The CalWORKs Project

Screening Guide

For

Substance Abuse, Mental Health and Domestic Violence

Issues in Welfare-to-Work Programs

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California Institute for Mental Health
2030 J Street
Sacramento, CA 95814-3120
(916) 556-3480

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Daniel Chandler

Joan Meisel

CALWORKS PROJECT

COLLABORATING ORGANIZATIONS AND STAFF

California Institute for Mental Health (www.cimh.org)
2030 J Street
Sacramento, CA 95814
(916) 556-3480
FAX: (916) 446-4519

Sandra Naylor Goodwin, PhD, MSW, Executive Director/Project Director

Joan Meisel, PhD, MBA, Policy and Practice Consultant

Daniel Chandler, PhD, Project Research Director

Pat Jordan, MSW, Project Consultant

Shelley Kushner, Program Manager

Children & Family Futures (www.cffutures.com)
4940 Irvine Blvd., Suite 202
Irvine, CA 92620
(714) 505-3525
FAX: (714) 505-3626

Nancy K. Young, PhD, Director

Sid Gardner, MPA, President

Karen Sherman & Shaila Simpson, Associates

Family Violence Prevention Fund (www.fvpf.org)
383 Rhode Island Street, Suite 304
San Francisco, CA 94103
(415) 252-8900
FAX: (415) 252-8991

Janet Carter, Managing Director

Kelly Mitchell-Clark, Program Manager

Cindy Marano, Consultant

Carol Ann Peterson, Consultant

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PART I: INTRODUCTION

Screening is one of a range of approaches to identifying TANF recipients with alcohol, drug, mental health or domestic violence issues.

At the inception of welfare reform, *alcohol and other drug, mental health, and domestic violence* (AOD/MH/DV) issues were widely thought to pose special hurdles for women attempting to use the new welfare reform services to increase their economic independence. In consequence, California and other states and localities established methods to identify and serve persons with AOD/MH/DV issues. Far fewer women than anticipated have been identified and served.

This guide provides information to administrators who are considering using screening instruments to assist in identifying women with AOD/MH/DV issues.[1]

Screening needs to be distinguished from assessment and "appraisal."

1. Screening is the use of a simple, usually brief, set of questions that can indicate the need for a thorough assessment of AOD, MH, or DV issues. The questions can be self-administered or administered by a staff member who may or may not be an AOD, MH, or DV specialist. The outcome of a "positive screen" is a referral to a specialist for an assessment. We are also specifically referring to screening "instruments," that is sets of questions that have been scientifically validated.[2]

2. Assessment is the detailed evaluation of diagnosis, severity, and history that is necessary in order to determine whether treatment or services are appropriate, and if so, to design a treatment or service plan.

3. Appraisal refers to one of the formal steps in the CalWORKs Welfare-to-Work process.[3]

Most commonly, a front-line eligibility or employment staff member would use a brief screening instrument in order to determine who should be referred for an in-depth assessment. Clients are asked a few questions, or asked to fill out a short paper and pencil form, and an established "cut-point" (number of positive answers) is used by staff in determining the need for an assessment. However, there are many other possible ways of administering screening instruments, including having the client fill out and score the form herself, perhaps in private or in a group situation.

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[1] A more general but very helpful manual on screening and assessment in TANF was recently published; it surveys practices in a number of states and includes learning disabilities as well as AOD/MH/DV issues. Thompson, T. S. & Mikelson, K. S. (2000). *Screening and Assessment in TANF/WtW: Ten Important Questions TANF Agencies and Their Partners Should Consider.* Urban Institute. Available on the web at: http://www.urban.org/authors/mikelson.html.

[2] Many counties ask questions about AOD/MH/DV, but they are ad hoc rather than having an empirical basis.

[3] While an "appraisal" might be used as an occasion for screening for AOD, MH or DV issues, it does not in itself have anything to do with screening for these problems.

Screening instruments could also be used by medical providers serving the CalWORKs population or by outreach workers at junior colleges. More comprehensive screening instruments could be used—as in the Portland, Oregon program described in Appendix I—by AOD/MH/DV professionals in an in-depth interactive educational session for new applicants. We will discuss the range of possible applications later on.

In this guide we present recommended instruments and considerations about screening drawn from prevalence research in two California counties, as well as from the literature on screening and from our study of the variety of ways of identifying women with AOD/MH/DV issues being used in California counties. A number of publications that cover *other* identification methods are available on the California Institute for Mental Health (CIMH) website: www.cimh.org/project.html.[4] A screening program should take its place in a multi-faceted effort that might include co-location of CalWORKs and AOD/MH/DV staff, outreach workers, home visits for sanctioned clients, media campaigns and intensive training of CalWORKs staff regarding AOD/MH/DV issues.

A Screening Program Will Involve Interagency Cooperation

Designing and implementing a screening program is very likely to involve interagency cooperation, whether the screening is for AOD, MH or DV issues or all of these. When we use the term "you" in this guide we are referring to an interagency planning group.

If you would like assistance establishing a screening program, please contact us.

Because establishing the mechanics of a screening program that will work within a CalWORKs setting is complex, CIMH would be interested in providing free consultation to any county wishing to introduce a screening program. This would also provide a golden opportunity to gather additional data from non-research settings that would assist the field in better understanding and calibrating screening instruments with the welfare population. Please contact CIMH Executive Director Sandra Naylor Goodwin, PhD, MSW, at (916) 556-3480.

Organization of the Rest of the Guide

Part II is a discussion of what to weigh when deciding whether or not to embark on a screening program. It presents the major reasons why identification rates have been lower than anticipated, and some of the advantages of screening.

Part III deals with the specific steps in designing a screening program. Foremost is the critical role that trust, confidentiality, training, safety and ethics play in any successful screening program. Other steps include:

[4] See especially: Meisel, J., & Chandler, D. (2000). *The CalWORKs Project Six County Case Study Project Report*. Sacramento: California Institute for Mental Health.

a) Fitting screening into your overall identification strategy

b) Determining the settings in which to screen

c) Selection of a screening instrument or instruments and cut-points

d) Ensuring a smooth transition to assessment and services

Although presented as "steps," planning has to take place concurrently for all the steps.

Part IV presents information on the brief screening instruments that were tested by the Project as part of its research in Kern and Stanislaus counties. It contains a summary of how the screening instruments were tested and the results of that testing. (More information is available in the *Screening Technical Manual.*[5])

Appendix I presents a summary description of projects in Portland, Oregon and in New Jersey which use screening instruments administered by AOD and MH specialists.

Appendix II provides a short description of more comprehensive screening instruments than the brief ones tested as part of the Project's research effort. Specialized instruments in South East Asian languages are also listed.

Appendix III presents information on why it is important that CalWORKs programs increase identification and services for persons with AOD, MH, and DV issues. It reviews information from the CalWORKs Project *Prevalence Report*[6] and other studies on the rates of occurrence of these issues within the welfare population, the barriers these issues constitute to employment, and the evidence that services can alleviate the issues and enhance employment.

Throughout this Guide we attempt to offer suggestions that apply across all three issues—AOD, MH and DV. However, there are differences in the role that screening may play for these three domains. For example, while denial may be involved in all three, resistance to treatment is much more likely with regard to AOD than mental health. And domestic violence, by its nature, is more likely to involve fears for safety (of the woman or her children). We have noted some of these differences in the text and footnoted some others.

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[5] Chandler, D. (2000). *Screening for Substance Abuse, Mental Health and Domestic Violence Issues in Welfare Reform Programs: A Technical Manual.* Sacramento: California Institute for Mental Health, www.cimh.org/project.html. This *Manual* contains the results of the testing we performed on the instruments recommended in Part IV.

[6] Chandler, D., & Meisel, J. (2000). *The Prevalence of Mental Health, Alcohol and Other Drug, & Domestic Violence Issues Among CalWORKs Participants in Kern and Stanislaus Counties*. Sacramento: California Institute for Mental Health, www.cimh.org/project.html.

PART II: WHY CONSIDER SCREENING?

What Causes Low Identification Rates?

A review of some of the major hypotheses for low identification rates of persons with AOD/MH/DV issues will assist in understanding how and under what circumstances screening might help to increase the rate.

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

2. Front-line CalWORKs staff (eligibility workers and employment coordinators) as a whole *have neither the time nor the capacity and support* to undertake the responsibility of identification.

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

    - Despite training, some staff still feel unprepared to address these issues with their clients.

3. CalWORKs participants do not recognize in themselves the signs of these problems, and/or they may deny the impact on their lives and on the lives of their children.

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

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

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

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

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

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

5. Finally, identification and treatment of AOD/MH/DV issues are also low in the general population. For example, studies have found only 20 to 40 percent of persons with a major depression disorder receive any sort of treatment. Rates are even lower for low-income persons, those receiving Medicaid (Medi-Cal), and persons of color.

How Might Screening Enhance Identification Rates?

Creating awareness: Identification through "self-declaring" assumes that the CalWORKs recipient is aware of having a problem and needs services. In fact, many people suffer from mental health symptoms, domestic violence, or misuse of alcohol or drugs without a clear understanding of the nature of their problems or that they might be helped by treatment or services.

Enhancing motivation for change: In a group setting, such as when AOD/MH or DV professionals address a Job Club or do an orientation, using screening instruments is a concrete way to get clients talking about signs/symptoms and what to do about them. For example, everyone could fill in the instrument and then there could be discussion of what the answers might mean. This approach is taken in Portland at orientation meetings and generates intense discussions.

Creating a culture of change: Screening, and the training that accompanies it, can help transform the "culture" of interpersonal contacts in a social services office. A screening program also implicitly leads staff to accept the importance of providing AOD/MH/DV services and to an acceptance of persons coping with these issues.

Taking advantage of windows of opportunity: People's receptivity to AOD/MH/DV services is likely to vary over time. In part this is due to experiences people have in welfare-to-work activities making them more aware of problems they might be having; and in part it is due to the trust in staff that develops over time. Screening instruments can ensure that these issues get raised at multiple points in the welfare-to-work career, i.e. screening could be done at entry, in Job Club, and when clients go to an employment counselor and prior to initiation of a sanctioning process.

Allowing referral without going through CalWORKs staff: Some participants might be willing to self-disclose to an AOD/MH/DV counselor who is independent of the welfare system, but might be reluctant to do so with the CalWORKs staff because of the fears noted earlier. If clients are able to take the tests in private and have them scored by AOD/MH/DV counselors, then a system could be created that bypasses the CalWORKs staff until a level of trust is developed that allows for disclosure. (In Los Angeles, a pilot program has CalWORKs applicants meet with and be screened by outreach workers who are in recovery themselves before they ever see an

eligibility worker.) Or screening might be done by Medi-Cal providers who serve CalWORKs participants.

What Are the Special Advantages of Screening Instruments?

Screening instruments have a number of potential advantages that are inherent in their nature.

- They have been found to be as accurate in identifying need for assessment as are line staff (not AOD/MH/DV professionals) who have been trained to identify possible AOD/MH/DV service needs.

- They are standardized, thus dealing with (or avoiding) inconsistent ways that staff approach these issues.

- Detection properties (cutoffs) are known and modifiable depending on needs of the user.

- Training of staff *may* be easier, less frequent or less costly if screening instruments are used.

- Screening instruments may also be particularly useful when there is a language/culture barrier—if the instrument is validated for each culture.

- Many counties already ask questions about AOD/MH/DV issues, but they are not using instruments with known psychometric properties. The brief instruments recommended here are likely to generate more valid and interpretable responses.

PART III: STEPS IN SETTING UP A SCREENING PROGRAM

In this section we present four steps in creating a screening program. First, you will need to determine how screening fits into your overall identification strategy. Second, you will need to deal with the context in which screening is to occur. Context means establishing trust, protecting privacy and confidentiality, providing staff training, and generating an organizational culture that supports identifying and serving persons with AOD/MH/DV issues. Third, you will need to deal with practical issues of which instruments, who administers, where and when. Finally, you will need to ensure that screening is tightly integrated with assessment and services. In practice, these steps are so closely inter-related that they must be considered together.

Step 1: Determine How Screening Will Fit into Your Overall Identification Strategy

Here are two questions you will need to answer:

- What do you hope to accomplish with your screening program? Which of the reasons for the lower-than-anticipated identification rates do you expect your screening program to address?

- How will screening relate to your other efforts to identify AOD/MH/DV issues? You might want screening to come early in the process as a stand-alone activity with direct referrals to assessment; or you might want screening to occur at those points where there is an event that leads you to suspect the participant is experiencing an AOD/MH/DV problem; or you may want to attempt outreach by screening in community agencies which serve many CalWORKs participants.

Working through the answers to these questions before you start will allow you to design a screening program which is more focused, easier to explain to staff and participants, and more conducive to monitoring and revising as necessary to accomplish your goals.

Step 2: Develop a Context that Supports Identification

It is absolutely critical that you attend to issues of trust, confidentiality, training, safety and ethics in the design and implementation of your screening program.

<u>Trust</u>

Screening instruments only “work” in a context of trust and helpfulness. Although the questions are not “direct”—such as “how often do you smoke marijuana?”—their purpose can be surmised by respondents. Honest answers can only be expected if the screens are administered in a setting in which CalWORKs participants believe that sensitive information they divulge will not be used against them.

Deal directly with the client's fear of having her children taken away due to drug use. Women who are alcoholic or using illegal drugs often fear that disclosing this fact to a welfare staff member will result in her children being taken away. Some women have had bad experiences with child welfare in the past or know other women who have. They lack trust. There are at least three possible approaches to defusing this fear:

- Create a clear county policy that states that no child welfare report will be made solely due to a woman reporting alcohol or drug use or entering a substance abuse treatment program. The policy should also say that discontinuing treatment will not in itself result in a CPS referral. The policy should also spell out the nature of abuse or neglect that *will* result in a CPS report, regardless of drug or alcohol use.[7] Make sure this policy is described in a brochure which women receive when they hear about AOD/MH/DV services that are available.

- Train staff (eligibility workers, employment counselors or outreach workers) to address this fear directly.

- Screening instruments, by their nature, generate a significant number of false positives. Thus, mandatory assessments based *only* on results of a screening test may generate resistance and resentment, and could even put participants who do not need services at risk of sanctions (if they do not attend an assessment). A system focused on positive motivation to change (including incentives[8]) needs to be the context for any screening.

Counties differ regarding whether assessments (and treatment) are mandatory if AOD problems are believed to exist. The CalWORKs recipient should be told the county's policy before she is asked to respond to any questions (on a screening instrument or in an interview) about alcohol or other drug use.

Deal directly with the client's fear of having her children taken away due to domestic violence. In some instances women have lost their children when they were the victims of domestic violence for "failure to protect" their children, or were threatened with removal if she did not leave. To defuse this fear:

- Create a clear county policy that states that no child welfare report will be made if a woman reports domestic violence (unless there is other evidence of abuse or neglect of the child). Make sure this policy is described in a brochure, which women receive when they hear about AOD/MH/DV services that are available.

- Train staff (eligibility workers or employment counselors or outreach workers) to address this fear directly.

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[7] Los Angeles is in the process of finalizing such a policy.

[8] A New Jersey experimental program, for example, gives monetary incentives for attending AOD treatment.

Ask clients about your intended procedures and the questions themselves. Use focus groups to ask clients how they think they would feel or react to different instruments or types of administration. Go even further and pre-test different types of administration and ask clients how they felt. In both of these cases, participants should be paid.

Demonstrate that you are there to help the client. AOD/MH/DV conditions are usually long-term, though they may be exacerbated by the crisis that brings a woman to CalWORKs. In general, applicants will have immediate concerns for their own health and safety and that of their children that take priority over addressing AOD/MH/DV issues. A good way to establish trust is to be of immediate and concrete assistance. If a woman's perceived need for food, housing, medical care, transportation and child care is not addressed by CalWORKs staff, she will have no reason to trust that disclosing AOD/MH/DV issues will result in receiving assistance. A caveat here is that a domestic violence shelter or a residential substance abuse treatment program may be the best way to address basic needs.

Inform CalWORKs applicants or recipients about AOD/MH/DV services before screening. Screening is more likely to be successful if those being screened have previously received information about AOD/MH/DV issues and services. Los Angeles requires that an "orientation" by AOD/MH/DV staff at all Department of Public Social Services offices occur prior to seeing an eligibility worker; or AOD/MH/DV staff could come into an initial Job Club training and describe services, lead a discussion, and administer a screening instrument.

Keep the issue of trust in mind as you develop all aspects of your screening program. There are decisions to be made at each of the steps we outline below. If you think, on balance, it will not be possible to generate a condition of trust for most encounters where screening is done, be wary of proceeding. Use of instruments where trust does not exist can increase mistrust, and alienate clients and staff.

Confidentiality

There are four basic aspects of any confidentiality plan, which need to be carefully considered, turned into written policies and used to train staff.

Privacy of Administration

- Whenever screening questions are administered orally on a one-to-one basis the participant needs to be assured of privacy. This means that participants should be screened alone—neither accompanied by a partner (especially for domestic violence screening) or children over two or three.[9]
- When screening questions are administered in a group setting and the forms collected for scoring, care needs to be taken to ensure that no person's form is viewed by another participant.

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[9] Zink, T. (2000). Should children be in the room when the mother is screened for partner violence? *Journal of Family Practice, 49*(2), 130-136.

Privacy of Discussions Regarding the Results of the Screening

- How one handles a discussion of results depends in part on the issue being screened for, and in part on who is doing the screening. If relatively untrained staff are doing the administration, you may want to protect privacy by allowing the client to score and keep her own form and discuss it only if she chooses. In this case, the screening is functioning to increase awareness and motivation in the client. However, if a health care provider or a licensed/certified AOD/MH professional or certified DV professional is administering the instrument, it is reasonable that results be discussed with each client. This issue may also be viewed differently for AOD, in which an element of coercion is often involved in getting persons addicted to drugs or alcohol to accept services. If the results are discussed, then privacy is essential.

- Administer in a group and make the forms anonymous. Describe how to score the form to the whole group so each person scores their own form.

Limited Access to Results of Screening

- Confidentiality also requires protecting the screening results from anyone except an AOD/MH/DV assessor. Negative screens can be destroyed. Brief instruments scored by the worker or the respondent herself could be simply given to the client along with a referral so that there is no need to keep them on file. If it is necessary to score screening items off-site (if the SF-12 Health Survey is being used, for example), establish tight confidentiality procedures and let the client know what they are. Results from machine-scored instruments then must be stored on computer and access strictly regulated. Fax-based scoring adds its own difficulties of restricting access around a fax machine.

Information Release and Informed Consent Forms

- These forms should be used where required and in most other instances. Any use of a screening instrument by an AOD, mental health or DV professional falls under state and federal confidentiality laws and requires an information release if the information is to be shared. While use of instruments by others, such as welfare eligibility workers or employment counselors, does not clearly fall under these laws and regulations, we suggest that an information release be signed any time intimate information is to be shared with someone else.[10] An informed consent is also a way of helping to allay client fears about how the information might be used. Staff must be carefully trained to abide strictly to the letter and spirit of policies and procedures.

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[10] See Winters, K. C. & Zenilman, J. M. (1994). Simple Screening Instruments for Outreach for Alcohol and Other Drug Abuse and Infectious Diseases. U.S. Department of Health and Human Services, Center for Substance Abuse

Training

While using formal, standardized instruments with known psychometric properties may reduce the need for training, training cannot be ignored. CalWORKs Project surveys of welfare eligibility and employment staff show that more training is strongly associated with making an increased number of AOD/MH/DV referrals. Training of those who administer screening instruments should include:

- Confidentiality and record keeping, particularly with respect to any substance abuse screening[11]

- Usefulness of screening and usefulness of treatment and servicesæMany workers know little about AOD/MH/DV issues or treatment/services. If they are to provide a respectful and trusting context for the screening, they must have an understanding of AOD/MH/DV issues, a belief in the value of treatment, and some degree of comfort with discussing AOD/MH/DV issues.

- Rationale for particular questions and understanding of any specialized language contained in the instrumentsæThe person administering screening questions must be able to interpret the results to the client. They also have to be able to deal with client questions and anxieties. The more explicit the questions are, the more important explaining the instrument and context is. Thus, the SF-12 Health Survey which uses indirect questions, needs little explanation; the Drug CAGE needs much more.

- Supervisors also need training about the instruments and procedures, as well as about supervisory roles and responsibilities in implementing the screening protocol.

Safety

Do not ask screening questions about DV in the presence of the participant's partner. Raising the issue of DV in this type of setting will either elicit a false answer and/or may jeopardize the woman's safety. It is essential that issues of DV be dealt with in privacy.

Ask further questions to protect women's safety. A positive answer to a screening question about physical violence requires a direct response by a worker to ensure that the woman is not in immediate danger.[12] The person administering the instrument (or a nearby specialist) must determine at a minimum:

Treatment, Rockwall II, 5600 Fishers Lane, Rockville, MD 20857. It includes a very good discussion of confidentiality directed at screeners in related agencies (like public health or welfare).

[11] Ibid.

[12] Some batterers are life-endangering. This assessment should be made by a domestic violence specialist.

- Is the woman's abuser with her at the time?
- Is the woman afraid of going home (with him or to him)?

If the answer to these questions is yes, there must be a plan for extricating her from the premises if necessary.

There are safety issues for persons with mental health or AOD issues as well. Severe depression can be a suicide risk, and there are grave risks, including death, that can be associated with detox. If you suspect safety is an issue, ask for immediate assistance from a mental health or AOD professional.

Culture and Ethics

Think about screening in the larger context of the organizational culture of welfare reform agencies. A new report by the Center for Substance Abuse Treatment[13] is devoted to a discussion of the need to address substance abuse issues in the context of welfare reform. It makes clear the larger context of deciding to use screening instruments:

> Welfare reform touches the heart of our country's deepest, most complex and sensitive social problems. It brings to the front our values about family, race, gender, poverty, stigma, blame, addiction, violence, and dependency. And, it places these problems and values squarely inside some of our most complicated bureaucracies—welfare, workforce development, child welfare, mental health, and substance abuse. The unprecedented opportunity that state [and county] officials have to develop innovative policies and services has not generally been matched by equivalent freedom to transform organizational systems and bureaucracies to best lead and direct policy innovations.
>
> It all comes down to the quality of a discussion between two people: a worker and a welfare recipient. Agency cultures, policies, strategies, and initiatives are all means to enhance the nature and outcome of these discussions. It is more likely that welfare recipients will talk about substance abuse or other problems that limit their ability to work if the discussion is characterized by trust, respect, and sharing of information. Honest discussions can also help workers make better eligibility decisions and determine the services a recipient needs in order to get ready for work.

[13] Nakashian, M. R., & Moore, E. A. (2000). *Identifying Substance Abuse Among TANF Eligible Families.* (Technical Assistance Publication (TAP) Series. XX.). U.S. Department Of Health And Human Services, Public Health Service, Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment. Rockwall II, 5600 Fishers Lane, Rockville, MD 20857.

If you plan to use screening instruments for AOD issues, we recommend you read this Technical Assistance Publication.

Include ethics and values clarification with staff as part of the screening program. As the evaluation of mandatory screening in Los Angeles has demonstrated, both staff and clients can be upset by procedures they feel are intrusive and coercive. An organization wishing to introduce screening needs to pay explicit attention to ethical and values questions regarding screening and treatment in the context of welfare. If, as emphasized here, the focus is on the development of trust, staff resistance should be much less than otherwise, but positive change cannot occur if staff do not feel "right" about the ways they are identifying CalWORKs participants who may need help with AOD/MH/DV issues.

Step 3: Determine Which Instrument(s) Will Be Administered When and Where, by Whom

Which Instrument(s)?

The decision regarding which screening instrument(s) to use will be driven by what you hope to accomplish with your screening program. The screening instruments that we tested in our research in Stanislaus and Kern include many of the better-known brief (3 to 5 questions) screening instruments. These will be most appropriate for those administrative settings:

- That rely on non-clinicians and non-specialists for administration
- Where time is limited

Other, longer screening instruments (10 to 150 questions)[14] might be considered in settings where:

- Clinicians or specialists will do the administration
- There is sufficient time
- The probability of the people having AOD/MH/DV issues is relatively high, i.e. they are having difficulty finding a job or have not retained work

In each situation it is an advantage to utilize a standardized instrument that has been "normed" on a population and in a setting that is most like CalWORKs. Part IV provides our recommendations on brief screening instruments based on our research with these instruments in Kern and Stanislaus counties. Appendix II contains recommendations for more comprehensive instruments and instruments for specialized purposes or populations.

[14] See Appendix II for a listing of such instruments.

You also need to decide what score on an instrument will result in a referral to an assessment. The establishment of cut-points involves a trade-off among inclusiveness, exclusiveness, and efficiency. Costs of screening include the costs of the instruments and their administration, costs of unnecessary assessments (false positives) and the costs of not detecting AOD/MH/DV conditions when they occur (false negatives). Problems that are not identified are more likely to be apparent only later through client noncompliance with CalWORKs requirements or inability to retain jobs. Ultimately, failure to provide services to those who need them defeats the purpose of welfare reform, which is to help poor parents become economically independent.

The trade-offs will also vary depending on the population you are screening, the issue you are screening for, and the characteristics of the service systems in your county. As an example, we have provided recommended cut-points for each of the brief screening tools we tested. However, you may weigh the costs differently from how we did, based on the costs of administering the instruments in your chosen setting(s), your system's capacity to handle many assessments, and the values you place on false negatives. You should refer to the *Screening Technical Manual* if you wish to consider cutoff points different from those we have recommended for general use. It provides information about detection rates at higher cutoff values.

The predictive properties of screening instruments within an actual CalWORKs setting have not been studied. Thus, we do not know the extent to which the brief screening instruments we tested in a research context will yield the same results when implemented within a CalWORKs setting. We strongly expect that the results will vary by county depending on the how the screening is actually done. It is therefore critical that you keep track of the results of your screening effort, i.e. your percentage of positive screens and the percentage of these that are determined to have the issue on assessment. If the percentage of positive screens is very low, you may want to consider lowering the cut-point; or, if you are getting too many false positives, you may want to raise it.

Who Administers?

Many types of staff come in contact with CalWORKs recipients, and under some circumstances all might be considered to administer screening questions. Eligibility workers have first contact usually, but are hampered by high case loads, limited privacy, limited training regarding AOD/MH/DV and low levels of comfort in discussing AOD/MH/DV issues.

Employment counselors are likely to have lower caseloads, more privacy, more training and more comfort with AOD/MH/DV.[15] Responsibility for job success falls on their shoulders, so responsibility for identifying and addressing barriers does too. The employment counselor will usually also be the person who stays in touch with any AOD/MH/DV treatment or service agency that becomes involved.

[15] See the report on our survey of eligibility and employment workers in five counties on the CIMH website: www.cimh.org/project.html.

AOD/MH/DV professionals (or paraprofessionals) are sometimes assigned to address new CalWORKs recipients in orientations or as part of the Job Club training. Generally they describe the services available and some signs or symptoms. Administration of screening instruments could be done in these groups. In fact, Portland has been very successful with an approach that requires all applicants to attend an AOD information session and a mental health information session. Professionals run these groups and administer screening instruments as part of the orientation. See Appendix I for a longer description of the Portland and New Jersey programs using screening by specialists.

In New Jersey, two models were tested using specialists administering screening instruments for AOD. In one, all sanctioned persons were interviewed by AOD professionals and screened. In the other, persons reporting lost eligibility cards, those applying for emergency assistance, and other high-risk clients were screened by specialized welfare staff. Both projects considerably increased the percentage of persons identified as needing AOD assessment or treatment. A detailed description of these experiments is in Appendix I.

Outreach workers may contact CalWORKs applicants or recipients at welfare offices—as in a pilot program at two social service offices in Los Angeles where paraprofessionals who are themselves graduates of a substance abuse treatment program administer a screening instrument before applicants even see an eligibility worker. Alternately, as in Alameda County, outreach workers may visit and talk to groups in many settings, such as junior college classes, where screening instruments could be used. Similar settings are Women Infant and Children (WIC) offices, childcare centers, and public health clinics.

One very good opportunity for identifying persons with AOD/MH/DV issues seems to be little used—the five day intensive “Job Club.” Generally the Job Club is taught by contract employees, often from a department of education or an employment agency. The focus, naturally, is on preparing to look for work; but in many cases women in these groups bond together, and a sensitive instructor could use the trust that develops in the group to introduce and administer screening instruments.

Finally, a quite different approach would be to attempt to get medical practitioners in the community to use the screens and to make referrals. All CalWORKs recipients are eligible for medical care through Medi-Cal. Numerous studies have shown that primary care medical providers do not consistently ask questions about depression, alcohol or drug problems and domestic violence. A CalWORKs program could mount an outreach campaign to Medi-Cal providers, explaining the availability of AOD/MH/DV services through CalWORKs and asking the providers to screen and refer using the recommended instruments (with an option for providers to use alternative, more detailed, instruments if they choose). The advantage to this approach is that it puts the screening and referral in the context of a confidential medical visit. Asking medical providers to screen also provides an opportunity to educate them about the AOD/MH/DV services available through CalWORKs. Both providers in the Comprehensive Perinatal Services Program and in Medi-Cal Managed Care Plans are required to screen. So these two programs would be a natural place to start.[16] This outreach approach might be combined with use of the instruments in other outreach sites as well as in CalWORKs offices.

Where Are the Instruments Administered?

Answering the “who” question also answered the “where” questionæscreening questions can be asked in private offices, as part of a group discussion about AOD/MH/DV issues, as part of a home visit, or in just about any place that outreach efforts are being conducted, including medical offices.

The table on page 18 summarizes many of the possible combinations of setting and staff.

How Are the Instruments Administered?

The instruments we have chosen are all available and can be administered in paper and pencil format. However, many CalWORKs recipients are likely to read at low levels. If the reading level of the persons being screened is not known, there are two alternatives:

- ***Read the questions aloud.*** The instruments can be administered orally by any staff member who is comfortable doing so; or reading them aloud in a group situation, such as Job Club, could make it less threatening. In either case, the instruments could be scored by the respondent herself (since the scoring rules are simple) or by the staff person.

[16] The Comprehensive Perinatal Services Program (CPSP), a very widely used state-funded program of enhanced medical services for pregnant women, requires an assessment of alcohol and other drug problems as well as mental health and domestic violence (DHS 4455 Initial Combined Assessment). All pregnant Medi-Cal recipients are eligible for the program. To convert this to a screening program for CalWORKs would only require: a) adding a data field so that providers knew who was CalWORKs eligible, and b) providing information and training regarding the availability of CalWORKs-funded AOD and MH (and DV in some counties) services. The Medi-Cal Managed Care Division of the state Department of Health Services requires all primary care providers in Medi-Cal Managed Care Plans to use the “Staying Healthy” assessment instrument. (See Policy Letter 99-07).

- ***Use a tape recorder.*** One experimental program in an emergency room used a tape recorder to ask DV questions and documented a detection rate equivalent to in-person screening.[17] Tape recordings have also been used in research in order to ask potentially threatening questions. Obviously, the person being screened would need to perceive the tape recording as an attempt to preserve her privacy rather than as a way of depersonalizing the encounter or avoiding work.

[17] Furbee, P. M., Sikora, R., Williams, J. M., & Derk, S. J. (1998). Comparison of domestic violence screening methods: a pilot study. *Annals of Emergency Medicine, 31*(4), 495-501.

Possible Screening Options: Staff and Setting

	WHO SCREENS	
Setting	**Generic Staff** (who have been trained)	**Specialist Staff**
Eligibility Interview	Eligibility Worker	Specialized Eligibility Worker[18]
Orientation Session		Paraprofessional Outreach Workers, Treatment/Service Staff
Job Club	Specially Trained Job Club Trainer	Invited Treatment/Service Staff
Employment Counselor Interview After Job Search	Employment Counselors	Employment Counselors Specializing in AOD/MH/DV[19]
Critical CalWORKs Junctures ▪ Apply for Emergency Aid ▪ Lost Eligibility Card ▪ Sanctioned ▪ Apply for Disability Exemption ▪ Did Not Retain Job ▪ Reapplying After Short Time Off Welfare		Specialist Social Services Staff
Other Social Service Programs: ▪ Cal-Learn ▪ Child Welfare[20] ▪ English as Second Language	Social Service Staff in These Programs	Paraprofessional Outreach Workers, Treatment/Services Staff
Community Settings ▪ WIC ▪ Childcare Centers ▪ Community Colleges ▪ Medi-Cal Providers (especially CPSP)	▪ Medi-Cal Providers Required as Part of CPSP or Managed Care Plan Regulations to Screen ▪ WIC Staff	Paraprofessional Outreach Workers

[18] Los Angeles uses this model very effectively in some Department of Social Services offices.
[19] Los Angeles adopted this as a pilot program. Its success is leading to system-wide implementation.
[20] Sacramento has pioneered screening for AOD in families with a child welfare case.

Step 4: Establish Procedures that Ensure a Smooth Linkage from Screening to Assessment or Services

It is common for persons who disclose an AOD/MH/DV issue to a CalWORKs staff member not to follow through with the referral to an assessment.[21]

There is a range of activities that the program can offer to assist the transition from a positive screen (or self-identification or behavioral observation) to an assessment or first service appointment. Efforts devoted to this part of the process will ensure that the screening program will yield its maximal benefits.

- ***Make the assessment as close in time and location to the original screening as possible***—It is unrealistic to think a client will call and arrange an appointment for an assessment. It is even unlikely to be sufficient for a worker to arrange an appointment while the client is still in the office. Co-location of assessment staff is ideal, especially if a client can be simply "walked down" to the assessor's office.

- ***Provide transportation to assessment visits***—Some counties have started assigning outreach workers to provide transportation to the appointment. CalWORKs funding has been used to purchase vans and pay for drivers to perform this function.

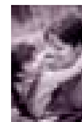
- ***Conduct home visits***—Assessors can make home visits if an assessment appointment is missed or for high-risk clients.

- ***Use specially trained "engagement" staff***—Some staff, particularly in AOD programs, are "engagement specialists." They have been trained in motivational interviewing. Such staff might be used as outreach workers (doing home visits, for example) or as a link to the assessment.

- ***Maintain contact until the person completes the assessment***—Someone must be assigned the responsibility of maintaining contact until the assessment appointment has been completed. In some counties, this is the person who does the screening (or makes the referral based on self-disclosure or behavioral observation). Once the referral is made, it may be the assessor who is assigned the responsibility to follow through if an initial appointment is not kept. This designated representative must have access to the supporting resources (e.g., transportation and child care) that can increase help. In either case, this is a crucial step that must be assigned to a specific staff member for each case.

- ***Maintain contact until the participant is actively engaged in services***—There is also a fall-off in attendance between the assessment and the engagement in services. Again, this is more likely to occur with those participants who fail to

[21] In Los Angeles, where completing an assessment is a requirement if a mental health referral is made, it is estimated by staff that at least 40 percent do not get to the assessment.



recognize an issue, are not fully committed to change, lack the belief that services will help and/or have other daily life barriers to following through with services. This is another critical point in which a personal connection can make all the difference.

An Example from Oregon

The following example illustrates a number of the points we have been making. Some welfare offices in Oregon, including those in Portland, run an "Addictions Awareness Class" for new TANF recipients that includes use of a screening instrument. These classes have been going on for about 6 years. They run two hours in length with about 15 people invited to each class. Classes are run by trained and experienced substance abuse counselors who are already co-located inside the welfare office. There is no written curriculum for the classes, because they rely heavily on discussion and each one unfolds on its own. However, there is a standard set of activities that takes place:

- First, the counselor presents an orientation to chemical dependency that describes the physical/biological aspects of addiction and explains addiction using a disease model. Issues relating to family members and AOD problems are addressed.
- Second, a 30-minute film/video is shown. These vary from day to day and counselor to counselor. These films are powerful and emotional and it is easy for them to bring up outbursts of feeling among the participants.
- Third, the SASSI (a comprehensive AOD screening instrument) is administered and discussed. Results are given to both the TANF participant and her worker.

Frequently the client is not ready to make the commitment to go into treatment. In order for the Assessment Specialist to keep the client engaged, encouraged and supported, she will continue to meet regularly with the client until the client is ready for treatment; oftentimes this is a weekly meeting. Another reason for meeting with clients on a regular basis is that frequently treatment facilities are at capacity and the client is put on a wait list. In order to prevent the client from "falling through the cracks" the Specialist will maintain an ongoing therapeutic relationship with the client.

PART IV: RECOMMENDED BRIEF INSTRUMENTS AND CUT-POINTS

How We Tested Brief Screening Instruments

As noted earlier in this Guide, using standardized instruments that have been validated on relevant populations enhances the usefulness of a screening program. The psychometric properties of most AOD/MH/DV screening instruments have not been described for a population of applicants and recipients of welfare. These properties might also be expected to differ after welfare reform (when the number of recipients is greatly reduced and the nature of the barriers to employment is different).

We incorporated testing and validation of some brief AOD/MH/DV screening instruments into the CalWORKs Project research in two California counties. The purpose was to determine which "worked better" in identifying participants with AOD/MH/DV issues, and to estimate the consequences of setting the "cut-points" at varying levels.

Research interviews were conducted with 347 women who had applied for cash aid (CalWORKs) in Stanislaus County and 356 women who were ongoing recipients of cash aid under CalWORKs in Kern County.[22] The research interview was designed to validly class each person as having or not having domestic violence issues, mental health diagnoses, and/or AOD abuse or dependence within the past 12 months. The questions from the screening instruments were included in the interviews so that we could compare the answers on these to the "gold standard" determinations.

The methodology for this research, and the characteristics of the samples, are described in a recent CIMH report available on the web.[23] More detail on the evaluation of the screening instruments is in the *Technical Manual*, available on the web.

What Are the Limitations of Our Testing Methods? Please note that the results derived from our research have important limitations:

- The instruments were only tested on women. In general, it has been found that prevalence and cut-points differ for men and women, so extrapolating to male CalWORKs recipients may not be valid. And the domestic violence screening instruments we tested were specifically designed for use with women.

- The research context, in which confidentiality is assured, is likely to be more conducive to disclosure of AOD/MH/DV issues than "real life" settings in which CalWORKs

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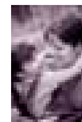
[22] Major city in Stanislaus is Modesto, and the population is 433,000; In Kern sampling was restricted to Bakersfield, with a population of 237,000.
[23] Chandler, D., & Meisel, J. (2000). *The Prevalence of Mental Health, Alcohol and Other Drug, & Domestic Violence Issues Among CalWORKs Participants in Kern and Stanislaus Counties*. Sacramento: California Institute for Mental Health, www.cimh.org.

recipients are likely to be screened—even if much attention is paid to establishing conditions of trust.

- We only tested brief screening instruments. We have suggested using them in some instances to trigger administration of more comprehensive instruments. There is a trade-off between brevity and validity. Our choice was to emphasize brevity. Some counties might choose to go directly to the more comprehensive instruments, especially if, like the Portland model described in Appendix I, the instruments are administered and interpreted by AOD, MH or DV professionals.[24]

- How useful the instruments are in identifying people needing assessment depends in part on the extent of the AOD/MH/DV issues in your county. The CalWORKs Project research suggests that prevalence can vary considerably across counties. The mix of race and age in a county's population can also affect how well screening instruments work.

What Do Our Recommendations Mean?

In each of the three areas—AOD, MH, and DV—we note the instruments that were tested and present summary information about the psychometric properties of the instrument that seemed to do the best job of maximizing correct identification and minimizing incorrect identifications. We present what you might expect with a given cut-point in terms of numbers correctly and incorrectly identified *if your conditions matched those we used in the research and the prevalence of the conditions was the same as in the two counties we studied.* We recommend this as a good place to start, but suggest very strongly that you keep data on what you find with the use of these cut-points so that you make adaptations as your screening program matures.

How You Can Get Copies of the Instruments

A Microsoft Word file that includes all the recommended instruments is available at the CIMH website—www.cimh.org—which you can use to tailor the specific instruments you wish to include in your screening. The file includes a Spanish translation of each instrument. With the exception of the SF-12, the questions are formatted with the assumption that they will be done as a paper and pencil test and then scored by the client herself. As noted above, there are many other possibilities.

Plan to Read the Technical Manual

If you get as far as wanting to choose an instrument, we suggest that you read the *Technical Manual* as well as these recommendations. It contains much more information about what you might expect using any instrument (including some not discussed here) at different cut-points.

[24] For mental health screening in South East Asian languages, using the longer instruments described in Appendix II is probably the only option.

Mental Health

In general, we would suggest screening for mental health issues as part of a broader health screening instrument, the SF-12 Health Survey. Use of this instrument is free, but requires permission, and you will need to have it scored by a vendor.[25] Translations to a number of languages are available.[26] We present the whole instrument so you can see if you might be interested in the physical health components, too.[27] The SF-12 is available in paper and pen and interview versions.

An alternative is to use a screen specific to mental health—the MH5—which we found to have very similar psychometric properties.

The logic behind our recommendations, and the information necessary to modify them to fit your situation (if necessary), are contained in the *Technical Manual.*[28] Below we present the SF-12 and then the MH5.

[25] Find vendors through: www.outcomes-trust.org/catalog/sf36.htm.
[26] IQOLA Project, The Health Institute, NEMC-345, 750 Washington St., Boston, MA 02111 or from a vendor.
[27] You really need to read the manual in order to understand how these health scores could be useful in the context of CalWORKs. Ware, J. E., Jr., Kosinski, M., & Keller, S. D. (1995). *SF-12: How to Score the SF-12 Physical and Mental Health Summary Scales*. Boston: The Health Institute, New England Medical Center.
[28] Chandler, D. (2000). *Screening for Substance Abuse, Mental Health and Domestic Violence Issues in Welfare Reform Programs: A Technical Manual.* Sacramento: California Institute for Mental Health, www.cimh.org/project.html.

The SF-12 Health Survey (used to screen for mental health issues)

Scoring **–** This instrument is scored so that low levels of symptoms and/or functional disability have higher scores. The cut-point we recommend for referring CalWORKs recipients for more extensive screening or for assessment for mental health issues is a "weighted" score of *less than* 35.93.

Psychometric properties **–** The psychometric properties of the mental health scale (there is also a physical health scale) of the SF-12 are described below with the cutoff score we found to be optimum (see the *Screening Technical Manual* for details).

MCS12 with Cutoff Score of 35.93 or Less	
Number screened	1000
Number with a diagnosis that interfered a lot with life and activities during past year	270
Number identified on test as a "positive" and referred for further testing assessment	220
Number of persons identified after further testing or assessment as having a disabling psychiatric condition within past year	130
Number of "false positives" who were referred for further testing or assessment but were not identified as having a disabling psychiatric condition within past year	90
Number of "false negatives" who were not referred for further testing or assessment but did have a disabling psychiatric condition within past year	140

The questions in the SF-12 Health Survey (not formatted as you would receive them from a vendor) are:

This questionnaire asks for your views about your health. This information will help keep track of how you feel and how well you are able to do your usual activities.

Please answer every question by marking one box. If you are unsure how to answer, please give the best answer you can.

1. In general, would you say your health is: [SAY EACH]

   EXCELLENT VERY GOOD GOOD FAIR POOR

The following items are about activities you might do during a typical day. Does <u>your health now limit you</u> in these activities? If so, how much?

2. …moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or going for a walk with your kids. Does your health now limit you a lot, limit you a little, or not limit you at all?

   YES, LIMITED A LOT

   YES, LIMITED A LITTLE

   NO, NOT LIMITED AT ALL

3. …climbing several flights of stairs. Does your health now limit you a lot, limit you a little, or not limit you at all in these activities?

   YES, LIMITED A LOT

   YES, LIMITED A LITTLE

   NO, NOT LIMITED AT ALL

During the past 4 weeks have you had any of the following problems with your work or other regular daily activities as a result of your physical health?

4. Accomplished less than you would like as a result of your physical health?

YES NO

5. Were you limited in the kind of work or other regular daily activities you do as a result of your physical health?

YES NO

During the past 4 weeks have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)?

6. During the past 4 weeks, have you accomplished less than you would like as a result of any emotional problems (such as feeling depressed or anxious[worried])?

YES NO

7. During the past 4 weeks, did you not do work or other regular activities as carefully as usual as a result of any emotional problems, such as feeling depressed or anxious?

YES NO

8. During the past 4 weeks, how much did pain interfere with your normal work, including both work outside the home and housework? Did it interfere…[EACH]

NOT AT ALL SLIGHTLY MODERATELY QUITE A BIT EXTREMELY

The next questions are about how you feel and how things have been with you during the past 4 weeks. For each question, please give the one answer that comes closest to the way you have been feeling.

9. During the past 4 weeks, how much of the time have your physical health or emotional problems interfered with your social activities like visiting with friends or relatives? Have they interfered…[EACH]

ALL THE TIME
MOST OF THE TIME
A GOOD BIT OF THE TIME
SOME OF THE TIME
A LITTLE OF THE TIME
NONE OF THE TIME

The next questions are about how you feel and how things have been with you during the past 4 weeks.

10. How much of the time during the past 4 weeks…have you felt calm and peaceful? (Read categories only if necessary.)

    ALL THE TIME
    MOST OF THE TIME
    A GOOD BIT OF THE TIME
    SOME OF THE TIME
    A LITTLE OF THE TIME
    NONE OF THE TIME

11. How much of the time during the past 4 weeks…did you have a lot of energy? (Read categories only if necessary.)

    ALL THE TIME
    MOST OF THE TIME
    A GOOD BIT OF THE TIME
    SOME OF THE TIME
    A LITTLE OF THE TIME
    NONE OF THE TIME

12. How much of the time during the past 4 weeks…have you felt downhearted and blue? (Read categories only if necessary.)

    ALL THE TIME
    MOST OF THE TIME
    A GOOD BIT OF THE TIME
    SOME OF THE TIME
    A LITTLE OF THE TIME
    NONE OF THE TIME

The MH5 Mental Health Screen

Scoring—The score on each of the five items must be added together and divided by five to get the average score. A lower score indicates greater need for assessment. If any question was not answered, add the scores of the remaining questions and divide by the number that were answered. Referral for more comprehensive tests or for assessment by a mental health professional would occur if the average score were *less than 2.9*.

Psychometric properties—The box below summarizes what you could expect if you screen 1,000 applicants—assuming you get results similar to those we got in the research interviews.

MH5 with Cutoff Score of 2.9 or Less	
Number screened	1000
Number with a diagnosis that interfered a lot with life and activities during past year	280
Number identified on test as a "positive" and referred for further testing assessment	250
Number of persons identified after further testing or assessment as having a disabling psychiatric condition within past year	143
Number of "false positives" who were referred for further testing or assessment but were not identified as having a disabling psychiatric condition within past year	107
Number of "false negatives" who were not referred for further testing or assessment but did have a disabling psychiatric condition within past year	137

The MH5 questions are:

1. How much of the time during the past 4 weeks have you felt calm and peaceful? **Please circle the number of the one best answer.**

    NONE OF THE TIME 1
    A LITTLE OF THE TIME 2
    SOME OF THE TIME 3
    A GOOD BIT OF THE TIME 4
    MOST OF THE TIME 5
    ALL THE TIME 6

2. How much of the time during the past 4 weeks have you been a very nervous person? **Please circle the number of the one best answer.**

    ALL THE TIME 1
    MOST OF THE TIME 2
    A GOOD BIT OF THE TIME 3
    SOME OF THE TIME 4
    A LITTLE OF THE TIME 5
    NONE OF THE TIME 6

3. How much of the time during the past 4 weeks have you felt so down in the dumps that nothing could cheer you up? **Please circle the number of the one best answer.**

    ALL THE TIME 1
    MOST OF THE TIME 2
    A GOOD BIT OF THE TIME 3
    SOME OF THE TIME 4
    A LITTLE OF THE TIME 5
    NONE OF THE TIME 6

4. How much of the time during the past 4 weeks…did you have a lot of energy? **Please circle the number of the one best answer.**

   NONE OF THE TIME 1
   A LITTLE OF THE TIME 2
   SOME OF THE TIME 3
   A GOOD BIT OF THE TIME 4
   MOST OF THE TIME 5
   ALL THE TIME 6

5. How much of the time during the past 4 weeks…have you felt downhearted and blue? **Please circle the number of the one best answer.**

   ALL THE TIME 1
   MOST OF THE TIME 2
   A GOOD BIT OF THE TIME 3
   SOME OF THE TIME 4
   A LITTLE OF THE TIME 5
   NONE OF THE TIME 6

Figure out your own average score.

1. **Add up each of the numbers you circled:**

   Question 1= ____
   Question 2= ____
   Question 3= ____
   Question 4= ____
   Question 5= ____
   TOTAL = ______

2. **Divide the total score you got by the number of questions you answered (usually it would be five).**

   Figure out your average score here: 5) ______ **Your total score**

3. **If your average score is less than 2.9, we would like you to talk to a mental health counselor who will help you decide whether you would like mental health counseling as part of your CalWORKs welfare-to-work activities. Please ask your eligibility worker or employment counselor for a referral.**

Alcohol

A number of short screening instruments for alcoholism or problem drinking are available. We tested three and recommend the TWEAK.[29]

Scoring—A "yes" answer to any question would result in a referral for a more comprehensive test (such as the SASSI) or for an assessment by a substance abuse specialist.

Psychometric properties—The box below summarizes what you could expect if you screen 1,000 applicants—assuming you get results similar to those we got in the research interviews.

TWEAK for Dependence, Abuse or Binge Drinking	
Number screened	1000
Number with a research-based diagnosis of abuse or dependence or who drank 5 drinks at a time at least once a month during the previous year	140
Number identified on test as a "positive" and referred for further testing assessment	110
Number of persons identified after further testing or assessment as meeting criteria for alcohol abuse or dependence or binge drinking within past year	77
Number of "false positives" who were referred for further testing or assessment but were not identified with dependence/abuse/bingeing within past year	33
Number of "false negatives" who were not referred for further testing or assessment but did report dependence/abuse/bingeing within past year	63

[29] Allen, J. P., & Columbus, M. (Eds.). (1995). *Assessing Alcohol Problems: A Guide for Clinicians and Researchers* (Vol. NIH Publication No. 95-3745). Bethesda, MD: National Institute on Alcohol Abuse and Alcoholism.

The questions in the TWEAK are:

Sometimes people may not be sure whether they need help with their drinking. Your honest answers to the following questions can help you decide whether you need to talk to a substance abuse counselor about your drinking.

1. How many drinks can you hold? (Without falling asleep or passing out)

   NUMBER OF DRINKS ____

2. Have close friends or relatives complained about your drinking in the past year? **Please circle yes or no.**

   YES NO

3. Do you sometimes take a drink in the morning when you first get up? **Please circle yes or no.**

   YES NO

4. Do you sometimes feel the need to cut down on your drinking? **Please circle yes or no.**

   YES NO

5. In the past 12 months has a friend or family member ever told you about things you said or did while you were drinking, that you could not remember? **Please circle yes or no.**

   YES NO

If you said you can hold six or more drinks *or* answered "yes" to one or more of the other questions, we suggest you to talk to a substance abuse counselor who will help you decide whether you need help with your drinking. This help is free and will count as part or all of your CalWORKs welfare-to-work activities. Please ask your eligibility worker or employment counselor how to see the counselor.

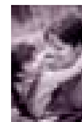
Drugs

We tested only one brief screening instrument for drugs, the Drug-CAGE. However, in our tests, two of the four items were not predictive of drug dependence or abuse at a statistically significant level. While we include all four questions here (and the cut-point is the sameæany "yes" is a positive for referral), we recommend that only the first two (italicized) questions (cut-down and annoy) be used for general screening. Their detection rate was as good as that for all four questions and two questions are less likely to raise defenses than are four.

Psychometric properties—The box below summarizes what you could expect if you screen 1,000 applicants—assuming you get results similar to those we got in the research interviews.

"Yes" on Either the "Cut-Down" or "Annoy" Items of the Drug-CAGE for Drug Dependence or Abuse	
Number screened	1000
Number with a research-based diagnosis of drug abuse or dependence during the previous year	60
Number identified on test as a "positive" and referred for further testing assessment	100
Number of persons identified after further testing or assessment as meeting criteria for drug abuse or dependence within past year	58[30]
Number of "false positives" who were referred for further testing or assessment but were not identified with drug dependence/abuse within past year	40
Number of "false negatives" who were not referred for further testing or assessment but did report drug dependence/abuse within past year	1

[30] Rounding from 58.3; the number of false negatives is rounded from 1.4.



The questions in the Drug-CAGE are:

Sometimes people may not be sure if they need help with their drug use or not. Your honest answers to the following questions can help you decide whether you need to talk with someone about your drug use.

1. In the last 12 months have you felt you should cut down on your drug use? (Please circle yes or no.)

   YES NO

2. In the last 12 months have people annoyed you by criticizing your drug use? (Please circle yes or no.)

   YES NO

3. In the last 12 months have you felt bad or guilty about your drug use? (Please circle yes or no.)

   YES NO

4. Sometimes people feel bad when a drug wears off. Did that ever happen to you in the past year? (Please circle yes or no.)

   NO Stop here and figure out your score.

   YES Answer 4.a. below.

   If "yes," 4a. Did you ever take another drug when that happened? (Please circle yes or no.)

   YES NO

If you answered both question 4 and question 4a "yes" OR you answered "yes" to one or more of the other questions, we suggest you to talk to a substance abuse counselor who will help you decide whether you need help with your drug use. This help is free and will count as part or all of your CalWORKs welfare-to-work activities. Please ask your eligibility worker or employment counselor how to see the counselor.

Domestic Violence

The Partner Violence Screen (PVS) consists of three items concerning safety and injury. We recommend it be supplemented by one other question on emotional abuse.

Psychometric properties**—**The box below summarizes what you could expect if you screen 1,000 applicants using the three questions from the Partner Violence Screen—assuming you get results similar to those we got in the research interviews. **Note: Because of its focus on physical violence, this screen will miss many cases of other types of domestic abuse. A longer instrument, such as described in Appendix II, is necessary to screen for the full range of domestic abuse.**

PVS Test for Physical Abuse: Current or Past Partner Made You Feel Unsafe; Hit or Otherwise Injured in Past Year	
Number screened	1000
Number of persons identified has having been physically abused during the previous year	210
Number identified on test as a "positive" and referred for further testing assessment	270
Number of persons identified after further testing or assessment as meeting criteria for physical abuse within past year	162
Number of "false positives" who were referred for further testing or assessment but were not identified with physical abuse within past year	108
Number of "false negatives" who were not referred for further testing or assessment but *did* report physical abuse within past year	48

We did not test the "emotional abuse" question with women without partners. For women *with* partners, we found that a total of 83 out of 315 women, or 26 percent, answered "yes" to the screening question of whether their partner had ever abused them emotionally. Of these 83 persons, 56 (67 percent) met the "gold standard" for "any abuse" within the previous year and 29 (35 percent) met the "gold standard" for "physical abuse" within the previous year.

The questions in the domestic violence screen are:

If you answer "yes" to any of the following questions concerning a past or present partner, please talk to an eligibility worker or employment counselor about how you can discuss your situation with a domestic violence counselor who can help you decide whether you need help with your domestic violence situation. This help is free and will count as part or all of your CalWORKs welfare-to-work activities.

1. Do you feel safe in your current relationship? **Please circle the letter in front of the best answer and answer all four questions.**

   A. I AM NOT IN A RELATIONSHIP RIGHT NOW

   B. NO

   C. YES

2. Is there a partner from a previous relationship who is making you feel unsafe right now?

   A. YES

   B. NO

3. Has a partner (current or past) abused you emotionally within the past year?

   A. YES

   B. NO

4. Have you been hit, kicked, punched, or otherwise hurt by someone within the past year?

   A. NO

   B. YES

   4a. If "YES," who did that to you?

   A. CURRENT PARTNER

   B. PREVIOUS PARTNER

   C. SOMEONE ELSE

APPENDIX I: SCREENING BY SPECIALISTS

PORTLAND, OREGON[31]

Overview—The Portland welfare program has its own orientation to TANF, which takes place immediately after the client turns in the required paper work.

In the first week of a person's application to welfare she/he is expected to attend a variety of classes on job searching, as well as an Addictions Awareness class and Mental Health 101. In most cases the classes are taught right at the welfare office. The AOD and MH classes are taught by licensed clinical staff who are co-located at the welfare office and who all have an expertise in DV issues as well as their own specific field.

The AOD Process

1) Addictions Awareness Class: two hours of classroom instruction and activity which includes instruction on the nature of addiction and codependence. In order to generate discussion amongst the clients, a film is shown on the effects of addiction on the family.[32] The SASSI addictions screening instrument is explained and administered at this time, as well. Clients expect that they and their case manager will independently receive the results, along with an appointment letter to have a full assessment if it is indicated.
2) Substance Abuse Assessment: The client meets individually with the Steps to Success AOD Assessment Specialist assigned to that particular branch. A full or partial assessment is done, based on the particular indicators for that specific client. If the client needs treatment, the Assessment Specialist assists them to get into treatment at that time.

The Mental Health Process

1) Mental Health Awareness Class: This classroom instructional activity covers an introduction to mental health counseling and why people might want to avail themselves of those services. There is a mental health questionnaire, the OQ45, which is brief. Occasionally the Zung Depression Scale is administered. Clients and their case managers receive results of both instruments. If further evaluation is warranted, the client is set up for an individual assessment.

2) Individual Assessment: The client receives an in-depth mental health assessment by the Mental Health Assessment Specialist. If it is determined the client needs further counseling, an appointment is made for ongoing counseling with a local mental health agency. The Specialist facilitates getting that client into treatment.

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[31] Information is from Christa Sprinkle, MA. Steps to Success Program, Mt. Hood Community College, Portland, Oregon.

[32] "Reflections on the Heart of the Child" presents addiction as a family, and particularly as a child issue. However, it is not very culturally diverse. Another film that is sometimes used is "Marijuana, The Mirror that Magnifies." Extracts from Bill Moyer's series on addiction may also be used. Only one film is shown at a session.

NEW JERSEY EXPERIMENTS[33]

There are three key elements of specialized screening. First, an interview format is used to establish rapport with the recipient. Discrepancies and inconsistencies in response to interviewer questions are carefully probed. In addition, concerns about privacy and confidentiality are addressed. Second, specially trained staff, although not necessarily addiction professionals, conduct the interviews. Third, because of resource allocation and cost associated with conducting interviews, only high-risk groups, i.e., those recipients who are thought to have a substance abuse problem, are screened. Specialized screening is designed to augment, but not replace, generic screening. A specialized screening program with these features was implemented in two counties in NJ.

One specialized screening program was implemented in a county with a relatively small TANF caseload of 469 recipients. Welfare regulations in NJ allow caseworkers to mandate a substance abuse assessment for any recipient who has failed a work activity. The county welfare office decided that all sanctioned clients would be required to undergo a substance abuse assessment prior to lifting the sanction. Letters were sent to sanctioned clients indicating that the sanction process could be stopped and benefits restored if the recipient came in for an interview. The type of interview was not specified and the tone of the letter was inviting and not punitive.

Clients responding to the letter were interviewed by an addiction counselor who was co-located at the welfare office. As part of the interview, counselors administered several standardized measures, including one that assessed substance use disorder diagnoses. As part of the interview, counselors also assessed for barriers to employability related to medical, mental health, employment, family, or legal problems. Reports were prepared and provided to caseworkers based on these assessments. Overall, 352 letters were sent to sanctioned clients and 86 clients (24%) responded to the letter and were interviewed between February and October 2000. Of these, 42 (49% of those interviewed) met criteria for a substance use disorder. In addition to the identification of substance abuse among sanctioned clients, the county also benefited from reports that detailed findings of other barriers to employability among sanctioned clients.

A second specialized screening program was implemented in a county with the largest caseload in NJ—16,401 recipients. The large caseload made it impractical to conduct in-depth interviews on all sanctioned clients. Instead, two welfare caseworkers with an interest in helping substance abusers were identified. These caseworkers had extensive experience in implementing special programs in welfare settings, but had minimal training in substance abuse assessment or treatment techniques. These caseworkers interviewed high-risk clients. These groups included: clients reporting a lost electronic benefit card, those applying for emergency assistance, clients

[33] Morgenstern, J., Riordan, A., Dephilippis, D., Irwin, T., Blanchard, K., McCrady, B. S., & McVeigh, K. (2000). Specialized Screening Approaches Can Substantially Increase the Identification of Substance Abuse Problems Among Welfare Recipients. *(Research Notes)*. Administration for Children and Families, New Jersey Department of Human Services.

who another caseworker suspected of having a substance abuse problem, and clients who responded positively to one or more items on the CAGE-AID.

In order to evaluate the effectiveness of this program, researchers examined two sets of data. Available data for the period of March through September 2000 indicated that 853 special screening interviews were conducted. Overall, 36.5% (N=312) resulted in a referral for further evaluation. Almost all those referred for an assessment were determined to have a substance abuse problem. Thus, specialized screening appeared to be an efficient method of identifying substance abuse problems. In addition, we compared the referral rates in the county where the special screening program was implemented to those of other NJ counties. Overall, the rate of referrals for substance abuse assessments in this county was 10.3% versus 4.4% for other NJ counties during the same 12-month period. Thus, specialized screening appeared to more than double the rate of referral for assessment.

APPENDIX II: MORE COMPREHENSIVE OR SPECIALIZED SCREENING INSTRUMENTS

The following instruments are more comprehensive than the short instruments validated in our research project. Although not validated psychometrically with a welfare reform population, at least two of the instruments (the SASSI and BASIS-32) have been used with welfare participants. We have also cited specialized tests, for example, for personality disorders, and instruments translated into South East Asian languages.

Alcohol and Other Drugs

1. **Recommended Instrument:** The Substance Abuse Subtle Screening Inventory (SASSI), has been tried in several welfare settings. There is a description of pros and cons as the instrument was used in the Portland project in Pavetti, L., Olson, K., Pindus, N., Pernas, M., & Isaacs, J. (1996). *Designing Welfare-to-Work Programs for Families Facing Personal or Family Challenges: Lessons from the Field*. The Urban Institute, Washington, D.C. and American Institutes for Research. Also see Appendix I in this report.

   The SASSI is a paper and pencil test that is designed to reveal both problems with alcohol and with other drugs. It includes both explicit questions about substance use and a scale that scores "denial" of substance use problems.

   Here are other important SASSI references:

   DiNitto, D. M., & Schwab, A. J. (1993). Screening for Undetected Substance Abuse Among Vocational Rehabilitation Clients. *American Rehabilitation, 19*(1), 12-20.

   Horrigan, T. J., Piazza, N. J., & Weinstein, L. (1996). The Substance Abuse Subtle Screening Inventory Is More Cost Effective and Has Better Selectivity than Urine Toxicology for the Detection of Substance Abuse in Pregnancy. *Journal of Perinatology, 16*(5), 326-330.

2. Winters, K. C., & Zenilman, J. M. (1994). *Simple Screening Instruments for Outreach for Alcohol and Other Drug Abuse and Infectious Diseases* (Treatment Improvement Protocol (TIP) Series 11): U.S. Department of Health and Human Services, Public Health Service, Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment. Contains screening tools for alcohol and other drugs (combined tool). Has a great deal of useful information about administration of screening instruments, including sections on confidentiality.

Psychiatric Disability

1. **Recommended Instrument:** The BASIS-32 is a 32-item instrument widely used in mental health programs, including in California (as part of the battery of the state-required

Performance Outcome System). It can be administered as a paper and pencil test or in interview format. Scoring is simple. Norms are available for clinical and U.S. population samples.

2. The SCID-II-Q(uick) is a self-report screening instrument specific to personality disorders, diagnoses that may be prevalent in the CalWORKs population, but which are not picked up by the instruments above. Nussbaum, D., & Rogers, R. (1992). Screening Psychiatric Patients for Axis II Disorders. *Can J Psychiatry, 37*(9), 658-660.

3. Mouanoutoua, V. L., & Brown, L. G. (1995). Hopkins Symptom Checklist-25, Hmong Version: A Screening Instrument for Psychological Distress. *Journal of Personality Assessment, 64*(2), 376-383. This instrument has now been translated and tested with all the major South East Asian cultural groups.

   Also see: Mouanoutoua, V. L., Brown, L. G., Cappelletty, G. G., Levine, R. V. (1991). A Hmong Adaptation of the Beck Depression Inventory. *Journal of Personality Assessment, 57*(2), 309-22; and: Hinton, W. L., Du, N., Chen, Y. C., Tran, C. G., Newman, T. B., Lu, F. G. (1994). Screening for major depression in Vietnamese refugees: a validation and comparison of two instruments in a health screening population. *Journal of General Internal Medicine 9*(4), 202-6.

   These instruments and scoring instructions are available through CIMH. Dr. Mouanoutoua can be reached at (559) 455-2175 in the Fresno County Department of Mental Health.

4. Robinson, J. P., Shaver, P. R., & Wrightman, L. S. (1990). *Measure of Personality and Social Psychological Attitudes*. San Diego: Academic Press, Inc. Contains descriptions of the psychometric properties of many tests and examples of the tests themselves. The two most relevant are the Beck Depression Inventory (widely used scale in 21-item or 13-item form); and the 13-item Center for Epidemiologic Studies Depression scale, which has been used in many welfare-to-work research studies.

5. A new 10-item screen for depression, the HANDS, developed for National Depression Screening days, is available for inspection on the web. Psychometrics are also described: www.nmisp.org/dep/dep-hands.htm.

Domestic Violence Screening

Recommended Instrument: Bernstein, D. P. (1998). A New Screening Measure for Detecting ‘Hidden’ Domestic Violence. *Psychiatric Times, XV*(11). We suggest this new instrument, designed specifically for screening in community settings rather than research; it is called the Partner Violence Inventory. It is available from CIMH. However, its cut-points have not been established. If used, we suggest working with CIMH to establish reliable cut-points.

APPENDIX III: BETTER IDENTIFICATION OF CALWORKS PARTICIPANTS WITH AOD/MH/DV ISSUES WILL PAY OFF

Mental Health and Welfare

Reported rates of psychiatric disorders are higher for the AFDC/TANF population than the general population. The National Comorbidity Study determined rates of psychiatric diagnoses in a probability sample of the US population in 1992.[35] The most prevalent diagnosis was major depression at 12.9 percent. In the CalWORKs Project research, major depression was found in 22 percent of recipients in Kern and 36 percent in Stanislaus. Other studies have confirmed the higher rates among welfare recipients.[36]

Mental health problems are likely to impair CalWORKs recipients' capacity to find and retain employment. Many mental health diagnoses are extremely debilitating. Frequently recipients have more than one condition at the same time. Over a quarter of the CalWORKs Project research subjects reported that a mental health condition interfered "a lot" with their normal functioning. Some studies done in other states have found a direct impact on employment from mental health conditions, especially depression.[37]

Mental health problems can be treated successfully if identified. Rates of successful treatment for depression, anxiety and other mental health diagnoses likely to occur among welfare recipients are similar for psychotherapy and medications. Relatively few studies have focused on vocational outcomes, but a 1992 meta-analysis found substantial success, albeit a good deal of variability from study to study.[38] A CIMH study of CalWORKs client satisfaction and staff ratings of closed mental health cases provides at least preliminary support for the helpfulness of mental health services delivered in the CalWORKs context. Current clients rated their services as helping them "a lot" in 45 percent of the cases. Clients rated services as being helpful in helping them work in 57 percent of the cases. Staff rated 49 percent of discharged clients as having improved on mental health issues.[39]

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[35] For mental health diagnoses we used a validated "short form" of the instrument that measured a limited set of diagnoses—those we thought most likely to be undetected in the CalWORKs population. The National Comorbidity Survey used DSMR-III definitions rather than DSM-IV. The CIDI-SF has been re-scored for DSM-IV.

[36] Danziger, S., Corcoran, M., Danziger, S., Heflin, C., Kalil, A., Levine, J., & Rosen, D. (1998). *Barriers to the Employment of Welfare Recipients.* Ann Arbor: University of Michigan, Poverty Research and Training Center, www.ssw.umich.edu/poverty/pubs.html; Jayakody, R., Danziger, S., & Pollack, H. (2000). Single Mothers, Mental Health and Substance Abuse: Implications for Welfare Reform. *Journal of Health Politics, Policy and Law, (In press)*.

[37] Ibid. See also: Barusch, A. S., & Taylor, M. J. (1999). *Understanding Families with Multiple Barriers to Self-Sufficiency*. Salt Lake City: University of Utah, Social Research Institute.

[38] Mintz, J., LI, M., MJ, A., & SS, H. (October 1992). Treatments of depression and the functional capacity to work [published erratum appears in *Arch Gen Psychiatry* 1993 Mar;*50*(3):241]. *Archive of General Psychiatry*, *49*(10), 761-768.

[39] This report, *Six County Survey Results,* is available at www.cimh.org.

Alcohol and Other Drugs and Welfare

Reported rates are higher for the AFDC/TANF population than the general population. The most recent comprehensive California information on AOD dependence is from the 1999 National Household Survey on Drug Abuse. The 12-month prevalence of illicit drug or alcohol dependence is 3.9 percent for females of all ages. Results among welfare recipients vary widely, often depending on the instruments used. A recent New Jersey study found 11.3 percent to have either an alcohol or a drug dependence or abuse disorder within the past 18 months. In the CalWORKs Project research the AOD dependence ranged from 6.3 percent in Kern to 10.1 percent in Stanislaus (age 18–64), two to three times the rate in the general public. Use of illicit drugs was considerably higher.

Substance abuse is likely to impair CalWORKs recipients' capacity to find and retain employment. Any use of illicit drugs may affect employment if employers use drug tests. More importantly, persons who abuse or are dependent on alcohol or other drugs are often much less likely to work or to retain work if they find it.[40]

AOD dependence and abuse can be treated successfully if identified. Although a chronic condition (in the way diabetes is), AOD dependence is successfully treated and can reduce welfare dependence.[41] The CIMH client and staff survey of CalWORKs recipients mentioned above showed significant effects for CalWORKs clients receiving AOD services. Of the clients surveyed, 71 percent felt their services had helped them "a lot" in dealing with their problems, with 86 percent feeling that their chances of working were better as a result of treatment. In addition, staff rated 54 percent of discharged clients as having made positive changes regarding AOD.[42]

Domestic Violence and Welfare

Reported rates are higher for the AFDC/TANF population than the general population. Studies that have surveyed AFDC and TANF populations indicate significantly higher rates of self-reported domestic violence both within the lifetime and within the last 12 months than for the general population.[43] In the Kern and Stanislaus County samples we studied, 35 and 49 percent, respectively, reported experiencing domestic violence in the prior 12 months; 16 and 25 percent reported physical violence.

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[40] Danziger, S., Kalil, A., & Anderson, N. J. (2000). Human Capital, Health and Mental Health of Welfare Recipients: Co-occurrence and Correlates. *Journal of Social Issues, (Forthcoming)* Available on the web at: www.ssw.umich.edu/poverty/pubs.html.

[41] For example, the 1997 National Treatment Improvement Evaluation Study (NTIES), a Congressionally-mandated five-year study of the impact of drug and alcohol treatment of over four thousand clients in hundreds of treatment units, documented less use of welfare and more employment after treatment. www.health.org:80/govstudy/f027/employ.htm.

[42] This report, *Six County Survey Results,* is available at www.cimh.org.

[43] See the studies in: Raphael, J., & Tolman, R. M. (1997). *Trapped by Poverty, Trapped by Abuse: New Evidence Documenting the Relationship Between Domestic Violence and Welfare*. Ann Arbor: Taylor Institute and the University of Michigan Research Development Center on Poverty, Risk and Mental Health.

Domestic violence contributes to some women's applying for AFDC/TANF. The lack of independent economic means is a major factor in many women's decisions to remain within an abusive relationship. Access to economic support through welfare has historically been one of the avenues by which women can extricate themselves from such relationships. As part of the CalWORKs Project, we surveyed 78 CalWORKs participants receiving domestic violence services in two counties. Of these, 37 percent reported that a domestic violence situation was entirely the reason for their applying for aid; another 18 percent said it contributed somewhat to their decision to apply for CalWORKs.[44] In the research project we report on here, 21 percent of women in both Kern and Stanislaus Counties reported having applied for welfare at some time in order to get away from an abusive situation.

TANF and some state welfare reform legislation provides for a domestic violence alternative. The domestic violence option allows women whose safety is endangered to be exempted or deferred from some welfare reform requirements. As implemented in California, counties largely decide on these exemptions and deferrals. In Los Angeles, for example, women fearing for their safety may be exempted from the work activity requirements entirely. Many women who will choose not to use the domestic violence option still desire and need assistance in dealing with domestic violence situations or consequences such as post-traumatic stress disorder (PTSD). The California Legislature has appropriated money each year for counties to provide services to CalWORKs recipients who also have AOD or mental health issues. Most social service departments have also made some arrangement for serving women with domestic violence issues. Even when abuse is in the past, PTSD may cause symptoms that require treatment.

Domestic violence services can be helpful to survivors receiving welfare. A CIMH survey of domestic violence service recipients and providers in Los Angeles and Stanislaus Counties (regarding women receiving CalWORKs) showed a number of positive results. Domestic violence client change was rated on four dimensions: client's safety, client's freedom from emotional abuse, client's freedom from harassment or stalking, and client's understanding of all her options in regard to her relationship with her abuser. Positive change was recorded for 73 to 87 percent of the DV clients, depending on the dimension. Women surveyed were likely to recommend their service provider to a friend (around 70 percent) and to feel they were better prepared to find work (over 60 percent).[45]

Many CalWORKs Recipients Have More Than One AOD/MH/DV Issue

Domestic violence and AOD issues are often found together, as are AOD and mental health and mental health and domestic violence. For example, one recent study shows that 57% of clients in

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[44] Meisel, J. & Chandler, D. (2000). *The CalWORKs Project Six County Case Study Project Report*. Sacramento: California Institute for Mental Health, www.cimh.org.
[45] This report, *Six County Survey Results,* is available at www.cimh.org.

a drug treatment program experienced domestic violence in the previous year.[46] Another recent study of co-morbidity between psychiatric disorders and domestic violence found: “Half of those involved in partner violence had a psychiatric disorder; one-third of those with a psychiatric disorder were involved in partner violence. Individuals involved in severe partner violence had elevated rates of a wide spectrum of disorders.”[47] In our research study in two counties, 21 percent (Kern) and 32 percent (Stanislaus) of all applicants had more than one AOD, DV or MH condition in the year prior to the interview. It is important that approaches to identifying AOD/MH/DV issues among CalWORKs recipients take account of the high likelihood of multiple issues. It is equally important that arrangements for AOD/MH/DV *services* to CalWORKs recipients include programs that can capably deal with multiple AOD/MH/DV issues and with other barriers to employment.

[46] Chermack, S. T., Fuller, B. E., & Blow, F. C. (2000). Predictors of expressed partner and non-partner violence among patients in substance abuse treatment. *Drug and Alcohol Dependence*, *58*(1-2), 43-54.
[47] Danielson, K. K., Moffitt, T. E., Caspi, A., & Silva, P. A. (1998). Comorbidity between abuse of an adult and DSM-III-R mental disorders: evidence from an epidemiological study. *American Journal of Psychiatry*, *155*(1), 131-133.

The California Institute for Mental Health is a non-profit public interest corporation established for the purpose of promoting excellence in mental health. CIMH is dedicated to a vision of “a community and mental health services system which provides recovery and full social integration for persons with psychiatric disabilities; sustains and supports families and children; and promotes mental health wellness.”

Based in Sacramento, CIMH has launched numerous public policy projects to inform and provide policy research and options to both policy makers and providers. CIMH also provides technical assistance and training services under contract to various funders.