

THE 1% PROBLEM: THE CASE OF THE MISSING CLIENTS

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ABSTRACT

As caseloads decline and states increase efforts for remaining TANF recipients to participate in the workforce, it is time to re-look at efforts to address substance abuse among welfare recipients. Many states included services for substance abuse in state plans and some states invested TANF funding in substance abuse services. This article updates the field on what happened in those states and leads to future directions for this "hard to serve" population.

As welfare reform began more than three years ago, many predictions were made about its impact, both from those who supported and those who opposed the legislation. Predictions were made about how many people would find jobs, how many children would be affected, and what kinds of supportive services would be needed by the welfare clients with the least job history and the most barriers to employment.

In some states, the debate included a hard look at the extent of substance abuse among welfare recipients. A number of projections were made—summarized at one point in a report we authored in early 1997—about how many recipients would require treatment for their alcohol or other drug (AOD) problems to get and keep a job. The consensus of the national estimates was in the range of 15-20%, with some states assuming that the level of actual AOD abuse among clients was much higher. Several states, including California, New Jersey, and Florida, set aside some of their TANF funds for AOD treatment services for TANF recipients. A larger number of states made significant changes in their efforts to provide services to these clients and to equip their front-line workers with the skills needed to identify substance abuse barriers to employment and to refer those recipients into treatment.

As of late 1999, we may know even less about the prevalence of substance abuse among TANF recipients. But we know a great deal more about how many have self-disclosed a problem or been referred to services for their substance abuse. And the answer is very few—with numbers lower than 1% of adult TANF recipients in many states. There are no summaries of nation-wide figures, but it seems unlikely that the totals will come anywhere near even the lowest estimates of need that were made two or three years ago.

What has happened? And what does it mean for the goals of family stability and improved family income which most of us agree should be the benchmarks for judging the success of welfare reform?

Before looking at the reasons for low referrals, we need to understand that referrals are a symptom of what is happening in an entire network of connections needed between

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recipients, welfare agencies, and treatment agencies. If those connections are weak, low referrals will be one of the symptoms. But increasing referrals to treatment, while a needed step, is not the same thing as a positive outcome for welfare reform or for treatment agencies. Asking a state or county how many referrals to treatment it has made and how to improve their referral process is an important place to begin the discussion about these clients' needs—but it is only one of the initial steps, and it is not even the first one. The first question is how many clients were identified as needing AOD services.

New Funding and the Re-allocation Threat

One reality should be made explicit and never taken for granted: there has never been a larger increase in the total funds available for substance abuse treatment of lower-income women with children. For advocates and service providers who have worked long and hard to increase the allocations of treatment slots for women from their current level of only one-third of all publicly funded slots—this extraordinary opportunity should not be taken for granted. When small increases in categorical funds or earmarks of a block grant are taken as victories for the cause of serving women with children—as they have been in recent years—this far greater expansion of potential funding should not be assumed to be a permanent feature of the ever-changing funding world. In California, recent state figures suggest that less than 10% of the available funds set aside last year for services to hard-to-serve clients had been claimed—which is a tragedy of large proportions, whatever the startup problems that explain the gap.

It is nearly certain that legislators will re-allocate these funds if it's shown they are not expended and thus, not needed. Some legislatures have already held hearings on that possibility. So from the perspective of those who have sought expanded funding for women's treatment programs, the TANF referral problem is not just a small administrative glitch—it is a matter of considerable urgency.

A final introductory comment: some close observers of states' initial experience have pointed out that the problem of low referrals is only one side of the problem, with the other side those clients who never even got into the TANF system or are among the so called "disconnected" who have left the welfare rolls without subsequent employment. From this perspective, clients who were deterred from seeking TANF status or dropped out of work requirements because of their AOD problems—who are counted in some states as successes because they are part of the population "leaving welfare"—are really the next cycle of child welfare cases, public health problems, and homelessness waiting to happen. The short-term savings from the exclusion of these cases from the rolls will be more than offset, it is argued, by higher state and local costs in other systems. To the extent that substance abusers are included in this population, those costs may be even higher.

Different Explanations for Low Referrals

Many explanations for low referrals have emerged from practitioners and policy leaders in the states and communities that have tried to understand this problem. We began listing them several months ago and then decided, when we had 31 different explanations, that some categories were needed. These are some of the comments we heard:

"The clients with the worst substance abuse problems were the first to drop out—either because they got sanctioned for not showing up or because they knew they couldn't pass a drug test. They're not showing up in referral to treatment because they're part of the group that already left welfare without getting a job."

"Clients are scared they'll lose their kids if they tell the truth about their drug problems."

"Most welfare agencies still use a 'don't ask, don't tell' approach to drugs and alcohol and the clients were quick to figure that out."

"Workers are afraid to ask, with all the workplace violence going on now."

"It is more work for caseworkers to identify clients with substance abuse problems, so it is not a priority for them."

"Clients are getting jobs anyway—if seven out of ten people with a substance abuse problem are working, what's so different about welfare clients getting a job even if they have a problem?"

"It's like fish in the water—they don't see it as a problem because everyone uses, so it's way down the list of problems they have on their mind when they walk in the door."

"Welfare agencies are just waiting for these clients to fail their first drug test so they will get serious about treatment."

"The treatment agencies aren't ready for these clients— they don't want them and they do little to serve them once they show up. They're called 'hard to serve'—but we've never even tried to serve most of them."

While it may seem as though these explanations can't all be true, with fifty states, thousands of workers and millions of clients involved, different explanations may be relevant in different jurisdictions. But sorting out which ones are true of which clients and agencies is the challenge that lies ahead, if we continue to believe that a significant number of former welfare and current TANF clients still need this help.

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Why Low Referrals? Categories of Explanations

One way of framing the problem and the appropriate responses is illustrated in the following table, which separates the causes of low referrals into those reasons that are primarily due to client behavior and those that appear to be primarily a result of systems problems.

| Site of Problem | Problem | Options for Corrective Action |
|------------------------|---|--|
| Client Level | Concerns about consequences | State and county policy statement; clarify TANF-child protection links; expand outreach |
| Client Level | Less job-ready clients now in system | Multiple assessments Outreach to multiple-needs clients Map fall-off points between interventions and across agencies |
| Worker Level | Discomfort in asking about sensitive/personal issues Lack of tools More paper work | Training and booster training Screening and assessment tools as part of comprehensive family assessments Use of out stationed workers in welfare offices Reduce paper work requirements for identifying AOD needs |
| Systems Level | No linkages across systems; no referral agreements, accountability for results, or shared outcomes | Develop communication procedures and protocols Develop shared outcomes Use out stationed workers in TANF offices |
| Systems Level | Organizational culture: wait for well-motivated clients; view of TANF as a punitive system to get clients off welfare rolls | Conduct outreach to multiple-needs clients; focus on early engagement instead of waiting for failure Framing TANF as a long-term effort to reduce downstream costs in other systems and improve client outcomes |

The Information Gap: A Self-fulfilling Prophecy?

A further problem is that most state and local information systems are not able to capture the hard data about the extent of clients' AOD problems and special TANF studies have not adequately addressed the AOD issue. In part this is due to the lack of data on client characteristics, and in part it is because the extensive studies of TANF outcomes have generally ignored AOD treatment issues or treated them as one of a long list of "support services issues." Some researchers, in fact, have argued that they should not focus on the AOD issue because they are already asking clients and workers so many questions about outcomes that they should not waste time on those issues where clients are unlikely to answer truthfully. This is partially a self-fulfilling prophecy, however, in that it relegates the problem to insignificance and doesn't seek information about it, which results in the problem having lower significance than the other client issues on which information is being collected.

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Some knowledgeable observers of AOD treatment history compare this to the analysis of health care utilization as it focuses on clients who don't demand the services they need. The very nature of AOD disorders result in under-utilization of services. In the sphere of private health insurance, those patients needing AOD treatment who are denied services deemed necessary by the counselor are rarely the patients who demand fair hearings on care denials. AOD patients rarely go to their general practitioner "demanding" a referral to a specialist, due to the power of denial as part of their condition. Thus, the health system's utilization data may inaccurately suggest that added services or benefits are not needed since they are not being used.

What are States and Communities Doing About the 1% Problem?

The most hopeful signals are coming from those states and localities that have recognized the problem of low referrals and are doing something about it. A critical step is knowing *where* clients are disappearing. Some states and counties have mapped their welfare systems by laying out each step in the process, from clients first entering TANF through final successful job placement and successful completion of support services treatment. For a client with AOD problems, each of these connections is a potential "drop-off point," where the number of clients moving on to the next step is significantly less than those who needed the step. One county found that 15% of clients had a positive screen showing a need for further assessment; 42% of those went for the assessment; 85% of those needed treatment; and half of those completed treatment. This meant that only 18% of clients with a positive screen completed treatment.

Employment may occur at any point while the recipient is going through this process. While moving off welfare and into employment is certainly a most desired outcome of welfare reform, we would suggest that *sustained* employment may be less likely among recipients with AOD problems who successfully *leave welfare* with a job, yet unsuccessfully *leave treatment* without completion.

Training has been used in many sites as a means of beginning to orient front-line welfare workers to the basics of screening for addiction. But training for addiction screening has been found in some areas to be a Band-Aid approach, in which one-time training which is not reinforced by policy changes, supervisors' encouragement, or reduced paper work means that workers revert to their original practice, since nothing else has changed. A thorough assessment of how training has affected AOD referrals might shed further light on this remedy.

Out-stationing workers from AOD agencies in welfare offices has been an approach used by several states and counties, and it has been a step forward. But we must remember that it has long been a fallacy of simplistic approaches to services integration that co-locating ineffective services will somehow make them effective—when all it really does is make them closer.

Outreach to clients in some states and counties has involved use of peer counselors, recovery "coaches," and other staffing that includes workers with both the personal and

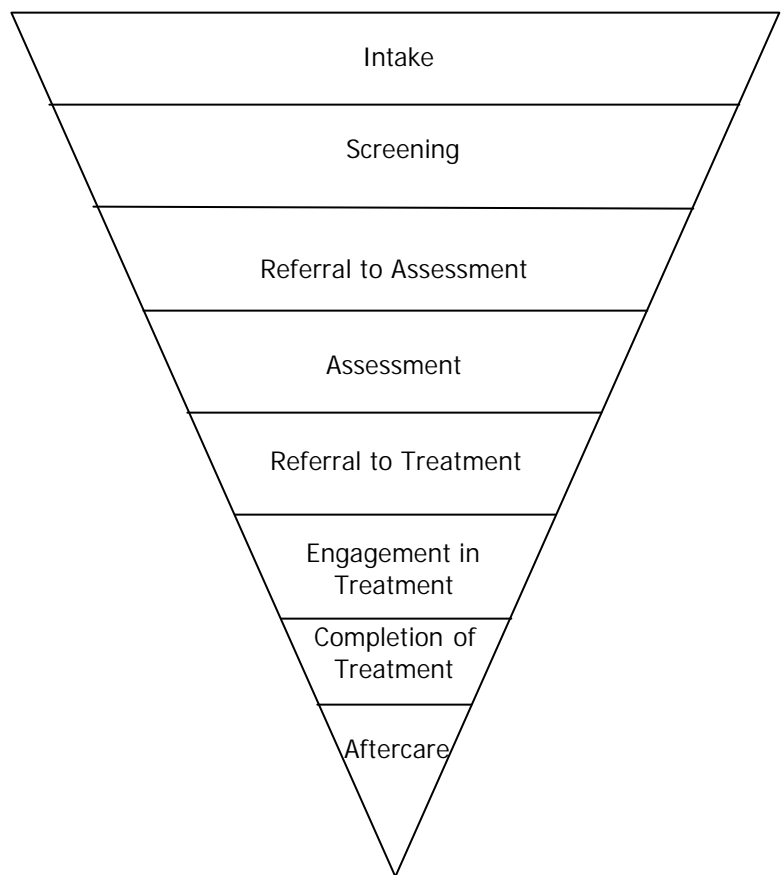
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cultural backgrounds needed to engage their clients and increase their motivate to change long-held behavior patterns.

Use of better screening instruments linked to staff training has enabled some states and counties to identify clients needing AOD treatment, and to reduce the “false positives” that result in high numbers referred who do not need treatment.

Better data is an essential part of responding to the 1% problem—both to see what the prevalence rates really are among the TANF population and to track what is happening to clients at each of the drop off points discussed above.

Interagency agreements, especially between welfare agencies and AOD providers and funders, are critical components of improved attention to TANF clients’ AOD problems. We must remember that historically these two agencies have never worked together. In a series of five regional forums held throughout California over the past year, we have worked with these two sets of agencies in more than thirty counties and seen genuine improvement. But these are not the only agencies whose help is critical to TANF clients’ success. Welfare-generated approaches would call for greater collaborative relationships with the traditional providers of employment support services—transportation, child care, literacy, job skills. The clients who need AOD services are very likely to have multiple barriers to employment and also need services provided by physical health, mental health, and domestic violence service providers.



Perhaps the most important connection needed, however, is to another set of agencies usually based in the same organization as the TANF staff, but often working as though they were in a different agency altogether: child welfare agencies. With a national average of half of all child welfare cases involved with the welfare system, and the inevitable effects on children of their parents’ welfare and AOD status, the states and counties which have moved to close the gap between welfare and child welfare have begun to address a critical need. The issues of substance abuse among the child welfare population have been addressed in five national

reports in the last two years, including the DHHS Report to Congress mandated by the Adoption and Safe Families Act.

Conclusion

Again, we must emphasize that increasing the number of referrals for AOD treatment is not a positive outcome. It is an important prerequisite for positive treatment outcomes, employment, and family stability—but it is not the goal. The steps to the real goals are clear: knowing who needs help, finding them, referring them to treatment, assuring that they get good treatment and stay in it, and then following up to make sure that employment and family stability are positive results of treatment. Those are the needed actions, not merely making referrals. The low number of referrals is a loud and clear signal that this full range of remedies is needed to improve outcomes for this vulnerable group of children in families affected by substance abuse.

Aftercare