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Evidence Brief

Substance abuse and misuse and links with welfare receipt

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Substance abuse and misuse and links with welfare receipt

Key points

- In New Zealand, alcohol use is very common. Recreational drug use is relatively common in many parts of New Zealand society. However, most people who use drugs and/or alcohol are **not** dependent on these substances.
- It is difficult to ascertain accurately the extent of problem substance use and abuse among benefit claimants.
- Substance misuse and dependence (especially of drugs) is associated with welfare receipt in many countries, including New Zealand. However, substance use (as opposed to a substance use disorder) alone is a weak predictor of employment success amongst welfare recipients.
- European countries typically provide access to benefits and some encourage treatment.
- The United Kingdom rejected plans to adopt mandatory drug testing and treatment orders for welfare recipients. However, it is proposed that welfare recipients not engaging in treatment will be subject to the same sanctions regime as other jobseekers.
- Australia grants benefits to those with substance abuse problems. It has also introduced income management for welfare recipients with substance abuse problems in some communities.
- In the United States people cannot receive disability payments if their primary incapacity is drug or alcohol dependence. States are permitted to drug test Temporary Assistance for Needy Families (TANF) recipients (not all do) and to penalise those who fail such tests. People convicted of a drug-related felony can receive a lifetime ban on TANF and Supplemental Nutrition Assistance Program (formerly Food Stamps) benefits.
- Drug tests detect recent drug use but provide no information about frequency of use, impairment or treatment needs.

Overseas policies on substance abuse and benefit receipt

The following table outlines policies that different countries follow to manage substance abuse and benefit receipt.

Country	Policy	Impact	Reference
	No specific conditions		
United Kingdom	The Work Capacity Assessment is used to identify benefit claimants whose work capacity is limited due to their substance misuse. Treatment is	• Impact of policy unknown. • Department for Work and Pensions (DWP) estimates that 6.6% of the total number of working age individuals accessing those benefits, and 7.4% of those aged	Hay & Bauld, 2008, 2010

Country	Policy	Impact	Reference
	encouraged but, at this stage, not mandatory.	under 25 accessing those benefits, are **problem drug users** (PDUs). It was estimated that around 8.2% of Jobseeker's Allowance (JSA) claimants, 8.1% of Income Support (IS) claimants, 4.4% of Incapacity Benefit (IB) claimants and 1.9% of Disability Living Allowance (DLA) claimants are PDUs (Hay & Bauld, 2008). • DWP estimates that 4.03% of DWP benefit claimants in England are **dependent drinkers**. The benefits with the greatest proportion of recipients estimated to be dependent drinkers are IB and IS (5.24% and 5.35% respectively (Hay & Bauld, 2010).	
Australia	Those with substance abuse problems who are not in work can receive welfare payments, often the Newstart Allowance. A person with a severe addiction can qualify for the Disability Support Pension.	• Unknown impact of the policy.	
Sweden	PDUs may qualify for sickness or invalid benefits, but only if the substance use disorder reduces their capacity to work.	• Unknown impact of the policy. • Numbers of welfare recipients with substance abuse problems are low.	Brucker, 2009; Harris, 2008
	Conditional access to benefits		
Norway	Sickness Benefit is only available to substance abusers with co-morbid mental health problems and is conditional on getting treatment for their substance abuse problem. Benefit is time limited and extensions are conditional on being in treatment.	• Unknown impact. • Numbers of welfare recipients with substance abuse problems are low.	
United States	Conditionality varies across states and benefit types. Since 1997, access to disability benefits (Supplemental Security Income Drug Addiction and Alcoholism (SSI DA&A)) is denied for those with substance abuse as their	• Proponents of the policy change estimated that 75% of former SSI DA&A beneficiaries would re-qualify for SSI benefits under another disability category, but only 35% of this population retained their SSI benefits (Hogan et al., 2008). • Some former SSI DA&A	Hogan et al., 2008; Orwin et al., 2004; Moore, 2011

Country	Policy	Impact	Reference
	primary incapacity.	beneficiaries became self-sufficient. Moore (2011) found terminated beneficiaries' employment increased by 20–30 percentage points. • Compared with those who retained SSI benefits, those who did not were almost twice as likely to report being homeless 6 months later (22% versus 12%) (Orwin et al., 2004).	
	Since 1997, US federal law has allowed states to deny access to the Temporary Assistance for Needy Families (TANF) for people who fail drug tests, and impose lifetime bans on TANF and the Supplemental Nutrition Assistance Program (SNAP) for people convicted of a drug-related felony. States are also able to make access to TANF conditional on undergoing treatment.	• Estimates of drug use amongst TANF recipients range from 6.6% to 37%. • **Impact of drug testing**: Under Florida's drug screening and testing pilot for TANF, 8,797 applicants and recipients were tested and 335, or 3.8%, tested positive for a controlled substance. There was little difference in employment and earnings between those who tested positive versus those who tested negative (ASPE, 2011).	ASPE, 2011

Concern has periodically been raised about the level of problem substance use among those in receipt of welfare payments and debate held about whether those who misuse substances, such as drugs and alcohol, should be receive welfare payments.

Drug and/or alcohol use is common in New Zealand

Alcohol is the most widely used recreational drug in New Zealand. Recreational drug use, especially of cannabis, is relatively common in many parts of New Zealand society (see Box 1). However, it is important to distinguish between substance use and substance dependency. While some of those using illicit and licit substances would meet diagnostic criteria for substance dependence (see Box 1), most do not. Most will discontinue substance use without any need for treatment (New Zealand Drug Foundation, 2011).

Substance use disorders usually emerge in late adolescence and when people are in their early 20s. A quarter of those who experience substance use disorder do so by age 16, half by age 18 and three-quarters by age 24 years (Baxter, 2008). Problematic substance use is linked to the development of mental health problems. The more severe the problems with substance use, the greater the likelihood of co-existent mental disorder (The Werry Centre, 2010).

Box 1: Substance use in New Zealand

Estimates suggest that, by the age of 21, around 80 percent of young people will have used cannabis on at least one occasion, with 10 percent developing a pattern of heavy dependent use (Fergusson & Boden, 2011).

The Ministry of Health (2010) found that:

- nearly one-in-two adults (49.0 percent) had used drugs (excluding alcohol, tobacco and BZP party pills) for recreational purposes at some point in their lifetime, equating to about 1,292,700 people in the total population aged 16–64 years in New Zealand[1]
- one-in-six (16.6 percent) people aged 16–64 years had used drugs (excluding alcohol, tobacco and BZP party pills) recreationally in the past year, representing almost half a million (438,200) New Zealanders aged 16–64 years. Most of these people had used cannabis, with 14.6 percent of all New Zealanders aged 16–64 years having used cannabis in the previous year[2]
- recreational drug use was more common amongst men, people in younger age groups and those of European/Other or Māori ethnicity.

The results of the 2006 New Zealand Mental Health Survey of New Zealanders aged 16 years and over indicated:

- 13.8 percent of the population (452,059 people or 1 in 7) are predicted to meet the criteria of a substance use disorder at some time in their lives and 3.5 percent (114,652 people) as having a disorder in the past 12 months
- 75 percent of those who develop a substance disorder do so by 25 years of age
- males have prevalence rates of substance use disorder double those for females
- after adjusting for socio-demographic correlates, prevalence rates for Māori are higher (6 percent) than for Pacific people (3.2 percent) and Others (3.0 percent).
- in terms of the standard medical diagnostic (DSM-IV) categories for mental health, in the past 12 months, 2.6 percent of the population experienced alcohol abuse, 1.3 percent alcohol dependence, 1.2 percent drug abuse and 0.7 percent drug dependence (Oakley Browne et al., 2006 in Rout, 2008).

[1] The prevalence of having ever used drugs for recreational purposes was highest for the following drugs: cannabis (46.4 percent), BZP party pills (13.5 percent), LSD and other synthetic hallucinogens (7.3 percent), amphetamines (7.2 percent), kava (6.3 percent) and ecstasy (6.2 percent).

[2] Among past-year cannabis users, 39.1 percent used cannabis at least weekly in the past year and over half (54.0 percent) had used cannabis at least monthly.

Substance use and welfare receipt

Links are evident between substance misuse and dependence and welfare receipt, but determining the size of the problem is difficult.

Substance misuse and dependence (especially of drugs) is associated with welfare receipt in many countries, including New Zealand (Hay & Bauld, 2008, 2010; Jayakody et al., 2004; Metsch & Pollack, 2007).

- **In New Zealand, there is an association between diagnosis of a substance dependence disorder and longer term benefit receipt.** The Dunedin longitudinal study[3] found that, overall, 13 percent, or 121 of the 939 study members who underwent mental health interviews at age 32, had some diagnosis of a substance dependence disorder, according to DSM-IV criteria in the prior 12 months. This captures people meeting the diagnosis for: (i) alcohol dependence, (ii) cannabis dependence and (iii) any other 'harder' drug dependence.[4] In an earlier analysis of the linked data, having a diagnosis of a substance dependence at age 32 was found to be positively associated with time spent receiving main benefits in young adulthood.[5] Close to 3 in 10 of the 10 percent of study members who spent more than 5 years receiving main benefits over the 11 to 12 years before their age 32 assessment had a diagnosis of substance dependence. Unpublished analysis shows that 36 percent of those receiving a benefit on the date of their age 32 assessment had a diagnosis of a substance dependence disorder, according to DSM-IV criteria in the prior 12 months (95 percent confidence interval 25–48 percent), compared with 11 percent of those not in receipt of a benefit (95 percent confidence interval 9–13 percent).[6]
- **In the United Kingdom, problem drug users (PDUs) were more likely to receive a benefit than dependent drinkers**. It was estimated that there were nearly 267,000 PDUs accessing the main Department for Work and Pensions benefits in England, in 2006 (Hay & Bauld, 2008). Around 160,000 individuals in receipt of one or more 'main benefits' are estimated to fall into the AUDIT 20+ dependent drinker group. Most (80 percent) PDUs of working age in England are estimated to be in receipt of a benefit, but only a quarter (25 percent) of AUDIT 20+ dependent drinkers are estimated to be claiming benefit. Dependent drinkers may be more able to sustain employment, or support themselves in other ways, than PDUs (Hay & Bauld, 2010).
- **In the United States, illicit substance use is higher amongst the unemployed**. A 2009 national survey of drug use found that, among adults aged 18 or older, the rate of illicit drug use was higher for unemployed people (17.0 percent) than for those who were employed full time (8.0 percent) or part time (11.5 percent) (Substance Abuse and Mental Health Services Administration, 2010). Amongst TANF recipients, substance use, and especially substance dependence, is associated with increased duration (and cycling) of welfare receipt (Bauld et al., 2010b; Metsch & Pollack, 2007; Podus et al., 2005).

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[3] The Dunedin study is a longitudinal study of a birth cohort of over 1,000 people born in Dunedin in 1972/73. At their age 32 assessment, 97 percent of those assessed consented to the Ministry of Social Development's data on their receipt of main benefits being linked into the study database.

[4] These are as follows: amphetamines (speed, diet pills, Dexedrine, ice), sedatives (tranquillizers, sleeping pills, barbiturates, Seconal, Valium, Librium, Xanax, Quaaludes, cocaine, crack), opiates (heroin, codeine, Demerol, Percodan, Talwin, morphine, methadone, opium, Darvon, Dilaudid, PCP, Angel Dust), hallucinogens (LSD, mescaline, peyote, DMT, mushrooms), inhalants (glue, toluene, gasoline, paint), and other (betel nut, nitrous oxide, amyl nitrite, poppers, ecstasy).

[5] See table A1 in www.msd.govt.nz/documents/about-msd-and-our-work/publications-resources/research/sole-parenting/lifecourse-factors-associated-with-benefit-receipt-full-report.pdf

[6] From unpublished tables from the Dunedin Multidisciplinary Health and Development Study.

It is difficult to ascertain accurately the extent of problem substance use and abuse among benefit claimants. Reasons for this include:

- substance use, especially illicit substance use, is a covert behaviour[7]
- the definition of problem substance use is not clear cut – it is a term that is often conflated with substance misuse, abuse, addiction and dependency. For example, in the United States, estimates of drug use amongst welfare populations range from 6.6 percent to 37 percent (Jayakody et al., 2004).

Substance use alone is a weak predictor of employment success

Substance use (as opposed to a substance use disorder) alone is a weak predictor of employment success amongst welfare recipients (ASPE, 2011; Lewis & Kenefick, 2011; New Zealand Drug Foundation, 2011; Substance Abuse and Mental Health Services Administration, 2010). For example, a 2009 US national survey of drug use found that, while the rate of past month illicit drug use was higher among unemployed people compared with those from other employment groups, most drug users in 2009 were employed (Substance Abuse and Mental Health Services Administration, 2010). Lewis and Kenefick (2011) found that substance use has been found to be as prevalent amongst employed TANF recipients as the unemployed.

Nevertheless, substance users in receipt of welfare payments appear to experience worse social and economic outcomes than non-users.

US researchers suggest these differences may not be attributable to substance use. Substance misuse is often a marker for unobserved characteristics and circumstances that are also associated with poor outcomes. For example, adverse experiences, such as childhood trauma or experiences of violence, may lead some women both to seek welfare and to initiate or increase their substance use (Jayakody et al., 2004; Pollack et al., 2002).

In the United States, many welfare recipients who use drugs or alcohol, and especially those with substance disorders, have other difficulties, including psychiatric disorders (Metsch & Pollack, 2005; Podus et al., 2005). Metsch and Pollack (2007) argue that substance misuse and dependence should be considered as one of many barriers threatening the wellbeing and social performance of welfare recipients. Substance use disorders are more common among TANF recipient mothers than non-recipient mothers. However, these disorders are less prevalent than other barriers, such as low educational attainment, transportation difficulties, physical and other mental health disorders.

[7] For example, one study found that 92 percent of those who tested positive for opiate or stimulant use denied having used them (Podus et al., 2005).

How do different jurisdictions address substance abuse amongst welfare recipients?

Policymakers have not had a unified approach to addressing substance abuse amongst welfare recipients.

- Some have seen substance abuse as evidence of an underlying antisocial outlook in need of correction, for example, through social, criminal justice and financial pressures.
- Others argue that substance abuse is a single problem to be treated and, once abstinence is achieved, self-sufficiency is possible.
- Some argue that substance misuse and dependence should be considered as one of many barriers threatening the wellbeing and social performance of welfare recipients.

Several countries provide access to benefits and some encourage treatment

- **Australia: substance users have access to benefits but may be subject to income management.** Australians with substance abuse problems who are not in work can receive welfare payments, often the Newstart Allowance, which is an unemployment benefit. Recipients are required to participate in activities designed to increase their chances of finding work (eg, applying for jobs, doing a course or working part time) but exemptions can be granted.

  A person with a severe addiction can qualify for the Disability Support Pension[8] if they provide medical evidence that they have a "dependence on alcohol or other drugs, well established over time, which is sufficient to cause prolonged absences from work. Reversible end organ damage may be present" (DEEWR, 2008; Harris, 2008).

  In some communities, the Australian Government has introduced controversial income management schemes for welfare recipients whose lifestyle or pattern of behaviour is considered threatening to child welfare (eg, this can include problems associated with drug and alcohol use). See the section on income management below.

- **Canada: substance abuse is classified as a disability, which means people diagnosed with this can qualify for disability benefits** (Brucker, 2007). Some provinces have challenged this (see Ontario[9]) but the courts have reinforced the view that substance abuse disorders are a disability. Various forms of public and private assistance are available to help with the cost of treatment.
- **Norway: access to the Sickness Benefit and Disability Allowance is conditional on getting treatment.** Access to the Sickness Benefit is restricted for clients with substance abuse problems. People applying for benefits in Norway must show that they have exhausted all medical and vocational rehabilitation

[8] The Disability Support Pension can take a while to process, so as a temporary measure claimants are placed on another payment (eg, Newstart Allowance with a medical certificate to cover the activity tests) while the payment is being assessed.

[9] See www.acbr.com/FAS/Supreme_Court_rules_addiction_is_disability.htm

options before being awarded benefits (Brucker, 2009). Receipt of the Sickness Benefit is only available for those with co-morbid mental health problems and is conditional on getting treatment for their substance abuse problem. Receipt of the Sickness Benefit is limited to 1 year, but this may be extended by a further year if the client is still in treatment (Harris, 2008).

Those who are disabled may receive a benefit entitled Temporary Benefit for up to 4 years while they take steps to improve their capacity for work. But they would have to have prospects for improved work capacity; if that was not the case then they could be eligible for a Disability Pension. If they refused to undertake relevant training or to receive treatment, their benefit would be stopped. Numbers of recipients with substance abuse problems are also low (Harris, 2008).

- **Sweden focuses on social reintegration.** No specific requirements are placed on Swedish welfare recipients with substance abuse problems. The focus is on social reintegration through alcohol or drug treatment (Harris, 2008). PDUs may qualify for sickness or invalid benefits but only if the substance use disorder reduces their capacity to work. If work capacity is reduced at least by a quarter for at least 1 year, and vocational rehabilitation measures are exhausted, any insured person can be granted activity compensation (always temporary) (ages 19–29), permanent sickness compensation (ages 30–64) or temporary sickness compensation (ages 30–64) (Brucker, 2009). Sweden has low levels of prevalence of drug use – something Hallam (2010) attributes to the social, cultural and ethnical homogeneity of Swedish society.
- **Germany: welfare recipients may be required to undergo rehabilitation.** Germans with substance abuse problems who are not in work can receive welfare payments if another rehabilitation attempt is unpromising, functional limitations preclude employment and permanent medical conditions are diagnosed. In awarding benefits, no distinction is made as to which substance is abused (eg, dependence on a legal drug like alcohol, an illegally obtained prescription drug like barbiturates or an illegal drug like heroin) (Brucker, 2009). Welfare recipients with substance abuse problems are not subject to mandatory drug testing and although rehabilitation cannot be imposed on anyone without their consent, there is pressure arising from the fact that those who do not make such application would lose their entitlement to sickness benefit if they do not undergo rehabilitation (Harris, 2008).
- **Netherlands: welfare recipients must look for work and participate in treatment if required.** Citizens can qualify for disability benefits if they have a substance use disorder that diminishes their capacity to work. In addition, recipients with a substance use disorder are required to do their best to get well and find a job or participate in a work-reintegration type programme or face termination of their benefit. Recipients with a substance use disorder are required to participate in a detoxification or treatment programme. The benefit agency pays[10] for and decides the type and intensity of treatment (Brucker, 2009).
- **United Kingdom: currently the focus is on encouraging substance misusers to engage with recovery services.** The new government elected in 2010 rejected the previous government's plan to pilot a new regime for problem drug users in receipt of the Employment and Support Allowance and Jobseeker's Allowance. A report by the Social Security Advisory Committee was critical of the plan and recommended it should not proceed as outlined. The main concerns were the expectation that clients undertake mandatory drug testing, having personal advisors identify problem drug users, and the use of sanctions as opposed to rewards (Social Security Advisory Committee, 2010).

[10] If the treatment is not covered by health insurance.

The current government's aim is, instead, to support substance misusers to engage with recovery services, which is considered to be more successful than coercion.[11] Under the Welfare Reform Bill 2011, if passed, treatment will not be mandatory for those with substance use problems. However, claimants with substance use problems who are not engaged in a structured recovery activity will be expected to actively look for work and accept reasonable offers of employment like other jobseekers. For jobseekers required to search for work, tougher sanctions[12] for non-compliance will be introduced under the Welfare Reform Bill 2011.

The Work Capability Assessment is used to identify benefit claimants whose work capacity is limited due to their substance misuse. However, the first review of the new Work Capability Assessments highlighted particular problems for people with mental disorders and other fluctuating conditions (UK Drug Policy Commission, 2011). The UK Drug Policy Commission (2011) argues these concerns apply equally to people with substance use problems.

United States: restricted access to welfare payments, drug testing, sanctions and income management

Access to welfare payments is restricted for those with substance abuse problems in many states.

- **Disability benefits are not awarded to those with primary conditions of substance use disorders**. In 1996, the passing of the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) limited the ability of substance users to obtain the Supplemental Security Income (SSI) and Social Security Disability Insurance payments for drug-related problems (Hogan et al., 2010). Individuals for whom drug or alcohol addiction was their primary incapacity had their benefits terminated. Those whose benefits were terminated could requalify for federal disability assistance based on other conditions, but existing studies indicate many did not (Hogan et al., 2010; Jayakody et al., 2004; Orwin et al., 2004). Moore (2011) found that terminated beneficiaries' employment increased by 20–30 percentage points. The employment effects are largest among the young, those with high pre-application earnings, and those who received benefits for around three years before termination (as compared with those who received benefits for shorter and longer periods). The findings are consistent with health improvements initially increasing beneficiaries' employment potential, before being outweighed by the negative consequences of an extended period out of the labour force. However, as Hogan et al. (2008) point out, many who lost SSI benefits suffered increased economic hardship following the policy change. See also the section on income management below.
- **Sole parents on benefit may be subject to drug tests and penalised.** US federal law currently includes two provisions specifically related to TANF recipients' substance use, both added by the 1996 PRWORA. The provisions refer to the use and abuse of illicit drugs.
    - First, states may require drug tests for welfare recipients and may penalise those who fail such tests.

[11] See HM Government (2010) *Drug Strategy 2010: Reducing Demand, Restricting Supply, Building Recovery* (https://webarchive.nationalarchives.gov.uk/20101208173722/http://www.homeoffice.gov.uk/publications/drugs/drug-strategy/).

[12] This is compared with the previous Bill.

- Second, the law includes a lifetime ban on TANF and Supplemental Nutrition Assistance Program (formerly Food Stamps) benefits for people convicted of a drug-related felony. States may modify or opt out of this ban, and many have done so. Some states also use a provision allowing the use of Individual Responsibility Plans to require substance abuse treatment for beneficiaries who need it and to sanction for non-compliance with that plan (ASPE, 2011).

- **Conditions may be attached to receipt of state General Assistance benefits regarding substance use.** Not all states have General Assistance (GA) programmes but, where they do, claimants receive financial assistance if they have a temporary incapacity, are low income and not eligible for any other public assistance besides Supplemental Nutrition Assistance (food stamps). Among those that provide GA programmes, some undertake substance abuse screening, and claimants may be required to undergo treatment, if referred (Pennucci et al., 2009).

Substance abuse testing and screening of welfare recipients

In the United States, many states conduct substance abuse screening and testing. The rationale varies considerably across the states, for example:

- some states are punitive and focus on savings (ASPE, 2011)
- some states use the drug tests to determine who needs to be referred to treatment programmes (often mandatory) in order to achieve employment goals (ASPE, 2011; Pennucci et al., 2009). Clients who do not attend the treatment programmes may be sanctioned (see below)
- drug testing in some states is related to child wellbeing – recipients who fail a drug test have their income managed by a third party who ensures benefits are spent to meet the children's needs (ASPE, 2011)
- some states also require clean drug tests as a condition of restoring benefits to recipients who have been convicted of drug-related offences (Lewis & Kenefick, 2011).

Various approaches are used to determine drug use amongst welfare recipients in the United States.

Drug testing welfare recipients

In the United States, states are authorised but not required to conduct drug testing[13] of TANF recipients and sanction those who test positive. While more than half of states have considered legislation that would require welfare agencies to administer drug tests to TANF applicants and/or recipients, few have enacted laws. The most common approach is drug testing for cause. This has been used in Arizona since 2009 and was accepted in Missouri in 2011. Twenty Indian tribes also use drug testing in their tribal TANF programmes. Only a few states have introduced broad, suspicionless drug testing.[14] This operated briefly in Michigan in 1999 before being suspended by the courts.

A drug screening and testing pilot for TANF recipients was implemented in Florida from January 1999 to May 2001. Of the 8,797 applicants and recipients tested, 335, or 3.8 percent, tested positive for a controlled substance. An evaluation of the pilot found little difference in employment and earnings between those who tested positive versus those who tested negative. The evaluation concluded that the cost of the programme did not justify the outcomes achieved and the programme did not warrant full implementation (ASPE, 2011).

Nevertheless, in 2011, Florida introduced suspicionless drug testing of all TANF clients. TANF recipients are responsible for the cost of their testing, which they will get back in their assistance if they qualify for it by passing the drug test. The Florida drug-testing policy treats all applicants who test positive for drugs the in same way: denial of welfare assistance. Someone who occasionally uses marijuana is treated the same as an addicted methadone addict. The Florida drug testing programme is currently under legal challenge (ASPE, 2011). See also the section on income management below.

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[13] This involves the analysis of body fluids (such as blood, urine or saliva) or hair or other tissue for the presence of one or more psychoactive substances. Drug testing is employed to monitor abstinence from psychoactive substances. See www.who.int/substance_abuse/terminology/who_lexicon/en/

[14] Either everyone is tested or a random subset is tested.

Drug tests are limited in their usefulness for several reasons.

- **Results cannot distinguish between occasional substance users and substance abusers.** Drug tests detect recent drug use but provide no information about frequency of use, impairment or treatment needs. If drug testing is used as a form of screening, many recipients likely to test positive will be casual drug users who do not satisfy diagnostic criteria for dependence (Pollack et al., 2002).

  Where drug testing is used for pre-employment purposes, it may mean that employers do not offer employment to talented people for what may be a one-off or recreational and non-problematic drug experience. This is more likely in a culture where experimental drug use is widespread (Roberts, 2004).
- **Common drug tests do not provide accurate information about alcohol use.**
- **Drug testing does not produce reliable estimates of drug use.** Whether drug use is detected depends not only on use but also on other factors such as the characteristics of each drug, individual metabolism and cut-off levels. Drug tests often fail to identify people using more powerful and addictive drugs (ie, cocaine or heroin) because these drugs exit the body's system in a matter of hours or days. Drug testing often does not distinguish between illicit use of street drugs and the legitimate use of certain prescription and over-the counter drugs (ASPE, 2011).
- **Widespread drug testing is often expensive and inefficient to administer, particularly if care is taken to ensure the tests are accurate.** It is not cost effective to test all applicants or participants. In the United States, the cost of catching a substance abuser was between US$20,000 and US$77,000 per person because few substance abusers were detected but many were tested (Lewis & Kenefick, 2011).

Question and answer screening approaches

These are the most commonly used approaches. If, based on the test, clients appear to have a substance abuse problem they are referred to specialists for a fuller assessment. The benefits of question and answer screening approaches are they are considerably cheaper to administer, are effective in determining drug users from drug abusers, can detect alcohol abuse and are less intrusive. In the United States most states use case managers to conduct the screening (Lewis & Kenefick, 2011). The main limitation of question and answer screening approaches is that the percentage of people identified with a substance disorder is typically low – between 1 percent and 3 percent (Nakashian, 2001). There are several reasons for this.

- Screening instruments are usually used to determine the extent of substance use once use is acknowledged and not whether substance use exists (Nakashian, 2001).
- Screening instruments rely on self-disclosure but substance abuse is a disease characterised by denial (Nakashian, 2001).
- Welfare office staff are not always trained in identifying alcohol and substance use disorders. In the case of TANF, TANF workers were provided little, if any, training on how to identify alcohol and substance use disorders (Metsch & Pollack, 2005).

However, specialised screening and case management[15] appear to be promising tools in identifying and treating substance use disorders (Metsch & Pollack, 2007). Screening and assessment for substance abuse should be targeted to those at highest risk for problematic use (Podus et al., 2006).

[15] See Morgenstern et al. (2009) and CASA (2009) regarding the importance of co-ordinated case management.

Impact of sanctions on substance use

According to the UK Drug Policy Commission (2008), the evidence base in this area is limited but there is some evidence that PDUs will not respond to sanctions as might be expected, particularly when their effect is delayed, and the greater use of incentivising change might be more effective and should be explored. UNDOC (2010) encourages the adoption of a health-oriented approach to illicit drug use and drug dependence rather than relying solely on a sanction-oriented approach. UNDOC argues there is increasing evidence that a health-oriented approach is the most effective in reducing illicit drug use and the social harm it causes.

Sanction rates are higher among those with substance abuse problems. US research indicates that welfare recipients sanctioned for not meeting work obligations are more likely to have substance misuse problems (Corman et al., 2010; Pollack, 2007; Schmidt et al., 2002).

In the United States, welfare recipients have faced specific sanctions against substance use. These sanctions are designed to deter claimants from misusing substances and encourage compliance with, or participation in, activities or programmes deemed to be in the best interests of claimants (Griggs & Evans, 2010). Griggs and Evans (2010) argue that systematic reviews of evidence in this area tend to show the potential benefits of incentives and treatment monitoring. They report there is little evidence on the relationship between programmes for substance users and benefit sanctions, although the CalWORKs (California Work Opportunity and Responsibility to Kids Act) evaluation is an exception. It found that:

- sanction rates among claimants referred to substance support services were low (4.7 per cent after the referral)
- claimants dropping out of supportive services were more likely to be sanctioned than ‘completers’ (Griggs & Evans, 2010).

Corman et al. (2010) found robust and compelling evidence that welfare reform led to a decline in illicit drug use and an increase in drug treatment among women at risk for relying on welfare, and some evidence that the effects operate, at least in part, through both TANF drug sanctions and work incentives.

Mandatory treatment versus voluntary treatment

The evidence is less clear on whether mandatory treatment is more or less effective than voluntary treatment.

Evidence shows mandatory treatment has positive outcomes

In the UK prison system, mandatory referrals have been made for treatment for several years. Malloch (2011) found prisoners who completed an order or intervention have lower reconviction rates than those who do not. Engagement with treatment, and readiness to engage with treatment, tends to be the precursor of success. Donmall et al. (2009) indicate there is an emerging body of research that suggests outcomes for these individuals are similar to those who enter treatment through other referral routes.

In the United States, the 1996 PRWORA reforms required recipients to access to treatment as a condition of receiving TANF. Three states found that welfare recipients who accessed treatment were more likely to find employment. A national treatment outcomes study found that those welfare recipients who accessed treatment were also more likely reduce their drug use (Bauld et al., 2010b).

Concerns about mandatory treatment

Recently, the UK Government debated the use of mandatory referrals to treatment for welfare recipients with drug problems. The Social Security Advisory Committee (2010) argued that voluntary rather than mandatory participation in treatment was more effective. Grover and Paynor (2010) do not recommend coercing people into drug treatment programmes or pathologising problem drug users – to do so is likely to have little effect in getting problem users into drug treatment programmes or paid work.

In the recent UK debate about requiring problem drug users on benefit to undertake treatment, concerns were frequently raised in parliament about the burden the new provisions would place on treatment services (Harris, 2010).

Where treatment is made mandatory, it is important that sufficient treatment services are available. In the United States, before January 1997,[16] SSI recipients with substance abuse problems were required to participate in a substance abuse treatment programme (if appropriate treatment were available). The lack of available and appropriate substance abuse treatment resources compromised the intent of the original policy mandate (Hogan et al., 2008). A similar situation exists for TANF recipients with substance use problems. In most states, not enough treatment options or resources are available to adequately confront the problem. Lack of access is further complicated by poverty, limited health insurance coverage and insufficient capacity of publicly funded treatment services (Parra, 2002).

[16] From this point onwards, people with substance abuse as their primary incapacity were denied access to SSI (Bauld et al., 2010b).

Treatment versus no treatment

Drug and alcohol dependency is a chronic and relapsing condition

Many people do not complete treatment programmes, and it has been estimated that fewer than 10 percent of people with drug or alcohol dependency who receive treatment experience continuous abstinence in the long term (New Zealand Drug Foundation, 2011).

Treatment is cost effective

Nevertheless, providing treatment services to individuals diagnosed with substance abuse disorders can improve client and taxpayer finance outcomes (Pennucci et al., 2009). Aos et al. (2006) found that, for adults who experience these problems, evidence-based treatment achieves roughly a 15 percent to 22 percent reduction in the incidence or severity of these disorders. This reduction produced about $3.77 in total life-time benefits per dollar of treatment cost. A UK study also found that drug treatment was estimated to be cost beneficial. For every £1 spent, an estimated £2.50 was saved, and, overall, drug treatment was found to be cost beneficial in 80 percent of cases (Donmall et al., 2009).

Time spent in treatment is important

Time spent in treatment is an important predictor of treatment success (Metsch & Pollack, 2005). In the United States, an evaluation of CalWORKs[17] claimants' capacity to look for, find and retain work appeared to be associated with the amount of time the claimant had been receiving services (and, significantly, whether the programme had been completed) (California Institute for Mental Health, 2005 in Griggs & Evans, 2010).

Psychological and/or drug abuse treatment alone was not predictive of decreasing drug use

For those who receive treatment, the availability of support and aftercare is crucial in reducing the risk of relapse (CASA, 2009; Malloch, 2011; Morgenstern et al., 2009). In the United States, the CASASARD programme[18] provides intensive case management for substance-abuse dependent women receiving TANF. It seeks to address the multiple, chronic and serious problems faced by participants. CASASARD is designed to use an intensive case-management approach that involves outreach, screening and assessment services to enhance motivation and increase engagement in treatment,

[17] CalWORKs (California Work Opportunity and Responsibility to Kids Act) is a government funded welfare programme to help low- or no-income families with minor children towards independence through promotion of personal responsibility and work as the first and foremost solution for self-sufficiency.

[18] CASASARD builds on the CASAWORKS for Families (no longer in operation) programme. CASAWORKS was a national demonstration programme that provided for women on welfare with substance abuse problems, in one concentrated course, drug and alcohol treatment; literacy, job, parenting and social skills training; family violence prevention and health care. This approach aimed to enable women to become self-sufficient, responsible parents and productive workers. CASAWORKS for Families operated at sites in 11 cities in nine states. An evaluation of CASAWORKS for Families programmes across the country was favourable, although the evaluators could not be certain that the results were actually caused by the intervention (Parker, 2009).

treatment provision, co-ordination of support services, monitoring and advocacy, aftercare follow up, peer support, relapse monitoring and crisis management. Compared with women who received the usual care 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
- showed a greater rate of increase in employment over time and were more than twice as likely (22 percent versus 9 percent) to be employed full time at month 24 (CASA, 2009).

Brown and Montoya (2009) suggest that offering drug-abuse prevention efforts in conjunction with employment may produce synergistic results that may otherwise go unrealised if tertiary drug prevention measures and employment opportunities remain separate. Brown and Montoya (2009) looked at employment as an intervention to reduce drug use and found a causal relationship between the two. That is, higher employment hours during one period predicted decreased substance use during a subsequent period. The welfare to work changes had the unintended consequence of reducing substance use. Employment is not a solution for all those on benefit with a substance abuse problem (eg, those whose drug use is so chronic or addiction so severe they require intensive inpatient drug abuse treatment; those with severe mental health problems) (Brown & Montoya, 2009).

Income management can be used to influence behaviour

The United States and Australia have used how benefits are paid to claimants to encourage socially responsible behaviour with regard to drugs and alcohol.

United States experience of income management

Before the 1996 PRWORA reforms, SSI recipients whose primary incapacity was addiction to drugs or alcohol were required to have their income managed by a third party – usually a case worker. Following the reforms, most people with drug and alcohol problems no longer qualified for SSI. Where drug addiction is not the primary cause of disability, payment may be made to a representative rather than the claimant, if it is considered by the authorities that it would "serve the interest of the individual because the individual also has an alcoholism or drug addiction condition … and the individual is incapable of managing such benefit" (Harris, 2008; Hogan et al., 2008).

In Florida, TANF claimants who fail the required drug testing may designate another individual to receive their benefit on behalf of their children (ASPE, 2011).

US research has found there is increased drug taking immediately after claimants receive benefit payments. Proposed measures to reduced spikes in drug taking include smaller but more frequent payments or payments in kind (eg, food or housing provision) (Harris, 2010).

Australian experience of income management

In Australia, the income management schemes implemented include:

- Income Management in the Northern Territory Emergency Response
- Child Protection Scheme of Income Management and Voluntary Income Management in Western Australia
- Income Management in the Cape York Welfare Reform Trial
- New Income Management.

Under income management, a portion of people's welfare payments is set aside for priority needs such as housing and food. Typically, the funds cannot be used to purchase excluded items such as alcohol, tobacco, pornography or gambling products. Participation can be voluntary or compulsory, depending on the scheme. Evaluations are still under way, but limited evidence is available to date.

In the 2011/12 Budget, the Australian Government made a commitment to implement income management from 1 July 2012 in an additional five local government areas.[19]

[19] See www.fahcsia.gov.au/sa/families/progserv/welfarereform/Pages/default.aspx

What we don’t know

With regard to moving welfare recipients with substance abuse problems into work, the evidence about what works for whom is weak.

Malloch (2011) states that drug addiction and dependence can be a long-term and complex condition, and it is probably impossible to isolate the impact of specific interventions from the broader social, political and economic context in which the individual sits. Nevertheless, more robust evidence is needed on which interventions promote reintegration and sustain recovery (such as housing, education, employment) and the integration of these services.

Many of the studies mentioned in this evidence brief were conducted during a time of general prosperity and low unemployment. The labour markets in many countries are now much less favourable. At the same time, many governments face constraints in financing health and social services (eg, drug and alcohol treatment). Previously effective policies aimed moving people with drug and alcohol problems into work may not be as effective in such an environment (Metsch & Pollack, 2007).

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