employment coordinator is informed rests with the client, but the better informed the AOD/MH/DV program staff are of the potential benefits to the client, the more assistance they can provide the client in weighing the alternatives.

Facilitating these referrals through the CalWORKs system is critical to a successful design. Having county AOD/MH/DV staff act as liaisons with CalWORKs for contract programs can make the job easier for these contract programs. Another approach is to have specialized eligibility workers and

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employment coordinators who are assigned to work with AOD/MH/DV clients and who can respond to these back-door referrals.

**Part III: IDENTIFICATION PROMISING PRACTICES**

This section describes a number of approaches that appear promising based on the experiences of the counties that are trying them.

**Promising Practices**

- ☑ Mandatory referrals for assessments for special populations
- ☑ Outreach
- ☑ Social marketing
- ☑ Screening

**A. MANDATORY REFERRALS FOR ASSESSMENTS FOR SPECIAL POPULATIONS**

*This approach tries to optimize the use of specialized AOD/MH/DV staff.*

Having every CalWORKs participant interviewed one-on-one by a skilled AOD/MH/DV staff person would be the ideal way to identify participants with a need for services; but two things prevent this solution: it is too expensive, and it runs contrary to the work-first approach. An alternative is to identify subsets of the population that are at particularly high risk for having an AOD/MH/DV issue, i.e., where the prevalence of the issues is likely to be higher than average.

These selected populations can then be referred automatically for an AOD/MH/DV assessment. Because this is only a subset of all the participants, the expense is less. And since the group has a higher probability of “failure”, it is a sensible modification to the work-first orientation.

There are two ways to identify these subpopulations. One is to pick the points in the Welfare-to-Work process where there is an indication of “failure.” The second is to focus on groups of participants who are particularly vulnerable to having an AOD/MH/DV issue.

*Events construed as “failures” are opportunities for referrals.*

There are events that occur that are construed as “failures,” e.g., not getting a job through job club/search, being non-compliant, being sanctioned, failing a drug test. These are all possible points at which an automatic referral for an AOD/MH/DV assessment might be in order, because there is a higher than average probability that such an issue is present.
## AOD/MH Screening During Appraisal
### Los Angeles County

Participants who do not get a job through Job Search receive an appraisal conducted by assessors under contract with the Los Angeles Department of Education. A longer screening instrument for AOD/MH issues than is used routinely with every Los Angeles CalWORKs participant during the eligibility process is included in the appraisal. The screening is part of a broader look at the education and training needs of the participant, and so can be presented within a more supportive environment.

**Contact:** David Asher  
562-922-8662

### Another Approach is to Routinely Refer Particularly Vulnerable Populations

There are also subsets of the CalWORKs population that may be particularly vulnerable to AOD/MH/DV issues, thus warranting a routine referral to an AOD/MH assessment. For example, CalWORKs cases that have child welfare involvement or all cases with a teen parent might be referred for an AOD/MH/DV assessment.

## Referrals on All Cases in Special Family Maintenance Program
### Kern County

Kern County has developed a special Kern Integrated Team Effort (KITE) program for CalWORKs family maintenance cases. All of the cases seen by the team are automatically referred to the CalWORKs Behavioral Health Team for an assessment.

**Contact:** Hal Lockey, KITE  
661-631-6071

## Referrals on All Teen Cases
### Shasta County

All cases that have a teen parent are automatically referred to the Behavioral Health Team for an assessment.

**Contact:** Steve Grimm  
530-225-5733
AOD/MH/DV staff must handle these assessments with special care.

The AOD/MH/DV staff doing these assessments must understand their different role with this kind of referral. In usual circumstances, the participant has been referred because s/he displayed some indication of one of the issues. The role of the assessment is to confirm that, and to obtain a more thorough understanding of the issue, so that appropriate services can be rendered.

With an automatic referral this is not the case. The main objective of the interview is to determine whether or not there is an issue. It is essential that the AOD/MH/DV staff person not approach the participant assuming that there is an issue.

B: OUTREACH

Outreach to other parts of the CalWORKs system can lead to additional portals for AOD/MH/DV referrals.

The CalWORKs Welfare-to-Work process includes more than just the eligibility and employment coordination functions done by the front-line welfare staff. Participants are referred to a number of education and training placements, as well as community service work sites, where they either spend considerable time and/or come into contact with a supervisor/teacher/trainer in these settings. In many instances, these people have more extended contact with the participant than the front-line welfare staff, so that they are in a good position to notice behavior that might indicate an AOD/MH/DV issue.

These programs can be a good source of referrals — but only if the AOD/MH/DV staff initiate contact with the supervisor/teacher/trainer, and inform them of what to look for and how and when to make referrals. These contacts need to be nurtured if they are to yield a consistent flow of referrals.

### TRI-CITY MENTAL HEALTH CO-LOCATION AT COMMUNITY COLLEGE

LOS ANGELES

The MH program in Tri-City has co-located staff at the Community College where many CalWORKs participants are engaged in vocational programs. This allows for either direct participant contact, or for referrals from the teachers in the programs.

Contact: Elsa Hilo
909-469-5830

Contacts with other programs likely to serve the same clientele can also lead to referrals.

Each county has generic programs that serve a broader range of low-income clients than just those on CalWORKs. Developing relationships with these programs can generate referrals of persons who are either in CalWORKs or who might qualify for CalWORKs.
EMERGENCY RESPONSE TEAMS AND TEMPORARY RESTRAINING ORDER (TRO) CLINICS
KERN COUNTY

The CalWORKs contract with the local DV program — the Alliance Against Family Violence — in Kern County includes payment for staff who participate in an emergency response ride-along program with the local police. The DV staff uses the opportunity to inform and educate the victim about CalWORKs and the range of services available to CalWORKs participants. DV staff also have a presence at the local TRO clinic, where they inform clients about CalWORKs and services available for DV issues through CalWORKs.

Contact: Jan Sublett
Alliance Against Family Violence
661-322-0931

CHRONIC LICE PROGRAM
SHASTA COUNTY

The CalWORKs program has contracted with three school districts to intervene with families where children have been truant and have chronic lice problems. Staff do home visits and make referrals to the CalWORKs Behavioral Health Team as appropriate.

Contact: Steve Grimm
530-225-5733

C: SOCIAL MARKETING

All counties do some social marketing.

Every county produces brochures and information sheets — usually designed by program staff — about available CalWORKs AOD, MH, and DV services. At a minimum, these should be translated into appropriate languages. Where possible, the messages and the format should be tested with prospective clients to assure that the information is understandable and appealing.

A few counties have devoted substantial resources to professionally designed social marketing campaigns.

Two of the six case study counties — Alameda and Monterey — have utilized professionally designed social marketing messages and campaigns, including posters, videos, and radio spots. Sacramento County has also developed social marketing materials.

Some of these materials are available for use by other counties, thus minimizing the expense of developing such a campaign from scratch.
SOCIAL MARKETING

These counties worked with professional public relations firms to develop messages, materials, and strategies for appealing directly to CalWORKs participants about the advantages of receiving AOD or MH services. They utilized focus groups to create a campaign that would be culturally and ethnically appropriate to the CalWORKs populations.

Contacts:  Maxine Heiliger, Alameda County, 510-567-8102  
Deborah McAlahney, Monterey County, 831-755-8488  
Toni Moore, Sacramento County, 916-874-9754

D: SCREENING

The use of brief screening instruments by eligibility workers and employment coordinators in the welfare office setting yields small numbers of identified participants.

Los Angeles County has utilized a brief screening instrument (four AOD and four MH questions) with all applicants and all re-determinations. While the screening has identified some participants (roughly 5% of those screened), it is perceived negatively by some participants and some CalWORKs staff as intrusive and offensive.

A similar effort in New Jersey met substantial resistance from front-line staff, who either failed to conduct the screening on all participants or did so in such a cursory fashion that the results were deemed to be not successful.

The difficulty is the setting, not the screening instruments.

These screening instruments are readily transparent to participants, i.e., they ask fairly clearly about AOD, MH, or DV issues. Unless participants feel a level of trust and that the disclosure of these issues will not harm them, they will not provide honest answers. Similarly, if the staff doing the screening has neither adequate time, nor training, to deal with positive answers, they will avoid doing the screening in a thorough manner.

Changing the setting will yield better results, while improving the screening instrument probably will not. Los Angeles tried both as part of two pilot projects.

➢ Every new applicant had a home visit. The identification of AOD/MH/DV issues in this setting increased.

➢ A longer AOD screening instrument was used in the regular office setting. The identification rates did not increase.
Screening can be effective if used in the right setting.

Some counties and other states are using screening instruments within selected settings and with selected participants as an alternative (or in addition) to having the eligibility or employment coordination staff routinely screen every participant. Settings are selected in which, there are, at a minimum, trust, time, and confidentiality. Some examples follow:

- Screening done in group settings, like a presentation or job club, in which everyone completes the screening instrument and self-scores it—this is followed by a discussion in which the leader indicates what the scores on the screening instrument mean in terms of when someone should think about seeking help.

- Screening done by AOD/MH/DV staff on an individual basis as part of a mandatory referral for selected subpopulations (see Part IV, Promising Practice A). In these instances, adequate time must be allotted to put the screening into a trusting and helpful context.

- Screening done by paraprofessionals who are themselves in recovery, as in the Los Angeles pilot (see the example of the Los Angeles pilot in Part I, Principle D). The trust established by the setting allows the screening to be more effective.

For more information about how to use screening in an effective manner, see the CalWORKs Screening Guide.7

Part IV: CHECKLIST

Here is a checklist that you can use to see how your county’s system of identification is doing.

<table>
<thead>
<tr>
<th>Principle A: Recognize and address the barriers to identification</th>
<th>1) Do you have a policy that clearly states that an AOD/MH/DV issue by itself will not lead to a referral to CPS? Is this shared with participants?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2) Do you present information to participants about how to recognize if they have an AOD, MH, or DV issue that might interfere with employment?</td>
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<tr>
<td></td>
<td>3) Do you present information about how AOD/MH/DV services have been helpful to prior CalWORKs participants?</td>
</tr>
<tr>
<td>Principle B: Establish a trusting environment</td>
<td>1) Are your eligibility workers and employment coordinators able to spend sufficient time with each participant to establish a trusting relationship?</td>
</tr>
<tr>
<td></td>
<td>2) Do CalWORKs staff have a “helping” approach?</td>
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</tbody>
</table>

7 The Screening Guide can be downloaded from www.cimh.org or copies can be obtained by calling CIMH at 916-556-3480
### 3) Is your CalWORKs office set up so that conversations with CalWORKs staff occur in private?

**Principle C: Try multiple methods at multiple times**

1) How many times are participants told about AOD, MH, and DV services?
2) In how many different ways are CalWORKs participants approached about AOD, MH, and DV issues?
3) In how many different locations (or steps in the process) are CalWORKs participants approached about AOD, MH, and DV issues?

**Principle D: Track results**

1) Do you have a system that tracks identification and referral by who identified the issue and where the identification occurred?
2) How many new methods of identification have you tried in the last twelve months? Did they work? If not, did you change them?

**Best Practice A: Co-location of AOD/MH/DV staff at welfare sites**

1) Do you have co-located AOD, MH, DV staff at CalWORKs sites where the eligibility workers and employment coordinators work?
2) Are the co-located staff available full-time at these sites or are they available on-call within a set amount of time?
3) Do you have co-located staff at other sites, e.g., One-Stops, community colleges, training programs, work sites?
4) What do the co-located staff do to build relationships with the staff at the program where they are located?
5) Would all the program staff where you have co-located CalWORKs staff know the names of the co-located staff and how to contact them?

**Best Practice B: Presentations on AOD/MH/DV issues and services to CalWORKs participants**

1) Do you have AOD, MH, and/or DV staff that do presentations at Orientations? At job clubs? At other sites?
2) How long are the presentations?
3) Are the presentations interactive?
4) Do you have a strategy for how to handle self-disclosures made during these presentations?

**Best Practice C: Training of CalWORKs and AOD/MH/DV staff**

1) When was your last AOD, MH, and DV training for CalWORKs staff?
2) Are AOD, MH, and DV training provided on a regular schedule to CalWORKs staff?
3) Does the training include policies and procedures for making referrals? For communicating with the AOD/MH/DV program?
4) Is there AOD, MH, and DV training for other than the CalWORKs front-line welfare staff?
5) Do AOD, MH, and DV program staff get training on CalWORKs?
6) Is there cross-training of AOD, MH, and DV program staff who serve CalWORKs participants?

<table>
<thead>
<tr>
<th>Best Practice D: Enhancing “back-door” referrals</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Do all AOD/MH/DV program staff inquire about CalWORKs status? Are they required to?</td>
</tr>
<tr>
<td>2) Are all AOD/MH/DV program staff trained to discuss with their clients the issue of including the services in the Welfare-to-Work Plan?</td>
</tr>
<tr>
<td>3) Do you have CalWORKs staff assigned to specific AOD/MH/DV programs that serve large numbers of CalWORKs clients?</td>
</tr>
<tr>
<td>4) Do you have CalWORKs staff assigned specifically to deal with AOD/MH/DV providers who want to facilitate their clients becoming CalWORKs eligible and/or having their services included in their Welfare-to-Work Plans?</td>
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<table>
<thead>
<tr>
<th>Promising Practice A: Mandatory referrals</th>
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</thead>
<tbody>
<tr>
<td>1) Do you have mandatory referrals at any point in your Welfare-to-Work process?</td>
</tr>
<tr>
<td>▪ If no job obtained after job search?</td>
</tr>
<tr>
<td>▪ If lose a job?</td>
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<tr>
<td>▪ If fail a drug test?</td>
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<tr>
<td>▪ If non-compliant?</td>
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<tr>
<td>2) Do you have mandatory referrals for any subpopulations?</td>
</tr>
<tr>
<td>▪ Participants involved with child welfare?</td>
</tr>
<tr>
<td>▪ Teens?</td>
</tr>
<tr>
<td>▪ Those approaching time limits?</td>
</tr>
<tr>
<td>3) Do you have special procedures for doing these assessments?</td>
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<table>
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<tr>
<th>Promising Practice B: Outreach</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Has the AOD/MH/DV staff established relationships (and done training) with other parts of the CalWORKs process?</td>
</tr>
<tr>
<td>▪ Job clubs?</td>
</tr>
<tr>
<td>▪ Education and training sites?</td>
</tr>
<tr>
<td>▪ Community service and other job sites?</td>
</tr>
</tbody>
</table>
| Promising Practice C: Social marketing | 2) Has the AOD/MH/DV staff done outreach to other sites where CalWORKs participants spend time?  
   - WIC?  
   - Primary health care sites and emergency rooms?  
   - Childcare centers?  
  | 1) Have you translated all of your brochures and information sheets into threshold languages?  
  2) Have you asked your clients about the brochures and information sheets you use?  
  3) Have you thought about a more professional social marketing effort?  |
| Promising Practice D: Screening | 1) Have you instituted any brief universal screening efforts? Have you tested their effectiveness?  
  2) Have you instituted any specialized screening efforts at least as pilot projects? |
Chapter II: SERVICES FOR PARTICIPANTS WITH AOD, MH, OR DV ISSUES

The biggest challenge for providers of AOD, MH, and DV services remains engaging CalWORKs clients in the service programs. No-show rates continue to be high, and many clients begin and then drop out of special AOD, MH, and DV services.

This chapter highlights the principles, best practices, and promising practices in the counties’ delivery of services to CalWORKs participants with AOD, MH, and DV issues.

Part I: SERVICE PRINCIPLES

Principles

- Utilize some specialized staff or programs
- Individualize services
- Attend to gender issues
- Begin evaluation efforts

Principle A: Utilize some specialized staff or programs.

Providing services to the CalWORKs population is not “business as usual” for any of the three service areas. All three systems must deal with the following unique features of providing services to these clients:

- A set of complex and detailed CalWORKs rules and regulations which are part of providing services under this funding stream;
- A focus on employment issues which have not traditionally been a foremost concern for the service systems;
- A need to consider the impact of other barriers in the delivery of services;
- A requirement to coordinate services with the CalWORKs program, and
- A largely female client population.

Additionally, each service system faces some unique challenges in the way it is being asked to approach this population.
MH: The mental health system is being asked to serve a different population. Most public mental health programs have spent the last two decades focused on clients who are the most seriously mentally ill.

AOD: The AOD system is being asked to assertively try to engage clients in services, rather than waiting for them to seek services.

DV: The DV system is being asked to interact more with official county agencies in order to provide coordinated services for their clients.

In our experience, those AOD/MH/DV programs that have designated special staff to serve the CalWORKs participants have been more effective. It is very difficult for regular service providers to devote the time and effort to learning about CalWORKs and to adapting program structures without some special staff that can focus specifically on this population. Some counties have hired entirely new staff and constructed a special CalWORKs program. Some have contracted with programs that have developed specific programs just for CalWORKs clients. In other counties, AOD/MH/DV programs have had a liaison staff person who, at a minimum, ensures that all the CalWORKs-specific coordination occurs as required.

**Principle B: Individualize services.**

The CalWORKs population that has AOD/MH/DV issues is diverse. There are some participants who have a single issue that can be addressed through traditional brief services. And there are others who have more than one of the issues, along with other significant barriers to employment that may require intensive longer-term services.

It is important that we not stereotype participants with an assumption that all participants with an AOD/MH/DV issue are seriously impaired and unable to work without special services. Women on TANF are already stigmatized, and we need to be careful not to stigmatize them further. Initially, some counties automatically assumed that participants needing AOD, MH or DV services were not able to engage in any work activities in their initial stage of treatment/services. They soon discovered that for some participants, being able to work or engage in job readiness and job seeking activities was very therapeutic. Now many programs are building work activities into their programs at the beginning, for those who are ready.

It is also important to recognize that some CalWORKs participants find it easier to engage in a group setting, while others respond better to individual services. Some respond better to an educational approach rather than formal counseling. Programs need to offer a variety of services, all directed at moving participants toward employability and self-sufficiency.

We also need to recognize that there is a subset of CalWORKs participants who will need intensive services if they are to make progress toward a goal of self-sufficiency. These participants may need to focus exclusively on their treatment/service program at first and may need services over a longer period of time. They also may need a case manager who can help them prioritize the many demands that are being made on their time.
Services need to be culturally appropriate and accessible. Participants of diverse cultures need to be in settings that are comfortable for them. Services need to be responsive to cultural differences and incorporate natural, informal support and helping networks within each participant's particular community.

Programs that individualize services to address the unique needs of each client have a better chance of engaging and retaining CalWORKs participants.

**Principle C: Attend to gender issues.**

The CalWORKs clients receiving AOD, MH, and DV services are predominantly female, and all of the females are mothers. Services that address the special features of the issues faced by females and mothers will be more readily accepted and more worthwhile than non-gender specific services.

This is most obvious in the arena of DV. The CalWORKs Project research indicated that in Kern, 39% of those with an AOD diagnosis and 48% of those with a MH diagnosis also report some type of intimate partner abuse within the last 12 months. The figures for Stanislaus are even higher, with 62% of those with an AOD diagnosis and 59% of those with a MH diagnosis reporting an instance of intimate partner abuse within the last 12 months. AOD and MH services must recognize the high likelihood of co-occurring domestic abuse issues and be able to address the role that abuse plays in the AOD and MH issues.

Similarly, services for CalWORKs DV survivors must be able to address accompanying AOD and MH issues that may result from the trauma of the abuse. More than half of those with a DV issue in the last 12 months in Kern and Stanislaus also had a diagnosable AOD or MH problem.

The following statement addresses the need for gender-specific AOD services.

> There is an ever-expanding research base demonstrating that cultural expectations for females are different from those for males; that the pathways to substance abuse for females are different than those for males; that women's bodies respond to substances differently than do men's; and that the physiological, psychological, and social consequences of substance abuse are different for women than for men.

Two conclusions may be drawn from this information. First, treatment needs are likely to be different for women, as well. Women's issues must be an integral part of services to females. Second, because of the historic and extant dynamics governing the social interactions between males and females, it is often advantageous to females that they be treated separately from males.8

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The development of separate programs for females has been more prominent in the AOD than the MH field, but the underlying issues of trauma resulting from physical or sexual abuse suggest that MH services might benefit from separate services as well. In both Kern and Stanislaus, 13% of the interviewed CalWORKs females had indications of post-traumatic stress disorder within the last 12 months resulting from a physical or sexual assault at some point in their lives.

The Women in Healing program, cited below as a best practice, has developed a curriculum that specifically addresses the issues of trauma in the lives of its women clients.

*Principle D: Begin evaluation efforts.*

The newness of providing AOD, MH, and DV services to the CalWORKs population has required that virtually all attention be directed toward getting identification, referral, and service components operating efficiently. There has been, consequently, less attention paid to the issue of how effective these efforts are, i.e., the extent to which the services that are received make a difference.

Evaluating the effectiveness of AOD/MH/DV services for the CalWORKs participants is a difficult task. The first challenge is to identify the goals against which the services should be measured. Should the services be considered effective if they alleviate the AOD, MH, or DV issues that brought the person into services? Or should they be considered effective only if they increase the likelihood that the client obtains employment? Or only if they increase the chances that the client remains in a job?

No goals for these services have been specified on a statewide basis by CalWORKs, although the Joint CalWORKs Committee has discussed the issue. At a county level, selecting specific criteria and measuring against them will allow you to assess the helpfulness of specific programs and services. The selection of goals will be a tradeoff between what you would ideally like and what is feasible to accomplish with the data systems and resources available.

The second complexity is how to measure these goals. Most programs now collect some outcome information as part of their routine operations. These procedures and methods should be reviewed to determine which of these are relevant to CalWORKs clients and the manner in which they are served. Then, additional or alternative instruments or procedures can be adopted for the CalWORKs clients.

Tracking the employment history of clients is outside the usual scope of AOD/MH/DV programs and requires coordination with CalWORKs staff. Counties that are able to share databases will be able to measure effectiveness more easily and comprehensively.

Despite the complexities, counties and their programs can make a start at gathering outcome data. At a minimum, counties should be collecting basic referral and utilization information. Most counties have developed some method by which to track the number of referrals to AOD, MH, and DV from CalWORKs staff. It is important to establish a clear definition of a “referral” across systems, i.e., is it a list of providers the participant can call if s/he wants to or is it an actual referral to a specific person or place, which the referrer will notify about the referral?
On the AOD/MH/DV service side, the system should track the number of CalWORKs participants who are receiving services — both those who have been referred directly from CalWORKs and those who have come through other sources. Each county should have a clear policy about who it considers a CalWORKs client receiving AOD, MH, or DV services for the purposes of reporting under the CalWORKs Welfare-to-Work 25 Activity Report.

Tracking the kinds and amounts of services that CalWORKs participants receive can also be helpful. It can help in understanding how long clients are receiving services and the pattern of service usage within each system.

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**CALWORKS ALCOHOL, DRUG, AND MENTAL HEALTH DATA TRACKING AND OUTCOME SYSTEM YOLO COUNTY**

The Yolo County Department of Alcohol, Drug and Mental Health Services has developed a Microsoft Access database and a user interface written in Visual Basic, which allows the county to track information about CalWORKs participants who are referred to AOD and MH.

The system collects the following kinds of information:

- Assessment of human resource, situational, and physical disability barriers to employment;
- AOD and MH program attendance;
- Reason for termination; and
- MH outcome measures including Basis 32, California Quality of Life and MHSIP.

With this database, the system is able to begin to address the following kinds of questions:

- What barriers do CalWORKs AOD and MH clients face?
- How are barriers related to AOD and MH treatment and success in employment services?
- Do clients get better in treatment?
- How does treatment affect participation in employment services?

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Part II: BEST PRACTICES

The following represent five programs or practices, which we consider best practices, that would be appropriate for any CalWORKs service system.

<table>
<thead>
<tr>
<th>Best Practices</th>
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<tbody>
<tr>
<td>☑ Using multidisciplinary approaches</td>
</tr>
<tr>
<td>☑ Providing case management</td>
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<tr>
<td>☑ Providing childcare and transportation</td>
</tr>
<tr>
<td>☑ Maintaining contact and providing services when specific AOD, MH, or DV services are refused</td>
</tr>
<tr>
<td>☑ Providing clean and sober living environments for AOD and DV clients</td>
</tr>
</tbody>
</table>

A: MULTIDISCIPLINARY APPROACHES

Programs must have the capacity to address more than one issue.

The CalWORKs Project Prevalence Study indicates that between one-fifth and one-third of the CalWORKs population has more than one of the three (AOD/MH/DV) issues. This is consistent with what we know clinically about the relationship among these issues.

Given the number of participants with multiple barriers to employment, comprehensive programs that can address more than a single issue offer the most efficient and effective approaches. The more places a recipient has to go, and the more people s/he has to deal with, the less likely s/he is to remain in services. Also, it avoids the job of coordinating multiple services. Programs that can address multiple issues eliminate some of the barriers that result in recipients’ not following through with service recommendations.

Multiple organizational structures are possible to accomplish this goal.

Ideally, a single program could provide state-of-the-art services to a client in all three areas. This requires a system and staff commitment to integrated services and flexibility in program design. The advantages are a simpler system for the client and an increased sensitivity to all three issues on the part of the staff. Below are two examples — one a county- and community-based organization (CBO) partnership and the other a contract program that provides services for women with all three issues.
INTEGRATED AOD/MH/DV TEAM
STANISLAUS COUNTY

Stanislaus County has a CalWORKs-specific Behavioral Health Services team that has county AOD and MH staff that work full-time as members of the team. The team also has a staff person from the local DV program who works 80% of the time as a team member paid for by the county. Most of the AOD, MH, and DV services are provided by the team members, although they utilize other AOD, MH, DV system services as necessary. The close collaboration of the team has resulted in the development of services for participants with dual issues, e.g., a Women in Healing program for women with AOD and DV issues.

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INTEGRATED SERVICE IN CONTRACT PROGRAM
LOS ANGELES COUNTY

SHIELDS is a contract provider to both the Department of Mental Health and the Department of Substance Abuse in Los Angeles County. SHIELDS has a formal program for those who are AOD and MH dually diagnosed as well as a general sensitivity on the part of the staff to the importance of both the AOD and the MH issues. The agency also provides DV services to all of its clients who need them.

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Where such integrated service programs are not possible, developing close relationships with other programs is essential. In Los Angeles, some of the DV programs have developed official Memoranda of Understanding (MOUs) with mental health programs, so that both can have timely access to assessments by the other program.

B. CASE MANAGEMENT

The intensity of the daily needs of many clients makes case management an important service.

Many of the participants face multiple major daily life challenges when they are first referred for AOD, MH, or DV issues. These include unstable housing, legal difficulties, problems with their children, and immigration issues. These needs are often more pressing and immediate than the AOD, MH, or DV issue. Program staff report that addressing these pressing needs is a critical part of the service program.

9 Shasta County has also adopted this model with a staff person from the local DV program working full-time with the AOD and MH staff on the Behavioral Health Team.
➢ It alleviates some of the stress and allows the client to turn her focus to the AOD, MH, or DV issue.

➢ It demonstrates that the program can be helpful to the client, thus enhancing engagement.

➢ It begins to build trust in a relationship with a program staff person.

The stress of raising a family in poverty creates major ongoing difficulties for clients. The availability of an ongoing intensive daily support service cannot be underestimated.

*What is needed is a hands-on case management rather than a “linkage/service broker” model.*

Some counties refer to the CalWORKs staff person that is responsible for developing and monitoring the Welfare-to-Work Plan with the participant as a case manager. This is a “linkage/service broker” model in which the case manager develops a plan of services and then directs the client to where those other services can be obtained. The CalWORKs staff have virtually all their contact with clients in their offices. While this is an important function, it is not what we mean here by case management.

Hands-on case management is direct assistance that occurs outside the office, e.g., taking a client to a housing agency to fill out forms, going with a client to meet with her child’s teacher, going with a client to a utility office to work out a payment plan to get the utilities turned back on. This is direct assistance that not only helps resolve other issues but also builds a relationship with the case manager.

Case management of this sort does not require a master’s level staff; in fact, it can often be done by a trained paraprofessional. But it does require time. Most programs find that a case management caseload of over 15 or 20 clients does not allow the kind of time required. As noted in an example below, a case management program can be structured in different ways depending on the needs of the clients and the kinds of staff available, but it always means smaller caseloads than those usually carried by CalWORKs staff.

*This kind of case management is more traditionally available in the MH than the AOD or DV systems.*

The MH system has developed this kind of case management as an important component of its services for persons who are seriously mentally ill who often need this type of intensive one-on-one support. This kind of service has not traditionally been a part of AOD or DV services, but these programs are beginning to appreciate the usefulness of the service.
THREE LEVELS OF CASE MANAGEMENT  
STANISLAUS COUNTY

Every client seen by the Behavioral Health Services team in Stanislaus is assigned a case manager. The frequency of contact with the case manager varies with the needs of the client. Those with the lowest level of need meet with a case manager once a month; those with moderate needs meet with their case manager once a week. The clients needing intensive case management will be seen a couple of times a week or as needed. The AOD counselor is the case manager for those clients receiving predominantly AOD services, particularly for those with a minimum level of need. Most MH clients have a paraprofessional worker, rather than a clinician, as their case manager.

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C: TRANSPORTATION AND CHILDCARE

The direct provision of childcare and transportation will enhance program attendance.

The CalWORKs program provides funds for transportation and childcare. But obtaining and organizing these support services to attend AOD/MH/DV services remains a significant barrier for many CalWORKs participants. A program staff person in Kern told us “a lot of their ability to stay in services depends upon their resources — transportation, childcare, etc.”

➢ Transportation: Riding the public transit system can be intimidating and take considerable time. Participants with cars often lack insurance. One program staff person told us some clients will use their bus passes as barter for other things they feel they need more.

➢ Childcare: In some areas there is a shortage of childcare slots; and some mothers are reluctant to leave their child(ren) with others.

AOD/MH/DV programs that provide their own transportation and have childcare on-site are able to overcome these barriers.

VANS  
STANISLAUS COUNTY

The Stanislaus Behavioral Health Services team has two vans each with a full-time driver. The vans are used to pick up clients for their appointments. In addition to overcoming the transportation barrier the drive allows the client to establish a relationship with the drivers, who are selected for their ability to relate well to the clients.

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CHILDCARE SLOTS FOR AOD DAY TREATMENT PROGRAM
SHASTA COUNTY

The Shasta County Day Treatment Program allows women to bring their babies into the treatment setting until they are four months of age. The program also has 12 slots of on-site day care. Each of the clients also provides some care in the day care setting under the supervision of the childcare supervisor.

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Some programs are experimenting with “child watch” programs.

If parents are on the site, the program does not have to be officially licensed as a childcare center. Thus, it is possible for a treatment program to have a childcare worker to manage the children as long as the parent is also on the site. One county plans to give parents beepers so that they can be contacted immediately if their child is having a problem.

D: PROGRAMS FOR PARTICIPANTS WHO REFUSE SPECIAL SUPPORT SERVICES

Most participants with AOD, MH, and DV issues will not complete a full course of services for these issues.

Some participants who are identified and referred for an assessment fail to complete the assessment. County estimates of these dropouts from referral to assessment range from 20% to 50%. Another group of participants complete the assessment but then fail to show up for the services to which they are referred. Many clients who begin services attend only briefly and leave before the program considers their treatment objectives as having been met.

Yolo County has carefully tracked the percentages of participants who “drop-off” at each stage. They identify and refer 22% of their CalWORKs participants to a MH assessment and 10% to an AOD assessment. They lose 20% at the assessment stage. About half of those assessed actually attend a first treatment session. And less than half of those complete a full course of treatment. Putting all this together, they estimate that only 16% of those originally identified and referred for an assessment actually complete services.

The CalWORKs and AOD/MH/DV service providers need to put greater emphasis on things that will increase client engagement — aggressive outreach, eliminating barriers to attendance, and enhancing motivation. But even with all these, many clients will not complete services. But the problems created by the AOD, MH, and DV barriers remain and need to be addressed by the CalWORKs program if these participants are to be successful in the transition from welfare to work.
Intensive services for these participants can be helpful even if they do not include traditional AOD, MH, or DV services.

Some of the participants with AOD, MH, and DV issues that refuse services for these issues will accept support that is offered in a different way. This may be because they can avoid the stigma of the AOD, MH, or DV services or because they are in denial about the existence of the problem. Or it could be that the actual support services received from a non-AOD/MH/DV program are more helpful at that particular time in a person’s life.

Many counties now have special programs for the “hard-to-serve.” These are focused on participants who have multiple barriers and/or who are hard to engage in Welfare-to-Work activities. These programs sometimes operate as a special part of the CalWORKs program, with lower caseloads and more experienced staff. Or, in some instances, the CalWORKs program contracts with community-based organizations to serve these participants.

These programs are a good setting for clients with AOD, MH, or DV issues who have not been engaged in an AOD, MH, or DV program. The smaller caseloads and the emphasis on multiple barriers allow them to receive much of the support and services they need, even if they are not receiving traditional AOD, MH, or DV services.

People who operate these “hard-to-serve” programs have found that large proportions of their clientele have AOD, MH, or DV issues. Manager of these programs try to have expertise in AOD, MH, or DV issues either directly on their staff or available through consultation. They try to engage their clients in traditional AOD, MH, and DV services, but continue their services whether or not the client accepts those other specialized services.

BUILDING SUCCESSFUL TOMORROWS (BST)
STANISLAUS COUNTY

Stanislaus County has established a team within its StanWORKs program designed to provide intensive services to participants who have been sanctioned or who have failed to become engaged in Welfare-to-Work activities. The team consists of more experienced social workers, a public health nurse, and an AOD clinician. They utilize a strengths model and operate with maximum flexibility in their efforts to engage a family. They work closely with the Stanislaus Behavioral Health Services (BHS) team. BHS will refer clients whom they have not been able to engage in services to BST. The more generic focus of BST and its ability to provide very individualized and aggressive outreach services will sometimes be successful in engaging these clients.

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REDWOOD AGENCY
HUMBOLDT COUNTY

The Redwood Agency is a community action agency that provides a wide range of services. One of its programs has been an intensive case management program for CalWORKs clients with multiple barriers. Almost all of their clients reportedly have AOD issues, and about two-thirds have been victims of domestic violence. The program provides intensive case management services, with caseloads of 25 to 30 clients. They maintain contact with clients for an extended period of time, which allows them to build trust with the family.

Staff include MSWs and senior social work interns from Humboldt State. All of the staff have had some experience with AOD, MH or DV issues, and a few have an ADP certification. All staff attend a day-long AOD and MH training. They attempt to get as many of their clients as possible into AOD, MH, or DV services, and they have very good relationships with the programs offering these services; but, they do not condition their case management services on the participant attending the AOD/MH/DV services.

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E: CLEAN AND SOBER LIVING ENVIRONMENTS

Maintaining abstinence in an unstable and/or non-supportive living environment is extremely difficult.

Overcoming an AOD dependence or abuse problem is a difficult task. Doing so within the context of raising children in poverty is even more challenging. An unstable living situation makes it almost impossible. The high cost of rental housing in many communities prevents many such women from maintaining stable housing; in fact, many often experience periods of homelessness, as well as having to move on a regular basis.

An important component of relapse prevention is avoiding the stimuli that previously led to substance use. It is far easier to maintain abstinence if the person is able to leave the prior environment and move into an environment that contains supports for abstinence, as opposed to continual exposure to the old stimuli.

Some CalWORKs programs are working closely with clean and sober living situations for women and children.

Some, but not all, counties have programs that provide clean and sober living situations for women and their families. These vary in the extent of program activity that accompanies the housing. This is a valuable resource for the CalWORKs program since it greatly increases the chances that a
woman will be able to navigate the distance from welfare to self-sufficiency while maintaining abstinence.

**PUEBLO DEL MAR**  
**MONTEREY COUNTY**

Pueblo Del Mar is a joint program between the Housing Authority and the County Behavioral Health Department. It has 56 apartments for a 24-month clean and sober transitional housing program for families who have AOD problems. The program component is operated by an AOD contract provider, but no direct treatment services are provided on-site. The program does provide life skills and other classes on-site. All of the CalWORKs families who live at Pueblo Del Mar have a single specialized CalWORKs employment coordinator who is responsible for ensuring that the participants are engaged in education, training, and employment activities off-site that will prepare them for when they move on from Pueblo Del Mar.

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**SAMARITAN HOUSE AND LAURA’S HOUSE**  
**STANISLAUS COUNTY**

Catholic Charities operates two clean and sober transitional living houses in Stanislaus County, each of which can accommodate 16 women and 30+ children. Most of the residents are in recovery. The average length of stay is about 6 months, but they allow women to stay for up to 12 months. Most of the women are also receiving AOD, MH or DV services, some on-site and some in programs in the community. A range of educational and vocational services is also provided either on- or off-site. If a resident uses substances s/he can be expelled from the program. S/he has to wait six months before being readmitted or can go to the other program after 30 days if there is an opening. Services are also provided for the children.

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Part III: PROMISING PRACTICES

A: SUPPORTIVE SERVICES

Many CalWORKs participants experience anxiety and depression for which they are unlikely to receive specialized MH services.

The prevalence study in Kern and Stanislaus indicates that at least one-quarter of the CalWORKs female population experiences anxiety and/or depression serious enough to be considered a diagnosable condition. Additional persons have milder symptoms of these disorders.

Services for the general CalWORKs population can be helpful in addressing some of these issues.

A number of counties have offered voluntary classes in topics like stress management and anger management, but attendance is usually not sufficient to warrant the staff resource. One successful approach is to have the classes count as Welfare-to-Work activities. This is effective if the CalWORKs employment coordinators view the classes as useful to their clients. The classes are also useful for clients who are enrolled in special AOD, MH or DV services.

SUPPORTIVE SERVICES
STANISLAUS COUNTY

The Stanislaus Behavioral Health Services team operates a series of late afternoon General Services classes on topics such as stress management, time management, anger management, parenting, self-esteem. The classes are an hour and a half to three hours. Most of the classes are time-limited to a few weeks or a month. BHS also provides Courage to Change, a class that consists of two all-day sessions that addresses motivation to change.

Clients already receiving services through BHS might be assigned to attend certain classes. The Department of Employment and Training also assigns some of its CalWORKs clients to attend these classes as part of their Welfare-to-Work Plan.
The staff assigned to these classes are particularly adept at engaging participants through a series of interactive exercises. CalWORKs participants are finding the classes useful, and the staff are also identifying some participants in each class who are appropriate for more intensive BHS services. The staff is better able to engage the participants identified in this way in the specialized services because of the relationship developed through the classes.

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CLASSES AT COMMUNITY COLLEGE
LOS ANGELES

The Tri-City Mental Health Agency provides a wide range of direct services to CalWORKs clients. Since they have a number of clients who also attend school at Mt. San Antonio Community College, Tri-City has out-stationed staff who are able to provide these services at the College which makes them more convenient for their clients. Tri-City also has a drop-in group time at the College every day at noon. This is a resource that can be used by any of the CalWORKs participants who attend the College, not just those who are actual MH clients.

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PART IV: CHECKLIST

Below is a checklist of activities about your AOD/MH/DV service systems that you can use to see how you are doing.

<table>
<thead>
<tr>
<th>Principle A: Utilize some specialized staff</th>
<th>1) Do you have specialized AOD/MH/DV programs for CalWORKs clients?</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>2) What percentage of your AOD/MH/DV staff working with CalWORKs clients have this as their full-time or predominant assignment?</td>
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<td></td>
<td>3) Do your contract programs have staff assigned only or predominantly to CalWORKs clients?</td>
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<td></td>
<td>4) How well do your CalWORKs AOD/MH/DV staff (in county and contracted programs) know the CalWORKs rules?</td>
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<table>
<thead>
<tr>
<th>Principle B: Individualize services</th>
<th>1) Are your assessment procedures adequate to determine the specific needs of your clients?</th>
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<tbody>
<tr>
<td></td>
<td>2) Do your AOD/MH/DV programs have enough diversity, either within each one or across all of them, to provide different levels and types of services?</td>
</tr>
</tbody>
</table>
| Principle C: Attend to gender issues | 3) Would an independent reviewer looking at your client service plans note substantial variation related to the specific needs of the clients?  
4) Have you changed any of your services or service approaches within the last year? Do you have an ongoing group or forum that routinely addresses the need to try different service approaches?  
5) Do your AOD/MH/DV programs allow participants to participate in work activities as individually appropriate? Are your services culturally appropriate and accessible?  
6) Do you use natural and informal community supports? |
| Principle D: Begin evaluation efforts | 1) Are all your AOD and MH staff adequately trained to deal with the impact of DV issues?  
2) Are gender issues incorporated into all your AOD, MH, and DV programs for CalWORKs participants?  
3) Do you have sufficient female-only services/programs for AOD, MH, and DV?  
4) Do you have adequate AOD and DV residential programs to accommodate mothers with their children? |
| Best Practice A: Using multidisciplinary approaches | 1) Do you have an integrated team that provides services to clients with AOD, MH, and/or DV issues?  
2) Do your AOD/MH/DV programs have expertise within them... |
| **Best Practice B:** Providing case management services | 1) Do all your AOD/MH/DV programs have the expertise and capacity to provide intensive hands-on case management?  
2) What are the caseloads for your case managers?  
3) Are case management services reimbursed within all three (AOD/MH/DV) service areas?  
4) Do you have a system for determining who needs intensive case management services? |
| **Best Practice C:** Providing childcare and transportation | 1) Do your AOD/MH/DV programs offer childcare on site? At a location that is convenient for those coming to the service site?  
2) Do your AOD/MH/DV programs offer transportation to their services?  
3) Are the childcare and transportation services offered by AOD/MH/DV programs reimbursed? |
| **Best Practiced D:** Maintaining contact and providing services when services for AOD/MH/DV issues are refused | 1) Do you have a mechanism for tracking accurately and comprehensively those that are referred for AOD/MH/DV assessment/services who do not complete services?  
2) Do you have special programs for the hard-to-serve that have small caseloads to which these individuals can be referred?  
3) Do your special hard-to-serve programs have expertise in AOD/MH/DV issues?  
4) Do your CalWORKs staff have training in what to do with their clients with AOD/MH/DV issues that refuse services for these issues? |
| **Best Practice E:** Providing clean and sober living environments for CalWORKs participants with AOD and DV issues | 1) Does your county have adequate clean and sober living environments for CalWORKs women in recovery from AOD issues?  
2) Does your county have transitional living environments for CalWORKs women who are survivors of DV? |
| **Promising Practice A:** Supportive services for the general CalWORKs population | 1) Do you have behaviorally-oriented classes available to all CalWORKs participants?  
2) Have you actively marketed these classes?  
3) Do the class hours count as Welfare-to-Work activities?  
4) Are the classes included as required parts of some Welfare-to-Work Plans?  
5) Do you have staff running these classes who are particularly adept at engaging clients? |
Chapter III: DOMESTIC VIOLENCE

The domestic violence (DV) service and advocacy community has historically had few official ties to county government.

In most counties, the DV service system consists of community-based service and advocacy organizations. Most DV programs were started by grassroots advocates with a social change as well as a client service mission. The programs were wary of professionals and government bureaucracy, not wanting to be co-opted. This has changed somewhat in the last decade as programs have hired professional staff and become more reliant on government funding. But in most communities, prior to CalWORKs, the local DV provider had little contact with and no funding from the local department of social services.

The DV service community has been reluctant to offer services to survivors with AOD or MH problems.

Initial research into DV issues attempted to identify characteristics that would differentiate DV victims from non-victims. DV advocates believed that any correlation between being a DV victim and having AOD or MH problems would be used to “blame the victim,” i.e., to conclude that the AOD and MH issues were part of the cause of the DV. They worried that by focusing on AOD or MH issues they would be negating their position that any woman can become a DV victim and that any AOD and MH issues were the result and not the cause of the DV.

A second reason why DV programs have been reluctant to provide services for women with AOD or MH problems is that they lack expertise and staffing in these areas. Funding has not historically been adequate to support professional counseling staff. This has changed in recent years with more programs providing direct counseling and, in some cases, obtaining funding through AOD and MH channels.

Each of the six counties has enhanced the domestic violence component of its CalWORKs program since the last report.

As evidence accumulates about the very high prevalence of DV within the TANF population, the question of how best to address this issue has gained increasing attention. All six case study counties now have an organized DV component to their CalWORKs program and designated funding to support it.

This chapter provides a set of principles for successfully addressing domestic violence issues within the CalWORKs population. Next there is a description of promising practices and approaches and finally, a checklist you can use to assess the domestic violence component of your CalWORKs program.
Part I: PRINCIPLES

Principle A: Involve the DV advocacy community.

DV service and advocacy organizations should play a role in the drafting, implementing, and monitoring of procedures for identifying CalWORKs participants who have DV barriers to employment, in the provision of services to address these barriers, and in the informing of participants of their rights under the Family Violence Option (FVO).

Those counties that already had organized advocacy connected to county government were quickly able to develop a plan for providing DV advocacy and services for the CalWORKs population. In Los Angeles, for example, the DV Coordinating Council is linked to a unit of county government, and its prompt action resulted in a Board of Supervisors’ allocation of up to $15 million for DV services to CalWORKs participants. The DV unit also played a prominent role in the development of procedures for informing CalWORKs participants about the FVO and the availability of services.

Counties that had no prior formal DV community/county relationships and where the DV community did not pursue CalWORKs funding or contracts for services experienced much slower growth of their CalWORKs DV service components.

Principle B: Secure ongoing funding for DV services

Funding for DV services is a county decision. Unlike AOD and MH, there is not a separate statewide allocation of funds for DV services. Yet, many counties have decided on their own to provide funds for DV services for CalWORKs participants. Dedicated funding for DV services is available in all six of the case study counties. In four of the six counties, the funding came from the county CalWORKs single allocation, in one county from the AOD allocation, and in one other from a direct augmentation of county general funds.

DV advocates appear to be making strides throughout the state in having at least some funds set aside for DV services for CalWORKs participants.

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10 Legislation (SB 217, Kuehl) is currently pending at the state level to establish such a funding source.
11 CarolAnn Peterson. Funding Resources for Domestic Violence Programs. Family Violence Prevention Fund. This document is available to be downloaded at the CIMH web site: www.cimh.org.
The CalWORKs Project DV Institutes, sponsored by the State Department of Social Services (SDSS), have provided advocates and CalWORKs staff with information on available funding sources and created momentum by highlighting the many counties in which funding is provided.

The CalWORKs Project Prevalence Report’s findings on the high occurrence of DV within the CalWORKs population are useful information in advocating for funding for these services.

**Principle C: Learn all the relevant Family Violence Option (FVO) rules.**

The advocacy for the original Family Violence Option (FVO) focused largely on the need to protect women who might be placed in danger if forced to meet all the terms of PRWORA. The requirements for cooperation with child support efforts and the establishment of paternity were particularly worrisome. Advocates were also concerned that the time limits might not allow enough time for DV survivors to attain self-sufficiency.

California adopted the FVO, and the SDSS subsequently drafted regulations with input from the DV community. The regulations contain a definition of domestic abuse, standards for informing participants of the provisions of the FVO and of the availability of DV services, procedures for the development of individualized welfare to work plans, confidentiality and notice requirements; and a description of the kinds of program waivers that may be granted.

Bay Area Legal Aid has developed *A Guide for Advocates on CalWORKs and Domestic Violence.* Under the FVO, basically any program requirement can be waived, pursuant to a determination of good cause, where compliance would make it more difficult for individuals receiving assistance to escape abuse or unfairly penalize individuals who are or have been abused. The Guide lays out clearly and explicitly the most important of these potential waivers, including the work activity requirements and time limits. It presents useful information on special circumstances for DV survivors in relationship to teens living with parents, child support, maximum family grant, drug convictions, and immigration status.

Given the complexity of the CalWORKs regulations it is unlikely that regular CalWORKs staff will understand all the ways in which the standard Welfare-to-Work program might need to be adapted to a DV survivor. It is incumbent on the CalWORKs program, however, to ensure that this expertise exists within the program, so that all the potential advantages of the FVO can be obtained as appropriate.

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13 The only program requirements that cannot be waived concern deprivation, assets, and income.

14 For example, the prohibition on receipt of aid for persons convicted of drug offenses can be waived if the felony resulted from a situation in which the person was influenced by a DV situation to commit the felony.
Principle D: Ensure a range of appropriate services

CalWORKs women who are survivors of DV need not only the regular CalWORKs services in order to gain employment, but also appropriate services to deal with the issues of abuse. These services should be accessible for CalWORKs women whether or not they avail themselves of any waivers. A comprehensive set of services would entail at least the following: shelter, transitional housing, case management, individual and group counseling, legal support, emergency response, family advocates, and vocational services.

Part II: PROMISING PRACTICES

This section describes three different approaches that counties have developed for addressing the barrier of domestic violence for CalWORKs participants. They are presented as “promising” practices rather than “best” practices for two reasons:

➢ There has not been sufficient experience with any of them nor any formal evaluation.

➢ Contextual factors play such a large role in the counties where they are being implemented that replication in other counties may be difficult.

What is critical is that each county have a model that clearly defines the roles and responsibilities of the CalWORKs staff and the local DV agencies.

Promising Practices

☑ Include staff from DV programs on CalWORKs integrated teams.
☑ Contract with DV programs to provide all services.
☑ Have a combination of county and contract DV staff and services.

A: INCLUDE DV STAFF ON INTEGRATED SERVICE TEAMS

The integrated model has many advantages.

In this approach — begun in Stanislaus and now also in operation in Shasta — staff from the local DV program become members of an integrated county-operated behavioral health team. The DV staff person, who thus fulfills both waiver and service roles, makes FVO waiver recommendations. Having a staff person from the local DV program as a regular member of an integrated team has a number of advantages.

➢ It increases the level of sensitivity and expertise of the other AOD and MH team members about DV issues.

➢ It allows for a prioritizing of needs among multi-problem clients.
It allows for CalWORKs-specific blended programming, e.g., the Women in Healing program in Stanislaus for clients with AOD and DV issues.

It creates a solid linkage and builds trust between CalWORKs and the local DV program, e.g., enhancing the likelihood that the local DV program will accept the CalWORKs worker’s judgement about waiver requests.

It facilitates the broader reconciliation of perspectives and enhances the working relationships between local DV programs and the county bureaucracy, e.g., in Stanislaus, DV staff now also work with CPS and the District Attorney Family Support Unit.

WORK WITH DISTRICT ATTORNEY FAMILY SUPPORT AGENCY AND CPS STANISLAUS COUNTY

The DV member of the BHS has worked directly with the DA Family Support staff to clarify what information is required to substantiate a waiver of child support enforcement. Through the relationships developed in this process, the Family Support unit is participating in joint meetings with other parts of the system working with CalWORKs families. The DV staff person says this was a difficult process “but sometimes it just takes time to find the right person within the other agency.”

The DV member of the BHS is also working collaboratively with the DV specialist who works for child welfare. They collaborate on CalWORKs cases they have in common, both sit on the Child Welfare Services Interface Committee, and both are helping to shape the Family Resource Conference model so that it will address issues of safety and power in families where there is DV.

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While potentially the most effective, this model is not an easy one to implement. It requires:

- Particularly talented DV staff who can maintain their local DV program perspective while accommodating the needs of county programs; and,

- County AOD and MH leadership willing to work with a local DV program as an equal partner.
WOMEN IN HEALING
STANISLAUS

Women in Healing is a program for women who have both AOD and DV issues. It focuses on a) nurturing non-violent parenting, b) dealing with AOD issues, and c) overcoming trauma. It is an open group that meets for three hours, four times a week. Each meeting begins with an hour check-in followed by a two-hour educational program focusing on one of the three program foci. Not all of the participants are able to participate in the full program. The average length of attendance is six months. At present, there are about 30 women enrolled in the group with about 16 coming every week.

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B. CONTRACT WITH DV PROGRAMS TO PROVIDE ALL SERVICES

Relying solely on DV programs works in Los Angeles because of the strong history of DV advocacy and the DV community’s relationship with the county.

Of our six counties, only Los Angeles has a county DV unit that preceded CalWORKs. The DV unit rests within the Senior and Community Services Department. It has historically provided staffing for the DV Coordinating Council, and volunteers conducted a 6-1/2-hour training for the DPSS staff. The unit does not provide any direct services.

It thus was a logical extension of the existing structure for the DV unit to be involved in the planning for how DV would be involved in CalWORKs, but for any direct services to be provided by the plethora of DV community agencies. There have now been three phases of funding from the DV unit. The third phase, for FY 00-01, totals $12 million for 41 contract agencies.

The DV unit organizes the service system through the specifications in the contracts with the DV service agencies. So, for example, when the county decided to have AOD/MH/DV presentations to CalWORKs participants in district and GAIN offices, the DV unit made this a requirement of the contracts and organized a schedule by which the DV contract programs would be present in the appropriate CalWORKs offices.

The waiver recommendation authority is split in Los Angeles. The DA Child Support Division makes decisions about waiver of child support enforcement; all the other waivers are done by the DV contract agencies. Those DV agencies that provide comprehensive services can provide the waiver recommendations and the service components within the same program, but those without comprehensive services, e.g., the legal programs, may do only waiver recommendations and legal services and make referrals for other services.
This system fits the landscape of the DV system in Los Angeles, which has a number of strong DV programs and a history of active advocacy. It allows the programs to maintain a separation from the county so that they can take advocacy positions. As an example, the DV programs have objected to the mandatory home visiting pilot. The additional funding has allowed the programs to add staff and provide a number of additional useful services, e.g., the children’s program at Wings (see Chapter 5).

The major limitation to this approach is that each DV program must build its own liaison with its local AOD/MH programs and its DPSS and GAIN offices. This is a tall order for some of the DV programs, given the complexity of the service systems, their newness to this type of collaboration, and, in some cases, the attitudes of the other players. It is not surprising, therefore, that it has worked better in some regions than in others.

The model also entails substantial duplication in the “learning of the rules.” Each local program must learn the complexity of the CalWORKs rules itself, lacking an “inside” CalWORKs person who becomes familiar with all the intricacies of the rules. The central county DV unit staff provide some support, but this is not their primary function.

C: HAVE A COMBINATION OF COUNTY AND CONTRACT DV STAFF AND SERVICES

_The combination of county staff and contract programs seems to be the easiest model to implement._

In this model — used in Alameda, Kern, and Monterey — county staff play a coordinating and direct client role, in addition to supervising contracts with local DV programs. These systems generally split the waiver from the service components, with the county staff doing the waivers and the contract programs the services. But this is not always so clear a line, since the county staff may also provide some direct case management and counseling.

➤ _The Kern program, in January 2000, hired two clinical county staff in the Department of Human Services. They do intakes on DV referrals from CalWORKs staff, make decisions on waivers, do some short-term counseling, and make referrals to and track services from the contract DV program. Starting in July 2000, DHS began a contract with the local DV program that before had been providing services on referral from CalWORKs without a contract. The contract funds two emergency response teams and one victim advocate. The county staff has also instituted a 4-hour training for DSS staff based on “healthy relationships,” which they think has been more effective than direct DV training._
In early 1999, a county staff person was hired in Monterey to be the DV liaison. She does intakes on all the referrals, makes decisions about waivers, provides some direct case management, and makes referrals to and tracks attendance at services at the local DV programs. The county staff also does presentations at job clubs about DV issues and services.

The Alameda DV system design involves a collaboration between special DV county resource specialists and a coalition of DV providers. Five county resource specialists are now co-located at welfare offices and at a local law clinic. They do intakes on referrals, provide referrals to DV programs, grant waivers, and act as liaisons to the DV programs.

The liaison function of county DV staff can make the work of the DV agencies easier, but this works only if the relationships are carefully tended. In at least one of the counties, there continues to be a lack of understanding and tension between the DV providers and the CalWORKs program.

It is also clear from the three counties that use this model (Kern, Monterey, and Alameda) that the background and orientation of the county DV staff and the structure of the whole CalWORKs process will impact how the model is implemented. The delivery of short-term counseling and the nature of the DV training in Kern are the result of the clinical training of the county DV staff while the county staff in Alameda, who have more traditional DV backgrounds, appear to do more case finding and advocacy.

Part III: CHECKLIST

The following table illustrates some questions you can ask about the DV component of your CalWORKs program.

| Principle A: Involve the DV advocacy and service community. | 1) Do the DV agencies and advocate groups participate in a formal way in the design and implementation of the DV component of CalWORKs?  
2) Are there regular meetings with the DV agencies and advocate groups to review how things are going?  
3) Have the DV agencies and advocate groups reviewed your CalWORKs DV policies and procedures? |
|---|---|
| Principle B: Secure ongoing funding for DV services. | 1) Are the DV agencies in your community funded specifically for the services they provide for CalWORKs clients?  
2) Are you working with DV advocates around strategies to ensure ongoing financing for these services? |
| Principle C: Learn all the relevant FVO rules | 1) Has anyone in the county been trained by San Francisco Legal Aid, or a similar group, on all the aspects of the FVO?  
2) Do all CalWORKs staff know who they should contact if they have a question about the FVO rules and regulations?  
3) Have your DV policies and procedures been reviewed by a group like SF Legal Aid that knows the details of the FVO?  
4) Have staff from CalWORKs and your local DV programs attended a CalWORKs Project DV Regional Institute sponsored by the SDSS? |
| Principle D: Ensure a range of appropriate DV services | 1) Do you have a complete list of all the services provided by the DV agencies in your county?  
2) Have you consulted with the DV agencies about gaps in services that might be appropriate for CalWORKs survivors? Have you attempted to address these gaps? |
| Promising Practices | 1) Do you have DV services integrated into a CalWORKs team with AOD and MH providers?  
2) Do you have identified special DV staff that are CalWORKs employees who perform a direct service role? A liaison role?  
3) Do you have contracts with community DV agencies to provide services?  
4) Do you have clear policies and procedures for how DV waivers are requested, reviewed, and decided?  
5) Do you have an ongoing process for reviewing your model of organizing DV services? Does it include the DV community agencies? |
Chapter IV: EMPLOYMENT SERVICES

The CalWORKs program is intended to move participants from welfare to work — thus the obvious need to address employment issues. This represents new territory for many AOD, MH, and DV service providers.

Each system has some experience dealing with employment issues. Some AOD approaches consider employment as part of recovery. Publicly funded mental health programs are now expected to accomplish vocational goals with their clients with serious mental illness. DV programs must attend to safety issues in the workplace. But consistent attention to employment issues with clients in the CalWORKs program requires new approaches and skills.

Some AOD, MH, and DV programs focus only on the barriers to employment created by the AOD/MH/DV issues, leaving the education and training activities related to achieving concrete vocational goals to vocational programs. Other AOD, MH, and DV programs are incorporating these vocational elements directly into their programs.

This chapter first presents a set of principles necessary for success with employment programs for CalWORKs participants with AOD, MH, and DV issues. This is followed by a set of promising practices. The lack of empirical data and the general newness of the area make us reluctant to claim any as a best practice. The final section consists of a checklist that you can use to assess how well your vocational services are suited to the needs of participants with AOD, MH, or DV issues.

Many of the program examples in this chapter come from counties other than our six case study counties. The CalWORKs Project attempted to find examples of innovative programs in this area, in preparation for one of its Satellite Broadcasts.

Part I: PRINCIPLES

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<thead>
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<th>Principles</th>
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<td>✓ Attend to employment issues as early as feasible</td>
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<td>✓ Provide long-term contact with recipients</td>
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<tr>
<td>✓ Assist recipients in finding the right job and career path</td>
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<tr>
<td>✓ Utilize staff with specific vocational skills and expertise</td>
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<td>✓ Be creative in putting together a program</td>
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Principle A: Attend to employment issues as early as feasible.

The purpose of employment services for CalWORKs participants with AOD, MH, and DV issues is to find and keep a job — hopefully one that the participant enjoys and that will pay a wage that allows the family to be self-sufficient.
Many of the participants with AOD, MH, and DV issues have multiple other barriers to employment. These include human resource barriers (e.g., low education levels, lack of basic skills, lack of work history, and low literacy), situational barriers (e.g., lack of good child care and convenient transportation), and physical health limitations. The more of these barriers a participant has, the less the chances that the person can find and keep a job.

It is thus essential that no time or potential resource be lost in overcoming as many of these barriers as possible within the CalWORKs time frames. The earlier that a vocational assessment can be done, the sooner a vocational plan can be completed and implemented. Some AOD, MH, and DV programs are doing (or arranging for) a vocational assessment at the same time as the initial assessment that establishes the treatment/service plan. Unless the AOD, MH, or DV services to be provided will be very short term — one or two sessions — the issue of vocational goals and needs should be addressed. Timing is, of course, crucial to attaining the participant’s full engagement with a vocational plan. If there are other more urgent issues — as there often are as participants enter services — these should be addressed first, before adding the vocational assessment and plan. But, as soon as possible, the need for a vocational plan should be raised with the client and at least the initial steps taken to complete it.

**Principle B: Provide long-term contact with recipients.**

Programs that have the capacity to follow clients for extended periods of time have clear advantages. The long-term contact allows the building of trust with program staff and allows the staff to better understand how the AOD/MH/DV issues interfere with the client’s employment goals.

Attention to job retention and advancement is becoming increasingly important in California and nationally, as attention shifts from the goal of reduced caseloads to the attainment of self-sufficiency. Obtaining employment during the early years of PRWORA has not been difficult for most recipients because of the low unemployment rates. But the ability to earn a wage that allows for self-sufficiency is another matter. It requires not only the ability to retain employment but also to advance.

Job retention is even more important for CalWORKs participants with AOD/MH/DV issues. The AOD/MH/DV issues make the retention of employment problematic, even with a carefully selected job environment. Ongoing support during the early stages of employment and the ability to utilize the program’s resources in the event of job problems, are critical to employment success for many clients.
**Principle C: Assist recipients in finding the right job and career path.**

The motto of CalWORKs is “a job, a better job, a career.” Turning this into a reality is particularly important for participants with AOD/MH/DV issues and other barriers. A couple of strategies appear useful.

One is to build on the client’s strengths. A realistic vocational plan must document all the areas that need attention, thus creating a plan that consists mostly of deficits. But success will be more achievable if the plan builds on what the client likes to do and is good at. Having a goal that is appealing and having activities the client is good at can help sustain motivation.

A second strategy is to carefully individualize the vocational plan. While many vocational programs have group classes (for example, computer skills or work experience activities such as maintenance or food preparation), these should not be the full vocational plan for a client. Each of these activities can serve a purpose in the person’s vocational plan, but the full range of activities needs to be individually tailored to meet the goals of the particular client.

**Principle D: Utilize staff with specific vocational skills and expertise.**

AOD, MH, and DV issues create special challenges for people in the workplace. Someone who is in AOD recovery should avoid a job setting where expected socializing includes consuming alcohol; someone with a personality disorder that makes getting along with others problematic will likely do better in a job where she can work mostly by herself; and someone with post-traumatic stress disorder will likely have difficulty with an overbearing supervisor.

Professional vocational rehabilitation expertise is helpful in understanding how to select a job environment that is suited to both the capacities of the client and the likely impacts of an AOD/MH/DV issue.

**Principle E: Be creative in putting together a program.**

Perhaps more than in other areas addressed in this report, the building of a good employment program for clients with AOD, MH, and DV barriers to employment requires creativity in putting the pieces together. There is no one obvious model by which these programs can or should be structured or funded.

The workforce development field is undergoing basic change as significant as that of welfare reform. This both complicates and adds opportunity for developing appropriate vocational services for CalWORKs participants with AOD, MH, and DV issues. The first Case Study Report briefly described the Department of Labor Welfare-to-Work (WtW) grant program and the Workforce Investment Act. Because of the importance of these developments, the CalWORKs Project has in its second round of Regional Forums included a one-day Employment Institute to assist in the cross-fertilization among CalWORKs, workforce development, and AOD/MH/DV staff.
The Exhibit contains information on alternative sources of funding and resources that can be used to provide a comprehensive specialized employment program for CalWORKs participants with AOD, MH, and DV issues.

### ALTERNATIVE SOURCES OF FUNDING AND RESOURCES

- **The CalWORKs AOD and MH allocations** can support vocational services that are part of AOD and MH programs.

- **Department of Labor Welfare-to-Work (DOL WtW) grants** are designed specifically to serve CalWORKs participants who have multiple barriers.
  - Some of these grants have gone to AOD, MH, or DV programs to augment the employment component of their programs.
  - Some generic DOL WtW grantees have formed strong alliances with AOD, MH, DV programs to serve their clients.
  - Most generic DOL WtW grantees serve AOD, MH, and DV clients who happen to be in their programs, but do not make any special effort to recruit them.

- **Regular CalWORKs Single Allocation funds** can be used to support special employment efforts with special populations.
  - Many counties contract with community-based organizations to do various aspects of the vocational component of CalWORKs. These can include programs specifically designed for those with multiple barriers, including AOD, MH, and DV issues.
  - Some counties have their own CalWORKs staff assigned to work intensively and in combination with AOD, MH, or DV specialists on vocational issues with multiple barrier clients.

- **The Workforce Investment Act (WIA)** combines workforce-related activities of multiple departments and organizations into a single program that is governed at the local level by a Workforce Investment Board. Partner agencies are required to provide a set of core services available to anyone and supplemental services, including special services, for those with barriers such as AOD, MH, or DV. Services are to be co-located at One-Stop sites.

- **The Employment Readiness Demonstration Project (ERDP)** was funded by the State Department of Social Services to develop screening procedures for identifying hard-to-employ CalWORKs participants and to test the effectiveness of a set of programs specifically designed to address hard-to-employ participants. Some useful models resulted from this demonstration program.
The Department of Rehabilitation (DR) has strict Severity of Disability Standards that restrict the kinds of clients with whom they can work. A few CalWORKs participants — usually those with physical disabilities — might qualify for their services. Some DR services, however, are available to most multiple-barrier CalWORKs clients — most notably assessments. Some programs have developed good working relationships with the Department of Rehabilitation staff in order to maximize the use of this valuable resource.

Part II: PROMISING PRACTICES

We have found a number of interesting ways in which the program components have come together for meeting the vocational needs of CalWORKs participants with AOD/MH/DV issues. The lesson to be taken from this is that you can make a start at building a program from wherever you sit in the scheme of services, i.e., if you are in a CalWORKs office, an AOD/MH/DV program, a county-based rehabilitation or employment and training office, or a community based organization that provides vocational services.

**Promising Practices**

- Incorporating employment services into AOD/MH/DV programs
- Utilizing existing vocational services with addition or linkage to AOD/MH/DV specialists
- Providing peer support and mentoring

A: INCORPORATING EMPLOYMENT SERVICES INTO AOD/MH/DV PROGRAMS

Highlighted below are three examples of programs that have incorporated vocational services into their regular AOD, MH, and DV programs.
ASIAN-AMERICAN DRUG ABUSE PROGRAM (AADAP)
LOS ANGELES COUNTY

The AADAP is a community-based organization that provides a variety of AOD programs. Its vocational component is supported by funds from CalWORKs, a DOL WtW grant, and WIA funds. It has served 760 CalWORKs participants in its vocational component under its DOL WtW grant since 1998.

The employment services component is a separate department within the agency. It has 31 staff, including 9 case managers, 5 job developers, 4 liaisons with CalWORKs, 2 counselors, 3 trainers, 2 childcare workers, and 2 supervisors.

AADAP utilizes a work-first philosophy where job search is used as an assessment for employability. If a client is unsuccessful in obtaining a job, s/he receives a job readiness class. A Welfare-to-Work Plan is developed for each client; the plan includes an assessment of how much direction and support the client will need. AADAP offers work experience, subsidized employment, GED, computer and office skills training on-site along with childcare. It also provides post-employment services. Staff have flexible hours to be available to clients that are working. When MH or DV issues are identified, referrals are made to other agencies.

As a community-based organization, AADAP takes advantage of its ties to its community. It sponsors employer breakfasts, and employers come to the site to do job interviews. At the agency’s big community fundraiser, awards are presented to employers who have hired its clients.

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TRI-CITY MENTAL HEALTH
LOS ANGELES COUNTY

Tri-City is a public mental health organization that in FY 99-00 served over 130 CalWORKs participants. It has a separate Employment Services division that provides job readiness, placement, and retention services. It also has computer classes onsite. Staff generally work in a team with a clinician, case manager, and vocational staff.

The program’s employment services are CARF accredited and the Employment Services division is in the process of becoming a vendor for the Department of Rehabilitation.
Clients have the choice of getting their vocational services either through Tri-City or through the regular GAIN program. When Tri-City provides the vocational services, they coordinate closely with the local GAIN office to report on the clients' hours.

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1736 POWER PROGRAM
LOS ANGELES COUNTY

1736 Family Crisis Center is a community agency that offers a range of services to battered women and their children. It received a DOL WtW grant late in 1999 to begin an employment component, 1736 POWER Program. Most of the participants in the POWER program are also receiving services from 1736. Employment counselors work intensively with individual clients to develop specialized vocational plans. They utilize the WIA One-Stop to access training programs for their clients. They plan on developing on-site work experience locations.

Staff believe that a certain level of stability must be attained in a survivor’s life before she can begin to address vocational issues. The client’s case manager serves an important ongoing role with clients, and works with clinicians and employment staff to create integrated client plans that include employment goals.

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B: UTILIZING EXISTING VOCATIONAL SERVICES WITH ADDITION OF OR LINKAGE TO AOD/MH/DV SPECIALISTS

This general approach has the vocational services as the base with the addition of AOD, MH, DV expertise and services added onto or integrated with it. The first program described below is a new effort located in a county Office of Education (with a DOL WtW grant) that is focusing specifically on clients in AOD recovery. The second is a program located in CalWORKs—a special Rehabilitation Unit that combines vocational expertise with AOD and MH staff.

PARTNERS IN RECOVERY
TULARE COUNTY

Partners in Recovery is a small program with a single staff person who is funded to work through a WtW grant with 30 clients over an 18-month period. She is an educational specialist and vocational counselor who was working within the general DOL grant before starting this program. She recruits her clients from three AOD recovery programs. She contacts them 30 days before they finish their AOD program. The first part of the program
is a two-week placement in one of three work experience sites (hospitality and food preparation, maintenance and landscaping, and building trades) in conjunction with a job readiness class. This is followed by 30 days of paid community service, which the clients do at their AOD recovery program. This is followed by 90 hours of paid work experience with a private provider in conjunction with attaining a job placement. The program also includes a retention component.

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CALWORKS REHABILITATION UNIT  
EL DORADO COUNTY

This is a team of 10 county staff – two rehabilitation counselors (hired under a social worker classification), two AOD, two MH, two employment and training workers, and two social services aides. The rehabilitation staff also serve as the employment coordinators who do the WTW Plan. The team combines clinical services, vocational rehabilitation services, and case management. The program’s budget also funds 10% of a counselor at the Department of Rehabilitation—this facilitates referrals for DR assessments and potential services.

The team recruits clients at CalWORKs group orientation. They ask 8 questions about MH and AOD which are answered confidentially by the participants. They encourage the clients to self-refer to the team if they answer yes to any question. They also receive referrals of participants who do not get jobs after job search and of participants referred for sanctioning.

The team conducts an in-depth assessment of social, legal, medical, and vocational factors; provides job readiness and job retention workshops; makes job training referrals; does job analysis and job modifications and one-on-one job coaching.

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C: PROVIDING PEER SUPPORT AND MENTORING

Many CalWORKs participants with multiple barriers lack self-confidence and optimism about their futures. Participants with AOD/MH/DV issues may drop out of treatment/services because they doubt that they can stick with it or that it will help even if they do. These feelings are exacerbated when they are faced with vocational challenges that may seem daunting.

One strategy is to create an environment in which there is group encouragement and support for making change, and group celebration of successes.
The Jefferson Wellness Center provides a range of services for mental health clients, including vocational services. One aspect of the employment program is community job development. A staff member drives a group of clients in a van to various places that are taking job applications. She uses the time in the van to deal with issues that arise while they are applying. She finds that the clients in the van develop a tight group and are able to provide encouragement and reinforcement for each other. She thinks this kind of competitive job search is less stigmatizing and more esteem-building than other approaches.

Contact: Linda Ramos
909-955-8000

Another common approach is to utilize graduates as role models and/or mentors. Some AOD/MH/DV programs hire program graduates as regular staff. They not only have a special understanding of the difficult circumstances that the program’s clients face, but they also provide role models for the current clients, highlighting that change is possible. The Asian American Alcohol and Drug Program utilizes program graduates who are working at a particular worksite as mentors for other clients who enter the same workplace.

**Part III: CHECKLIST**

The following checklist is intended to be helpful in assessing the vocational components of your CalWORKs program as they relate to participants with AOD/MH/DV issues.

| Principle A: Attend to employment issues as early as feasible | 1) Do your AOD, MH, and DV programs have a policy about either doing or obtaining a vocational assessment on all clients who receive more than very short-term services?  
2) Do your AOD, MH, and DV programs routinely include vocational goals in treatment/service plans? |
| --- | --- |
| Principle B: Provide long-term contact with recipients | 1) Do your AOD, MH, and DV programs have the capacity to provide long-term services?  
2) Do your AOD, MH, and DV programs routinely maintain some type of contact with participants after they leave active services?  
3) Do your AOD, MH, and DV programs provide services as needed for participants after they become employed? |
| Principle C: Assist recipients in finding the right job and career path | 1) Do you routinely attempt to determine the participant’s vocational interests and skills?  
2) Do you have information about career paths that lead to jobs with pay and benefits that allow for self-sufficiency? |
<table>
<thead>
<tr>
<th><strong>Principle D:</strong> Utilize staff with specific vocational expertise and experience</th>
<th>3) Do you do job development for specific jobs that fit the needs and interests of your clients?</th>
</tr>
</thead>
</table>
| **Principle D:** Utilize staff with specific vocational expertise and experience | 1) Do you have specialized staff with vocational expertise and experience as part of your AOD, MH, or DV programs?  
2) Do you have such staff available to serve as consultants to your AOD/MH/DV programs? |
| **Principle E:** Be creative in putting together a program | 1) Is there a forum in the county to bring together all the agencies and funding sources that might support a special vocational program (or program component) for CalWORKs participants with AOD, MH, or DV issues?  
2) How are the Department of Labor Welfare-to-Work grantees in your county involved with CalWORKs participants with AOD/MH/DV issues? Do they have special service components for these clients? Do you have mechanisms to get this type of participant to them?  
3) What role does your Department of Vocational Rehabilitation play with CalWORKs participants? Are you able to get comprehensive services for some of your clients? Do you routinely use this source for assessments? |
| **Promising Practices** | 1) Do your AOD, MH and DV programs serving CalWORKs recipients provide vocational services, such as job readiness, placement, and retention services?  
2) Have you explored using DOL WtW grants to serve CalWORKs participants with multiple barriers?  
3) Have the existing vocational services programs in your county received training on AOD/MH/DV issues?  
4) Do the vocational service programs in your county have staff with the expertise to serve recipients with AOD/MH/DV barriers to employment?  
5) Do your programs provide peer support for participants with AOD, MH, or DV issues for the process of finding and keeping a job?  
6) Do you have mentoring programs related to the workplace for participants with AOD, MH, or DV issues?  
7) Do AOD/MH/DV program graduates who are employed play a role in your programs? |
Chapter V: SERVICES FOR CALWORKs CHILDREN

The majority of individuals on the CalWORKs caseload are children. A desired outcome from PWRORA was that parents who left welfare for work would provide greater economic security and better role models for their children. Alternatively, welfare reform critics worried that it would place children at risk of neglect if families were discontinued from aid because of sanctions or time limits.

The CalWORKs AOD and MH allocations can be used for services for CalWORKs children if the behavioral health problems being addressed constitute barriers to the parents’ employment. Beyond this, the Single Allocation can be used for any children’s service that enhances the well-being of a CalWORKs family. CalWORKs Incentive Funds are even more flexible, and can be used for serving children in any “needy family.”

In the first Six County Case Study Report we related county efforts at better coordinating their child welfare and CalWORKs caseloads, particularly for those families with AOD, MH, or DV issues. This chapter expands upon that information by presenting a set of principles for providing services to children in CalWORKs families. This is followed by some promising trends and practices, and a checklist counties can use to assess their progress in coordinating and providing services for CalWORKs children.

Part I: PRINCIPLES

<table>
<thead>
<tr>
<th>Principles</th>
</tr>
</thead>
<tbody>
<tr>
<td>✓ Recognize and attend to the special needs of children of parents with AOD, MH, and DV issues</td>
</tr>
<tr>
<td>✓ Provide a family-focused service system for CalWORKs participants</td>
</tr>
<tr>
<td>✓ Ensure that CalWORKs coordinates with other agencies/programs involved with participants</td>
</tr>
</tbody>
</table>

Principle A: Recognize and attend to the special needs of children of parents with AOD, MH, and DV issues.

Children living in poverty, whether receiving TANF or not, are at risk for a variety of negative outcomes—ranging from poor nutrition to poor school performance. Children in families where mental illness, alcohol and other drug problems, and domestic violence occur suffer added risks (Knitzer and Cauthen, 1999). Studies of the impact of these issues on children in families receiving aid (AFDC or TANF) are limited, but support the general conclusion that the children are subject to higher rates of depression, behavior problems, developmental delay, post-traumatic stress disorder

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(in the case of children witnessing domestic violence), and lowered self-esteem. There is extensive non-welfare-specific literature documenting these points. In addition, longitudinal studies reveal higher rates of alcohol and drug abuse and psychiatric problems for these individuals as adolescents and adults. Frequently, these problems are not identified or treated (often because the parents’ problems are untreated).

The first Six County Case Study Report included ratings by AOD/MH/DV staff on the parenting ability of specific CalWORKs clients. Of the 385 cases that staff reported on, 12.5% rated the client as deficient or unsafe in her/his parenting abilities, and 22% were rated as inconsistent in their parenting. This data clearly points to the importance of looking at the needs of children when serving CalWORKs adults with AOD, MH and DV issues.

Assessing the needs of the children of adults receiving AOD/MH/DV services is a first step. Los Angeles County MH requires all of its directly operated and contracted programs to conduct a family assessment when they receive a CalWORKs referral, rather than just an assessment of the adult recipient.

This policy requires that the programs serving adults have, at a minimum, sensitivity to children’s issues sufficient to make appropriate referrals for special services for children. Ideally, staff with children’s experience would be part of the assessment process. For those AOD, MH, and DV programs that traditionally serve only adults, this represents a major change in focus and organization.

**Principle B: Provide a family-focused service system for CalWORKs participants.**

While the goals of PRWORA are family-focused, e.g., “providing assistance to needy families so that children may be cared for in their own homes,” the emphasis on attaining economic self-sufficiency has driven the design and implementation of Welfare-to-Work services. To meet the full intent of welfare reform, CalWORKs must attend to the full range of needs of the whole family, rather than just the economic status of the parent(s).

CalWORKs programs are doing this in two ways — one at a full program level and one at the case level. Some counties are using CalWORKs dollars, particularly the Incentive Funds, to support general programs for CalWORKs children and families. At the case level a family-focused approach includes, at a minimum, assessing the needs of all members of the family at both intake and throughout the Welfare-to-Work process.

**Principle C: Ensure that CalWORKs coordinates with other agencies/programs involved with CalWORKs participants.**

Some of the CalWORKs families are involved with other programs. Some are child welfare cases; some are under the jurisdiction of the criminal justice system; some have children with special educational needs. Additionally, the families may be receiving services from the AOD, MH, and/or DV systems either separately or in conjunction with one of these other agencies or programs.
These services need to be coordinated. This can be a difficult task even within the same agency or department, let alone across agencies and departments. The first *Six County Case Study Report* noted the challenges that social service systems face in enhancing cooperation between their child welfare and the CalWORKs programs.

The ideal solution is a single service plan for the whole family rather than each program’s having a separate plan for individual family members. Another solution is regular communication among programs to ensure that families are not facing competing demands. Integrated teams that include CalWORKs and staff from multiple other agencies are an effective approach for families with multiple agency contacts. Whatever the model (and we describe some below), the overriding principle is that CalWORKs be aware of the other agencies and programs with which its families might be engaged.

**Part II: PROMISING PRACTICES**

Because counties have focused initially on identifying and serving the adult CalWORKs population, efforts to provide services to the children in CalWORKs families are at a beginning stage. Services specifically targeted to this population have not been developed to the point where one can identify CalWORKs child/youth services best practices; however, we describe here some promising practices.

### Promising Practices

- ✅ Using multi-disciplinary staff to address the multiple needs of CalWORKs/child welfare cases
- ✅ Supporting general programs for CalWORKs children
- ✅ Providing assistance to children of CalWORKs adults receiving AOD/MH/DV services

**A: USING MULTI-DISCIPLINARY STAFF TO ADDRESS THE MULTIPLE NEEDS OF CALWORKS/CHILD WELFARE CASES**

*Program initiatives for CalWORKs/Child Welfare families have increased within the six counties.*

Some counties have moved beyond identifying the overlap between CalWORKs and child welfare caseloads to addressing the multiple needs of these families with coordinated services. Some counties are exploring a coordinated case plan between child welfare and CalWORKs.

Program models vary, but a common thread is a multidisciplinary staff that includes specialists in AOD, MH, or DV, as well as staff from CalWORKs and child welfare.
# Families In Partnership

**Stanislaus County**

Families In Partnership (FIP) is an intensive pre-court program designed for families with AOD issues where the child is at risk of being placed. The program also serves some family maintenance and family reunification cases. Stanislaus is trying to have all the FIP clients that are on CalWORKs assigned to special eligibility workers and employment coordinators to enhance the communication with the FIP team.

FIP consists of one MH, two AOD, two probation, and four child welfare staff. Rather than providing services directly, team members act as liaisons with their respective agencies, facilitating quick access to services. The program makes many referrals to the CalWORKs Behavioral Health Services (BHS) team. The program also has two vans with drivers. They respond rapidly to urgent daily living situations, such as obtaining housing and food, and any other crisis that makes the child at imminent risk of being placed.

*Contact: Virginia Wilson  
209-558-3357*

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# KITE

**Kern County**

KITE (Kern Integrated Team Effort) serves CalWORKs family maintenance cases. It is staffed by two child welfare social workers and three CalWORKs staff. In a pilot of the program, more than half the cases were receiving court-ordered AOD services. The program design now requires all cases to be referred to the CalWORKs Behavioral Health Team for an assessment and follow-up behavioral health services. The BHT staff is in regular communication with the KITE team about the behavioral health services being provided.

*Contact: Hal Lockey  
661-631-6071*
B: SUPPORTING GENERAL PROGRAMS FOR CALWORKS CHILDREN

A number of counties have used their CalWORKs incentive funds to support general programs for CalWORKs children.

Kern County issued a Request for Proposals in December 1999 to over 600 community organizations for services to CalWORKs parents and children. They received 51 proposals and funded 20 with $3 million of incentive funds. Four general types of programs were funded: childcare related, after-school activities, mentoring programs, and education programs. These programs sometimes serve a broader group than CalWORKs families or children; the initiative funds a percentage of the program costs equivalent to the estimated ratio of CalWORKs clients to total clients.

A few counties have initiated major campaigns under the immediate direction of the Boards of Supervisors to improve the lives of low-income families.

The Los Angeles Board of Supervisors launched a Long-Term Family Self-Sufficiency initiative that consists of 46 projects using $370 million of CalWORKs incentive funds. All of the projects are designed to enhance the ability of families to achieve self-sufficiency.

Stanislaus County developed a single plan (called the Renaissance Project) that would make use of CalWORKs incentive funds, the Tobacco Tax dollars, and funds from Proposition 10 — roughly $250 million over the next ten years. The planning process included substantial input from community constituencies. Each of the programs, including CalWORKs, will coordinate its use of funds to meet specific goals in the Renaissance Plan.

The San Francisco County Board of Supervisors started a “High-Quality Childcare Initiative” to provide early childhood mental health services for at-risk and high-risk young children from CalWORKs and low-income families at center-based childcare programs and family childcare providers. The program is supported by $730,000 of county funds, combined with $1.2 million in CalWORKs childcare dollars and CalWORKs mental health funds.

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16 The childcare programs include a program to train CalWORKs participants to become licensed childcare providers; a program to do short, intensive training for exempt childcare providers who want to become licensed; and a program to provide drop-in childcare capacity at the DHS building. The education programs include a parent and sibling support group for families with special needs children, GED programs, and a family literacy program.
CalWORKs dollars are often added to other funding sources for these child and family centered programs.

Many of the initiatives already cited reflect this approach. Here is another example.

**GREAT BEGINNINGS SHASTA COUNTY**

The Great Beginnings program in Shasta is a home visiting program that is dedicated to child abuse prevention and treatment. It began with a grant from a state joint program between the Office for Criminal Justice Planning and the Office of Child Abuse Prevention. New Beginnings has 11 staff that conduct home visits to families with children under five years of age. They also operate counseling programs for children who are victims of abuse. They utilize a strengths-based model and have MH, AOD and DV specialists who work with them. They accept referrals from multiple sources, including BHS, which serves adult CalWORKs parents with AOD/MH/DV issues.

New Beginnings is supported by eight different funding sources, some of which have fairly specific eligibility and service criteria. The CalWORKs funding is more general and, in the words of the director, is like the “mortar around the bricks.”

**Contact:** Chris Moats  
Family Services Agency  
530-243-2024

Some of these general programs serve as points of identification of children with significant behavioral problems.

Shasta County CalWORKs contracts with the local school district to operate a chronic lice program. While in the homes of families to address the chronic lice problems, they observe the family situation and identify specific child behavioral health problems that need to be addressed. If the family is CalWORKs, a referral to the Behavioral Health Service Team is made.

San Francisco County has awarded contracts to eight community-based agencies to provide an array of mental health services, including direct intervention with families and children. The agencies do assessments and short-term therapeutic intervention, case consultations for particular children exhibiting behavioral or developmental problems, and therapeutic play groups.
C: PROVIDING ASSISTANCE TO CHILDREN OF CALWORKS ADULTS RECEIVING AOD/MH/DV SERVICES

Providing special services for children is most easily arranged in residential AOD and DV programs.

Many AOD and DV programs provide special programs for the children of the women residents. These settings also provide opportunities for parent training.

**SHIELDS**
**LOS ANGELES COUNTY**

Shields operates a range of AOD programs. Their residential program for mothers strives to serve the needs of the entire family. It is one of the few programs that has no limit on the number of children that a mother may bring with her into the residential program. The program includes family counseling and individual counseling for the children for whom it is appropriate. Staff feel that addressing issues of separation and abandonment are crucial, since many of the children have at some point been in out-of-home settings. The youth programs are called Heroes and Sheroes and are open to the youth even after they leave the residential setting.

**Contact:** Kathryn Icenhower  
323-242-5000, ext. 268

Some programs provide services for children while their parents are in outpatient group treatment/services.

The logistics of providing a consistent program for children are more difficult when the parents are receiving outpatient services than when they are in a residential program. When the parents are receiving group services, a concurrent program for the children can be provided. An added benefit is that parental attendance increases, because they value the services being provided to their children.

**FIRST STEP**
**STANISLAUS COUNTY**

First Step is a six-month perinatal intensive outpatient AOD program with joint funding from AOD, child welfare, and CalWORKs. The staff consists of two AOD counselors and four child development teachers. The program provides a daily three-hour child development program for any of the mother’s children under six. As the mother progresses through the three phases of the program, her child is able to attend the child development center.

**Contact:** Judy Diane Lewis  
209-544-3408
The WINGS DV program in Los Angeles offers a “little wings” group that meets at the same time as the women’s education and support groups. In that group, the children deal with issues of anger management and conflict resolution. There is an active art program for the children, which is used to facilitate the child’s expression of family issues.

Contact: Ana Interiano
626-915-5191

Stanislaus initiated two programs for the children of some of their CalWORKs clients with AOD/MH/DV issues. In collaboration with the Center for Community Services they provided an eight-week summer program for the children of AOD clients (CAPI) and for the children of women DV survivors (Kids Count). Services for children included field trips and other activities that expose them to a range of experiences. Staff find the programs useful in understanding the impact of the AOD and DV issues on the children and how recovery can affect family dynamics.

Referrals into the two programs come from the CalWORKs Behavioral Health Services (BHS) team and from Families in Partnership (FIP), a family maintenance program for families with AOD issues. Two people from FIP and one from BHS staffed CAPI.

The logistics of getting all the children to a program at once has been a challenge. The county will be merging the two programs together and beginning the children’s groups during the summer, when arranging attendance is less problematic.

Contact: Carlos De La Cerda
209-558-4352

Some AOD/MH/DV agencies also provide individual services for children of the adults they serve.

Again, attention needs to be paid to the logistics of providing these services in a manner that is convenient to the parents. That means either having the children’s services on the same site or at a nearby site, so that the adult and child services can be concurrent, if at all possible.
**COLLEGE HEALTH**  
**KERN COUNTY**

College Health, a contract agency, provides AOD and MH services for CalWORKs participants in some of the outlying areas of Kern County. It emphasizes family-focused services that address the needs of the children of the CalWORKs clients they serve. College Health estimates that it has an open child case on about one-third of its CalWORKs clients. They operate a special substance abuse group for teens; anger management groups for children and teens; and joint groups with parents and children in addition to individual child counseling.

**Contact:** Joni Lanza  
760-379-3412

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**TRI-CITY MENTAL HEALTH CENTER**  
**LOS ANGELES COUNTY**

Tri-City Mental Health Center has a CalWORKs program and a children’s mental health program on the same site. CalWORKs children who have MH problems can get services at the same place and during the same times as their parent(s).

**Contact:** Elsa Hilo, Psy.D.  
909-469-5830

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**WEST CENTRAL FAMILY MENTAL HEALTH**  
**LOS ANGELES COUNTY**

The West Central Family Mental Health Center collaborates with the Los Angeles Child Guidance Center that is located next-door. Staff from both agencies co-lead a 10-week parenting skills group for CalWORKs participants. Child Guidance Center staff also provide “child watch” services for the children during the time their parent is in group. Some of these children have been identified as needing services and are being seen in ongoing treatment by Child Guidance Center staff.

**Contact:** Chris Warren  
323-298-3680
Part III: CHECKLIST

Below is a set of questions you might ask about the services for children within your county.

| Principle A: Recognize and attend to the special needs of children of parents with AOD, MH, and DV issues | 1) Do your trainings for CalWORKs staff about AOD/MH/DV issues address the impacts of these issues on children?  
2) Do your CalWORKs AOD/MH/DV programs for adults have procedures for assessing impacts of these issues on the children?  
3) When CalWORKs recipients are referred for AOD/MH/DV services, do they receive a full family assessment? |
| --- | --- |
| Principle B: Provide a family-focused CalWORKs service system | 1) Are you using any of your AOD or MH allocation for services for children?  
2) Are there mechanisms in place so that program staff that identify a child as needing counseling services can provide that service or make a direct referral?  
3) Do CalWORKs staff inquire about the status and needs of all family members? |
| Principle C: Ensure that CalWORKs coordinates with other agencies/programs involved with participants | 1) Do your CalWORKs staff routinely inquire on each of their cases about other agency/program involvement?  
2) Do you have mechanisms for checking overlap between CalWORKs cases and cases involved with child welfare, criminal justice, or probation?  
3) Do you have routine mechanisms for coordinating with the schools that have CalWORKs children? |
| Promising Practice A: Using multidisciplinary staff to address the multiple needs of CalWORKs/child welfare cases | 1) Do you have a joint team that serves CalWORKs clients that are on the child welfare caseload? If not, do you assign these child welfare cases to specialized CalWORKs staff?  
2) Have you considered a single case plan for families that are both CalWORKs and child welfare cases?  
3) Are there any AOD, MH, or DV staff included as a regular part of a combined CalWORKs/child welfare team?  
4) If not, are there routine referrals for assessments for AOD, MH, and DV issues? |
| Promising Practice B: Supporting general programs for CalWORKs children | 1) Do you have CalWORKs programs specifically for CalWORKs children?  
2) Do you provide childcare or “child watch” services in conjunction with activities of CalWORKs recipients? |
<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>3) Have you entered into any partnerships with existing children’s programs to serve children of your CalWORKs clients?</td>
<td></td>
</tr>
<tr>
<td>4) Have you used Incentive Funds for new children-or family-focused programs for CalWORKs and/or other low-income families?</td>
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</tbody>
</table>

**Promising Practice C:**
Providing assistance to children of CalWORKs adults receiving AOD/MH/DV services

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Do your AOD and/or DV residential programs include specific programming for children?</td>
<td></td>
</tr>
<tr>
<td>2) Do your outpatient AOD, MH, and DV programs have programs for the children of their clients? Do the programs receive extra funds to support these programs? Are they able to provide services for children at a site and time that is convenient for the parents?</td>
<td></td>
</tr>
<tr>
<td>3) Do you have programs that provide the children/youth the opportunity to address the impacts of living in a family with AOD, MH, or DV issues?</td>
<td></td>
</tr>
<tr>
<td>4) Do your outpatient adult AOD, MH, and DV programs have special procedures for ensuring a smooth referral to services for children identified with special needs?</td>
<td></td>
</tr>
</tbody>
</table>
Chapter VI: WHO IS RECEIVING AOD AND MH SERVICES AND WHAT SERVICES ARE THEY RECEIVING?

Part I: CONTEXT

This chapter presents information about the CalWORKs clients who are receiving AOD and MH services and the services they are receiving. The data comes from the Management Information Systems (MIS) of the six case study counties. Although there are difficulties in using this data, particularly in comparing counties, we believe it supports several key findings. Appendix 2 contains a discussion of data limitations and more detailed tables for some of the comparisons.

Counties were asked to supply information on all adult clients served in their AOD or MH systems who were recipients of CalWORKs cash assistance. It includes, therefore, all CalWORKs adult clients whether or not they were identified and referred from a CalWORKs office, whether or not they had the AOD/MH services included in their Welfare-To-Work Plans, and whether or not the services were paid through the special AOD or MH allocations. While clients may not be part of the special CalWORKs AOD or MH services, they are still subject to all the time limits and work activity requirements of the regular program.17

We also utilized information from the CalWORKs Project Prevalence Report in some of the findings that follow. The CalWORKs Project has gathered prevalence data on random samples of CalWORKs female single heads-of-household in two of the six case study counties—Kern and Stanislaus. Research staff not connected with the county welfare or the behavioral health staff gathered diagnostic information through independent interviews. Detailed information about the methodology of the study and its results can be found in reports on the CIMH web site.18

17 There are two exceptions. Los Angeles MH does distinguish those clients who have their MH services as part of their Welfare-to-Work Plan from those who do not. We, therefore, sometimes present separate data for the two groups—one labeled LA-WTW (services in the WTW Plan) and LA-not WTW (services not in the WTW Plan). The other exception is Shasta County, where the total numbers served and the client characteristics are for ALL their CalWORKs clients, while the service utilization information is for only those clients directly funded by the CalWORKs allocations and seen at some point by the specialized CalWORKs Behavioral Health Team.

Part II: FINDINGS

FINDING 1: COUNTIES ARE SERVING INCREASING NUMBERS OF CALWORKS CLIENTS WITH AOD AND MH BARRIERS.

The overall percentage of adult CalWORKs participants who received an AOD or MH service in FY 99-00 ranged from 4% to 13%.

The graph below shows adult clients served in AOD or MH programs as a percentage of the total number of adult CalWORKs recipients in each county during the course of the year.\(^{19}\) These percentages thus include in the denominator TANF recipients who are exempt from Welfare-To-Work or in the formal noncompliance state. The percentages receiving AOD or MH services would be higher if the denominator consisted only of those enrolled in and complying with Welfare-to-Work.

PERCENTAGE OF TOTAL CALWORKS PARTICIPANTS RECEIVING AN AOD OR MH SERVICE DURING FY 99-00\(^{20}\)

<table>
<thead>
<tr>
<th>County</th>
<th>AOD</th>
<th>Mental Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alameda</td>
<td>2.8%</td>
<td>3.8%</td>
</tr>
<tr>
<td>Kern</td>
<td>3.8%</td>
<td>8.5%</td>
</tr>
<tr>
<td>Los Angeles</td>
<td>0.7%</td>
<td>3.2%</td>
</tr>
<tr>
<td>Monterey</td>
<td>1.5%</td>
<td>10.5%</td>
</tr>
<tr>
<td>Shasta</td>
<td>3.4%</td>
<td>5.1%</td>
</tr>
<tr>
<td>Stanislaus</td>
<td>4.8%</td>
<td>8.1%</td>
</tr>
</tbody>
</table>

\(^{19}\) The numbers for the denominator were provided by the Data Analysis and Publications Branch of the State Department of Social Services.

\(^{20}\) The figures for Monterey may be somewhat misleading since a number of the “MH” clients have a primary AOD diagnosis, thus somewhat overstating the MH and understating the AOD percentages.
The Los Angeles MH figures do not include CalWORKs participants served only in their fee-for-service private provider network. Unfortunately, these network providers do not provide complete and accurate Medi-Cal aid code reporting—only 13% reported an aid code. Based on the aid code reporting for that 13%, we estimate an additional 2,100 adult CalWORKs MH clients for FY 99-00, which would raise the MH percentage to 4.8%, and the total (AOD and MH) for LA to 5.6%.

More MH than AOD clients are served.

As shown above, substantially more CalWORKs participants received MH than AOD services in five of the counties, Shasta is the exception. The larger percentage of MH than AOD clients likely reflects:

➢ The higher prevalence of such disorders in the CalWORKs population;

➢ The fact that the barriers to self-identification are believed to be greater for AOD than MH issues; and,

➢ The less reliable reporting of CalWORKs clients in the AOD than the MH data systems.
The percentage of CalWORKs participants receiving AOD or MH services has generally increased over the last three fiscal years.

The graph below shows the percentage of CalWORKs clients receiving either AOD or MH services in each of the last three fiscal years. 21

### PERCENTAGE OF CALWORKS PARTICIPANTS RECEIVING AN AOD OR MH SERVICE DURING FY 97-98, 98-99, 99-00 (A MISSING BAR INDICATES DATA IS UNAVAILABLE FOR THAT YEAR) 22

<table>
<thead>
<tr>
<th>County</th>
<th>FY 97-98</th>
<th>FY 98-99</th>
<th>FY 99-00</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alameda</td>
<td>6.6%</td>
<td></td>
<td>10.0%</td>
</tr>
<tr>
<td>Kern</td>
<td></td>
<td>12.3%</td>
<td></td>
</tr>
<tr>
<td>Los Angeles</td>
<td>1.7%</td>
<td>4.6%</td>
<td>3.9%</td>
</tr>
<tr>
<td>Monterey</td>
<td>2.5%</td>
<td>8.5%</td>
<td>12.0%</td>
</tr>
<tr>
<td>Shasta</td>
<td></td>
<td>8.2%</td>
<td>8.4%</td>
</tr>
<tr>
<td>Stanislaus</td>
<td>5.4%</td>
<td>9.8%</td>
<td>12.9%</td>
</tr>
</tbody>
</table>

21 The actual numbers are shown in Appendix 2.
22 Some of these percentages for FY 97-98 and FY 98-99 differ from those in the first Case Study Report because a new and more accurate figure for the denominator has been used here.
The table below shows the actual number of clients. In some instances, the absolute numbers have declined while the percentages have increased, because of the shrinking caseload. While the total Los Angeles MH number shows a decrease, the specific CalWORKs MH program funded through the allocation, in which the MH services are included in the Welfare-To-Work Plan, has increased dramatically from zero in FY 97-98, to 1,043 in FY 98-99, to 3,489 in FY 99-00.

<table>
<thead>
<tr>
<th></th>
<th>FY 97-98</th>
<th>FY 98-99</th>
<th>FY 99-00</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>AOD</td>
<td>MH</td>
<td>AOD</td>
</tr>
<tr>
<td>Alameda</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kern</td>
<td>N/A</td>
<td>1,464</td>
<td>107</td>
</tr>
<tr>
<td>Los Angeles</td>
<td>149</td>
<td>4,771</td>
<td>776</td>
</tr>
<tr>
<td>Monterey</td>
<td>26</td>
<td>202</td>
<td>100</td>
</tr>
<tr>
<td>Shasta</td>
<td>416</td>
<td>N/A</td>
<td>343</td>
</tr>
<tr>
<td>Stanislaus</td>
<td>353</td>
<td>616</td>
<td>470</td>
</tr>
</tbody>
</table>
FINDING 2: CERTAIN SEGMENTS OF THE CALWORKS POPULATION WITH AOD AND MH ISSUES ARE UNDERREPRESENTED AMONG THOSE WHO ARE RECEIVING AOD AND MH SERVICES.

Persons with alcohol problems are underrepresented.

The vast majority of CalWORKs clients receiving AOD services are being treated for drug issues as opposed to alcohol problems. The figure below shows the proportion of AOD clients being treated for an alcohol problem.

PERCENTAGE OF ALL CALWORKS AOD CLIENTS WITH ALCOHOL DEPENDENCE OR ABUSE AS PRIMARY DIAGNOSIS\(^{23}\) (FY99-00)

- Alameda: 8%
- Kern: 15%
- Monterey: 15%
- Shasta: 38%
- Stanislaus: 16%

We have two reasons for concluding that persons with alcohol problems are underrepresented.

- Among those with abuse and dependence diagnoses in the CalWORKs Project Prevalence Study and in most prevalence studies, alcohol dependence is at least as prevalent as illicit drug dependence. The CalWORKs Project Prevalence Study found that in Kern 7.2% had alcohol abuse or dependence vs. 3.5 percent for other drugs; in Stanislaus it was 7.9% vs. 8.4%.\(^{24}\) In the 1999 National Household Survey of Drug Abuse, the percentage of California women with alcohol dependence was 2.9% vs. 1.8% for other drugs.

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\(^{23}\) AOD diagnostic information is not available for Los Angeles. They do, however, have data on the “primary drug at admission.” The percentage with an “other drug” as primary is twice as high as for alcohol.

\(^{24}\) There is overlap between those dependent on drugs and those dependent on alcohol.
Heavy drinking or drinking on the job commonly impairs work performance even when abuse or dependence is not involved. Apparently, programs are not identifying this non-dependent level of alcohol impairment, despite evidence that it can be effectively treated.

The AOD programs are serving more whites, fewer young and older, and fewer college-educated clients than found in the research group of participants with an AOD diagnosis.

In Kern, 56% of the AOD clients receiving services are white compared to 38% of those identified in the CalWORKs Prevalence Study as having diagnosable AOD dependence or abuse. In Stanislaus the percentages are 64% receiving services are white compared to 26% in the Prevalence Study sample.

In both counties, there are lower percentages of clients in the under 25 age range receiving AOD services than were found in the Prevalence Study sample — 18% vs. 40% in Kern and 19% vs. 28% in Stanislaus. The programs are also serving fewer clients in the over 45 age range than found in the Prevalence Study sample — 4% vs. 12% in Kern and 4% vs. 30% in Stanislaus.

Programs also serve fewer clients with more than a high school education than found in the Prevalence Study group of participants with an AOD diagnosis — 10% vs. 18% in Kern and 10% vs. 26% in Stanislaus.

FINDING 3: Most of the MH clients and all of the AOD clients receiving services have significant impairments.

From 43% to 65% of the MH clients have diagnoses indicating a severe mental disorder.

Diagnosis is often a good guide to prognosis in persons with mental health disorders. Substantial numbers of clients had diagnoses of Major Depression, Post-Traumatic Stress Disorder, Bipolar Disorder, and other psychoses. The less severe disorders, such as anxiety disorders and adjustment disorders, may nonetheless cause significant impairment in ability to function.

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25 Jonathan Howland, PhD, principal investigator of a work site alcoholism study in 1998 says: “Contrary to conventional wisdom, workplace productivity is not only impacted by those with the illness of alcoholism, but by those non-dependent employees who sometimes drink heavily the night before work or who drink at lunch. Excessive alcohol use, which upsets sleep and decreases concentration, can affect the employee and productivity goes downhill, even if the person does not have the classic hangover symptoms of headache and nausea. By not focusing on these types of drinking behaviors, work sites are missing key opportunities to affect the bottom line and their company’s overall performance.” In addition, 21% of workers reported their productivity was affected because of co-workers’ drinking, including being injured or put in danger, having to re-do work, or covering for a co-worker. Howland, J., & Mangione, T. (1998) “Alcohol and Work” in To Improve Health and Health Care. Robert Wood Johnson Foundation.

PERCENTAGE OF CALWORKS MENTAL HEALTH CLIENTS WITH A SEVERE MENTAL ILLNESS

From 45% to 83% of MH clients in the respective counties have Global Assessment of Functioning (GAF) scores that indicate major impairments in at least one role area.

Another measure of MH severity is the Global Assessment of Functioning (GAF) rating done at admission. GAF scores range from 0 to 100, with scores under 50 reflecting serious impairments in functioning. Descriptions of the more serious categories are as follows:

- 31 – 40: Some impairment in reality testing or communication (e.g., speech at times illogical, obscure or irrelevant) OR major impairment in several areas, such as work or school, family relations, judgment, thinking, or mood (e.g., depressed man avoids friends, neglects family, and is unable to work)

- 41 – 50: Serious symptoms (e.g., suicidal ideation, severe obsessional rituals, frequent shoplifting) OR any serious impairment in social, occupational, or school functioning (e.g., no friends, unable to keep a job)

27 Severe mental illness includes Major Depression, Post-Traumatic Stress Disorder, Bipolar Disorder and Other Psychoses. See the table “MH Diagnoses of CalWORKs Participants Receiving MH Services” in Appendix B for detail by diagnosis.
The differences between the scores of the two Los Angeles groups are instructive. Those with the MH services as part of the WTW Plan were usually identified through the regular CalWORKs eligibility and Welfare-To-Work processes, while the others entered MH services by other means. The latter group has a higher percentage of clients with GAF scores under 40 than does the group with services in the WTW Plan (43% vs. 31%) indicating that those clients paid for through the MH allocation are somewhat less impaired, on average, than those paid for through Medi-Cal.

### A group of the most severely impaired CalWORKs MH clients may qualify for SSI.

A question can be raised about why the sizable minority of CalWORKs MH clients with psychotic diagnoses and low GAF scores are not on SSI. County CalWORKs and MH staff indicated during interviews that they believe some CalWORKs participants would meet the criteria for SSI.

Most counties already have staff that provide assistance in the SSI application process to general relief/assistance clients who have disabilities serious enough to qualify for SSI. Counties are now using the same type of staff to assist CalWORKs clients with more serious disabilities to at least consider applying for SSI.

Not all clients who might qualify for SSI will choose this option. Opportunities for entering (or re-entering) the work force are greater if the person remains on CalWORKs, given the wide range of...
support services that this program provides. What is important is that programs recognize when a client might qualify for SSI and at least pursue a discussion of this option with the client.

**Virtually all AOD CalWORKs clients have alcohol or other drug “abuse or dependence” diagnoses.**

Substance “dependence” is a diagnosis involving “a maladaptive pattern of substance use, leading to clinically significant impairment or distress.” It is characterized by having at least three of the following symptoms: tolerance, withdrawal, taking a substance in larger amounts or over a longer period than was intended, persistent desire or unsuccessful efforts to cut down or control substance use, spending a great deal of time on substance-related activities, reduction or loss of important social, occupational or recreational activities, and, continuation despite knowledge of a severe substance-caused physical or psychological problem. Thus, dependence may or may not involve physiological addiction. In virtually all cases, it is a long-term condition, though one that is responsive to treatment.

A related diagnosis is substance “abuse.” It also involves “a maladaptive pattern of substance use, leading to clinically significant impairment or distress.” It is characterized by the presence of one or more of the following: recurrent substance use resulting in a failure to fulfill major role obligations at work, school, or home, recurrent use in situations in which it is physically hazardous, recurrent substance-related legal problems, and continued substance use, despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance. If dependence can be diagnosed, an abuse diagnosis is not applicable.

Thus, substance dependence and abuse are clinically defined constellations that include substance use patterns, individual impairment, distress or addiction, and significant social dysfunction.

The table below shows the percentages of those CalWORKs participants receiving AOD services who have alcohol and other drug dependence or abuse diagnoses.28 Drug dependence is the most frequent diagnosis for those being served.

<table>
<thead>
<tr>
<th></th>
<th>Alameda N=591</th>
<th>Kem N=746</th>
<th>Monterey N=75</th>
<th>Stanislaus N=477</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol dependence</td>
<td>4</td>
<td>9</td>
<td>11</td>
<td>12</td>
</tr>
<tr>
<td>Drug dependence</td>
<td>61</td>
<td>60</td>
<td>45</td>
<td>65</td>
</tr>
<tr>
<td>Alcohol abuse</td>
<td>4</td>
<td>6</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Drug abuse</td>
<td>27</td>
<td>25</td>
<td>33</td>
<td>14</td>
</tr>
<tr>
<td>Other/deferred/none</td>
<td>4</td>
<td>1</td>
<td>1</td>
<td>4</td>
</tr>
</tbody>
</table>

28 Neither Los Angeles nor Shasta collects this diagnostic data uniformly on all its AOD clients.

29 Shasta County did not distinguish between dependence and abuse. The overall figure for alcohol dependence or abuse was 32% and for drug dependence or abuse was 68%.
For many AOD and MH clients, clinical barriers combine with age and education barriers

In general, the CalWORKs participants receiving AOD and MH services are similar to CalWORKs participants overall with respect to gender, age and education. As in the CalWORKS population overall, a large majority of persons receiving AOD or MH services are female (in most programs it is over 75%, as it is overall). Although gender may itself be a barrier in the workplace (especially for single mothers who must manage childcare and deal with sick children in jobs that offer little or no sick leave), those over age 45 and those with less than a 9th grade education experience critical barriers.

The next graph shows that in a number of the counties 10% to 25% of the persons receiving AOD or MH services are over age 45. The second graph shows wide variability, but a significant number of programs have close to 20% of their clients with less than a 9th grade education.
FINDING 4: A SUBSTANTIAL NUMBER OF CALWORKS CLIENTS RECEIVING SERVICES HAVE BOTH AOD AND MH DIAGNOSES.

Up to 17% of the MH clients are reported to have a secondary AOD dependence or abuse diagnosis.

The graph below shows the percentages of CalWORKs clients being served in mental health programs that have concurrent alcohol and other drug dependence or abuse diagnoses. Relying on research-based prevalence data in two counties (Kern and Stanislaus) we would expect at least 15% to 20% of the MH clients to also have a diagnosable AOD problem.

We believe that these figures from the county MH MIS underestimate the extent of dual diagnoses among the population receiving services, based on survey information collected directly from service providers, as reported in the first Case Study Report. MH service providers in four of the counties provided information on a sample of their specific clients, and reported from 28% to 35% as having a secondary AOD dependence or abuse problem.
PERCENTAGE OF CALWORKS MH CLIENTS WITH A SECONDARY AOD DIAGNOSIS (FY99-00)

The three counties with the highest percentages have integrated AOD and MH teams that provide services to those clients that are referred from CalWORKs. This integrated team approach may be responsible for a heightened awareness of the issues of dual diagnosis.

The clients in Los Angeles with services in their WTW plan have all been assessed by a special group of clinicians who have been alerted to the high likelihood of dual diagnosis. This is in contrast to those served by private MH clinicians who generally lack this orientation.

We do not have data from the county MIS on the percentage of AOD clients that are identified as having MH issues. The survey of AOD providers in four of the counties, reported in the first Case Study Report, indicated that 18 to 54 percent of the AOD clients also had a MH diagnosis.

**FINDING 5: ENGAGEMENT OF CLIENTS APPEARS TO BE A MAJOR PROBLEM, PARTICULARLY FOR THE MH SYSTEM.**

*There is substantial variation among the counties in the distribution of number of service contacts*

The table below shows the distribution of total contacts for MH clients in the six counties. Los Angeles and Alameda counties have the highest percentages of clients with less than 5 contacts per client and the lowest percentages with more than 9 contacts per client. Kern has the lowest percentage of clients with less than 5 contacts and the highest percentage with more than 9 contacts. Monterey, Shasta, and Stanislaus are between these extremes.
While interpretation of the data is difficult, client engagement appears to be a major problem.

It is characteristic of most mental health systems that many clients receive only a few services. Sometimes this results because their problems are quickly resolved or they at least feel better, because the services are not helpful, or because the perceived benefit may not be worth the cost (financial and time/effort).

We suspect that the relatively high percentage of clients with short-term services results, at least in part, from their not being engaged in the services.

- The level of severity of the MH problems identified in this population in terms of diagnosis and GAF scores suggests that a higher percentage of the clients should be receiving longer-term services. For many clients, the services may be either perceived as not helpful or as not worth the effort required to attain them.

- In the first Case Study Report we presented data from AOD and MH providers who were asked to note the circumstances under which 320 of their discharged clients had left services. Roughly half of these clients were said to have left before successful completion of services, i.e., they had stopped before goals were met, refused contact, and/or couldn’t be located. This is, in fact, an underestimation of the problem of lack of engagement, since the sample included only clients who had been in services for at least 30 days.30

- Counties with specially designed staff and programs for CalWORKs clients appear to do a better job at engaging clients. Kern and Stanislaus both have specially designated teams of staff who conduct assessments at the welfare site and also provide some services at those sites. The team’s sole focus is engaging clients who are referred, and there is a greater focus on and capacity for outreaching to clients who fall out of services. Los Angeles, on the other hand, has relied primarily on its regular service providers once a CalWORKs participant is identified as needing MH services. These regular MH pro-

30 Data from Yolo County indicates that only 16% of the clients that are originally referred for AOD or MH services complete a full course of services.
programs, for the most part, are understaffed and lack the capacity to do aggressive outreach for clients who either failed to attend their first appointment or who came once or twice and then dropped out. Thus, the percentage of clients who became engaged in ongoing MH services is smaller in Los Angeles than in the other counties.

➢ Staff in every county we have visited cite engagement of clients in services as a primary problem. In some instances, services are difficult for clients to attend because of transportation and childcare issues. Clients may have too many other daily life obstacles that impede their capacity to focus on their MH issues, and services may not be relevant or helpful.

The number of contacts per client is higher and less varied across counties for AOD than for MH clients.

The table below shows the average number of contacts for the AOD clients in each county that could produce this information.

| NUMBER OF AOD SERVICE CONTACTS PER CALWORKS CLIENTS RECEIVING AOD SERVICES (FY99-00) |
|-----------------------------------|----------------|----------------|----------------|----------------|
| < 5                               | 13%            | 16%            | 6%             | 26%            |
| 5 - 24                            | 21%            | 43%            | 28%            | 30%            |
| 25 - 60                           | 20%            | 26%            | 21%            | 25%            |
| >60                               | 44%            | 15%            | 46%            | 20%            |
| Mean                              | 111            | 31             | 44             |                |
| Median                            | 47             | 19             | 19             |                |

It appears that once CalWORKs participants enter AOD services, they may be more successfully engaged than the MH clients. This could occur for a number of reasons.

➢ Some of the AOD clients are in services through a court order that increases their motivation to stay in services.31

➢ More clients use residential or day treatment services that provide intensive services over a short period of time. Thus, while the number of services is higher than for MH, the total time engaged in services may not be.

31 In surveys of roughly 600 CalWORKs participants in AOD, MH, or DV services, conducted as part of the first Case Study Report, 26.4% of the AOD clients said they were referred to the program by a court, probation, or CPS, compared to just 4.9% of the MH clients.
More of the AOD than the MH clients appear to enter the CalWORKs system *after* they are already in treatment and have a relationship established with the treatment staff.\(^{32}\)

While only representing about one-tenth of the AOD clients, those in methadone maintenance programs increase the mean and median numbers of contacts.

**FINDING 6: CASE MANAGEMENT IS USED FREQUENTLY WITHIN THE MH SYSTEM.**

*More than 60% of the MH clients in four of the counties received some case management services.*

The first row in the table below shows the percentage of MH clients in each county that received any case management services. This is followed by the mean and median number of case management units for those who received any such services.\(^{33}\)

**PERCENTAGE OF MH CLIENTS RECEIVING CASE MANAGEMENT SERVICES AND THE NUMBER OF CASE MANAGEMENT SERVICES FOR THOSE WHO RECEIVED ANY (FY99-00)**

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>% with any CM</td>
<td>3%</td>
<td>86%</td>
<td>65%</td>
<td>71%</td>
<td>41%</td>
<td>17%</td>
<td>63%</td>
</tr>
<tr>
<td>Mean # of CM units</td>
<td>2.5</td>
<td>18</td>
<td>5</td>
<td>7</td>
<td>4</td>
<td>8</td>
<td></td>
</tr>
<tr>
<td>Median # of CM units</td>
<td>2</td>
<td>10</td>
<td>3</td>
<td>3</td>
<td>2</td>
<td>4</td>
<td></td>
</tr>
</tbody>
</table>

There is diversity among the counties. Shasta did not routinely utilize case management, relying generally on individual therapy services. Alameda County made a policy decision that CalWORKs clients would have to meet the standards of their “target population” group in order to be eligible for case management services. Kern stands out in the percentage of clients receiving more extended case management services.

We should note that the case management services referred to are not brokerage-type case management but more direct hands-on assistance. The type of case management service that we observed in the site visits is described in Chapter II.

As noted in Chapter II, this kind of case management is not traditionally provided by outpatient AOD programs.

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\(^{32}\) In surveys of roughly 600 CalWORKs participants in AOD, MH, or DV programs conducted for the first *Case Study Report*, just 13.2% of the AOD clients, as opposed to 44.9% of the MH clients, had been referred from the welfare department.

\(^{33}\) A table showing the percentage, with varying numbers of units of CM services, is in Appendix B.
FINDING 7: COUNTIES DIFFER IN THEIR PATTERN OF MH AND AOD SERVICES TO CALWORKS CLIENTS.

The variations among counties in MH services provided (other than case management) reflect the type of program designed in each county.

The table below shows the percentage of clients served who received each particular service. The figure in parentheses is the median number of service contacts for those who received that service.

PERCENTAGE OF MH CLIENTS RECEIVING DIFFERENT KINDS OF SERVICES AND THE MEDIAN NUMBER OF SERVICE CONTACTS FOR THOSE RECEIVING THAT KIND OF SERVICE (FY99-00)

<table>
<thead>
<tr>
<th>% Receiving (Median # contacts)</th>
<th>Alam. N=873</th>
<th>Kern N=1,718</th>
<th>LA WTW N=3,489</th>
<th>LA No WTW N=3,390</th>
<th>Shasta N=53</th>
<th>Stan. N=809</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual Services</td>
<td>99% (3)</td>
<td>82% (4)</td>
<td>57% (2)</td>
<td>34% (2)</td>
<td>74% (3)</td>
<td>73% (1)</td>
</tr>
<tr>
<td>Group Services</td>
<td>2% (3)</td>
<td>32% (4)</td>
<td>2% (3)</td>
<td>4% (3)</td>
<td>20% (2)</td>
<td>26% (5)</td>
</tr>
<tr>
<td>Medications</td>
<td>0</td>
<td>N/A</td>
<td>34% (3)</td>
<td>48% (3)</td>
<td>41% (3)</td>
<td>41% (4)</td>
</tr>
<tr>
<td>Crisis Stabilization</td>
<td>0</td>
<td>N/A</td>
<td>2% (1)</td>
<td>10% (1)</td>
<td>0</td>
<td>25% (1)</td>
</tr>
<tr>
<td>Inpatient</td>
<td>0</td>
<td>N/A</td>
<td>4% (6)</td>
<td>10% (7)</td>
<td>0</td>
<td>15% (3)</td>
</tr>
</tbody>
</table>

The following are some of the patterns in the above data:

➢ At least one-third of the clients in each county, except Alameda, receive medication-monitoring services.

➢ The pattern of services in Alameda County reflects its policy that CalWORKs participants are eligible for only individual and group services unless they are part of the “target population.” This demonstrates how policy decisions can influence the pattern of care clients receive, even where the diagnostic and GAF scores indicate relatively similar populations.

➢ Group services are a clear part of the program for a subset of the MH clients in Kern and Stanislaus and Shasta, but not in Los Angeles or Alameda.
A small but significant minority of the CalWORKs clients have a hospital stay or a crisis stabilization visit. These percentages are higher for the Los Angeles “not WTW” than “WTW” clients. It is likely that this same pattern holds in the other counties for whom we cannot separate the data; i.e., this type of service is probably more likely with clients who have entered the MH system in ways other than through a CalWORKs referral.  

Most AOD clients receive both individual and group services with a significant portion also using residential services.

The table below shows the percentage of each county’s CalWORKs AOD clients who received each kind of service and the median number of units of that service they received.

<table>
<thead>
<tr>
<th>% Receiving (Median # Contacts)</th>
<th>Alam. N=648</th>
<th>Kern N=774</th>
<th>Mont. N=75</th>
<th>Stan. N=477</th>
</tr>
</thead>
<tbody>
<tr>
<td>Methadone Maintenance</td>
<td>34% (240)</td>
<td>13% (47)</td>
<td>4%</td>
<td>8% (203)</td>
</tr>
<tr>
<td>Residential</td>
<td>15% (65)</td>
<td>13% (47)</td>
<td>47%</td>
<td>22% (29)</td>
</tr>
<tr>
<td>Group Services</td>
<td>53% (15)</td>
<td>59% (9)</td>
<td>73%</td>
<td>60% (13)</td>
</tr>
<tr>
<td>Individual Services</td>
<td>36% (2)</td>
<td>71% (5)</td>
<td>79%</td>
<td>87% (2)</td>
</tr>
<tr>
<td>Intensive Outpatient</td>
<td>10% (14)</td>
<td>9% (1)</td>
<td>0</td>
<td>1% (45)</td>
</tr>
</tbody>
</table>

The above data indicate the following patterns of AOD service usage:

- Group services are a more common form of service for AOD clients than MH with both a higher percentage of clients receiving the service and a higher median number of units of service.

- Residential services were used by nearly half of the AOD clients in Monterey, nearly a quarter in Stanislaus, and 13 - 15% in Alameda and Kern counties.

- Methadone maintenance programs were used by about 10% of the clients except for Alameda County, where about one-third were in a methadone maintenance program. These figures generally reflect the percentage of AOD clients in each county that were listed as having heroin as the primary substance.

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34 Additionally, the CalWORKs AOD and MH allocations are not supposed to be used for “medical” services, so that other sources of funds are generally used for inpatient stays.
FINDING 8: CURRENT DATA SYSTEMS FOR AOD, MH AND DV CALWORKS PARTICIPANTS RECEIVING SERVICES ARE LIMITED.

County AOD and MH data systems can provide useful information on ALL CalWORKs clients receiving services.

Obtaining reliable information that is consistent across counties on the number and percentage of CalWORKs participants receiving services is not an easy task. Our analysis used data from the six counties’ AOD and MH management information systems. It included data on ALL CalWORKs clients who received an AOD or MH service during FY 99-00, no matter how they entered services, how their services were paid for, or whether the services were in the Welfare-to-Work Plan.

Some similar data is collected statewide.

Data similar to what is reported here could be available on a statewide basis for the MH system once the new Client Information System is fully implemented.

The AOD statewide system could report on total numbers of CalWORKs clients, but this information is likely to not be accurate or complete since it relies heavily on the reporting of contract agencies. No client-specific service utilization information is yet available on a statewide basis for the AOD system.

Standardized service information for CalWORKs recipients receiving domestic violence services is not available statewide or at a county level.

There are no consistent definitions across counties that allow for meaningful distinctions among the CalWORKs clients as to funding source or connection to the CalWORKs system.

As noted at the beginning of the chapter, there is no consistent definition across the counties for what kind of CalWORKs client or what kind of service will be funded through the AOD or MH allocation as opposed to the regular funding sources. This creates a problem in trying to understand the summary information reported by the counties to the SDSS on the Welfare-to-Work 25 form.
Part III: SUMMARY OF FINDINGS AND MAJOR POLICY AND PRACTICE IMPLICATIONS

FINDING 1: COUNTIES ARE SERVING INCREASING NUMBERS OF CALWORKS CLIENTS WITH AOD AND MH BARRIERS.

The overall percentages served in FY 99-00 in the six case study counties ranged from 4% to 13%; the percentage increased in four of the five counties from the previous fiscal year.

Counties that are following good identification and service delivery practices are able to provide AOD or MH service to 12% to 13% of the CalWORKs population during a fiscal year. While the percentages are smaller in many counties, this level of attainment by some, coupled with the information in the CalWORKs Prevalence Report, indicates that the need is there, and with adequate funding and good programs, this level of service is possible.

POLICY AND PRACTICE IMPLICATIONS:

➢ CalWORKs funding should continue for AOD and MH services for this population, so that all counties can continue to develop their programs and increase the percentages of clients that they identify and serve.

FINDING 2: CERTAIN SEGMENTS OF THE CALWORKS POPULATION WITH AOD AND MH ISSUES ARE UNDERREPRESENTED AMONG THOSE WHO ARE RECEIVING AOD AND MH SERVICES.

Groups so identified include Hispanics, the young (under 25) and older (over 45) in AOD programs, and those with alcohol dependence or abuse problems.

POLICY AND PRACTICE IMPLICATIONS:

➢ Counties should augment their efforts to identify those Hispanic clients that might be in need of AOD or MH services. Additionally, special efforts appear to be called for in terms of reaching the younger and the older age groups.

➢ Counties should make greater efforts to identify and treat alcohol problems. While alcohol problems may not appear to constitute as significant a barrier to employment as do other drug problems, counties should be mindful of the impact that alcohol abuse and dependence and drinking on the job can have on the ability to maintain employment.

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35 We only have FY 99-00 data for Alameda County and so cannot compare with the prior year.
FINDING 3: MOST OF THE MH CLIENTS AND ALL OF THE AOD CLIENTS RECEIVING SERVICES HAVE SIGNIFICANT IMPAIRMENTS.

*Given the level of impairment, the AOD and MH problems CalWORKs clients are being treated for do represent significant barriers to employment if not addressed.*

**POLICY AND PRACTICE IMPLICATIONS:**

- **AOD and MH services will need to be fairly intensive and, in some instances, longer-term than originally estimated.** Accommodations will need to be made in the Welfare-To-Work plans of these individuals to allow for sufficient time — both in terms of hours a week and number of months — to at least stabilize these conditions.

- **Counties should enhance their SSI advocacy programs to ensure that any participant that qualifies for SSI has access to this benefit.** Careful consideration should be given on a case-by-case basis to the relative long-term benefits for the participant and her/his family of staying on CalWORKs, with its wider range of potential supports, as opposed to obtaining the steadier income from SSI.

- **Changes are needed in the exempt status to provide the needed time to address the barriers.** The exemption process should be structured to ensure that clients obtain access to needed AOD and MH services, as well as other services that will assist their movement towards self-sufficiency. This would entail the following changes in the CalWORKs law:

  - Persons who are exempt because of an AOD or MH impairment should have their five-year lifetime clock stopped for the duration of their exemption, so long as they are participating in active treatment for their impairment.

  - Persons who are exempt because of an AOD or MH impairment should be able to volunteer for Welfare-To-Work activities and have a WTW Plan that would allow them access to education, training, and other supportive services while they are exempt, without their time clock ticking.
FINDING 4: A SUBSTANTIAL NUMBER OF CALWORKS CLIENTS RECEIVING SERVICES HAVE BOTH AOD AND MH DIAGNOSES.

Severity and difficulty of treatment are increased if both AOD and MH problems exist. While not measured in this data, we also know from the Prevalence Study that there is great overlap, as well, with DV issues.

POLICY AND PRACTICE IMPLICATIONS:

➤ Both AOD and MH programs serving CalWORKs participants should have the capacity to identify the other problem and to either provide directly, or through referral, services for the other problem. Integrated services that identify and treat both issues concurrently are the preferred approach, but are quite limited in their availability. The same recommendation is made for DV issues and services.

FINDING 5: ENGAGEMENT OF CLIENTS APPEARS TO BE A MAJOR PROBLEM, PARTICULARLY FOR THE MH SYSTEM.

Data from the counties indicate that many clients have very short episodes of care, compared to the severity of their conditions. This conclusion is supported by data in the first report that most clients leave services before treatment staff believe they should. Front line CalWORKs and treatment staff indicated in interviews that the difficulty engaging clients in services is a major obstacle to success.

POLICY AND PRACTICE IMPLICATIONS:

➤ The principles and practices outlined in Chapters I through III are intended to enhance client engagement.

➤ Policymakers and practitioners need to recognize the multiple challenges that CalWORKs clients face—in addition to their AOD, MH, and DV issues—that make it difficult for them to engage in a treatment/service program. Because of the recurring and persistent nature of the issues, some clients will need repeated exposures to treatment/services before they succeed in overcoming these barriers.

FINDING 6: CASE MANAGEMENT IS USED FREQUENTLY WITHIN THE MH SYSTEM.

More than 60% of the clients in four of the counties’ MH programs received CM services. This is not traditionally a service that is available within the AOD system.

POLICY AND PRACTICE IMPLICATIONS:

➤ A “hands-on” case management model is needed to assist clients in obtaining the services and supports they need. Caseloads need to be small enough to allow sufficient time to develop a relationship with the client and to be available to intervene as issues arise.
AOD programs should develop this same type of service with the flexibility of the CalWORKs AOD allocation.

**FINDING 7: COUNTIES DIFFER IN THEIR PATTERN OF MH AND AOD SERVICES TO CALWORKs CLIENTS.**

The differences appear to reflect a) county choices about the design of their service systems and b) the lack of availability of some services in some counties.

**POLICY AND PRACTICE IMPLICATIONS:**

- Counties should review their available services, with attention to filling in gaps in services. CalWORKs AOD and MH funds can assist in the development of new services.

**FINDING 8: CURRENT DATA SYSTEMS FOR AOD, MH AND DV CALWORKs PARTICIPANTS RECEIVING SERVICES ARE LIMITED.**

Statewide data is limited even on the total numbers of CalWORKs clients receiving AOD, MH, or DV services. The lack of consistent definitions across systems and across counties makes it impossible to draw conclusions about the specific use of the AOD and MH allocations, separate from the overall funding of services for all CalWORKs clients.

**POLICY AND PRACTICE IMPLICATIONS:**

- Counties should clearly define whom they consider a Welfare-To-Work client for the purposes of the multiple reporting systems. Creating a single standard that applies to the multiple reporting systems allows for a clearer picture of the service system. The following major reporting systems should have the same definition within any one county:
  - Who is counted as receiving an AOD or MH service on the monthly Welfare-to-Work 25 reporting to the SDSS;
  - Who is counted as Welfare-to-Work on the CADDS reporting system to the state ADP and on the CIS reporting system to the state DMH; and,
  - Who is counted in the invoicing from the county departments of AOD and MH to the county CalWORKs program for the purposes of the use of the CalWORKs AOD and MH allocations.

- Ideally, the State Department of Mental Health, the State Department of Alcohol and Drug Programs and the State Department of Social Services would create a uniform definition that each department would then use in its data reporting relationships to the counties.
## APPENDIX A: Changes in the Six Counties

<table>
<thead>
<tr>
<th>County</th>
<th>Changes</th>
</tr>
</thead>
</table>
| **Alameda** | - Outreach workers continue to see clients until they have completed two visits to the provider to whom they have been referred  
- BH clinical social worker co-located at three Self-Sufficiency Centers  
- BH support groups located at education sites  
- SSA has contracts for outreach to specific sanctioned families  
- Trying vocational program for SPMI with CalWORKs BH clients  
- New DOL WTW contract with New Bridge for clients with AOD issues  
- Survey of childcare providers to find out what MH services might be useful  
- Hiring of five county DV resource specialists |
| **Kern** | - Specialized employment coordinators for AOD/MH/DV clients  
- More structured DV system – two new DHS DV liaison positions and a contract with DV agency  
- Weekly orientation to BH services while waiting for initial assessment appointment  
- BH doing brief assessments on all participants approaching 18 to 24 month time limit  
- Restructuring of entire intake process to include more focus on identifying barriers; includes a home visit  
- Formal AOD screening added to new intake process  
- Use of Incentive Funds to fund 20 programs for children and families — first time DHS has funded this type of activity  
- KITE program provides integrated services for CalWORKs Family Maintenance cases; automatic referral to BHS |
| **Los Angeles** | - Implementation of Community Assessment and Service Centers (CASCs) in each SPA that do assessments for AOD and MH  
- Pilot project in two DPSS offices that has AOD/MH program doing prescreening for AOD/MH/DV of all new participants prior to eligibility  
- Pilot project that has home visiting on all new applicants to verify eligibility and inform about supportive services  
- Inclusion of AOD/MH/DV presentations in eligibility orientations, including versions in Asian languages  
- Working on policy directive that says that disclosure of AOD not sufficient, in itself, for referral to CPS  
- Specialized GAIN workers for AOD/MH/DV cases  
- Incentive Funds used for large Long-Term Family Self-Sufficiency Project that will fund 46 programs  
- Major effort in MH system to integrate child and adult services  
- MH trying to integrate more vocational services into their programs  
- Some co-location now required in contracts with DV providers |
### APPENDIX A: Changes in the Six Counties

<table>
<thead>
<tr>
<th>Monterey</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Reorganization of Job Search to have two days a week of group education and support sessions</td>
<td></td>
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<tr>
<td>All of BH reorganized into a central intake process</td>
<td></td>
</tr>
<tr>
<td>Attempt to have all CalWORKs clients receiving BH services utilize the specific CalWORKs EAP services</td>
<td></td>
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<tr>
<td>Child/Family Services training EAP staff about child and family issues</td>
<td></td>
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<tr>
<td>Shifted to a shorter MH assessment form</td>
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</tr>
<tr>
<td>EAP maintaining weekly contact with clients for four weeks after contact with a network provider</td>
<td></td>
</tr>
<tr>
<td>Starting a Disability Assessment Unit that will review CA 61s</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Shasta</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Added a staff person from the DV program to the Behavioral Health Team</td>
<td></td>
</tr>
<tr>
<td>Expanded BH services for CalWORKs participants to other parts of the county besides Redding</td>
<td></td>
</tr>
<tr>
<td>Hired an SSI advocate to work with CalWORKs clients who might qualify for SSI</td>
<td></td>
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<tr>
<td>BHT developing closer relationships with a range of programs serving CalWORKs families</td>
<td></td>
</tr>
<tr>
<td>Reorganization of AOD day treatment program</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Stanislaus</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Building Successful Tomorrows — a program through CSA with AOD staff that engages families who have been sanctioned</td>
<td></td>
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<tr>
<td>BHS provides van and drivers for transportation to services</td>
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<tr>
<td>Provision of programs for children while parents in treatment</td>
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<tr>
<td>Development of a curriculum for AOD and DV focused on trauma recovery</td>
<td></td>
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<tr>
<td>Expansion of BHS services for general CalWORKs population</td>
<td></td>
</tr>
<tr>
<td>Maturation of BHS AOD day treatment program</td>
<td></td>
</tr>
<tr>
<td>Addition of BHS presentation during StanWORKs Orientation</td>
<td></td>
</tr>
<tr>
<td>Increased coordination between BHS DV specialist and DA Family Support Unit</td>
<td></td>
</tr>
<tr>
<td>Moving towards specialized StanWORKs staff for clients in AOD/MH/DV programs</td>
<td></td>
</tr>
<tr>
<td>County combining planning and funds from CalWORKS Incentive Funds, Tobacco Tax, and Proposition 10</td>
<td></td>
</tr>
<tr>
<td>Direct referrals from Department of Employment and Training to BHS, rather than having to go through employment coordinator</td>
<td></td>
</tr>
<tr>
<td>Three levels of case management by BHS team</td>
<td></td>
</tr>
</tbody>
</table>
APPENDIX B: County AOD and MH MIS Data

This Appendix provides additional background information and complete tables for the information in Chapter VI: Who Is Being Served and What Services Are They Receiving? The first part describes in greater detail the characteristics of the data systems and the information provided. The second part contains the more detailed tables.

Part I: CONSIDERATIONS REGARDING THE MIS DATA ON CALWORKS AOD AND MH CLIENTS

The AOD and MH allocations were designed to fund new and/or more services.

As originally conceived, the CalWORKs AOD and MH allocations would fund services for CalWORKs participants whose AOD and MH problems were barriers to employment. There was an expectation that the funds would provide services to clients over and above what was being provided prior to CalWORKs — either in terms of additional clients and/or additional services.

The MH allocation supports more aggressive outreach and, potentially, new services.

All CalWORKs participants are eligible for Medi-Cal services. Medi-Cal recipients are eligible for a wide range of mental health services so long as they are determined to be “medically necessary.” These include outpatient individual and group services, medication monitoring, case management, emergency and inpatient services.

So what is new and different about the services funded through the MH allocation? It can fund more aggressive identification efforts, i.e., it can provide line item support for staff whose function is to identify and assess CalWORKs participants for MH problems. And it can fund services for conditions that might not be considered medically necessary under strict Medi-Cal definitions, e.g., family problems which might not meet the diagnostic requirements but which are impediments to employment.

The AOD allocation supports identification efforts and increases the capacity of the AOD system.

The state’s Medi-Cal AOD benefits are quite limited; they include certain detoxification services, methadone maintenance, and selected outpatient services. They do not include the residential or intensive day services needed by many CalWORKs participants nor any case management. Thus, most of the AOD services that are relevant for the CalWORKs population are supported by AOD block grant funds.
The distinctions between services funded by the CalWORKs allocation and other sources are not always clear.

The initial purpose of the allocations was to accommodate an expected large increase in the numbers of clients who would be identified as needing AOD and MH services. Some counties expected an increase in the kinds of services they were already providing, while others thought there might be a difference in the kinds of clients and therefore the kinds of services that would be needed.

In reality it has been a bit of both.

- There are a large number of CalWORKs participants who receive services through “regular” channels; that is, they are not referred through the CalWORKs process, they are not funded through the AOD or MH allocation, nor are their AOD and MH services part of their WTW Plan.

- There are many CalWORKs participants who are identified through the CalWORKs process, but who receive services through the “regular” system of care; that is, the services they receive may be funded through the AOD or MH allocation, but are provided by programs that serve other public clients.

- There are some CalWORKs participants who receive special services designed specifically for CalWORKs participants no matter how they are identified; that is, the CalWORKs allocation funds special programs designed for these clients whether identified through the CalWORKs process or otherwise.

Each county has developed its own means of identifying clients and/or services that would be funded through the special AOD and MH allocations

The original budget language required that CalWORKs clients be identified, assessed and served, but left the details of the billing arrangements to each county. Counties have developed Memorandums of Understanding between their AOD/MH departments and the CalWORKs program that describe what qualifies as a billable activity under the allocations. The State Department of Social Services (SDSS) did not establish a single standard. In fact, the SDSS took the position that the counties should be innovative and flexible in the use of the money in order to enhance the identification and service efforts.

The first Six-County Case Study Report distinguished between “direct” and “indirect” clients

In the first Six County Case Study Report, we distinguished between direct and indirect TANF clients. The former were linked to CalWORKs either because they had been referred by CalWORKs staff, and/or had the services in their Welfare-to-Work Plans, and/or were funded out of the CalWORKs AOD and MH allocation. An important finding in that report was that in each county the number of indirect clients was larger than the number of direct clients. That finding led to two important recommendations:
- **Procedures are needed to facilitate back-door referrals.** AOD and MH programs need to inquire more consistently about the CalWORKs status of their clients in order to educate them about the potential benefits and any costs of having their services included in their Welfare-To-Work Plans. Additionally, procedures are needed to ensure that providers can easily make connections to the CalWORKs program for any such clients.

- **Identification needs to occur outside the CalWORKs offices.** Since most of the clients were coming from sources other than the official CalWORKs system, efforts should be made to enhance these other referral sources. In some counties, this is done through direct outreach to clients and in others through outreach workers who make contacts with other agencies and organizations where CalWORKs participants are found.

**The differences among the counties in policy and practice have made the distinction between direct and indirect less clear.**

The distinction between direct and indirect is done differently by each county so that there can be no consistent interpretation of the relative percentages of direct to indirect clients across the counties. Because of the lack of a consistent definition, we decided for this report to collect data only on the total number of clients, i.e., all those with an aid code that indicates they are receiving TANF cash assistance.\(^1\) The data in Chapter VI: Who Is Being Served and What Services Are They Receiving and in this Appendix thus reflect more service than what is provided only through the AOD and MH allocations.

**The descriptive information thus represents all CalWORKs participants who receive AOD or MH services.**

The information describes the number of CalWORKs clients who received an AOD or MH service during FY 99-00, no matter how they were identified or how they entered services. Thus, there is an inevitable mix of participants. The data should not, therefore, be interpreted as reflective of services created specifically for CalWORKs clients from the AOD and MH allocations with the purpose of overcoming barriers to employment.

**The Los Angeles MH data is different on two counts:**

- The first unique feature about Los Angeles is that their system of care includes a large network of Medi-Cal fee-for-service private providers whose data is not included.

- The second fact is that the Los Angeles MH Department has been consistent in its interpretation of direct and indirect clients for those clients seen by county providers and organizational providers under contract with the Department of Mental Health. To qualify as the former, the client must have the MH services included in the WTW Plan.

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\(^1\) The data includes participants with aid codes of 30 and 35 (family group and two parent family) which represent the vast majority of TANF adults on Medi-Cal. There are a number of other small categories of TANF eligibility, which we did not include.
Because of this consistency, we have separated their data on occasion. Those clients who have their services included in their Welfare-to-Work Plan are labeled “MH-WTW” and those that do not are labeled “MH-Not WTW.”

**The AOD data is likely to be understated.**

The data was collected for all clients in the counties’ MIS, based on their Medi-Cal eligibility code number. Mental health providers have a greater incentive to include this information than do AOD providers. As noted above, most MH services are reimbursed by Medi-Cal, so that providers are in the habit of billing Medi-Cal and, therefore, have the procedures in place to establish the Medi-Cal status of their clients.

Since most AOD services are not reimbursed by Medi-Cal, many of the AOD providers do not routinely query their clients about their Medi-Cal status. While they are supposed to indicate which clients are on CalWORKs, they have little incentive for doing so since their reimbursement does not vary whether or not the person is a CalWORKs client.

**The numbers reported by the counties to the SDSS show lower levels of service receipt than what we report.**

The SDSS reports on the percentage of Welfare-To-Work enrollees who are reported by the counties to be receiving an AOD, MH, or DV service during a particular month. These figures tend to be significantly lower than what is reported below. We are reluctant to use these SDSS figures as accurate measures of the percentage of CalWORKs participants receiving services.

The state has not provided a clear definition of who is to be counted as receiving services so that the definitions vary across the counties. Some count only those that they have referred for services; some count anyone who has a service as part of the WTW Plan, whether or not the service was actually received.

**The number of services per client episode is understated in this data.**

The data covers services provided during a single full fiscal year, from July 1, 1999 to June 30, 2000. It therefore represents the number of services that a particular client received during that fiscal year only. For a client whose service episode went across fiscal years, we will have captured only those services included that occurred during this one fiscal year. So, for example, the amount of service recorded for a client who received services in the prior fiscal year as well as FY 99-00 would be undercounted, as would the number of services received by a client who had not yet been discharged during FY 99-00.

What the data represents is a picture of the services provided by a county during a single fiscal year. Because the episodes of care are so short for most clients, we do not believe that this way of presenting the data is misleading, so long as the reader keeps the methodology in mind.
Part II. DETAILED TABLES AND GRAPHS

COMPARISON OF AOD VERSUS MH CLIENTS SERVED DURING FY 99-00

AOD AND MH CALWORKS CLIENTS (FY 99-00) AS A PERCENTAGE OF ALL CALWORKS PARTICIPANTS IN THE COUNTY

<table>
<thead>
<tr>
<th></th>
<th>Alameda</th>
<th>Kern</th>
<th>LA</th>
<th>Monterey</th>
<th>Shasta</th>
<th>Stanislaus</th>
</tr>
</thead>
<tbody>
<tr>
<td>AOD % of Total TANF</td>
<td>2.8%</td>
<td>3.8%</td>
<td>0.7%</td>
<td>NA</td>
<td>5.1%</td>
<td>4.8%</td>
</tr>
<tr>
<td>MH % of Total TANF</td>
<td>3.8%</td>
<td>8.5%</td>
<td>3.2%</td>
<td>NA</td>
<td>3.4%</td>
<td>8.1%</td>
</tr>
<tr>
<td>Total Client % of Total TANF</td>
<td>6.6%</td>
<td>12.3%</td>
<td>3.9%</td>
<td>12.0%</td>
<td>8.4%</td>
<td>12.9%</td>
</tr>
</tbody>
</table>
### PERCENTAGE OF CALWORKS PARTICIPANTS RECEIVING AN AOD OR MH SERVICE DURING FY 97-98, 98-99, 99-00

<table>
<thead>
<tr>
<th>County</th>
<th>FY 97-98</th>
<th>FY 98-99</th>
<th>FY 99-00</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alameda</td>
<td>6.6%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kern</td>
<td>10.0%</td>
<td>12.3%</td>
<td></td>
</tr>
<tr>
<td>Los Angeles</td>
<td>1.7%</td>
<td>4.6%</td>
<td>3.9%</td>
</tr>
<tr>
<td>Monterey</td>
<td>2.5%</td>
<td>8.5%</td>
<td>12.0%</td>
</tr>
<tr>
<td>Shasta</td>
<td></td>
<td>8.2%</td>
<td>8.4%</td>
</tr>
<tr>
<td>Stanislaus</td>
<td>5.4%</td>
<td>9.8%</td>
<td>12.9%</td>
</tr>
</tbody>
</table>

### PERCENT FEMALE, BY AOD OR MH (75% IS CALIFORNIA MEAN)

- **Alameda**: 85% AOD, 85% Mental Health
- **Kern**: 74% AOD, 84% Mental Health
- **Los Angeles**: 73% AOD, 84% Mental Health
- **Monterey**: 50% AOD, 72% Mental Health
- **Shasta**: 76% AOD, 85% Mental Health
- **Stanislaus**: 85% AOD, 85% Mental Health
### RACE/ETHNICITY OF CALWORKS CLIENTS RECEIVING AOD OR MH SERVICES (FY99-00)

<table>
<thead>
<tr>
<th></th>
<th>White</th>
<th>African American</th>
<th>Mexican, Latin American, Hispanic</th>
<th>Asian, Pacific Islander</th>
<th>Other/Unknown</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alameda TANF</td>
<td>18%</td>
<td>39%</td>
<td>21%</td>
<td>18%</td>
<td>3%</td>
</tr>
<tr>
<td>Alameda MH</td>
<td>18%</td>
<td>33%</td>
<td>9%</td>
<td>14%</td>
<td>25%</td>
</tr>
<tr>
<td>Alameda AOD</td>
<td>27%</td>
<td>51%</td>
<td>14%</td>
<td>2%</td>
<td>7%</td>
</tr>
<tr>
<td>Kern TANF</td>
<td>39%</td>
<td>16%</td>
<td>43%</td>
<td>1%</td>
<td>1%</td>
</tr>
<tr>
<td>Kern MH</td>
<td>58%</td>
<td>12%</td>
<td>27%</td>
<td>1%</td>
<td>2%</td>
</tr>
<tr>
<td>Kern AOD</td>
<td>56%</td>
<td>6%</td>
<td>30%</td>
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<td>2%</td>
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<tr>
<td>LA TANF</td>
<td>12%</td>
<td>29%</td>
<td>52%</td>
<td>5%</td>
<td>1%</td>
</tr>
<tr>
<td>LA MH WTW</td>
<td>20%</td>
<td>22%</td>
<td>36%</td>
<td>8%</td>
<td>14%</td>
</tr>
<tr>
<td>LA MH Not WTW</td>
<td>20%</td>
<td>33%</td>
<td>30%</td>
<td>5%</td>
<td>12%</td>
</tr>
<tr>
<td>LA AOD</td>
<td>31%</td>
<td>36%</td>
<td>28%</td>
<td>2%</td>
<td>3%</td>
</tr>
<tr>
<td>Monterey TANF</td>
<td>22%</td>
<td>9%</td>
<td>65%</td>
<td>3%</td>
<td>2%</td>
</tr>
<tr>
<td>Monterey MH</td>
<td>36%</td>
<td>9%</td>
<td>45%</td>
<td>5%</td>
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</tr>
<tr>
<td>Monterey AOD</td>
<td>45%</td>
<td>20%</td>
<td>21%</td>
<td>3%</td>
<td>11%</td>
</tr>
<tr>
<td>Shasta TANF</td>
<td>85%</td>
<td>2%</td>
<td>4%</td>
<td>5%</td>
<td>4%</td>
</tr>
<tr>
<td>Shasta MH</td>
<td>81%</td>
<td>2%</td>
<td>4%</td>
<td>4%</td>
<td>9%</td>
</tr>
<tr>
<td>Shasta AOD</td>
<td>79%</td>
<td>3%</td>
<td>9%</td>
<td>1%</td>
<td>7%</td>
</tr>
<tr>
<td>Stanislaus TANF</td>
<td>49%</td>
<td>7%</td>
<td>34%</td>
<td>9%</td>
<td>1%</td>
</tr>
<tr>
<td>Stanislaus MH</td>
<td>55%</td>
<td>7%</td>
<td>26%</td>
<td>6%</td>
<td>6%</td>
</tr>
<tr>
<td>Stanislaus AOD</td>
<td>64%</td>
<td>8%</td>
<td>25%</td>
<td>1%</td>
<td>3%</td>
</tr>
</tbody>
</table>

### AGE DISTRIBUTION BY PROGRAM (FY99-00)

<table>
<thead>
<tr>
<th></th>
<th>&lt;25</th>
<th>26-35</th>
<th>36-45</th>
<th>&gt;45</th>
<th>Median</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alameda MH</td>
<td>15%</td>
<td>33%</td>
<td>33%</td>
<td>19%</td>
<td>37</td>
</tr>
<tr>
<td>Alameda AOD</td>
<td>9%</td>
<td>43%</td>
<td>38%</td>
<td>10%</td>
<td>36</td>
</tr>
<tr>
<td>Kern MH</td>
<td>19%</td>
<td>41%</td>
<td>32%</td>
<td>7%</td>
<td>33</td>
</tr>
<tr>
<td>Kern AOD</td>
<td>18%</td>
<td>43%</td>
<td>35%</td>
<td>4%</td>
<td>33</td>
</tr>
<tr>
<td>LA MH WTW</td>
<td>10%</td>
<td>29%</td>
<td>37%</td>
<td>24%</td>
<td>38</td>
</tr>
<tr>
<td>LA MH Not WTW</td>
<td>18%</td>
<td>32%</td>
<td>34%</td>
<td>16%</td>
<td>35</td>
</tr>
<tr>
<td>LA AOD</td>
<td>16%</td>
<td></td>
<td></td>
<td></td>
<td>34</td>
</tr>
<tr>
<td>Monterey MH</td>
<td>19%</td>
<td>33%</td>
<td>35%</td>
<td>13%</td>
<td></td>
</tr>
<tr>
<td>Monterey AOD</td>
<td>15%</td>
<td>51%</td>
<td>28%</td>
<td>7%</td>
<td></td>
</tr>
<tr>
<td>Shasta MH</td>
<td>13%</td>
<td>36%</td>
<td>38%</td>
<td>13%</td>
<td>36</td>
</tr>
<tr>
<td>Shasta AOD</td>
<td>32%</td>
<td>34%</td>
<td>26%</td>
<td>8%</td>
<td></td>
</tr>
<tr>
<td>Stanislaus MH</td>
<td>19%</td>
<td>36%</td>
<td>33%</td>
<td>11%</td>
<td>34</td>
</tr>
<tr>
<td>Stanislaus AOD</td>
<td>19%</td>
<td>45%</td>
<td>32%</td>
<td>4%</td>
<td>33</td>
</tr>
</tbody>
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### HIGHEST GRADE LEVEL COMPLETED BY CALWORKS CLIENTS RECEIVING AOD AND MH SERVICES (FY99-00)

<table>
<thead>
<tr>
<th></th>
<th>&lt;9 Years</th>
<th>9-11 Years</th>
<th>12 Years</th>
<th>&gt;12 Years</th>
<th>Median</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alameda MH</td>
<td>18%</td>
<td>28%</td>
<td>31%</td>
<td>23%</td>
<td></td>
</tr>
<tr>
<td>Alameda AOD</td>
<td>3%</td>
<td>37%</td>
<td>43%</td>
<td>16%</td>
<td></td>
</tr>
<tr>
<td>Kern MH</td>
<td>10%</td>
<td>36%</td>
<td>38%</td>
<td>17%</td>
<td>12</td>
</tr>
<tr>
<td>Kern AOD</td>
<td>14%</td>
<td>43%</td>
<td>33%</td>
<td>10%</td>
<td>11</td>
</tr>
<tr>
<td>LA MH WTW</td>
<td>20%</td>
<td>31%</td>
<td>32%</td>
<td>17%</td>
<td>11</td>
</tr>
<tr>
<td>LA MH Not WTW</td>
<td>16%</td>
<td>32%</td>
<td>34%</td>
<td>18%</td>
<td>12</td>
</tr>
<tr>
<td>LA AOD</td>
<td>8%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Monterey MH</td>
<td>19%</td>
<td>34%</td>
<td>27%</td>
<td>19%</td>
<td></td>
</tr>
<tr>
<td>Monterey AOD</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shasta MH</td>
<td>12%</td>
<td>26%</td>
<td>38%</td>
<td>26%</td>
<td>12</td>
</tr>
<tr>
<td>Shasta AOD</td>
<td>5%</td>
<td>33%</td>
<td>44%</td>
<td>17%</td>
<td></td>
</tr>
<tr>
<td>Stanislaus MH</td>
<td>21%</td>
<td>33%</td>
<td>35%</td>
<td>10%</td>
<td>11</td>
</tr>
<tr>
<td>Stanislaus AOD</td>
<td>9%</td>
<td>45%</td>
<td>35%</td>
<td>10%</td>
<td>11</td>
</tr>
</tbody>
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### MH DIAGNOSES OF CALWORKS PARTICIPANTS RECEIVING MH SERVICES (FY99-00)

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Alam. N=873</th>
<th>Kern N=1,716</th>
<th>LA WTW N=3,489</th>
<th>LA No WTW N=3,390</th>
<th>Shasta N=53</th>
<th>Stan. N=809</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adjustment disorders</td>
<td>8%</td>
<td>12.5%</td>
<td>8.5%</td>
<td>8%</td>
<td>13%</td>
<td>17%</td>
</tr>
<tr>
<td>Anxiety, phobias, panic disorder</td>
<td>4%</td>
<td>15%</td>
<td>10%</td>
<td>8%</td>
<td>13%</td>
<td>9%</td>
</tr>
<tr>
<td>PTSD</td>
<td>8%</td>
<td>6%</td>
<td>6%</td>
<td>2%</td>
<td>2%</td>
<td>7%</td>
</tr>
<tr>
<td>Major depression</td>
<td>26%</td>
<td>30%</td>
<td>42%</td>
<td>41%</td>
<td>36%</td>
<td>29%</td>
</tr>
<tr>
<td>Bipolar</td>
<td>5%</td>
<td>5%</td>
<td>4.5%</td>
<td>8%</td>
<td>11%</td>
<td>5%</td>
</tr>
<tr>
<td>Other mood disorders(^3)</td>
<td>20%</td>
<td>2%</td>
<td>17%</td>
<td>14%</td>
<td>13%</td>
<td>19%</td>
</tr>
<tr>
<td>Psychosis</td>
<td>7%</td>
<td>2%</td>
<td>7%</td>
<td>11%</td>
<td>9%</td>
<td>4%</td>
</tr>
<tr>
<td>V Codes</td>
<td>1%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>3%</td>
</tr>
<tr>
<td>Other, unknown, deferred</td>
<td>21%</td>
<td>27%</td>
<td>5%</td>
<td>6%</td>
<td>2%</td>
<td>8%</td>
</tr>
</tbody>
</table>

\(^2\) Seventy-two percent of the Alameda MH clients had an “unknown” education level so no median is reported and the percentages should be viewed cautiously.

\(^3\) The major diagnoses in this category were dysthymia and depressive disorders not otherwise specified.
### GAF Scores of CalWORKS Clients Receiving MH Services (FY99-00)

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 41: Unable to function in several areas</td>
<td>72%</td>
<td>44%</td>
<td>35%</td>
<td>47%</td>
<td>8%</td>
<td>15%</td>
<td>21%</td>
</tr>
<tr>
<td>41-50: Serious impairment in job or social areas</td>
<td>11%</td>
<td>35%</td>
<td>37%</td>
<td>35%</td>
<td>39%</td>
<td>60%</td>
<td>35%</td>
</tr>
<tr>
<td>51-60: Moderate difficulty in job or social areas</td>
<td>12%</td>
<td>16%</td>
<td>18%</td>
<td>10%</td>
<td>34%</td>
<td>25%</td>
<td>30%</td>
</tr>
<tr>
<td>&gt; 60 Mild problems, if any</td>
<td>5%</td>
<td>5%</td>
<td>10%</td>
<td>8%</td>
<td>18%</td>
<td>0</td>
<td>14%</td>
</tr>
</tbody>
</table>

### Diagnosis of CalWORKS Clients Receiving AOD Services (FY99-00)

<table>
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<tr>
<th></th>
<th></th>
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<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol dependence</td>
<td>4%</td>
<td>9%</td>
<td>11%</td>
<td>32%</td>
<td>12%</td>
</tr>
<tr>
<td>Drug dependence</td>
<td>61%</td>
<td>60%</td>
<td>45%</td>
<td>65%</td>
<td></td>
</tr>
<tr>
<td>Alcohol abuse</td>
<td>4%</td>
<td>6%</td>
<td>4%</td>
<td></td>
<td>4%</td>
</tr>
<tr>
<td>Drug abuse</td>
<td>27%</td>
<td>25%</td>
<td>33%</td>
<td>14%</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>4%</td>
<td>1%</td>
<td>1%</td>
<td></td>
<td>4%</td>
</tr>
</tbody>
</table>

### Primary Substance Used by CalWORKS Clients Receiving AOD Services (FY99-00)

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Cocaine</td>
<td>28%</td>
<td>7%</td>
<td>28%</td>
<td>33%</td>
<td>2%</td>
<td>4%</td>
</tr>
<tr>
<td>Alcohol</td>
<td>10%</td>
<td>14%</td>
<td>25%</td>
<td>16%</td>
<td>32%</td>
<td>17%</td>
</tr>
<tr>
<td>Methamphetamines</td>
<td>14%</td>
<td>43%</td>
<td>18%</td>
<td>27%</td>
<td>41%</td>
<td>40%</td>
</tr>
<tr>
<td>Heroin</td>
<td>35%</td>
<td>22%</td>
<td>18%</td>
<td>7%</td>
<td>4%</td>
<td>15%</td>
</tr>
<tr>
<td>Marijuana</td>
<td>7%</td>
<td>8%</td>
<td>8%</td>
<td>8%</td>
<td>20%</td>
<td>7%</td>
</tr>
<tr>
<td>PCP</td>
<td>4%</td>
<td>5%</td>
<td>1%</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Other opiate</td>
<td>1%</td>
<td>1%</td>
<td>1%</td>
<td>0</td>
<td>1%</td>
<td>1%</td>
</tr>
<tr>
<td>Other drug</td>
<td>1%</td>
<td>2%</td>
<td>2%</td>
<td>9%</td>
<td>0</td>
<td>1%</td>
</tr>
</tbody>
</table>
### PERCENTAGE OF MH CLIENTS WITH A SECONDARY AOD DIAGNOSIS (FY99-00)

<table>
<thead>
<tr>
<th>County</th>
<th>% of MH Clients with a Secondary AOD Diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alameda</td>
<td>5%</td>
</tr>
<tr>
<td>Kern</td>
<td>10.5%</td>
</tr>
<tr>
<td>LA W tW</td>
<td>6%</td>
</tr>
<tr>
<td>LA Not W tW</td>
<td>1%</td>
</tr>
<tr>
<td>Shasta</td>
<td>17%</td>
</tr>
<tr>
<td>Stanislaus</td>
<td>11%</td>
</tr>
</tbody>
</table>

### NUMBER OF MH SERVICE CONTACTS PER CALWORKS CLIENT RECEIVING MH SERVICES (FY99-00)

<table>
<thead>
<tr>
<th>Number of Contacts</th>
<th>Alam. (N=873)</th>
<th>Kern (N=1,718)</th>
<th>LA WTW (N=3,489)</th>
<th>LA Not WTW (N=3,390)</th>
<th>Mont. (N=509)</th>
<th>Shasta Direct (N=53)</th>
<th>Stan. (N=809)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>30%</td>
<td>9%</td>
<td>43%</td>
<td>51%</td>
<td>23%</td>
<td>9%</td>
<td>19%</td>
</tr>
<tr>
<td>2-4</td>
<td>30%</td>
<td>14%</td>
<td>34%</td>
<td>26%</td>
<td>26%</td>
<td>26%</td>
<td>18%</td>
</tr>
<tr>
<td>5-8</td>
<td>14%</td>
<td>14%</td>
<td>13%</td>
<td>14%</td>
<td>18%</td>
<td>41%</td>
<td>15%</td>
</tr>
<tr>
<td>9-24</td>
<td>19%</td>
<td>28%</td>
<td>9%</td>
<td>8%</td>
<td>24%</td>
<td>20%</td>
<td>28%</td>
</tr>
<tr>
<td>25-60</td>
<td>7%</td>
<td>23%</td>
<td>1%</td>
<td>1%</td>
<td>6%</td>
<td>2%</td>
<td>15%</td>
</tr>
<tr>
<td>&gt;60</td>
<td>0</td>
<td>12%</td>
<td>0</td>
<td>0</td>
<td>5%</td>
<td>2%</td>
<td>4%</td>
</tr>
<tr>
<td>Mean</td>
<td>7</td>
<td>27</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>2%</td>
<td>16</td>
</tr>
<tr>
<td>Median</td>
<td>10</td>
<td>14</td>
<td>2</td>
<td>2</td>
<td>6</td>
<td>8</td>
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### NUMBER OF AOD SERVICE CONTACTS PER CALWORKS CLIENTS RECEIVING AOD SERVICES (FY99-00)

<table>
<thead>
<tr>
<th>Number of Contacts</th>
<th>Alam. (N=648)</th>
<th>Kern (N=620)</th>
<th>Mont. (N=75)</th>
<th>Stan. (N=477)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>1%</td>
<td>6%</td>
<td>5%</td>
<td>12%</td>
</tr>
<tr>
<td>2-4</td>
<td>12%</td>
<td>10%</td>
<td>1%</td>
<td>14%</td>
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<tr>
<td>5-8</td>
<td>5%</td>
<td>11%</td>
<td>12%</td>
<td>9%</td>
</tr>
<tr>
<td>9-24</td>
<td>16%</td>
<td>32%</td>
<td>16%</td>
<td>21%</td>
</tr>
<tr>
<td>25-60</td>
<td>20%</td>
<td>26%</td>
<td>21%</td>
<td>25%</td>
</tr>
<tr>
<td>&gt;60</td>
<td>44%</td>
<td>15%</td>
<td>46%</td>
<td>20%</td>
</tr>
<tr>
<td>Mean</td>
<td>111</td>
<td>31</td>
<td>44</td>
<td></td>
</tr>
<tr>
<td>Median</td>
<td>47</td>
<td>19</td>
<td>19</td>
<td></td>
</tr>
</tbody>
</table>
PERCENTAGE OF MH CLIENTS RECEIVING CASE MANAGEMENT SERVICES AND THE NUMBER OF CASE MANAGEMENT SERVICES FOR THOSE WHO RECEIVED ANY (FY99-00)

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>% with any CM</td>
<td>3%</td>
<td>86%</td>
<td>65%</td>
<td>71%</td>
<td>41%</td>
<td>17%</td>
<td>63%</td>
</tr>
<tr>
<td>1-4 CM units</td>
<td>75%</td>
<td>29%</td>
<td>75%</td>
<td>63%</td>
<td>70%</td>
<td>78%</td>
<td>53%</td>
</tr>
<tr>
<td>5-8 CM units</td>
<td>25%</td>
<td>17%</td>
<td>13%</td>
<td>15%</td>
<td>10%</td>
<td>11%</td>
<td>21%</td>
</tr>
<tr>
<td>9-24 CM units</td>
<td>0%</td>
<td>31%</td>
<td>10%</td>
<td>14%</td>
<td>12%</td>
<td>11%</td>
<td>19%</td>
</tr>
<tr>
<td>&gt;25 CM units</td>
<td>0%</td>
<td>24%</td>
<td>1%</td>
<td>7%</td>
<td>8%</td>
<td>0%</td>
<td>7%</td>
</tr>
<tr>
<td>Mean # of CM units</td>
<td>2.5</td>
<td>18</td>
<td>5</td>
<td>7</td>
<td>4</td>
<td>8</td>
<td></td>
</tr>
<tr>
<td>Median # of CM units</td>
<td>2</td>
<td>10</td>
<td>3</td>
<td>3</td>
<td>2</td>
<td>4</td>
<td></td>
</tr>
</tbody>
</table>