

Santa Clara County's CalWORKs Behavioral Health Screening

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EXECUTIVE SUMMARY

Best practice in addressing the behavioral health (BH) needs of CalWORKs (CW) clients includes identifying clients early and offering services at the time of access to benefits and employment services. While San Francisco's CW program has been addressing BH issues within on-going case management, there is room for improvement by offering BH referrals earlier in the process. In this case study, we are looking at the Santa Clara County (SCC) model of early BH screening and intervention.

The CalWORKs Health Alliance (HA), a partnership between Santa Clara County Social Services Agency (SSA) and Santa Clara Valley Health & Hos-

pital System's (SCVHHS) Department of Alcohol & Drug Services (DADS) and Mental Health Department (MHD), partnered with five community behavioral health care service providers to provide BH screening and service delivery for employable CW clients. The Department of Employment and Benefits Services (DEBS), in partnership with the HA, implemented BH screening and service referrals at the time of CW orientations. The use of clinicians as opposed to DEBS staff made the crucial difference when SCC attempted to increase the number of client referrals to BH services.

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Introduction

Since 2006, when the federal government reauthorized the Temporary Assistance for Needy Families (TANF) program, work participation rates (WPR) have driven CalWORKs (CW) employment services practice. One big factor influencing counties' failure to meet WPR is the many Behavioral Health (BH) challenges employable clients are facing.

Aside from meeting requirements for WPR, there are other benefits for offering timely BH services. A comprehensive approach yields multiple benefits to both the community and counties. Early intervention will save money down the road. Each government agency can be a one-stop access point by acting as a referral resource. An example of this approach is the Linkages philosophy and practice that emphasizes prevention and coordination of services between CW, Family and Children Services (FCS) and community-based organizations (CBOs). The savings in cost for all levels of government are multiplied when we consider the other long-term problems associated with children in foster care.

Most counties do a reasonably good job of providing BH services to the community. In this case study, we will look at Santa Clara County's (SCC) unique approach of using a triage model and clinical staff to screen for and refer to BH services needs.

Program Goals

The goals of SCC's BH service approach are:

- Increase work participation.
- Prevent negative long-term consequences due to unmet BH needs.
- Provide early and comprehensive BH needs assessments and service referrals.

- Increase client access to SSI benefits.
- Prevent child maltreatment and decrease FCS caseloads.

Santa Clara County Model for BH Screening

Mental health (MH), substance abuse (SA), and domestic violence (DV) are significant barriers to self-sufficiency in Santa Clara County (SCC), as in other counties. To meet this challenge, SCC is partnering with the Health Alliance (HA). Initially, several of the attempted strategies designed to increase referrals to their BH service providers failed; for example, training employment counselors (ECs) on BH issues and offering joint training with ECs on how to make referrals did not lead to increased service referrals. On the other hand, a significant increase in BH referrals occurred when clinicians were used to screen and refer clients.

HA partners present their respective BH services at CW orientations. Clients are individually screened and referred after their orientation, and can make service appointments on the spot. The referral and appointment information is passed on to the EC; this information is integrated into the client appraisal and assessment for employment services at the beginning of Welfare to Work (WTW) services.

SCC started a new model for BH screening in February, 2009, in partnership with the HA. This partnership enabled five community-based organizations (Asian Americans for Community Involvement (AACI), Asian American Recovery Services (AARS), Catholic Charities, Gardner Family Care, and the County Mental Health Services Team) to partner with DEBS in addressing employable clients' BH issues. These agencies present their services at ori-

entation, where WTW expectations and BH services are presented to and discussed with clients. After the orientation, each client meets individually with one of several HA staff present in a nearby cubicle. The HA worker has a conversation with the client guided by the “Client Well-Being Questionnaire”. This screening tool has six areas of exploration: counseling, emotional well-being, personal and physical safety, drug and alcohol use, gambling, and a possible request for an appointment with one of the service providers.

DV services are screened for by the HA staff, but services to community-based organizations are done by the DEBS Social Work unit. MH and SA counseling appointments are set up immediately after the screening by the clerk supervisor, who sets up an appointment with a community partner agency with the help of a special on-line scheduling program.

According to the 2009 report of the SCC Employment Services Bureau, 95% of clients at orientation were screened by the HA. One-third of clients had been identified with BH issues and had accepted a HA referral; of these, about 50% of clients showed up for their appointments.

SCC successfully addressed initial challenges that arose when implementing this model. After being screened for BH needs, clients see their EC with the BH service appointment form in hand. Initially, when HA staff had called clients after orientations, some of the clients had gone home instead of meeting with their EC. At first, ECs were unhappy about “outside” staff, unfamiliar with DEBS expectations and procedures, working with their clients. Additionally, some ECs felt then that it took time away from their meetings with clients.

To address these challenges, SCC held meetings between ECs and HA staff to discuss client flow and to address misperceptions between staff. HA increased the number of staff at each screening and accessed more cubicles in which to do the screenings. HA staff shortened the screening time from 10 minutes to 5–7 minutes. HA staff or ECs can both now call clients after orientations. HA staff and ECs make sure that each client meets with the other staff team before leaving. HA appointment and referral forms

are put in ECs’ inboxes to indicate whether BH services were requested and if referrals or appointments were made. HA staff meet quarterly to improve on their services.

One challenge that continues to remain is providing a confidential setting for the BH screening; this challenge is due to space limitations.

San Francisco County’s Current Model of BH Screening

San Francisco Human Services Agency (SF-HSA) has developed several strategies to meet the BH challenges of CW clients. SF is using a BH service contract partner, Westside Community Counseling Services (WSCC), to provide services. CW staff informs and refers clients to BH services throughout the time a client is working with CW. A unit of social workers (SWU) does outreach and home visits upon referral, including SSI outreach and advocacy. DV services are offered on-site at the main office and are also accessible through out-stations. SW referrals are triggered by non-compliance with WTW, and other service needs. For example, results of a learning needs assessment tool may lead to a referral for Learning Disability testing by WSCC. Cases active in both CW and FCS, known as “linked” cases, are assessed and referred to BH services. Service delivery between these programs is coordinated in “Linkages meetings”.

Successful Strategies

The following strategies utilized by SCC-DEBS have been found to be successful:

- Informing clients of BH services throughout the life of a case
- Using clinicians to screen clients at the beginning of WTW engagement
- Making on-line appointments for services immediately following BH screening
- Collaborating with HA to deliver BH services
- Meeting quarterly with agency staff and service providers to improve service delivery
- Using Learning Disabilities (LD) assessments and workshops through a program called “Keys to Success”

- Having the Social Work unit make referrals to DV services in the community

Additionally, the following strategies utilized by SF county-HSA have been found to be successful:

- Informing clients of BH services throughout the life of a case
- Having the SW unit helping clients access BH services
- Implementing SSI outreach and advocacy
- Co-locating CW staff and DV services staff in the main office

Fiscal Implications

According to the “Annual Report for the CalWORKS Health Alliance, Fiscal Year 2009”, the CalWORKS Health Alliance received \$3,533,416 in State General Funds for its CalWORKS mental health and substance abuse services in Fiscal Year (FY) 2009–2010. Due to the current budget crisis, there is an expected decrease in funding for 2010–2011. The Health Alliance spent over 96% of its funding in FY 2009–2010, which is significant because new allocation levels are partly based on the percentage of previously allocated funds expended.

HA staff administering CW-BH screenings are clinicians, including Masters-level interns from contract agencies. If San Francisco wants to implement this model, additional MH funding is needed or SF providers need to adjust how services are delivered.

SF County uses a work order to the Department of Public Health (DPH), who in turn contracts out BH services to CBOs, similar to SCC. CW clients can access these services on their own or through referrals by CW staff. SF HSA contracts directly with a CBO to deliver DV services to CW clients. Linked cases are served through CW funded services as much as possible, to the fiscal benefit of the county.

Currently, SF CW staff are responsible for BH screening and referrals. To implement the SCC model and use clinical staff for BH screening, staff from SF's own CBO, Westside Community Counseling Services (WCCS), would be used. WCCS could hire additional staff or shift the duties of existing staff. SF HSA has a work order of about \$3.8 million for the

DPH for Fiscal Year 2009–2010. Based on the assumption that two clinicians would be needed after each daily orientation for about one hour to administer the BH screening, this additional responsibility would amount to a quarter-time position (.25 FTE), or approximately \$25,000. In 2011, when the long-term CW changes take effect, the cost would have to be doubled to \$50,000 of additional work order funds.

Recommendations

I am recommending the implementation of an adaptation of the SCC model of BH screening. The two components I recommend for implementation are using clinicians to screen for BH needs and moving screening up-front in the client engagement process. My recommendation, in contrast to the SSC model, is to not limit the screening to currently employable clients, but to include all CW clients in this process. Not only is this best practice, but it is also preparation for the long-term changes coming to CW in July 2011, when ineligible clients will have to be engaged in employment activities or risk having their child-only grants reduced by sanction. It is expected that this client population will face significant barriers to participating in employment activities and that their families' basic needs risk being unmet when gradual sanctions are applied.

As San Francisco HSA is facing cuts, a reorganization of job duties within WSCC to provide these services is the most likely way clinical staff will be provided for screening. WSCC staff could get help from the CW SW unit that is currently doing a small BH screening project of its own.

Moving BH screening up-front would mean moving screening to after orientation. Screening before orientation would not be fiscally sound, as about one-third of the clients who complete intakes will not be eligible for CW and therefore, will not be eligible for CW-BH services. Currently, only employable clients are scheduled for orientations. I recommend gradually changing the process and referring all clients to orientation, as it will prepare clients for the long-term CW changes and will allow for BH

screening of clients currently ineligible for employment services.

Conclusions

This case study indicated that using clinicians to screen and refer clients with BH needs significantly increases referrals to and use of BH services. Currently, BH services are underutilized by CW clients in SF. Best practice and fiscal prudence indicate prevention, rather than intervention at a later time when problems have mushroomed and are harder to treat. SCC demonstrates a successful model of early screening and increases in service referrals. SCC successfully overcame the initial challenges of bringing in non-CW staff to work with their ECs. SF county can learn from the successes and challenges SCC mastered so it can implement a modified version of the SCC model. This model is certainly worthy of consideration by other counties as well.

Acknowledgments

I would like to acknowledge and thank the SCC management team. In particular, I would like to acknowledge Denise Boland, DEBS Administrator, who provided me with the Annual Report 2009 of SCC and introduced me to her team of managers. I want to thank Frank Motta, Project Manager, for hosting the initial orientation for the BASSC participants with projects in SCC. My special thanks go to John Larson, Senior Health Care Program Manager, for inviting me to observe SCC's orientation and BH screening process, as well as a CW Advisory quarterly meeting with the Health Alliance partners.

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