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Work First New Jersey
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Work First New Jersey Evaluation

Addressing Barriers to Employment: Detecting and Treating Health and Behavioral Problems Among New Jersey's TANF Clients

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EXECUTIVE SUMMARY

While substantial progress has been made in reducing families' dependence on cash welfare, important challenges remain. A majority of those on TANF when Work First New Jersey (WFNJ) was introduced have left welfare, and most of those leaving the rolls have secured jobs. Some TANF recipients, however, have had difficulty finding and keeping jobs, and leaving welfare. Evidence indicates that these individuals experience a variety of personal problems. This report examines New Jersey's state-sponsored efforts to identify and provide services to clients with health and behavioral problems. It focuses on how counties identify those with potential problems, provide treatment and support services, and help them make the transition to work.

SUMMARY OF FINDINGS

While staff appear to be identifying a large fraction of TANF recipients with health and behavioral problems, staff refer only a modest fraction to relevant services. Previous WFNJ evaluation reports indicate that a substantial and growing fraction of New Jersey's shrinking caseload have health and behavioral problems that can impede their ability to secure jobs. County welfare staff are using enhanced screening and assessment methods to identify physical health, mental health, and domestic abuse problems. However, screening appears to be less successful in identifying learning disabilities and drug and alcohol problems. While efforts to detect serious personal problems have met with some success, still only a modest fraction of those identified as having problems are referred to, or participate in, services offered through WFNJ.

Efforts to detect and assess personal employment barriers could be improved by clarifying screening procedures, providing more training and support for case managers, and facilitating communications among agencies that have contacts with TANF clients. While most counties appear to have implemented the screening and assessment procedures developed by the state, some frontline staff are confused about the purpose and use of the new screening tools. State and county officials could improve case managers' capacity to detect client problems by offering more training, limiting their caseloads, and providing offices that afford greater privacy. Enhancing communications among training vendors, service providers, and welfare staff could also help case managers identify clients who have health and behavioral problems.

New Jersey may be able to help more clients use available treatment by filling gaps in services, helping clients follow through with treatment, and modifying work activities to better reflect treatment demands. Counties have experienced shortages of certain mental health and substance abuse services needed by TANF clients, as well as services for those with multiple barriers. Welfare officials may be able to help fill these gaps by providing additional treatment and support resources, and educating providers about the circumstances and needs of TANF clients. County staff could encourage more clients to follow through with treatment by informing them about services and working more closely with providers to coordinate treatment and work activities. Success in treatment and employment could be further improved by expanding the menu of work activities, and increasing the availability of transitional treatment, housing, and job services.

BACKGROUND

In 1997, New Jersey implemented its welfare reform initiative, Work First New Jersey, which includes the federal five-year time limit on cash assistance, work requirements for most clients, and expanded services. Over the first five years under WFNJ, and in the context of a strong economy, New Jersey experienced an unprecedented reduction of nearly 60 percent in its welfare caseload. However, among those remaining on Temporary Assistance for Needy Families (TANF), most do not have jobs, and many—particularly those with longer welfare spells—have serious problems that limit their ability to work.

To help address clients' difficulties in securing jobs, New Jersey has implemented three service approaches. First, the state offers all TANF recipients free child care and transportation subsidies to help make work possible. Second, the state places most of those unable to find a job in some type of activity designed to develop their skills and work readiness. Third, over the past five years, the state has developed screening procedures and several initiatives to identify and assist clients with health and behavioral problems—specifically, the Substance Abuse Initiative (SAI) and Substance Abuse Research Demonstration (SARD), the Mental Health Initiative (MHI), the Vocational Rehabilitation Initiative (VRI) and the Family Violence Option Initiative (FVOI). The main features of these initiatives are described in Table 1.

As part of a larger WFNJ evaluation for the New Jersey Department of Human Services (NJDHS), Mathematica Policy Research, Inc. (MPR) conducted a study of state-sponsored efforts to identify and provide services to clients with serious health and behavioral problems. This study has examined the state and county efforts to address recipients' health and behavioral problems, some common implementation challenges, and options for overcoming these challenges. Our main findings—based largely on interviews with state officials and agency staff in nine counties, surveys and group discussions with TANF recipients, and administrative data—focus on three main questions:

1. How prevalent are serious personal barriers, and how consistently do staff identify and address them?
2. What methods do agency staff use to identify clients' serious personal barriers, and how might these methods be enhanced?
3. What approaches do staff use to engage clients in treatment, and what new strategies should be considered?

While economic trends and budgetary conditions will constrain the range of feasible policy options for enhancing TANF programs, policymakers and practitioners remain interested in ways to address common health and behavioral problems. This report is intended to inform this process.

TABLE 1

NEW JERSEY INITIATIVES ADDRESSING BARRIERS TO EMPLOYMENT[a]

Initiative	Counties	Brief Description
Substance Abuse Initiative (SAI)	All 21	Welfare caseworkers refer clients identified with possible substance abuse issues to the initiative's care coordinators for an assessment. If appropriate, the care coordinator refers the client for treatment services with a provider in the SAI treatment network.
Substance Abuse Research Demonstration (SARD)	Atlantic Essex	SARD was a demonstration project that was designed to measure the effects of enhancing substance abuse services available to welfare recipients in two counties. The demonstration ended in June 2002. Similar to SAI, SARD provided screening, assessment, and treatment services for welfare recipients with substance abuse problems. SARD differed from SAI, however, in that it provided more intensive case management services and some financial incentives for clients to participate.
Mental Health Initiative (MHI)	Atlantic Camden Essex Hudson Passaic Union[b]	Welfare caseworkers can refer clients with possible mental health issues to an intensive case management services (ICMS) provider for assessment. If appropriate, ICMS case managers refer clients to mental health providers for treatment, and to a supported employment agency for job placement and postemployment follow-up services.
Family Violence Option Initiative (FVOI)	All 21	When a welfare client discloses that she is a victim of domestic abuse, CWA employees or specially trained staff can refer her to a rape care or domestic violence program for services, such as risk assessments, emergency shelter, counseling, and help with legal documents. These clients can also request federally authorized waivers from TANF work participation or other requirements, which are automatically granted subject to completing their risk assessment.
Vocational Rehabilitation Initiative (VRI)	Camden Essex Hudson Mercer Passaic Union[c]	Welfare caseworkers can refer TANF clients to the New Jersey Department of Labor, Division of Vocational Rehabilitation Services (DVRS) using a screening guide to identify clients with possible disabilities. Referred clients receive the DVRS's comprehensive assessment, and they may be placed in DVRS services—including treatment, assistive technology, job placement, and job coaching.

[a]For more detailed information about these initiatives, see Appendix A.

[b]These six counties currently participate in the initiative. Previously, the initiative was also implemented in Cumberland, Monmouth, and Ocean counties. However, in all counties, welfare offices can refer TANF clients to DVRS for services.

PREVALENCE OF BARRIERS, BARRIER DETECTION, AND SERVICE REFERRALS

An examination of the prevalence of serious barriers among New Jersey TANF recipients serves several purposes. It (1) sheds light on the importance and progress of the state initiatives designed to address these barriers, (2) indicates the size of the group that potentially could benefit from these initiatives, and (3) helps gauge the progress of client screening efforts. The extent of implementation progress is further indicated by the fraction of clients who have been referred to services, relative to the fraction who have been identified as having a health or behavioral problem. While this type of analysis by necessity relies on approximations, it does highlight some issues facing the state initiatives.

- ***Health and behavioral employment barriers are common among TANF recipients.***

A personal problem is a serious employment barrier if it prevents someone from working or makes it more difficult to meet employer expectations, thus decreasing the chances that those who find employment can retain their jobs. Prior research suggests that several health and behavioral difficulties are prevalent among TANF recipients and that they may limit employment success.

Drawing on the WFNJ Evaluation surveys and other sources, we found that, of those receiving TANF between July 2000 and June 2001, one in four said their health problems limited the amount or kind of work they could do. Many recipients reported mental health problems, with depression being the most common. A 1998 study concluded that approximately 20 percent of New Jersey welfare recipients were problem users of drugs or alcohol at some point during the past 18 months. Service providers note that clients who are problem users often fail employers' drug screens and, as a result, have trouble securing good jobs. A recent study confirmed that TANF recipients who were problem users were more likely than other TANF recipients to be fired from their last full-time job. While relatively few New Jersey welfare recipients say that they have been victims of domestic violence, this may reflect survey limitations or a tendency to accept violence as normal and not worthy of mention. In response to one of the WFNJ client surveys, only about 7 percent said that they were a "victim of physical violence or abuse from spouse or partner" during the past 12 months. However, studies conducted in other states, where TANF recipients were interviewed at greater length, indicated that a larger fraction of recipients—about 15 percent—may have had experiences that involve some physical abuse.[1]

Welfare recipients with a health or behavioral problem often have multiple problems. For example, a quarter of New Jersey TANF recipients classified by NJDHS as problem substance users reported that they had some history of psychiatric treatment, compared to only 10 percent of others (Kline et al. 1998). Longer-term welfare recipients are particularly likely to face multiple employment barriers (Rangarajan and Wood 2000).

[1]For example, in response to a survey of a representative sample of TANF recipients in one Michigan county, 15 percent of respondents reported that they had been hit, threatened with a weapon, or forced into sexual activity by a spouse or partner during the past year (Danziger et al. 1999).

Studies suggest that those with multiple barriers are substantially less likely to work than those facing only one barrier (Rangarajan and Wood 2000; and Danziger et al. 1999).

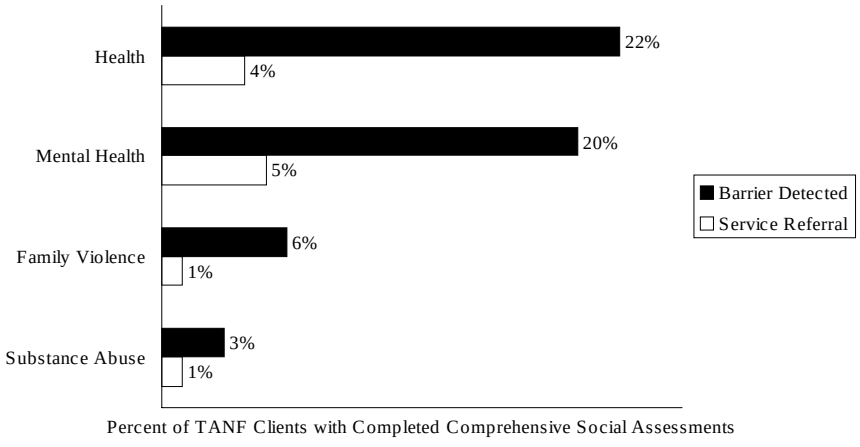
- ***Staff often identify clients' physical and mental health barriers but appear to have been less successful in detecting substance abuse and learning problems.***

New Jersey officials have recognized that certain personal problems seriously impede employment progress, and may be more common among long-term recipients. In 2000, to help identify and assist clients with these problems, NJDHS introduced the Comprehensive Social Assessment (CSA), a screening questionnaire used by frontline staff to identify clients with health and behavioral problems or with other potential barriers, such as lack of child care or transportation. During the period 2000 through spring 2003, the state required county staff to use the CSA to screen all clients with 34 or more months of cumulative welfare receipt.[2]

Staff who conduct the CSA screenings with longer-term recipients have succeeded in identifying many clients with physical and mental health problems, perhaps representing the majority of clients in this group with health problems. In 2002, welfare staff identified a physical or mental health problem among 31 percent of the long-term recipients completing a CSA. These CSAs indicated that 22 percent had a physical health problem, 20 percent had a mental health problem, and 12 percent had both types of problems (Figure 1).

FIGURE 1

HEALTH AND BEHAVIORAL BARRIERS DETECTED AND SERVICE REFERRALS IN 2002



Source: Tabulations of Comprehensive Social Assessment files, Mathematica Policy Research, Inc.

[2]The state currently plans to ask counties to expand the target population and require counties to administer the CSA to all those with 12 or more months of welfare receipt.

In addition, although there is some imprecision in available estimates of the actual prevalence of domestic violence among New Jersey TANF recipients, welfare staff appear to be identifying at least a substantial fraction—if not most—of the recipients who have recently been abused by a partner. The CSA data indicate that staff identified a domestic violence issue among about 6 percent of all longer-term recipients.

At the same time, though, staff appear to be identifying few clients with either substance abuse problems or learning disabilities. Staff identified a substance abuse problem among 3 percent of the clients completing a CSA in 2002. Based on the available estimates of the actual rate of substance abuse among New Jersey TANF recipients, it appears that this rate may account for less than one-sixth of all problem users. The version of the CSA used in 2002 did not include questions focused on learning problems. While the counties implementing the VRI were given a checklist indicating which clients should be referred to the DVRS for an assessment to identify possible disabilities, including learning disabilities, few such referrals have been made. The state currently is planning to add new questions on learning disabilities to the CSA, which could increase the number of clients referred for DVRS assessments.

- ***Once problems are detected, welfare staff refer only a modest fraction of clients to services.***

After detecting a potential personal barrier, staff can respond in several ways. They may refer clients for a more detailed assessment to specific services. They may encourage clients to see a doctor to determine whether they are capable of working and to request deferrals from work requirements if they are not. Drawing on the CSA and other administrative data, we gauge the extent to which welfare staff make referrals for services or defer clients from work requirements when they are identified as having specific personal problems.

Welfare case managers conducting the CSAs appear to refer only a small percentage of clients for more thorough assessments or services related to health and behavioral barriers. For each of the four types of serious personal problems covered in the CSA—physical health (which could include disabilities), mental health, substance abuse, and family violence—only 1 to 5 percent of the clients completing a CSA were referred to services (Figure 1).

Other data confirm the low rate of referrals for detailed assessments or services through the WFNJ-sponsored initiatives designed to address health and behavioral barriers. For example, about 2.2 percent of all TANF cases at some point in fiscal year 2001 were referred for an SAI or SARD assessment. In the 10 counties that have participated in the VRI, only about 1.1 percent of TANF clients were on the DVRS caseload as of December 2002. Similarly, in the six counties implementing the MHI, only about 1.4 percent of TANF cases were being served as of October 2001.

While some clients with health problems see doctors as part of the deferral process, CSA data indicate that most long-term recipients who report a health or behavioral problem are neither deferred nor referred for any service by their case manager. Some of the clients with identified problems, who were neither referred or deferred, may already be in some type of treatment, and case managers may be aware of this. Nonetheless, these findings suggest that additional assessment or follow-up effort may be needed to assist some clients with documented health and behavioral problems.

SCREENING AND ASSESSING CLIENTS

Assessing personal problems usually requires time in which to broach sensitive topics, skills in interviewing and interpretation, and a setting conducive to private conversation. One approach is to create a process that involves both a screening and an assessment stage. Screenings conducted by welfare staff are designed to identify those clients who may have particular problems. Staff can then refer clients who screen positively for a specialized assessment to confirm whether a problem exists, discuss treatment options, and identify an appropriate treatment provider.

Several WFNJ efforts to address TANF clients' personal barriers involve both screening and assessment. While it is called an "assessment," the CSA actually is a screening tool used by frontline case managers to detect potential employment barriers. The SAI/SARD, MHI, and VRI also involve initial screening and follow-up assessment. We examined how state, county, and local organizations are implementing screening and assessment procedures to detect health and behavioral problems, and identified some of the challenges they have in common: (1) confusion about the purpose of the CSA, (2) delays in completing vocational rehabilitation assessments, (3) limited interagency communication on screening and assessment issues, and (4) a need for additional staff training and investments in office facilities.

- ***Most case managers say the CSA is a helpful screening tool, but some are confused about how to make full use of it.***

While many staff are making good use of the CSA, others are confused about the purpose and use of this tool. Some case managers noted that the CSA had prompted them to ask clients some useful questions related to their problems and service needs. Supervisors from two counties indicated that the CSA data are helpful for planning and developing new services. However, some case managers and supervisors, at least initially, seemed to be misinformed about the CSA's purpose, suggesting that it was mainly to provide state staff with data on clients' needs, rather than to help them identify and address barriers. By fall 2002, when MPR conducted the most recent round of interviews, this confusion was less common than shortly after the CSA was introduced in 2001. Further, some case managers are unsure how to use the CSA information, or whether they can share information in the CSA with assessment staff in other agencies, and with service providers.

Options for Refining CSA Screening Process. State and county officials could provide case managers with more guidance on the multiple objectives of the CSA and the types of service needs and potential referrals related to the client problems covered in the CSA questionnaire. Officials might also try to facilitate appropriate sharing of CSA information with other assessment staff and service providers: case managers could more routinely ask clients who are referred to other agencies whether they would permit such information sharing and sign a standard release form.

- ***Welfare staff often refrain from referring clients for vocational rehabilitation assessments because of concerns about delays in completing these assessments.***

The state has encouraged county welfare agencies to identify TANF recipients who may have disabilities and who might benefit from the assessments and services available

through DVRS. While all county welfare agencies have long been able to refer clients to DVRS, in practice, welfare staff have made few such referrals. The state created the VRI in part to help those counties with the largest welfare caseloads identify clients who should be referred to DVRS, and to provide funding for assessments and services.

However, during the first two years of the VRI's implementation, there has been no significant increase in the number or percentage of TANF clients receiving DVRS assessments and services. Many welfare staff suggest that they are reluctant to refer clients to DVRS, in part because DVRS assessments can take a long time to complete. DVRS staff, in turn, note that assessing welfare recipients for potential disabilities is, by its nature, often difficult and time-consuming. DVRS staff also suggest that the original screening guidelines provided to counties could be improved so that the guidelines better help welfare staff identify clients who are likely to benefit from vocational rehabilitation services.[3]

Options for Strengthening VRI Screening and Assessment. NJDHS and DVRS might consider a number of strategies for clarifying how and when county agencies can refer TANF recipients for DVRS assessments. Managers from DHS and DVRS could jointly review those policies and provide counties with clearer guidance on which groups of TANF recipients should be referred to DVRS, the time allowed for DVRS assessments, and whether or when clients referred to DVRS must participate in work or training activities.

- ***Detection of substance abuse and mental illness depends in part on interagency communications and the use of information signaling potential client problems.***

Although counties have adopted specific screening instruments and procedures, detecting potential substance abuse and mental health problems remains difficult. TANF clients are often unaware of their problems, or reticent about acknowledging they have problems. Welfare staff can sometimes detect potential problems based on clients' demeanor, their attendance or performance in work or training activities, their speech patterns, or their responses to screening questions. Staff members at other agencies working with TANF recipients may have useful opportunities to observe these signals. Many counties, but not all, appear to have succeeded in involving staff from multiple agencies in this process.

The way county staff are organized and communicate with one another may be affecting detection efforts. The large intercounty variation in both the fraction of TANF clients who have been referred to the SAI and SARD initiatives and the fraction who have entered treatment highlight the potential importance of county programs, procedures, and staff roles in detection efforts. The site visit interviews point to three factors that may be contributing to the efficacy of these efforts. First, the potential for more effective detection appears to be enhanced when county welfare agencies are supported by, and communicate with, training vendors and service providers working with clients. Second, in some counties, specialized county agency staff play an important

[3]In some counties, DVRS and county welfare staff have worked together to modify the way welfare staff identify clients who are referred to DVRS; this cooperation appears to have contributed to the growth in DVRS referrals and to the reduction in the number of clients DVRS refers back to welfare agencies.

role in the screening process. Third, several counties have targeted more intensive screenings and assessments on sanctioned clients and those receiving Emergency Assistance, groups who appear to have a higher likelihood of suffering from some health and behavioral problems.

Options for Enhancing Substance Abuse and Mental Health Screening. County managers could expand the screening roles of specialized staff and service providers, particularly those staff and agencies that already have a great deal of contact with TANF clients. In addition, several counties have demonstrated the potential value of targeting more frequent and intensive screenings on higher-risk clients, including those who have been sanctioned, those applying for Emergency Assistance, and clients who have been referred to child protective services. Counties could also better inform all clients of the substance abuse and mental health services available. To handle periods of peak demand, agencies might consider identifying back-up staff who can conduct assessments so that all clients identified as having problems can be assessed and referred to services promptly.

- ***Agencies' overall capacity to detect problems can be enhanced through staff training, limiting average staff caseloads, and investing in office space and communication systems.***

The efficacy of efforts to detect clients' health and behavioral problems depends not only on agency procedures, but also on staff resources and other agency assets. Our site visits suggested that what case managers learn about clients' personal problems depends, in part, on staff's interviewing skills, their caseloads, the quality of office space, and agencies' telephone and computer systems.

The need for additional case management training is suggested by the expanding screening functions performed by these staff, as well as their traditional career paths. As a result of the new state initiatives, the screening responsibilities of case managers have expanded substantially. In several counties, most case managers were initially hired for income-eligibility positions and then secured promotions to case management. County staff participating in the site visit discussions noted that they would welcome state assistance in developing case manager screening skills, including when and how to broach sensitive issues and how to address clients' concerns about admitting they have certain problems.

Case managers' ability to detect client problems depends not only on their training, but also on their caseloads and the time they can spend with each client. The number of TANF clients assigned to case managers varies across New Jersey's 21 counties. In the counties with large concentrations of TANF cases, each case manager, on average, is responsible for more than 150 clients. In some counties, case managers have average caseloads of fewer than 75 cases.

Case managers need not only the time to work with clients, but also adequate office space, voice mail, and e-mail systems for private communications. Observation of case managers at work suggests that their offices do not always provide sufficient privacy to facilitate frank discussions with clients on sensitive issues. In some counties, case managers have neither voice mail nor e-mail, which impedes their ability to stay in touch with clients and staff in other agencies.

Options for Enhancing Case Managers' Skills and Support. Even where resource constraints limit state and county investments in case management, officials might consider some incremental changes that could enhance client screening capabilities. State and county managers could work together to develop workshops on screening issues, such as how to detect particular problems and effective interviewing techniques. Counties could identify specialized staff or senior case managers who can serve as resources for specific problems and issues, such as how to identify signs of mental illnesses and learning disabilities. Through more careful assignment of cases, counties could try to limit the variability, if not the average level, of individual case manager's caseloads. Counties could install better partitions around case managers' desks or better access to conference rooms. Investments in voice mail and e-mail systems could facilitate private communications with clients and service providers.

ENGAGING CLIENTS IN TREATMENT AND WORK

Once staff identify a client health or behavioral problem, they often must overcome other hurdles to help clients secure appropriate treatment services. First, staff must determine what services clients need, then locate a provider with sufficient capacity. Second, even when openings in treatment programs are available, clients' fears or family responsibilities may need to be addressed before treatment can begin. Third, connecting TANF clients to treatment is sometimes made more challenging because they are expected to meet TANF work requirements, either through treatment activities alone or through a combination of treatment and approved work-participation activities. Ultimately, they must make the transition to independent employment. Treatment and work requirements need to be smoothly integrated. If one or more of these conditions are not met, clients may fail to enter or complete treatment.

- ***Shortages in services sometimes delay treatment or discourage clients from seeking help.***

When appropriate services are not available, clients may need to postpone treatment or accept services that do not fully address their needs. If treatment providers and services are in short supply locally, clients may need to leave their communities in order to receive treatment. Such delays and constraints in the availability of services sometimes lead clients to decide not to enter treatment.

Our discussions with state staff and staff in the nine case study counties suggest that some service gaps in New Jersey are limiting client access to mental health services, substance abuse treatment, and services for clients with multiple health and behavioral problems. Case managers in several counties reported that they sometimes have difficulty identifying a mental health care provider who is willing to serve TANF clients without putting them on a long waiting list. Few private providers of outpatient mental health services accept Medicaid because Medicaid rates for these services are very low. There is rising demand for the services available through public community mental health care centers. Since these centers cannot accommodate all those who request services, they must give priority to those with the most serious mental illness or those in crisis. Staff also reported shortages of several types of substance abuse services, including residential treatment for women with children. The availability of other types of substance abuse services varies by region, with southern New Jersey generally having

less capacity than northern New Jersey. Although significant fractions of TANF recipients experience multiple serious barriers to employment, treatment options for individuals with co-occurring problems are limited.

The shortage of these services highlights the important function performed by the specialized SAI, SARD, and MHI staff who match clients to providers. For example, these staff are often familiar with services throughout the state and can help clients balance the need to find a provider as close as possible to their community, one with treatment slots available soon, and one offering the types of treatment and support services needed by the client. When openings are not immediately available, staff can follow up with clients so as to maintain their readiness to enter treatment.

Options for Filling Service Gaps. State and county officials and other stakeholders may be able to expand the supply of services in short supply by increasing payment rates for certain services or offering technical assistance to help providers manage licensing and paperwork burdens. State policymakers might consider expanding the six-county MHI initiative to ensure that all counties have access to mental health case managers familiar with available services and providers. The state could encourage more providers to offer integrated services for clients with multiple problems, or could experiment with co-enrollment in SAI, MHI, and other programs.

- ***Often, before clients can enter treatment, programs need to address clients' fears, deal with family crises, or address child care or transportation problems.***

Clients' denial of problems and concerns about treatment often pose challenges for staff. Staff noted that it is not unusual for clients to go through a period of denial before they "take ownership" of their problems and consider treatment. Client focus group participants expressed concerns about being labeled "crazy," "addicted," or "stupid" if they sought treatment for serious problems. Some clients are wary of taking medication or entering treatment or shelters, which they view as unsafe. Staff suggested that engaging in client-centered negotiations, coordinating with sanction policies, and offering incentives are useful strategies to overcome resistance to entering treatment.

Personal and family circumstances also make TANF recipients a challenging group to engage and retain in treatment. Many clients with health or behavioral problems have tenuous housing arrangements or serious family problems. In addition, TANF clients often need help with child care and transportation arrangements. While WFNJ provides some support services to address these needs, even a short delay in making logistical arrangements gives clients time to change their minds about treatment; or the time could be long enough for available treatment slots to disappear. Several strategies have been used to overcome obstacles to treatment, including providing more intensive case management or direct services to alleviate family and logistical obstacles.

Options for Preparing Clients for Treatment. State and county agencies could offer more staff training to help case managers and other staff respond to clients' concerns about treatment and settings. Programs could also experiment with modest incentives designed to induce clients to enter treatment or stay in it. Counties could make greater use of specialized case managers to help clients stabilize housing situations, deal with their family crises, and arrange child care or transportation services. Finally, the state could pay treatment providers to offer some of these services.

- ***Available work and training activities do not always complement treatment schedules and priorities, or adequately support the transition from treatment to employment.***

WFNJ is designed to prepare all clients for work, including those with serious health and behavioral problems. This objective is reflected in the requirement that most clients participate in some work and training activities, as well as the expectation that most service providers will help clients find appropriate work activities or jobs. Each of the new treatment initiatives has made substantial progress integrating work participation with treatment. Nonetheless, county staff continue to face three ongoing challenges: (1) improving the match between available work activities and treatment needs, (2) providing access to transitional services and supported work activities, and (3) ensuring that all staff understand work requirements, and communicate about clients' placement and progress.

Staff reported some difficulties finding work or training activities that complement clients' treatment schedules and needs. Some standard work and training activities are too inflexible to accommodate the demanding and sometimes unpredictable aspects of treatment. The difficulty reconciling treatment and work activities has led some counties to deemphasize work activities for those in treatment. In addition, the part-time work experience activities available to those in treatment sometimes offer only limited supervision and guidance, while other available activities may not adequately reflect clients' needs, interests, and competencies.

Some clients could benefit from structured supported work activities and other transitional services that are not readily accessible. As TANF clients complete treatment or leave shelters, they sometimes need transitional housing or halfway houses, which are in short supply. Through the Vocational Rehabilitation Initiative (VRI), New Jersey sought to expand access for TANF clients to the supported work activities available through DVRS. However, welfare case managers are reluctant to make use of these activities. Welfare staff are concerned that DVRS assessments and activities take a long time to complete, and DVRS staff are uncomfortable imposing work mandates on TANF clients. Sometimes welfare case managers reassign TANF clients to other activities before they have a chance to participate in supported work or employment services, leading DVRS staff to question whether it makes sense to devote much time to working with TANF recipients.

For counties to provide well-integrated treatment services and work participation activities, state and county staff, service intermediaries, and providers all need to be familiar with work requirements and work closely together. Coordination can be difficult. Lingering confusion among county welfare staff about work activity requirements and participation status for clients in treatment initiatives sometimes results in mixed messages to clients or disrupted services. Providers and initiative staff sometimes have difficulty gaining access to administrative information or to updates about the status of individual clients. Staff in several counties were also confused about how deferrals and domestic violence waivers affect clients' access to WFNJ work activities.

Options for Integrating Work, Treatment, and Transitional Supports. Officials and program staff could develop more work activities that are compatible with clients' treatment schedules, offer adequate supervision, and reflect the diverse needs, competencies, and interests of clients in treatment. Within the constraints of federal

requirements, New Jersey may be able to delay imposing, or to reduce, hourly requirements for individuals with the most serious problems who are in treatment. NJDHS may be able to help expand transitional housing and other supports. Policymakers could clarify the conditions under which clients can be referred to DVRS and the allowable range and duration of vocational rehabilitation services. Appointing liaisons, providing office space to co-locate frontline staff, conducting joint training, and scheduling management meetings can improve coordination among agency partners.

I

INTRODUCTION

Substantial progress has been made in reducing families' dependence on cash welfare, but some important challenges remain. In 1997, New Jersey implemented its welfare initiative, Work First New Jersey (WFNJ), which includes the federal five-year limit on cash assistance, work requirements for most clients, and expanded services. During the first five years of WFNJ, in the context of a strong economy, New Jersey experienced an unprecedented reduction in its welfare caseload. Most of those leaving TANF appear to have succeeded in securing jobs (Wood, Deke, and Rangarajan 2003). Some TANF recipients, however, have had more difficulty finding and keeping jobs. The state has granted time limit exemptions or extensions to most of those reaching the 60-month time limit, since they usually have documented health or behavioral problems, low literacy, or other conditions that make it difficult for them to secure jobs.

To help address clients' health and behavioral problems, New Jersey has implemented several new initiatives. Specifically, state and county agencies have developed new programs to assist clients with substance abuse, mental illness, physical and mental disabilities, or domestic violence problems. These programs are designed to complement state programs designed to address other employment barriers including child care, transportation, training and job search assistance programs.

As part of a larger WFNJ evaluation for the New Jersey Department of Human Services (DHS), Mathematica Policy Research, Inc. (MPR) conducted a study of these state and county efforts to address TANF recipients' health and behavioral problems.[1] The study has examined the extent to which staff are identifying clients with these problems and getting them into treatment programs, the strategies staff are using to detect and address client problems, and some options for overcoming common challenges. This study, one component of the WFNJ Evaluation's Program Study (see text box), has yielded three key findings:

1. ***While staff appear to be identifying a large fraction of TANF recipients with health and behavioral problems, staff refer only a modest fraction to relevant services.*** Previous WFNJ evaluation reports indicate that a large and growing fraction of New Jersey's shrinking caseload have health and behavioral problems that can impede their ability to secure jobs. County welfare staff are using enhanced screening and assessment methods to identify physical health, mental health, and domestic abuse problems. However, screening appears to be less successful in identifying

[1]Previous reports of the evaluation's Program and Community Studies have examined state and county efforts to help alleviate the external logistical barriers that welfare clients and former welfare clients might encounter, and have examined some earlier efforts to address clients' serious personal employment barriers (Rosenberg et al. 2003; Haimson et al. 2001; Rosenberg et al. 2000).

THE WFNJ EVALUATION: A COMPREHENSIVE LOOK AT WELFARE REFORM IN NEW JERSEY

- The ***Client Study*** is tracking a statewide sample of WFNJ families over a five-year period to establish what happens to them before and after they leave welfare. Focusing on clients who participated in WFNJ during its first 18 months of operation, this study is documenting the welfare receipt, employment levels, income, health, housing arrangements, and other indicators of WFNJ clients' general well-being and quality of life. It is identifying factors affecting individuals' success in moving from welfare to work and is documenting changes in these measures over time. The study uses three main types of data: (1) a series of five longitudinal surveys with a statewide sample of as many as 2,000 WFNJ clients, conducted at 12-month intervals; (2) information from state administrative data systems on a larger sample of 10,000 WFNJ clients, documenting such outcomes as their welfare receipt, employment levels, and earnings; and (3) three rounds of in-depth, in-person interviews with a subset of WFNJ clients, designed to gather more detailed, qualitative information about their lives. In addition, the study includes a survey of a more recent cohort of WFNJ clients, to examine how the characteristics and outcomes of clients have changed over time.

- The ***Program Study*** is exploring operational challenges and promising strategies for overcoming them, to help state and county staff identify and address key implementation issues. It is also helping the state develop performance indicators to guide program improvement efforts. The analysis draws on state administrative data and three rounds of site visits to a subset of the state's 21 counties. During these visits, site visitors interview a variety of county staff members, conduct case file reviews, and observe key program activities. Topics for rounds of data collection include (1) progress in WFNJ implementation, (2) working TANF leavers' access to post-TANF benefits, and (3) efforts to address TANF clients' employment barriers.

- The ***Community Study*** included case studies in three areas—Newark, Camden City, and Cumberland County—to understand local opportunities and challenges facing welfare reform. The case studies focused on the employment patterns and service needs of low-income parents, the jobs available in local labor markets, and the local institutional response to welfare reform. The analysis drew on a survey of low-income residents, an employer survey, and interviews with local service providers and other stakeholders.

- The ***Child-Only Study*** examined a statewide sample of New Jersey families receiving child-only TANF grants. Child-only TANF families include those headed by nonparent caretakers (typically, grandparents), as well as those headed by parents who are ineligible for TANF because they are on Supplemental Security Income (SSI) or because of their immigration status. The study included a survey of more than 500 adult caretakers of children on these cases, supplemented by detailed qualitative interviews with a subsample of these cases and by an analysis of state administrative records data. The study focused on the characteristics and origins of these cases, as well as on the stability and economic security of these households.

- The ***UI Study*** analyzed how the UI program functions as a safety net for TANF recipients who have exited welfare and found jobs. The study relied on administrative welfare records, UI earnings and claims data, and survey data for a subsample of WFNJ clients tracked by the Client Study who had left welfare and found jobs. The study calculated the proportion of these WFNJ clients who achieved monetary eligibility for UI benefits during the first few years after leaving welfare for work and how this proportion changed when eligibility rules were varied. The study also examined factors affecting nonmonetary eligibility, such as reasons for job separations. Finally, the study examined the actual use of UI benefits among these clients.

learning disabilities and drug and alcohol problems. While efforts to detect serious personal problems have met with some success, still only a modest fraction of those identified as having problems are referred to, or participate in, services offered through WFNJ.

2. ***Efforts to detect and assess personal employment barriers could be improved by clarifying screening procedures, providing more training and support for case managers, and facilitating communications among agencies that have contacts with TANF clients.*** While most counties appear to have implemented the screening and assessment procedures developed by the state, some frontline staff are confused about the purpose and use of the new screening tools. State and county officials could improve case managers' capacity to detect client problems by offering more training, limiting their caseloads, and providing offices that afford greater privacy. Enhancing communications among training vendors, service providers, and welfare staff could also help case managers identify clients who have health and behavioral problems.

3. ***New Jersey may be able to help more clients use available treatment by filling gaps in services, helping clients follow through with treatment, and modifying work activities to better reflect treatment demands.*** Counties have experienced shortages of certain mental health and substance abuse services needed by TANF clients, including services for those with multiple barriers. Welfare officials may be able to help fill these gaps by providing additional treatment and support resources, and educating providers about the circumstances and needs of TANF clients. County staff could encourage more clients to follow through with treatment by informing them about services and working more closely with providers to coordinate treatment and work activities. Success in treatment and employment could be further improved by expanding the menu of work activities, and increasing the availability of transitional treatment, housing, and job services.

The rest of this introduction provides additional background on (1) the policy context (2) study design, and (3) organization of this report.

A. POLICY CONTEXT AND EFFORTS TO ADDRESS BARRIERS

The federal Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) has encouraged parents receiving cash assistance to leave welfare and secure employment. PRWORA eliminated Aid to Families with Dependent Children, a program that provided ongoing cash assistance to families with poor children, replacing it with Temporary Assistance for Needy Families (TANF). To receive continuing aid under TANF, clients are required to work or participate in work experience and training activities. PRWORA also limited to five years the cumulative time most families can receive federally funded cash assistance. Many state TANF programs have adopted a work-first approach designed to encourage clients to find jobs and leave welfare before reaching their five-year time limit.

New Jersey has implemented the requirements of TANF through the WFNJ program, directed by the Division of Family Development (DFD) within the DHS, and administered by county welfare agencies. WFNJ aims to improve family well-being through employment and welfare independence. According to the state's WFNJ Web site, "Work First New Jersey emphasizes work as the first step toward building a new life and a brighter future. Our goal is to help people get off welfare, secure employment and become self-sufficient, through job training, education and work activities." The WFNJ program emphasizes work through the structure of its program, including its job diversion program, immediate job search activities, and community work experience program (Rosenberg et al. 2000).

In part, due to this work-first approach, as well as a strong economy, many welfare clients found jobs and left welfare in the first five years after WFNJ was implemented in 1997. Welfare caseloads declined by nearly 60 percent between the summers of 1997 and 2002. Moreover, most of those leaving welfare have secured jobs. The WFNJ Client Study conducted several follow-up surveys of a representative sample of recipients who were on TANF between July 1997 and December 1998.[2] Four and a half years after entering WFNJ, 79 percent were no longer receiving welfare, and about 63 percent of these TANF leavers were working (Wood, Deke, and Rangarajan, September 2003).

Some clients, however, continue to remain dependent on welfare. Of the original longitudinal WFNJ client study sample, 21 percent were still on TANF when interviewed four and a half years after they entered WFNJ. Just over 80 percent of these clients were not employed. In addition, more than a third (36 percent) of those off TANF were not employed; about 40 percent of this group was neither living with an employed spouse nor receiving SSI or UI. By November 2002, more than 2,000 TANF recipients had reached or surpassed the 60-month time limit. The state has granted time limit extensions or exemptions to most of these recipients, so that those with documented health problems or other serious problems can continue to receive support and complete treatment, basic education programs or other activities designed to prepare them for the labor market.[3]

To help address clients' difficulties in securing jobs, New Jersey has implemented three sets of initiatives. First, to help make work possible, the state offers all TANF recipients free child care and transportation subsidies. Second, the state places most of those who are unable to find a job in some type of activity designed to develop their skills and work readiness; typically, these activities combine work experience with some type of training or basic education. Third, over the past five years, the state has developed several initiatives to assist clients with serious health and behavioral problems. This report examines counties' experience implementing this third set of initiatives.

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[2]The longitudinal client study sample includes clients who entered WFNJ from the Aid to Families with Dependent Children (AFDC) caseload in June 1997 and continued to receive TANF in July 1997 and clients who were not on the AFDC caseload when WFNJ was implemented but who started receiving TANF between July 1997 and December 1998.

[3]PRWORA permits states to exempt 20 percent of their total caseload (including child-only cases) from time limits, but not from work activity requirements. WFNJ allows exemptions (for example, for those over 60 years of age or permanently disabled) as well as up to two six-month extensions for adults who could work with more assistance. For federal purposes, New Jersey's extended and exempted cases are both considered exempted cases.

During the past five years, DHS and local county welfare agencies have implemented initiatives designed to address four main types of health and behavioral barriers to employment: the Substance Abuse Initiative and the Substance Abuse Research Demonstration (SAI/SARD), the Mental Health Initiative (MHI), the Family Violence Option Initiative (FVOI), and the Vocational Rehabilitation Initiative (VRI) (see Table I.1).[4] Except for the FVOI, each of these initiatives provides additional resources to help welfare caseworkers (1) identify clients' personal problems through self-disclosure or formal screening, (2) diagnose their need for treatment or services, and (3) engage clients in initiative-funded treatment or transitional activities.[5] The state also introduced the Comprehensive Social Assessment (CSA), a questionnaire county welfare staff administer to long-term TANF clients to better identify their personal problems, their ability to work, and the services they need.

While the goal of these initiatives and other services is to enable clients with serious personal barriers to participate in WFNJ activities and eventually become gainfully employed, the state recognizes that not every client can work. According to DHS, "While helping people get off of welfare and into a job is the central focus of WFNJ, when people are not able to go to work due to a disability or other reason, DHS's goal is to provide assistance to residents who need it to acquire and sustain the basic necessities of life, like food and shelter." One alternative for individuals with severe physical or mental disabilities may be the SSI program for the poor and disabled. In a joint initiative with DHS, Legal Services of New Jersey is helping disabled TANF recipients apply for SSI, which is not time-limited.

While economic trends and budgetary conditions will constrain the range of feasible policy options for enhancing TANF programs, policymakers and practitioners remain interested in ways to address common health and behavioral problems. State and county agencies in New Jersey are continuing to explore ways to enhance screening and assessment procedures and treatment programs. This report is intended to inform this process by describing the range of issues staff face and options for overcoming common challenges. While we have not estimated the cost of these options, we have included both options that are likely to be require only a small amount of resources as well as some that will probably be more costly. The cost and relevance of each option will depend on a variety of factors including federal welfare policy changes, shifting responsibilities of state and county agencies, changes in TANF caseloads, and economic trends.

[4]More details on these initiatives are provided in Appendix A.

[5]While the FVOI does not provide funding for services, it establishes procedures for welfare caseworkers to follow when discussing options with domestic abuse victims and for referring clients to an assessment with the local rape or domestic violence program. It has also provided additional training to CWA staff, and informational brochures for TANF clients in English and Spanish.

TABLE I.1

NEW JERSEY INITIATIVES ADDRESSING BARRIERS TO EMPLOYMENT[a]

Initiative	Counties	Brief Description
Substance Abuse Initiative (SAI)	All 21	Welfare caseworkers refer clients identified with possible substance abuse issues to the initiative's care coordinators for an assessment. If appropriate, the care coordinator refers the client for treatment services with a provider in the SAI treatment network.
Substance Abuse Research Demonstration (SARD)	Atlantic Essex	SARD was a demonstration project that was designed to measure the effects of enhancing substance abuse services available to welfare recipients in two counties. The demonstration ended in June 2002. Similar to SAI, SARD provided screening, assessment, and treatment services for welfare recipients with substance abuse problems. SARD differed from SAI, however, in that it provided more intensive case management services and some financial incentives for clients to participate.
Mental Health Initiative (MHI)	Atlantic Camden Essex Hudson Passaic Union[b]	Welfare caseworkers can refer clients with possible mental health issues to an intensive case management services (ICMS) provider for assessment. If appropriate, ICMS case managers refer clients to mental health providers for treatment, and to a supported employment agency for job placement and postemployment follow-up services.
Family Violence Option Initiative (FVOI)	All 21	When a welfare client discloses that she is a victim of domestic abuse, CWA employees or specially trained staff can refer her to a rape care or domestic violence program for services, such as a risk assessments, emergency shelter, counseling, and help with legal documents. These clients can also request federally authorized waivers from TANF work participation or other requirements, which are automatically granted subject to completing their risk assessment.
Vocational Rehabilitation Initiative (VRI)	Camden Essex Hudson Mercer Passaic Union[c]	Welfare caseworkers can refer TANF clients to the New Jersey Department of Labor, Division of Vocational Rehabilitation Services (DVRS) using a screening guide to identify clients with possible disabilities. Referred clients receive the DVRS's comprehensive assessment, and they may be placed in DVRS services—including treatment, assistive technology, job placement, and job coaching.

[a]For more detailed information about these initiatives, see Appendix A.

[b]These six counties currently participate in the initiative. Previously, the initiative was also implemented in Cumberland, Monmouth, and Ocean counties. However, in all counties, welfare offices can refer TANF clients to DVRS for services.

B. STUDY DESIGN

This study is designed to describe and assess New Jersey's recent efforts to address welfare recipients' health and behavioral problems. Most of these efforts are coordinated through the four initiatives targeting clients' personal barriers (SAI/SARD, MHI, FVOI, and VRI). We focus on counties' experiences implementing these initiatives and related county efforts to deal with clients' health and behavioral barriers.[6]

Three sets of research questions frame this study:[7]

1. ***How prevalent are serious personal barriers, and how consistently do staff identify and address them?*** What fraction of TANF recipients have personal barriers that interfere with or limit the work they can perform? To what extent are WFNJ staff identifying clients' barriers and referring clients to services?

2. ***What methods do agency staff use to identify clients' serious personal barriers, and how might these methods be improved?*** What are counties' experiences implementing specific screening and assessment procedures? In what ways are state and local agencies seeking to enhance local agencies' overall organizational capabilities for identifying clients' barriers?

3. ***What approaches do staff use in engaging clients in treatment, and what new strategies should be considered?*** Are needed treatment and services available and accessible? How are welfare agencies engaging individuals in treatment or other appropriate services? How are counties integrating treatment with work?

To address these questions, we collected data from five sources: (1) interviews with agency staff in nine counties; (2) group discussions with current and former WFNJ/TANF recipients; (3) interviews with state-level policymakers; (4) a review of state legislation, policies, rules, and procedures; and (5) other research and administrative data.

The primary data source for this report are the site visits and telephone interviews we conducted with staff in 9 of the state's 21 counties. During the site visits, most of which were conducted in fall 2002, we interviewed administrators and staff of county welfare agencies and treatment providers and reviewed six to eight casefiles with welfare case managers to understand how clients' personal barriers are identified and addressed. In most counties, we also interviewed in person or by telephone the staff of the county employment and training agency, WFNJ vendors, and regional offices of the Division of Vocational Rehabilitation Services, which is part of the New Jersey Department of Labor. We also made use of previous interviews with county agency and treatment staff

[6]However, this study did not measure the impacts of these initiatives on clients' outcomes.

[7]Since the FVOI and MHI were in the early stages of implementation, we could not address all of the research questions for these two initiatives. This, is particularly true of the FVOI which just started when we completed most of our data collection. However, the report does examine the prevalence of domestic violence within the WFNJ population and counties' approaches to engaging victims of domestic violence in appropriate services.

conducted in 1999, 2000, and 2001 as part of the WFNJ evaluation's Community and Program studies.

The nine counties selected for interviews differed on important characteristics (Table I.2).[8] Several counties (Camden, Essex, and Hudson) selected have large TANF caseloads, while others have much smaller caseloads (Atlantic, Bergen, and Cumberland). Counties also have had varying degrees of success in moving clients off TANF. For example, the caseload in Bergen County has decreased by 66 percent since the implementation of WFNJ, while the Mercer County caseload has decreased by 45 percent. Several counties have also deferred large portions of their caseloads from participating in the WFNJ work requirements (typically because those clients have health problems), while others have deferred much smaller portions.

TABLE I.2

KEY CHARACTERISTICS OF STUDY COUNTIES

County	TANF Caseload			Percentage of Caseload Deferred
	Number of All Cases[a]	Percentage of Caseload[a]	Percentage Change 7/97–12/02	
Atlantic	1,412	3.6	–48.9	16.8
Bergen	804	2.1	–65.8	27.8
Camden	4,135	10.6	–61.4	22.6
Cumberland	1,244	3.2	–59.1	42.0
Essex	11,304	28.9	–54.1	16.3
Hudson	5,576	14.2	–61.6	18.0
Mercer	2,267	5.8	–45.7	14.6
Monmouth	1,517	3.9	–56.1	20.0
Passaic	3,018	7.7	–51.5	18.8
All 21 Counties	**39,162**	**—**	**–57.5**	**20.2**

Source: DHS administrative records.

[a]Caseload data are for December 2002.

[8]Data collection and analyses for a study on working TANF leavers' access to post-TANF supports occurred concurrently in the same counties (see Rosenberg et al. 2003).

We held two group discussions with current or former TANF recipients in the Newark and Camden regions. The clients discussed their views about whether and how the WFNJ program helped them overcome personal problems. We recruited welfare clients who, based on assessments, appeared to have experienced at least one serious personal problem. The groups discussed their current activities, personal or family problems that limited their daily activities or employment, and help they sought or received to address these problems through the welfare office or elsewhere in their communities.

Further, we interviewed state policymakers and administrators to understand their perspective on the employment challenges welfare recipients face and to learn about the state initiatives designed to address these challenges. In addition, we reviewed state-level instructions, regulations, and other documents relating to these initiatives.

Finally, we used data and findings from other parts of the WFNJ evaluation, New Jersey administrative data, and findings from other studies. Results from the WFNJ Client Study provides some information on the prevalence of serious personal employment barriers among TANF recipients in New Jersey. Data from several administrative data sources provided information on the extent to which staff detect specific problems and refer clients to services. The main administrative data source was the Comprehensive Social Assessments (CSAs) conducted with clients who have 34 or more months of cumulative TANF receipt. In addition, we draw on administrative data from the SAI/SARD, VRI, and MHI initiatives. We also make some use of other national and state studies relating to the prevalence of health and behavioral barriers among TANF recipients and programs designed to address these barriers.

The timing, form, and geographic scope of the study's data sources shape the scope and type of findings in this report. Interviews conducted in the nine study counties were helpful in suggesting the experiences and perceptions of a variety of staff in many state and county agencies, but in some cases they may not be fully representative of the experiences of all staff in the study counties or of staff in non-study counties. Finally, procedures and policies may have changed after our site visits, so our findings only capture developments through 2002.

C. ORGANIZATION OF REPORT

The rest of this report is organized around the study's three main research questions. In Chapter II, we present estimates of the prevalence of serious personal barriers among the welfare population and compare them to the numbers of WFNJ clients whom county staff have identified as having these barriers and referred for treatment. Chapter III examines the way in which staff screen and assess clients' personal employment barriers, and Chapter IV assesses efforts to engage clients in appropriate treatment services. Both of these last two chapters examine implementation approaches and key challenges staff faced in the nine study counties. These two chapters also identify some options state and county agencies might consider as they seek to assist clients with health and behavioral problems.

II

PREVALENCE OF BARRIERS, DETECTED BARRIERS, AND REFERRALS

The prevalence of health and behavioral problems among TANF recipients indicates the potential demand for some of the WFNJ services the state has been developing. The importance of the substance abuse, mental health, vocational rehabilitation, and family violence initiatives depends in part upon the overall number of recipients who experience these types of problems. Policymakers are also interested in whether these problems are common among the longer-term recipients approaching their 60-month TANF time limit. While the state can, and has, exempted many individuals with serious health problems from TANF time limits, a central objective of WFNJ is to address clients' employment barriers so they can secure jobs, support their families, and ultimately become independent of TANF.

KEY FINDINGS FROM THIS CHAPTER

- ***Serious health and behavioral conditions are common among TANF recipients in New Jersey.*** In response to a 2002 WFNJ survey, one in four TANF recipients said their health problems limited the amount or kind of work they can do. Other studies suggest that one in five New Jersey recipients are problem users of drug and alcohol and a substantial fraction are probably victims of domestic violence.
- ***Those with serious personal problems often face multiple barriers to employment.*** Many recipients with a health or behavioral problem have other serious problems, making it harder for them to remain employed. For example, a quarter of New Jersey recipients with substance abuse problems have a history of psychiatric problems.
- ***Welfare staff frequently detect physical and mental health problems but less often identify substance abuse.*** A large fraction (31 percent) of the long-term recipients who complete the Comprehensive Social Assessment (CSA) are identified by welfare staff as having a physical or mental health problem. This finding, in conjunction with the findings from surveys of long-term recipients suggest that staff may be identifying clients with serious health problems. However, staff appear to be identifying a smaller fraction of those with substance abuse problems.
- ***Welfare staff refer only a small percentage of clients with identified health or behavioral problems to WFNJ-sponsored services.*** While CSA data suggest that staff often detect some health or behavioral problems, these data indicate that many clients with identified problems are not referred to any relevant services, suggesting that some additional follow-up effort or enhancement in services is needed.

In addition to shedding light on the number of potential beneficiaries of state initiatives designed to address personal barriers, estimates of the prevalence of these barriers provide a rough benchmark for gauging these initiatives' implementation progress. In particular, one can begin to assess these initiatives by comparing estimates of (1) the percentage of TANF recipients who have specific problems, (2) the percentage identified by welfare staff as having (or potentially having) these problems, and (3) the percentage of recipients staff refer to services designed to address those problems. The extent to which staff are succeeding in identifying clients with problems is suggested by the relative size of the first two groups. The size of the third group, relative to the second, indicates the extent to which, once staff identify clients with problems, they are able to refer those clients to relevant services.

This type of analysis, by necessity, relies on approximations and comparisons of measures that are not entirely comparable. Most estimates of the prevalence of specific personal barriers are approximations, since they are based on survey data that reflect the perceptions of respondents about their own problems.[1] By contrast, estimates of the extent to which staff detect clients' problems are drawn from administrative data, and are based largely on staff judgments about clients' problems. Even if the estimated prevalence of a specific barrier appears to be identical to the percentage of clients identified by staff as having that problem, it is still possible that staff have identified the wrong clients. Nonetheless, by comparing the incidence and detection of specific problems, one can begin to characterize in broad terms the progress of state and county efforts to address those problems.

The rest of this chapter is organized around an analysis of two main questions:

1. Approximately what fraction of TANF recipients have specific serious personal problems that are likely to interfere with employment or limit the kinds of work they can do?
2. How many clients with these barriers have staff identified, and how many have staff referred to related WFNJ services?

A. PREVALENCE OF SERIOUS PERSONAL BARRIERS

Defining a serious personal employment barrier requires some judgment. A personal problem is an employment barrier if it prevents someone from working entirely or if the problem makes it more difficult for employed individuals to meet their employer's expectations, increasing the chances that they will lose their job. Most personal problems that potentially interfere with work are defined along a continuum. For example, many people with mild cases of depression can function effectively in the workplace, whereas those with major depression tend to have greater difficulty securing and retaining jobs. While it is useful to distinguish between mild and severe problems, this is not always feasible based on the data sources available. Nonetheless, one can sometimes gauge whether the group reporting a type of problem tends to have difficulty in the labor market

[1]As noted by the General Accounting Office (GAO), such estimates may be either too high (for example, if some respondents incorrectly believe they have specific health problems) or too low (if some respondents are not aware of their health problems). See GAO 2002.

by comparing the group's average employment rate with that of the rest of the welfare population.

This section synthesizes information available on the prevalence of some specific personal barriers among TANF recipients. Unless otherwise stated, estimates are for the adults heading TANF cases (and exclude cases where children are the only TANF recipients). Where possible, we provide estimates for TANF recipients in New Jersey. In some cases, we draw upon national data on welfare recipients or welfare studies conducted in other states to address questions about which there is only limited data for New Jersey. Where the information is available, we compare the labor market success of recipients experiencing a particular problem to that of other recipients. Below, we first provide estimates of the incidence of each of three types of barriers among welfare recipients—health and mental health problems and disabilities, substance abuse problems, and domestic violence—then examine how many recipients face multiple serious barriers.

- ***Physical and mental health problems are common and increasingly prevalent among those remaining on TANF in New Jersey, and particularly among long term recipients.***

TANF recipients are more likely than the general national population to report several specific physical and mental health conditions that can affect employment. TANF recipients responding to a WFNJ evaluation survey conducted in 2000 reported high rates of asthma, diabetes, and arthritis; the fraction of recipients reporting each of these conditions was about two to eight times that of the national population (Rangarajan and Wood 2000).[2] Mental health problems were also common among recipients responding to the survey, with depression being the most prevalent. More than one in five respondents reported that health problems limited the amount or kind of work they could do. Overall national studies indicate that physical or mental impairments are three times more common among TANF recipients than among other U.S. families (GAO 2002).

A larger fraction of long-term recipients report health problems than do other TANF recipients, suggesting that efforts to address these problems might be particularly urgent for many of those approaching or reaching the 60-month TANF time limit. A large fraction of those still on welfare at the time of the 2000 WFNJ survey—who had been on TANF, on average, just over two years—reported physical and mental health problems. About 34 percent of this group said they had some type of health problem that limited the type or amount of work they could do, compared to only 20 percent of those who had left TANF. More than 4 in 10 (42 percent) reported that their physical health led them to

[2]These estimates of the percentage of New Jersey TANF recipients with various problems are based on a WFNJ Evaluation Client Survey conducted in 2000 with a random sample of those on TANF between 1997 and 1998. In 2000 when this survey was conducted 34 percent of the respondents were still on TANF. Some of the findings below draw upon a 2002 survey of a more recent cohort on TANF between 2000 and 2001. Both of these surveys as well as the other data used in the chapter pertain to adult-headed TANF cases and hence exclude all "child only" cases where the parent or guardian is not on the case. The national estimates of the prevalence of health and personal problems among adults in the U.S. are from the U.S. National Center for Health Statistics, Vital and Health Statistics.

accomplish less than they would like compared to 25 percent of those off TANF. Three in 10 said their mental health led them to not do work as carefully as usual, compared to 22 percent of those no longer on TANF.

As welfare caseloads declined in New Jersey, the fraction of those on TANF with serious health and mental health problems appears to have grown. The percentage of recipients reporting that their health is poor grew from 8 percent among those on TANF between June 1997 and July 1998, to 13 percent of those who were on TANF between June 2000 and July 2001 (Wood, Deke, and Rangarajan, June 2003). Mental health problems appear to have become particularly common: the fraction of recipients who said that a doctor told them they have a mental health problem grew from 11 percent in the early cohort to 16 percent in the more recent cohort. This trend probably is due, at least in part, to the fact that those with physical or mental health problems were less likely to secure jobs and leave TANF during the three-year period following the introduction of WFNJ, when caseloads dropped by more than half.

Low rates of employment among those with health problems suggest that these problems are important to address to help recipients improve their labor market prospects. The analysis of the 2000 survey data indicated that those who had not worked in the past two years were much more likely to report serious health problems than those who had worked (Rangarajan and Wood 2000).[3] The fact that health problems appear to impede many TANF recipients' job prospects and are increasingly experienced among those remaining on welfare lends support to state efforts to focus resources on identifying and addressing these problems.

- ***A significant fraction of New Jersey TANF recipients—probably about one out of five—are problem users of drugs or alcohol.***

Estimating substance abuse rates can require a combination of methods because some people are reluctant to admit they have a problem. One New Jersey study of TANF recipients sought to more reliably estimate the prevalence of drug and alcohol problems by combining telephone interviews with random drug testing (Kline et al. 1998). Conducted for the New Jersey Department of Health and Senior Services (NJDHSS) between October 1997 and June 1998, the study estimated the fraction of TANF recipients who were problem users of drugs or alcohol. It defined as "problem users" those recipients who either tested positive for heavy drug use or reported serious symptoms relating to substance or alcohol abuse during the past 18 months.

The NJDHSS study indicated that a significant minority of New Jersey TANF recipients (about 20 percent) were problem users during the past 18 months. Most of this group (71 percent) had a problem only with drugs, 8 percent had a problem with alcohol,

[3]One must be cautious in interpreting these findings, because unemployed recipients may be more aware of, or more likely to report, their health problems than are recipients who are employed and who have comparable health problems. It is also likely, however, that recipients with serious health problems have more difficulty securing and holding onto jobs.

and 21 percent had a problem with both drugs and alcohol.[4] A larger fraction of TANF recipients (32 percent) reported using some illicit drugs during the past 18 months, but some of these respondents did not report any symptoms or dependence on drugs, and hence were not classified as problem users.

Problem users of drugs or alcohol often experience difficulty getting or holding onto jobs. Several welfare agency and service provider staff interviewed during site visits noted that addicts often fail employers' drug screens and, as a result, have trouble securing good jobs. A recent survey of employers in seven New Jersey counties, which MPR conducted as part of the WFNJ Evaluation, indicated that drug tests are now common for entry-level positions available to those with modest levels of education and experience (Haimson et al. 2001). Moreover, among these low-education jobs, the positions paying above-average wages were particularly likely to require a drug test.[5] Problem users of drugs or alcohol also can have difficulty meeting an employer's expectations after they have secured a job. For example, in response to the NJDHSS survey, 17 percent of problem users said they were fired from their last full-time job, compared to only 8 percent of other TANF recipients.

- ***While few TANF clients view themselves as victims of domestic violence, more acknowledge they have been hit or forced to have sex.***

Relatively few welfare recipients say that they have been victims of domestic violence. For example, in response to the 1999 WFNJ Evaluation client survey, about 7 percent said that they were a "victim of physical violence or abuse from spouse or partner" during the past 12 months (Rangarajan and Wood 1999). In response to a similar question posed in a New Jersey Legal Services survey, 9 percent reported being a victim of abuse (Legal Services of New Jersey 2000).

These low rates, however, may reflect survey methods or a tendency to accept violence as normal and not worthy of mention. When TANF recipients have been interviewed at greater length about their relationships with their partners, many report recent experiences that involve physical abuse. For example, in one Michigan county, about 15 percent of TANF recipients reported that they had been hit with a fist or object, beaten, choked, threatened with a weapon, or forced into sexual activity by a spouse or partner during the past year (Danziger et al. 1999). This somewhat higher estimate of physical and sexual abuse is roughly comparable to estimates from some other recent surveys of TANF recipients, and is more than four times the national average for all women (Rafael 1995).

Domestic violence can negatively affect employment. Although the effects of domestic violence on TANF recipients' employment appear to depend on the form of

[4]While both the drug tests and surveys were used to estimate the prevalence of drug use, only the surveys were used to estimate the prevalence of alcohol abuse. The authors of the NJDHSS study acknowledge that, for this reason, their estimates of alcohol abuse were probably low. The most common drugs used were marijuana, cocaine, and heroin.

[5]This WFNJ Community Study survey of a random sample of 1,282 employers in seven New Jersey counties indicated that, among jobs requiring at most a high school degree, 43 percent of positions paying above-average wages require drug tests, compared to 26 percent of positions paying below-average wages.

abuse and the individual's situation, some studies suggest that persistent and recent domestic violence does undermine welfare recipients' ability to secure or hold onto jobs. One recent study with more detailed information on the persistence of abuse found that TANF recipients experiencing several instances of abuse—including one incident in the past year—are substantially less likely than other recipients to secure jobs and leave welfare (Tolman et al. 2002). These findings support the rationale of federal policies that allow welfare agencies to exempt victims of domestic violence from work participation requirements and TANF time limits.

- ***Those with serious personal problems often face multiple barriers to employment.***

Serious personal problems can contribute to other problems or make it harder to resolve them, thus making sustained employment difficult. Sometimes one serious problem leads to another. For example, those with mental illnesses sometimes self-medicate, which can lead to a drug abuse problem. When people have serious health or behavioral problems, they sometimes also have difficulty dealing with logistical employment-related issues, such as coordinating child care or transportation.

Several recent studies suggest that welfare recipients experiencing certain health and behavioral problems tend to have additional serious problems. For example, a quarter of New Jersey TANF recipients classified by the DHSS study as problem users of drugs or alcohol reported that they had some history of psychiatric treatment, compared to only 10 percent of other TANF recipients (Kline et al. 1998). In addition, 30 percent of those who reported a substance abuse problem at some point in their lives also reported having chronic physical health problems (compared to only 18 percent of other TANF recipients). Similarly, domestic violence and mental illnesses frequently co-occur. For example, nearly half of the TANF recipients in California's Kern and Stanislaus counties who had experienced domestic violence during the past 12 months also had a mental health problem (California Institute for Mental Health 2000).

Longer-term welfare recipients may be particularly likely to face multiple employment barriers. Among the long-term recipients completing New Jersey's CSA who reported a mental health problem, more than half (58 percent) were also classified by staff as having a physical health problem. The CSA data also indicate that 52 percent of those with substance abuse problems and 65 percent of those with domestic violence problems also had mental health problems. Similarly, the longer-term TANF recipients responding to the WFNJ Evaluation surveys were more likely than other respondents to report multiple serious employment barriers (Rangarajan and Wood 2000).[6]

Those with multiple barriers are substantially less likely to work than those facing only one barrier. Danziger et al. (1999) found that the chances of working at least 20 hours per week declines substantially with each additional barrier a TANF recipient

[6]For example, the 2000 WFNJ Evaluation Client Survey found that 52 percent of those still on welfare at the time of the survey had two or more of the following six problems: (1) a serious health problem (reporting three or more out of six possible indicators of severe health problems), (2) another household member on SSI, (3) no high school diploma or GED, (4) no work experience while they were on TANF and none during the two years prior to entering TANF, and (5) living in a single-adult household with a child under age six (Rangarajan and Wood 2000).

faces. This study covered barriers relating not only to health and behavioral issues but also to education, work experience, skills, perceived discrimination, and transportation. Similarly, the WFNJ evaluation study found that TANF recipients who never worked are much more likely to face multiple barriers than are those who have worked. More than three-quarters of those who had never worked since entering WFNJ had two or more barriers, compared to only about a third of those who had worked (Rangarajan and Wood 2000). These findings suggest that clients facing multiple barriers may need extra help to secure and retain jobs.

B. EXTENT TO WHICH STAFF IDENTIFY AND ADDRESS PERSONAL BARRIERS

New Jersey officials have recognized that certain serious personal problems are common among those remaining on TANF and particularly among longer-term recipients. In 2000, DHS introduced the CSA, a questionnaire designed to help frontline staff screen for health, mental health, substance abuse, domestic violence, and other problems.[7] During the period 2000 through spring 2003, the state required county staff to use the CSA to screen all clients with 34 or more months of cumulative welfare receipt.[8]

This section examines the extent of progress in detecting and addressing specific health and behavioral barriers. The analysis draws on CSA data indicating the extent to which welfare staff identify specific issues among longer-term recipients and refer those clients to relevant services. In addition, we make use of administrative records indicating counts of clients deferred from work requirements due to health problems, as well as counts of those participating in the state-sponsored substance abuse, vocational rehabilitation, and mental health initiatives.

The main findings discussed below focus on two issues: (1) the extent to which welfare staff involved in screening clients are identifying specific health or behavioral problems, and (2) how often staff refer clients with identified problems to WFNJ-sponsored assessments or services.

- ***Welfare staff frequently identify potential physical and mental health problems but less often detect substance abuse or learning disabilities.***

The staff who conduct the CSA screenings identify a large number of actual or potential health and mental health problems (Figure II.1). In 2002, when staff conducted CSA screenings exclusively with longer-term TANF recipients, welfare staff identified a physical or mental health problem among 31 percent of the clients they screened (not shown). More specifically, among the clients completing the CSA, staff indicated that 22 percent had a physical health problem, 20 percent had a mental health problem, and 12 percent had both types of problems. By comparison, 34 percent of the longer-term recipients responding to the 2002 WFNJ client survey reported that they had a health problem that limited the type of work they could perform (Wood, Deke, and Rangarajan

[7]In addition, the CSA includes questions relating to other employment-related issues, such as child care, transportation, clothes, legal issues, housing, work experience, language, and dependents with health or other problems.

[8]The state currently plans to ask counties to expand the target population and require counties to administer the CSA to all those with 12 or more months of welfare receipt.

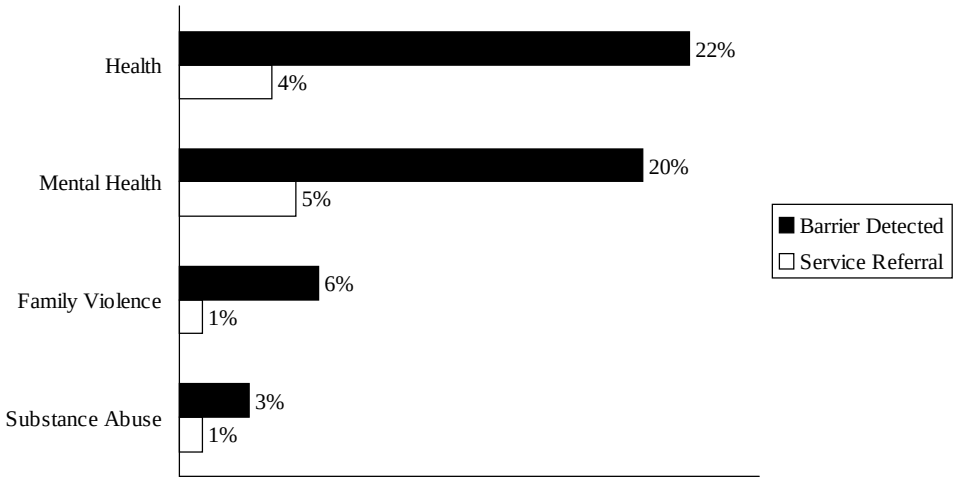
June 2003). This suggests that staff conducting the CSA may be identifying a majority of the longer-term TANF recipients with serious health problems.

Although there is some imprecision in available estimates of the prevalence of domestic violence among New Jersey TANF recipients, welfare staff appear to be identifying at least a substantial fraction—if not most—of the recipients who have recently been abused by a partner. The CSA data indicated that staff identify a domestic violence issue among about 6 percent of all longer-term recipients. As noted above, studies in New Jersey and other states suggest that between 7 and 15 welfare recipients have recently experienced a domestic violence problem. Thus staff probably are identifying a large fraction of those with these problems.

In contrast to the substantial progress made in identifying health and domestic violence problems, welfare staff appear to be having difficulty detecting substance abuse problems. Staff identified a substance abuse problem among only 3 percent of the clients completing a CSA in 2002. However, the actual rate of substance abuse among long-term recipients probably is considerably higher. As noted above, the 1997 DHSS study indicated that approximately 20 percent of all TANF recipients in New Jersey were problem users of drugs. While this study was conducted five years before the period covered by the CSA data, there is no reason to believe that the rate of substance abuse

FIGURE II.1

HEALTH AND BEHAVIORAL BARRIERS DETECTED
AND SERVICE REFERRALS
IN 2002



Source: Tabulations of Comprehensive Social Assessment files, Mathematica Policy Research, Inc.

among welfare recipients has declined appreciably during the intervening years. Nor is there reason to believe that substance abuse is less common among the longer-term recipients completing the CSA than the general welfare population. Given the higher prevalence of health problems among longer-term recipients, one might expect that rates of drug abuse are somewhat higher among these recipients than among other TANF recipients. Thus, it appears that staff conducting the CSAs probably identify only a small fraction of problem users.

During the period covered by this study, staff were also identifying relatively few clients with learning problems or other disabilities that could be addressed through vocational rehabilitation. The version of the CSA staff administered in 2002 did not include questions focused on learning problems. However, the state gave the counties implementing the VHI a checklist indicating which clients should be referred to DVRS for vocational assessment.[9] While no data are available on the total number of clients referred by the CWAs to DVRS, only a small fraction of clients receive DVRS assessments or services at any point in time; for example, during October 2002, in the 10 counties that were involved in the VRI, only about 1 percent of all TANF recipients were receiving any assessment or services from the DVRS. The state is planning to incorporate some questions relating to learning disabilities into the CSA, and this could increase the number of clients referred for vocational assessments in the future.

- ***Welfare staff appear to refer only a modest fraction of clients with serious personal problems to WFNJ-sponsored services related to those problems.***

After detecting a personal barrier, staff can respond in several ways. They may refer clients for a more detailed assessment or to specific services. Or they may encourage a client to see a doctor and suggest that the doctor complete a deferral form indicating whether the client is capable of working or not. Drawing on the CSA and other administrative data, we gauge the extent to which welfare staff make referrals or defer clients with specific personal problems.

These data should be interpreted cautiously, since they may not account for all the types of services clients receive. For example, case managers may not accurately record all the referrals they make or may refer clients to services at other times. In addition, some TANF clients receive services outside of the SAI, MHI, and VRI initiatives and are referred to services by other staff aside from the welfare case managers completing the CSAs. Nevertheless, these data shed light on the extent to which welfare staff completing the CSAs are referring clients to services after identifying specific types of personal problems.

Welfare case managers conducting the CSAs appear to refer only a small percentage of clients for assessments or services related to personal barriers. For each of the four types of serious personal problems referrals covered in the CSA—physical health, mental health, substance abuse, and family violence services—only 1 to 5 percent of the clients completing a CSA are referred to assessments or services related to those issues (Figure

[9]These criteria focus on whether clients have not found a job after participating in two or more work activities, have low levels of education, and have a long history of TANF receipt.

II.1). This implies that, among the clients staff have identified as having a problem, only about 17 to 33 percent are referred to services.

Furthermore, whether referred after completing a CSA or at some other point, only a small fraction of TANF recipients appear to be receiving detailed assessments or services through the WFNJ-sponsored initiatives designed to address personal barriers. For example, about 2.2 percent of all TANF cases at some point in fiscal year (FY) 2001 were referred for an SAI or SARD assessment in that 12-month period; only 1.7 percent completed an SAI or SARD assessment; and 1.2 percent entered SAI or SARD-sponsored substance abuse treatment.[10] In the 10 counties that have participated in the VHI, only about 1.1 percent of TANF clients were on the DVRS's caseload as of December 2002. Similarly, in the six counties implementing the MHI, only about 1.4 percent of TANF cases were being served as of October 2001. The small number of clients served by MHI is not surprising, given the fact that this program has limited funding and is in the early stages of implementation.

No doubt, some clients secure treatment in other ways and benefit from other kinds of state-sponsored services. For example, even before the MHI started, about 11 percent of the respondents to the first WFNJ survey (conducted in 1999) indicated that they received mental health treatment during the past year. In response to the same survey, about 5 percent reported receiving substance abuse treatment during the past year, which exceeded the fraction of the adult cases who entered SAI-funded treatment programs in fiscal year 2001.

In addition, many clients with health problems see doctors as part of the deferral process. Welfare staff defer from WFNJ work requirements about 21 percent of all TANF cases. The most common reason for excusing clients from the WFNJ work requirement is a client health problem, accounting for two-thirds of all deferrals in the state (or 14 percent of all TANF cases). This suggests that a considerable fraction of clients with documented health problems are receiving some treatment that has been reviewed by case managers.

Nonetheless, it appears that most long-term recipients who complete the CSA and report health or behavioral problems are neither deferred nor referred to any service because of these problems. Among the clients that case managers classified as having a physical health, mental health, substance abuse, or domestic violence problem in 2002, only about one out of six were deferred from WFNJ work requirements for one of these reasons. Only one-third of the clients identified as having one of these four problems were either deferred from work requirements or referred to services relating to their problems. This suggests that some additional follow-up effort or enhancements in available services may be needed to assist clients with documented health or behavioral problems.

In sum, these findings suggest that welfare agencies may be identifying most of the serious health and behavioral problems—with the important exception of substance abuse and learning disabilities—but face difficulties getting clients into relevant services. The

[10]These percentages are based on (1) SAI/SARD counts of the number of clients who were referred, assessed, and entered treatment and (2) MPR estimates of the total number of unduplicated adult-headed cases receiving TANF during the period July 2000 through June 2001.

site visit interviews suggest several likely explanations for these findings. In particular, some frontline staff appear to have difficulty interpreting and using the screening information they collect from clients. As discussed in the next chapter, these difficulties can both impede accurate detection of problems and make it harder to follow up on the problems that staff identify. After detecting problems, staff sometimes also have difficulty identifying relevant services, engaging clients in those services, and integrating services with work activities—issues discussed in Chapter IV.

III

DETECTING AND ASSESSING CLIENT BARRIERS

Identifying health and behavioral barriers to employment can be challenging. While some problems manifest themselves conspicuously, others are harder to detect and confirm. For example, a client's appearance and response to standard screening questions may not reveal whether she has a learning disability, drug addiction, or domestic violence problem. Also, many clients are reticent to share much information about their personal problems with welfare staff. Whether or not clients are willing to discuss their problems, effective screening usually requires time to broach sensitive topics, skills in interviewing and interpretation, and a setting conducive to private conversation.

KEY FINDINGS FROM THIS CHAPTER

- ***Most case managers say the Comprehensive Social Assessment (CSA) is a helpful screening tool but some are confused about how to make full use of it.*** While many staff appear to make good use of the CSA, others report being confused about its purpose, how to determine which services clients need, and when the CSA can be shared with specialized assessment staff. State and county officials might provide case managers with more guidance relating to these issues.

- ***Welfare staff often refrain from referring clients for vocational rehabilitation assessments because of concerns that assessments can take a long time.*** While welfare staff are reluctant to refer TANF clients to the Division of Vocational Rehabilitation Services (DVRS) because of concerns that the division's assessments often take several weeks to complete, DVRS staff suggest that their TANF clients have complex problems requiring a lengthy assessment. Welfare and DVRS officials could clarify which recipients should be referred to DVRS and the time allowed for assessments.

- ***Detection of substance abuse and mental illness depends in part upon inter-agency communications and use of information signaling potential client problems.*** Detection efforts could be enhanced by improving communications between welfare staff and other agencies working with TANF clients. Some counties have also demonstrated the value of targeting more frequent screenings on higher-risk clients.

- ***Agencies' capacity to detect problems may be enhanced through staff training, limiting staff caseloads, and investing in office facilities.*** Even though limited resources may be available for case management, officials could consider incremental changes to enhance staff screening capabilities. Managers could develop more workshops on specific screening issues, identify more staff who can serve as resources on specific problems, limit the variability in case managers' caseloads, and give staff access to private office space, voice mail and e-mail systems.

One approach to adapting to the limited resources available in many welfare offices is to create a process that involves both a screening and an assessment. Welfare agencies in New Jersey and other states have approached problem detection in a variety of ways, but typically they have created a two-step process: (1) a brief screening by a case manager or other frontline staff member, followed by (2) an in-depth assessment by professional staff and specialists. Screenings are designed largely to identify those clients who appear to have problems. Some types of screening require staff to pose specific questions to clients, while other screening procedures consist of a set of general guidelines on how to gauge whether a client may have a problem. If the screening indicates that clients may have a serious problem, staff refer them for a specialized assessment to confirm whether or not they have the problem, discuss alternative treatment options, and refer them to an appropriate treatment provider.

Several WFNJ efforts to address TANF clients' personal barriers involve both screening and assessment. In addition to the Individual Responsibility Plan (IRP), a short form identifying clients' work history and education, there are now five types of screening or assessment, each of which the state introduced following the federal welfare reform of 1996:[1]

Comprehensive Social Assessment (CSA) for Long-Term Recipients. While called an "assessment," the CSA is actually a long-term screening tool used by frontline case managers to detect a variety of potential employment barriers among long term TANF recipients. Through April 2003, frontline county staff administered the CSA to all clients with 34 months of TANF receipt. The questions in the instrument cover several topics, including not only personal problems such as physical and mental illnesses, domestic violence, and substance abuse, but also child care, transportation, and other more common problems that can affect employment. If a serious health or behavioral problem is detected, clients can be referred for one of the assessments described below.

Substance Abuse Screening and Assessment. Under both the SAI and SARD, counties screen clients for substance abuse using a standardized form, the CAGE Aid, at the point of application and redetermination, when clients fail at a work activity, when emergency assistance is requested, and if substance abuse is suspected. In addition, the CSA includes screening questions relating to substance abuse. If, during a screening, clients indicate they use drugs or have a drinking problem, case managers refer them to SAI/SARD Care Coordinators for an assessment. If Care Coordinators confirm that a client has a substance abuse problem, they determine what type of treatment is appropriate and refer the client to treatment services funded by SAI or SARD.

Mental Health Initiative (MHI) Screening and Assessment. The six counties participating in the MHI screen welfare recipients for mental health problems using the CSA (if the client is a long-term recipient), a standard 10-item screening form provided by the state, or some similar screening tool developed by the county. When a screening indicates that a client is likely to have a mental health problem, staff refer the client to MHI Intensive Case Management staff for a more extensive assessment. These MHI staff confirm whether the client has a mental health problem and, if so, what types of services the client needs. Those with mental health problems are enrolled in the program

[1]See Appendix A for additional information about these initiatives.

and referred for treatment services and supportive employment activities managed by MHI staff.[2]

Vocational Rehabilitation Initiative Checklist and Assessments. Instead of a structured screening instrument, the state has provided guidelines and a brief checklist indicating how case managers can identify clients who have a high probability of having some type of learning problem or other disability. County staff can refer these clients to the Division of Vocational Rehabilitation Services (DVRS)—which is part of the New Jersey Department of Labor (NJDOL)—for a vocational rehabilitation assessment. If DVRS confirms that a client has a disability and could benefit from vocational rehabilitation, the client is referred to services.

Family Violence Option Initiative Screening and Assessment. Case managers screen for domestic violence as part of the CSA, as well as informally during conversations with clients. Those needing or requesting assistance are referred to specific welfare staff who are familiar with available shelters and other services. If a TANF client states that she is experiencing domestic abuse and would like a waiver from either WFNJ work requirements or the 60-month TANF time limit, she is referred to a domestic violence or rape care program for a risk assessment to determine whether complying with welfare requirements poses a danger for her or her children. As long as she completes the assessment, the waiver is granted.

Drawing on our site visits to the nine study counties, this chapter examines how state, county, and local organizations are seeking to implement screening and assessment procedures. (Since the FVOI was not fully implemented at the time of our interview, we do not focus on this initiative below.) The rest of this chapter is organized around an analysis of two main questions:

1. ***What are the challenges faced by welfare staff implementing specific WFNJ screening and assessment procedures?*** How are counties responding to these challenges? How might procedures be improved?
2. ***In what ways are agencies seeking to enhance case managers' overall capacity to detect client barriers?*** What case management skills are needed to identify clients' personal barriers? What types of modifications in case managers' offices and communication systems are helpful?

A. REFINING SCREENING AND ASSESSMENT PROCEDURES

Ideally, screening and assessment procedures should be clear and staff should know how to implement them. These procedures should provide staff with guidance as to when clients are to be screened and which instruments should be used. To the extent possible, procedures and instruments should indicate the information that staff should obtain from clients, as well as how to make use of that information. If more intensive screenings are targeted to particular groups of clients, the screenings should be of clients who can be identified fairly easily and who are more likely than others to have serious problems.

[2]If the MHI staff determine that a client's mental health problems stem largely from substance abuse, they refer the client to SAI or SARD.

While a "model" screening and assessment process would achieve each of these objectives, this is not always feasible, given the complexity of clients' personal problems and the myriad demands on case managers' time.

This section examines the way in which staff in the nine case study counties have implemented the screening and assessment procedures developed by the state initiatives, the challenges staff sometimes face, and some options for overcoming these challenges. Below, we present findings and options pertaining to: (1) case managers' use of the CSA, (2) the process by which clients are referred for vocational rehabilitation assessments, and (3) ways in which staff have approached detection as part of the two initiatives focused on substance abuse and mental health problems.

- ***Most case managers say the CSA is a helpful tool, but some are confused about how to make full use of it.***

The CSA, the tool case managers administer to long-term recipients, has several potential uses. It is intended to help county staff determine which clients need services or more extensive assessments, identify clients who should be exempted from work requirements or the 60-month time limit on TANF receipt, and estimate aggregate levels of client needs for purposes of planning new services. The two DHS written instructions to counties relating to the CSA allude to each of these objectives, but place particular emphasis on the value of the CSA as a case management tool to help identify and address clients' barriers.[3]

Many county staff suggested that the CSA is helpful in identifying clients' service needs. Some case managers noted that the tool prompted them to ask clients questions relating to their potential service needs, including questions they had not posed consistently in the past. Others suggested that, prior to the introduction of the CSA, they posed very similar questions to their clients, but that the instrument nonetheless has provided a convenient way of assembling and synthesizing information on clients' problems. Staff from two counties indicated that the CSA data were also helpful for planning and administrative purposes. For example, in Atlantic County, staff used the CSA data to help plan programs for welfare recidivists, and Passaic County has used the information to determine how many, and which, types of cases to assign to case managers.

Some county staff have been confused about the purpose of the CSA, although this problem may be becoming less common. During site visit interviews MPR conducted in 2000 and 2001, many case managers and supervisors voiced the impression that the CSA's main purpose was to provide state staff with data on clients' needs or to allow the state to determine whether longer-term recipients should be exempted from the 60-month time limit; these staff did not appear to realize that the CSA was also intended to help case managers identify and address client problems. By fall 2002, however, when MPR conducted the most recent round of interviews, most county staff appeared to be aware that the CSA is intended as a case management tool.

[3]The second DHS instruction (issued on October 10, 2000) emphasized the value of the CSA as a case management tool noting: "Based on the information obtained from these assessments, the primary goals are to address any barriers that are identified and to schedule the client for an appropriate employment directed activity at the earliest possible opportunity."

Some case managers are also unsure how to use the CSA information. Some staff suggested that it was not always obvious how to respond to the types of problems clients described in response to the CSA questions. In addition, when staff do make referrals, they are not always sure whether or not they are supposed to share any of the information in the CSA with the professional staff who conduct assessments or deliver services to clients. Some assessment staff and service providers associated with the new initiatives note that they would appreciate some of the client information in the CSA when they first meet with clients.[4]

The fact that some staff have been confused about the purpose and use of the CSA may have contributed to the low rate of client referrals. As noted in Chapter II, while welfare staff administering the CSA identify a substantial number of client problems, they refer a smaller subset of clients for more detailed assessments or services (see Figure II.1). By improving case managers' understanding of the purposes of the instrument and how best to use it, state and county officials may be able to increase the rate of referrals to appropriate services. It is important to recognize, however, that even if case managers fully understand the purpose and use of the instrument, and try to refer most clients with problems to assessments or services, some clients probably will refuse assistance.

State and county staff seeking to refine the CSA screening process might consider the following specific options:

Remind staff of the purpose of CSA. State and county officials could remind staff about the multiple objectives of the CSA through written instructions, appropriate supervision, and training. These communications could emphasize that staff are expected to follow up on client problems identified in the CSA.

Provide more guidance to help staff map client problems to specific service needs. Currently the CSA contains referral codes suggesting some of the services to which clients with specific problems can be referred. State and county managers could provide case managers with additional guidance about the types of service needs and potential referrals relating to each of the main client problems covered in the CSA.

Clarify how the CSA complements other screening and assessment procedures. The state could clarify whether and when the CSA can substitute for other types of screening such as the standard SAI, MHI, and VRI screening procedures.

Ask clients with service needs whether some or all of the information in the CSA can be shared with professionals in other agencies. In most counties visited, the CSA is never shared with the assessment staff and service providers involved in state-sponsored initiatives. Supervisors suggested that the lack of information sharing is due to concerns about both client confidentiality and the burden on staff who would need to ask clients to sign waivers and copy and send the CSA. In Mercer County, however, staff typically ask clients with service needs whether the CSA can be shared and, if so, ask them to sign a release. Other counties might explore ways of sharing completed CSAs

[4]Staff conducting assessments often pose a standard sequence of questions. However, if and when there is some prior indication of a particular problem from the CSA, they could probe further to confirm that the client has that problem and to gauge how serious it is.

with relevant staff when clients permit this and are referred to SAI, MHI, DVRS, or other service providers.

- ***Welfare staff often refrain from referring clients for vocational rehabilitation assessments because of concerns about delays in completing these assessments.***

State officials have encouraged county welfare staff to identify clients who may have disabilities and need vocational rehabilitation services. While all county welfare agencies have long been able to refer clients to DVRS, in practice, welfare staff made few such referrals. Recognizing that a substantial number of recipients have disabilities, the state created the VRI to help counties with the largest caseloads identify clients who might have disabilities—including learning problems and other disabilities that are not easy to detect.[5] The mix of counties involved in the VRI has changed over time; currently, it includes six of the counties with the largest welfare caseloads.[6] DHS gave the VRI counties a set of guidelines and a one-page checklist indicating which groups of TANF recipients should be referred to DVRS; these selection criteria focus on whether clients have had difficulty in WFNJ activities, have low educational attainment, are longer-term recipients, or have been sanctioned.[7] After welfare staff refer the client, DVRS staff are expected to complete a detailed assessment and, if appropriate, place the client in services.

The VRI has not appreciably expanded referrals of TANF recipients to DVRS. In April 2000, just after the VRI was launched, DVRS' administrative records indicated that, statewide, there were 464 TANF clients on the division's caseloads, including both TANF clients being assessed and those receiving vocational rehabilitation services. During the subsequent two years, there was no appreciable change in the number or percentage of TANF clients receiving DVRS assessments and services.[8]

County welfare staff in several of the counties participating in the VRI suggest that they are reluctant to refer many clients to DVRS, in part because DVRS assessments and services can take a long time to complete. Welfare staff say they are concerned that clients referred to DVRS are not participating in any activity, which may reduce counties' measured client participation rates and slow individual clients' progress toward self-

[5]In addition the VRI provides funding to cover the costs of TANF clients' DVRS assessments and services.

[6]The six counties currently participating in the VRI are Camden, Essex, Hudson, Mercer, Passaic, and Union. About 78 percent of the state's TANF cases are in these six counties. Initially, the VRI was implemented in eight counties: Atlantic, Essex, Camden, Cumberland, Hudson, Monmouth, Ocean, and Passaic. (See Appendix A.)

[7]Specifically, counties were expected to refer the following groups of clients to DVRS: (1) those who have not made progress in two or more WFNJ activities and either do not have a high school diploma or GED or are illiterate, (2) those who have received TANF for 60 months and are not participating in other activities, (3) those whose case had been closed due to sanction and been sanctioned at least two previous times while on TANF, (4) clients participating in the Substance Abuse Initiative and who had been cleared for treatment by the SAI care coordinator, and (5) deferred clients who voluntarily agree to participate.

[8]By December 2002, 426 TANF clients were on DVRS's caseload. Thus, the percentage of regular TANF cases on DVRS's caseload statewide rose from 0.9 percent to 1.1 percent. In the 10 counties participating in the VRI, the percentage of TANF cases on DVRS's caseload rose from 0.8 percent to 1.1 percent.

sufficiency. Staff in several counties suggested that they refer clients to DVRS only as a last resort.

DVRS staff, in turn, note that assessing the problems of welfare recipients is often difficult and time-consuming. Many TANF clients referred to DVRS tend to miss appointments; this is understandable, since several counties refer mostly those clients who have failed in other activities. These clients tend to have multiple problems and have difficulty participating in any activity. Moreover, assessments sometimes involve meeting with several professionals—including DVRS staff and outside doctors or contractors. Some assessments involve supported work activities during which staff monitor clients' performance and try to resolve problems.

DVRS staff suggest that, if the VRI screening tool were refined, it would help staff identify clients likely to benefit from vocational rehabilitation services. In several counties, many, if not most, of the clients welfare staff refer to the DVRS have no disabilities. DVRS staff note that the screening tool does not take full advantage of information that welfare staff often have about clients' physical condition and learning problems. With the exception of the inclusion of deferred clients who agree to volunteer for services, the VRI screening checklist does not refer to any client disabilities.

In some counties, DVRS and county welfare staff have worked together to modify the way welfare staff identify clients who are referred to DVRS. For example, in Cumberland County, welfare staff have been referring to DVRS all clients with "limited deferrals"—cases where doctors have documented that clients have some type of health problem, but have indicated that the clients can still do certain types of work.[9] In Passaic County, a contractor who works with hard-to-place TANF clients has developed a short list of questions for clients that includes whether the clients were ever enrolled in special education classes and whether the client has difficulty performing simple calculations or following instructions. These strategies may have contributed to Cumberland's relatively high rate of referrals of TANF cases to DVRS, as well as to the recent growth of TANF referrals in Passaic.[10] DHS currently plans to incorporate questions relating to learning disabilities into the CSA, which should help counties identify more clients who can benefit from DVRS services.

In considering ways to enhance the partnership between DHS and DVRS, state and county staff could explore the following options:

Refine criteria for identifying clients to be referred to DVRS. Currently, counties do not refer to DVRS all the clients who meet the selection criteria suggested by DHS. In addition, some DVRS staff question these selection criteria, since many of the TANF referrals are inappropriate. Case managers could make greater use of information about clients' performance in activities, test scores, responses to the new CSA questions on

[9]Cumberland DVRS staff suggested that, while some of the clients with limited deferrals are appropriate, a substantial fraction have injuries or other health problems that make them incapable of working or participating in vocational services. This suggests that clients' doctors may not always complete the deferral form correctly.

[10]The fraction of Cumberland TANF cases on DVRS's caseload (about 6 percent) is larger than that of any other county in the state. Passaic has experienced one of the larger increases in TANF cases on DVRS's caseload rising from 0.9 percent in April 2000, to 1.8 percent in December 2002.

learning disabilities, and information that doctors provide to staff about clients' problems. DHS and DVRS staff might modify the checklist that case managers use to identify clients who need vocational rehabilitation services, incorporating these types of questions.

Agree on limits on time allowed for various types of assessments. DFD and DVRS could develop mutually acceptable targets for how long assessments may take. These targets may need to be flexible or at least vary, depending on the types of potential client problems, since diagnosing certain problems requires longer assessments.

Clarify client work requirements and welfare/DVRS responsibilities for engaging clients. The state might consider clarifying whether clients involved in various types of assessments are expected to participate in some work, job search, or training activities for a specified minimum number of hours per week. The state could consider waiving most requirements for clients initially, as long as clients participate in an assessment. Participation requirements for clients referred to DVRS could grow gradually over time. Both DVRS and county welfare staff could take on some responsibility for getting clients to keep both their DVRS and other appointments. Counties could consider the strategy employed in Mercer, where welfare case managers often escort clients to their first DVRS appointment. In addition, clients receive a letter indicating that they might be sanctioned if they repeatedly fail to show up for scheduled DVRS appointments.

- ***Detection of substance abuse and mental illness depends, in part, on interagency communications and the use of information signaling potential client problems.***

Many people are reticent about acknowledging that they have a substance abuse problem or a mental illness. While some are not fully aware that they have a problem, others realize they have a problem but are too ashamed to admit it. Welfare recipients sometimes fear that acknowledging their problem could jeopardize their benefits or custody of their children. Some people are willing to consider seeking help only during or immediately after a crisis, thus creating a brief window of opportunity to address the problem.

Signals indicating a potential client problem can emerge in diverse contexts involving a variety of staff and organizations. For example, staff can detect potential problems based on clients' demeanor, their attendance or performance in work and training activities, and their speech patterns or response to questions. While these signals, in isolation, may not be clear, when combined, they can suggest a serious problem. Given the limits on staff time and the complexity of such coordination efforts, welfare agencies probably cannot involve in the detection process all the staff who have contact with recipients. However, many counties have succeeded in involving multiple staff in this process.

The way county staff are organized and communicate with one another may be affecting detection efforts. The large intercounty variation in both the fraction of TANF clients who have been referred to the SAI and SARD initiatives and the fraction who have entered treatment highlight the potential importance of county programs,

procedures, and staff roles in detection efforts (see Table III.1).[11] Atlantic and Essex, the two counties implementing the SARD, have the largest percentage of TANF clients who are assessed and who enter treatment, which suggests that the SARD initiative probably has succeeded in expanding substance abuse detection. Even among the other 19 counties, all of which implement the SAI program, the fraction of clients referred to SAI varies a great deal. While this may be due, in part, to variation in the extent of substance abuse problems among those remaining on TANF in each county, it may also be due partly to differences in county organization and detection efforts. The site visit interviews point to four dimensions along which county substance abuse and mental health detection efforts vary, each of which may be contributing to the efficacy of these efforts: (1) the extent to which training vendors and service providers play a role in detecting client problems, (2) the role of specialized welfare staff in the screening process, (3) the extent and ways staff target specific groups of clients for more intensive screenings, and (4) the challenges staff face in completing assessments in a timely manner.

The potential for more effective detection appears to be enhanced when county welfare agencies are supported by, and communicate with, training vendors and service providers working with clients. Most welfare case managers participating in the site visit discussions noted that providers of employment and training services can detect substance abuse and mental health problems because they observe clients frequently and are aware when clients' performance or attendance is poor. In addition, some clients seeking help go directly to local service providers for help. Some county welfare agencies have made a concerted effort to involve training vendors and service providers in identifying clients with personal problems. For example, Passaic County has shared information on the purpose and design of the VRI, SAI, and MHI with most training vendors, leading at least one vendor to refer several clients to each of these initiatives.

In some counties, specialized county agency staff play important roles in the screening process. While specialized SAI and MHI staff are mainly responsible for conducting assessments once a likely client problem has been identified, in some counties these staff also are involved in the initial screening process. For example, Atlantic County's SARD staff conducted many substance abuse screenings, thus relieving case managers of this responsibility. In some cases, specialized case managers or other county welfare staff also play a role in the screening process. In Essex County, staff in the welfare department's social services office conduct many of the screenings for both substance abuse and mental health. The efficacy of these approaches may depend, in part, on whether clients' regular case managers are able to share useful client information with the specialized staff involved in screening; for example, the screening staff may be more successful when case managers brief them on a client's personal goals or apparent problems.

[11]While participation in SAI/SARD varies a great deal by county, this is not the case for the MHI, the state-supported mental health demonstration implemented in six counties. Participation in the MHI is constrained by funding limits that cover only about 100 clients in each county.

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TABLE III.1

NUMBER OF TANF CLIENTS PARTICIPATING IN SUBSTANCE ABUSE INITIATIVE AND SUBSTANCE ABUSE RESEARCH DEMONSTRATION
JULY 2000 THROUGH JUNE 2001

	Number of Clients Participating			Percent of All Adult Cases on TANF		
County	Referred to Assessment[a]	Assessed[a]	Entering Treatment[a]	Referred to Assessment[b]	Assessed[b]	Entering Treatment[b]
Atlantic*	88	52	63	6.3%	3.7%	4.5%
Bergen	15	11	11	1.4%	1.0%	1.0%
Burlington	20	21	3	1.7%	1.8%	0.3%
Camden	42	42	31	0.7%	0.7%	0.5%
Cape May	4	4	3	0.7%	0.7%	0.5%
Cumberland	25	26	24	1.5%	1.5%	1.4%
Essex*	628	400	279	3.7%	2.4%	1.7%
Gloucester	24	15	4	2.8%	1.8%	0.5%
Hudson	67	57	28	0.8%	0.7%	0.4%
Hunterdon	1	1	0	1.6%	1.6%	0.0%
Mercer	35	29	19	1.4%	1.1%	0.7%
Middlesex	43	34	27	2.2%	1.7%	1.4%
Monmouth	42	42	33	2.2%	2.2%	1.7%
Morris	1	0	0	0.4%	0.0%	0.0%
Ocean	21	17	11	1.9%	1.6%	1.0%
Passaic	60	51	31	1.4%	1.2%	0.7%
Salem	17	14	6	3.8%	3.2%	1.4%
Somerset	8	5	7	1.9%	1.2%	1.7%
Sussex	10	11	8	6.8%	7.4%	5.4%
Union	63	62	52	2.0%	2.0%	1.7%
Warren	0	0	0	0.0%	0.0%	0.0%
State	1,214	894	640	2.2%	1.7%	1.2%

[a]The counts of clients participating are from administrative records.

[b]The percentages are based on the ratio of (1) the number of clients participating (the first three columns above) to (2) estimates of the number of adult cases ever on TANF between July 2000 through June 2001, which were generated using New Jersey's FAMIS welfare records files.

*Essex and Atlantic counties participated in the Substance Abuse Research Demonstration. All 21 counties participated in the Substance Abuse Initiative.

Several counties have targeted more intensive screenings and assessments on three groups of clients who appear to have a relatively high likelihood of suffering from mental health or substance abuse problems: sanctioned clients, clients receiving Emergency Assistance, and clients referred to child protective services. For example, Essex County staff routinely screen all sanctioned clients for mental health problems. Similarly, Essex and Atlantic SARD initiatives required sanctioned clients to complete substance abuse assessments when staff believed they might be using drugs. (Subsequently, the state required all counties to adopt this policy.) In addition, Essex SARD staff routinely screen Emergency Assistance clients for substance abuse and more recently have begun screening TANF clients referred to child protective services. One substance abuse study indicated that a large fraction of both sanctioned clients and clients receiving Emergency Assistance are problem users (Morgenstern et al. 2001).[12]

Counties' location, caseloads, and resources can affect the challenges staff face in ensuring that substance abuse and mental health assessments are conducted in a timely fashion. In most cases, SAI and MHI assessments are quite timely and are conducted within a day or two of a referral. However, lags in assessments sometimes occur due to logistical problems or staffing constraints. In rural parts of the state, a single SAI care coordinator is responsible for conducting client assessments in more than one county. As a result, the coordinator must stay in touch with staff in several welfare agencies and move between county offices to conduct assessments, which sometimes leads to small delays in assessments. In some urban counties with large welfare caseloads, referrals to MHI sometimes surpass the capacity of the professional staff responsible for assessments, forcing welfare staff to delay referrals. In addition, in urban counties where case managers are responsible for a larger number of clients, they are less likely to have time to follow up to make sure clients make their appointments with assessment staff. Welfare agency space constraints have also prevented the SAI initiative from filling some open assessment positions. Finally, in both urban and rural areas, unpredictable factors can increase the administrative burden on the specialized SAI and MHI assessment staff, thus making it more difficult for them to complete assessments quickly. For example, a recent change in Medicaid policy required SAI staff to reassess most GA cases, which, in turn, forced them to delay substance abuse assessments for new TANF cases.

In seeking to refine local efforts to detect substance abuse and mental health problems, state and county staff may wish to consider the following broad strategies and options:

Facilitate communications among staff and organizations that can help identify potential client problems. Both specialized staff and service providers can play important roles in the detection process if they are encouraged to do so and are supported by welfare staff. Specialized staff may be most helpful in assisting with screening efforts when case managers can provide them with some background information on their clients. To enhance communications with service providers and vendors, welfare staff

[12]The SARD-sponsored study found that nearly half of all the sanctioned clients in Atlantic County completing substance abuse assessments met criteria for a substance abuse disorder. In addition, the researchers concluded that Essex's effort to screen Emergency Assistance clients had substantially contributed to the county's success in detecting substance abuse among welfare recipients. (Morgenstern et al. 2001).

may want to meet periodically with these organizations and discuss the sorts of client problems and behavior that should trigger a referral to a case manager. Counties could further encourage such vendor referrals by making sure case managers respond to them in a timely way and perhaps modifying vendor performance measures so that appropriate referrals are treated as positive outcomes.

Help staff identify high-risk groups that can receive more intensive screenings. In addition to conducting routine screenings for substance abuse and mental health problems, several counties have demonstrated the potential value of targeting more frequent and intensive screenings on higher-risk clients such as sanctioned clients, those applying for Emergency Assistance, and TANF recipients who have been referred to child protective services. The state could sponsor studies designed to help counties determine whether there are other effective predictors of substance abuse, mental illness, or domestic violence.

Promote services to clients. One strategy for encouraging clients with potential problems to seek help is simply to inform them of the services available, including services available through the welfare agency and other services they can access directly. Some counties have tried to explicitly and aggressively promote services to clients. For example, in Essex, SAI and SARD coordinators frequently attend TANF recipients' initial WFNJ group orientations and describe the substance abuse services available and how they can access them.

Expand SAI and MHI assessment staff or help them respond to peak demands. While most substance abuse and mental health assessments are conducted quickly, assessment staff sometimes have difficulty accommodating a surge in the number of referrals. The state could consider expanding the number of SAI and MHI assessment staff. County welfare agencies could also try to make more space available so SAI can at least fill open assessment staff positions. To handle peak demands, SAI and MHI managers might consider identifying back-up staff who can conduct assessments. Alternatively, when a backlog of referrals develops, agencies could try to relieve assessment staff of some of their administrative burdens so that they can minimize delays in assessments.

B. INVESTING IN AND SUPPORTING WELFARE CASE MANAGERS

The efficacy of efforts to detect clients' health and behavioral problems depends in large part upon county welfare agencies overall case management resources. Our site visits suggested that the amount and quality of the information case managers obtain about clients' personal problems depends, in part, on these staff's interviewing and other skills, their average caseloads, the quality and amount of office space available to them, and their telephone and computer systems.

Drawing on the site visit interviews with county staff, this section focuses on two types of investments in case management that can affect welfare agencies' overall capacity to detect client problems: (1) training and hiring additional case managers, and (2) enhancing their office space and phone and computer systems.

- ***Agencies' capacity to identify client problems can be enhanced by investing in case managers' skills and limiting their caseloads.***

The need for, and role of, welfare case managers has been evolving in New Jersey. As state and county agencies have expanded efforts to detect and address client employment barriers, the responsibilities of case managers have expanded. In addition to their growing role in detecting client barriers, case managers are now responsible for helping those leaving welfare to take advantage of a variety of new post-TANF benefits and services. Effectively carrying out all these functions often requires new skills or additional staff.

The need for more case management training is also suggested by the career paths of many case managers. In several counties, where case management and income-eligibility functions are performed by separate staff, many case managers were initially hired for income-eligibility positions and then secured promotions to case management. Fortunately, staff who seek these promotions often have relevant skills and interests. Nonetheless, because of collective bargaining and civil service constraints, staff seniority, rather than skill, often determines which interested staff win promotions. County staff participating in the site visit discussions often noted that they would welcome state assistance in developing a variety of case manager screening skills, including when and how to broach sensitive issues and how to help clients get past feelings of shame or concerns about the repercussions of admitting they have a serious drug problem or mental illness. While state and county welfare agencies have sponsored some workshops on various screening issues—including the use of the CSA and the importance of domestic violence problems—case managers probably could benefit from more training.

Case managers' ability to detect client problems depends not only on their training but also on their average caseloads and the amount of time they can spend with each client. Average caseloads vary a great deal across counties. For example, in the counties with the largest concentrations of TANF recipients, each case manager, on average, is responsible for more than 150 clients. By contrast, in some of the more affluent counties, case managers have average caseloads of fewer than 75 cases. Since counties are responsible for a portion of case management costs, the counties with larger welfare caseloads bear a larger financial burden for these costs. However, at least one of the counties with a large welfare caseload has not spent all its state allocation of case management funding.

In counties where each case manager is responsible for relatively large numbers of cases or where case managers are responsible for other functions, case managers have fewer opportunities to detect clients' personal problems. In particular, staff can less frequently meet with clients, ask them how they are doing, observe their behavior, and mention the availability of various services they might need. Case managers with large caseloads also have difficulty staying in touch with other staff who work with their clients.

Even though resource constraints are likely to limit the size of state and county investments in case management, officials can consider a number of incremental changes that could enhance welfare agencies' screening and assessment capabilities:

Hire and promote case managers who are comfortable discussing personal issues. Even where it is not feasible to hire social workers, counties can screen applicants for case management positions and hire or promote those candidates who seem

the most comfortable discussing sensitive issues and who appear to have the capacity to motivate clients to seek help.

Offer staff more training on interviewing and problem solving. While some training has been provided to case managers in most, if not all, counties, this training often is too brief and does not go into enough detail on important screening issues. The state and counties could work together to develop workshops on how to detect specific personal problems through observation, interviews with clients, and monitoring clients' behavior in work and training activities.

Identify staff who can serve as resources on particular issues. Currently, most county welfare agencies have some specialized staff who provide advice to other case managers about how to screen and deal with substance abuse (the SAI or SARD care coordinators) and domestic violence problems (Family Violence Option representatives). Counties could identify specialized staff or senior case managers who would serve as resources for other specific problems and issues, such as how to identify signs of mental illnesses and learning disabilities.

Limit the variability, if not the average size, of individual case managers' caseloads. The caseloads of individual case managers vary substantially, both within and between counties in the state. In the near term, county officials could seek to reduce the variability of caseloads across case managers through more careful assignment and reassignment of cases. In the longer term, the state might explore ways of limiting average case manager caseloads in all counties. As a first step toward this objective, the state could monitor county staffing levels and the number of cases assigned to individual case managers.

- ***Improving office space and communication systems could help staff detect client problems.***

Case managers need not only to have adequate skills and time to work with individual clients, but also other forms of support. Our discussions with county staff highlighted the value of office space that allows for private conversations with clients. In addition, the quality of phone and computer systems seems to affect the ability of case managers to stay in touch with both clients and staff in other agencies who have contact with clients.

Observation of case managers at work suggests that their offices do not always provide sufficient privacy to facilitate frank discussion with clients on such sensitive issues as substance abuse, mental illness, and domestic violence. In some counties, staff sit at open desks with few, if any, partitions. In addition, since most offices do not have any toys or play area for children, children often sit with parents while they discuss issues with case managers.

Some counties have explored ways of providing case managers with access to shared private space for purposes of discussing private issues with clients. For example, Mercer County recently made a private office available to the welfare staff member serving as the Family Violence Option Initiative liaison. The liaison uses this office when she meets with clients to discuss domestic violence problems. After discussing the problem and the types of relevant services available, the liaison can leave the room so that clients in crisis can call shelters or other service providers.

In some counties, case managers have neither voice mail nor e-mail, which impedes their ability to stay in touch with clients and staff in other agencies. When clients and other service providers try to reach case managers, they often receive a busy signal. Some service provider staff suggested that they often give up trying to reach case managers by phone.

Counties could explore the following options:

Provide staff with space that is sufficiently private for them to discuss sensitive issues. Where feasible, counties could seek to provide private offices or conference rooms where case managers can speak privately with their clients. Alternatively, counties could at least install partitions around case managers' desks so clients can have a relatively private conversation with their case manager.

Explore the feasibility of creating on-site play space for children. A small play area can permit clients to speak privately to case managers without being distracted or inhibited by children.

Equip staff with voice mail and e-mail. Investing in these systems could help case managers stay in touch with both their clients and other service providers who may be aware of clients with personal problems.

IV

ENGAGING CLIENTS IN TREATMENT AND WORK

Once staff identify a client health or behavioral problem, they often must overcome institutional and psychological hurdles to help clients secure appropriate treatment services. Staff must determine what types of services clients need and locate a provider with sufficient capacity. Clients sometimes must be convinced that the treatment can benefit them, and their child care and transportation needs must be addressed. Treatment and work requirements need to be smoothly integrated. If one or more of these conditions are not met, clients may fail to enter or complete treatment. Examining these hurdles and the way programs have sought to overcome them can help enhance treatment services.

KEY FINDINGS FROM THIS CHAPTER

- ***Shortages in various treatment services sometimes delay placements, and may be jeopardizing successful treatment.*** Staff report shortages in selected substance abuse and mental health treatment, as well as some services for those with multiple health and behavioral problems. Officials may be able to address these service gaps by increasing payment rates and funding, creating intermediaries who match clients to available services, and informing providers about the family circumstances and service needs of TANF clients.

- ***Programs need to address clients' family and logistical problems, as well as their fears about treatment.*** Some clients are reluctant to enter treatment because they are concerned about being stigmatized, being medicated, or losing access to their children. Many clients who are interested in treatment have difficulty meeting family responsibilities and arranging child care and transportation. These concerns highlight the potential value of providing clients with more information about the potential benefits of treatment, some participation incentives, and support services.

- ***Work and training activities do not always complement treatment schedules and priorities.*** The range of work and training activities available to those in treatment often is limited. Some clients are placed in activities and services with overlapping schedules. Work activity staff are not always aware of, or sensitive to, clients' problems and needs. Officials could consider expanding the menu of work activities and increasing the use of integrated transitional employment and treatment services.

New Jersey maintains a broad infrastructure of treatment services that are available to assist individuals, including those on TANF, who have serious personal problems, including:

Substance Abuse. Drug and alcohol treatment services are available at 300 sites in New Jersey and include short- and long-term inpatient (residential) care, outpatient services and intensive outpatient services, inpatient and outpatient detoxification or emergency detoxification ("detox") services, methadone programs, halfway houses, juvenile programs, and programs for mentally ill and chemically addicted (MICA) patients who have dual mental illness and substance abuse diagnoses. In 2002, 117 providers operating at 185 sites were part of a network of programs accepting TANF referrals from SAI and SARD Care Coordinators.

Mental Health. The Division of Mental Health Services funds six psychiatric hospitals, psychiatric units in six county hospitals, and 120 community based, not-for-profit organizations that provide crisis services, group homes, outpatient services—for example, periodic counseling, therapy or assistance taking and monitoring medication, partial hospitalization or partial care, integrated case management, and supported employment services (job placement, interviewing, supervised work, and follow-up support).

Domestic Abuse. Every New Jersey county has at least one domestic violence program that provides shelter and nonresidential services, and a rape care program. Domestic violence programs are supported through the Division on Youth and Family Services in the state's Department of Human Services, and rape care programs are supported through the Division on Women in the state's Department of Community Affairs. Individuals who are in danger may seek shelter at the domestic violence shelter in their county, or shelter staff will help them locate shelter in another county. New Jersey also offers emergency payments to partially subsidize housing or transportation costs to help women escape violent households. Domestic violence programs may also provide counseling, assistance with requests for restraining orders, housing and financial advocacy, and children's services.

Disabilities. The Division of Vocational Rehabilitation Services (DVRS) within the state's Department of Labor has an office in each of New Jersey's 21 counties. Individuals who are diagnosed with a disability, but who are still able to work, can access treatment, assistive technology, and employment assistance, such as work adjustment training, job placement, and job coaching. DVRS counselors coordinate services through a network of physicians and other professionals, suppliers of prosthetic devices or assistive technology, and community-based rehabilitation programs.

This chapter examines three issues that can affect TANF clients' participation in these and other treatment programs. First, the capacity and availability of services affects whether staff can quickly place clients into appropriate services. Second, even when openings in treatment programs are available, clients' fears or their family responsibilities may need to be addressed before treatment can begin. Third, connecting TANF clients to treatment is sometimes made more challenging because they are expected to meet 35-hour weekly TANF work requirements, either through treatment activities alone or through a combination of treatment and approved work participation activities, and they

must ultimately make a transition to independent employment. We examine these three issues in turn, in each of the three main sections of the chapter.

A. THE AVAILABILITY OF TREATMENT SERVICES

Although many treatment options exist in New Jersey, matching clients with appropriate services is not always straightforward. According to staff in the nine case study counties, the number of people seeking substance abuse and mental health treatment sometimes exceeds the capacity of local providers. In addition, staff suggested that few providers are well equipped to deal with clients who have multiple problems.

- ***Staff report shortages of some types of mental health and substance abuse treatment services, highlighting the need to expand these services and improve efforts to match clients to them.***

Shortages in services can take several forms. When no appropriate services are available, clients sometimes are placed on waiting lists, thus delaying treatment. If local treatment providers and services are in short supply, clients may need to leave the area in order to receive treatment, or settle for some type of service that does not fully address their problems. These types of delays and constraints in the availability of services sometimes discourage clients from pursuing treatment at all. Service gaps sometimes affect those seeking substance abuse treatment, as well as clients needing mental health services.

Staff indicated that is often difficult to refer clients in a timely manner to mental health services, particularly clients who do not currently have severe symptoms. Few private providers of outpatient mental health services accept Medicaid because Medicaid rates for these services are very low. There is rising demand for the services available through public community mental health care centers. Since these centers cannot accommodate all those who request services, they must give priority to those with the most serious mental illness or those in crisis. County welfare staff in several counties reported that they sometimes encounter delays of several weeks when they try to refer TANF clients to mental health services. Consequently, some case managers make referrals only when clients have severe symptoms or specifically request help with a mental health problem.

Staff also reported local shortages of several types of substance abuse services, which sometimes forced them to refer clients to less intensive services or to services far from their communities. Some types of treatment shortages are common throughout the state. For example, there are few residential treatment slots available for women who want or need to bring their children to the treatment facility. Filling this shortage may be important, not only because alternative child care options may be limited for these families, but also because some research suggests that mothers are more likely to successfully complete residential treatment if they are able to maintain regular contact with, and care for, their children (NGA Center for Best Practices). Other shortages appear to vary by region and treatment modality. The most intensive shortages appear to be concentrated in southern New Jersey. For example, TANF clients in Atlantic, Cumberland, Camden, and Mercer counties who need residential care often must be placed with providers in northern New Jersey or in Pennsylvania. Staff in some counties

also reported shortages of intensive outpatient treatment, of some detoxification services, and of treatment programs that include methadone maintenance services.[1]

The shortages in treatment capacity highlight the important function often performed by the specialized staff who match clients to substance abuse and mental health services. The SAI or SARD staff and, in six counties, the MHI staff, refer clients to substance abuse and mental health services, respectively. These staff can help minimize the effect of shortages because they usually are familiar with services throughout the state. Based on a client's expressed needs, SAI, SARD and MHI staff can help the client select the most appropriate provider with available slots, balancing the need to find a provider as close as possible to the client's community, one with treatment slots available soon, and one offering the types of treatment and support services needed by the client. Interviews with county staff suggested that the MHI program may be helping clients secure appropriate treatment somewhat more quickly than is typically the case in counties that do not have MHI programs.[2]

Care Coordinators and MHI staff may improve treatment access in other ways. For example, over time, they develop relationships with treatment provider staff. Through these contacts they are sometimes able to elicit special efforts by providers to accommodate TANF clients with emergency needs. These relationships may also place them in a position to educate and inform providers about the particular needs of TANF clients. For example, one Care Coordinator who reported that more substance abuse treatment providers are adding methadone services had the impression that this was due, at least in part, to SARD staff advocating for these services over several years. Finally, when there are delays in accessing treatment, specialized case managers can follow up with clients to help maintain their readiness to begin treatment until it becomes available. In contrast, CWA case managers said they rarely have time to follow up with clients after making an initial referral for mental health services.[3]

Policymakers could consider several alternatives to increase substance abuse and mental health treatment resources and to enhance clients' access to appropriate services:

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[1]One problem is that, while methadone is intended largely to replace heroin use, some individuals simultaneously abuse both heroin and methadone, and thus need treatment for both problems. For these reasons and other philosophical ones, as well as the logistical burden of dispensing methadone, some substance abuse programs do not provide treatment for methadone users.

[2]Although the MHI staff in one county reported delays of up to three months for their TANF clients to see a psychiatrist or to begin individual counseling, staff in the other MHI counties reported no unusual delays finding appropriate treatment resources for their clients. (At least one MHI county however reached the limit for the number of clients MHI was funded to serve.) By contrast, delays were common in three of the four non-MHI counties visited. The exception was Bergen which created its own mental health program that is somewhat similar to the MHI.

[3]There may be additional effects of SAI and SARD on substance abuse treatment. There were significant shifts in placement type, along with increases in utilization of residential care and all types of outpatient care among women, after implementation of SAI and SARD. These changes may be due to the use of intermediate case managers with substance abuse expertise, managed care components of the initiatives, or other factors (New Jersey Substance Abuse Prevention and Treatment Advisory Task Force, p. 37).

Provide more technical assistance and training to provider staff. The state could also provide technical assistance to help small providers manage licensing and paperwork burdens. Some studies have suggested that these burdens discourage small providers from serving TANF or Medicaid clients or from accepting state contracts. State and county agencies could also try to ease substance abuse facilities' staffing shortages by developing or supplementing efforts to attract and train qualified staff members.

Implement MHI in additional counties and expand MHI capacity. Currently the MHI's mental health services operate in only 6 of the state's 21 counties. Staff in non-MHI counties expressed great interest in implementing the initiative. State policymakers might consider expanding the initiative to additional counties with sufficient caseload levels to justify the minimum fixed program costs. As a less costly alternative or for smaller counties, the state could help fund multicounty mental health case managers to perform assessment, referral, and case supervision functions. Counties could share staff, similar to the staffing structure for SAI Care Coordinators in smaller counties. The state could also examine whether the existing MHI capacity levels should be expanded in the counties with the greatest demand for mental health services.

Assess adequacy of provider rates and funding. Ultimately, policymakers need to assess the adequacy of Medicaid payment rates and funding for services in short supply. While few public resources may be available in the near term, state and county officials could at least begin to examine which provider fees should be increased. In addition, state officials could help providers secure federal or private grants to help pay for services, particularly for demonstration projects targeted to women with children.

- ***Treatment programs and services for individuals with multiple serious barriers are in short supply.***

Although significant fractions of TANF recipients experience multiple serious barriers to employment, treatment options for individuals with co-occurring problems are limited. This is the case not only in New Jersey, but in most other states as well. A study by the U.S. Department of Health and Human Services found that 41 states had no specific programs or strategy to address recipients' multiple barriers, and only six states provided formal guidance on how to work with recipients who have multiple barriers (Office of Inspector General 2002).

Many clients with substance abuse problems have poor mental health as well (and vice versa), but there are obstacles to concurrent treatment of these two problems. In fact, treatment for individuals who are diagnosed with both mental health and substance abuse disorders is a recognized problem in substance abuse treatment (Sciacca 1991; and Kirby and Anderson 2000). There are some substance abuse programs in New Jersey for individuals who are diagnosed with both types of problems, but most substance abuse or mental health providers are not equipped to address both problems. Because the Certified Alcohol and Drug Counselors who staff most substance abuse treatment programs are not trained to deal with mental illness, only substance abuse treatment providers with specialized staff can treat mental health problems. Many substance abuse treatment programs do not accept clients who are taking mood-altering drugs, including those taken for mental health disorders. DVRS will not take clients with substance abuse disorders unless they have been clean and sober for a period of three months, making it difficult for SAI or SARD clients to access their services. Program operators, case managers, or

others sometimes assume that mental health problems will abate on their own once alcohol or drug abuse is reduced, obviating the need for mental health interventions (Sciacca 1991).

Although some clients have both mental health and substance abuse problems, DFD decided that individual clients should be referred to either SAI or MHI, but not to both initiatives. For clients with both problems, SAI or SARD and MHI staff are instructed to determine which of the problems is "primary"—that is, which problem came first or is causing the other. Clients are supposed to be referred, first, to the initiative that addresses their primary problem. However, there are no clear guidelines for determining which of the problems is primary—not only within New Jersey's initiative procedures, but among treatment professionals in general.

Few providers have the training or organizational capacity to assess or treat other combinations of problems, including not only substance abuse and mental health but domestic violence and learning problems or other hidden disabilities. For example, most MHI and SAI staff suggested that they can refer clients who disclose abusive or violent relationships to emergency shelters; but they lack the mechanisms needed to integrate other types of domestic abuse services into their practices, and have little or no experience collaborating with domestic violence programs. Staff do not test for physical or learning disabilities, nor do they provide services to address such problems. Similarly, while DVRS has assessments and services designed to deal with clients with multiple disabilities, including learning or other hard-to-diagnose problems, domestic abuse services are not integral to their activities.

State and county officials may want to consider the following options to increase capacity to treat TANF clients who face multiple barriers:

Expand programs providing integrated services for those with multiple barriers. State and county staff could explore ways to encourage providers to offer services designed for clients with specific combinations of problems. For example, by increasing payment rates and technical assistance, the SAI or MHI initiatives may be able to attract more providers who can treat both substance abuse and mental health problems concurrently.

Develop SAI/MHI co-enrollment and team case management procedures. In areas where integrated substance abuse and mental health services are not available or are in short supply, the state could experiment with co-enrollment in SAI and MHI services, to test whether suitable case management and treatment approaches could be worked out. Counties could also experiment with more cross-training and team case management to ensure that all staff interacting with clients are communicating. Team case management efforts might include DVR staff and family violence staff when this is appropriate.[4]

[4]Permitting co-enrollment would require the development of team case management approaches and protocols. Although these types of arrangements may be workable, they would not necessarily eliminate barriers to concurrent treatment by providers.

B. ENGAGING AND RETAINING TANF CLIENTS IN TREATMENT

Personal and family characteristics and circumstances can make TANF recipients a challenging group to engage and retain in treatment and services, compounding the impact of treatment shortages and delays. First, some clients are reluctant to face the reality of serious problems, or have fears and concerns about treatment approaches or implications. Second, many individuals also face difficulty reconciling treatment requirements with their family responsibilities, and with logistical problems such as child care and transportation. Below, we examine each of these two types of obstacles to treatment, including strategies some counties are using to address them and additional steps welfare officials could consider.

- ***More information and education, along with additional incentives, might help reduce resistance to treatment and help alleviate fears and concerns of some TANF clients***.

Denial of problems and the perceived stigma associated with serious personal problems are obstacles to engaging TANF clients in treatment. Staff noted that it is not unusual for clients receiving their first diagnosis for substance abuse or mental health problems to go through a period of denial before becoming able to "take ownership" of these problems and consider treatment. Many also tend to be concerned about stigma. Focus group participants told us they would be labeled "crazy," "addicted," or "stupid" if family members or friends learned they were sent to mental health, substance abuse, or vocational rehabilitation services. Staff members need to work hard with some clients just to convince them that getting counseling or other treatment did not mean they were "crazy" or "stupid."

Apart from concerns relating to stigma, some clients also experience fears about treatment and services. For instance, several focus group participants said they worried that if they were diagnosed with depression, they would "just be put on drugs." Domestic abuse staff find that even individuals with serious safety concerns sometimes are reluctant to enter a shelter, because emergency shelter environments are austere, residents share communal kitchen and bathroom facilities, and daily life is regimented. TANF clients are sometimes afraid of losing welfare, housing, or other public benefits while in treatment, and may be particularly fearful of drawing the attention of child welfare authorities if their substance abuse or mental health disorders are discovered, or if intensive treatment limits their ability to care for and supervise their children.

Staff reported that engaging in client-centered negotiations, coordinating with sanction policies, and offering incentives all appear to be useful strategies to overcome resistance to entering substance abuse treatment. SAI staff try to identify the specific issues that make clients reluctant to enter intensive treatment, then negotiate with them to enter a lower level of care if necessary, in order to initiate treatment. One approach sometimes used is to ask clients to sign an informal agreement stating, "I understand that I need [recommended treatment], but I will participate in [alternative treatment] for 30 days, and if my situation does not improve, in order to maintain my SAI enrollment, I will go into [recommended treatment]." Staff also take advantage of state mandates that sanctioned clients with suspected substance abuse problems must complete substance

abuse assessments and, if needed, attend treatment for 10 consecutive days in order to end their sanction.[5] As a positive motivator, the SARD provided incentives when clients began treatment and at specific treatment milestones. The SARD evaluation now underway may provide some evidence on the potential usefulness of these types of incentives.

Options to further reduce resistance and fears about treatment services include better educating and informing both clients and providers.

Inform and educate more clients about serious personal barriers and available services. State and local welfare staff could work with experts in mental health, substance abuse, domestic abuse, and disability fields to develop user-friendly, consistent, and effective brochures, flyers, or presentations about serious personal barriers for clients. Counties could also recruit clients who have succeeded in overcoming serious barriers and who are willing to share their stories and participate in group orientations or other types of meetings to extol the benefits of treatment. Counties might combine both strategies by convening a group of current and former TANF clients who have completed treatment services to develop materials addressing treatment concerns based on their experiences and perspectives, to be distributed to other recipients as a way of encouraging them to seek and complete treatment.

Provide more staff training related to overcoming resistance to treatment. As part of staff training activities conducted to familiarize CWA staff with potential barriers and screening tools or procedures, mental health, substance abuse, disability, and domestic violence experts can attend and share strategies for minimizing denial and stigma. They can share information about treatment environments, expectations, and conditions, and help staff develop strategies to address concerns about treatment approaches and settings. State or county welfare staff, in turn, can help educate providers about child welfare and how admitting problems and participating in treatment may (or may not) affect access to other services or assistance, such as public housing. Frontline CWA and initiative workers may need help developing strategies to address client fears about losing custody of their children, while still protecting the safety of those children and families.

Consider expanding the use of incentives. Experimenting with incentives designed to induce clients to enter or stay in treatment. Potential incentives could include cash or in-kind gifts or services. Some have suggested "stopping the clock" for TANF clients while they are fully complying with treatment requirements or engaging in intensive treatment modalities, or providing additional flexibility in meeting work requirements through education or training as long as individuals satisfactorily maintain treatment compliance and progress.

[5]This procedure is also mandated for mental health problems, but it was unclear whether counties had begun to implement the procedure for those cases where mental health problems were suspected.

- ***Some TANF clients need help with family crises or needs, along with child care and transportation arrangements, before they can begin treatment.***

Staff sometimes have to help TANF clients overcome personal and family issues before clients can enter treatment. Some staff estimated that large fractions of their TANF clients had tenuous housing arrangements or serious family problems that interfered with treatment. Focus group participants described problems with special needs children (such as children who were ill, in special education, or having behavioral problems), responsibilities for other family members who were ill or in trouble, or other family crises, such as incidents of serious crime, that affected their ability to cope with daily demands. CWA staff, along with providers, sometimes help TANF clients obtain housing, pay their utility bills, or obtain family counseling or assistance so that clients can begin to focus on their treatment needs.

In addition to resolving family pressures, TANF clients often need help with child care and transportation arrangements in order to enter or continue treatment. Although WFNJ provides subsidies for both, even a short delay in making these logistical arrangements gives clients time to change their minds about treatment, or the delays could be long enough for available treatment slots to disappear.[6] Few clients are able to rely on family members, spouses, or significant others to provide child care and supervision over the 28 days or more required to complete residential treatment stays. Many also need transportation out of the area, or back and forth on a daily basis, in order to attend treatment programs; but staff in several counties reported delays getting transit vouchers or other supports through the CWA.

Several strategies have been used to overcome obstacles to treatment, including providing more intensive case management or direct services to alleviate family and logistical obstacles. For example, SARD Care Coordinators carried somewhat lower caseloads than their SAI counterparts, so they could provide additional assistance and supervision to help keep TANF clients in treatment.[7] An outpatient substance abuse treatment provider used by Cumberland County allows women to bring their children to treatment, and is thinking of becoming a child care provider so as to increase available child care services, as well as receive reimbursement for child care. Some substance abuse and mental health treatment programs provide immediate transportation in program-owned vehicles for clients who agree to enter treatment. In addition, some providers report referring some TANF clients to in-house family therapists or coordinating with CWA staff to help resolve housing problems. These experiences suggest that treatment service providers could use information to help them anticipate and plan for the circumstances and needs of TANF clients.

A variety of additional service strategies could help clients overcome obstacles to treatment:

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[6]According to state regulations, WFNJ participants who are in treatment are eligible for the same work supports as those who are engaged in other activities.

[7]When the SARD evaluation is completed, it may provide evidence of the relative effectiveness of SARD, compared to SAI program components. The use of incentives and more intensive case management are the main differences between the two programs.

Provide more intensive case management services. In addition to specialized case managers or counselors who conduct assessments and oversee treatment, family service workers or social workers could be made available to assist TANF clients. These caseworkers could help clients stabilize housing situations, work out individual and family problems, or deal with disruptions or emergencies that might otherwise interrupt treatment.

Encourage providers to offer child care and transportation services. Working with other state agencies, DHS could help providers identify TANF or other funding resources to establish or reimburse on-site child care or provider-based transportation services. Alternatively, the state or counties could arrange meetings between transportation or child care agencies or specialists and treatment providers to explore ways to expand or tailor services that meet client and provider needs.

C. INTEGRATING TREATMENT AND WORK

A central objective of WFNJ, including most of the treatment programs funded through the program, is to prepare clients for work. This objective is reflected in two features of the treatment programs designed for TANF clients with health and behavioral problems. First, once intensive treatment phases have been completed or once clients have become stabilized in treatment or on medication, clients in these programs typically become subject to the 35-hour per week work requirement, although their hours of treatment are usually counted towards the requirement. Second, in addition to providing treatment, the state expects the initiatives to help clients find appropriate work activities and jobs.[8] Ultimately, of course, it is hoped that these clients will make a successful transition to independent employment and off of welfare.

While each of the treatment initiatives is structured somewhat differently, each is designed to accommodate the work requirements and employment goals of WFNJ. MHI case managers and DVRS staff are responsible for placing clients into activities that meet the 35-hour participation requirement. MHI staff conduct group employment preparation activities for participants, then places clients into employment once they are ready. DVRS staff can place clients into temporary work activities first, or directly into employment. In contrast, welfare case managers have lead responsibility for placing clients who are receiving substance abuse treatment into appropriate work activities. SAI care coordinators and providers support work by informing welfare case managers of clients' work readiness, progress in treatment, and current treatment schedule. A common strategy used by welfare case managers to help substance abuse clients meet work requirements is to assign them to standard WFNJ part-time work experience positions, most of which are in community-based organizations or public agencies.

While these initiatives have made progress integrating work participation with treatment, some challenges remain. Our discussions with CWA and initiative staff suggest that there are three types of opportunities to better integrate work and treatment

[8]The exception is that clients with domestic abuse problems are eligible for temporary but renewable waivers exempting them from various TANF requirements, including work requirements. However, consistent with the experience in other states, counties reported that, to date, few TANF clients have opted to utilize available waivers.

activities: (1) confirming that work activities and treatment schedules are compatible with each other, (2) expanding work activities and incorporating more transitional treatment and employment services, and (3) improving coordination and communication among case managers, service providers, and work activity supervisors. We discuss each of these issues in turn below.

- ***Developing work activities that more consistently accommodate treatment schedules could make both work and treatment more productive for TANF clients.***

Staff reported some difficulties finding work or training activities that complement clients' treatment schedules, due to the demands of both work activities and treatment regimes. Some of the standard work and training activities available through county welfare and workforce agencies are too inflexible to accommodate the demanding and sometimes unpredictable aspects of treatment. For example, participants sometimes need unanticipated time off for doctor or clinic visits or to attend legal proceedings. On the provider side, because TANF clients represent a small proportion of their caseloads, few substance abuse providers have adapted their treatment plans to accommodate employment schedules. In addition, when evening intensive outpatient programs are unavailable for substance abuse treatment, clients must attend programs during the day, thus further limiting their work participation options.

The difficulty reconciling treatment and work activities has led some counties to deemphasize work activities for those in treatment. In one county, staff indicated that they stopped placing clients in substance abuse treatment in any work activities because staff feel it is too impractical or difficult to schedule these activities around treatment. SAI staff in the county expressed frustration over this situation, explaining that they viewed work participation as an important component of client treatment plans that can improve skills and self-esteem.

Counties may be better able to integrate work participation activities with treatment for serious personal barriers in a variety of ways:

Develop more work activities that are compatible with clients' treatment schedules. County staff could identify specific organizations or work experience positions that are best aligned with the demands of treatment. It may be worthwhile to develop positions with interested agencies that could be tailored to the demands of specific treatment regimes. Partnerships with community-based rehabilitation agencies could open some positions in sheltered workshops where staff and work routines can better accommodate treatment activities and demands.

Encourage treatment providers to accommodate work activities. Staff could inform more treatment providers about the importance of work activities and ask them to revise treatment schedules, where possible, to better accommodate these activities. Programs could more consistently consider providers treatment schedules before referring TANF clients to their programs.

Consider modifying work requirements for clients in treatment programs. Within the constraints of federal policy and requirements, New Jersey may be able to delay imposing, or reduce, hourly requirements for individuals in some phases of

treatment even after intensive treatment has ended or clients have become more stable in treatment or on medication. Or the state could allow clients in treatment or early recovery to pursue basic or general education and training activities, as long as they are complying fully with treatment regimes and/or attaining treatment and recovery benchmarks (also strengthening incentives to complete treatment, as suggested earlier).

- ***Expanding the range of work activities and incorporating more transitional* approaches *may enhance some clients' treatment outcomes and ease the way to independent employment.***

In addition to matching clients' treatment schedules, work activities should, ideally, be responsive to their health and behavioral problems, while also providing opportunities for clients to make a successful transition from treatment to independent employment. The difficulties counties have experienced fall into three areas: (1) identifying work activities that are responsive to clients needs and competencies, (2) providing more access to transitional treatment and housing, and (3) taking advantage of the activities and supports available through DVRS.

The work activities available to clients in treatment are sometimes either unresponsive to their current needs or are very limited in the range of career interests and skills to which they pertain. The part-time work experience activities available to clients while they are in substance abuse treatment are sometimes inappropriate, because workplace supervisors have limited time or training in dealing with individuals with such problems. These individuals may need even closer supervision and guidance than other TANF clients. Although MHI staff are better prepared to provide such supervision and guidance for those experiencing mental health problems, some of the job preparation activities they operate are sometimes routine and may not consistently match clients' interests and competencies.

Transitional treatment programs and housing opportunities can be useful for individuals recovering from serious personal barriers, but these may not be available to TANF clients. SAI Care Coordinators suggested that increased use of halfway houses would be beneficial as a way to keep recovering drug or alcohol abusers from returning immediately to their old neighborhoods, activities, and problems, all of which may have contributed to substance abuse in the past. However, few slots are available in existing facilities, especially for women with children. Furthermore, the types of activities residents engage in may not be compatible with TANF work requirements. Domestic abuse and CWA staff members also cited transitional housing as a critical need for women and their families who leave emergency shelters but lack immediate resources for independent living. While transitional housing is available in some counties through domestic abuse programs and other entities, supplies typically are extremely limited and waiting lists are long.

Finally, while DVRS providers offer a broad range of transitional work activities and support services (in sheltered workshops for example), followed by placement in regular jobs, several factors have complicated efforts to provide TANF clients with access to these services. County welfare staff are reluctant to refer clients to DVRS, in part because the agencies assessments and services tend to take a substantial amount of time (see discussion in Chapter III). Second, while DVRS services are designed to help participants prepare for jobs, traditional DVRS participants are not mandated to work.

Consequently some DVRS staff are not accustomed to imposing work and training activity mandates, and find it hard to work with those TANF clients who are not motivated to work. Third, CWA case managers sometimes re-assign TANF clients to other WFNJ activities before they can complete DVRS activities. For these reasons, several DVRS staff said that their TANF clients are less likely to complete DVRS services and secure jobs than are their other clients, leading some staff to question whether it made sense to devote much time to working with TANF recipients.

New Jersey officials could explore several strategies to expand the range and quality of work activities and transitional services:

Help staff develop meaningful work activities with adequate supervision. State and county staff could try to identify more community-based work activities managed by staff who are able to closely supervise and guide clients in treatment. In addition, counties could collaborate more closely with MHI staff to help expand the array of work activities available to clients with mental illnesses who participate in MHI.

Work with other stakeholders to increase access to halfway houses and other transitional housing programs. Welfare officials may be able to increase the availability of transitional treatment and housing programs by working with other state agencies and interest groups to increase the number of these facilities in New Jersey. Increasing reimbursements for these facilities is another available strategy. Making work activity requirements more flexible could better accommodate the types of activities emphasized by halfway houses.

Clarify allowable duration of vocational rehabilitation activities and increase the capacity for DVRS staff to work with TANF clients and their CWA caseworkers. State policymakers should clarify the conditions under which clients can be referred to DVRS for vocational rehabilitation activities, thus removing the uncertainty about this issue among county staff. This should include some guidance about the allowable range and duration of vocational rehabilitation services and how DVRS staff can accommodate the TANF work participation mandate. In addition, local welfare and DVRS frontline staff should communicate more frequently about individual clients' needs and status.

- ***Clarifying procedures and enhancing interagency communications could help integrate treatment and work.***

For counties to provide well-integrated treatment services and work participation activities, state and county staff, intermediaries, and providers need to work closely with one another. Yet coordination among multiple, independent entities can be difficult. For one thing, procedures and requirements can be confusing. For another, the multiple organizations involved in initiatives have different objectives and structures. In these discussions, staff focused on two related issues: (1) the need to clarify policies and procedures relating to work requirements, and (2) the importance of ongoing communication and coordination mechanisms.

Lingering confusion among CWA staff about work activity requirements and participation status for clients in treatment initiatives sometimes results in mixed messages to clients or disrupted services. Several case managers were unsure when to

impose full 35-hour requirements, and how to appropriately document compliance in the state's OMEGA client tracking system. A few were also uncertain whether to impose work requirements on clients engaged in substance abuse treatment programs out of county or in remote locations distant from feasible work or training activities, or when to transfer client cases to the county where treatment was taking place. Providers and initiative staff sometimes have difficulty getting access to administrative information, as well as information about the status of individual clients. As a result of discrepancies, uncertainties, and miscommunications, some clients receive conflicting instructions about work from initiative staff and CWAs, get pulled out of treatment activities and assigned to work participation prematurely, or they have their TANF cases closed unexpectedly. While not widespread, these problems can be disruptive for both clients in treatment and their providers.

Staff cited specific coordination practices that had helped establish and strengthen partnerships. Practices frequently mentioned were designating and maintaining administrative liaisons to each other's organizations, holding regular joint management and networking meetings, cross-training, and outstationing some staff in other agencies. Interviewees mentioned that these types of activities helped them learn about TANF and WFNJ requirements, meet key staff, work out referral and monitoring procedures, access key services for TANF clients, and develop more trusting and productive staff relationships.

However, not all counties have implemented effective coordination practices. For example, the MHI required each participating county to provide a liaison to work directly with MHI staff, but some counties no longer have designated liaisons. Whereas most SAI Care Coordinators have established good relationships with county welfare staff, some still lack adequate office space. In a few cases, welfare staff expressed resentment about giving up space to SAI or other staff from external agencies. Some of the agencies leading the new initiatives said they needed more direct contact with CWA case managers, particularly to get feedback on client activities and employment, in order to head off problems that might short-circuit treatment or employment success.

In addition, staff in several counties were confused about how deferrals and domestic violence waivers affect clients' access to WFNJ work activities. Some staff suggested that they were not sure whether clients using deferrals for health problems or choosing domestic violence waivers are allowed to participate in any work or training activities. According to case managers, some clients who disclose domestic abuse want to participate in work activities, but are concerned about their ability to meet strict TANF requirements. In these situations, staff are uncertain whether requesting waivers in order to ease TANF requirements precludes these clients from participating in WFNJ activities on a voluntary basis. Some of these clients fear becoming isolated if they cannot continue to participate, while others are striving to "live normal lives" and view employment as an important step toward financial independence from their abusive partners.

Several options to improve coordination are available to the state, as well as to local counties themselves.

Agencies could co-locate more staff, designate staff liaisons, or adopt other coordination strategies. Facilitating interagency communication is a continuing priority

as local welfare systems expand to include more local partners. Appointing liaisons, providing office space to co-locate front-line staff where possible and appropriate, conducting joint training, and scheduling management meetings can all be helpful. Agency managers could also seek ongoing feedback from partners to ensure that staff are collaborating appropriately.

Clarify whether deferrals and domestic violence waivers limit clients' access to work activities. Because work activities can be a valuable aspect of the treatment and recovery process, many staff suggested that deferrals and domestic violence waivers should not preclude participation in WFNJ work and training activities. One shelter administrator asked whether the state might consider "half-waivers" that would relax some work requirements while still allowing participation in WFNJ activities and services to continue for domestic abuse victims.

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APPENDIX A

WORK FIRST NEW JERSEY INITIATIVE PROFILES

FAMILY VIOLENCE OPTION INITIATIVE (FVOI)

General Objective: To implement the federal family violence option, which New Jersey adopted to allow victims of family violence to request waivers from certain TANF requirements such as time limits, work requirements, child support cooperation, and immigrant residency status. States adopting the option are required to implement universal notification, maximum opportunities for clients to self-disclose issues, and screening procedures.

Sponsors: Division of Family Development (DFD), New Jersey Department of Human Services; DFD contracts with the New Jersey Coalition for Battered Women (the state's coalition for family violence core services programs) to administer the initiative.

Counties: All New Jersey counties

ORGANIZATIONAL STRUCTURE

Local Partners: FVOI is a collaborative effort between the county welfare agencies (CWAs) and their respective family violence and rape care centers in each county.

Program Structure: Each CWA has appointed one or more staff members (referred to as FVOI representatives) who received special training so that caseworkers or any CWA employee can refer individuals with potential domestic violence problems to them, for confidential assistance. Clients requesting waivers are referred for a risk assessment with the counties' designated family violence or rape care center.

Implementation Status: In each county, the FVOI representatives have been identified and trained to provide services to clients indicating domestic violence problems. For the initiative to be fully implemented, all CWA employees also had to be trained. As of 2002, agencywide training had not been conducted in many counties.

SERVICES PROVIDED

Target Population(s): FVOI targets all TANF applicants and recipients reporting family violence.

Participation Requirements: Any individual can take advantage of available services, whether or not she requests a waiver. A risk assessment is mandatory for any individual who requests a waiver from a TANF requirement. If a WFNJ client requesting a waiver does not complete the risk assessment, the client's waiver is cancelled, and the client must then comply with all standard WFNJ work participation requirements. However, clients can access domestic violence services without applying for a waiver or completing a risk assessment.

Screening: New Jersey complies with the federal universal notification requirement by distributing a safety brochure developed by the Coalition for Battered Women. The brochure contains a self-test about abusive behavior and hotline numbers for service providers; county offices offer brochures from the local rape care and from family violence programs as well. Initial points of contact can come from any CWA program. CWA staff must also inform all individuals about the FVOI and about community services available for victims, making it clear that confidential help is available and voluntary.

WFNJ recipients can disclose a potentially harmful situation at any point. Once a client shares this information, a caseworker refers the individual to one of the CWA's FVOI liaisons. FVOI liaisons do not conduct formal screenings (though checklists are used to get a sense of the individual's situation); instead, they engage in conversations to encourage honest, frank disclosure. The liaisons assist clients in making informed choices about CWA program requirements and the waiver option (for example, requesting a time limit waiver) and refer them to local family violence and rape care programs for further assistance.

Assessment: Clients requesting a waiver and other clients requesting services receive a risk assessment conducted by the family violence or rape care program. The waiver from WFNJ requirements can last as long as the individual situation dictates, although risk assessments must be reviewed and recertified every six months. The turnaround time for a risk assessment is 10 calendar days from the initial referral date, but processing can happen more quickly in crisis situations.

Services: DHS-designated domestic violence programs providing core services can provide a variety of services if requested by the client, whether or not she requests a TANF waiver. Professional staff help clients develop a safety and service plan; staff also evaluate the dangers of clients' situations. They and the clients discuss any history of violence, legal issues, safety planning, medical needs, current patterns of violence, and intervention services. Relevant information is forwarded to the FVOI representative and to the respective caseworker at the CWA.

MENTAL HEALTH INITIATIVE (MHI)

General Objective: To identify, assess, and provide essential mental health and job readiness services to WFNJ/TANF recipients who may be suffering from mental illness, to enable them to meet WFNJ work requirements and eventually obtain employment and self-sufficiency.

Sponsors: Division of Mental Health Services (DMHS) and Division of Family Development (DFD), New Jersey Department of Human Services (NJDHS)

Counties: Atlantic, Camden, Essex, Hudson, Passaic, and Union

ORGANIZATIONAL STRUCTURE

Local Partners: DFD contracts with DMHS, which in turn, contracts with local providers to deliver MHI services. In each of the participating counties, one non-profit provides the Integrated Case Management Services (ICMS) and another non-profit provides the supported employment (SE) services. These non-profits are typically community-based organizations community hospitals, or medical centers. The local service providers collaborate with county welfare agencies to develop procedures for screening and referring welfare recipients to MHI.

Program Structure: MHI employs a team concept with multiple point-of-service contacts. Caseworkers from the county welfare agencies identify appropriate candidates and make referrals to the local ICMS agency. Trained mental health clinicians at the agency receive these referrals and conduct assessments, offer services, and make referrals to the SE agency which provides work activities, job placement assistance, and postemployment support services.

Implementation Status: MHI began as a pilot program in Atlantic County in April 2000, and was expanded to five other counties with the largest TANF caseloads in April 2001—Camden, Essex, Hudson, Passaic, and Union. (MHI also provides services to General Assistance clients in these six counties and in Mercer County.)

SERVICE DELIVERY

Target Population(s): MHI targets (1) WFNJ/TANF recipients who have received 34 or more months of cash assistance, have not been deferred, and demonstrate a mental health condition that may prevent them from securing and maintaining employment, and (2) nondeferred recipients who may have a mental health condition and have not demonstrated progress toward self-sufficiency.

Participation Requirements: Participation in MHI is voluntary for clients with mental illness who are participating in WFNJ activities. Those individuals who attend the assessment voluntarily and are diagnosed with a mental health condition can opt to participate in the recommended mental health activity (which becomes his or her WFNJ work-related activity) or choose another WFNJ work-related activity.

Sanctioned clients who may have a mental illness are required to meet with the ICMS case manager for a mental health assessment. If mental health treatment is indicated, the individual must attend the treatment program for two weeks to remove the sanction, then continue with the treatment as a mandatory work-related activity.

Screening: Clients are identified with a potential mental health problem and subsequently referred to MHI in one of three ways:

(1) Welfare caseworker administers the comprehensive social assessment and identifies a mental health issue

(2) After conclusion of substance abuse treatment, the SAI care coordinator concludes that the client may have a mental health problem

(3) Clients self-identify a mental health problem when completing an Individual Development Tool form during an Individual Responsibility Plan (IRP) development/update meeting, or when completing a Welfare-to-Work/TANF MHI Questionnaire

Assessment: Once referred for a mental health assessment, the WFNJ/TANF recipient meets with a clinician at the ICMS agency. Clinicians determine the degree to which a mental illness is interfering with employment and self-sufficiency and, along with the welfare case manager and SE staff, decide on a service plan.

Case Management: In addition to assessment and referrals for appropriate services, ICMS staff are responsible for followup and case management of these services, such as reviewing weekly timesheets and monthly summaries to monitor participation and progress. They also report to the CWA about WFNJ/TANF clients' participation and progress in MHI.

Services: Services could include psychiatric evaluation and medication, outpatient counseling, partial care/psychological rehabilitation, or other mental health services.

If full-time mental health services are not required, the mental health agency may conclude that clients can participate in job readiness and employment services with MHI employment specialists at the partnering SE agency. Employment services could include vocational readiness determination, career profiling, community-based occupational exploration, job search skills, alternative work experience with support, support plan development, individualized job placement, and ongoing employment support.

SUBSTANCE ABUSE INITIATIVE (SAI) AND SUBSTANCE ABUSE RESEARCH DEMONSTRATION (SARD)

General Objectives: To establish a coordinated, comprehensive continuum of substance abuse services for WFNJ recipients who may be unable to fulfill work-related requirements due to drug and/or alcohol addiction. To assess the effects of more intensive services, New Jersey developed a five-year research component, the Substance Abuse Research Demonstration (SARD), in two counties, Atlantic and Essex. SARD is a random assignment evaluation, using SAI clients as the control group.

Sponsors: The Division of Family Development (DFD), and the Office of Planning and Special Initiatives, New Jersey Department of Human Services (DHS); Division of Addiction Services (DAS), New Jersey Department of Health and Senior Services; the National Council of Alcoholism and Drug Dependence (NCADD), New Jersey affiliate.

Counties: SAI operates in all New Jersey counties, and SARD operates in Atlantic and Essex counties.

ORGANIZATIONAL STRUCTURE

Local Partners: SAI and SARD are collaborative efforts between county welfare agencies, NCADD, and community treatment service providers. DAS monitors the Treatment Provider Network, a statewide group that accepts referrals from SAI/SARD care coordinators (substance abuse clinicians) and delivers the actual substance abuse treatment services for the initiative.

Program Structure: Under both SAI and SARD programs, clients who demonstrate a possible drug or alcohol addiction are referred by the county welfare agencies (CWAs) to local care coordinators, employed and supervised by NCADD. Coordinators determine the severity of substance abuse and the need for treatment. If treatment is indicated, they refer clients to an appropriate member of the Treatment Provider Network, authorize treatment, arrange initial appointments, monitor service utilization, and coordinate treatment as a work activity with CWA caseworkers.

Implementation Status: The programs began in August 1998. In each county, at least one SAI/SARD care coordinator, employed through NCADD, coordinates services. SARD ended in June 2002, but SAI is ongoing.

SERVICES PROVIDED

Target Population(s): SAI and SARD target WFNJ recipients whose previous job-seeking or employment record indicates that drug or alcohol abuse may be impeding

their ability to fully participate in a work activity or to secure and retain employment.[1]

Participation Requirements: Assessment and treatment is voluntary for clients who have an identified substance abuse problem and have been participating in WFNJ activities. An SAI assessment is mandatory for those clients who fail to fulfill a work-related activity due to a possible substance abuse problem. If treatment is prescribed, it can become the sole required work-related activity.

Screening: WFNJ clients can be identified as potential problem substance abusers in one of several ways: (1) clients can approach their caseworker, (2) employers or WFNJ vendors can contact caseworkers, or (3) CWA workers themselves might identify a substance abuse problem using the Cage Aid, which they use to screen clients at intake and redetermination.

Assessment: Once a welfare recipient is referred (usually within three days), the SAI/SARD care coordinator performs an in-depth substance abuse assessment to determine the appropriate type of treatment at a member of the Treatment Provider Network; treatment is not necessary for all referrals. Coordinators utilize the Addiction Severity Index (ADI), the Level of Care Index (LOCI), and the American Society of Addiction Medicine placement criteria (ASAM PPC-2) for assessing clients and determining the appropriate course of treatment. The goal is for clients to receive emergency care immediately, urgent care within 24 hours, and routine care within three days.

WFNJ recipients may transition to other levels of care and become available for work-related activities, as clinically indicated. Before moving clients from one treatment level to another, service providers use the ASI-Lite (a condensed version of the Addiction Severity Index) to assess progress and forward the results to the care coordinator. Coordinators receive the ASI-Lite results and decide upon the next level of appropriate care placement. If this process reveals that the client would be able to return to resume work-related activities, the care coordinator notifies the welfare caseworker.

Case Management: In addition to assessment and provider placement, care coordinators are responsible for ongoing case management and monitoring. As clients transition to different levels of treatment, care coordinators track progress and attendance and forward case updates to county welfare agencies.

SARD provides more intensive case management services. SARD care coordinators have smaller caseloads than their SAI counterparts, and are involved in screenings clients, provide parenting guidance, family counseling, home visits, and referrals to other social services. In addition, SARD offers financial incentives to induce clients to participate and stay in treatment.

[1] SAI also serves General Assistance recipients, but the information in this report is based on their experiences working with TANF clients.

Services: Treatment may include out-patient, intensive out-patient, substance abuse partial care, halfway house, therapeutic community, short-term residential, sub-acute residential detoxification, and in-patient acute care detoxification.

VOCATIONAL REHABILITATION INITIATIVE (VRI)[1]

General Objective: To identify, assess, and provide essential vocational rehabilitation services to WFNJ/TANF recipients who have a mental and/or physical impairment that has prevented them from meeting their work requirements, as well as to enable clients to secure and retain steady employment.

Sponsors: Division of Family Development (DFD), New Jersey Department of Human Services; Division of Vocational Rehabilitation Services (DVRS), New Jersey Department of Labor

Counties: Camden, Essex, Hudson, Mercer, Passaic, Union

ORGANIZATIONAL STRUCTURE

Local Partners: County welfare agencies (CWAs) identify and refer disabled participants to the regional DVRS office for assessments and services.

Program Structure: County welfare agencies are VRI's initial point of contact for potentially eligible WFNJ recipients. After a CWA referral to DVRS, a DVRS vocational rehabilitation counselor conducts assessments and makes referrals to appropriate vocational rehabilitation services. Counselors also are responsible for coordinating services and case management.

Implementation status: In October 1999, the initiative began as a pilot in Atlantic, Camden, Cumberland, Essex, Hudson, Monmouth, Ocean, and Passaic counties. Currently, it operates in six counties: Camden, Essex, Hudson, Mercer, Passaic, and Union. However, all CWAs can refer TANF clients to regional DVRS offices for DVRS-funded services.

SERVICES PROVIDED

Target Population(s): VRI targets WFNJ recipients who may have a mental and/or physical disability that hinders them from full employment and, ideally, self-sufficiency.

Participation Requirements: Clients referred to the DVRS through the initiative are required to follow through with the DVRS assessment and other DVRS activities, if warranted. Failure to do so results in sanctions. Deferred clients can volunteer to participate in DVRS activities.

Screening: CWAs complete a prescreening form for those WFNJ recipients who they suspect may have a disability that prevents them from meeting their work requirements. The form lists four criteria which, if at least one is met,

[1] Also known as the Welfare-to-Work Disability Case Management Initiative.

automatically trigger a referral to a DVRS counselor. These criteria include WFNJ recipients (1) who have been unsuccessful over a period of at least six months in making progress in at least two WFNJ activities and do not have a high school diploma or General Educational Development (GED) certificate and/or tests below an eighth-grade reading level; (2) who have received benefits for 60 cumulative months and are not currently participating in work-related activities; (3) whose case has been closed due to sanction at least once and has been sanctioned while receiving benefits at least twice; and (4) participating in the Substance Abuse Initiative and has been cleared by his or her treatment coordinator to participate in VRI.

Assessment: Once WFNJ recipients receive a referral from a CWA, they are notified about an initial appointment with a vocational rehabilitation counselor within five business days. Counselors assess clients and review available medical records to determine whether a disability is present, or they may refer clients to physicians, psychiatrists, or other specialists for a diagnosis.

Case Management: In addition to conducting assessments and making referrals, vocational rehabilitation counselors handle case management and serve as the conduit of information between service providers and caseworkers from the CWAs. They also submit quarterly-level service reports to the agencies and keep caseworkers informed about VRI participants who fail to participate or have been terminated from VRI.

Services: Individuals who have a disability that does not preclude employment are then eligible for DVRS services. Counselors develop an Individual Employment Plan for each client and can refer clients for vocational counseling, career guidance, specialized skills training, job coaching, supported employment, on-the-job training, selective job placement, rehabilitation technology, specialized tools and equipment, therapeutic assistance, physical and cognitive restorative assistance, and to any other services necessary to obtain employment.