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CASASARD[SM]: Intensive Case Management for Substance-Dependent Women Receiving Temporary Assistance for Needy Families

A CASA* White Paper

January 2009

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Accompanying Statement
By Joseph A. Califano, Jr., Chairman and President

Substance abuse and addiction constitute this nation's number one public health problem, contributing to more than 70 health conditions and to the five leading causes of death. Our failure to prevent and treat it costs society more than $600 billion each year, driving up costs of government and causing untold human tragedy. The mission of The National Center on Addiction and Substance Abuse (CASA) at Columbia University includes identifying effective methods of reducing these costs. This report spotlights a promising new approach to reduce the human and economic costs of addiction in our welfare system and to achieve the goals of welfare reform. Other CASA research has found that for each unemployed female welfare recipient with a substance use disorder who becomes substance-free and self-supporting, the economic benefit to society is about $48,000 annually in avoided welfare, health care and criminal justice costs, and contribution to the economy in employment.

Best estimates are that eight to 20 percent of women receiving Temporary Assistance for Needy Families (TANF) have a substance use problem that interferes with their functioning. I believe that these estimates are low. Many of those remaining on the rolls may in fact have behavioral health problems such as addiction and related mental illnesses that go undetected. TANF recipients have a great incentive to hide addictive disorders, not only because of the denial inherent in addiction, but because they may face loss of benefits or custody of their children.

In recent years, brain science research has revealed that addiction--like depression, asthma or high blood pressure--is a chronic disease, and one that can be prevented and treated effectively. To date this knowledge has not been applied to addressing the needs of the welfare population. Women with addictive disorders who receive TANF are significantly more

impaired than those without such disorders. They have more physical and mental health problems and are less likely to have graduated from high school or have labor market skills. They are more likely to be investigated or supervised by child protective services, and more likely to be living in unstable housing and to have limited access to transportation. These women are older, have spent more time on welfare and have two to three times more co-occurring problems than their non-substance abusing counterparts.

To address these formidable problems, CASA in collaboration with the Jersey Department of Human Services, Rutgers University and the National Council on Alcohol and Drug Dependence, initiated CASA's Substance Abuse Research Demonstration (CASASARD[SM]). Based on the premise that the chronic disease of addiction must be identified, treated and managed over time, the demonstration was designed to test an intensive case management approach (ICM) that involved outreach, screening, assessment, services to enhance motivation and increase engagement in treatment, treatment provision, coordination of support services, monitoring and advocacy, aftercare follow-up, peer support, relapse monitoring and crisis management. CASA rigorously evaluated this approach against the standard practice of assessment and referral, called usual care (UC). Participants were randomly assigned to each.. The demonstration was conducted in Atlantic (including Atlantic City) and Essex (including Newark) Counties, New Jersey.

CASASARD[SM] is the first major system level test of the chronic disease management approach to addiction and its results suggest that it should be extended immediately to other states. CASA's evaluation shows, for the first time, the ability of intensive case management to effectively address addictive disorders in the welfare population--increasing participation in treatment and recovery which is a necessary precondition to achieving and sustaining employment. Compared with women who received the UC approach of screening and referral, those who received intensive case management:

- Received significantly more time and services from their caseworkers;
- Achieved rates of initiation, engagement and retention in outpatient substance abuse treatment that were two to three times as great as for usual care;
- Achieved significant reductions in substance use compared with usual care: women in the intensive condition were almost twice as likely to be completely abstinent at the 12 and 24 month follow-ups as those in the standard practice group (41 percent vs. 25 percent at 12 months and 47 percent vs. 24 percent at 24 months); and,
- Showed a greater rate of increase in employment over time and were more than twice as likely (22 percent vs. 9 percent) to be employed full-time at month 24.

These are striking outcomes. They suggest that a long term care strategy of treatment and abstinence first create the conditions where employment can better be achieved and sustained, even among this seriously disabled population. Previous CASA research has found that for each unemployed female welfare recipient with a substance use disorder who becomes substance-free and self-supporting, the economic benefit to society is about $48,000 annually in avoided welfare, health care and criminal justice costs, and contribution to the economy in employment. In New Jersey alone, this could amount to economic benefits of as much as $35 million per year.[*]

[*] 28,680 adults received TANF in NJ in 2006 (National Center for Children in Poverty). Up to 20 percent have substance use disorders (5,736). The net percent (22 percent in ICM minus nine percent in UC) expected to achieve full time employment in 24 months is 13 percent or 746. The total expected economic benefit is 746 times $48,000 in economic benefits or $35.8 million.

CASA has long been interested in treating the substance abuse and dependence problems of women on welfare and in 1998 initiated a national demonstration program, CASAWORKS℠ for Families, designed to help alcohol and other drug addicted mothers receiving TANF benefits achieve recovery and self-sufficiency. CASAWORKS℠ was the first national demonstration program to provide these women, in one concentrated course: alcohol and other drug treatment, literacy, job, parenting and social skills training, family violence prevention and health care. This groundbreaking approach was designed to enable these women to become self-sufficient, responsible parents and productive workers. The CASAWORKS℠ model showed significant promise in increased abstinence and employment. CASASARD℠ is the next step in addressing the multiple needs of this population and the goals of welfare reform.

CASASARD℠, is a ten year demonstration project that is still in operation. It represents the pioneering work of Jon Morgenstern, PhD, Vice President and Director of CASA's Division of Health and Treatment Research and Analysis and collaborators.[*] The study was funded by The National Institute on Drug Abuse, the Administration for Children and Families, and the Annie E. Casey Foundation.

CASA would like to acknowledge and thank Jeanette Page-Hawkins, Director, Division of Family Development, New Jersey Department of Human Services, and other Division Staff for their extraordinary work on this project.

CASA staff members responsible for this White Paper are Jon Morgenstern, PhD, CASA Vice President and Director of Health and Treatment and Analysis, Charles Neighbors, Ph.D., MBA, Associate Director, and Susan E. Foster, MSW, CASA Vice President and Director of Policy Research and Analysis. Jane Carlson and Jennie Hauser handled the administrative duties.

CASA alone is responsible for the facts and conclusions herein.

[*] For a list of journal articles on CASASARD℠ and contact information on the demonstration, see Appendix A.

CASASARD℠:
Intensive Case Management for Substance-Dependent Women Receiving Temporary Assistance for Needy Families

Since the passage of federal welfare reform legislation in 1996, the focus of federal and state welfare programs has been to get recipients off welfare and do it quickly. This approach, aided by a strong economy and several creative initiatives in states and counties, initially resulted in dramatic declines in welfare caseloads.

As the rolls declined, states were faced with a growing realization of the multiple and handicapping circumstances many remaining recipients face, including substance use disorders and other mental health issues, poor work skills, low educational attainment, difficulty securing child care and transportation, health problems and engagement with the child welfare system. For those left on the rolls, there is a huge disconnect between the welfare system's goals of fast turnover and the capacity of recipients to find work quickly and remain employed. For these remaining recipients, there is simply no quick fix.

The combination of substance use disorders and poverty extends its influence through succeeding generations.[1] Children of individuals with substance use disorders face much greater risk of becoming substance dependent themselves.[2] Becoming sober and responsible adults and effective parents is not only of paramount importance to the goals of welfare reform, but also to the children of these women since it reduces the chances that they will turn to addictive substances and require welfare services in the future.

The good news is that there is another approach that holds promise for reducing both the damaging consequences to families and children and the corresponding costs to society. This approach involves facing head on the chronic disease of addiction and its co-occurring health and social problems, and providing intensive

case management and services to address them. This is the approach pioneered though CASASARD℠.

Results of this approach show that welfare recipients are more likely to enter and attend treatment and stay in treatment longer than those with standard services, and are almost twice as likely to remain abstinent. These factors appear to be essential preconditions for self-sufficiency; women who enter and stay in treatment for a sufficient period of time and achieve abstinence are likelier to become employed after participating in treatment and the benefit appears to increase over time. The strategy underlying CASASARD℠ offers, for the first time, women on welfare with substance use disorders and multiple other health and social problems a way to get the treatment they need in order to move toward the goals of effective parenting and self-sufficiency.

National Welfare Strategy

The Personal Responsibility and Work Opportunity Act of 1996 transformed an entitlement program to one of temporary cash assistance--Temporary Assistance for Needy Families or TANF. It also devolved significant authority and accountability from the federal government to the states. TANF emphasizes rapid movement into the labor force. Under TANF regulations, women who fail to participate in mandated work activities face sanction and loss of benefits. States that fail to meet work participation goals face federal financial sanctions.

The Deficit Reduction Act of 2005 reauthorized TANF, placing additional pressure on states and recipients. For example, it added new definitions for approved work activities and changed the basis on which work participation is calculated. In addition, the Act specified the narrow conditions under which participation in substance abuse treatment can be counted as a work activity.

While welfare reform and its reauthorization give states wide latitude to design programs to help low-income people attain self-sufficiency, including those with substance use disorders,[3] it also has the potential for a profoundly negative impact on low-income people with substance use disorders and their costs to government. The policy of sanctioning welfare recipients for failure to comply with new welfare regulations *without a concerted effort to address their health and mental health problems, including addiction*, is the equivalent of denying health care. The effect of this denial is to compound the problems these women face and raise costs to state and federal governments.

The Realities of Women on Welfare with Substance Use Disorders

Addiction in American society today, like many chronic diseases before it, remains highly stigmatized. The stigma especially is pronounced among low-income mothers who may fear loss of welfare benefits or loss of custody of their children if they provide accurate reports of their substance use.[4] Because of this problem, it is difficult to obtain accurate data on prevalence rates of substance use disorders among women on welfare.

The research that does exist, however, consistently suggests significantly higher rates of substance use among female welfare recipients compared with other women.[5] Published estimates of the prevalence of substance use, misuse and dependence prior to TANF range from six to 37 percent.[6] Best estimates suggest that up to 20 percent of women on TANF have a substance use problem that probably interferes with their functioning.[7] Some studies suggest that this may be a significant underestimate of the true prevalence of the problem.[8]

Efforts to move substance-dependent TANF recipients rapidly into the labor force without addressing their chronic disease and related problems are not likely to be effective. Studies show that female TANF recipients with substance dependence have significantly more social and health care problems that are barriers to employment, are less likely to obtain

employment, more likely to be sanctioned, and have substantially higher rates of involvement with child protective services than women without a substance use disorder.[9] Substance-dependent women on welfare have spent more time on welfare and have two to three times more co-occurring problems than TANF recipients without substance use disorders.

These high rates of health, mental health and social barriers to employment show in stark relief the difficulty states face in moving these women into stable employment in a short period of time. Simply referring these women to addiction treatment has been demonstrated to be ineffective; business as usual simply will not work.

A Long-Term Care Strategy

Despite rising concern about the failure of our current approaches to moving female TANF recipients with substance use disorders into employment, there has been an absence of research to guide policy and program development. Studies have shown that community-based addiction treatment, especially outpatient treatment, is poorly matched to the needs of substance-dependent, low-income mothers[10] who too often fail to enter and engage in treatment and whose outcomes are poor if they do.

An alternative, science-based approach views substance dependence as a chronic illness.[11] This approach suggests that in order to improve outcomes, treatment must include coordination of social and other health care services in addition to treating the substance use disorder, and that long-term care strategies, similar to those used for other chronic diseases, must replace the current system of episodic acute care.[12]

Intensive case management (ICM) has been identified as a promising approach for substance dependent women on TANF because it is consistent with strategies to manage chronic diseases, and uses long-term care and coordinated services strategies to provide relapse monitoring and support to clients, and to address other health and social needs and over extended time periods.

To date, studies examining the effectiveness of ICM for substance dependence have had mixed findings.[13] Until this demonstration, however, no reported study has tested the effectiveness of ICM for substance dependent women receiving TANF.

The Intervention

The CASASARD℠ demonstration involved a randomized field trial testing the effectiveness of two models of care[*]:

- Usual Care (UC). This model involves screening and referral to treatment; treatment and support services were provided to those who chose to participate. This was the standard of care in New Jersey at the time of the study. As of 2000, every state reported having some type of screening and referral for substance-related problems within their welfare departments.[14]

- Intensive Case Management (ICM). This model was designed to provide coordinated social and health care services and long-term support and monitoring from outreach to aftercare in addition to substance abuse treatment and support services.

Substance-dependent women were identified in welfare offices through a two part process. First, a brief screening questionnaire was given to all women applying for welfare benefits to identify those who might have a substance use disorder. Second, those women who gave answers suggesting the possibility of a substance use disorder underwent a more thorough assessment to determine whether the person indeed had this diagnosis.

[*] Three-hundred two participants were randomly assigned to each model (161 to intensive case management and 141 to usual care).

The screening occurred as part of TANF benefit eligibility determination. Participants were recruited from welfare offices in two urban counties in New Jersey--Essex (including Newark) and Atlantic (including Atlantic City). Results below are reported for those recruited in Essex County.

The selection criteria for participation in the demonstration were:

- Meeting criteria for a DSM-IV* substance abuse or dependence diagnosis;
- TANF eligible;
- Entering New Jersey's welfare-to-work program and not deferred for a medical problem; and,
- Ability to speak English well enough to complete an interview.

Women were excluded if they currently were psychotic, receiving or seeking methadone treatment, seeking long-term residential treatment or currently stably engaged in treatment for a substance use disorder.

Participants were recruited from September, 1999 to May, 2002. Welfare workers administered a brief screening measure--the CAGE-AID[15]--to all individuals applying for or seeking re-determination of TANF benefits, as per New Jersey State welfare regulations. Women responding positively to two or more questions on the CAGE-AID were referred for further evaluation to trained addictions professionals who were co-located at the welfare offices. The addictions professionals screened women to determine whether these women met criteria for a DSM-IV substance use disorder diagnosis. Those who met the criteria for this diagnosis were further assessed to determine whether they met other criteria for the study. If so, the addictions professionals explained the study and secured informed consent from women who agreed to participate. Women were free to decline to participate in the study.

Screening in welfare settings does not capture everyone with substance use problems. In the CASASARD℠ demonstration, approximately seven percent of welfare participants screened positive for substance use problems. Of those screening positive, 47 percent did not meet other eligibility criteria (e.g., receiving methadone treatment, seeking long-term residential treatment) and 4.1 percent refused; the remaining eligible participants were randomly assigned to one of the two treatment options†--UC or ICM. Clinical staff for both conditions were masters level addiction counselors.

Usual Care (UC)

Women assigned to UC met with a clinical care coordinator who reviewed with their client the need for addiction treatment and the level of care that was recommended. Initial appointments were scheduled with treatment facilities. Counselors contacted the treatment program periodically to review clients' progress and authorize additional treatment, although a minimal amount of case monitoring was delivered proactively. For clients failing to attend a first session, outreach was limited to several phone calls and letters. Clients could return to be reassessed and assigned to treatment if initial treatment failed or at any time during the 24 months of study participation.

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* Substance abuse is defined as exhibiting any one of the following conditions in the previous year: 1) serious problems at home, work or school caused by substance use; 2) substance use in situations where it is physically hazardous (e.g., driving a car); 3) substance-related legal problems; or, 4) continued use even though it caused serious problems with friends and family. Substance dependence is defined as recurrent substance use resulting in three or more of the following within the same 12 month period: 1) tolerance; 2) withdrawal; 3) substance taken in larger amounts or over longer period of time than intended; 4) persistent desire or unsuccessful efforts to cut down or control use; 5) a great deal of time is spent in obtaining the substance or recovering from its effects; 6) important social, occupational or recreational activities are given up or reduced because of use; 7) continued use despite physical or psychological problems.

† 95.9 percent or 302 persons.

Intensive Case Management (ICM)

ICM was based on a detailed written manual[16] consisting of five phases:

1. Outreach and assessment;

2. Planning, motivational enhancement, and treatment engagement;

3. Treatment coordination, monitoring, and advocacy;

4. Aftercare follow-up, peer support, and relapse monitoring; and,

5. Crisis management and termination.

Women randomly assigned to ICM met with a pair of case managers who operated as a team. One case manager was a masters level addiction professional and the other a paraprofessional in recovery. Both were located in segregated clinical space at the local welfare office. In the outreach and assessment phase of ICM, case managers identified tangible barriers to treatment entry such as child care, transportation, and housing problems and helped arrange for the provision of needed services. If needed, case managers engaged in extensive outreach efforts including home visits and contacting family members.

In phase two, case managers addressed the women's concerns about or resistance to enter treatment using evidence-based motivational-counseling strategies.

Once women entered treatment, case managers assisted treatment programs in coordinating needed services, such as child care, health care, or legal or housing assistance, and met with women weekly. They also helped with job readiness skills, connecting women to job training programs, making sure they showed up and working with job finders. Clients also received incentives for attending treatment in the form of vouchers that could be used to purchase items such as children's toys or cosmetics.

When women neared completion of treatment, case managers worked with women to connect them to employment training experiences. Once women were connected with job training programs, case managers monitored their progress through regular visits. Case manager contact with women continued upon successful job placement to ensure that women received needed relapse prevention skills.

One case manager was assigned to approximately 15 families. Case manager contact with women was based on need and phase of treatment. For example, in periods of crisis, case managers often had daily contact, whereas if women were in stable situations, contact was reduced to two visits per month. Case management services were provided throughout the 24 months of follow-up.

Compliance with the Model

Supervisors' periodic reviews of clinical cases and researchers' reviews of clinical charts were used to assure compliance with the treatment models. Interviews and urine screens were used to confirm participants' self-reports of alcohol and other drug use.

Characteristics of Participants

Consistent with national findings that female TANF recipients with substance dependence have significant other health, mental health and other social problems, women TANF recipients in the SARD demonstration had the following characteristics:

- Most were African-American and in their mid-30s.

- Over half reported no labor market skills, 82 percent reported no work as the typical pattern of employment in the last three years and 45 percent had not graduated from high school.

- Their median annual income was less than $10,000 and participants had received

welfare benefits as an adult for an average of 12 years.

- They were parents to an average of three to four children, most of whom were older than age five.

- They showed chronic patterns of problem substance use:

  - 99.1 percent reported regular use or misuse of some substance, defined as at least three times a week for a year or longer.

  - 69.8 percent were dependent on heroin or cocaine.

  - Less than five percent were intravenous drug users (IDU), because IDUs almost always were referred for methadone maintenance treatment.

  - They drank alcohol to intoxication or used illicit drugs on about 20 days in the past month.

  - On average, they reported using/misusing substances regularly for about 13 years. For about one-third, problems were severe enough to require inpatient detoxification or rehabilitation (21 to 28 days) prior to a referral to outpatient care based on American Society of Addiction Management (ASAM) patient placement criteria.

- About 45 percent reported depressive symptoms indicative of a major depressive disorder. Twenty percent met criteria for post-traumatic stress disorder (PTSD). Twenty-five percent were in the lowest quartile in terms of their physical health status.

- More than half had been arrested. Twenty percent needed services to resolve a current legal problem. Almost 40 percent reported at least one incident of severe domestic violence (e.g., being beaten up or threatened with a weapon) in the past year.

- The overwhelming majority (84.3 percent) had been investigated by child protective services; about one-third were under current investigation and of those investigated, the mean number of investigations was 5.8.

- Only about 40 percent of families were intact.*

- About half lived in unstable housing; 25 percent reported being homeless in the past three months.

- Twenty percent reported living with someone who drank heavily or used illicit drugs.

- About 40 percent reported extreme problems in accessing transportation to carry out routine tasks of life.

Promising Results

The two randomly assigned groups did not differ in terms of income, education, alcohol and other drug use, family composition, employment or legal, medical or psychiatric problems. Because clients in ICM were somewhat older than clients in UC, program results were adjusted for age.

As expected, women in ICM received a significantly higher dose of case management services than did women in UC. Women receiving ICM engaged in services approximately twice as long as clients in UC and had approximately three times as many direct contacts with their caseworker. ICM case managers spent almost five times more time delivering services to clients in ICM.

* All biological children under 18 living with mother.

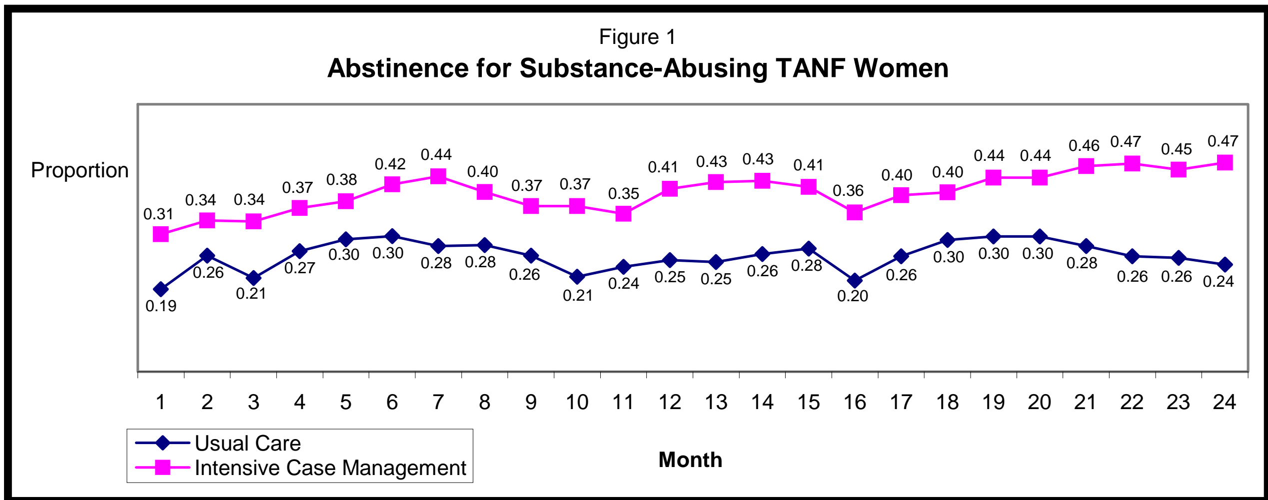
Higher Rates of Treatment Initiation, Engagement and Retention

Women who received ICM were 32 percent likelier than those in the UC group to enter[*] treatment (66.5 percent vs. 50.3 percent). Women in the ICM group were 77 percent likelier to engage[†] in treatment (60.3 percent vs. 34.0 percent), and more than twice as likely (129 percent) to stay in treatment[‡] during the first three months of treatment (42.2 percent vs. 18.4 percent) compared with those in the UC group.

Women in the ICM group were almost twice as likely to complete an outpatient course of treatment than their UC peers (43.5 percent vs. 22.7 percent).

Greater Abstinence from Substance Use

More women receiving ICM were completely abstinent during each of the 24 months than were women receiving UC. (Figure 1) In month 12, ICM participants were 64.0 percent more likely to be abstinent compared to those in the UC group (41.0 percent vs. 25.0 percent). Further, abstinence rates increased among ICM participants over time. By the 24 month follow-up, abstinence rates of the ICM group were almost twice that of the UC group (46.9 percent vs. 24.0 percent). Increasing rates of abstinence were associated with increased participation and retention in treatment.



Higher Long-Term Rates of Employment

Perhaps the most significant outcomes were those related to employment. Substance dependent women receiving TANF have lower rates of any type of employment than those who are not substance dependent. Further, because of the TANF focus on immediate employment, participants in the UC approach had higher rates of employment than those in the ICM approach in the first year of follow-up. These results were short-lived, however. By month 14, the rates had converged and by the end of the two-year follow-up, employment among the ICM group notably eclipsed that of the UC group, showing increasing gains. (Figure 2) By month 24, the

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[*] Entering treatment was defined as an inpatient treatment admission within the first 30 days or an outpatient service and any additional services within 14 days.
[†] Engagement, an intermediate step between initially accessing care and completing a full course of treatment, was operationalized as attending two additional days of treatment within 30 days after initiating treatment.
[‡] Retention was defined as having successfully "engaged" in treatment and attended at least two sessions of treatment in the third month after initiation of care.

percent of women in the ICM group who were employed full time was more than double that of those in usual care (22 percent vs. 9 percent).

Among employed women, those in the UC group had slightly higher rates of abstinence in the first three months--perhaps commensurate with the pressures of the TANF program to obtain and retain employment. By month six, however, rates of abstinence among employed women in UC began a notable decline. Abstinence rates among the ICM group, where the focus was on entering and staying in treatment, eclipsed abstinence rates of the UC group by month five and continued to improve over time. While rates of abstinence among the UC groups showed appreciable increases between months 10 and 17, they never surpassed those of the ICM group and again declined substantially after month 17. (Figure 3)

Benefits of a Long-term Care Approach

One important premise of the ICM approach is that addressing addiction is an important pre-condition for entry into the work force. These differences in employment rates and abstinence among those employed suggest that the ICM approach has sustained benefits that grow over time. Early abstinence significantly predicted later employment.

These finding are of enormous significance for achieving the goals of welfare reform. They suggest that a long term care approach that focuses on providing treatment, increasing

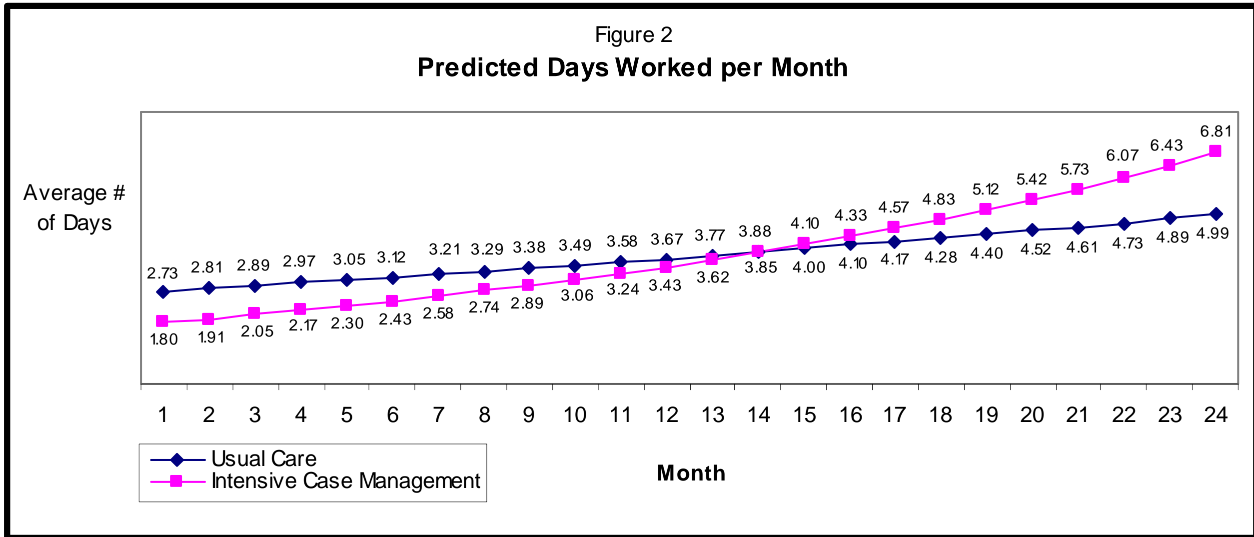

Figure 2
Predicted Days Worked per Month

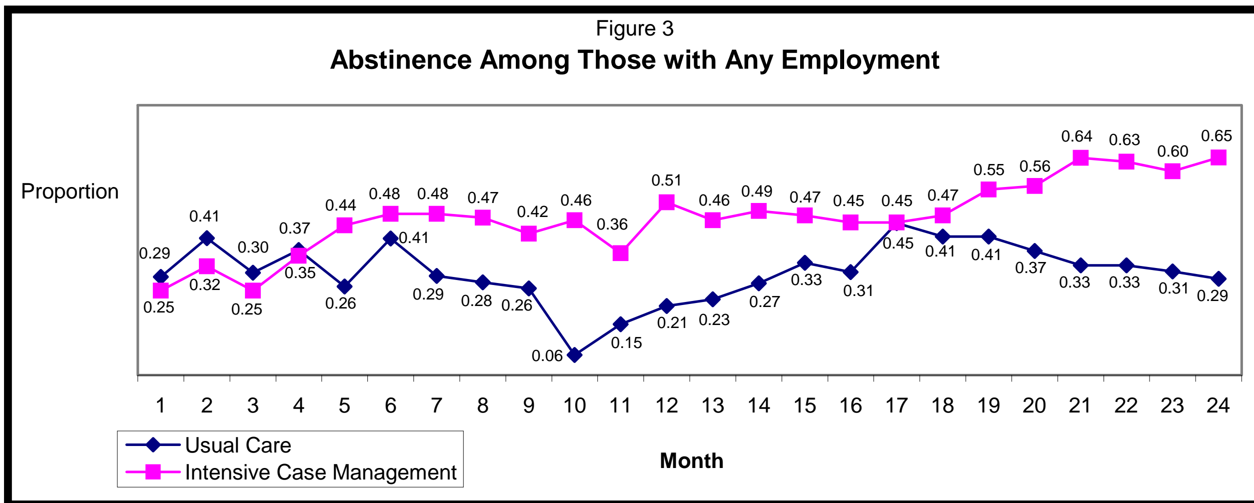

Figure 3
Abstinence Among Those with Any Employment

treatment retention, and achieving abstinence are essential preconditions for better and more sustainable employment outcomes.

Study Limitations

There are several limitations to this study. First, while the results from this study are directly relevant to work-eligible women with substance use disorders who are receiving TANF, their applicability to people using methadone is unclear since they were excluded from the CASASARD^SM demonstration. Second, since screening for substance use problems in welfare settings is only modestly effective, we do not know if there would be any differences in the success of the model for those who are identified as having substance use disorders during screening and those who are not. Third, employment outcomes were based on self-reported data. Most welfare studies use administrative data, but do not include 'off the book' or 'under the table' employment.

Another limitation is that this study employed a manual-guided approach to ICM and provided an array of services. The extent to which findings would generalize to other versions of case management is unclear. Also, this study was conducted in the context of welfare reform. Participants were not seeking treatment for substance use disorders, but were identified using screening procedures in welfare offices as codified by statute in New Jersey. It is unclear whether results would generalize to providing ICM to patients already in treatment.

Finally, findings do not provide a clear explanation of whether improvements in abstinence rates were the result of increased participation in addiction treatment, the independent effects of the case management, or which aspects of the ICM may have been more effective. For example, recent findings have supported the effectiveness of more minimal long-term interventions that simply monitor substance dependent clients over extended periods.[17] Further research is needed to address these issues.

Link to Welfare Reform Goals

This study shows the utility of a long-term care strategy to attaining the employment goals of welfare reform for women on welfare with substance use disorders. The first step in achieving this goal is for women to achieve sobriety; this is a function of getting them into treatment and keeping them there long enough to make a difference.

The ICM approach facilitated access to tangible social services and provided psychological support to assist women in entering and remaining in treatment. Moreover, this approach provided long-term monitoring and support, critical components of managing the chronic relapsing nature of substance dependence.

CASASARD^SM has demonstrated that ICM is an effective strategy for engaging and retaining substance dependent women receiving TANF in treatment and thereby reducing their substance use. CASASARD^SM also demonstrated that ICM is practical and feasible to implement within the regular operations of welfare offices. A key result of this approach is the growing rates of employment among ICM participants that appear to be linked directly to treatment participation, receipt of intensive case management services and abstinence.

Public Health and Welfare Implications

Risky substance use and addiction is a national public health problem costing society more than $600 billion each year.[18] Untreated, it contributes to more than 70 conditions that require hospitalization and is a major contributor to the five leading causes of death in America. It accounts for more than 10 percent of national spending on health care.[19]

Each year, the nation spends more than $25 billion on welfare alone. For each unemployed female welfare recipient with a substance use disorder who becomes substance-free and self-supporting, the economic benefit to society is

about $48,000 annually in avoided welfare, health care and criminal justice costs, and contribution to the economy in employment.[20]

CASASARD[SM] is the first major system wide test of a chronic disease approach to addiction. It offers a way for TANF recipients with substance use disorders to turn their lives around and for governments to avoid a broad range of substance related costs. The findings from the CASASARD[SM] model are the strongest to date supporting the hypothesis that intensive case management improves access, engagement, retention, abstinence and employment for substance-dependent clients. Only one other study has reported positive outcomes for an intensive intervention for substance dependent women receiving TANF and that was CASAWORKS for Families[SM].

These findings have important implications for intervening with substance-dependent women receiving TANF. Many welfare settings have procedures for screening people for alcohol and other drug problems at the time of benefit eligibility determination and then assessing and referring them to treatment. Other welfare settings do not provide even this level of intervention. Very few welfare settings offer intensive case management. An intensive case management approach is likely to be less expensive and more feasible to implement than other evidence-based behavioral or pharmacological interventions for substance dependence because it augments existing treatment services rather than requiring treatment programs to dramatically change their practice.

The results of the CASASARD[SM] evaluation also have implications for the delivery of care to a broader population of disadvantaged, substance-dependent people. The majority of people in publicly funded addiction treatment are referred by welfare and child welfare or criminal justice agencies. These populations share a similar set of problems with those in this demonstration (chronic substance problems, co-occurring disorders, poor social supports) and face a fragmented service system that provides disconnected, acute episodes of care. Further research is needed to determine whether ICM may be an effective intervention for this larger population.

An important next step is to document the cost avoidance and savings that result from the ICM model compared with UC. CASA has received funding from the National Institute on Drug Abuse to conduct a cost-benefit analysis of this nature that would show the taxpayer burden of providing services to TANF women and of providing UC, and the savings and benefits resulting from the ICM approach. An analysis such as this is important because the magnitude and types of costs incurred by TANF women with substance use disorders often are hidden and affect multiple sectors of government including, for example, criminal justice, housing, child welfare and Medicaid. This forthcoming analysis will provide policymakers with important new information about the high costs of failing to effectively treat mothers with substance use disorders and the benefits to taxpayers and government budgets of reducing the problem.

Recommendations

The results of this research provide evidence to support the following recommendations that can be adopted immediately:

- All states should employ intensive and ongoing case management for female welfare recipients with substance use disorders.

- Local and state agencies including welfare, child welfare, Medicaid, and addiction treatment agencies should increase their collaborative efforts to coordinate services that support intensive case management.

- The federal government should:

  - Increase flexibility in welfare reform work rules to allow treatment to count as a fulltime work activity.

- Fund demonstration projects that encourage development and testing of novel approaches to integrate social services and treatment for low-income individuals with substance use disorders.

- Fund cost-effectiveness studies of case management to determine the extent to which such programs save public funds by breaking the intergenerational cycle of poverty and addiction;

- Allow flexibility in how Medicaid funds are used to support service integration; and,

- Share the burden of costs with states for developing information technology that routinely monitors performance based on definable outcomes.

- Federal and state officials should educate policymakers and welfare and other service caseworkers on the nature of addiction and benefits of treatment, and put in place mechanisms to evaluate the efficacy of programs to screen for, prevent and treat risky substance use and addictive disorders.

Appendix A

Peer-Reviewed Journal Articles on the CASASARD^{SM} Demonstration

For a more detailed description of the CASASARD^{SM} study, see the following peer-reviewed journal articles:

- Morgenstern, J., McCrady, B.S., Blanchard, K.A., McVeigh, K.H., Riordan, A., & Irwin, T.W. (2003). Barriers to employability among substance dependent and non-substance affected women on federal Welfare: Implications for Program Design, *Journal of Studies on Alcohol, 64*(2), 239-246.

- Morgenstern, J., & Blanchard, K.A. (2004). Dealing effectively with substance use problems among mothers on welfare. *Connection, Academy Health,* 4-7.

- Blanchard, K.A., Sexton, C.C., Morgenstern, J., McVeigh, K.H., McCrady, B.S., Morgan, T.J. & Irwin, T.W. (2005). Children of substance-abusing women on federal welfare: Implications for child well-being and TANF policy. *Journal of Human Behavior in the Social Environment*.

- Morgenstern, J., & Blanchard, K. A. (2006). Welfare reform and substance abuse treatment for welfare recipients. *Alcohol Research & Health, 29*(1), *63-67*.

- Morgenstern, J., Blanchard, K.A., McCrady, B.S., McVeigh, K.H., Morgan, T.J., & Pandina, R.J. (2006). A Randomized Field Trial Examining the Effectiveness of Intensive Case Management for Substance Dependent Women Receiving Temporary Aid to Needy Families (TANF). *American Journal of Public Health, 96*(11), 2016-2023.

- Morgenstern, J., Blanchard, K., Kahler, C., Barbosa, K., McCrady, B.S., & McVeigh, K.H. (2008). Testing Mechanisms of Action for Intensive Case Management. *Addiction, 103*(3), 497-477.

- Morgenstern, J., Neighbors, C., Kuerbis, A., Riordan, A., Blanchard, K., McVeigh, K.H., Morgan, T.J., & McCrady, B. (2009). Improving 24-Month Abstinence and Employment Outcomes for Substance-Dependent Women Receiving Temporary Assistance for Needy Families with Intensive Case Management. *American Journal of Public Health, 99*(2), 328-333.

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Notes

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