The Employment Retention and Advancement Project

Results from the Substance Abuse Case Management Program in New York City

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The findings and conclusions presented herein do not necessarily represent the official position or policies of HHS.

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Overview

This report presents implementation and one-and-one-half-year impact results for the Substance Abuse Case Management (SACM) intervention, a program funded by the New York City Human Resources Administration (HRA) and operated by its contracted vendor, University Behavioral Associates (UBA). SACM provided intensive care management services to public assistance recipients — primarily childless, single adults participating in the New York Safety Net program — who were identified at a welfare office as possibly having a substance abuse issue. SACM services included assessing the nature and severity of the substance abuse, making referrals to substance abuse treatment providers and (when appropriate) to welfare-to-work activities, and facilitating client engagement with all service providers. The goals of SACM were to increase client engagement in treatment and to improve the recovery and employability of participants. The evaluation followed a sample of public assistance applicants and recipients who were referred for a substance abuse assessment from June 2003 to June 2005.

SACM is one of 16 innovative models across the country that MDRC is evaluating as part of the Employment Retention and Advancement (ERA) Project under contract to the Administration for Children and Families (ACF) in the U.S. Department of Health and Human Services, with additional funding from the U.S. Department of Labor for the evaluation of SACM, in which eligible individuals were assigned to one of two groups. Those assigned to the SACM group could receive intensive care management services from UBA. Those assigned to the usual care group received many of the same services provided by UBA but at less intensity and with less coordination. The report's findings thus indicate whether SACM was more effective than HRA's regular approach in providing substance abuse case management services.

Key Findings

- **The general sequence of services was similar for the SACM group and the usual care group, but the intensity of services was much greater in SACM.** Though both groups received initial assessments to determine the nature and severity of the substance abuse, relative to usual care, SACM's assessment was more intense, was more clinically focused, and was conducted by a psychologist or clinical social worker rather than a Credentialed Alcoholism and Substance Abuse Counselor. In addition, the level of staff interaction with SACM clients was greater, due to smaller caseloads (anywhere from one-half to two-thirds the caseload in usual care) and a less fragmented approach. Case management services to encourage treatment retention were especially intensive in SACM relative to usual care, where case management was virtually nonexistent.

- **Compared with the usual care group, the SACM group was slightly more likely to be referred to, and to enroll in, substance abuse treatment.** In addition, the SACM group was more likely to be referred to employment services. SACM was somewhat more successful in linking clients to substance abuse treatment — an important first step. This improvement could be due to an increase in the number of clients whom SACM found to be in need of treatment relative to the number identified in usual care and/or to the more intensive services provided by SACM. SACM also led to a small increase — 3.1 percentage points above the control group level of 40.8 percent — in the proportion of clients referred to HRA employment programs.

- **During the 1.5-year follow-up period, SACM had no effect on employment and benefits receipt for the full sample.** There was no increase in the proportion of the SACM group who were employed relative to the usual care group. SACM did lead to a reduction in benefits receipt for the subgroup who received Temporary Assistance for Needy Families (TANF).

MDRC will continue to track the employment paths of both the SACM and the usual care group and will present longer-term results in the future.

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About the Employment Retention and Advancement Project

The federal welfare overhaul of 1996 ushered in myriad policy changes aimed at getting low-income parents off public assistance and into employment. These changes — especially cash welfare's transformation from an entitlement into a time-limited benefit contingent on work participation — have intensified the need to help low-income families become economically self-sufficient and remain so in the long term. Although a fair amount is known about how to help welfare recipients prepare for and find jobs in the first place, the Employment Retention and Advancement (ERA) project is the most comprehensive effort thus far to ascertain which approaches help welfare recipients and other low-income people stay steadily employed and advance in their jobs.

Launched in 1999 and slated to end in 2009, the ERA project encompasses more than a dozen demonstration programs and uses a rigorous research design to analyze the programs' implementation and impacts on research sample members, who were randomly assigned to the study groups. The study was conceived and funded by the Administration for Children and Families in the U.S. Department of Health and Human Services; supplemental support has been provided by the U.S. Department of Labor. The project is being conducted by MDRC. Most of the ERA programs were designed specifically for the purposes of evaluation, in some cases building on prior initiatives. Because the programs' aims and target populations vary, so do their services:

- **Advancement programs** focus on helping low-income workers move into better jobs by offering such services as career counseling and education and training.
- **Placement and retention programs** seek to help participants find and hold jobs and are aimed mostly at "hard-to-employ" people, such as welfare recipients who have disabilities or substance abuse problems.
- **Mixed-goals programs** focus on job placement, retention, and advancement, in that order, and are targeted primarily to welfare recipients who are searching for jobs.

The ERA project's evaluation component investigates the following aspects of each program:

- **Implementation.** What services does the program provide? How are those services delivered? Who receives them? How are problems addressed?

- **Impacts.** To what extent does the program improve employment rates, job retention, advancement, and other key outcomes? Looking across programs, which approaches are most effective, and for whom?

A total of 16 ERA models have been implemented in eight states: California, Illinois, Minnesota, New York, Ohio, Oregon, South Carolina, and Texas. But — given significant differences in implementation in the three sites operating the Texas model — the project ultimately will yield 18 independent estimates of site effectiveness.[1]

The evaluation draws on administrative and fiscal records, surveys of participants, and field visits to the sites.

[1]Past reports list 15 ERA models. This number was changed, however, to recognize that one of the tests in Riverside, California, actually involved two models, given the two initiatives' different sets of service providers and program rules. Note that "site effectiveness" refers to the effectiveness of different models or to the effectiveness of a model that was implemented very differently in a number of locations.

Acknowledgments

The Employment Retention and Advancement (ERA) evaluation would not have been possible without the cooperation, commitment, and hard work of a wide range of administrators and staff in all the ERA sites. Notably, findings from all the sites in the evaluation contribute to addressing the study's key questions. All the sites stepped forward to innovate in a challenging and important area of social policy and practice, and as much can be learned from models that so far are not showing economic impacts as from those that are.

For the evaluation of New York City's Substance Abuse Case Management (SACM) program, the following individuals deserve special thanks.

At the New York City Human Resources Administration (HRA), former commissioner Jason Turner was responsible for initiating the study, and subsequent commissioners Verna Eggleston and Robert Doar continued to support it. Frank Lipton, Swati Desai, and Joan Randell all played critical roles in the study's implementation and provided thoughtful comments on this report. We would also like to acknowledge the contributions of Larry Andres, Maureen Deevey, Vernell Inniss, Margaret Rhoden, Lynn Miyazaki, and Dave Ferguson. In addition, we would like to acknowledge David Moses at the New York State Department of Labor, who prepared automated employment and earnings data files for this analysis.

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Finally, we would like to extend our deep appreciation to the thousands of sample members who participated in the study.

The Authors

Executive Summary

This report presents interim results from an evaluation of New York City's Substance Abuse Case Management (SACM) program, a large-scale initiative for welfare applicants and recipients who have substance abuse issues.[1] SACM seeks to connect participants with both treatment and employment services. The SACM evaluation is part of the national Employment Retention and Advancement (ERA) project. Conceived and funded by the Administration for Children and Families (ACF) in the U.S. Department of Health and Human Services, the ERA project is testing 16 innovative models across the country that aim to promote steady work and career advancement for current and former welfare recipients and other low-wage workers. MDRC — a nonprofit, nonpartisan research organization — is conducting the ERA project under contract to ACF and is producing a similar interim report for each site in the project.

The evaluation focuses on the SACM program in the Bronx, one of the city's five boroughs. Operations there began in early 2001, and nearly 10,000 clients were served through September 2008. SACM has national relevance because many states are looking for effective models to assist the hardest-to-employ welfare recipients, including those with substance abuse problems and other health-related barriers to employment. Such models may be particularly important in the wake of changes in federal law in 2006 that require many states to substantially increase the share of welfare recipients who are engaged in work activities.

Origin and Goals of the SACM Program

Over the past 10 to 15 years, many states have expanded work requirements to include a much broader share of the welfare caseload. Federal legislation in 1996 accelerated this process by requiring states to ensure that a specific proportion of all recipients were working or preparing for work and by limiting most families to 60 months of federally funded assistance under Temporary Assistance for Needy Families (TANF), the main cash assistance program for low-income families with children.

As states began to work with a larger share of the TANF caseload, and as caseloads declined dramatically, many states began to focus more attention on the substantial barriers to employment facing many recipients on the welfare rolls. Some states began to develop new employment-oriented programs for recipients with mental health problems, drug and alcohol

[1]The New York City Human Resources Administration (HRA) referred to the program as the Comprehensive Service Model. The name "Substance Abuse Case Management" is used in this report because it more clearly describes the intervention.

abuse issues, physical disabilities, and other serious behavioral and health problems. Little is known about the effectiveness of these targeted approaches.

New York City has been particularly aggressive in attempting to ensure that all welfare recipients are engaged in work activities. The city's policies assume that virtually everyone on welfare should either participate in work-related activities, take specific steps to stabilize a medical problem, or apply for federal disability benefits. As part of this effort, beginning in the late 1990s, the Human Resources Administration (HRA, the city's welfare agency) developed a set of tailored programs for recipients facing particularly serious barriers to employment. One of these initiatives, the Substance Abuse Case Management program, was directed to recipients who abuse drugs or alcohol.[2] SACM was designed to address the fact that many people with substance abuse problems — particularly, low-income people — do not remain in treatment long enough to benefit, and so they face significant barriers to employment.

This evaluation focuses on the SACM program in the Bronx, which is operated under contract to HRA by University Behavioral Associates (UBA), a nonprofit behavioral health management services organization.[3] The goal of the program is to "assist public assistance clients in their path to abstinence, self-sufficiency, and employment." In brief, UBA's program assesses recipients to determine whether they need substance abuse treatment and, if so, what type of treatment and any other assistance they need; refers them to an appropriate treatment provider; monitors the provision of treatment over time; assists clients in remaining in treatment; and connects clients with welfare-to-work activities as appropriate. In contrast, the usual services ("usual care") provided to recipients with substance abuse problems include many of the same components but are less intense and less likely to be coordinated. Thus, the evaluation focuses on whether more focused and more intensive case management services lead to higher levels of treatment referral, enrollment in treatment services, and ultimately higher levels of employment and reduced benefits receipt relative to usual services.

The SACM Evaluation

The SACM evaluation's design takes advantage of the automated system that HRA uses to schedule welfare applicants and recipients for substance abuse assessments. Under this process, clients are screened for substance abuse in local welfare offices, and those who are

[2]The ERA project is also evaluating another of the special initiatives, the Personal Roads to Individual Development and Employment (PRIDE) program, which targeted recipients who had work-limiting medical conditions. See Dan Bloom, Cynthia Miller, and Gilda Azurdia, *The Employment Retention and Advancement Project: Results from the Personal Roads to Individual Development and Employment (PRIDE) Program in New York City* (New York: MDRC, 2007).

[3]In New York, HRA contracted with three organizations — one in Manhattan, one in Brooklyn, and one in the Bronx — to deliver case management services to recipients needing substance abuse treatment.

deemed to be at risk are scheduled for further assessment. In the Bronx, these assessments are conducted by UBA, but the program has limited capacity. Thus, the scheduling system is designed to refer recipients needing an assessment to UBA unless the program's slots are full. When that occurs, recipients needing an assessment are referred to HRA's Substance Abuse Service Center until more slots became available at UBA. After carefully assessing the scheduling system, the researchers concluded that the assignment of clients to UBA (the SACM group) or to the Substance Abuse Service Center (the usual care group) was essentially random and that recipients who were assigned to the two programs would likely be comparable on measurable and unmeasurable characteristics. In order to preserve the integrity of the research design, clients who were referred to the Substance Abuse Service Center during the sample recruitment period were prevented from being referred again to UBA.

MDRC is tracking a total of 8,831public assistance applicants and recipients who were referred to SACM and usual care between 2003 and 2005. The study is using data provided by the New York City and the State of New York that show participation in substance abuse treatment as well as each individual's monthly welfare and food stamp benefits and any employment in jobs covered by the state's unemployment insurance (UI) program. At this point in the evaluation, one and one-half years of follow-up data are available for each person in the analysis. Because the process of assigning individuals to the two groups was nearly random, any significant differences that emerge in measured outcomes over time (for example, in employment or in participation in substance abuse treatment) can plausibly be attributed to the SACM program rather than to differences in the characteristics of clients assigned to the two programs; such differences are known as the *impacts* of SACM.

In reviewing the results presented below, it is important to consider two limitations of the research design. First, as is true in many studies in which individuals enter the research at the point of referral rather than at the point of program participation, the research sample for this study includes people who received few or no services from either the SACM or the usual care program. For example, some people were applying for welfare when they were referred to the two programs and never actually started receiving benefits (both programs serve only people receiving public assistance), while others were assessed by one of the two programs and were found not to need substance abuse treatment. In addition, a small fraction of the people who were assigned to the SACM group were later referred to the Substance Abuse Service Center.[4]

[4]About 5 percent of those in the SACM group completed only an assessment at the Substance Abuse Service Center during the follow-up period. These "crossovers" have the effect of weakening the treatment difference between the two groups, and they suggest that the results of the study may be a conservative estimate of SACM's impacts. Crossovers in the reverse direction (individuals who were initially referred to usual care but then participated in SACM) would have been much more damaging to the design, but they were very rare, in large part because HRA agreed to program its management information system to prevent this from happening.

Overall, about 23 percent of the SACM group never completed an initial assessment at UBA, and another 9 percent were assessed but were found not to need substance abuse treatment. Although the main analysis focuses on everyone in the two research groups — including nonparticipants — a separate analysis examines results only for people who showed up to their assigned program and completed an assessment. These results may provide some insight into the effects of the SACM services themselves. In general, both the main analysis and the separate analysis find strikingly similar results on the main outcomes of interest.

Second, the study relies solely on HRA program-tracking data to measure participation in substance abuse treatment. These data are useful for determining whether sample members initially enrolled in a treatment program; however, they do not allow for reliable measurement of other outcomes, including retention in treatment over time — the key short-term goal of the SACM program. In addition, the HRA data do not track treatment participation during periods when sample members did not receive public assistance. Finally, the data do not measure the extent to which sample members used drugs during the study period. A complementary study of SACM by the National Center on Addiction and Substance Abuse (CASA) at Columbia University is measuring treatment retention and substance use using surveys and biological testing, albeit for a small subset of the research sample.

Finally, as is often the case in long-term studies, HRA made some important changes in the SACM program during and after the study period — notably, changes designed to increase the program's focus on employment. The impact of those changes, if any, may not be reflected in the study's results.

The SACM Target Population

A large majority of sample members are males not living with children who were receiving (or applying for) Safety Net assistance. Safety Net is a New York State program that serves childless adults and, since 2001, TANF recipients who have reached their 60-month time limit on federally funded benefit receipt. The proportion of mothers on TANF in the sample is quite small (about 5 percent). This reflects general differences in substance abuse patterns between the TANF and Safety Net populations. Also, there is anecdotal evidence that mothers are less likely to report substance use because they are concerned about triggering a child welfare investigation. The sample members were relatively old when they entered the study (an average age of 38), compared with those in most welfare-to-work studies. Most had no recent work history. Only about one-third had been employed in the prior year.

Key Findings on Program Implementation

- **The general sequence of services was similar for SACM and usual care clients, but the intensity of services was much greater in SACM.**

UBA staff conducted an assessment to determine the nature and severity of each client's substance abuse issue; made appropriate referrals for treatment; and when a participant was determined to be nonexempt (that is, no longer required to undergo intensive substance abuse treatment services and thus able to engage in employment services), they made a referral to an employment vendor. This was similar to the flow through the usual care program. However, the staff conducting the assessments differed. UBA assessment staff were mostly psychologists and clinical social workers, leading to a broader, more clinically focused assessment, whereas the usual care group was assessed by Credentialed Alcoholism and Substance Abuse Counselors who tended toward a more functionally focused employability assessment. In addition, once clients were referred to a treatment provider, the level of ongoing staff interaction was much greater at UBA. The average UBA staff member carried a caseload of 40 clients, one-half to two-thirds the caseload of a typical HRA Substance Abuse Service Center eligibility worker. Further, UBA had more frequent and consistent contacts with clients and was more likely to call clients in (for example, clients suspected of being noncompliant) for routine and case-issue reassessments. The Substance Abuse Service Center, on the other hand, focused primarily on welfare eligibility issues.

Although there are clear distinctions between the SACM and usual care programs, it is important to note that the evaluation is not comparing SACM with a "no-service" control group. Rather, it is assessing the impact of SACM over and above the effects produced by a usual care program that also sought to refer clients to substance abuse treatment and to enforce a requirement to participate in treatment.

- **The SACM group was more likely than the usual care group to be referred to substance abuse treatment and to enroll in treatment.**

A higher proportion of the SACM group (73 percent) were referred to a substance abuse treatment program relative to the usual care group (69 percent). In addition, those in the full SACM group were slightly more likely to enroll in substance abuse treatment programs (65 percent) relative to the usual care group (61 percent). Although these differences are not very large, it should be noted that, in both groups, almost everyone who was assessed and deemed in need of treatment was referred to a treatment provider. Thus, it would have been very difficult for SACM to generate a large impact on treatment referrals.

One reason why the SACM group was somewhat more likely to be referred to treatment is that UBA staff were more likely than their counterparts in the Substance Abuse Service

Center to assess individuals as being in need of substance abuse treatment. It is not possible to determine whether this was due to the more clinically focused nature of UBA's assessment (that is, UBA's assessment did a "better job" of uncovering substance abuse issues), or to the Substance Abuse Service Center's narrower focus on substance abuse that functionally limited employment, or to some other factor. Regardless, the higher levels of treatment enrollment for the SACM group could be attributed to the increase in those being found to need treatment and/or to the more intensive follow-up services that UBA clients received once they were assigned to a care manager, which facilitated their enrollment into substance abuse treatment. In any case, the impact on treatment enrollment was somewhat larger (almost 7 percentage points) when the analysis was restricted to those who completed an assessment.

- **SACM led to a small increase in the proportion of the sample who were referred to an employment program.**

About 44 percent of the SACM group and 40 percent of the usual care group were referred to HRA employment programs. There are a number of possible reasons for this result, though no evidence is available to provide definitive explanations. The increase could be due to differing initial assessment results across the two groups. Another possibility is that SACM was better at transitioning exempt participants through substance abuse treatment programs and into welfare-to-work activities.

Key Findings on Economic Impacts

- **SACM had no effect on UI-covered employment during the 1.5-year follow-up period. Overall employment levels were relatively low, compared with a typical welfare population.**

As shown in Table ES.1, SACM had no statistically significant effect on employment in Quarters 2 through 7 relative to the Substance Abuse Service Center.[5] For example, just over one-third of the SACM group worked in a UI-covered job at some point during the follow-up period, and the employment rate for the usual care group was similar. An analysis of results for the subgroup of those receiving TANF similarly revealed no statistically significant effects on employment, and there was also no significant impact on employment among those who completed an initial assessment. Earnings data — provided as group averages — were not tested for statistical significance. However, the difference between the two research groups in average UI-covered earnings was less than $200 over the six-quarter follow-up period.

[5]Differences between the two research groups that are marked with asterisks are termed "statistically significant," meaning that it is quite unlikely that they arose by chance and very likely are due to the program.

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Table ES.1

Impacts on Substance Abuse Treatment, HRA Employment Program Referrals, UI-Covered Employment, and Public Assistance for the Full Sample

New York City Substance Abuse Case Management

Outcome	SACM Group	Control Group (Usual Care)	Difference (Impact)	P-Value
Substance abuse treatment (%)				
Referred to substance abuse treatment	72.9	68.6	4.3 ***	0.000
Enrolled in substance abuse treatment	64.8	61.3	3.5 ***	0.001
Employment program (%)				
Referred to HRA employment programs	43.9	40.8	3.1 ***	0.003
Employment in Quarters 2-7 (%)				
Ever employed	37.6	36.3	1.3	0.180
Average quarterly employment rate	17.5	16.7	0.8	0.144
Employed 4 consecutive quarters	9.1	8.9	0.2	0.772
Income in Quarters 2-7 ($)				
Amount of cash assistance received	2,407	2,477	-70	0.281
Amount of food stamps received	1,631	1,652	-21	0.403
Total measured income[a,b]	6,809	6,706	103 [b]	NA
Sample size (total = 8,831)	4,670	4,161		

SOURCES: MDRC calculations from public assistance records from New York City, UI wage records from the State of New York, and action code data from the New York City Work, Accountability, and You (NYCWAY) system.

NOTES: This table includes only employment and earnings in jobs covered by the New York unemployment insurance (UI) program. It does not include employment outside New York or in jobs not covered by UI (for example, "off-the-books" jobs, some agricultural jobs, and federal government jobs).

Estimates were regression-adjusted using ordinary least squares, controlling for pre-random assignment characteristics of sample members.

Rounding may cause slight discrepancies in calculating sums and differences.

A two-tailed t-test was applied to differences between outcomse for the program and control groups. Statistical significance levels are indicated as: * = 10 percent; ** = 5 percent; and *** = 1 percent.

Dollar averages include zero values for sample members who were not employed or were not receiving TANF or food stamps.

The p-value indicates the likelihood that the difference between the program and control groups arose by chance.

NA = not applicable.

[a]This measure represents the sum of UI earnings, TANF, and food stamps.

[b]This difference is not tested for statistical significance because the UI earnings data were provided as group averages.

- **SACM had no effect on benefits receipt for the full sample, but it did lead to a reduction in receipt for the subgroup of TANF recipients.**

SACM had no consistent effects on benefits receipt for the full sample (Table ES.1). When focusing on the sample of mothers who were on TANF, however, it appears that SACM did lead to a statistically significant reduction in cash assistance receipt: 13 percentage points less in Quarter 7 (not shown).

Large percentages of sample members in both research groups left welfare during the study period — often because they were sanctioned for failing to comply with substance abuse treatment or other HRA requirements — and many cases closed and opened several times. This pattern of caseload "churning" often interrupted UBA's follow-up with clients because SACM services were generally provided only to individuals who had an open welfare case.

Conclusion

The SACM program is an ambitious attempt by HRA to provide enhanced services to a particularly hard-to-serve population: substance abusers receiving public assistance. The majority of participants were not TANF clients but, rather, participants in the state's Safety Net program. The evaluation was designed to measure the impacts of SACM above and beyond the effects produced by a usual care program that also assessed clients, referred them for mandatory substance abuse treatment when appropriate, and provided some level of follow-up. The study found that SACM clients had higher rates of enrollment in substance abuse treatment than the usual care clients. However, owing to data limitations, it was not possible to determine whether SACM affected rates of retention in substance abuse treatment or abstinence rates.

The SACM program had no effect on employment or benefits receipt for the full sample through the first one and one-half years of follow-up, although there was a reduction in cash assistance receipt for the subgroup of TANF recipients. As noted earlier, HRA sought to increase SACM's focus on employment, so these results might be different if the study were conducted today.

MDRC will continue to track the SACM and usual care groups and will present longer-term impacts in the future. This may be important, given that it can take a significant amount of time for individuals to make progress in substance abuse treatment. However, the interim results highlight some of the challenges that may confront efforts to implement intensive case management services for substance abusers in the context of the welfare system. For example, programs that can serve clients only while they receive welfare benefits may struggle to sustain engagement when clients move on and off welfare, sometimes as a result of sanctions for noncompliance with program requirements.

Introduction

This report presents interim results from a rigorous evaluation of New York City's Substance Abuse Case Management (SACM) program, a large-scale initiative targeting welfare recipients who are substance abusers.[1] The program is administered by several nonprofit organizations working under contract to the City of New York. This evaluation focuses on the SACM program in the Bronx (one of the city's five boroughs), which has operated since 2001 and has served more than 10,000 people through September 2008.

The SACM evaluation is part of the national Employment Retention and Advancement (ERA) project. Conceived and funded by the Administration for Children and Families (ACF) in the U.S. Department of Health and Human Services (HHS), the ERA project is testing innovative program models across the country that aim to promote steady work and career advancement for current and former welfare recipients and other low-wage workers. MDRC — a nonprofit, nonpartisan research organization — is conducting the ERA project under contract to ACF and is producing a similar interim report for each site in the project. For the SACM study, MDRC is working closely with the National Center on Addiction and Substance Abuse (CASA) at Columbia University.

This Introduction provides background on the national ERA project and on New York City's substance abuse case management initiative. It also describes the research design for the evaluation and the characteristics of the study participants.

Overview of the National ERA Project

In the wake of the 1990s welfare reforms, which made long-term welfare receipt much less feasible for families, policymakers and program operators have struggled to learn what kinds of services and supports are best able to help long-term recipients find and keep jobs and to help former recipients stay employed and increase their earnings. The Employment Retention and Advancement (ERA) initiative was developed to increase knowledge on effective strategies to help both of these groups move toward self-sufficiency.

The project began in 1998, when the U.S. Department of Health and Human Services (HHS) issued planning grants to 13 states to develop new programs. The following year, HHS

[1]The New York City Human Resources Administration (HRA) referred to the program as the Comprehensive Service Model. The name "Substance Abuse Case Management" is used in this report because it more clearly describes the intervention.

selected MDRC to conduct an evaluation of the ERA experiments.[2] From 2000 to 2003, MDRC and its subcontractor, The Lewin Group, worked closely with the states that had received planning grants, and with several other states, to mount tests of the ERA program models.

Ultimately, a total of 16 ERA models (also called "tests") were implemented in eight states, including New York. Almost all the models target current or former recipients of Temporary Assistance for Needy Families (TANF) — the cash welfare program that mainly serves single mothers and their children — but the models are very diverse. One group targets low-wage workers and focuses on advancement. Another group (which includes SACM) targets individuals who are considered "hard to employ" and primarily aims to move them onto a path toward steady employment. Finally, a third group of models has mixed goals and targets a range of populations, including former TANF recipients, TANF applicants, and low-wage workers in particular firms. Some of these program models initiate services before individuals go to work, while others begin services after employment. Appendix Table A.1 describes each ERA model and identifies its goals and target populations.

The Substance Abuse Case Management (SACM) Program

Rules requiring welfare recipients to work or prepare for work have existed for at least 30 years, but most states did not begin enforcing these requirements until the 1980s. Even then, a large proportion of welfare recipients were exempt from work-related requirements, either because they had young children or because they had health problems that limited their ability to work.

In the 1990s, many states expanded work requirements to a much broader share of the welfare caseload. The federal Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996 accelerated this process by requiring states to ensure that a specific proportion of all recipients were working or preparing for work and by limiting most families to 60 months of federally funded assistance. Changes to the TANF program that were passed by Congress in January 2006 are putting additional pressure on states to deliver employment services to hard-to-employ recipients.[3]

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[2]The U.S. Department of Labor has also provided funding to support the ERA project.

[3]Under the 1996 law, states are required to ensure that specific percentages of TANF recipients are participating in work activities. However, the required "work participation rates" facing states were reduced by one percentage point for each percentage point reduction in a state's TANF caseload. Because caseloads fell dramatically, most states faced very low required rates. The 2006 TANF changes restructured the "caseload reduction credit" so that most states need to significantly increase participation in work activities in a short period or risk fiscal penalties.

As states began to work with a larger share of the TANF caseload, and as caseloads declined dramatically, many states began to focus more attention on the substantial barriers to employment facing those recipients who remained on the welfare rolls. Some states began to develop new employment-oriented programs for recipients who had mental health problems or physical disabilities or who abused drugs and alcohol or had other serious behavioral or health problems. Evaluations of broadly targeted welfare-to-work programs in the 1990s found that such programs were able to increase employment for long-term recipients who had low levels of education and work experience but that outcomes for these recipients were much worse than for recipients who had fewer employment barriers.[4] Little is known about the effectiveness of the newer, more targeted approaches.

New York State and New York City seek to ensure that all welfare recipients who can work are engaged in work activities.[5] State and city policies assume that a very large proportion of the adults receiving welfare — whether through TANF or through the state- and locally funded Safety Net program that primarily serves childless adults — should either participate in work-related activities, take specific steps to stabilize a medical problem, or apply for federal disability benefits.[6] As part of this effort, beginning in the late 1990s, the city's welfare agency, the Human Resources Administration (HRA), developed a set of tailored programs for populations facing particularly serious barriers to employment. One of these initiatives, the Substance Abuse Case Management program, was directed to recipients whose employability is limited by drug or alcohol abuse.[7]

There is evidence that substance abuse is associated with worse employment outcomes,[8] but estimates of the percentage of welfare recipients who have substance abuse problems vary substantially.[9] Studies have found that substance abuse treatment can be effective but that many people do not stay in treatment long enough to benefit; this is especially true for low-income populations who face many barriers to remaining in treatment.[10]

Sustaining participation is a consistent problem in many areas of behavioral health treatment, and several kinds of initiatives have been developed to help people enter and remain

[4]Michalopoulos and Schwartz (2000).

[5]For general information on New York City's welfare reform efforts, see Savas (2005).

[6]Some categories of adult recipients are considered permanently "unengageable" — for example, those who test positive for Human Immunodeficiency Virus (HIV) and are symptomatic. Other categories, such as recipients who are caring for a child under 3 months old, are considered temporarily unengageable.

[7]Another of the special initiatives, the Personal Roads to Individual Development and Employment (PRIDE) program — which targeted recipients who had work-limiting medical conditions — is also being evaluated as part of the ERA project. See Bloom, Miller, and Azurdia (2007).

[8]Chandler et al. (2004).

[9]Jayakody, Danziger, Seefeldt, and Pollack (2004).

[10]McLellan, Lewis, O'Brien, and Kleber (2000).

in treatment. Most relevant to SACM is the New Jersey Substance Abuse Research Demonstration (SARD), which tested an intensive case management model for substance-abusing women on TANF. In the model tested in SARD, case managers met with women who had been identified as needing treatment in order to identify and address initial barriers, such as child care or transportation problems. Case managers used motivational counseling strategies to try to persuade women to enter treatment, and then they worked with the women and their treatment providers to try to keep participants in treatment over time. Case managers' efforts included home visits, contacting family members, and coordinating other needed services with treatment. The goal was to move participants into welfare-to-work activities.

A random assignment evaluation that compared SARD's Intensive Case Management program with a more limited Care Coordination approach found that case management generated large increases in participation and retention in substance abuse treatment, as well as increases in abstinence rates.[11] Impacts on longer-term employment and public assistance outcomes are less certain.

In New York, HRA contracted with three organizations — one in the Bronx, one in Brooklyn, and one in Manhattan — to deliver case management services to recipients needing substance abuse treatment. As discussed further below, these services differ in some ways from the SARD program. In addition, in New York City, most of the individuals who have been referred for substance abuse services have been childless adults receiving Safety Net benefits rather than single mothers receiving TANF.

This evaluation focuses only on the SACM program in the Bronx, which is operated by University Behavioral Associates (UBA), a nonprofit behavioral health management services organization.[12] The goal of the UBA program is to "assist public assistance clients in their path to abstinence, self-sufficiency, and employment."[13] In brief, UBA's program assesses recipients to determine whether they need substance abuse treatment and, if so, what type and level of treatment and any other assistance they need; refers them to appropriate treatment and other service providers; works with the treatment provider to monitor progress in treatment over time; assists clients in remaining in treatment; and connects clients with welfare-to-work and other activities as appropriate. Participation in substance abuse treatment is mandatory for those assessed to need it, though clients are not required to participate in UBA's case management services.

[11]Morgenstern et al. (2006).

[12]UBA was founded in 1995 by the Department of Psychiatry and Behavioral Sciences at Albert Einstein College of Medicine/Montefiore Medical Center.

[13]University Behavioral Associates program description.

The New York City Context

The two key cash assistance programs in New York are the Family Assistance program (New York's TANF program) and the state- and locally funded Safety Net program. The SACM program serves recipients from both programs, though, as noted above, most participants are Safety Net recipients. Previously called Home Relief, the Safety Net program serves childless adults and, since 2001, Family Assistance recipients who have reached the 60-month time limit on federally funded benefit receipt. Unlike many other states, New York State does not impose time limits on cash assistance receipt for families but, rather, moves cases to the Safety Net program after the 60-month point. In addition, New York does not use full-family sanctions (sanctions that cancel a family's entire welfare grant) to enforce work requirements in its TANF program; rather, recipients' grants are reduced in response to noncompliance with work requirements. Safety Net recipients without children, in contrast, can have their entire case closed in response to noncompliance with work requirements.

The New York City Family Assistance caseload has fallen dramatically in the past decade, from about 270,000 cases in 1997 to 102,000 cases in late 2007 — the latter number including cases that had moved to the Safety Net program after 60 months of benefit receipt. The traditional Safety Net caseload (consisting of childless adults) has also fallen by nearly half since 1997, although it has increased somewhat in recent years. It has gone from 150,000 in 1997 to 77,000 in 2002 to 81,000 in 2007.[14]

Although the unemployment rate in New York City was dropping during the period from 2004 to 2006, it remained slightly above the national average.

About the Evaluation

Research Questions

The ERA evaluation focuses on the implementation of the sites' models and their effects, or impacts. Key questions addressed in this report include the following:

- **Implementation.** How did HRA and UBA execute the SACM program? What services and messages did the program provide and emphasize?
- **Participation.** Did the SACM program succeed in engaging a substantial proportion of individuals in substance abuse treatment and work activities? What types of services did people receive?

[14]New York City Human Resources Administration.

- **Impacts.** Within the follow-up period, did the SACM program — compared with the usual rules and services for this population — increase employment and employment stability and reduce reliance on cash assistance?

The Research Design

The SACM evaluation compares clients who were referred to UBA's program with similar clients who received "usual care" — that is, the less intensive services that HRA provides when there is no room available at UBA. For simplicity, the two research groups are termed the "SACM group" (those who were referred to UBA for substance abuse case management) and the "usual care group," or the "control group."

As shown in Figure 1, the research design takes advantage of the automated system that HRA uses to schedule clients for substance abuse assessments. Staff in HRA welfare offices (known as Job Centers) administer a fairly simple substance abuse screening questionnaire to TANF and Safety Net applicants and recipients, and those who are identified as potentially having a substance abuse problem are required to undergo further assessment.[15] For recipients residing in the Bronx, assessments are conducted either by UBA or, when UBA has no appointment slots available, by HRA's Substance Abuse Service Center, located in Manhattan.

UBA seeks to maintain a constant caseload of 1,000 clients in the SACM program, so when clients exit the program, slots become available for new participants.[16] When this occurs, UBA notifies HRA, which opens the specified number of appointment slots in its automated scheduling system the next morning. When HRA staff in Bronx Job Centers access the scheduling system, clients who need a substance abuse assessment are automatically scheduled for appointments at UBA until its available slots are full. Any recipients who come in after that point (until the next batch of UBA slots open) are scheduled for appointments at the Substance Abuse Service Center, where they are assessed and then receive the more limited services described below (that is, usual care).

After carefully assessing the scheduling system, MDRC and CASA concluded that the assignment of Bronx clients to SACM (UBA) or usual care (the Substance Abuse Service Center) was essentially random and that recipients assigned to the two programs would likely be comparable in terms of measurable and unmeasurable characteristics. Thus, if the study tracked recipients assigned to the two programs and compared their outcomes over time, any

[15]The screening tool was a modified version of the CAGE, a widely used instrument. Caseworkers asked applicants and recipients a series of questions about alcohol and drug use, and those who answered "yes" to at least a specified number of the questions were referred for assessment. In addition, caseworkers looked for certain visual signs of substance abuse and could refer a client for assessment if those signs were present.

[16]The UBA caseload was decreased from 1,000 to 700 clients in 2006 owing to budget cuts.

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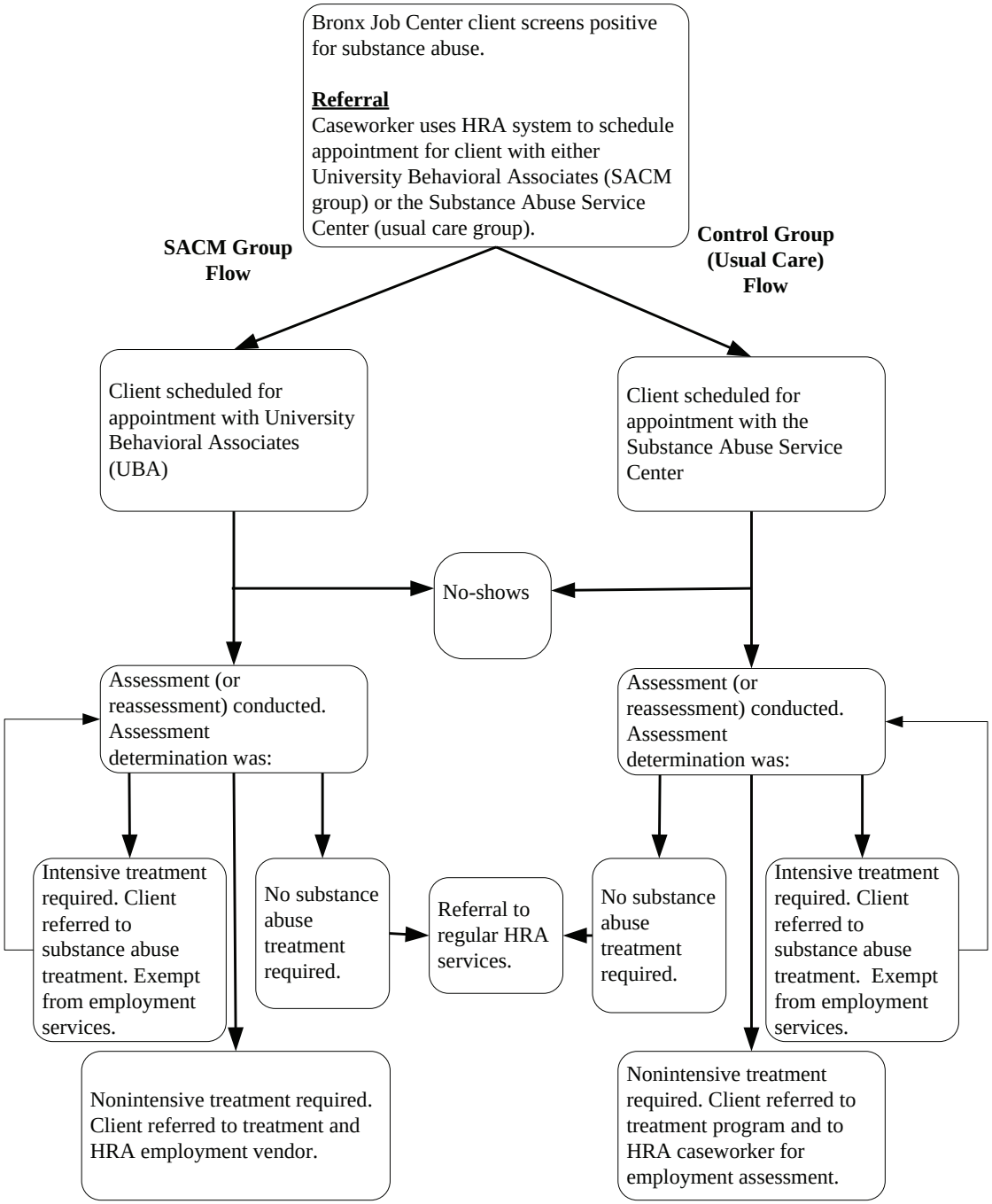
Figure 1

Program Flow for Bronx Clients

New York City Substance Abuse Case Management



significant differences that emerged (for example, in substance abuse treatment participation or employment) could plausibly be attributed to the SACM program rather than to differences in the characteristics of clients assigned to the two programs. (As discussed in detail below, some people in the SACM and usual care groups never actually received services from their assigned program.)

Randomness was facilitated by the fact that workers in several Bronx welfare offices were using the system simultaneously, and so staff had no way of knowing when the SACM slots would be filled. Yet there were two main causes for concern — both related to the fact that new SACM appointment slots always became available to caseworkers first thing in the morning. First, once an HRA worker saw that a client had been referred to usual care, the worker knew that any clients who were subsequently referred for assessment that day would also be referred to usual care. Thus, in theory, if the worker knew that a particular client would be referred to usual care and wanted that client to be referred to SACM instead, the worker could ask the client to return the next morning, in the hope that new SACM slots would be open at that point. However, interviews with supervisors and staff suggested that this possibility was extremely remote.

The second and potentially more salient issue is that clients who entered the Job Center in the morning were probably more likely to be referred to SACM than to usual care, since new SACM slots always became available in the morning. If there are systematic differences between clients who enter the office in the morning and those who enter in the afternoon, the groups might not be completely similar. This issue is discussed further below.

The Counterfactual: What Is SACM Being Compared With?

The evaluation compares the SACM program at UBA with usual care — the services that a client would receive after being referred to the Substance Abuse Service Center. As shown in Figure 1, clients in both groups are assessed and, when appropriate, are referred to substance abuse treatment and employment services. As discussed in detail in the report's next section, "The Implementation of SACM," the key differences are that SACM clients receive a much more extensive, clinically focused assessment at UBA and that UBA staff have relatively small caseloads and provide active case management, interfacing directly with treatment providers (and other organizations) to try to promote both retention and high-quality treatment. The assessment at the Substance Abuse Service Center is more narrowly focused on employ-ability, and the follow-up after the referral to treatment is much more limited; HRA staff monitor compliance with treatment mandates in order to assess their clients' ongoing eligibility for benefits. In addition, UBA's SACM program operates under performance-based contracts that may shape program and staff priorities. Despite these important differences, it is important to emphasize that the study is measuring the impact of SACM over and above a set of existing

services that may, in themselves, improve access to treatment and generate other positive outcomes.

The Target Population and Research Samples

The evaluation's main impact analysis compares the 8,831 public assistance applicants and recipients who were referred to SACM (4,670) or to usual care (4,161) between June 2003 and June 2005. Table 1 shows selected demographic characteristics of these clients at baseline (the time of random assignment), drawn from New York State's welfare database.

A large majority of sample members are males who were not living with children and were receiving (or applying for) Safety Net assistance. The sample of mothers on TANF is quite small. This may reflect underlying differences in substance abuse patterns between the TANF and Safety Net populations, though there is anecdotal evidence that some mothers are reluctant to report substance use because they are concerned about triggering a child welfare investigation.[17] Table 1 also shows that the sample members were relatively old at baseline, compared with those in most welfare-to-work studies; that most people had no recent work history; and that more than half had been noncompliant with HRA work or treatment requirements in the prior year.

Appendix Table A.2 shows that there are several statistically significant differences between the baseline characteristics of the SACM group and usual care group.[18] For example, the SACM group has a slightly higher proportion of males and was somewhat less likely to have received cash assistance in the prior year. None of the differences is large in numerical terms, but differences are a cause for some concern. As discussed above, some differences may relate to the fact that individuals who entered the welfare office in the morning were more likely to be referred to SACM. The impact analysis controls for the differences in baseline characteristics, but the presence of the differences suggests that the results should be viewed with caution; as noted above, individuals were not assigned to the two groups through an entirely random process.

Despite the differences in some baseline characteristics, analysis of data for the full sample probably provides a reasonably valid estimate of the impact of the SACM program as compared with usual care (subject to the cautionary notes mentioned above). However, the

[17] Officially, the child welfare agency should become involved only if substance abuse leads to child abuse or neglect.

[18] As explained below in the section "Impacts on Participation in Substance Abuse Treatment and Employment Programs" (see Box 2 on page 39), differences between the two research groups that are marked with asterisks in the tables are termed "statistically significant," meaning that it is quite unlikely that they arose by chance and very likely are due to the program.

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Table 1

Selected Characteristics of Sample Members at Baseline

New York City Substance Abuse Case Management

Characteristic	Total
Gender (%)	
Male	70.2
Female	29.8
Race/ethnicity (%)	
Hispanic	45.2
Black	43.5
Other	11.3
Age (%)	
30 or younger	20.2
31 to 40	36.4
41 or older	43.3
Average age (years)	38
No children under case (%)	97.4
Housing status (%)	
Renting, not public/subsidized	56.0
Homeless/emergency/temporary housing	28.0
Treatment center	4.2
Other[a]	11.8
English is the primary language (%)	90.6
Case type (%)	
Safety Net	94.3
TANF	5.3
Employed during prior quarter (%)	17.2
Employed during prior year (%)	32.3
Received cash assistance during prior year (%)	49.5
Received food stamps during prior year (%)	62.0
Completed assessment at UBA or Substance Abuse Service Center in prior year (%)	18.7
Referred to substance abuse treatment in prior year (%)	6.0
Enrolled in substance abuse treatment in prior year[b] (%)	17.8
Not compliant with HRA programs in prior year[c] (%)	54.7
In substance abuse treatment at random assignment (%)	6.3
Sample size	8,831

(continued)

Table 1 (continued)

SOURCES: MDRC calculations from public assistance records from New York City and UI wage records from the State of New York. Baseline data from the New York City Work, Accountability, and You (NYCWAY) system and the Welfare Managment System.

NOTES: Results in this table are weighted by month of study entry.

This table includes only employment in jobs covered by the New York unemployment insurance (UI) program. It does not include employment outside New York or in jobs not covered by UI (for example, "off-the-books" jobs, some agricultural jobs, and federal government jobs).

[a]"Other" category includes renting public or subsidized housing, own home or apartment, and unknown.

[b]Some sample members enrolled in a treatment program without a referral from HRA. This measure includes any treatment program listed in the NYCWAY system.

[c]"Not compliant" category includes FTC (failure to comply with program requirements), FTR (failure to report to mandatory appointment), NOI (notice of intent to close public assistance), and sanctions.

effects may be seriously "diluted" by the presence of many sample members who received little or no services from either program. For example, some people were applying for welfare when they were referred to the programs and never actually started receiving benefits (both the SACM and the usual care program were targeted to people receiving public assistance), while others were assessed by one of the two programs and were found not to need substance abuse treatment. In addition, some people who were assigned to the SACM group were later referred to the Substance Abuse Service Center.[19]

To address this issue, a limited set of analyses (presented in Appendix Table C.4) focuses on the 6,211 sample members who *showed up* at their assigned assessment site (UBA or the Substance Abuse Service Center) within three months after referral. (Table 2 presents the subsamples of the full research sample.) While analyses based on this "show-up sample" have the benefit of excluding more than 2,500 sample members who did not receive the services being compared (thus targeting the analysis more directly to those who received services), the impacts measured for the show-up sample are less reliable than those measured for the full sample because the decision to show up is not random. Compared with sample members who did not show up, for example, those who showed up were, on average, older and more likely to have been referred to treatment in the prior year (not shown). In addition, although small, there

[19]About 5 percent of those in the SACM group completed an assessment at the Substance Abuse Service Center only during the follow-up period. These "crossovers" have the effect of weakening the treatment difference between the two groups and suggest that the results of the study may be a conservative estimate of SACM's impacts. Crossovers in the reverse direction (individuals who were initially referred to usual care but then participated in SACM) would have been much more damaging to the design, but they were very rare, in large part because HRA agreed to program its management information system (MIS) to prevent this from happening.

The Employment Retention and Advancement Project

Table 2

Subsamples of the SACM Research Sample

New York City Substance Abuse Case Management

	SACM Group	Control Group (Usual Care)	Total
Full sample	4,670	4,161	8,831
Showed up at appropriate program within 3 months (show-up sample)[a]	3,186	3,025	6,211
Completed CASA screening form (screened sample)[b]	841	582	1,423
Signed consent form allowing access to STARS data[c]	722	475	1,197
Completed CASA follow-up interviews[d]	236	166	402

SOURCES: Administrative data from the New York City Work, Accountability, and You (NYCWAY) system and survey data from the National Center on Addiction and Substance Abuse (CASA) at Columbia University.

NOTES:

[a]The show-up sample refers to sample members who showed up at either UBA or the Substance Abuse Service Center within three months after study entry.

[b]National Center on Addiction and Substance Abuse (CASA) at Columbia University, New York.

[c]Substance Abuse Tracking and Reporting System (STARS) is a database maintained by HRA that tracks clients' progress in treatment.

[d]A total of 421 people completed at least one of the CASA follow-up interviews. However, 19 of these individuals are not part of the full sample.

is a difference between the two research groups in the percentage of sample members who showed up at their assigned program within three months: 68 percent of the SACM group, compared with 73 percent of the usual care group.[20] Thus, the main analysis in this report focuses on the full sample.

As part of a companion study, CASA conducted a series of in-depth follow-up interviews with a small fraction of the people in the SACM and usual care groups. As a first step in identifying individuals for the follow-up interviews, CASA staff completed a screening form with some of the clients who showed up at either UBA or the Substance Abuse Service Center. The screening form provides much more detailed information about these sample members than was available from the welfare database.[21] Although the 1,423 individuals who completed the CASA screening form (Table 2) are not necessarily representative of the full sample, the

[20]The section below entitled "Impacts on Participation in Substance Abuse Treatment and Employment Programs" indicates that 82 percent of the SACM group and 85 percent of the usual care group ever completed an assessment within 1.5 years after study entry. (Among the SACM group, 77 percent completed assessment at UBA, and about 5 percent completed assessment at the Substance Abuse Service Center.)

[21]Individuals who completed the CASA screening form also signed a consent form that, among other things, allowed the research team to access data about their participation in substance abuse treatment from the Substance Abuse Tracking and Reporting System (STARS).

information is quite useful. For example, the screening data show that a substantial proportion of those who showed up at the two programs reported multiple barriers to employment (such as legal issues, health problems, and unstable housing) and were involved with numerous public systems (criminal justice, child welfare, and so on); however, many also reported that they were already receiving substance abuse treatment and had no recent substance use.[22]

A subset of those who completed the screening form (n = 402) participated in the CASA in-depth interviews. In selecting subjects for the interviews, CASA sought to target those who were most likely to participate in and benefit from the case management services (that is, those whose substance use was problematic but who did not have severe mental illness). Thus, CASA's follow-up interviews target a particular subgroup that is not intended to represent the full sample. Moreover, through in-person interviews and drug testing, CASA collected data on such outcomes as substance use that are not available for the full sample. Thus, while the two analyses are complementary, the results from CASA's in-depth interviews — which are not publicly available as of this writing — cannot be compared directly with the results presented in this report, most of which rely on administrative data and focus on the full sample of nearly 9,000 people.

Data Sources

The following data sources are used in this analysis:

- **Baseline Data.** As noted above, clients' demographic characteristics — such as gender, race/ethnicity, age, primary language — were collected from New York's Welfare Management System (WMS) database at the time that the sample members entered the study. Additional background information is available for those who showed up at one of the programs and completed the CASA screening form.

- **Program Participation and Field Research Data.** Information on program operations is available from interviews with staff at UBA and the Substance Abuse Service Center and from reviews of participants' case files conducted during several site visits. In addition, data on sample members' participation in employment activities and substance abuse treatment are available from New York City Work Accountability and You (NYCWAY), an "action code" database maintained by HRA that tracks all events for a given case. Although NYCWAY data are quite useful, they provide information only on activities and events that occur while sample members have an active public

[22]Morgenstern et al. (2008).

assistance case. As discussed further in the section on participation impacts, this limitation hinders the study's ability to measure key outcomes, such as retention in substance abuse treatment, because many sample members left welfare during the study period and because people can continue treatment after leaving assistance. One and one-half years of follow-up data are available for all sample members.

- **Substance Abuse Tracking and Reporting System (STARS).** This database maintained by HRA tracks clients' progress in treatment. It includes information on compliance with substance abuse treatment, facility admissions and discharges, substance tests, and other measures. As shown in Table 2, these data are available for individuals who completed the CASA screening form and signed a consent form (n = 1,197). STARS data are used in a limited way in the analysis, however, because (1) they cover only the period during which sample members received public assistance and (2) the SACM and usual care clients for whom STARS data are available may not be comparable.

- **Employment and Public Assistance Data.** Employment and public assistance impacts are estimated using automated state unemployment insurance (UI) wage files and city TANF and food stamp eligibility and payment records. Data on average earnings are shown for descriptive purposes but are not used to estimate program effects.[23] One and one-half years of follow-up data are available for all sample members. For an early cohort, two years of follow-up data are available.

Roadmap of the Report

This report focuses on program implementation, participation, and impacts. The next section, "The Implementation of SACM," further describes the two research groups and the implementation of services for each. Then "Impacts on Participation in Substance Abuse Treatment and Employment Programs" presents impacts on these key short-term outcomes using data from NYCWAY. The report's concluding section, "Impacts on Employment and Benefit Receipt," presents employment and public assistance outcomes for the first year and a half after study entry.

[23]Earnings data were supplied by the state as averages for groups of sample members, rather than for individuals.

The Implementation of SACM

The New York City Substance Abuse Case Management (SACM) program model is one of the innovative approaches being evaluated as part of the national Employment Retention and Advancement (ERA) project. SACM was an ambitious attempt by the New York City Human Resources Administration (HRA) to ensure that clients with special needs — in this case, substance abuse — were receiving appropriate treatment and making progress toward self-sufficiency. Rather than providing direct services, the SACM vendors coordinated and facilitated care provided by treatment providers, employment vendors, and other service delivery systems, such as physical and mental health and legal systems.

The SACM model was fairly complicated. As described below, staff from the Bronx SACM vendor — University Behavioral Associates (UBA) — were responsible for determining the type and level of substance abuse treatment required, assessing whether clients were ready to participate in employment-related activities, making referrals to the range of services required by clients, following up those referrals, and monitoring clients' progress toward recovery and employment. UBA assessments (and reassessments) were mandatory; clients who did not show up for these appointments could be sanctioned (that is, they could have their welfare benefits reduced) or have their case closed. Attending the substance abuse treatment program to which they were referred and participating in assigned employment activities if required were also mandatory. However, meeting with UBA staff was not mandatory.

The major steps in the flow through standard HRA services (the "usual care" group) were similar to the SACM intervention, though the intensity of the assessment and the nature of ongoing interactions with program staff differed considerably. Compared with the SACM assessment, the usual care assessment — which was conducted by contracted vendors housed in an HRA building — was less comprehensive across multiple domains and was less clinically focused. Clients who were found to need intensive substance abuse treatment would receive little ongoing case management from HRA.[24] Once it was determined that a usual care client could participate in employment services while participating in substance abuse treatment, the case was transferred to an HRA caseworker who addressed ongoing eligibility-related issues; issues affecting employment were handled by the employment services vendor. SACM clients, on the other hand, received care management services from UBA until their HRA case was closed or through 90 days of employment. Table 3 summarizes the key differences between the services for the two groups.

[24]Clients were assigned to an HRA worker who handled welfare eligibility issues. In addition, their substance abuse treatment provider would likely provide some case management services.

The Employment Retention and Advancement Project

Table 3

Comparison of UBA Comprehensive Case Management and Usual Care

New York City Substance Abuse Case Management

	University Behavioral Associates (UBA): Substance Abuse Case Management (SACM)	Substance Abuse Service Center: Usual Care
Assessment	Clinically focused 2- or 3-hour intensive assessment to determine presence and severity of substance abuse and presence of any other barriers; includes standardized clinical assessment tools.	Employment-focused 45-minute assessment conducted by vendor to determine presence and severity of substance abuse and presence of apparently disabling physical/mental health issues.
Referrals	UBA makes appropriate treatment referral, addresses other barriers using in-house staff or by making appropriate referrals.	Vendor makes appropriate treatment referral; recommends that client's HRA caseworker make a referral to the health care system contracted by HRA if vendor believes mental/physical health issue is severe enough.
Case Management: Exempt Clients	Staff carry small caseloads (approximately 35-47) and monitor clients' progress on a regular basis; intensive case management services, including field visits (for example, to treatment provider's facility) to ensure client is attending treatment program and to identify and address emerging barriers.	Vendor gives clients exempted from work requirements a return appointment to reevaluate employability status. Vendor staff do not carry caseloads, so a client may see different staff when reassessments are conducted.
Case Management: Nonexempt Clients	Same as above, plus work with clients to develop an employment plan and to monitor their progress.	Case is assigned to HRA caseworker for eligibility-related case management, full employability assessment, and development of employment plan. Vendor will see clients only for occasional reassessments requested by HRA worker. Once a client is referred to employment program, HRA worker does little case management for that client, primarily focusing on eligibility issues. Caseload sizes ranged from 99 to 155, with a cap of 165 cases per worker.
Staff	Assessment/evaluation staff are clinically oriented, including clinical social workers and psychiatrists.	Vendor staff are Credentialed Alcoholism and Substance Abuse Counselors (CASACs); a minimum of a high school diploma/GED is required as well as the completion of New York State's Office of Alcoholism and Substance Abuse Services credentialing requirements. HRA staff are standard eligibility workers; staff receive some training in working with substance abusing populations: a 1-day general course in substance abuse and a 2-day course in working with substance abuse issues; periodic case conference meetings with a vocational rehabilitation specialist.

SACM was a significant investment for HRA. The initial contract awarded UBA was $16 million over three years.[25] It required UBA to carry an active caseload of 1,000 clients, but this was reduced to 700 clients on January 1, 2006, due to HRA budget cuts.

The SACM Framework: Structure, Management, and Staffing

Organizational Structure

SACM services were provided by contracted vendors funded by HRA. In the Bronx, the vendor was UBA, a not-for-profit behavioral health management services organization that is a subsidiary of the Albert Einstein College of Medicine/Montefiore Medical Center. UBA was founded in 1995 by Montefiore's Department of Psychiatry and Behavioral Sciences.

The UBA SACM model did not directly offer substance abuse treatment or employment services to SACM participants; rather, its staff facilitated the coordination of the delivery of these and other services and helped ensure that participants made progress toward their recovery and self-sufficiency goals. As such, the SACM model also relied on other categories of service providers. First, substance abuse treatment was supplied by agencies located throughout the Bronx. Substance abuse treatment providers were licensed by the New York State Office of Alcoholism and Substance Abuse Services (OASAS), and treatment was funded by public assistance insurance (Medicaid) alone or in conjunction with OASAS local assistance funds.[26] HRA was able to have treatment providers comply with its reporting standards because the providers wanted referrals from HRA (which had letters of agreement with the providers). Second, employment preparation services were supplied by other vendors through HRA contracts once a client was determined to be nonexempt from employment services. (About four months before the end of the follow-up period for the SACM evaluation, HRA replaced the program that supplied employment services with the Back to Work Program).[27] Lastly, health, mental health, legal, and other services were supplied by an array of providers in the community. During the follow-up period, HRA made two changes that affected UBA clients.

Management and Staff

Within UBA, three units were responsible for providing services to SACM clients:

[25]The $16 million contract represents gross costs, rather than net costs. There are also costs associated with the usual care services.

[26]Residential treatment was funded with Congregate Care Level II cash assistance dollars and OASAS local assistance funds.

[27]In some cases, treatment programs or other providers offered employment preparation services to clients who were found to be temporarily exempt from work activities because of substance abuse.

- **The Evaluation Unit.** Staff within the evaluation unit were responsible for conducting initial assessments of new participants and making referrals to substance abuse treatment providers. After a participant enrolled in treatment, they also conducted subsequent reassessments to evaluate progress toward recovery and self-sufficiency. These staff were generally *Clinical Social Workers* (CSWs) or psychologists. The unit was overseen by an *Evaluator Supervisor.*

- **The Care Management Unit.** Once the initial assessment was completed, ongoing case management was provided by *Care Managers,* most of whom were CSWs and/or Credentialed Alcoholism Substance Abuse Counselors (CASACs). UBA had about 32 care managers, divided into four teams. Each care manager was responsible for working with a group of treatment providers; participants were assigned to care managers based on the substance abuse treatment provider to which they had been referred. *Care Manager Supervisors* were responsible for overseeing approximately eight care managers each. A primary responsibility for these supervisors was to review the New York City Work Accountability and You (NYCWAY) database — an "action code" database maintained by HRA to track all events for a given case, to ensure that all data entries related to clients' activities were up to date.

- **The Competitive Employment Rewards Unit.** This unit was created to incentivize employment retention, given the performance-based payments associated with this outcome in UBA's contract (discussed below). It also facilitated the collection of employment documentation that HRA required in order to verify retention and authorize the retention performance payment. Led by the *Competitive Employment Rewards Coordinator,* staff in this unit worked with clients who had obtained employment, and they tried to address any issues that might make it difficult for the clients to keep their jobs; this unit also provided rewards for remaining employed. To collect a reward, a client had to visit UBA and provide documentation, and so the incentive program gave UBA staff an opportunity to see how the client was doing.

All program services were overseen by the *Program Director,* a clinical psychologist. There was also a *Deputy Program Director,* whose responsibilities evolved over time. At the time that interviews were conducted for this report, the deputy director focused primarily on ensuring that UBA met HRA milestones and also tracked clients who had co-occurring and/or

unstable medical conditions that resulted in referral to HRA's WeCARE program (described in Box 1).[28] The deputy director also supervised the *Vocational Coordinator,* who was responsible for interfacing with employment vendors and providing in-house training on employment-related issues. UBA also employed a *Medical Director,* who trained staff to identify medical conditions based on the types of medications that clients were prescribed and who helped staff understand the federal disability application process. As a medical doctor with a specialty in psychiatry, the medical director was also able to assist with diagnosing health conditions and — for participants who were referred to WeCARE — could effectively communicate with WeCARE psychiatrists about clients' needs. Finally, for clients who were assessed to be unable to work, the medical director assisted with the process of applying for federal disability benefits.

UBA operated out of a main site and a satellite location in the Bronx. Clients were assigned for ongoing care management at whichever office was more convenient for them. However, all assessments (described below), were conducted at UBA's main location.

Funding

A portion of HRA's contract with UBA was performance based. Initially, 20 percent of the funding was tied to meeting performance milestones, and the remainder was cost based. As of July 2005, however, 40 percent of the contract became performance based. An important performance milestone was related to substance abuse treatment, with payments being tied to 30, 90, and 180 days of treatment retention. Employment placement and retention was also rewarded, with payments being tied to the same milestones. Other performance milestones included completion of a wellness program, four weeks of consecutive involvement in a work activity, and attainment of federal disability benefits.

SACM Services

Overview of Participant Flow

This section describes the flow of participants through the SACM intervention.

- **Assessment/Evaluation.** Clients who were referred to UBA began with an in-depth, clinically focused evaluation. The evaluators would determine whether substance abuse were a barrier to employment; if so, they would as-

[28] "WeCARE" is an acronym for the Wellness, Comprehensive Assessment, Rehabilitation, and Employment program. UBA tracked WeCARE clients because it received "credit" for those whom it referred to the program who achieved performance-based milestones for completion of wellness plans or for obtaining employment or approval for federal disability benefits while in WeCARE.

Box 1

HRA's WeCARE Initiative

In 2004, HRA created WeCARE (the Wellness, Comprehensive Assessment, Rehabilitation, and Employment program), a large and ambitious initiative. WeCARE serves welfare recipients who have work-limiting medical or mental health conditions. Under this program, a wide set of services and populations is brought under one roof by two main vendors, each serving specific boroughs of the city and each with a number of subcontractors. Recipients who report that they have a medical condition that prevents them from participating in regular work activities are referred directly to one of the vendors, which conducts a comprehensive "biopsychosocial assessment" that includes a medical exam. Unless the recipient is found to be fully employable, she or he remains with the vendor, which provides a range of services. The vendor develops a "wellness plan" for individuals who have untreated or unstable medical conditions, performs diagnostic vocational evaluations to assess functional limitations, provides tailored employment services and intensive case management, and — when appropriate — assists with the application process for Supplemental Security Income (SSI). Since the program began, the WeCARE vendors have assessed more than 100,000 individuals (Kauff, 2008).

sess the severity of the substance abuse and the most appropriate treatment modality and level of care and would make an appropriate mandatory referral, based on their best clinical judgment. They would also note the need for ancillary services, such as mental health or physical health services, and would make the needed referrals. Clients could also be referred for other services throughout their tenure with UBA.

- **Care Management.** Once the treatment referral was made, clients were assigned to a care manager based on the treatment provider to which they had been referred. Care managers were responsible for ensuring that the participants were making adequate progress toward achieving their treatment and self-sufficiency goals.

- **Substance Abuse Treatment.** To continue receiving cash assistance benefits, participants were required to attend the substance abuse treatment mandated by HRA.[29] Care managers interfaced with treatment providers to monitor clients' compliance with and progress in treatment.

[29]Safety Net participants could have their case closed due to noncompliance if they failed to attend substance abuse treatment sessions. Since New York State does not have a full-family sanction, Temporary (continued)

- **Employment Services.** Once participants were determined no longer to need intensive substance abuse treatment, they were considered nonexempt from work activities and were referred for mandatory employment services, provided by an HRA contracted vendor. If welfare applicants were determined to be nonexempt, they were referred to a specialized vendor that worked with applicants prior to their approval for cash assistance. As discussed further below, UBA management and staff felt that the program model evolved to become more employment focused. Therefore, it is possible that a proportion of the clients who were not referred to an employment vendor may have received some employment services from UBA, such as informal job preparation skill-building or information on potential job leads.

- **Retention Services.** Once a UBA client became employed and the HRA case was closed, UBA could continue to provide services for 90 days. Primary activities included ensuring that the client's Medicaid and food stamp benefits were in order and conducting regular outreach to determine whether the client was successfully engaging in employment and to identify and address any issues that could endanger employment retention.

The following sections describe each of these components in detail. The information presented was obtained primarily through semi-structured interviews with staff who were involved with each aspect of program services.

Assessment/Evaluation

Aside from the reception staff and a nurse who took a brief medical history and conducted a toxicology screening, the evaluation unit was the first exposure to program services that clients who were referred to UBA had with the agency. During the initial appointment, evaluators conducted a semi-structured clinical interview that covered a client's substance abuse, mental health history, and employment history. UBA's clinical assessment approach used such diagnostic batteries as the Structured Clinical Interview for DSM-IV-TR (SCID), a semi-structured diagnostic interview designed to help assessors make reliable DSM-IV psychiatric diagnoses; and the SF-12, a 12-item standardized questionnaire that assesses physical and mental health status.[30] The evaluators also used a "motivational interviewing" technique to determine the client's level of motivation to comply with treatment recommendations, and they

Assistance for Needy Families (TANF) participants who had children would be removed from the case, resulting in a lower monthly grant amount.

[30]The DSM-IV-TR is a text revision of the *Diagnostic and Statistical Manual of Mental Disorders* (4th ed.), which is published by the American Psychiatric Association and is often used to identify and classify mental health disorders.

used a "stages of change" model to try to overcome resistance to treatment. The evaluators also conducted a urine toxicology screening that was supervised by a registered nurse. At the conclusion of the interview, the evaluator would send the client back to the waiting room, at which time the staff would review the documentation and make a decision about the level and type of treatment. Generally, one of the following three determinations was made:

- *No treatment required.* The evaluators determined either that there was no substance abuse problem present or that the problem did not affect the client's employability. Such cases were referred back to HRA, and the clients were no longer UBA clients.[31] Approximately 11 percent of the assessed sample were determined by UBA not to require treatment.

- *Nonexempt from work activities.* The evaluators determined that substance abuse treatment was required, but the level of treatment allowed the client to participate in employment activities concurrent with treatment. Mandatory participation in substance abuse treatment was generally for fewer than 15 hours per week. These cases were also referred to as *nonintensive* in terms of treatment needs. About 29 percent of cases were initially assessed as being nonexempt.

- *Exempt from work activities.* In some cases, the presence of substance abuse was deemed to be severe enough to require the client to be exclusively engaged in treatment. These clients would not be referred to employment activities until they became nonexempt. Such cases were also referred to as *intensive* in terms of required treatment. About 60 percent of the assessed UBA sample were initially determined to be exempt from work requirements.

In some cases, the assessment determined that the presence of a co-occurring condition such as diabetes or uncontrolled high blood pressure warranted referral to another of HRA's programs for special populations. Examples include specialized services for those with HIV/AIDS or WeCARE for those whose employability was limited by physical and/or mental health conditions that required a more intensive medical evaluation. UBA continued to track clients who were referred to WeCARE.

In addition, if the evaluator believed that the client might be eligible for Supplemental Security Income (SSI) or Social Security Disability Income (SSDI), the client would be referred to the medical director for a more comprehensive evaluation. If the medical director believed that the client could qualify for federal disability benefits, UBA would assist with the applica-

[31]These individuals are included as SACM group members in the ERA impact analysis.

tion process. Since moving someone on to federal disability was considered a positive program outcome by HRA, UBA assisted with the application process for those clients who appeared to be eligible.

After making a determination about the appropriate type and level of treatment, the evaluator would immediately begin contacting substance abuse treatment providers to make an appointment for the client. Referrals were based on the intensity of treatment required, the treatment modality deemed most appropriate, proximity to the client's home or work site, and the availability of appointments. Examples of treatment modalities include residential treatment (clients are treated at a facility where they must reside); methadone maintenance (clients are provided medication to alleviate withdrawal symptoms); drug-free outpatient treatment (that is, no methadone); alcohol-only outpatient treatment; mentally ill chemical abuser (MICA) treatment (the client has a severe mental illness as well as a substance abuse issue); and so on.[32] UBA's treatment philosophy was not to rely solely on methadone maintenance programs. Clients requiring methadone maintenance were also referred to another treatment provider for group and individual drug counseling.[33] Several evaluators noted during field interviews that they would steer clients toward those treatment providers that had demonstrated success with clients in the past and that supported UBA's philosophy of moving clients toward employment.

Once the referral appointments were set, the evaluator would ask the client to return to the office, would review the referral/appointment and the HRA-mandated participation requirements that were detailed in the "treatment contract" (a document generated by UBA that outlined a proposed treatment plan), and would then contact the assigned care manager to speak with the client in person (if the care manger was on the premises) or by telephone.

UBA believed that the process described above ensured that a client was connected with a treatment provider as quickly as possible and that the process prevented clients from falling through the cracks.

After the handoff to the care manager took place, the evaluator would next see the clients who were referred for intensive treatment — those exempt from HRA work requirements — during a reevaluation of progress after about three months. The primary purpose of the reevaluation was to gauge the progress that the client had made in substance abuse treatment, to make changes in the treatment plan if appropriate, and to determine whether the client's status could be changed to nonexempt. Reevaluations of exempt clients generally took place every 90

[32]UBA continued to serve MICA clients once they were referred to a MICA treatment facility.

[33]Such clients were mandated by HRA to participate in outpatient treatment; compliance with methadone maintenance was not mandatory. This could lead to lower levels of compliance for these clients, since outpatient treatment is more demanding and time intensive than methadone maintenance alone.

days. Efforts were made to have the same evaluator see the same clients for subsequent reevaluations, but this was not always possible.

Although the evaluators did not carry active caseloads, they were quite busy. Most reported conducting two or three evaluations and/or reevaluations per day, with each session lasting from 30 minutes (typically, a reassessment) to several hours. Evaluators also prepared a treatment contract and a detailed summary of their assessment that became part of the clients' UBA file and, with appropriate consent, could be shared with treatment providers.

Most evaluators reported having minimal contact with a client's HRA worker. There was also little ongoing interaction with a client's care manager after an evaluation had been completed.

Care Management

UBA's program philosophy focused on "care management" rather than case management. While case management tends to take a client-focused approach with the direct provision of services, care management, as defined by UBA, focuses on regular contact with the providers to optimize clients' service receipt. Care managers reported some apprehension about this distinction. Many were trained clinicians and found it challenging to adopt UBA's program philosophy in lieu of providing extensive direct counseling or case management services to clients.

As discussed above, each care manager was responsible for overseeing the services of UBA clients who were referred to a particular treatment provider or providers.[34] This ensured that the care manager was able to become familiar with the client's treatment program staff. Care managers also collaborated on an ongoing basis with a client's other service providers — medical, psychiatric, legal, and so forth.

During their initial meetings with clients, care managers reviewed the treatment referral, the employment service referral (if applicable), other services needed by the client, and the treatment contract with the client. Though care managers were not involved in the initial treatment referral, they reported making treatment recommendations to evaluators during reassessments or if the client was not engaging successfully in treatment services.

At the time of the field visits for this report, most UBA care managers said that they were carrying caseloads of anywhere from 35 to 47 clients; the average caseload among those

[34]Care managers reported being assigned to work with anywhere from one to six treatment providers. A provider that had many UBA clients may have had more than one care manager assigned to work with them and clients.

who were interviewed was 41. This is significantly smaller than the caseloads carried by most HRA workers, and yet nearly all care managers reported that they would have been able to do a better job if their caseloads were capped at the 35 clients that UBA set as the target caseload size.[35] Care managers would see clients formally an average of two to three times per month (perhaps more often, initially) and would generally visit them at their treatment provider; informal contacts via telephone could take place weekly. Typically, care managers spent half their time in the office (completing paperwork and entering data into NYCWAY and the UBA database, meeting new clients, and seeing current clients who requested an office visit), and they were "in the field" the other half of the workweek.[36]

An analysis of UBA contact data for a small sample of clients that was conducted during early field research supports the care managers' reports of frequent contact with clients. On average, UBA clients in this sample were contacted 20 times during the six-month follow-up period. When other, nonclient contacts are taken into account, the UBA case managers had, on average, 33 contacts during the six-month follow-up period. (Nonclient contacts included sending information to HRA workers or talking with clients' family members or service providers.) Moreover, according to a case file review of 10 UBA clients, the number of contacts between clients and the program staff appears to have been regular and frequent (weekly, biweekly), as mandated in the program design. Gaps in contact appears to reflect clients' relapsing or noncompliance, among other reasons.

Most care managers reported visiting each of their assigned treatment programs about once a week, allowing them to observe clients in their treatment setting and conduct one-on-one meetings when possible. Care managers noted that, after some initial resistance, treatment providers became cooperative in allowing such visits. One care manager stated that a treatment provider had even set up a temporary office for her to use at the facility.

Care managers were also responsible for monitoring clients' participation with the HRA employment vendors. At one point, UBA had *Vocational Care Managers* who played the same role with the employment vendors that care managers did with treatment providers: they were responsible for connecting with the employment vendors that provided HRA-mandated employment services to clients. (They did not play this role in the sites where clients participated in the work experience program.) UBA management found this approach to be disruptive, however. The handoff between the two types of care managers was challenging, and clients would often move between employment vendors and a work experience program, necessitating

[35]The caseload size for HRA workers in the Substance Abuse Service Center ranged from 99 to 155, with a cap of 165 cases per worker.

[36]Program managers reported that, initially, most meetings took place at UBA offices. However, they decided that it would make for a stronger model if care managers met with clients in the treatment facilities.

reassignments of vocational care managers. Therefore, the Vocational Care Manager position was eliminated. Instead, a *Vocational Coordinator* interfaced with all the employment vendors and worked with the care managers to help them maintain clients' employment focus.

Since it was not mandatory for clients to meet with UBA staff, care managers developed creative ways of keeping clients engaged with the program. Some care managers noted that they participated in group sessions with clients to demonstrate their commitment to helping clients achieve sobriety. Others mentioned meeting clients in "neutral" settings, such as restaurants or cafes, to help them feel more comfortable about the meeting. Another popular way of keeping clients connected was to schedule a reassessment even if it was outside the usual time frame — something not typically done under usual care. If UBA management or staff felt that a client was not engaging sufficiently in substance abuse treatment or employment services, they would call the individual in for a reassessment — knowing that the client would be unlikely to show, given the person's lack of commitment. This could lead to a sanction or case closure, since clients are required to participate in substance abuse assessments and reassessments. If the case was closed, the client would often reapply for cash assistance and would again be referred to UBA, giving another opportunity to emphasize that engaging with UBA could lead to achieving recovery and employment goals.

Treatment Services

Substance abuse treatment services are not discussed in detail in this report because that is the focus of a companion study being conducted by the National Center on Addiction and Substance Abuse (CASA) at Columbia University.[37] In summary, substance abuse treatment providers offered a range of levels for outpatient services, including Intensive Outpatient, Early Sobriety Maintenance, Sobriety Maintenance, and Relapse Prevention.[38] Individuals were placed at the appropriate level of care based on the assessment discussed above, and they could move to more intensive or less intensive treatment levels, depending on their needs. Typical care-level assignments were Intensive Outpatient (approximately 20 hours per week) and Nonintensive Outpatient (approximately 10 hours per week), including both individual and group-based services. The providers reflected a range of practice models.[39] Clients were also generally encouraged to participate in self-help groups and activities held during day and evening hours at the provider's site.

[37]CASA plans to publish results from its study in peer-reviewed journals over the next few years.

[38]When appropriate, some clients were first referred for residential treatment.

[39]Examples of practice models included 12-step, cognitive behavioral therapy, motivational interviewing, Gestalt therapy, solution-focused treatment, family systems treatment, and stages of change and psychoeducational models. A number of substance-use treatment providers offered acupuncture as an adjunctive intervention.

Some clients with opiate-use problems were referred to methadone or buprenorphine maintenance programs, which offered individualized health care and medically prescribed drugs to relieve withdrawal symptoms, reduce the craving for opiates, and bring about a biochemical balance in the body. As mentioned above, many of UBA's clients were referred to a methadone maintenance program and were also mandated to an outpatient substance abuse treatment program.

Substance abuse treatment providers were required by HRA to utilize the Substance Abuse Tracking and Reporting System (STARS) — an Internet-based system — to report on clients' treatment attendance, compliance, and outcomes. UBA care managers also could access STARS, allowing them to monitor the information that treatment providers reported to HRA.[40] Field interviews with UBA staff suggest that many care managers felt that they had a direct impact on treatment quality because treatment providers understood that care managers, and UBA, had the power of referral. If care managers were not satisfied with the treatment being provided to clients, they would recommend a change.[41] UBA staff reported that this helped ensure that clients were receiving the highest-quality treatment service possible.

Employment Services

HRA typically provides employment services to its clients through contracted vendors. UBA's clients were no exception: clients who were determined to be nonexempt, and therefore work-ready, were referred by UBA staff to an employment vendor. Recipients (clients with an active, open public assistance case) were referred to an employment vendor by their care manager. If the nonexempt clients were applicants whose public assistance had not yet been approved, they were referred to an employment vendor that specialized in quickly moving clients into jobs.[42] UBA evaluators generally made this referral, since it occurred early in a client's tenure with UBA (often on the first day).

The structure of services was similar at both types of employment vendors. Generally, a new group of participants would undergo orientation together at the vendor's site. The vendors referred to this as a new start. That first day was made up of educational achievement testing — including administering the Tests of Adult Basic Education (TABE), to determine clients'

[40]The Substance Abuse Service Center also reviewed STARS data for all HRA clients in substance abuse treatment. UBA's goal was to identify an issue prior to HRA's determining that a client was noncompliant.

[41]The vendor responsible for overseeing the assessments of participants in the usual care group could also refer them to another treatment provider if the original assignment seemed not to be a good match. Changes in treatment provider under usual care were less timely, however, since such issues were more likely to be identified during reassessments than through the ongoing monitoring of clients, as in SACM.

[42]By referring work-ready applicants to these specialized employment vendors, HRA hoped to engage clients in work quickly. If obtained, employment would render the receipt of public assistance unnecessary, and the application would be denied or withdrawn before opening the case.

literacy levels — and an explanation of what the clients could expect during their tenure with the program.[43] Every day for two weeks, clients then reported to participate in workshops focused on employability skill-building activities (such as résumé development and interviewing skills), to conduct job searches, and to meet with the job developers. If they did not obtain employment during the initial two-week orientation period, clients were referred to a work experience program to begin an unpaid work placement.[44] During the initial two-week orientation, clients were expected to participate 35 hours per week. Some vendors accommodated the requirements of substance abuse treatment programs, while others asked participants to attend their treatment groups at night. Once clients moved on to their work experience program, their expected work participation hours — including substance abuse treatment, the work experience program assignment, and working with the employment vendor two days per week — would total 35 hours per week.

UBA clients were referred to employment vendors for "special populations," meaning that these vendors had experience delivering services to clients who had particular barriers to employment.[45] Some vendors were even more specialized and targeted substance abusers or clients with criminal justice backgrounds. All employment vendors noted that as far as they knew, they served relatively few UBA clients on a weekly basis. Each new start generally included a handful of UBA clients.[46]

During field interviews, those employment vendors with little experience working with substance abusers noted that they thought UBA clients were more difficult to work with than their other clients, whereas vendors with more substance abuse experience reported that the clients were easier to work with, citing UBA's model as a factor in making it easier. All vendors reported some contact with UBA staff, particularly with the vocational coordinator. Program

[43]The TABE measures a person's grade level in such areas as reading, math, and language skills.

[44]Work experience placements were not necessarily within clients' employment vendors. Therefore, clients may have been required to go to their employment vendor and then to a different location for their work experience assignment. In general, UBA reported that there was an attempt to limit the number of vendors that provided work experience placements, in order to make it easier for UBA to monitor clients' participation and to address any issues quickly.

[45]Many of the employment vendors to which UBA referred clients also served other HRA clients. HRA did not require that clients be referred to an employment vendor in the client's borough of residence, as long as the client's commute to the vendor took less than an hour. In fact, one of the Bronx SACM vendors was located in Manhattan, a different borough of New York City.

[46]As mentioned above and in the report's Introduction, some clients were referred to specialized programs, such as WeCARE and the Personal Roads to Individual Development and Employment (PRIDE) program. The vocational rehabilitation tracks of those programs provided employment services.

managers at the employment vendors spoke very positively about UBA and noted how much they valued its contributions.[47]

Similar to the role that they played with treatment providers, UBA care managers worked with employment vendors to ensure that clients met participation requirements and also to negotiate conflicts. For example, a treatment provider might require something of the client that conflicted with something that was required by the employment vendor. Because care managers had established relationships with both vendors, they could negotiate the situation to ensure that the client was not adversely affected.

Even though care managers did not provide direct employment services, they reported struggling with the employment focus that they needed to adopt, particularly when UBA management asked them to take on a more active role with the employment vendors after the Vocational Care Manager position was eliminated. Staff felt that they did not necessarily have the appropriate training, but they recognized the importance of working collaboratively with employment service providers, since getting participants employed had significant financial implications for UBA. Supervisory and managerial staff agreed for the most part that care managers did not have the background needed to deal with the vocational aspects of their job, and training was consistently cited as an important need. In an attempt to fill this gap in knowledge and skills, the vocational coordinator tried to provide in-house training whenever possible.

Retention Services

UBA developed an incentive program to encourage and reward clients for reaching milestones in employment retention. For example, on Day 1 of employment, clients received an alarm clock radio; at other milestones, clients received a Metrocard that provided access to New York City buses and subways for one month (valued at about $70 in 2004) as well as a $50 gift certificate. This incentive program was also the mechanism by which UBA obtained the employment verifications required by HRA in order to receive credit for the employment placement and subsequent retention milestones.[48] It was the responsibility of the *Retention Coordinator* to oversee this component of the program. The retention coordinator carried a caseload of 135 to 140 clients. In order to collect their reward, clients had to visit UBA and provide documentation of employment (for example, pay stubs). The meeting would also provide an opportunity to determine whether the client required any additional assistance.

[47]HRA required that one of its representative be present at all the interviews of employment vendors that were conducted for this research.

[48]UBA believed that if it had been able to access state unemployment insurance records, that would have facilitated the ability to document employment and achieve higher employment milestones. However, the agency was not able to access that data source.

Although care managers were supposed to remain engaged with clients through the first 30 days of employment, most noted that they were focused primarily on the clinical status of the client and felt that it was the role of the retention coordinator to focus on ongoing employment — which was a challenge, given the retention coordinator's large caseload.

Noncompliance

Though all public assistance recipients were provided with a mechanism to resolve negative case actions — referred to as a conciliation process — the consequences of noncompliance depended on the type of public assistance case. Single adults with no dependent children were participants in the Safety Net program and would have their case closed for noncompliance. A noncompliance determination for a Family Assistance case, on the other hand, meant that only the adult head of household would be removed from the case; though the benefit amount would be reduced, the case would remain open. Depending on the reason for noncompliance, a case could be sanctioned for a set period of time. During the sanctioning period, Safety Net clients could not reapply for benefits, and Family Assistance clients could not be added back to the case.

Care managers reported that many participants "recycled" through the program, making it difficult for the clients to achieve their treatment and employment goals. Staff noted that case closures were a relatively common occurrence, especially given that a nonexempt client would need to meet the participation requirements of substance abuse treatment, job search activities, and the work experience placement.[49]

Once a case was closed by HRA for noncompliance, UBA could continue to serve that client for 30 days. UBA would call in clients to determine why their HRA case was closed and would try to resolve the issue within that 30-day window. For example, if the case was closed because the client failed to participate in treatment, UBA would try to determine whether that client should be reengaged with the same treatment provider or be referred to a different provider.

If the HRA case was not reopened within that time frame, the client's UBA case would be closed. A client who reapplied for benefits would most likely again be referred to UBA, unless UBA specifically requested that the client no longer be referred.[50]

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[49]There are many reasons why a client's case might close, aside from noncompliance with substance abuse treatment or a work activity or becoming employed; examples include not submitting required paperwork and missing recertification appointments.

[50]If UBA staff believed that the UBA model was not going to benefit a client who had come through the system several times, they would request that HRA no longer refer the client to UBA. Such clients instead would be referred to the Substance Abuse Service Center. The center, however, could not transfer cases to

(continued)

Care managers noted that they often spent more time with chronically noncompliant clients because they viewed such clients as "needier," citing their previous failure in the program as evidence. Some care managers mentioned that they were "tougher" with recycled clients because they felt that the clients needed this to ultimately succeed.

Performance-Based Contracts

As described at the beginning of this section of the report, HRA developed a performance-based contract with UBA that required the vendor to meet specific milestones in order to receive a portion of the funding. One milestone related to treatment. Portions of UBA's payments were tied to a client's successfully remaining in treatment for 30, 90, and 180 days; similar milestones existed for finding and maintaining employment. In addition, HRA recognized certain case dispositions — such as approval for federal disability benefits, the completion of a wellness plan, or four consecutive weeks in a work activity — as successful outcomes that were reimbursed as performance milestones.[51]

The performance-based nature of the contract did lead to some changes or enhancements to the program model, though program management noted that UBA had always met, or exceeded, the performance benchmarks outlined in its contract with HRA. These changes or enhancements are discussed below.

- **UBA developed a means by which it sought to affect the quality of substance abuse treatment services provided to clients.** As noted above, UBA would closely monitor clients' progress in treatment. If staff believed that adequate progress was not being made, they would discuss this with the treatment provider and, if they believed that their concerns were not being addressed, would ask for a different treatment intervention or refer the client to another program. UBA staff felt that this allowed them to have a significant impact on the quality of treatment even though they were not directly providing the treatment. UBA management felt that this was an important practice, since a significant proportion of the performance reimbursement was tied to treatment retention outcomes.

- **UBA developed expertise on the SSI/SSDI application process and developed systems to track and monitor clients referred to WeCARE.** As noted above, approval for federal disability benefits was considered a posi-

UBA, in order to protect the integrity of the study; this would ensure that clients who were assigned to the control condition (the usual care group) did not receive UBA services.

[51]These targets were fungible, meaning that if UBA exceeded a target for one milestone but fell short of another, the excess could be "applied" toward the target shortfall.

tive case disposition by HRA. Recognizing that some clients were likely to meet eligibility requirements, UBA's medical director developed expertise in determining whether functional impairment due to level of disability might qualify a client for SSI/SSDI, as well as expert in navigating the application process. As discussed in the section below entitled "Impacts on Participation in Substance Abuse Treatment and Employment Programs," this focus may have led to a small increase in the number of UBA clients whose SSI/SSDI applications were accepted.

In addition, UBA received payments for milestones achieved by UBA clients who were also receiving WeCARE services. Therefore, UBA's deputy director tracked and monitored such clients. This was done not only to ensure that UBA received credit, when appropriate, but also because UBA management believed that such monitoring was necessary to ensure that clients continued to make progress toward their goals (such as successful completion of a wellness plan or obtaining competitive employment).

- **UBA developed an employment focus within the program.** Though UBA always promoted the idea of employment and the provision of employment services as a goal for substance abusers, the UBA model as initially conceived was focused primarily on treatment retention; employment vendors were chiefly responsible (and continue to be responsible) for vocational services. However, UBA staff quickly realized that their model could play a role in helping clients successfully engage with the employment vendors. This focus was underscored once the performance-based contracts enhanced the payments provided to UBA for employment placements and job retention. The addition of the vocational care managers earlier in the implementation, and later the vocational coordinator, allowed UBA to integrate an employment focus into the model; this focus included occasionally duplicating some of the services provided by the employment vendors, to reinforce their value to participants.

- **UBA created an incentive to reward job retention and encourage clients to document continued employment.** Employment retention was also an important milestone in the contract. However, in order for UBA to receive credit for achieving the retention targets, HRA needed documentation to verify employment. As noted above, since many clients were unreliable in providing such documentation, the Competitive Employment Rewards Unit was created to reward clients for achieving retention milestones; in order to collect those rewards, clients had to provide employment documentation that

UBA, in turn, could send to HRA to obtain payments for performance milestones.

- **UBA created approaches to encourage staff to achieve performance milestone targets.** UBA management developed systems to encourage staff to maintain a focus on achieving milestones. For example, managers required staff to generate monthly status reports; since staff had to review all their cases to generate this report, it would provide them with an opportunity to determine whether the cases assigned to them were making adequate progress toward their goals. Management would also set program targets and monthly team outcome targets; care management teams that achieved their targets were treated to a celebratory lunch.

The UBA Office Environment

The UBA waiting room — designed to be similar to the waiting room in a doctor's office — was spacious and well lit, with multiple windows facing the street. It had many bulletin boards to highlight information about health and employment, as well as other reading materials on the side tables. The receptionist was available to answer questions, and the office itself was not overwhelmed by a large number of clients at any one time, so that clients did not have to wait long to be assessed.

Services for the Usual Care Group

The usual care group was served by the Substance Abuse Service Center, which housed two groups of staff: the vendor-employed Credentialed Alcoholism and Substance Abuse Counselors (CASACs), who conducted substance abuse assessments, and the HRA workers, who were assigned to monitor eligibility issues for substance abuse clients.

The Substance Abuse Service Center was located in an HRA building in Manhattan and focused on serving "special needs" clients, such as substance abusers and sanctioned clients. The beginning of this section about program implementation details some of the differences between the case management approaches used at UBA and at the Substance Abuse Service Center (see Table 3 above). Key distinctions between the two include differences in the initial assessment, in the nature and intensity of case management, in how noncompliance affected case management services, and in the physical environment within which each program operated. These differences are described in more detail below.

- **Assessment.** Cases that were referred to the Substance Abuse Service Center were assessed using New York State's required substance abuse assessment. Developed by the state Office of Alcoholism and Substance Abuse Services

(OASAS), this assessment focused primarily on the nature and severity of the substance abuse and how substance abuse affected employability. Assessments were conducted by CASACs employed by the National Association on Drug Abuse Problems (NADAP), an HRA contractor. These assessments were not as comprehensive or as clinically focused as the UBA evaluation, which included screenings for physical and mental health conditions, suggesting that these assessments were less likely to uncover co-occurring issues or other potential barriers to engaging successfully in treatment and employment, such as additional mental health disorders or factors like uncontrolled high blood pressure. Guided by the assessment results, the CASAC would determine whether a client required treatment, the extent to which the substance abuse affected the client's ability to participate in work activities, and the appropriate level and type of treatment; then the client would be referred (as a mandatory requirement) to a specific substance abuse provider. If the client was considered exempt from work activities and needed no referrals for other ancillary services, the CASAC unit would plan to reassess the exemption status within 90 days.[52] If the client was considered nonexempt or was required to participate in employment-related activities or needed a referral for ancillary services, the case would be handed to the HRA Substance Abuse Service Center workers, who had received some training in working with substance abusing clients.

- **Case Management.** Case management services provided by the Substance Abuse Service Center, relative to UBA services, were minimal.[53] Vendor staff who conducted the client assessments were not responsible for ongoing case management. In fact, these workers did not maintain assigned caseloads. Therefore, exempt clients received little if any ongoing case management, and a client's reassessment was not necessarily conducted by the same person who conducted prior assessments. Once a client was found to be nonexempt and was therefore referred to the Substance Abuse Service Center, the HRA workers conducted an employment assessment and referred the client to an employment vendor or to WeCARE. The HRA worker was also responsible for making all other referrals for ancillary services for both exempt and nonexempt clients and for monitoring the case on an ongoing basis.[54] Similar to UBA's

[52]Exempt clients were assigned to an HRA worker responsible for monitoring eligibility-related issues.

[53]HRA officials believed that *no* case management services, as defined by HRA, were provided.

[54]At the time that the field visits for this study were conducted, treatment compliance monitoring for exempt clients was conducted by a few designated HRA case workers since such clients had not yet been referred to an ongoing HRA worker.

approach, these HRA workers were assigned to work with specific treatment providers.[55] However, field interviews suggest that once an employment vendor was assigned, the HRA worker was responsible primarily for eligibility-related issues and would not provide ongoing case management. Caseloads for HRA workers ranged from 99 to 155, with a cap of 165 cases; this could be two to three times a UBA worker's average caseload.

- **Noncompliance.** The two groups of workers also differed in terms of how noncompliance affected a case. Services immediately ceased at the Substance Abuse Service Center for cases that were closed because of a noncompliance sanction or other reason. Therefore, unlike the UBA group, the usual care group received no case management services to help resolve whatever issue had led to the negative action.

- **Office Environment.** Another key difference between the two groups was the office environment within which each program operated. This could be important, since it might affect clients' attitudes toward, and completion rates of, their initial substance abuse assessment as well as their engagement in program services. The Substance Abuse Service Center's waiting room was located in a large city-government building. There were no windows in the waiting room, which was often overcrowded (with more clients than chairs), and the reception area itself was very busy. Interviews with assessment staff suggest that clients often waited quite a while (an hour or longer) before being seen. This was attributed to a state regulation that required that applicants be seen if they showed up on the day of or the day after their appointment, regardless of their appointment time, as long as they showed up. This could lead to significant delays in client flow. Staff mentioned having to deal with clients who were angry by the time they were seen, due to frustration over the wait time and conditions in the waiting room.

This section has discussed and compared SACM services and the services provided to the usual care group. The next section uses data from NYC HRA databases to analyze which services each group utilized.

[55]Subsequent discussions with HRA management suggest that this approach was later abandoned.

Impacts on Participation in Substance Abuse Treatment and Employment Programs

The New York City Substance Abuse Case Management (SACM) program model is being evaluated as part of the national Employment Retention and Advancement (ERA) project. This section of the report presents the effects of SACM on referrals to substance abuse treatment and to programs under contract to the New York City Human Resources Administration (HRA) — notably, referrals to employment and health assessment programs. This section also presents the effects of SACM on participation in and compliance with substance abuse treatment and on receipt of federal disability benefits. The findings presented here are important for interpreting the results of SACM on employment, earnings, and public assistance receipt, which are discussed in the report's concluding section.

The analysis uses data from the New York City Work, Accountability, and You (NYCWAY) database, which is one of HRA's management information systems. NYCWAY tracks clients through employment, substance abuse treatment, and other required activities, and it interfaces with the New York State Welfare Management System (WMS), which, in turn, tracks the status of cases served by the Temporary Assistance for Needy Families (TANF) and Safety Net programs. HRA required staff from both the SACM program and the standard ("usual care") program to record their clients' activities in NYCWAY. Descriptive analyses are also presented using the Substance Abuse Tracking and Reporting System (STARS), a separate database that allows substance abuse treatment programs to provide information on clients' compliance with and progress in treatment, including such status changes as employment spells, graduations, discharges, substance abuse test results, and transfer requests.[56]

Before discussing the participation findings, it is important to introduce a note of caution about NYCWAY. Since staff track participation only in HRA programs, additional services that sample members received in the community were not recorded in NYCWAY. Furthermore, participation in both NYCWAY and STARS is tracked only while an individual has an active TANF or Safety Net case. Therefore, participation in substance abuse treatment was not recorded in these systems if a sample member's case was closed or denied. An examination of

[56]Impacts were not estimated using the STARS data, since these data were available only for a small proportion of the full sample (those who showed up to either research group and who signed a consent form; n = 1,197). Furthermore, key background characteristics of the STARS sample SACM group differed from the background characteristics of the STARS sample usual care group.

the data shows that both research groups include significant "churning" (that is, public assistance cases closed, reopened, and then closed again). Therefore, participation in substance abuse treatment programs may be underestimated, since an individual may have continued treatment even without an active public assistance case. Although only minor differences in public assistance receipt were found for the two research groups — suggesting that the underestimates are not more severe for one group than for the other — this caution should be kept in mind when interpreting the results.

Box 2 explains how to interpret the impact tables presented in the remainder of the report.[57] All the differences discussed in this section between the treatment group (SACM group) and the control group (usual care group) are statistically significant unless otherwise indicated.

- **A slightly smaller proportion of the SACM group than the control group completed an initial assessment. During the assessment, however, the SACM program was more likely than the usual care program to find that sample members needed substance abuse treatment.**

As noted in the preceding section ("The Implementation of SACM"), individuals were referred to either the SACM or the usual care group after being identified with a possible substance-use disorder. This identification process was based on a fairly simple screening tool administered by welfare workers and was not designed to determine the level or type of treatment that an individual required. Furthermore, the screening process sometimes identified people who did not actually need substance abuse treatment. Therefore, once sample members showed up at their assigned program, they went through a comprehensive substance abuse assessment (as described in the preceding section; see "Assessment/Evaluation").

The first panel of Table 4 shows that the SACM group was slightly less likely than the control group to complete such an assessment during the 1.5-year follow-up period. About 82 percent of the SACM group and 85 percent of the control group completed an assessment, for a small but statistically significant difference of 2 percentage points. The majority of the sample members who did not complete an assessment never did show up at either SACM or the usual care program during the follow-up period. According to the tracking data, many of these

[57]Covariates in the regression model include gender, race/ethnicity, age, prior employment, prior TANF receipt, prior food stamp receipt, number of children, housing status, HRA compliance status in the year prior to random assignment, and participation in substance abuse treatment in the year prior to random assignment.

Box 2

How to Read the Impact Tables in the ERA Evaluation

Most tables in this report use a similar format, illustrated below. The top panel shows several participation outcomes for the SACM group and the control group (usual care). For example, the table shows that about 65 (64.8) percent of the SACM group and about 61 (61.3) percent of the control group ever enrolled in treatment.

The "Difference" column in the table shows the differences between the two research groups' participation rates — that is, the SACM program's impact on participation. For example, the impact on participating in drug-free treatment can be calculated by subtracting 20.4 percent from 28.2 percent, yielding a 7.8 percentage point increase.

Differences marked with asterisks are statistically significant, meaning that it is quite unlikely that the differences arose by chance. The number of asterisks indicates whether the impact is statistically significant at the 1 percent, 5 percent, or 10 percent level (the lower the level, the less likely that the impact is due to chance). For example, as shown below, the SACM group model had a statistically significant impact of 7.8 percentage points at the 1 percent level on participating in drug-free treatment, meaning that there is a 99 percent chance that the results are not due to chance. (One asterisk corresponds to the 10 percent level; two asterisks, the 5 percent level; and three asterisks, the 1 percent level.) The p-value shows the exact levels of significance.

The bottom row shows the average number of months between random assignment and first enrollment in drug treatment. Measures shown in italic type are considered nonexperimental because they include only a subset of the full report sample — in this case, those clients who enrolled in treatment. Since the subset is not chosen randomly but is determined by behavior after random assignment, there is no guarantee that the SACM and control groups are similar in terms of characteristics. Therefore, differences in these outcomes may not be attributable to the SACM program. Statistical significance tests are not conducted for nonexperimental measures.

1.5-Year Impacts on Substance Abuse Treatment and Enrollment

Outcome (%)	SACM Group	Control Group (Usual Care)	Difference (Impact)		P-Value
Enrollment in substance abuse treatment (%)					
Ever enrolled in treatment	64.8	61.3	3.5	***	0.001
Alcohol	17.6	13.3	4.3	***	0.000
Drug-free	28.2	20.4	7.8	***	0.000
Rehabilitation	2.1	3.5	-1.4	***	0.000
Mentally ill chemical abuser (MICA)	2.5	0.1	2.4	***	0.000
Methadone	21.3	25.5	-4.2	***	0.000
Residential	10.4	11.4	-1.0		0.139
Number of types of treatment enrolled	0.8	0.7	0.1	***	0.000
Average number of months between random assignment and first enrollment in substance abuse treatment[a] (%)	*3.2*	*3.3*	*-0.2*		

NOTE: [a]Some clients were enrolled in substance abuse treatment at random assignment.

individuals never had a TANF or Safety Net case approved.[58] As noted in the report's Introduction, even if individuals did not show up at their assigned program, they are included in the impact analysis because they were assigned to the research sample.[59]

The second row of data in Table 4 shows that 84 percent of the control group completed an assessment at their assigned program (the Substance Abuse Service Center), while only 77 percent of the SACM group completed an assessment at their assigned program (Universal Behavioral Associates, or UBA). This discrepancy may be attributable to the fact that UBA sometimes discharged clients who failed to show up for assessment.[60] Those clients returned to their job center and then may have been referred for another attempted assessment at the Substance Abuse Service Center, which did not have the ability to discharge clients.[61] As the results indicate, about 5 percent of the SACM group (82 percent minus 77 percent) completed an assessment at the Substance Abuse Service Center; these individuals remain part of the SACM group for the analysis.

As noted above, one purpose of the initial assessment was to determine the level of substance abuse treatment that an individual required. At the end of the assessment, an individual could be found to be (1) exempt from work requirements and in need of intensive treatment, (2) nonexempt from work requirements but in need of treatment, or (3) nonexempt from work requirements and not in need of treatment.[62] The top panel of Table 4 also shows that the SACM program was more likely than the usual care program to find individuals in need of treatment; SACM group members were more likely to be classified as either exempt or nonexempt and in need of substance abuse treatment. Conversely, the usual care program was more likely to find that sample members did not need treatment.

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[58]Administrative data show that 66 percent of the sample members in both research groups who never showed up did not receive cash assistance during the follow-up period, compared with only 13 percent of the sample members who did show up.

[59]A sensitivity analysis was conducted to examine the effects of SACM when excluding sample members who did not show up to their assigned program within three months after their initial referral. The results show that, compared with the full sample, the "show-up" sample had slightly higher participation rates. However, the overall results for the show-up sample and the full sample are similar; see Appendix Table C.5.

[60]The program group had a limited number of slots. Discharging clients for various reasons opened a slot for a new client.

[61]A total of 13 percent of the program group members were referred to the control group during the follow-up period. As discussed above, individuals who were initially referred to the program group and then transferred to the control group are included in the program group results. Consequently, this may have diminished the study's ability to detect small effects of the SACM program.

[62]Some sample members who were found exempt from work requirements were also referred to other HRA programs for "special populations."

The Employment Retention and Advancement Project

Table 4

1.5-Year Impacts on Assessment and Substance Abuse Treatment

New York City Substance Abuse Case Management

Outcome	SACM Group	Control Group (Usual Care)	Difference (Impact)	P-Value
Assessment				
Completed assessment (%)	82.4	84.5	-2.0 ***	0.009
Completed assessment at assigned program (%)	77.1	84.3	-7.2 ***	0.000
Initial assessment status (%)				
Exempt from work requirement	49.4	46.7	2.7 **	0.010
Nonexempt but substance abuse treatment required	24.0	22.1	1.9 **	0.034
Nonexempt and no substance abuse treatment required [a]	9.1	15.8	-6.7 ***	0.000
Was ever nonexempt from HRA work requirement (%)	66.2	68.8	-2.6 ***	0.008
Referrals to substance abuse treatment				
Was ever referred to substance abuse treatment [a] (%)	72.9	68.6	4.3 ***	0.000
Alcohol	25.0	18.0	7.0 ***	0.000
Drug-free	38.9	26.7	12.2 ***	0.000
Rehabilitation	5.6	9.0	-3.3 ***	0.000
Mentally ill chemical abuser	3.5	0.1	3.5 ***	0.000
Methadone	22.6	26.8	-4.3 ***	0.000
Residential	4.3	7.3	-3.1 ***	0.000
Number of referrals (%)				
0	27.1	31.4	-4.3 ***	0.000
1	32.1	34.1	-2.0 **	0.046
2	19.8	18.4	1.3	0.113
3 or more	21.0	16.1	5.0 ***	0.000
Average number of referrals	1.5	1.3	0.2 ***	0.000
Number of treatment modality referrals (%)				
Was never referred	27.1	31.4	-4.3 ***	0.000
1 treatment modality	51.3	52.3	-1.0	0.354
2 treatment modalities	17.0	13.6	3.4 ***	0.000
3 or more treatment modalities	4.7	2.8	1.9 ***	0.000
Enrollment in substance abuse treatment				
Was ever enrolled in treatment (%)	64.8	61.3	3.5 ***	0.001
Alcohol	17.6	13.3	4.3 ***	0.000
Drug-free	28.2	20.4	7.8 ***	0.000
Rehabilitation	2.1	3.5	-1.4 ***	0.000
Mentally ill chemical abuser	2.5	0.1	2.4 ***	0.000
Methadone treatment	21.3	25.5	-4.2 ***	0.000
Residential	10.4	11.4	-1.0	0.139

(continued)

Table 4 (continued)

Outcome	SACM Group	Control Group (Usual Care)	Difference (Impact)		P-Value
Number of types of treatment enrolled	0.8	0.7	0.1	***	0.000
Average number of months between random assignment and first enrollment in substance abuse treatment program[b] (%)	*3.2*	*3.3*	*-0.2*		
Number of months between random assignment and first enrollment in substance abuse treatment program[b] (%)					
1 month	38.0	37.7	0.2		0.823
2 to 3 months	11.0	8.3	2.7	***	0.000
4 to 6 months	6.3	5.0	1.3	***	0.007
6 months or more	6.6	6.8	-0.2		0.683
Sample size (total = 8,831)	4,670	4,161			

SOURCES: MDRC calcualtions using action code data from the New York City Work, Accountability, and You (NYCWAY) system and data from the Welfare Management System.

NOTES: See Appendix B.

[a]Many clients were later reassessed as needing substance abuse treatment.

[b]Some clients were already enrolled in substance abuse treatment at study entry.

Differences in the assessment results may be attributable to the differing nature of the assessments at UBA and at the Substance Abuse Service Center, discussed in the preceding section ("The Implementation of SACM"). For example, SACM staff leading the assessments included clinical social workers (CSWs) and a psychiatrist, whereas the usual care staff were Credentialed Alcoholism Substance Abuse Counselors (CASACs). Similarly, the SACM assessment was designed to identify barriers and drug use by using such drug-testing and diagnostic batteries as the SF-12, a 12-item standardized questionnaire that assesses physical and mental health status. The assessment, therefore, was designed to detect more barriers than the standard substance abuse assessments used by the usual care staff.

While in treatment, individuals in both research groups were reassessed to determine whether their level of treatment should be changed. For instance, it was expected that many sample members who had been found to need intensive substance abuse treatment at their initial assessment would be able to meet the HRA work requirements during the later phases of treatment and would transition from exempt to nonexempt status. As indicated in the top panel of Table 4, the SACM group was slightly less likely than the control group to be found non-exempt during the follow-up period, perhaps because the initial SACM assessment was more likely to find clients to be exempt.

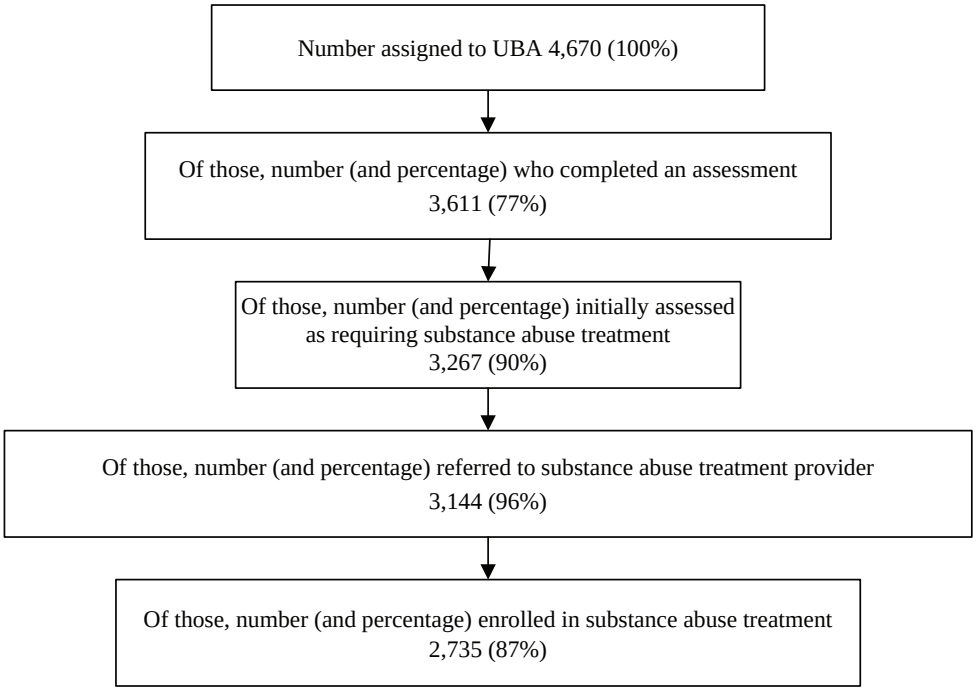
Box 3 presents the flow of participation among UBA program group members.

Box 3

Participant Flow at University Behavioral Associates

As described in the text, all individuals who were referred to University Behavioral Associates (UBA) are included in the analysis, regardless of whether they were assessed or referred for substance abuse treatment. Therefore, the percentages presented in the impact tables include individuals who were never assessed by the program and who thus never had the opportunity to be referred for treatment. The chart below presents the numbers and percentages of participants at various points in the flow of UBA services. It begins with the 4,670 participants who were assigned to the program; this total is presented in each of the impact tables. As the chart moves further into the flow, it presents the numbers and percentages relative to those in the pool of participants who could have accessed a particular service.

For example, the second and third boxes in the flowchart show that, of the 3,611 participants who were assessed by the program at some point during the 15-month follow-up period, 3,267 particicpants, or 90 percent of those assessed, were found to be in need of substance abuse treatment. This analysis is a linear representation of a client flow that did not always occur sequentially. Therefore, some participants who skipped a step in the flow may not be reflected in the analysis. In addition, some clients who were initially assessed as not requiring substance abuse treatment may subsequently have been referred for substance abuse treatment; such cases are not included in this flow. Nonetheless, the analysis suggests that once clients showed up at UBA, very few dropped out. Another important point related to service delivery is the high level of noncompliance. Additional analysis (not shown) found that nearly 63 percent of the 3,267 participants who were deemed to be in need of substance abuse treatment had their case closed due to noncompliance at least once during the 1.5-year follow-up, suggesting that there were likely interruptions in program services over the course of the follow-up period.



- **Members of the SACM group were more likely than those in the control group to be referred to a substance abuse treatment program.**

The second panel of Table 4 shows the type and number of referrals to substance abuse treatment that were made for both research groups during the follow-up period. Since SACM found more sample members to be in need of treatment, a larger proportion of the SACM group than of the control group was referred to treatment. As shown in the table, SACM increased the percentage who were referred to a substance abuse treatment program by 4.3 percentage points — a small but statistically significant impact.

Differences in the type of referrals were also found. SACM was less likely to refer sample members to methadone, residential, and in-patient rehabilitation treatment programs and was more likely to refer sample members to outpatient alcohol, drug-free, and mentally ill chemical abuser (MICA) treatment programs.[63] Results also indicate that, compared with the control group, SACM was significantly more likely to refer individuals to treatment multiple times throughout the 1.5-year follow-up period. For instance, about 21 percent of the SACM group were referred to three or more treatment programs, compared with 16 percent of the control group. The difference of 5 percentage points is statistically significant.

Two factors discussed in the preceding section about program implementation may explain the differences in the number and type of referrals. First, although both research groups could transfer clients who were not performing well in a specific treatment program to a different treatment program, SACM's close monitoring, which included weekly contacts with clients or treatment providers, may have resulted in more clients' being transferred to different substance abuse treatment programs. Second, the SACM and usual care programs had different referral strategies. For instance, the usual care program would refer clients to residential treatment if they were homeless, following the state guidelines, but SACM would make referrals to housing services while clients attended outpatient treatment. Similarly, if an individual was already enrolled in a methadone maintenance program, SACM was likely to refer the individual to a drug-free program, whereas the usual care program would not.

- **Members of the SACM group were slightly more likely than those in the control group to enroll in substance abuse treatment programs.**

[63]Note that when a referral is made to two types of treatment programs (for example, methadone and drug-free programs), only one referral can be entered into the NYCWAY database.

Since SACM staff closely monitored and spent a significant amount of time with clients during the initial assessment, SACM was expected to increase the number of clients who would enter substance abuse treatment programs. In addition, SACM staff also worked closely with HRA eligibility caseworkers in having sample members' welfare cases approved or reopened. This is an important factor, since members of both research groups needed to have an active TANF or Safety Net case in order to work with an individual.[64]

The bottom panel of Table 4 presents data on enrollment in substance abuse treatment programs. Note that the results show the treatment enrollment regardless of whether the referral was made by SACM or by the usual care program. Some sample members were already enrolled in treatment at the time of study entry, and some enrolled in treatment on their own after study entry. Therefore, some discrepancies between the type of referrals and enrollments were found. For instance, the percentage of sample members who were referred to residential treatment is lower than the percentage who enrolled. Among the full research sample, the findings show that SACM increased the proportion of sample members who enrolled in treatment: 65 percent of the SACM group, compared with 61 percent of the control group. The increase may be related to the increased referrals, which, in turn, may have been a result of the SACM program's finding a larger percentage of sample members in need of treatment during the initial assessment. The increase may also be attributed to the more intensive follow-up services that UBA clients received, which may have facilitated their enrollment into substance abuse treatment.

One of the biggest challenges for substance abuse treatment programs is retaining individuals in treatment. Past studies have shown that the longer someone remains in treatment, the better the outcome.[65] By providing intensive monitoring, SACM expected to increase the number of sample members who remained in treatment longer. Based on NYCWAY data, the latest status with HRA was used to examine the attrition rates for substance abuse treatment.[66] About 15 percent of both the SACM and the control group remained in treatment at the end of the follow-up period; the research groups had no difference on this measure (not shown).

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[64]SACM also worked with individuals for 30 days after a case was closed or not approved. During this time, the program would assist clients in having their cases approved or reopened.

[65]Hubbard, Craddock, and Anderson (2003).

[66]The latest status measure reflects the last action codes found in NYCWAY for each individual prior to the 1.5-year follow-up period. Since participation in NYCWAY is tracked only while a TANF or Safety Net case is open, the measure can reflect a status early during the follow-up period. In fact, during the last six months of the follow-up period, only about 50 percent of the sample members had any action codes in the database.

There may be several reasons for the low percentage of sample members remaining in treatment at the end of the follow-up period. As is shown later in this section, noncompliance with substance abuse treatment programs was high among both research groups. In addition, the STARS data indicate that abstinence may have been an issue; just under half of the SACM and control group members tested positive for any drug use during the 1.5-year follow-up period (Figure 2). Another possible explanation for these results is that the NYCWAY and STARS data are incomplete. As noted at the outset of this section, sample members whose TANF or Safety Net cases were closed or denied were no longer tracked in the HRA databases. Results from the administrative records data show that less than half of both research groups were receiving cash assistance at the end of the follow-up period. (See the next section, "Impacts on Employment and Benefit Receipt.") Although such reasons are evident in the data, it is unclear how much these factors contributed to the low rates of treatment participation.

- **SACM led to a small increase in the proportion of sample members referred to HRA's employment-related programs. The SACM group was less likely than the control group to be referred to an HRA-contracted provider that assessed employability for individuals who reported health problems.**

Individuals with substance use disorders may need services in addition to substance abuse treatment in order to improve their prospects for employment. This section presents data on program referrals reported in the HRA database. As noted above, referrals to programs that were not connected to HRA are not reflected in these results. Table 5 shows that the SACM group was slightly less likely than the control group to be referred to programs (like WeCARE) that provide in-depth employability assessments for clients who report functional limitations due to physical or mental health conditions. One possible explanation for this result is that SACM had a medical director who could assess sample members' health conditions and their impact on employability. Therefore, referrals to the Health Services System and WeCARE may not have been considered necessary by SACM.

As shown in Table 5, SACM led to a small increase in the proportion of sample members who were referred to an HRA-contracted employment program: a difference of 3.1 percentage points above the control group level of 40.8 percent. This result may mean that SACM was more successful in making referrals to employment programs or was more successful in transitioning exempt participants through substance abuse treatment and into an employment program. According to the NYCWAY data, among sample members who were found nonexempt during the follow-up period, SACM referred a higher percentage of clients (66 percent) to an employment program, compared with the usual care program (57 percent; not shown).

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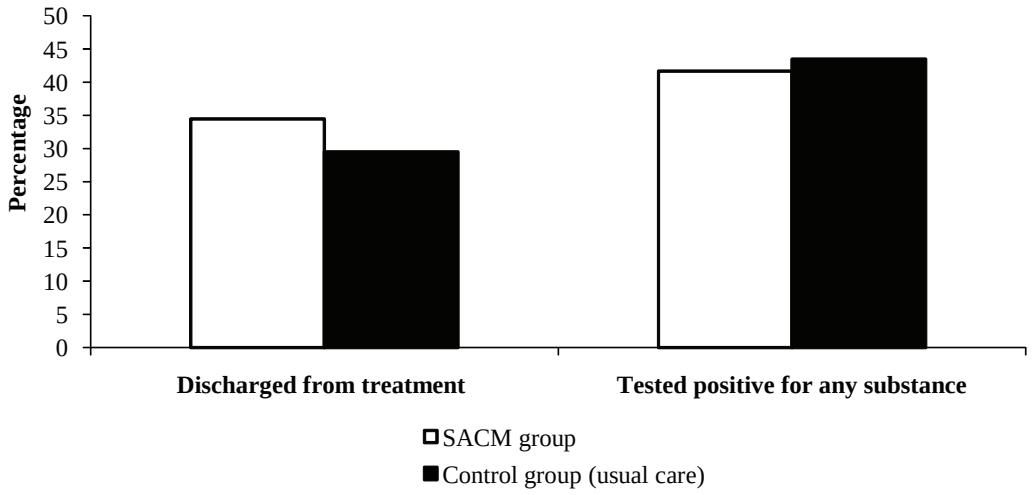
Figure 2

Substance Abuse Treatment Outcomes for the Screened Sample

New York City Substance Abuse Case Management



SOURCE: Substance Abuse Tracking and Reporting System (STARS) maintained by HRA.

NOTES: Impacts were not estimated using STARS data since data are available only for a subset of the sample who showed up at UBA or the Substance Abuse Service Center and signed a consent form (n = 1,197). Furthermore, the STARS sample may not be representative of the full administrative sample.

Results in this figure are weighted by month of study entry.

- **The SACM group was more likely than the control group to apply for federal disability benefits.**

Since SACM had staff who focused on assisting clients with obtaining federal disability benefits, SACM was expected to increase the number of individuals who applied for and received these benefits. SACM increased the number of sample members who applied for disability benefits by 1.6 percentage points above the control group average of 10.4 percent. Yet SACM only slightly increased the proportion of sample members who had their application

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Table 5

1.5-Year Impacts on HRA Program Referrals, Receipt of Federal Disability Benefits, and Compliance

New York City Substance Abuse Case Management

Outcome (%)	SACM Group	Control Group (Usual Care)	Difference (Impact)	P-Value
Referrals				
Referred for health assessment	33.6	38.9	-5.3 ***	0.000
Health Services System	30.9	36.4	-5.5 ***	0.000
WeCARE	15.7	17.5	-1.8 **	0.021
Referred to HRA employment program	43.9	40.8	3.1 ***	0.003
PRIDE	6.4	10.7	-4.3 ***	0.000
Employment service provider	17.0	15.1	1.9 **	0.014
VESID	1.4	1.3	0.1	0.596
Work experience program	15.7	17.6	-1.9 **	0.017
Skills assessment program	25.7	17.8	7.9 ***	0.000
WeCARE vocational rehabilitation services	4.9	5.5	-0.6	0.192
Federal disability benefits				
Applied for federal disability benefits	12.1	10.4	1.6 **	0.015
Application denied	4.7	4.8	-0.1	0.904
Application accepted	2.6	1.7	0.9 ***	0.006
Compliance				
Noncompliant with HRA mandates	92.2	94.1	-1.9 ***	0.000
Notice of intent	61.3	59.8	1.5	0.158
Conciliation initiated	37.0	44.3	-7.3 ***	0.000
Fair hearing and conference: good cause granted	23.8	26.9	-3.1 ***	0.001
Case closed due to noncompliance	56.2	55.9	0.3	0.787
Noncompliant with substance abuse program	35.1	30.0	5.1 ***	0.000
Noncompliant with recertification/application process	8.6	9.0	-0.4	0.559
Noncompliant with employment program	21.1	27.0	-5.8 ***	0.000
Noncompliant with other HRA programs	0.1	0.1	0.0	0.831
Sample size (total = 8,831)	4,670	4,161		

SOURCES: MDRC calculations using action code data from the New York City Work, Accountability, and You (NYCWAY) system.

NOTES: See Appendix B.

accepted during the follow-up period.[67] The process of applying for and obtaining disability benefits is lengthy; it is estimated to take the Social Security Administration about three months to respond to an application.[68] Appealing a denied application can lengthen this process considerably.

- **Compared with the control group, SACM led to a small decrease in the proportion of sample members who were found to be out of compliance with HRA mandates. Despite this decrease, SACM did not lead to fewer case closures for noncompliance.**

Unlike the usual care staff, SACM case managers (called "care managers") had small caseloads and monitored people closely. They also provided active outreach, and clients were reevaluated often to determine whether there were any issues that would prevent them from successfully attending and complying with treatment. Outreach and monitoring were key elements of the SACM treatment, since noncompliance with work requirements and other mandates, such as substance abuse treatment, resulted in a greater risk of sanctioning or case closures.

The bottom panel of Table 5 shows that high percentages of sample members in both research groups were noncompliant with HRA requirements. SACM led to a small decrease in the number of sample members who were found to be noncompliant. The results also show that SACM decreased the number of sample members for whom a conciliation was initiated and who had a fair hearing.[69] Despite these results, the differences between the research groups on the percentage of sample members who had their cases closed is not statistically significant. However, differences in the reasons for case closures were found: SACM group members were more likely than control group members to have their cases closed for not complying with substance abuse treatment but were less likely than control group members to have their cases closed for not complying with employment programs.

[67]It is important to note that the impacts on federal disability application and receipt are very small but are statistically significant due to the large sample size.

[68]Lassiter (2007).

[69]Conciliation is a process by which recipients may be able to resolve a noncompliance issue before a penalty is imposed.

Impacts on Employment and Benefit Receipt

The national Employment Retention and Advancement (ERA) project is evaluating innovative program models across the country that aim to promote steady work and career advancement for current and former welfare recipients and other low-wage workers. Among the models being tested is the New York City Substance Abuse Case Management (SACM) program in the Bronx, one of the city's five boroughs.

As described in the report's Introduction, the goal of the SACM program was to help public assistance recipients whose employability was limited by drug or alcohol abuse: "to assist public assistance clients in their path to abstinence, self-sufficiency, and employment."[70] Compared with the "usual care" program that the city's Human Resources Administration (HRA) offers, the SACM model provided more comprehensive substance abuse and other assessments and greater involvement with substance abuse treatment programs to help clients move through treatment and employment programs. Clients who were assessed as not in need of intensive treatment were expected to participate in employment activities and services while in treatment. Those who were in need of treatment for serious substance abuse were exempt from employment activities until they made sufficient progress in treatment to participate in work activities. For simplicity, this report calls the two research groups the "SACM group" (those who were referred to UBA for substance abuse case management) and the "usual care group," or the "control group."

Results presented in the preceding section suggest that SACM's effects on employment and benefit receipt would be small. (See Tables 4 and 5 in "Impacts on Participation in Substance Abuse Treatment and Employment Programs.") For example, the program had a small impact on the number of clients who were referred to HRA-contracted employment services. In terms of substance abuse treatment, the preceding section documents that although the SACM group enrolled in treatment at a higher rate than the control group, this difference is small.

This section of the report presents effects on employment and benefit receipt for the first year and a half after study entry. As in the preceding section, impacts are presented for the full sample, including individuals who were assigned to the research study but who never showed up at UBA or the Substance Abuse Service Center for an assessment and those who showed up but never received subsequent services.[71] Data on welfare receipt come from city

[70]University Behavioral Associates (UBA) program description.

[71]Selected impacts for subsets of the full sample are presented in Appendix Table C.5. Results for the show-up sample are similar to those presented here. There are modest and statistically significant impacts on employment for the screened sample. However, given the non-random process for selection into the screened sample, these results are only suggestive.

and state benefits records, and data on employment and earnings come from state unemployment insurance (UI) wage records. Although UI data capture most civilian employment, they do not include self-employment, out-of-state employment, independent contractors, or federal employees; nor do they capture informal, or "cash," jobs — the type of work that may be prevalent for this population. Thus, UI data most likely underestimate employment rates for both research groups.[72]

- **About one-third of the control group worked at some point during the 1.5-year period, although only about 17 percent worked in any given quarter. Average earnings were fairly low.**

Public assistance applicants and recipients were referred to either UBA or the Substance Abuse Service Center based on their responses to a short substance abuse screening tool. For this reason, individuals in the research sample faced substance abuse problems of varying severity, and some of them subsequently were assessed as needing little or no treatment. Nonetheless, the employment data shown in Table 6 suggest that this sample is a hard-to-employ group. The column labeled "Control Group (Usual Care)" presents the outcomes that would have occurred for the research sample in the absence of SACM, or given the typical services offered to individuals who were identified by HRA as substance abusers.[73]

Table 6 shows that a little more than a third of the control group worked at some point during the 1.5-year follow-up period and that 17 percent worked in the last quarter. Employment rates for the control group in any given quarter ranged from 15 percent to 17 percent and showed no upward trend over time (Appendix Table C.1). In addition, those who found jobs often did not keep them long. Only 9 percent of the control group worked for four consecutive quarters, representing one in four individuals who ever worked. Earnings were also low among workers. For example, individuals who worked at some point during Quarter 7 earned an

[72]Another source of employment data is the Family Independence Administration 3A (FIA-3A) job-notice form, which HRA requires vendors to complete once a client reports finding a job. However, there are a couple of reasons to believe that these data may not be valid for evaluation purposes. First, while all employment venders received payments for submitting these forms, UBA also received payments. In fact, UBA set up an incentive program to encourage participants to turn in evidence of employment so that UBA could complete an FIA-3A and receive the milestone payment. For active UBA clients, both the employment vendor and UBA could potentially collect documentation for the FIA-3A forms for participants. Thus, it seems likely that employment for UBA clients is more likely to be reported using these forms than for the control group, leading to incorrect estimates of the program's effect. Second, employment rates during the first year and a half were much lower when calculated using the FIA-3A forms (about 11 percent) than when using UI records (36 percent), suggesting that the former source misses a fair amount of employment.

[73]As discussed in the report's Introduction, the process by which individuals were placed into either research group suggests that this group represents a valid counterfactual for the SACM group.

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Table 6

Impacts on UI-Covered Employment and Public Assistance for the Full Sample

New York City Substance Abuse Case Management

Outcome	SACM Group	Control Group (Usual Care)	Difference (Impact)	P-Value
Quarters 2-7				
Ever employed (%)	37.6	36.3	1.3	0.180
Average quarterly employment rate (%)	17.5	16.7	0.8	0.144
Number of quarters employed	1.0	1.0	0.0	0.144
Employed 4 consecutive quarters (%)	9.1	8.9	0.2	0.772
Earnings ($)	2,771	2,577	195 [b]	NA
Ever received cash assistance (%)	77.9	78.0	-0.1	0.941
Number of months received cash assistance (%)	7.0	7.1	-0.1	0.323
Amount of cash assistance received ($)	2,407	2,477	-70	0.281
Ever received food stamps (%)	92.1	92.8	-0.6	0.265
Number of months received food stamps	10.3	10.4	-0.1	0.307
Amount of food stamps received ($)	1,631	1,652	-21	0.403
Total measured income[a,b] ($)	6,809	6,706	103 [b]	NA
Quarter 7				
Employed (%)	18.3	17.0	1.3	0.106
Earnings ($)	570	547	22 [b]	NA
Earned $2,500 or more (%)	16.1	14.6	1.5 [b]	NA
Ever received cash assistance (%)	38.7	40.0	-1.3	0.208
Amount of cash assistance received ($)	383	389	-6	0.696
Ever received food stamps (%)	61.2	62.6	-1.4	0.155
Amount of food stamps received ($)	239	249	-10 *	0.067
Total measured income[a,b] ($)	1,191	1,185	6 [b]	NA
Sample size (total = 8,831)	4,670	4,161		

SOURCES: MDRC calculations from UI wage records from the State of New York and public assistance records from New York City.

NOTES: See Appendix B.

This table includes only employment and earnings in jobs covered by the New York unemployment insurance (UI) program. It does not include employment outside New York or in jobs not covered by UI (for example, "off-the-books" jobs, some agricultural jobs, and federal government jobs).

[a]This measure represents the sum of UI earnings, cash assistance, and food stamps.

[b]This difference is not tested for statistical significance because the UI earnings data were provided as group averages.

average of $3,160 (not shown), which represents a wage of just over $6 per hour for full-time, full-quarter work.

Despite fairly constant employment rates, cash assistance receipt rates for the control group fell over the follow-up period.[74] Table 6 shows, for example, that 40 percent of the control group received cash assistance (TANF or Safety Net) in Quarter 7, down from 61 percent in the quarter just after study entry. (Appendix Tables C.2 and C.3 present quarterly data.) Food stamp receipt rates fell from 84 percent to 63 percent over the same period. These reductions in the control group's benefit receipt, although sizable, are less than typically observed in other welfare-to-work studies.

- **The SACM group did not work more than the control group over the follow-up period.**

A comparison of the SACM and control group columns in Table 6 indicates that SACM had no effect on employment rates. For example, 38 percent of the SACM group worked at some point over the follow-up period, compared with 36 percent of the control group. The two groups also had similar rates of employment retention, as measured by the percentage working four consecutive quarters, and similar rates of employment in the last quarter of follow-up. Although earnings data are shown in the table, they are not subjected to a formal test of statistical significance.[75] Thus, the true effect of the program on earnings is not known.

- **The SACM group and the control group had similar rates of benefit receipt over the follow-up period. Some early differences in receipt rates did not persist.**

The bottom rows in each panel of Table 6 present effects on benefit receipt. Although not shown here (see Appendix Tables C.2 and C.3), the SACM group had somewhat lower rates of receipt of cash assistance and food stamps in Quarters 3 through 5. These effects did not persist to Quarter 7, however, with the exception of a very small reduction in the amount of food stamps received ($10). In addition, the effects during the early quarters were quite small, resulting in no statistically significant differences over the period as a whole.

- **SACM's effects generally did not vary across subgroups defined by prior substance abuse treatment or by prior TANF application/receipt.**

[74]Cash assistance receipt rates may also have fallen over time if more individuals were moving into jobs not captured by the UI data.

[75]Earnings data from state UI records were provided not at the individual level but, instead, as averages for groups of individuals, and so statistical tests cannot be applied.

Table 7 presents the program's effects for two subgroups. First, a subgroup is defined based on previous treatment status: whether or not individuals were in substance abuse treatment in the year prior to study entry (the first two panels of the table). Although the program had few effects for the full sample, that sample contains a fair number of individuals who may have been substance users, for example, but who did not suffer from substance abuse. About 40 percent of individuals who showed up for an assessment were determined to be either non-exempt from work activities (and therefore able to pursue employment activities while also attending treatment) or not in need of substance abuse treatment. This group may be less likely to need or benefit from SACM's approach, compared with individuals who need more intensive treatment. The report's Introduction describes the Substance Abuse Research Demonstration (SARD) in New Jersey, which targeted TANF recipients who were already determined to need treatment and which was found to have large effects on treatment participation rates. In the present study, although no data were collected at baseline to determine the need for treatment, treatment status in the prior year is used as a proxy.

The second subgroup is defined by prior TANF application or receipt (the last two panels of Table 7). In addition to being the target of the SARD evaluation, this group is of interest, given that many TANF agencies are seeking interventions for recipients who have substance abuse problems, even though they may be a fairly small segment of the caseload.

The first two panels of Table 7 present results by treatment status in the year prior to study entry. In terms of control group outcomes — representing the counterfactual — employment rates are somewhat lower for the group in treatment in the previous year than for the group not in treatment. This difference suggests that this variable is correlated to some degree with the severity of substance abuse, although it may reflect different rates of treatment participation.[76] Nonetheless, the results show no impacts for either group. The only statistically significant difference is for referral to HRA employment programs, showing larger effects for the group not in treatment in the year before entering the study.

The last two panels of Table 7 present effects for the subgroup defined by TANF application/receipt in the year prior to study entry. The results show a few differences in impacts that are statistically significant. For the TANF group, SACM does appear to have led to a 13 percentage point reduction in cash assistance receipt in Quarter 7, and this impact is statistically significantly different from the impact for the non-TANF group. In contrast, impacts on employment for the two groups are not statistically significantly different. One final difference between the two groups is the effect on treatment enrollment. SACM led to no increase in

[76]In addition, 55 percent of individuals who were in treatment in the year before study entry were initially assessed by UBA as exempt from work requirements, compared with 48 percent of those who were not in treatment in the prior year (not shown).

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Table 7

1.5-Year Impacts on UI-Covered Employment, Public Assistance, Substance Abuse Treatment, and HRA Employment Program Referrals for Subgroups

New York City Substance Abuse Case Management

Outcome (%)	SACM Group	Control Group (Usual Group)	Difference (Impact)	P-Value	P-Value for Subgroup Differences
In treatment in year prior to study entry					
Quarters 2-7					
Ever employed	33.7	32.7	1.1	0.626	0.906
Average quarterly employment	14.6	14.0	0.7	0.573	0.904
Earnings	2,304	2,201	103 [a]	NA	NA
Quarter 7					
Employed	15.2	12.7	2.5	0.139	0.430
Received cash assistance	47.2	48.0	-0.8	0.754	0.756
Received food stamps	68.8	69.7	-0.9	0.704	0.806
Participation outcomes					
Ever enrolled in treatment	74.4	72.4	2.0	0.380	0.415
Referred to HRA employment programs	44.8	45.3	-0.5	0.840	0.088
Sample size (total = 1,548)	845	703			
Not in treatment in year prior to study entry					
Quarters 2-7					
Ever employed	38.5	37.1	1.4	0.203	
Average quarterly employment	18.0	17.2	0.8	0.195	
Earnings	2,863	2,641	222 [a]	NA	
Quarter 7					
Employed	19.0	18.0	1.0	0.257	
Received cash assistance	36.7	38.3	-1.6	0.140	
Received food stamps	59.7	61.2	-1.5	0.177	
Participation outcomes					
Ever enrolled in treatment	62.4	58.4	4.0 ***	0.000	
Referred to HRA employment programs	44.0	39.8	4.2 ***	0.000	
Sample size (total = 7,283)	3,825	3,458			

(continued)

Table 7 (continued)

Outcome (%)	SACM Group	Control Group (Usual Care)	Difference (Impact)	P-Value	P-Value for Subgroup Differences
TANF applicant or recipient at study entry					
Quarters 2-7					
Ever employed	32.7	33.4	-0.7	0.872	0.625
Average quarterly employment	16.9	16.1	0.8	0.725	0.901
Earnings	2,499	2,306	193 [a]	NA	NA
Quarter 7					
Employed	19.3	15.0	4.3	0.193	0.252
Received cash assistance	45.2	58.6	-13.4 ***	0.004	0.005
Received food stamps	65.4	75.3	-9.9 **	0.019	0.022
Participation outcomes					
Ever enrolled in treatment	50.3	55.7	-5.4	0.241	0.045
Referred to HRA employment programs	40.9	36.2	4.8	0.293	0.777
Sample size (total = 472)	232	240			
Not TANF applicant or recipient at study entry					
Quarters 2-7					
Ever employed	37.5	36.1	1.4	0.151	
Average quarterly employment	17.1	16.6	0.5	0.340	
Earnings	2,719	2,564	155 [a]	NA	
Quarter 7					
Employed	17.5	17.1	0.4	0.612	
Received cash assistance	38.9	39.0	-0.1	0.957	
Received food stamps	61.6	61.6	0.0	0.983	
Participation outcomes					
Ever enrolled in treatment	66.2	62.1	4.1 ***	0.000	
Referred to HRA employment programs	44.7	41.3	3.5 ***	0.001	
Sample size (total = 8,359)	4,438	3,921			

SOURCES: MDRC calculations from public assistance records from New York City, UI wage administrative records from the State of New York, and the New York City Work, Accountability, and You (NYCWAY) system.

NOTES: See Appendix B.

This table includes only employment and earnings in jobs covered by the New York unemployment insurance (UI) program. It does not include employment outside New York or in jobs not covered by UI (for example, "off the books" jobs, some agricultural jobs, and federal government jobs).

[a]This difference is not tested for statistical significance because the UI earnings data were provided as group averages and the number of groups was too small to provide a fair test.

Results in this table are weighted by month of study entry.

treatment enrollment for the TANF group (the negative effect of 5.4 percentage points is not statistically significant) but did lead to an increase in enrollment for the non-TANF group. It is not clear why SACM did not increase treatment enrollment for the TANF group. A much smaller proportion of the TANF group (about one-third) than of the non-TANF group (one-half) was initially assessed as exempt from work requirements (not shown).

* * *

The SACM model was an ambitious attempt by HRA to provide enhanced services to a particularly hard-to-serve population: substance abusers receiving public assistance. The majority of participants were not TANF clients but, rather, participants in the state's Safety Net program. The evaluation found that SACM clients had higher rates of enrollment in substance abuse treatment. It was not possible, however, to determine whether SACM affected either rates of retention in substance abuse treatment or rates of abstinence. The SACM program also had no effect for the full sample on employment, earnings, or benefits receipt, although there was a reduction in cash assistance receipt for the subgroup of TANF recipients.

MDRC will continue to track the SACM and usual care groups and will present longer-term impacts in the future. This may be important, given that it can take a significant amount of time for individuals to make progress in substance abuse treatment.

Appendix A

Supplementary Tables for “Introduction”

The Employment Retention and Advancement Project

Appendix Table A.1

Description of ERA Models

State	Location	Target Group	Primary Service Strategies
Advancement projects			
Illinois	Cook County (Chicago)	TANF recipients who have worked at least 30 hours per week for at least 6 consecutive months	A combination of services to promote career advancement (targeted job search assistance, education and training, assistance in identifying and accessing career ladders, etc.)
California	Riverside County Phase 2 (Work Plus)	Newly employed TANF recipients working at least 20 hours per week	Operated by the county welfare department; connects employed TANF recipients to education and training activities
California	Riverside County Phase 2 (Training Focused)	Newly employed TANF recipients working at least 20 hours per week	Operated by the county workforce agency; connects employed TANF recipients to education and training activities with the option of reducing or eliminating their work hours
Placement and retention (hard-to-employ) projects			
Minnesota	Hennepin County (Minneapolis)	Long-term TANF recipients who were unable to find jobs through standard welfare-to-work services	In-depth family assessment; low caseloads; intensive monitoring and follow-up; emphasis on placement into unsubsidized employment or supported work with referrals to education and training, counseling, and other support services
Oregon	Portland	Individuals who are cycling back onto TANF and those who have lost jobs	Team-based case management, job search/job readiness components, intensive retention and follow-up services, mental health and substance abuse services for those identified with these barriers, supportive and emergency services

(continued)

Appendix Table A.1 (continued)

State	Location	Target Group	Primary Service Strategies
Placement and retention (hard-to-employ) projects (continued)			
New York	New York City PRIDE (Personal Roads to Individual Development and Employment)	TANF recipients whose employability is limited by physical or mental health problems	Two main tracks: (1) Vocational Rehabilitation, where clients with severe medical problems receive unpaid work experience, job search/job placement and retention services tailored to account for medical problems; (2) Work Based Education, where those with less severe medical problems participate in unpaid work experience, job placement services, and adult basic education
New York	New York City Substance Abuse (substance abuse case management)	TANF recipients with a substance abuse problem	Intensive case management to promote participation in substance abuse treatment, links to mental health and other needed services
Projects with mixed goals			
California	Los Angeles County EJC (Enhanced Job Club)	TANF recipients who are required to search for employment	Job search workshops promoting a step-down method designed to help participants find a job that is in line with their careers of interest
California	Los Angeles County (Reach for Success program)	Newly employed TANF recipients working at least 32 hours per week	Stabilization/retention services, followed by a combination of services to promote advancement: education and training, career assessment, targeted job development, etc.
California	Riverside County PASS (Post-Assistance Self-Sufficiency program)	Individuals who left TANF due to earned income	Family-based support services delivered by community-based organizations to promote retention and advancement

(continued)

Appendix Table A.1 (continued)

State	Location	Target Group	Primary Service Strategies
Projects with mixed goals (continued)			
Ohio	Cleveland	Low-wage workers with specific employers making under 200% of poverty who have been in their current jobs less than 6 months	Regular on-site office hours for counseling/case management; Lunch & Learn meetings for social support and presentations; and supervisory training for employer supervisors
Oregon	Eugene	Newly employed TANF applicants and recipients working 20 hours per week or more; mostly single mothers who were underemployed	Emphasis on work-based and education/training-based approaches to advancement and on frequent contact with clients; assistance tailored to clients' career interests and personal circumstances
Oregon	Medford	Newly employed TANF recipients and employed participants of the Oregon Food Stamp Employment and Training program and the Employment Related Day Care program; mostly single mothers	Emphasis on work-based and on education/training-based approaches to advancement and on frequent contact with clients; assistance tailored to clients' career interests and personal circumstances; access to public benefits purposefully divorced from the delivery of retention and advancement services
Oregon	Salem	TANF applicants	Job search assistance combined with career planning; once employed, education and training, employer linkages to promote retention and advancement
South Carolina	6 rural counties in the Pee Dee Region	Individuals who left TANF (for any reason) between 10/97 and 12/00	Individualized case management with a focus on reemployment, support services, job search, career counseling, education and training, and use of individualized incentives
Texas	Corpus Christi, Fort Worth, and Houston	TANF applicants and recipients	Individualized team-based case management; monthly stipends of $200 for those who maintain employment and complete activities related to employment plan

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Appendix Table A.2

Selected Characteristics at Baseline, by Research Group

New York City Substance Abuse Case Management

Characteristic	SACM Group	Control Group (Usual Care)	Total		P-Value
Gender (%)					
Male	71.7	68.6	70.2	***	0.002
Female	28.3	31.4	29.8		0.002
Race/ethnicity (%)					
Hispanic	45.1	45.3	45.2		0.979
Black	43.6	43.4	43.5		0.979
Other	11.2	11.3	11.3		0.979
Age (%)					
30 or younger	19.9	20.6	20.2		0.258
31 to 40	37.2	35.5	36.4		0.258
41 or older	42.9	43.8	43.3		0.258
Average age (years)	38	38	38		NA
No children under case (%)	97.9	96.8	97.4	***	0.001
Housing status (%)					
Renting, not public/subsidized	56.7	55.2	56.0	**	0.037
Homeless/emergency/temporary housing	28.3	27.6	28.0		0.037
Treatment center	4.1	4.4	4.2		0.037
Other[a]	10.9	12.8	11.8		0.037
English is the primary language (%)	90.6	90.7	90.6		0.976
Case type (%)					
Safety Net	94.6	93.9	94.3		0.303
TANF	5.0	5.7	5.3		0.303
Employed during prior quarter (%)	16.9	17.6	17.2		0.382
Employed during prior year (%)	31.8	33.0	32.3		0.219
Received cash assistance during prior year (%)	48.0	51.3	49.5	***	0.002
Received food stamps during prior year (%)	60.7	63.3	62.0	**	0.012
Completed assessment at UBS or Substance Abuse Service Center in prior year (%)	18.5	19.0	18.7		0.601
Referred to substance abuse treatment in prior year (%)	6.3	5.7	6.0		0.260
Enrolled in substance abuse treatment in prior year[b] (%)	18.2	17.3	17.8		0.273
Not compliant with HRA programs in prior year[c] (%)	53.4	56.0	54.7	**	0.014
In substance abuse treatment at random assignment (%)	6.0	6.7	6.3		0.185
Sample size	4,670	4,161	8,831		

(continued)

Appendix Table A.2 (continued)

SOURCES: Baseline data from UI wage records from the State of New York and the New York City Work, Accountability, and You (NYCWAY) system and the Welfare Managment System.

NOTES: Results in this table are weighted by month of study entry.

In order to assess differences in characteristics across research groups, chi-square tests were used for categorical variables, and t-tests were used for continuous variables.

This table inlcudes only employment in jobs covered by the New York unemployment insurance (UI) program. It does not include employment outside New York or in jobs not covered by UI (for example, "off-the-books" jobs, some agricultural jobs, and federal government jobs).

[a]"Other" category includes renting public and subsidized housing, own home or apartment, and unknown.

[b]Some sample members enrolled in a treatment program without an HRA refferal. This measure includes any treatment program listed in NYCWAY system.

[c] "Not compliant" category includes FTC (failure to comply with program requirements), FTR (failure to report to mandatory appointment), NOI (notice of intent to close public assistance), and sanctions.

Appendix B

Notes for Tables and Figures Displaying Results Calculated with Administrative Records Data

Estimates were regression-adjusted using ordinary least squares, controlling for pre-random assignment characteristics of sample members.

Rounding may cause slight discrepancies in calculating sums and differences.

A two-tailed t-test was applied to differences between outcomes for the program and control groups. Statistical significance levels are indicated as: * = 10 percent; ** = 5 percent; and *** = 1 percent.

Italic type indicates comparisons that are nonexperimental. These measures are computed only for sample members who were employed. Since there may be differences in the characteristics of program group and control group members who were employed, any differences in outcomes may not necessarily be attributable to the ERA program. Statistical tests were not performed.

Dollar averages include zero values for sample members who were not employed or were not receiving TANF or food stamps.

The p-value indicates the likelihood that the difference between the program and control groups arose by chance.

NA = not applicable.

Results in this table are weighted by month of study entry.

Appendix C

Supplementary Impact Tables

The Employment Retention and Advancement Project

Appendix Table C.1

Impacts on Quarterly UI-Covered Employment and Earnings for the Full Sample

New York City Substance Abuse Case Management

Outcome	SACM Group	Control Group (Usual Care)	Difference (Impact)	P-Value
Ever employed (%)				
Quarter of random assignment	15.9	15.1	0.7	0.260
Quarter 2	16.1	15.2	0.9	0.231
Quarter 3	16.9	17.1	-0.2	0.763
Quarter 4	17.3	16.8	0.5	0.496
Quarter 5	17.9	16.7	1.2	0.129
Quarter 6	18.3	17.1	1.2	0.120
Quarter 7	18.3	17.0	1.3	0.106
Total earnings ($)				
Quarter of random assignment	235	223	12 [a]	NA
Quarter 2	304	272	32 [a]	NA
Quarter 3	410	391	19 [a]	NA
Quarter 4	452	424	28 [a]	NA
Quarter 5	498	457	41 [a]	NA
Quarter 6	538	485	53 [a]	NA
Quarter 7	570	547	22 [a]	NA
Sample size (total = 8,831)	4,670	4,161		

SOURCE: MDRC calculations from UI wage administrative records from the State of New York.

NOTES: See Appendix B.

This table includes only employment and earnings in jobs covered by the New York unemployment insurance (UI) program. It does not include employment outside New York or in jobs not covered by UI (for example, "off-the-books" jobs, some agricultural jobs, and federal government jobs).

[a]This difference is not tested for statistical significance because the UI earnings data were provided as group averages.

The Employment Retention and Advancement Project

Appendix Table C.2

Quarters 2-7, Impacts on Food Stamp Receipt and Payments for the Full Sample

New York City Substance Abuse Case Management

Outcome	SACM Group	Control Group (Usual Care)	Difference (Impact)	P-Value
Ever received food stamps (%)				
Quarter of random assignment	95.8	95.4	0.4	0.352
Q2	84.2	83.5	0.7	0.369
Q3	71.7	73.5	-1.9 **	0.042
Q4	68.0	69.4	-1.5	0.119
Q5	65.9	67.6	-1.7 *	0.075
Q6	64.1	64.2	-0.1	0.908
Q7	61.2	62.6	-1.4	0.155
Amount of food stamps received ($)				
Quarter of random assignment	248	248	-1	0.819
Q2	326	323	3	0.548
Q3	274	279	-5	0.326
Q4	269	271	-3	0.611
Q5	263	269	-6	0.231
Q6	261	261	0	0.996
Q7	239	249	-10 *	0.067
Sample size (total = 8,831)	4,670	4,161		

SOURCE: MDRC calculations from food stamp administrative records from New York City.

NOTES: See Appendix B.

The Employment Retention and Advancement Project

Appendix Table C.3

Quarters 2-7, Impacts on Cash Assistance Receipt and Payments for the Full Sample

New York City Substance Abuse Case Management

Outcome	SACM Group	Control Group (Usual Care)	Difference (Impact)	P-Value
Ever received cash assistance (%)				
Quarter of random assignment	49.7	46.7	3.0 ***	0.002
Q2	63.0	61.3	1.7 *	0.080
Q3	52.3	53.8	-1.5	0.128
Q4	46.4	48.5	-2.1 **	0.036
Q5	43.0	45.3	-2.4 **	0.019
Q6	41.1	42.0	-0.9	0.374
Q7	38.7	40.0	-1.3	0.208
Amount of cash assistance received ($)				
Quarter of random assignment	240	232	8	0.263
Q2	415	404	11	0.295
Q3	414	415	-1	0.942
Q4	402	434	-31 **	0.030
Q5	398	428	-30 *	0.054
Q6	395	408	-13	0.406
Q7	383	389	-6	0.696
Sample size (total = 8,831)	4,670	4,161		

SOURCE: MDRC calculations from TANF/Safety Net administrative records from New York City.

NOTES: See Appendix B.

The Employment Retention and Advancement Project

Appendix Table C.4

Impacts on UI-Covered Employment and Public Assistance for the Show-Up Sample

New York City Substance Abuse Case Management

Outcome	SACM Group	Control Group (Usual Care)	Difference (Impact)		P-Value
Quarters 2-7					
Ever employed (%)	39.0	37.4	1.6		0.169
Average quarterly employment rate (%)	18.2	17.5	0.7		0.284
Number of quarters employed	1.1	1.1	0.0		0.284
Employed 4 consecutive quarters (%)	9.6	9.6	0.0		0.979
Earnings ($)	2,918	2,726	192 [b]		NA
Ever received cash assistance (%)	89.4	86.4	3.0	***	0.000
Number of months received cash assistance	8.3	8.3	0.0		0.861
Amount of cash assistance received ($)	2,803	2,854	-51		0.518
Ever received food stamps (%)	95.9	95.5	0.3		0.524
Number of months received food stamps	11.4	11.3	0.1		0.531
Amount of food stamps received ($)	1,812	1,808	5		0.880
Total measured income[a,b] ($)	7,533	7,388	145 [b]		NA
Quarter 7					
Employed (%)	19.6	18.1	1.5		0.117
Earnings ($)	610	583	28 [b]		NA
Earned $2,500 or more (%)	17.1	15.4	1.7 [b]		NA
Ever received cash assistance (%)	43.5	44.3	-0.8		0.527
Amount of cash assistance received ($)	425	436	-11		0.567
Ever received food stamps (%)	65.3	65.7	-0.4		0.707
Amount of food stamps received ($)	261	268	-7		0.304
Total measured income[a,b] ($)	1,297	1,287	10 [b]		NA
Sample size (total = 6,211)	3,186	3,025			

SOURCES: MDRC calculations from unemployment insurance (UI) wage records from the State of New York and public assistance records from New York City.

NOTES: See Appendix B.

The show-up sample refers to sample members who showed up at either UBA or the Substance Abuse Service Center within three months after study entry.

This table includes only employment and earnings in jobs covered by the New York unemployment insurance (UI) program. It does not include employment outside New York or in jobs not covered by UI (for example, "off-the-books" jobs, some agricultural jobs, and federal government jobs).

[a]This measure represents the sum of UI earnings, TANF, and food stamps.

[b]This difference is not tested for statistical significance because the UI earnings data were provided as group averages and the number of groups was too small to provide for a fair test.

The Employment Retention and Advancement Project

Appendix Table C.5

Comparison of Impacts for the Full, Show-Up, Screened, and CASA Follow-Up Samples

New York City Substance Abuse Case Management

Outcome	SACM Group	Control Group (Usual Care)	Difference (Impact)	P-Value
Quarters 2-7				
Ever employed (%)				
Report sample	37.6	36.3	1.3	0.180
Show-up sample	39.0	37.4	1.6	0.169
Screened sample	41.5	36.2	5.3 **	0.031
CASA follow-up sample	44.2	41.8	2.5	0.612
Average quarterly employment (%)				
Report sample	17.5	16.7	0.8	0.144
Show-up sample	18.2	17.5	0.7	0.284
Screened sample	19.0	16.0	3.0 **	0.032
CASA follow-up sample	19.0	18.3	0.7	0.802
Number of quarters employed				
Report sample	1.0	1.0	0.0	0.144
Show-up sample	1.1	1.1	0.0	0.284
Screened sample	1.1	1.0	0.2 **	0.032
CASA follow-up sample	1.1	1.1	0.0	0.802
Ever received cash assistance (%)				
Report sample	77.9	78.0	-0.1	0.941
Show-up sample	89.4	86.4	3.0 ***	0.000
Screened sample	88.4	87.3	1.1	0.536
CASA follow-up sample	92.5	86.0	6.5 **	0.041
Amount of cash assistance received ($)				
Report sample	2,407	2,479	-72	0.268
Show-up sample	2,803	2,854	-51	0.518
Screened sample	2,679	2,560	119	0.457
CASA follow-up sample	2,587	2,526	60	0.825
Ever received food stamps (%)				
Report sample	92.1	92.8	-0.6	0.265
Show-up sample	95.9	95.5	0.3	0.524
Screened sample	96.9	96.6	0.3	0.796
CASA follow-up sample	98.1	96.8	1.4	0.387
Amount of food stamps received ($)				
Report sample	1,631	1,652	-21	0.404
Show-up sample	1,812	1,808	5	0.880
Screened sample	1,781	1,786	-5	0.929
CASA follow-up sample	1,805	1,831	-26	0.805

(continued)

Appendix Table C.5 (continued)

Outcome	SACM Group	Control Group (Usual Care)	Difference (Impact)	P-Value
Quarter 7				
Ever employed (%)				
Report sample	18.3	17.0	1.3	0.106
Show-up sample	19.6	18.1	1.5	0.117
Screened sample	21.1	16.7	4.4 **	0.035
CASA follow-up sample	24.3	20.0	4.3	0.317
Ever received cash assistance (%)				
Report sample	38.7	40.0	-1.2	0.217
Show-up sample	43.5	44.3	-0.8	0.527
Screened sample	46.1	48.5	-2.5	0.351
CASA follow-up sample	45.0	48.0	-3.0	0.563
Ever received food stamps (%)				
Report sample	61.2	62.6	-1.4	0.155
Show-up sample	65.3	65.7	-0.4	0.707
Screened sample	67.3	71.2	-4.0	0.108
CASA follow-up sample	74.6	71.8	2.7	0.559
Participation outcomes, Year 1.5				
Enrolled in treatement (%)				
Report sample	64.8	61.3	3.5 ***	0.001
Show-up sample	79.8	73.2	6.7 ***	0.000
Screened sample	79.9	74.9	5.0 **	0.027
CASA follow-up sample	86.3	77.7	8.6 **	0.028
Referred to employment programs (%)				
Report sample	43.9	40.8	3.1 ***	0.003
Show-up sample	49.3	43.6	5.7 ***	0.000
Screened sample	52.7	45.7	7.0 ***	0.009
CASA follow-up sample	54.4	53.1	1.3	0.809

SOURCES: MDRC calculations from public assistance records from New York City, UI wage records from the State of New York, and action code data from the New York City Work, Accountability, and You (NYCWAY) system.

NOTES: See Appendix B.
The report sample includes 8,831 sample members; SACM group: 4,670; control group: 4,161.
The show-up sample includes 6,211 sample members; SACM group: 3,186; control group: 3,025.
The screened sample includes 1,423 sample members; SACM group: 841; control group: 582.
The CASA follow-up sample includes 402 sample members; SACM group: 236; control group: 166.
Statistical significance levels are indicated as follows: *** = 1 percent; ** = 5 percent; * = 10 percent.
Impacts are weighted by month of random assignment.

The Employment Retention and Advancement Project

Appendix Table C.6

1.5-Year Impacts on Assessment and Substance Abuse Treatment for the Show-Up Sample

New York City Substance Abuse Case Management

Outcome	SACM Group	Control Group (Usual Care)	Difference (Impact)	P-Value
Assessment				
Completed assessment (%)	100.0	100.0	0.0	NA
Completed assessment at assigned program (%)	100.0	100.0	0.0	NA
Exemption status (%)				
Initially exempt from work requirement	59.1	54.4	4.7 ***	0.000
Initially nonexempt but treatment required	31.4	28.0	3.4 ***	0.004
Initially nonexempt and no treatment required[a]	9.5	17.6	-8.2 ***	0.000
Was ever nonexempt from HRA work requirement (%)	75.2	76.1	-0.9	0.399
Referrals to substance abuse treatment				
Was ever referred to substance abuse treatment[a] (%)	89.8	82.5	7.3 ***	0.000
Alcohol	32.0	22.6	9.5 ***	0.000
Drug-free	50.1	33.0	17.2 ***	0.000
Rehabilitation	6.2	10.6	-4.4 ***	0.000
Mentally ill chemical abuser	4.8	0.1	4.7 ***	0.000
Methadone	26.9	32.0	-5.1 ***	0.000
Residential	5.0	8.8	-3.8 ***	0.000
Number of referrals (%)				
0	10.2	17.5	-7.3 ***	0.000
1	37.0	39.5	-2.5 **	0.043
2	24.6	22.2	2.4 **	0.027
3 or more	28.2	20.8	7.4 ***	0.000
Average number of referrals	2.0	1.6	0.4 ***	0.000
Number of modality referrals (%)				
Was never referred	10.2	17.5	-7.3 ***	0.000
1 modality	61.7	61.9	-0.2	0.838
2 modalities	21.9	16.9	5.0 ***	0.000
3 or more modalities	6.3	3.7	2.6 ***	0.000
Enrollment in substance abuse treatment				
Was ever enrolled in treatment (%)	79.8	73.2	6.7 ***	0.000
Alcohol	22.9	17.0	5.9 ***	0.000
Drug-free	37.5	26.0	11.5 ***	0.000
Rehabilitation	2.3	4.2	-1.9 ***	0.000
Mentally ill chemical abuser	3.4	0.1	3.4 ***	0.000
Methadone treatment	25.5	30.3	-4.8 ***	0.000
Residential	10.6	11.4	-0.8	0.305

(continued)

Appendix Table C.6 (continued)

Outcome	SACM Group	Control Group (Usual Care)	Difference (Impact)		P-Value
Number of types of treatment enrolled	1.0	0.9	0.1	***	0.000
Average number of months between random assignment and first enrollment in substance abuse treatment program[b] (%)	*2.2*	*2.4*	*-0.2*		
Number of months between random assignment and first enrollment in substance abuse treatment program[b] (%)					
1 month	55.1	52.1	2.9	**	0.019
2 to 3 months	14.5	11.0	3.6	***	0.000
4 to 6 months	4.6	3.3	1.3	***	0.008
6 months or more	4.3	4.4	-0.1		0.866
Sample size (total = 6,211)	3,186	3,025			

SOURCES: MDRC calculations using action code data from the New York City Work, Accountability, and You (NYCWAY) system and data from the Welfare Management System.

NOTES: See Appendix B.

The show-up sample refers to sample members who showed up at either UBA or the Substance Abuse Service Center within three months after study entry.

[a]Some clients were later reassessed as needing substance abuse treatment.

[b]Some clients were already enrolled in substance abuse treatment at study entry.

The Employment Retention and Advancement Project

Appendix Table C.7

1.5-Year Impacts on HRA Program Referrals, Receipt of Federal Disability Benefits, and Compliance for the Show-Up Sample

New York City Substance Abuse Case Management

Outcome (%)	SACM Group	Control Group (Usual Care)	Difference (Impact)	P-Value
Referrals				
Referred for health assessment	39.1	46.6	-7.6 ***	0.000
Health Services System	36.1	44.0	-7.9 ***	0.000
WeCARE	17.3	19.2	-1.9 **	0.047
Referred to HRA employment program	49.3	43.6	5.7 ***	0.000
PRIDE	7.7	13.6	-5.9 ***	0.000
Employment service provider	21.3	16.9	4.4 ***	0.000
VESID	1.9	1.5	0.4	0.204
Work experience program	18.9	20.1	-1.1	0.250
Skills assessment program	26.9	15.6	11.4 ***	0.000
WeCARE vocational rehabilitation services	6.0	6.7	-0.7	0.275
Federal disability benefits				
Applied for federal disability benefits	15.0	11.9	3.1 ***	0.000
Application denied	6.1	5.9	0.2	0.726
Application accepted	3.3	2.0	1.4 ***	0.001
Compliance				
Noncompliant with HRA mandates[a]	90.7	92.4	-1.8 **	0.012
Notice of intent	72.0	67.7	4.3 ***	0.000
Conciliation initiated	42.7	50.1	-7.4 ***	0.000
Fair hearing and conference: good cause granted	28.5	31.3	-2.9 **	0.011
Case closed due to noncompliance	62.3	59.7	2.6 **	0.036
Noncompliant with substance abuse program	41.4	33.3	8.1 ***	0.000
Noncompliant with recertification/application process	6.0	7.2	-1.2 *	0.059
Noncompliant with employment program	24.0	29.8	-5.8 ***	0.000
Noncompliant with other HRA programs	0.1	0.2	0.0	0.614
Sample size (total = 6,211)	3,186	3,025		

SOURCES: MDRC calculations using action code data from the New York City Work, Accountability, and You (NYCWAY) system and data from the Welfare Management System.

NOTES: See Appendix B.

The show-up sample refers to sample members who showed up at the either UBA or the Substance Abuse Treatment Center within three months after study entry.

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MDRC is a nonprofit, nonpartisan social and education policy research organization dedicated to learning what works to improve the well-being of low-income people. Through its research and the active communication of its findings, MDRC seeks to enhance the effectiveness of social and education policies and programs.

Founded in 1974 and located in New York City and Oakland, California, MDRC is best known for mounting rigorous, large-scale, real-world tests of new and existing policies and programs. Its projects are a mix of demonstrations (field tests of promising new program approaches) and evaluations of ongoing government and community initiatives. MDRC's staff bring an unusual combination of research and organizational experience to their work, providing expertise on the latest in qualitative and quantitative methods and on program design, development, implementation, and management. MDRC seeks to learn not just whether a program is effective but also how and why the program's effects occur. In addition, it tries to place each project's findings in the broader context of related research — in order to build knowledge about what works across the social and education policy fields. MDRC's findings, lessons, and best practices are proactively shared with a broad audience in the policy and practitioner community as well as with the general public and the media.

Over the years, MDRC has brought its unique approach to an ever-growing range of policy areas and target populations. Once known primarily for evaluations of state welfare-to-work programs, today MDRC is also studying public school reforms, employment programs for ex-offenders and people with disabilities, and programs to help low-income students succeed in college. MDRC's projects are organized into five areas:

- Promoting Family Well-Being and Child Development
- Improving Public Education
- Raising Academic Achievement and Persistence in College
- Supporting Low-Wage Workers and Communities
- Overcoming Barriers to Employment

Working in almost every state, all of the nation's largest cities, and Canada and the United Kingdom, MDRC conducts its projects in partnership with national, state, and local governments, public school systems, community organizations, and numerous private philanthropies.

ERA NYC-SACM Figure Descriptions

Label: Figure 1: Program Flow for Bronx Clients

Text Description: This flow chart illustrates the movement of clients in the New York City Substance Abuse Case Management study. A caseworker at the city's Human Resources Administration (HRA) used the HRA system to schedule appointments for public assistance clients who screened positive for substance abuse. Members of the program group (also called "the SACM group") were scheduled for an appointment at University Behavioral Associates (UBA). Members of the control group (also called "the usual care group") were scheduled for an appointment at the Substance Abuse Service Center. Both groups of clients who kept their appointment then underwent an assessment for potential substance abuse. Some clients from both groups were "no-shows" who did not keep their scheduled appointment.

During the assessment, one of three determinations was rendered. (1) In both groups, a client who was determined not to require substance abuse treatment was referred back to regular HRA services. (2) Also in both groups, a client who was determined to require intensive substance abuse treatment was declared exempt from employment services and was referred to substance abuse treatment. (3) Among clients who were determined to require nonintensive substance abuse treatment, members of the SACM group were referred to a treatment program and to an HRA employment vendor, while members of the usual care group were referred to a treatment program and to an HRA caseworker for employment assessment.

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Label: Figure 2: Substance Abuse Treatment Outcomes for the Screened Sample

Text Description: This bar graph displays the percentage of the program group (also called "the SACM group") and the percentage of the control group (also called "the usual care group") who either were discharged from treatment or tested positive for any substance, as recorded in the Substance Abuse Tracking and Reporting System (STARS) maintained by the New York City Human Resources Administration (HRA.)

Among the SACM group, about 35 percent of clients were discharged from treatment, and about 42 percent tested positive for any substance. Among the control group, about 30 percent were discharged from treatment, and about 44 percent were found to have tested positive for any substance.

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