

Employability

Substance Use Disorders and Employability Among Welfare Recipients

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The 2006 welfare reform legislation (Deficit Reduction Act of 2005) imposed more stringent work requirements and defined the amount of time cash assistance recipients are allowed to be exempted from the work requirement because of substance use treatment. As there is little empirical literature on the employability of substance users, it is difficult to know whether it is realistic to expect individuals with substance use disorders to meet the increased work requirement. Based on a comprehensive evaluation of nearly 9,000 substance-misusing welfare recipients from 2001 to 2007, University Behavioral Associates (UBA) Comprehensive Services Model program in Bronx, New York, found that 60% of recipients were not exempted from the work requirement owing to substance misuse at the outset, and an additional 24% were found nonexempt after 3 months of intensive outpatient treatment coupled with case management, resulting in a total of 84% of the UBA clients not being exempted from the work requirement because of substance misuse by Day 90. UBA also found that 25% of substance-misusing clients were able to obtain employment, and most successfully retained those jobs over the course of 6 months. These findings are discussed in relation to the new law's work requirements and the issue of the employability of substance misusers. Finally, the value of case management in serving this hard-to-engage population is discussed.

Keywords substance use disorders; welfare; employment; disability; treatment attendance, case management

Introduction

The welfare reform legislation of 1996 (Personal Responsibility and Work Opportunity Reconciliation Act) established categories of work activities required of all welfare recipients. However, these categories were not defined by law or regulation, and states had great flexibility in determining how each category was structured. When Temporary Assistance for Needy Families (TANF) was reauthorized in 2006 (Deficit Reduction Act of 2005), the work requirements for welfare recipients with substance use disorders became more clearly and strictly defined. States are now limited in how long welfare recipients can

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participate in physical, mental health, and substance use treatment¹: individuals are limited to 4 consecutive weeks (6 weeks total) per fiscal year.

Although this is now public policy, there are few empirical data on whether substance-misusing welfare recipients can meet these work requirements within the specified time frame. In a comprehensive review of the substance misuse and welfare literature, Metsch and Pollack (2005) reached several conclusions relevant to the new law: (1) although substance use is prevalent among the cash assistance (CA) population, diagnosable substance use disorders are relatively uncommon, and substance misuse is not a major factor for the population remaining on CA; (2) substance misuse is associated with poor work outcomes; (3) substance misuse is only one of many barriers to employment and is associated with other barriers, such as comorbid medical and psychiatric disorders; (4) substance misuse is increased among welfare recipients in sanction and is associated with nonwork administrative exits from CA; (5) remaining on CA improves access to substance abuse treatment (presumably due to insurance coverage); and (6) case management can be effective at engaging substance-abusing CA recipients to improve treatment attendance and, in some cases, to improve work outcomes.

Relevant to this general topic, this journal devoted a special issue to substance misuse and employability (Magura and Staines, 2004). Although substance misuse is associated with poor employment, Magura, Staines, Blankertz, and Madison (2004) concluded that standard substance user treatment does not improve employment outcomes. Possible explanations include lack of work skills, lack of motivation for employment, and stigma among employers (Magura and Staines, 2004). The special issue examined several vocational programs designed specifically for substance misusers. Some programs focus on increasing motivation for employment, while others develop prevocational and vocational skills, and the most promising programs focus on rapid job search and placement.

Most of the articles in the special issue did not directly address the clinical implications of the new welfare law; however one article surveyed how the new law impacts substance user treatment providers (Benoit, Young, Magura and Staines, 2004). The authors criticized the "moral" judgments implicit in the 1996 welfare legislation requiring welfare recipients to work, referencing the discrimination that substance-misusing welfare recipients must face, their lack of training and education to meet the work requirements, and the disorganization of the welfare bureaucracy. As this was a qualitative survey, the article did not present quantitative data on whether substance misusers were able to meet the work requirements of the new law.

In the current article, we will present data that directly address the employability of substance-misusing welfare recipients. In the absence of empirical data, it is difficult to know whether it is realistic to expect individuals manifesting substance use disorders to meet the work requirement (Montoya, Bell, Atkinson, Nagy, and Whitsett, 2002). Critical issues to consider, among others, include the following:

¹Treatment can be briefly and usefully defined as a planned, goal-directed, temporally structured change process, of necessary quality, appropriateness, and conditions (endogenous and exogenous), which is *bounded* (by culture, place, time, etc.) and can be categorized into professional-based, tradition-based, mutual-help-based (AA, NA, etc.), and self-help ("natural recovery") models. There are no unique models or techniques used with substance users—of whatever types and heterogeneities—that are not also used with nonsubstance users. In the West, with the relatively new ideology of "harm reduction" and the even newer quality of life treatment-driven model, there are now a new set of goals in addition to those derived from/associated with the older tradition of abstinence-driven models. Editor's note.

- Is the work exemption of 4–6 weeks due to substance misuse a reasonable period of time to expect these individuals to become employable, or is it a longer period of intensive substance user treatment necessary to achieve employability (Metsch, Pereyra, Miles, and McCoy, 2003)?
- What are the criteria for employability, and how many substance misusers will meet those criteria within the allowable time frame?
- Will sanctions have a negative impact on substance misusers who are likely to be removed from the welfare rolls due to noncompliance (Metsch and Pollack, 2005; Nakashian and Moore, 2000; Schmidt, Dohan, Wiley, and Zabkiewicz, 2002)?
- Or, alternatively, will the coercive pressure of losing CA and other benefits make it more likely that substance misusers will comply with the treatment mandate (Satel, 2005)?

Finally, we will describe the impact of a case management program for substance-misusing welfare recipients.

Comprehensive Services Model Program

In New York City, the prevalence of substance use disorders among welfare recipients has been estimated at 6.5% (Satel, 2005).² That this rate might be higher than in other localities may be due to the inclusion of a separate general assistance population. New York State has a Safety Net Program for single adults, childless couples, and people who have exceeded the 60-month limit on federal TANF assistance. Though the program is state-funded, engagement expectations and participation in programs are uniform for both TANF and Safety Net recipients.

New York State welfare law regulations require that all CA clients be screened at Job Centers for substance misuse issues. Individuals identified by the screen are then referred for a substance misuse evaluation by a Credentialled Alcoholism and Substance Abuse Counselor. Based on that evaluation,³ clients are referred for substance user treatment at the appropriate level of care and may be exempted from the work requirement. Clients must participate in treatment as a condition of their continued eligibility for CA, and must be reevaluated on, at minimum, a quarterly basis. This is the program described by Benoit et al. (2004) from the treatment providers' perspective.

The Comprehensive Services Model (CSM) program was developed by the New York City Human Resources Administration (NYC HRA) to meet the regulations of the New York State for CA recipients who are identified in the Job Centers as substance misusers. It consists of the clinical evaluation and reevaluation(s), an employability determination based on that evaluation, a referral for mandated substance user treatment to 1 of 40 state-licensed programs in the geographic region, a referral for mandated work activity (when appropriate), and a referral for further evaluations and services, all supported by a large case management staff (composed of M.A.-level social workers and B.A.-level social work assistants at a ratio of 23 clients to each case manager). As a case management program, the CSM program does *not* provide treatment or vocational services, but refers clients for these

²Substance use (as measured by survey or hair testing) among welfare recipients is much higher (i.e., 37%), but we know that many more people use substances than meet the diagnostic criteria for a substance use disorder (Grant and Dawson, 1996; Jayakody, Danziger and Pollack, 2000).

³Based on the outcome of the clinical evaluation, the client may be (1) exempt from work activity participation owing to the need for more than 15 hr per week of intensive substance use treatment, (2) nonexempt from work activity participation but still require at least 7 hr per week of substance user treatment, or (3) nonexempt and require no substance user treatment.

services to appropriate community-based programs. Since these programs provide quite different clinical services and levels of ambulatory care (i.e., alcohol misuser outpatient, drug-free outpatient, methadone maintenance, mentally ill/chemically addicted [MICA] services) and clients move between these levels of care, there is no standardization in the treatment provided to clients in the CSM program. It is treatment-as-usual within the confines of the welfare policy mandate. The aims of the CSM program are to help clients achieve recovery from their drug use and self-sufficiency.

University Behavioral Associates (UBA) is a behavioral management services organization founded by the Department of Psychiatry and Behavioral Sciences at Montefiore Medical Center and Albert Einstein College of Medicine in 1995 (Wetzler, Schwartz, Karasu, and Sanderson, 1997). UBA was awarded a CSM contract for the Bronx, New York, in 2001.

As these clients are known to have many obstacles to employment, the UBA CSM program includes a multidisciplinary staff to evaluate each client in a range of functional domains, not just in terms of their substance use and vocational abilities. This front-end comprehensive evaluation is intended to also identify medical and psychiatric comorbidities so as to individually match clients to needed services and refer them for these services simultaneously and expeditiously. The UBA CSM program has evaluated nearly 9,000 CA recipients with substance use disorders in the 6 years for which descriptive data are available on recipients' work capacities.

Methods

Population

Participants include all clients who received a clinical evaluation at UBA from April 2001 to April 2007. Clients were referred to UBA from the Job Center at the time of application for CA, based on a cursory screen to identify substance misuse issues. A total of 8,959 clients appeared for the evaluation and were enrolled in the program (i.e., in need of substance abuse treatment and living in the Bronx). Initial evaluation data from these 8,959 participants are presented. As clients moved off CA, they were discharged from the UBA CSM program. This attrition meant that clients varied in their longevity in the program, owing to positive outcomes (i.e., achieving self-sufficiency through employment or obtaining Supplemental Security Income [SSI]), negative outcomes (i.e., sanction due to noncompliance with welfare law requirements), or neutral outcomes (i.e., move out of region). The mean duration in the UBA CSM program was 5.8 months (median of 4.5 months). Thus, initial evaluation data are reported on all participants, but only subgroups of these clients are included in the 3- and 6-month reevaluations.

Evaluation Methods

At the time of the initial appointment at UBA, all clients were evaluated using an abbreviated Addiction Severity Index (McLellan et al., 1992). This interview generated substance use disorder diagnoses and level of care determinations, identified history of prior substance abuse treatment, and ultimately produced an employability determination. CSM clients were deemed to be employable if their substance use was not frequent (i.e., only on weekends or less often) and only had a minor or moderate impact on the client's global functioning. Motivation for work and recent work experience (i.e., more than 6 months during past 2 years) also contributed to the employability determination.

A psychologist or social worker collected socio-demographic data (i.e., age, gender, marital status, education level), employment history, housing status, and legal issues and used an abbreviated Structured Clinical Interview for the *Diagnostic and Statistical Manual of Mental Disorders—Fourth Edition* (Spitzer, Williams, Gibbon, and First, 1992) to generate Axis I diagnoses (American Psychiatric Association, 1994). A nurse obtained medical history and collected urine for toxicological analysis.

Case managers completed an initial Comprehensive Service Plan and monthly updates on every client. These assessments reported the client's ongoing attendance at treatment and work activity assignments, using a global rating for the prior month's time frame. Data on treatment attendance were obtained from the treatment program's monthly report in the NYC HRA's Substance Abuse Tracking and Reporting System database (NYC HRA/Department of Social Services [DSS], 2006) or, alternatively, from direct communication with the treatment program. Clients were considered fully compliant with substance user treatment if they attended their program regularly (a minimum of four visits per week for intensive treatment clients) and showed significant progress in their recovery. Either partially compliant clients were attending program regularly but not showing significant clinical gains, or they were making clinical progress while not meeting all of the attendance requirements.

Data on work activity compliance were obtained from the work program's report in the NYC Work, Accountability and You database (NYC HRA/DSS, 2006). Attendance with initial appointment and continued attendance was reported for work activity. Data on employment were obtained from the client based on documentation (i.e., pay stubs, letter from employer) of more than 20 hr of employment per week. Job retention data were also obtained for 1-month, 3-month, and 6-month duration using comparable documentation. Data on Social Security Disability were obtained based on documentation of the letter of notification from the Social Security Administration.

Results

As can be seen in Table 1, the individuals evaluated by the UBA CSM program were disproportionately male, unmarried, and older, representing a predominantly Safety Net (general assistance) population. This contrasts with the typical TANF population in the United States, which is overwhelmingly female (90%) and younger (49% of the US TANF recipients are between 20 and 29 years of age; US Department of Health and Human Services, 2007). The UBA population had little education, and a subgroup had significant housing problems and/or current legal involvement. In terms of diagnosed substance use disorder, alcohol use disorder was the most common diagnosis, but most clients met the criteria for three or more substance use disorders. As demonstrated by their urine toxicology findings, more than half were using substances at the time of the initial evaluation. This population utilized a considerable amount of inpatient detoxification, with an average of three lifetime admissions per patient.

In addition to the identified substance use disorders, there was considerable psychiatric and medical comorbidity. More than half of the clients had an Axis I psychiatric disorder. One sixth of the clients had at least one prior psychiatric hospitalization. Three quarters of the clients also had a chronic, severe medical condition with asthma, hepatitis C, and tuberculosis being the most common diagnoses.

As may be seen in Table 2, clients were referred to various levels of ambulatory substance treatment. The majority of clients were referred to a drug-free outpatient program, whereas a substantial minority of them were referred to either alcohol outpatient or

Table 1
Substance-misusing welfare population: descriptive data

Number of clients evaluated	8,959
Mean age	39.0 years
Gender	67% male
CA status	
TANF	7%
Safety Net	93%
Marital status	13% married
Education	50% do not have GED ^a or high school degree
Housing	15% homeless or unstable housing
Current legal status	18% probation or parole
Diagnoses	
Alcohol use disorder	80%
Cannabis use disorder	76%
Cocaine use disorder	60%
Opioid use disorder	51%
Meet criteria for three or more substance disorders	51%
Prior inpatient detoxification	53% (33% in past 6 months) Mean: three hospitalizations
Urine toxicology at intake	52% test positive (excluding alcohol)
Psychiatric comorbidity	
Any Axis I disorder	56%
Mood disorder	37%
Anxiety disorder	20%
Psychotic disorder	10%
Past psychiatric hospitalization	17%
Medical comorbidity	
Chronic condition	74%
Asthma	22%
Hepatitis C	21%
Tuberculosis	17%

^aGED = General Equivalency Diploma.

methadone maintenance programs. A few clients with significant psychiatric comorbidity were referred to certified MICA programs. Out of the clients evaluated by UBA, 85% attended their initial appointment at the substance user treatment program to which they were referred. Two thirds of the clients remained fully or partially compliant with treatment attendance after 3 months of case management by UBA.

Table 3 presents data related to employability. Even though this population had severe substance use disorders, at the initial evaluation only 40% were deemed exempt from work, owing to the need for intensive substance user treatment. By 3 months, only 16% were still work exempt because of substance misuse. By 6 months, 90% were not work exempt because of substance use disorders, but 25% remained work exempt for other reasons (i.e., medical or psychiatric disorders), and thus 65% were ultimately evaluated

Table 2
Substance user treatment referral and attendance

Ambulatory substance user treatment referral ^a	55%
Drug-free outpatient	29%
Alcohol misuser outpatient	23%
Methadone	3%
MICA	
Clients attending initial appointment at ambulatory substance user treatment program	85%
Clients remaining compliant with substance user treatment attendance for at least 3 months	68%
Duration in CSM program	Mean: 5.8 months Median: 4.5 months

^aPercentages total greater than 100% because of referrals to multiple treatment programs for certain clients.

to be “employable.” Of that group of “employable” clients, 82% attended the initial work activity appointment, and 71% remained compliant with attendance for at least 3 months.

Although many of these clients were “employable” and participated in work activities, only 25% of them obtained documented employment.⁴ Of them 88% retained jobs at 1 month; 74% retained jobs at 3 months; and 64% retained jobs at 6 months.⁵ Although job retention dropped over the course of 6 months, very few clients reapplied or returned to CA (i.e., less than 20% of the clients who obtained employment). The mean time to employment while in the UBA program was 4 months, but there was considerable variability.

Lastly, 12% of UBA clients were eligible for federal disability benefits (SSI or Social Security Disability Insurance [SSDI]) owing to comorbid medical or psychiatric disorders (as substance use disorders are not justification for receipt of disability benefits).

Discussion

Since Congress, with its reauthorization of welfare in 2006, made the work participation requirements more stringent, it is of interest to know whether substance misusers are able to meet these work requirements after a period of treatment. The UBA CSM program evaluated and provided case management services to a large population of welfare recipients with substance use disorders. Although the vast majority of clients in the program were funded under a general assistance benefit—New York State Safety Net—rather than with federal TANF funds (and are therefore older and more likely to be male), an examination of their employability may help us to better understand whether or not the new federal work requirements are realistic. A general assistance population is known to be more likely to have substance use disorders than a TANF population (Schmidt, Weisner, and Wiley, 1998), but the impact of substance use disorders on employment is comparable in these two populations (Zabkiewicz and Schmidt, 2007).

⁴We suspect that many other clients who became noncompliant with our program obtained “undocumented” employment (Young and Benoit, 2004), but we have no reliable data to support that speculation.

⁵Clients commonly obtained jobs in the following sectors: maintenance, childcare, retail, security, and food service.

Table 3
Work

Clients work exempt owing to substance misuse at initial evaluation	40%
Clients work exempt owing to substance misuse at 3 months	16%
Referral for an approved work activity	65%
Clients attending initial appointment at work activity program	82%
Clients remaining compliant with work activity attendance for at least 3 months	71%
Clients obtaining documented employment	25%
Job retention at 1 month	88%
Job retention at 3 months	74%
Job retention at 6 months	64%
Mean time in program to employment	120 days
Clients obtaining social security disability	12%

Based on our initial evaluation, we found that this population had severe, long-standing substance use disorders, with active addiction to multiple substances,⁶ significant comorbid psychiatric and medical disorders, limited education, and, in some cases, ancillary obstacles to employment. A separate research group, led by Jon Morgenstern, reported a similar finding based on a sub-sample of 1,431 UBA CSM clients. Morgenstern, Hogue, Dasaro et al. (2008) found that the majority of substance use clients in this setting had at least two barriers to employment. This is consistent with prior research finding that substance use disorders rarely occur in isolation (see Metsch and Pollack, 2005; Olson and Pavetti, 1996).

Despite the complexity and severity of problems these clients face, on initial evaluation we found that 60% were not work exempt owing to substance misuse, and by 3 months a total of 84% were no longer work exempt owing to substance misuse. Ultimately, 65% of our clients were deemed to be “employable” and were referred for an approved work activity, and 82% of them attended that referral. But engaging in approved work activities is not the same as obtaining employment. While many of our substance-misusing clients were able to participate in an approved work activity, only one quarter of our population ultimately obtained documented employment, and some of them did not retain those jobs over the course of 6 months.

Our findings would suggest that the 2006 welfare reauthorization law’s 50% work participation rate is within reach for the substance misuse population but that stable employment is difficult for them to achieve.⁷ In other words, there are a large number of substance-misusing welfare recipients who are “employable,” but they either do not obtain employment or do not retain it once employed.⁸

⁶Since the population misuses multiple substances, we were unable to analyze data by drug of choice or link substance use characteristics with employability.

⁷The fact that the majority of employed clients never reapplied or returned to CA may suggest that even without stable documented employment, they were able to achieve some kind of financial self-sufficiency.

⁸The welfare think tank, MDRC, examined unemployment insurance (UI) data for the UBA CSM population (Martinez, Azurdia, Bloom & Miller, 2009). Using this measure of “on-the-books” jobs, they found that a higher percentage of clients (37%) obtained employment within six months of participating in the UBA CSM program.

The level of employability found among substance-misusing welfare recipients in our sample suggests that it is important to maintain high expectations regarding work. While some clients may require a period of intensive treatment, clinical gains can be consolidated once the patient is stepped down into nonintensive treatment and engaged in a concurrent work activity—if not “work first,” then at least “work early.”

Prior studies with substance misusers have not directly addressed the issue of employability determinations or meeting work participation requirements of the welfare reform law, but there have been several studies examining the impact of substance use disorders on employment, especially the large-scale Michigan Women’s Employment Study (Danziger, Kalil, and Anderson, 2000) and another study of welfare recipients in Texas (Montoya et al., 2002). In general, substance use disorders have been found to hurt employment (see Magura et al., 2004, for a review), which may be reflected in poor job retention or lower wages rather than poor job placement (Montoya et al., 2002; Schmidt, Zabkiewicz, Jacobs, and Wiley, 2007). However, it may be the configuration of co-occurring conditions, rather than substance use disorder alone, that accounts for the difficulty with employment (Gutman, McKay, Ketterlinus, and McLellan, 2003). Although our data do not include a benchmark among the general welfare population for comparison, the 25% employment figure we found seems low, and the job retention figures suggest that employment is not very stable in our substance-misusing population. As a point of reference, the Texas study found that 38% of substance misusers were working after 1 year in comparison to 48% of the general population (Montoya et al., 2002).

Our data also address the question of whether the welfare reform exemption for intensive substance user treatment for 4–6 weeks is adequate. We formally reevaluated clients after 3 months of treatment, and although this time frame is not identical to the federal guidelines, we found that 84% were not exempt because of substance misuse after 3 months of treatment. This would suggest that a relatively brief period of intensive treatment is adequate for clients to meet the engagement requirements. Our clients who ultimately obtained employment generally did so after 4 months of intensive or nonintensive treatment.

The literature has sometimes found that substance user treatment improves⁹ employment outcomes (Kirby and Anderson, 2000; Metsch et al., 2003; Wickizer, Campbell, Krupski, and Stack, 2000; see Magura et al., 2004, for a contrasting view) and that the longer the individual is in treatment, the greater is the impact on employment (Hubbard, Craddock, and Anderson, 2003). In one study, there was a jump in employment from 16% at baseline to 41% after 1 year of treatment (Gutman et al., 2003). In another study, the duration of treatment did not impact the number of people who became employed, but longer treatment improved job retention (Kamara and van der Hyde, 1998). We do not know whether longer periods of treatment for our clients would have resulted in more job placements or better job retention.

When considering the federal work participation requirement of 50%, it is important to also consider the issue of disability: Who is unable to work? Just as it is useful to identify those who are employable, it is equally relevant to identify the disabled because it removes inappropriate work expectations from people who are unable to function at that level and provides them with another path to self-sufficiency. From a fiscal standpoint, SSI and SSDI benefits are federally funded and are advantageous to states. We found that 12% of our

⁹Editor’s note: The reader is referred to Hill’s criteria for causation, which were developed in order to help assist researchers and clinicians determine if *factors* were *causes* of a particular disease or *outcomes* or were *merely associated* with it (Hill, 1965).

substance-misusing clients obtained federal disability, owing to medical and/or psychiatric disorders. Thus, in total, 37% of UBA clients left CA with financial self-sufficiency.

The Effectiveness of Case Management

Qualitatively speaking, it would appear that the UBA CSM program succeeded in engaging this complex population around the issue of substance user treatment, even though UBA did not provide treatment. Once enrolled in the UBA CSM program, there was a high rate of attendance at the initial appointment at the treatment program in the community (85%). But this was only the first step in the engagement process. We found that 68% of our clients remained compliant with substance user treatment attendance for at least 3 months. In the absence of a control group that did not receive case management services, it is impossible to conclude definitively that our program was effective at engaging substance misusers. Generally accepted benchmarks, however, can serve as points of comparison.

Our 68% treatment attendance rate at 3 months compares favorably with standard benchmarks. One relevant local comparison (also in NYC) is an evaluation and referral program for substance misusers (without case management) that found a 40% treatment attendance rate at 3 months (Satel, 2005). Another benchmark from the general substance misuse population comes from the Drug Abuse Treatment Outcomes Study, which found 33%–50% outpatient treatment compliance at 3 months, depending on the specific level of outpatient care (Simpson, Joe, and Brown, 1997). In both instances, the level of treatment attendance attained by UBA, using a comprehensive approach with case management, was superior.

Morgenstern, Hogue, Dauber et al. (2009) reported on a sub-sample of the UBA CSM population using a practical clinical trial design. They compared clients receiving case management from UBA ($n = 221$) to substance use clients evaluated in a Job Center who were referred for treatment without case management ($n = 173$), and followed them for 12 months. They concluded that UBA's case management program had a significant impact on enrollment in treatment, amount of treatment services obtained, and abstinence based on hair testing and urine screens.

A review of the literature of other case management programs for substance use disorders suggests that case management can be effective. Morgenstern and colleagues conducted two case management studies with a CA substance-misusing population. The first was the CASAWorks program, which also lacked a comparison group but found improved treatment and employment outcomes for substance-misusing TANF women receiving case management (Morgenstern et al., 2003). In a separate well-designed random-assignment study, Morgenstern et al. (2006) found substantially more engagement and retention in substance user treatment among female welfare recipients receiving intensive case management than among women who were merely screened and referred for treatment.

Although Morgenstern et al. (2006) targeted a much different population than UBA's—predominantly female, with methadone-maintained clients excluded, and unique obstacles to treatment (i.e., child care, transportation)—that study represents a good point of comparison with our findings. Morgenstern et al. (2006) found that 86% of the case-managed group attended the initial treatment appointment (as compared with 53% who attended when referred without case management). This is comparable to UBA's figure of 85% attendance at the initial treatment appointment. Morgenstern et al. (2006) also found that 43% of the case management group was abstinent at 15 months (as compared with 26% from the referral without case management group). Morgenstern et al.'s findings support the impact of case management on treatment attendance and clinical outcome.

In a subsequent publication (Morgenstern, Neighbors, Kuerbis et al., 2009), they reported on 24 month outcomes, finding that case management had almost double the rate of abstinence than usual care at follow up. They also found that the case management group was significantly more likely to be fully employed at 24 months than the usual care group. This effect on employment appeared over time, and suggests that case management has an effect on employment by helping clients to engage in treatment.

One interesting finding of the Morgenstern et al. (2006) study was that clients in the case management group only attended 42% of their assigned treatment appointments. Although this figure may seem low, it was four times the number of sessions attended by the control group. This was comparable to the UBA experience. There was a wide range of treatment attendance among UBA clients. It was rare for clients to be wholly compliant: some were quite good at attending; others were completely noncompliant despite our outreach efforts; and the rest were partially or intermittently compliant.

University Behavioral Associates Model of Case Management

The UBA CSM program is based on several important principles. First and foremost, although the general public is skeptical about the effectiveness of substance user treatment, there is a sizeable empirical literature demonstrating its effectiveness, across all levels of care (Hubbard et al., 2003; Hubbard, Craddock, Flynn, Andersen, and Etheridge, 1997; Luchansky, Brown, Longhi, Stark, and Krupski, 2000; Metsch et al., 2003; Nakashian and Moore, 2000; Schmidt et al., 1998; Wickizer et al., 2000). The UBA CSM program did not provide treatment, but we made every effort to link clients to appropriate levels of care. We worked collaboratively with treatment providers, reviewing treatment plans and clinical outcomes (Benoit et al., 2004). Although there was no standardization in treatment because of clients being engaged in different kinds and levels of care, we did adhere to a “treatment-first” philosophy.

Second, in our program, substance user treatment was mandated by the local social services agency, namely, the NYC HRA. Since motivation for treatment tends to fluctuate, we found that the mandate enhanced motivation. Like other coercive approaches to treatment (e.g. parole- or employer-mandated), poor compliance with treatment was intended to be associated with the threat of punishment. For UBA clients, the negative consequences included the loss of CA and other benefits, including Medicaid, Food Stamps, and energy assistance. Although this punishment was not as strong as imprisonment or job loss, it was not negligible (Satel, 2005). A limitation of the treatment mandate was the time lag between infraction (i.e., noncompliance) and punishment (i.e., loss of CA).¹⁰ As behavioral psychology has shown, the link between a target behavior and its punishment must be explicit and timely for it to be effective. Case management was intended to increase the linkage between noncompliance and the consequent loss of CA.

Third, vocational services were emphasized by UBA evaluators and case managers at the outset of treatment, and job placement was an explicitly defined goal discussed from the first day of enrollment. Work complements treatment (Platt, 1995), and a substance use diagnosis does not alter the expectation that welfare recipients are employable. Work provides structure, a high level of activity, and absorption in tasks, as well as improved self-esteem and social skills (Magura and Staines, 2004). The UBA CSM program challenged

¹⁰There were multiple steps in the infraction process before a client's case was closed, including the opportunity to request a fair hearing. Since the “fair hearing” process was adjudicated by administrative law judges, practically speaking, punishments tended to be rendered many months after an infraction occurred.

the culture of dependency, and we often found that clients were motivated and able to work, even if they were not completely abstinent.

Case management represented the fourth important program principle. UBA had a large staff of case managers to help this multiproblem population access benefits and services that it might have difficulty obtaining otherwise. We developed individualized comprehensive Service Plans with each client focusing on their strengths, and identified clean objectives and outcomes to be achieved. There was often a scarcity of services (i.e., housing child care, long waiting lists for psychiatric treatment, inadequate prescription coverage, etc.), but a problem with integration and coordination of services was equally important, as the social services world can be overwhelming to the individual client (McLellan et al., 1998). To help clients attend appointments, case managers often escorted clients to these appointments. We tracked attendance at work and treatment programs, and outreach to clients who were not attending treatment by visiting them at home and in the field. Case managers averaged two face-to-face contacts with clients per month as well as four telephonic contacts per month. Morgenstern, Blanchard, Kahler et al. (2008) have found that case manager contacts are directly related to improved treatment engagement and attendance at self-help groups. They found that the effects of case management were strongest for those clients who were initially less compliant. In other words, compliant clients tend to benefit less from case management.

Conclusion

Many alternative models of case management and intensive case management tend to focus on the relationship between the client and the case manager, in some cases fostering a counterproductive dependency. But in our model of case management, we believe that our relationship with providers is as important as our relationship with clients and we engaged treatment and work providers on the clients' behalf, often having joint case conferences to discuss the client's progress toward treatment and work goals.

The UBA CSM program demonstrated that case management programs for substance misusers can be successful at tracking hard-to-engage clients with multiple problems. The program was effective at getting clients to attend many different types of substance user treatment and work activity programs. The program was also successful at assisting the permanently disabled to obtain federal disability benefits. We were less effective at helping the majority of our clients obtain employment, but even helping one quarter of these clients get jobs could be considered a success.

In terms of study limitations, this was a retrospective analysis of 6 years of UBA client records. All data were presented in aggregate form, and the Health Insurance Portability and Accountability Act standards observed. The concern about collecting data on clients who are unaware that they may later be part of a study has been noted (Kleinig and Einstein, 2006). The assurance of confidentiality and the potential benefit of producing findings that will ultimately lead to better services and outcomes for clients would seem to outweigh the concern for not obtaining prior consent.

Since moving substance-misusing clients into employment was a major aim of the program, it certainly influenced the process of making employability determinations. This may in part explain the discrepancy between the relatively large number of clients who were deemed employable and the relatively smaller number who were able to find employment. However, the fact that so many clients were able to attend approved work activities with the help of case management suggests that the employability determinations were fairly accurate.

The findings presented here are also limited by the absence of random assignment. We cannot conclude that case management was responsible for the level of engagement without comparing it with a control group that did not receive these services. Another limitation of the study is the absence of follow-up data on clients who were discharged from the program. It is difficult to know if there were any adverse effects of the sanction process on substance-misusing recipients who were removed from the rolls (especially as compared with a more "lenient" policy). That many of our clients were eventually sanctioned and administratively discharged is consistent with the literature that people with substance use disorders are more likely to lose entitlements than the general welfare population (Schmidt et al., 1998; Metsch and Pollack, 2005). Substance misusers are less likely to meet all of the bureaucratic requirements of the welfare law (Schmidt et al., 2007). This means they recycle more often.

In addition, we do not have data on longer-term follow-up among clients who obtained employment (specifically whether their substance use disorders stabilized, whether they remained in treatment, and information about their general level of well-being), nor what happened to clients who did not retain jobs. The clients who lost jobs and were not reemployed and did not return to welfare may have been adversely financially impacted. Sanctioned clients may have lost insurance coverage and access to needed treatment services. Finally, we have not analyzed the specific characteristics of substance-misusing welfare recipients or specific kinds of substance misuse treatment that predict employment or employability. As these clients were quite diverse and were engaged in many different kinds and levels of treatment, it is difficult to know what accounts for the outcomes.

In conclusion, based on preliminary findings from a demonstration program, it may be worthwhile for local social services districts to invest in specialized case management for substance-misusing welfare recipients (although without a comparison group the cost-benefit ratio is difficult to evaluate). Although these findings pertain to a predominantly Safety Net general assistance population, the literature suggests that it may also be relevant to a TANF population with substance use disorders.

Declaration of Interest

The authors report no conflicts of interest. The authors alone are responsible for the content and writing of the paper.

RESUMEN

La empleabilidad entre los beneficiarios de asistencia con un trastorno por consumo de sustancias

La legislación de 2006 Reforma de Bienestar Social (Deficit Reduction Act of 2005), estableció requisitos más estrictos de trabajo y se definen la cantidad de tiempo de asistencia en efectivo (CA) los beneficiarios se les permite estar exentos de la obligación de trabajar debido a un tratamiento de uso de sustancias. Como hay poca literatura empírica sobre la empleabilidad de los consumidores de sustancias, es difícil saber si es realista esperar que las personas con trastornos por consumo de sustancias para satisfacer el requisito de aumento de trabajo. Sobre la base de una evaluación global de cerca de 9000 sustancias mal uso de beneficiarios de prestaciones sociales desde 2001 hasta 2007, de la Universidad de comportamiento Associates (UBA) Modelo Integral de Servicios (CSM) del programa en el Bronx, Nueva York encontró que el 60% de los receptores no estaban exentas de la obligación de trabajar debido a una sustancia mal uso, en primer lugar, y otro 24% se

encontraron no eximir a los tres meses de tratamiento ambulatorio intensivo, junto con la gestión de casos supone un total del 84% de los clientes de la UBA no está exento de la obligación de trabajar debido a abuso de sustancias por Día 90. UBA también encontró que el 25% de la sustancia de uso indebido de los clientes fueron capaces de obtener un empleo y con más éxito mantenido los puestos de trabajo en el transcurso de 6 meses. Estos hallazgos se discuten en relación a los requisitos de trabajo de la nueva ley, y la cuestión de la empleabilidad de hacen un uso indebido de sustancias. Por último, se discute el valor de la gestión de casos en el servicio a esta población.

L'employabilité des bénéficiaires d'aide sociale avec un trouble de consommation de substances

RESUME

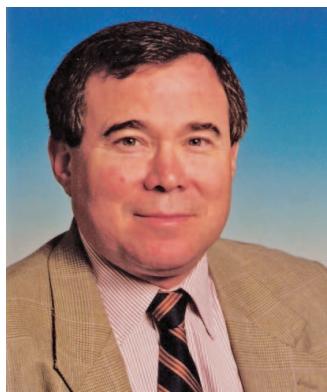
En 2006, Welfare Reform législation (Deficit Reduction Act de 2005) a imposé des exigences plus rigoureuses de travail et a défini le montant de l'aide ponctuelle de trésorerie (CA) personnes sont autorisées à être exemptés de l'exigence de travail due au traitement de la toxicomanie. Comme il ya peu de littérature empirique sur l'insertion professionnelle des toxicomanes, il est difficile de savoir s'il est réaliste d'attendre des individus avec des troubles liés aux substances utiliser pour satisfaire à l'exigence de travail accrue. Basé sur une évaluation globale de près de 9000 usagers de la substance aux assistés sociaux de 2001 à 2007, Université Associates Behavioral (UBA), des services complets de modèles (CSM) de programme dans le Bronx, New York a révélé que 60% des bénéficiaires ne sont pas exemptés de l'obligation de travailler en raison de la substance utilisation abusive au départ, et qu'un autre 24% se sont révélés non exemptés, après trois mois de traitement ambulatoire intensif couplé à la gestion des cas qui donne un total de 84% des clients UBA ne pas être exemptés de l'obligation de travailler en raison de l'abus de substances par jour 90. UBA a constaté que 25% de la substance abuser les clients ont pu obtenir un emploi, et le plus réussi à maintenir ces emplois au cours des 6 mois. Ces résultats sont discutés en relation avec les exigences du travail de la nouvelle loi, et la question de l'employabilité des usagers de drogues. Enfin, la valeur du case management au service de cette population est discutée.

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Glossary

Case management: A client-centered, strengths-based strategy involving assessment and planning to link individuals to relevant services and community resources, including treatment programs. It includes assertive outreach, motivational enhancement, advocacy, and provider consultation.

Safety Net: The New York State's general assistance program for single adults.

Sanction: The full or proportional elimination of CA to individuals who are not engaged in pre-employment or rehabilitative activities.

Welfare: The provision of CA to eligible individuals under the 2006 welfare reform legislation (Deficit Reduction Act of 2005).

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