NHPF Issue Brief
No.771 / March 7, 2002

NATIONAL HEALTH POLICY FORUM

Welfare Reform and Substance Abuse: Innovative State Strategies

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OVERVIEW—*This issue brief highlights key facts about the impact of substance abuse on welfare reform and recipients of Temporary Assistance to Needy Families, or TANF. After outlining some of the data on the incidence of substance abuse as well as its costs and treatment, it concludes by describing innovative state welfare programs attempting to lower barriers to employment and self-sufficiency.*

The George Washington University
WASHINGTON DC

Welfare Reform and Substance Abuse: Innovative State Strategies

Many policymakers and the general public have long believed that at least a good portion of welfare recipients were not working and remained unemployed for long periods of time because of alcohol and other drug (AOD) use. Actual data about the incidence of such use have often been conflicting and incomplete. However, since the 1996 enactment of the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA), which eliminated the old welfare system and emphasized personal responsibility and work, understanding the extent of substance abuse among this population and finding ways to deal with it have become critical to the overall success of welfare reform. As the easier-to-place welfare recipients move out to work, the remaining pool is more likely to comprise those with the most recalcitrant impediments to steady employment. AOD dependency is widely considered to be one such barrier. Having been given broad authority under to test and sanction welfare recipients for use of controlled substances, a few states have integrated responses to substance abuse into their welfare-to-work programs and are showing promising results.

A BARRIER TO EMPLOYMENT

The number of people receiving Temporary Assistance to Needy Families (TANF), formerly Aid to Families with Dependent Children, has declined significantly since the passage of PRWORA, with the overall welfare caseload falling 58 percent between January 1996 and March 2001[1] and with a number of states reporting reductions of over 70 percent by the end of 2000.[2] As welfare benefits clocks tick away, however, many of the 5.4 million people still receiving TANF[3] face one or more major barriers to employment, such as those identified by Ariel Kalil and colleagues at the University of Michigan's Program on Poverty and Social Welfare Policy:

- Low schooling.
- Little work experience.
- Lack of the job skills and credentials employers value.
- Lack of "work readiness."
- Worries about employer discrimination.
- Mental health problems.
- Alcohol and drug dependence.
- Physical health problems and family stresses.
- Experiences of domestic violence.[4]

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Various lists of this type have been developed, some longer, some shorter. The greater the number of obstacles, the less likely a recipient is to find and keep work.[5]

None of the lists cite substance abuse as the barrier faced by the greatest number of recipients. It is, however, recognized as one of the most daunting. Research on the ability of such barriers to derail employment success indicates that, if substance dependence (as opposed to substance use) is combined with any one or two of the other employment obstacles, a welfare recipient has a less than 60 percent probability of working more than 20 hours a week.[6] Thirty hours per week on average is the work requirement prescribed by PRWORA as the minimum necessary to be counted as a TANF work participant.

Before PRWORA, estimates of the prevalence of substance abuse among welfare recipients ranged from 16 percent to 37 percent, depending in large part on the measure used.[7] Researchers at the National Institute on Alcohol Abuse and Alcoholism (NIAAA), using data from the 1992 National Longitudinal Alcohol Epidemiologic Survey (NLAES), estimated that 17.9 percent of welfare recipients were dependent on alcohol or drugs, compared to 8.9 percent of nonrecipients.[8]

Just as the figures varied before PRWORA—depending on how substance abuse was defined, what narrow aspect of use and abuse or dependence was being looked at, and what geographic or demographic criteria were used—no one is sure how many of the people still receiving TANF are AOD abusers. A number of studies have suggested a high prevalence of substance abuse among women receiving public assistance, with some studies reporting rates as high as 27 percent to 39 percent.[9] The U.S. Department of Health and Human Services estimated in August 2000 that at least 460,000 families on welfare—about 1.2 million parents and children—were affected by substance abuse.[10] (An even larger pool of parents with AOD problems and their children cycle in and out of welfare.) A recent U.S. General Accounting Office study estimated the range of TANF recipients with the "characteristic" of substance abuse at 3 percent to 12 percent (Table 1).[11] (State officials acknowledge that, absent testing of TANF recipients for substance use, determining the incidence of AOD use or dependency can be difficult because of the tendency of recipients to underreport their use/abuse.) Despite the lack of certainty over this issue, very few states are using their new testing authority to collect data with regard to the incidence of substance abuse among their welfare program participants. Whatever the prevalence of the problem, caseworkers, in particular, see substance abuse as perhaps the most intransigent of the barriers facing people trying to make the transition from welfare to permanent employment.

Studies have found that welfare "leavers" who have substance abuse problems may return to the welfare rolls as their use makes it more

DHHS estimated in August 2000 that at least 460,000 families on welfare—about 1.2 million parents and children—were affected by substance abuse.

TABLE 1
Prevalence of Selected Characteristics among TANF Recipients, Based on Selected Studies

Characteristic	Estimated Range of TANF Recipients with Characteristic (percent)	Number of Elected Studies Measuring Characteristic
Health problems or disabilities	20–40	12
Lack of high school diploma	30–45	8
Current domestic violence	10–30	7
Lack of job skills	20–30	3
Substance abuse	3–12	8
English as a second language	7–13	4
Multiple barriers	44–64	5

Note: Studies were conducted between 1997 and 1999. The estimates provided by each study are not directly comparable to those from other studies because each study defines characteristics slightly differently and examines a different specific population. For example, when measuring the incidence of substance abuse, one study counted only recipients who self-reported seeking substance abuse treatment while another counted recipients who case managers believed needed to address substance abuse problems. Likewise, the scope of the studies varies; most cover only a single state or community while one is national in scope. Because of difficulties identifying and measuring these characteristics, these studies may understate the prevalence of these characteristics among TANF recipients. Nonetheless, together these studies give a rough indication of the prevalence of these characteristics among TANF recipients.

Source: U.S. General Accounting Office, Welfare Reform: Moving Hard-to-Employ Recipients into the Workforce, GAO-01-368, March 2001.

difficult to meet the obligations of routine work.[12] A 1991 National Longitudinal Survey of Youth indicated that 63 percent of welfare recipients were substance abusers who had worked in the present or past year, but only 15 percent of those were employed for a full year.[13] More recent data, compiled by the Substance Abuse and Mental Health Services Administration (SAMHSA) for 1998, indicate that "public assistance" was the primary income source for 11.2 percent of persons admitted for treatment, certainly an indication of a severe problem that would affect the ability to work.[14]

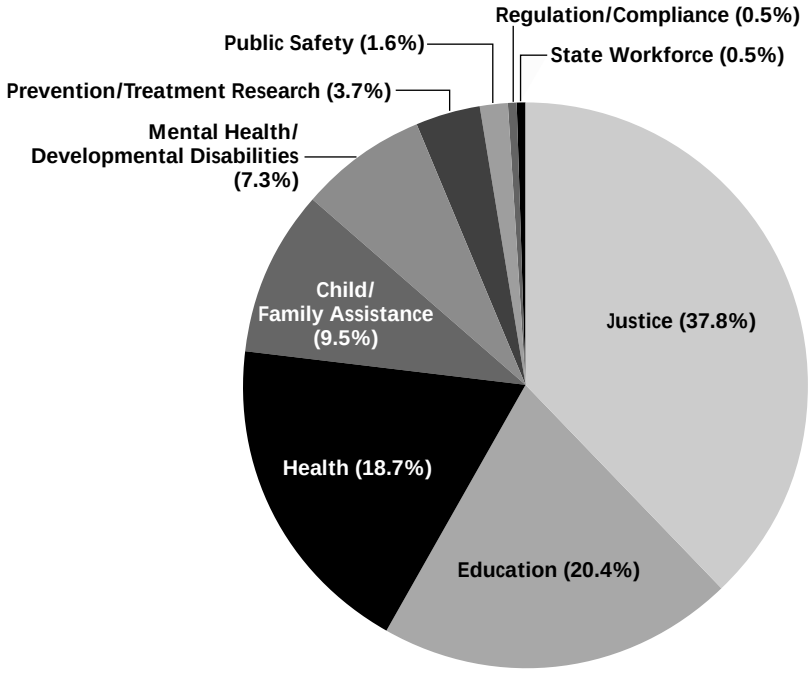
COSTS OF SUBSTANCE ABUSE

According to SAMHSA, drugs and alcohol cost taxpayers more than $294 billion annually in preventable health care costs, extra law enforcement, auto crashes, crime, and lost productivity.[15] In 1997, expenditures

on substance abuse and treatment nationwide totaled $11.9 billion, $7.3 billion of it from public coffers. In 1998, the federal government directly spent approximately $16 billion for prevention, treatment, and law enforcement related to drug abuse and addiction.[16] Much more was spent on coping with these problems through income support, child welfare, corrections, special education, Indian Health, Medicare, and Medicaid programs.[17]

State and local governments carry a heavy share of the burden. A January 2001 report by the National Center on Addiction and Substance Abuse at Columbia University (CASA) detailed the cost of substance abuse and addiction to state budgets (Figure 1). According to the report, in 1998 states spent $81.3 billion on substance abuse and its fallout. CASA found that total state 1998 spending for income support was $16.4 billion for TANF, general assistance, and state supplements to the Supplemental Security Income program. Of this total, CASA estimates, $2.4 billion (15 percent) was used to support individuals with substance abuse problems.[18] The study notes that for each dollar states spent on substance abuse problems, 96 cents were absorbed in costs for criminal justice, education, health care, child and family assistance, mental health, and public safety. The remaining 4 cents were used in prevention and treatment programs.[19]

FIGURE 1
Percentage of State Substance Abuse Spending by Category, 1998



Source: National Center on Addiction and Substance Abuse, "Shoveling Up: The Impact of Substance Abuse on State Budgets," Columbia University, New York, January 2001.

TREATMENT

In both the general population and among welfare recipients, substance abuse has been notoriously difficult to confront, treat, and monitor. For many in need of treatment, opportunities for diagnosis, treatment, and continued support in managing relapse are simply not available. Several factors contribute to this lack of access. Among them are poverty, limited health insurance coverage for substance abuse, and insufficient capacity of publicly funded treatment services. Other factors limiting treatment include failure of systems to identify and refer those in

need of treatment, restrictive policies and regulations, and resistance to treatment by some populations. According to SAMHSA, "between 13 and 16 million people need treatment for alcoholism and/or drugs in any given year, but only 3 million receive care."[20]

Women with small children (potential TANF recipients) are among the special populations most likely to be underserved.[21] They often have additional barriers to treatment, including "stigma and shame associated with a woman's substance abuse, the lack of early identification by professionals, lack of child care, lack of residential treatment programs that can accommodate mothers with children, and lack of transportation."[22] In addition, research indicates that women suffer different consequences of alcohol and drug usage than men and consequently may need access to gender-specific substance abuse treatment, which is in short supply.[23] Where such barriers have been overcome, a number of studies have demonstrated, substance abuse treatment has had "a pronounced positive impact" on reducing substance abuse and its consequences.[24]

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The Center for Substance Abuse Treatment (CSAT) at SAMHSA estimates that the average cost of an individual's substance abuse treatment episode was $2,941 while their average benefit to society in the year after treatment was $9,177. In the year after treatment, crime-related costs decreased by 75 percent, average health care costs decreased by 11 percent, and the individual's earnings increased by 9 percent. Overall, these results indicate that the economic benefits of treatment to society were over three times the cost of treatment."[25] CSAT Director H. Westley Clark emphatically states, "There is no other medical condition for which the American public would tolerate only $11.9 billion in treatment expenditures while enduring over $294 billion in total social costs. Treatment for substance abuse will lead to savings in other health care costs, in fewer hours lost on the job, and in fewer injuries and deaths due to automobile and other accidents."[26]

Federal funding for alcohol and drug treatment comes primarily from the Substance Abuse Prevention and Treatment Block Grant and other categorical funding available from SAMHSA. Most treatment programs have multiple sources of funding, including money from the criminal justice, welfare, Medicaid, and public housing systems. Some funding streams distinguish between medical and nonmedical services. Federal TANF funds and Welfare to Work (WtW) grants are restricted to nonmedical services only; other sources—including state maintenance-of-effort funds, Substance Abuse Prevention and Treatment (SAPT) block grants, and Title XX—do not make this distinction.

WELFARE TO WORK

In keeping with its philosophy of providing maximum flexibility to states, PRWORA did not specifically address funding of substance abuse programs when it was passed in 1996. AOD treatment was viewed in the

same light as other kinds of services—appropriate as long as it addressed the overalI goals of personal responsibility and self-sufficiency. However, this appproach presented several obstacles to states that wished to move aggressively to address alcohol and drug abuse among TANF recipients. In an effort to accommodate some of the need for substance abuse treatment, Congress amended PRWORA in the Balanced Budget Act of 1997. The change allowed TANF recipients who have been long-term recipients of welfare or have characteristics that would predict long-term welfare dependence to be eligible for nonmedical services under WtW if they required substance abuse treatment for employment and met at least one of two other sanctioned barriers to employment—(*a*) the lack of a high school diploma or GED, accompanied by low reading or math scores, and/or (*b*) a poor work history. On July 1, 2000, the law was further liberalized (P.L. 106-113, Title XXXIII) allowing states to use WtW block grant allotments for four new groups: long-term TANF recipients without specified work barriers, former foster care youths 18 to 24 years of age, TANF recipients who are determined by criteria of the local workforce investment board to have significant barriers to self-sufficiency, and non-TANF custodial parents with income levels below the poverty line. These changes gave additional grantees access to treatment benefits that could make a great difference in availability of intervention and treatment for those struggling with substance abuse and facing the ticking five-year benefit clock. Significant barriers still exist, however, if an employer of a WtW client has a drug-free workplace program (DFWP) or an employee assistance program (EAP) in place, because no WtW grant money may be utilized to provide substance abuse treatment to WtW participants in these employment situations.

TANF REGULATIONS

A TANF rule that became effective October 1, 1999, supports states' rights to test for substance abuse and to sanction those who are found to be abusers. Requiring states to assess skills, work experience, and employability of enrollees in TANF programs, the rule allows states to mandate substance abuse treatment as a way to better prepare participants to support themselves and their families. As mentioned above, TANF funds may be used for alcohol and drug treatment as long as they are not expended on medical services, which are typically paid for by Medicaid or targeted substance abuse treatment funds. TANF rules do not consider treatment services "TANF assistance," meaning that receipt of these services will not trigger work requirements or time limits for impaired individuals. The 1999 TANF rule also allowed states to opt out of the lifetime ban on benefits for individuals with drug felony convictions and to fund their substance abuse treatment. Another provision let states provide treatment for noncustodial parents.

INNOVATIVE STATE APPROACHES

Success inside this system of personal responsibility and opportunity is now defined in terms of work and independence. In this environment, some states have shown themselves to be proactive and successful at transitioning old AFDC bureaucracies into aggressive workforce training programs and job search counseling offices. Their success has led to the 6.5 million-person reduction in the national welfare caseload. Depending on the health of the economy, these state initiatives may mean brighter hopes for "stayers" and "leavers" who need more intensive case management. The federal regulations give states the ability to use their block grant balances to fund services to working former welfare recipients and those who have exhausted their 60-month time limit on cash assistance. As the eligibility of large numbers of recipients expires, this flexibility will increasingly be called into play. Even before the eligibility clock has run out, however, some states have been particularly aggressive in developing programs to assist welfare recipients with substance abuse problems.

Oregon

Prior to federal welfare reform, Oregon, along with the states of Kansas, Utah, and South Carolina, received waivers to incorporate alcohol and substance abuse treatment services into their states' work-oriented welfare programs. In 1992, Oregon began requiring local welfare offices to incorporate aggressive alcohol and drug programs into their plans and made those offices accountable for client outcomes by assessing performance measures attributable to all welfare recipients. These measures included total job placements, wage at placement, percentage of families who remain off assistance at 18 months, percentage of teen parents in school, percentage of eligibility decisions processed on time, and measures of efficiency in delivering program benefits.

Before implementation, Oregon policymakers developed a state philosophy "that alcohol and drug treatment, for most recipients, is simply one of the many equally important elements in a plan to help recipients become self-sufficient."[27] This philosophy of an integrated vision for all welfare recipients, regardless of individual barriers to work, was manifested most dramatically in Oregon's decision to place treatment professionals in welfare offices. Applicants for welfare assistance are required to seek employment immediately, and all are required to participate in activities designed to promote self-sufficiency. State officials do not view recipients' needs for both employment and substance abuse treatment as mutually exclusive. Participation in substance abuse treatment is not seen as rendering clients unemployable, and these clients are expected to simultaneously participate in treatment and work toward financial self-support.

Oregon is one of the few states with the ability to accumulate data on the characteristics of its welfare population. A 1997 Oregon Department

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of Human Resources report estimated that 50 percent of the state's caseload admitted to having alcohol- and/or drug-related problems.[28] More recent evaluations of the program in the Portland area show that 13 percent of the remaining welfare caseload is referred for further evaluation and that 85 percent of those individuals receive recommendations for substance abuse treatment. Initial screening of applicants indicates that 50 to 70 percent of new applicants have a high probability of needing treatment now or in the future.[29]

Although it operates a state-administered welfare plan, Oregon has shifted responsibility for program operations to 15 district offices. To support these local offices in treatment policies, the state has defined work-related activities in such a way as to encompass alcohol and drug treatment and has devolved the responsibility for structure and application of programs to local partnerships, which are better suited to create programs tailored to local needs. All Oregon districts have certified alcohol and drug treatment professionals in local offices at scheduled times each week to provide services that engage clients in treatment. A report on this program by Mathematica Policy Research, Inc., conducted for the Annie E. Casey Foundation, concludes, "Co-locating certified alcohol and drug professionals in the welfare office greatly facilitates the interface between the two systems and lets welfare offices stretch their limited case management resources."[30]

The Oregon Health Plan, the state's Medicaid program, is the primary funding source of medical treatment coverage for welfare recipients, including all medical-related alcohol and drug dependency services within its basic health benefits package. Since, as in all states, TANF funds may be used only to provide nonmedical components of substance abuse treatments, extensions of Medicaid coverage during participation in WtW activities become an essential element of access to treatment for Medicaid-eligible individuals. In another innovation, some residential programs have been able to apply clients' welfare benefits and food stamps to reimbursement for room and board, helping offset some of the cost to providers constrained by managed care reimbursement levels. Oregon gives parents a 90-day period in which they can receive treatment and not suffer the custodial loss of their children.

A study of employed individuals who had completed a publicly funded substance abuse treatment program in Oregon found that wages were 65 percent higher than for clients who did not complete treatment. Wages for people who engaged in some level of treatment were higher than those who did not, but the wages of those who had completed treatment were higher overall.[31] Researchers also found that Oregon saved $5.60 in direct public costs for each dollar spent on alcohol and drug treatment.[32] It appears that, consistent with the goals of PRWORA and work-oriented welfare programs, Oregon has managed to create a network of programs that increase wages and decrease welfare reliance.

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Tennessee

Tennessee's "Families First" program went into effect September 1, 1996—before federally mandated welfare reform was implemented. It operates under a Department of Health and Human Services–approved waiver that limits benefit periods to 18 months at a time (with a five-year lifetime limit), requires a personal responsibility plan (PRP) and a work plan for those not exempt from work requirements, and imposes sanctions for failing to comply with PRPs. The state Department of Human Services (DHS) oversees the Families First program offices, which are in all the state's 95 counties and coordinate with partners from other government divisions, community-based agencies, and faith organizations. In January 2000, after reviewing the successes and failures of the existing programs, DHS established a new offering for the TANF population that encompassed treatment services for substance abuse and other barriers to self-sufficiency. Individuals who receive Families First cash payments and who are transitioning off of Families First may receive assessment, counseling, and intensive clinical case management services through the Family Services Counseling (FSC) program. All Families First groups with an eligible adult can access FSC upon request.

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FSC provides screening, assessment, solution-focused brief therapy, clinical case management, advocacy, and referral services for long-term therapy or treatment, as well as assistance with the individual's PRP. Primary areas addressed by family services counselors are mental health, domestic violence, substance abuse, learning disabilities, and children's health and behavioral problems. The department considers these services a work component that Families First case managers can suggest as part of a work plan. Participation can result in modifications to all parts of the participant's PRP, including work hours, activities, sanction procedures, and time limits. Benefits offered in these referrals include additional resources for drug and alcohol treatment.

Though there is no mandatory testing for substance abuse, in some instances, a TANF case manager is required to offer referrals to services. A case manager must offer a referral to noncompliant individuals, clients that exhibit signs of one of the obstacles that FSC benefits are designed to address, any recipients identified by service providers as having obstacles that could be addressed by FSC benefits, or clients that are participating in self-initiated treatment. The program recommends that case managers offer referrals to any clients making frequent requests to renegotiate their PRPs or who manifest difficulty with work requirements.

A referral to FSC interrupts the time-limit components of TANF for at least one month while the assessment is conducted, with need for additional assessments resulting in longer interruptions. Those who agree to have the family services assessment or the family services component as part of their PRPs but then do not comply with the services plan will be subject to the conciliation and sanction process. Individuals leaving

Families First are eligible for FSC for 12 months after their program termination date.

Originally, DHS contracted with the state's Bureau of Drug and Alcohol Services to provide AOD treatment services. In June 2001, DHS shifted to direct contracting with providers of substance abuse treatments and created pilot programs across the state using private contractors within communities. The scope of services requires providers to deliver gender-responsive treatment, focusing on family recovery as well as work and self-sufficiency. In the first nine months of program activity, 260 Families First clients had requested drug and alcohol treatment services. By the end of the first year, 8,274 referrals had been made; of these, approximately 16 percent required drug or alcohol treatment. As in Oregon, Tennessee's Medicaid waiver program (TennCare) continues to pay for the portions of treatment needed by eligible Families First enrollees that are medical in nature. DHS has contracted with the University of Tennessee to administer and evaluate the implementation of Families First and family services counseling and provide periodic evaluations throughout the term of Tennessee's waiver.

Kansas

On the heels of PRWORA's authorization of mandatory substance screening for all cash assistance participants, the Kansas legislature in November 1996 established a pilot screening program within the state's welfare reform effort, KansasWorks. However, after reviewing available funding and benefits, Kansas implemented the program in all 105 counties and organized it into 11 administrative areas. Innovators in the Kansas Department of Social and Rehabilitation Services' Substance Abuse Treatment and Recovery (SATR) division had existing contracts with Regional Alcohol and Drug Assessment Centers (RADAC) for screening in other public assistance populations. When screening was made mandatory in all TANF work programs as part of the participants' employability assessments, it seemed a natural continuum to contract with this same nongovernmental entity for the provision of services for Kansas's TANF population.

Today, there is at least one RADAC counselor available in each of the 11 administrative areas to administer AOD screening assessments to all adults participating in employment preparation services. In FY 2000, nearly 45,000 adults in work programs across the state participated in this screening program. The KansasWorks program considers treatment for substance abuse a TANF work component, and all participants referred for counseling and treatment are subject to work program penalties, sanctions, and loss of assistance if they do not comply.

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Kansas's recently renamed Medicaid program, HealthWave, funds all the "medically necessary" portions of treatment; TANF funds are used to provide ancillary services such as child care and transportation. All

KansasWorks participants have mandatory work components in their participation requirements and no mental or physical health exemptions are offered. However, screening is done for potential Supplemental Security Income eligibility and assistance is given in applying for appropriate programs and services needed by the individual.

At each welfare office, one caseworker determines the client's eligibility for cash assistance, food stamps, medical assistance, job training, need for social services, child care, and transportation. The caseworker uses the Substance Abuse Subtle Screening Inventory (SASSI), a one-page pencil and paper test, to identify potential substance dependency in clients suspected of abuse. Any determination that a TANF participant is intoxicated while in a welfare office, any dismissal of a client from an employment situation or from any employment preparation service for substance abuse causes, any participant's substance abuse–related legal problems (such as driving under the influence), or an admission or medical diagnosis of an existing alcohol- and/or drug-related problem initiates a mandatory referral to a RADAC counselor for assessment. Individuals who are not initially identified as needing these services may be tested again if there is an indication of need ascertained by the economic and employment support (EES) worker. EES workers send the screening results to the RADAC counselors, who evaluate and refer clients to local contractors for appropriate treatment. New applications for assistance are not denied based on failure to seek counseling; however, an active TANF client's failure to follow through with RADAC would trigger sanctions.

Kansas's experience indicates that between 20 to 50 percent of all the state's TANF population will fail the SASSI screening test for substance abuse. In the early stages of an employment preparation project in coordination with Cessna Aircraft Company, KansasWorks discovered that 20 percent of its participants deemed "most likely to succeed of all the many applicants"[33] failed the Cessna mandatory drug screen. Kansas subsequently integrated mandatory screening into its eligibility process, better enabling participants to complete job training and obtain private-sector jobs in which drug screening may be a hiring tool.

Review of the state's Alcohol and Other Drug Assessment and Treatment program has brought changes and upgrades to the system. Originally, the assessment tool used in all but one office was a four-question CAGE questionnaire—so-called because it addressed attempts to *c*ut down on drinking, *a*nnoyance with criticisms about drinking, *g*uilt about drinking, and using alcohol as an *e*ye-opener—or a personal evaluation conducted by a caseworker. Over time it was discovered that in cases where the SASSI tool was not used, less than 2 percent of participants were referred to RADAC, compared to over 16 percent when SASSI was used. Caseworkers expressed concerns about their ability to make decisions regarding substance abuse dependency in others and their legal rights to do so. The Department of Social and Rehabilitation Services (SRS) addressed these

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concerns by requiring the SASSI tool in all eligibility determinations and having caseworkers refer all SASSI results to RADAC's trained assessment workers.

According to SRS, SASSI costs $1.25 per client and "provides invaluable information and saves months of case management and support service dollars spent on inappropriate work component assignments, not to mention the ticking away of TANF months."[34] However, the new high referral rates being achieved with this tool are not yet reflected in TANF participants continuing on to treatment. Less than 1 percent of those in the mandatory work program population go on to obtain treatment; most become employed and leave the program prior to treatment or suffer sanctions and remove themselves from TANF to avoid treatment. To address this problem, SRS has created a one-county pilot program, the Extra Effort Program, in which the RADAC affiliate and the EES staff, working together at one location, saturate the enrollee with information on program availability. This saturation includes not only education on TANF programs and HealthWave eligibility, but also information about programs dealing with domestic violence, child welfare, and transportation. It is hoped that this exposure to available programs will increase participants' utilization of needed services and educate participants about services available during transitions to work or during any subsequent periods of reliance on KansasWorks support. Kansas has not undertaken any formal evaluations of the success or failure of its most recent efforts.

New Jersey

Several states have experienced increased utilization of substance abuse treatment since implementing better-focused access to specialized programs. However, research in New Jersey, supported by the Robert Wood Johnson Foundation, is highlighting the difficulties in coordinating care across welfare and treatment program requirements.[35] The study compared treatment outcomes of New Jersey women receiving TANF benefits and qualifying for substance abuse treatment who were randomly placed into one of two different intervention conditions: care coordination (CC) and intensive case management (ICM). The women in the CC intervention were screened and received access to treatment in methods very similar to those used by Oregon and other states using a triage and referral system. The New Jersey ICM program offered participants a combination of strategies presented and coordinated by a case management team. This team attempted to resolve employment barriers—such as child care, transportation, and client denial and other psychological barriers—not commonly associated with substance abuse treatment. ICM also provided clients with vouchers for attending treatment.

Results of this study indicate that 88 percent of the ICM clients entered treatment, while only 65 percent of the CC population did so. Differences in outpatient treatment encounters were marked: 86 percent of

Research in New Jersey is highlighting the difficulties in coordinating care across welfare and treatment program requirements.

ICM clients and only 53 percent of CC clients entered this type of treatment. ICM was "significantly more effective in retaining clients in treatment…and effective in lowering barriers to treatment engagement."[36]

TANF REAUTHORIZATION

With the reauthorization of welfare reform coming up and the five-year lifetime limits already being reached, long, hard looks are being taken at the characteristics shared by the population remaining on the TANF rolls. The hardest-to-serve will comprise the majority of those who have not been able to gain permanent employment. Behavioral changes will be instrumental in success for both short-term and long-term welfare participants. The hardest-to-serve groups may contain many who, if it were not for their substance abuse or dependency, would be able to find and keep jobs.

President Bush's recent proposal to strengthen welfare reform work rules and expand state responsibilities recognizes this probability. At the same time it proposes raising the work requirement from 30 to 40 hours per week, the administration would give work credit to families engaged in short-term substance abuse treatment.

Changes in behavior seem to be the place where both the goals of welfare reform and treatment for substance abuse meet. The aggressive use of flexibility for local and state entities trying different ways to serve this population appears to be consistent with PRWORA's devolution of authority. Positive results in state programs using such flexibility have led many observers to conclude that, if welfare reform remains focused on sustaining personal and economic growth and changing family structure and stability, substance abuse treatment strategies may have a solid claim for consideration in the reauthorization process.

ENDNOTES

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