



Prepared for the Welfare Expert Advisory Group

Obligations and Sanctions Rapid Evidence Review

Paper 4: Drug Testing Obligations and Sanctions

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Executive summary

This rapid evidence review summarises evidence on drug testing obligations and sanctions tied to welfare assistance. It describes New Zealand's current settings, the prevalence of substance use and substance use disorders, and examples of policy approaches in other countries. It also summarises the limited evidence on the effects of drug testing obligations and sanctions.

Current settings require people receiving a main benefit with part-time or full-time work obligations, if they are referred to a job or training course where drug testing is part of the application process, to take and pass the drug test. Sanctions can be imposed for failure to comply or failure to pass the test. There is no requirement in the New Zealand system to participate in medical treatment in order to qualify for or continue to receive benefits. Around 100 sanctions are applied for drug-related obligation failures each year.

Substance use is common among New Zealanders. Almost half of all adults aged 16-64 will use recreational drugs in their lifetime. The latest Health Survey shows 12% used cannabis in the past year. The majority of people who use substances do not meet diagnostic criteria for substance use disorder.

Research in New Zealand and overseas has found that **welfare benefit recipients are more likely to use drugs and more likely to have a substance use disorder** than people not in receipt of benefit. Whether this association is partly causal is under-researched.

A review of studies focused on unemployed people finds evidence for causality running in both directions — problematic substance use increases the likelihood of unemployment, and unemployment is a significant risk factor for substance use and substance use disorders. Because many unemployed people do not receive welfare benefits, and many welfare benefit recipients are not unemployed, the generalisability of this evidence base is unclear.

Welfare benefit policy approaches and recent policy proposals vary across countries, and highlight differences in the degree to which drug use and dependence is seen as requiring a health-oriented versus a sanction-oriented response.

- In some states in the United States (US), welfare recipients who test positive in drug tests may lose access to benefits for a period, or may only retain or regain access if they comply with substance abuse treatment plans. Eligibility to Supplemental Security Income or Social Security Disability Insurance payments based on a primary diagnosis of 'drug and alcohol addiction' has been removed.

- In Australia, the Federal Government has proposed a two-year trial of random drug testing of Newstart and Youth Allowance recipients. Those testing positive will be placed on Income Management for 24 months. Those with repeat positive tests may be required to participate in activities designed to address their substance abuse.
- In the United Kingdom (UK), the current focus is on encouraging substance users to voluntarily engage with recovery services. An earlier proposal to use welfare benefits as a mechanism to compel people to address drug or alcohol addictions was abandoned in 2010 due to concerns about its likely effectiveness. A recent independent review recommends a number of changes, including moving away from a 'recover first/find work second' approach towards viewing employment and other meaningful activity as part of recovery.
- In Norway, access to Sickness Benefit has only been available for those with substance use disorders if they have co-morbid mental health problems, and is conditional on getting treatment for substance abuse problems. As a result of these and other policies, vulnerable drug users are largely excluded from the health and welfare systems. Norway is currently considering proposals to take a more health-oriented approach.

There is currently little evidence on the effects of drug testing obligations and sanctions for welfare recipients. Research from the US following the introduction of welfare reform provides some information on drug testing policies that share some similarities with New Zealand's current approach. However, there are no studies that convincingly estimate the distinct causal impact of drug testing policies separate from the broader set of welfare reform changes. There is no research on the effects of New Zealand drug testing obligations and sanctions.

A systematic review of other research from settings outside welfare benefit policy found limited evidence evaluating compulsory drug treatment. The available evidence does not, on the whole, suggest improved outcomes from compulsory treatment approaches, with some studies suggesting potential harms.

Alternative approaches that may improve the outcomes of welfare recipients who use drugs or have substance use disorders include improving access to drug and alcohol services for all New Zealanders with problematic drug and alcohol use, working with employers to improve access to employment opportunities, and intensive case management approaches that help those with substance use disorders access treatment and gain and maintain employment.

Purpose

This rapid review provides an overview of:

- New Zealand's **current settings** for drug testing in the welfare benefit system, and associated sanctions
- the prevalence of **substance use in New Zealand**
- the prevalence of **substance use among welfare recipients** and associations between substance use, welfare receipt, and the socio-economic outcomes of welfare recipients
- examples of current **policy approaches in welfare benefit systems internationally**

- **evidence on the effects of drug testing obligations and sanctions** tied to welfare assistance, including impacts on welfare receipt, employment and earnings, substance use, participation in treatment services, and child outcomes
- **alternative policy approaches** to the use of drug testing obligations and sanctions.

A separate paper in this series (Paper 1) provides an overview of the use of obligations and sanctions in welfare benefit policy, covering their rationale, frameworks for understanding how they might influence behaviour and outcomes, ways of categorising studies and effects, and approaches that might help minimise the need for sanctions to be used as a means of achieving public policy goals.

Current settings

New Zealand's pre-employment drug testing policy was introduced in 2013 as part of the then-Government's welfare reforms. The policy requires people receiving a main benefit with part-time or full-time work obligations, if they are referred to a job or training course where drug testing is part of the application process, to take and pass the drug test.¹

The primary policy rationale was to prevent drug use being a barrier to employment for beneficiaries, and to set the expectation that recreational drug use is "not an acceptable excuse for avoiding available work" (Bennett, 2012). At the time, around 40% of vacancies advertised through Work and Income required pre-employment drug tests, primarily for health and safety reasons (Bennett, 2012). Prior to the policy's introduction, clients could opt out of applying for suitable jobs that required a pre-employment drug test, if they would not be able to pass.

A graduated sanctions regime applies for failing to meet these obligations without good and sufficient reason. Under this regime, clients may have their benefit reduced, then suspended, then cancelled for 13 weeks for subsequent failures over a 12-month period. Clients with dependent children face a maximum sanction of a 50% benefit reduction. A client must have been given at least five working days to dispute or re-comply before any sanction is imposed.

Clients with work obligations may be required by Work and Income to undertake an activity to improve their work readiness and employment prospects. Activities can include work assessments, programmes or seminars, and rehabilitation, but not medical treatment.²

Each year since 2014/15, around 100 sanctions have been applied for an drug-related obligation failure. The number of people facing suspension of their benefit for drug-related obligation failure, or cancellation of their benefit and a 13 week stand down, has fluctuated between 22 and 36 per year.

Substance use in New Zealand

Data from the 2007/08 New Zealand Alcohol and Drug Use Survey showed that **substance use is common among New Zealanders**. Alcohol is the most widely used substance in New Zealand. Recreational drug use, especially use of cannabis, is relatively

¹ See [Social Security Act 2018 Section 147](#).

² See 1(d)(v) of the [Social Security Act 2018 Section 146](#).

common. Almost half of all adults aged 16-64 will use recreational drugs in their lifetime, with 17% using drugs in the past year. **One in five adults who used drugs in the past year reported harmful effects** due to their drug use. Common harmful effects included negative impacts on finances (11%), friendships and social life (9), and home life (8%). Drug use also impacted on some individuals' employment or study (7%) or led to them taking time off work or school (7%) (Ministry of Health, 2010).

It is important to distinguish between substance use and substance use disorder, which occurs when use leads to health issues or problems at work, school, or home. While some who use substances would meet diagnostic criteria for substance use disorder, the majority do not, and most discontinue substance use without any need for treatment (NZ Drug Foundation, 2011).

Data from the 2016/2017 New Zealand Health Survey indicates that:

- 79% of New Zealanders aged 15 years and over consumed alcohol in the past year, with one in five (20%) classified as 'hazardous' drinkers who could cause harm to themselves or others
- 12% used cannabis in the past year³; 1%⁴ used amphetamines⁵
- Use of cannabis and amphetamines is more common amongst men, people in younger age groups, Māori, and those living in the most deprived neighbourhoods.

Source: Ministry of Health (2017)

Information on the prevalence of substance use disorders among New Zealanders is limited. The most comprehensive estimates come from the 2006 NZ Mental Health Survey, which estimates that 1 in 7 New Zealanders (14%) will experience a substance use disorder at some point in their lives, while 3.5% met the criteria for a substance use disorder in the past 12 months. For the latter group, the most common type of substance use disorder was alcohol abuse (2.6% of the population) or alcohol dependence (1.3%), followed by drug abuse (1.2%) or drug dependence (0.7%) (Wells et al., 2007).

New Zealanders who develop a substance use disorder are more likely than average to be male, to have low income, to have low educational attainment, and to live in more deprived areas. After adjusting for socio-demographic characteristics, prevalence rates for Māori (6%) are higher than for Pacific people (3.2%) and all other ethnicities (3.0%) (Wells et al., 2007).

Substance use disorders usually emerge in late adolescence and early 20s — 75 per cent of New Zealanders who develop a substance use disorder do so by age 25 (Wells et al., 2007). Problematic substance use is linked to the development of mental health problems. The more severe the problems with substance use, the greater the likelihood of co-existent mental disorder (The Werry Centre, 2010).

³ For recreational or non-medical purposes.

⁴ Of those aged 16-64.

⁵ For recreational or non-medical purposes.

Substance use among welfare recipients

New Zealand longitudinal studies have found an association between drug use, substance use disorder, and welfare receipt. Following the lifecourse of a 1977 birth cohort, the Christchurch Health and Development Study found that individuals who used cannabis regularly had an increased risk of welfare dependence, even after adjusting for confounding factors such as socio-economic characteristics, childhood outcomes, and co-morbid health disorders (Fergusson et al., 2015). A study based on the longitudinal Dunedin Multidisciplinary Health and Development Study, following a 1972-1973 birth cohort, found that higher rates of substance use disorder at age 32 were associated with longer periods of welfare receipt in early adulthood, with close to three in ten study members who spent five or more years supported by benefit in early adulthood meeting the criteria for substance use disorder in the prior 12 months. This study, however, did not assess the direction of this relationship or control for confounding factors (Welch & Wilson, 2010). A more recent analysis of the Dunedin Study data identified welfare dependence as one of several financial difficulties more common among individuals who report regular and persistent cannabis use and/or dependence by age 38, even after controlling for confounding factors. Heavy cannabis use and dependence was associated with more harmful economic and social problems than alcohol dependence (Cerdá et al., 2016).

These findings align with international evidence that welfare benefit recipients are more likely to use drugs and more likely to have substance use disorders when compared with the general population. This evidence base includes studies from the United States (US) (see Pollack et al., 2002; Jayakody et al., 2004; Delva et al., 2000), England (Hay & Bauld, 2008), Norway (Pedersen, 2011), and Australia (Slade et al., 2009). A large body of literature shows higher rates of substance abuse among people who are unemployed compared with people who are employed (Henkel, 2011).

Whether the associations found in New Zealand and overseas welfare benefit studies are partly causal, and if so the nature and direction of the causal paths, is under-researched.

A review of studies focused on substance use and disorders for people who are unemployed finds evidence for causality running in both directions, but because many unemployed people do not receive welfare benefits, and many welfare benefit recipients are not unemployed, the generalisability of this evidence base to those receiving welfare benefits is unclear. The review found:

- problematic substance use increases the likelihood of unemployment and decreases the chance of finding and holding down a job
- unemployment is a significant risk factor for substance use and the subsequent development of substance use disorders
- unemployment increases the risk of relapse after alcohol and drug addiction treatment (Henkel, 2011).

It is important to note that while rates of substance use are higher among welfare benefit recipients compared with the general population, studies show **the majority of welfare recipients are not current substance users, and do not have substance use disorders.**

There are a number of difficulties in accurately estimating the extent of substance use and dependency among welfare recipients:

- Studies largely rely on self-report data and substance use may be under-reported by welfare recipients, often due to stigma or fear of losing welfare benefits (Metsch & Pollack, 2005). Studies that rely on data from screening tests can also yield inaccurate estimates, often because the staff conducting these tests lack appropriate training (Morgenstern & Blanchard, 2006; Metsch & Pollack, 2005). These concerns are less likely to affect results from longitudinal studies, where use of standardised measures is more common, and where they allow participants to be forthcoming as a result of their trust in the confidentiality of the study (Cerdá et al., 2016). Estimates drawn from drug testing of welfare recipients also have a number of limitations, as covered later in this review.
- Definitions of substance use and substance use disorders vary across studies. Estimates of prevalence depend, eg, on whether alcohol and/or prescription or legal drugs are counted as substances in a given study (ASPE, 2011; Metsch & Pollack, 2005).
- New Zealand welfare benefit administrative data do not capture information on health conditions unless provision of this information is a requirement for assessing eligibility for benefit. As a result they provide only a partial picture of substance use and dependency among welfare benefit recipients. In addition, substance use disorder may not be recorded if the primary reason for benefit receipt is another health condition or a disability. Those with 'substance abuse' as their primary recorded incapacity make up 5.1% of recipients of Jobseeker Support - Health Condition or Disability and 1.7% of recipients of Supported Living Payment recipients.

Research from the US on mothers receiving Temporary Assistance for Needy Families (TANF) found that those who were frequent substance users exhibited **a greater number of barriers to work and had more complex needs** than non-users. Over 80% had low work experience and lack of transportation, and around half had few job skills, low levels of educational achievement, and generalised anxiety disorder. A higher number of barriers to work correlated with a lower likelihood that TANF recipients entered employment in the 12 months covered by the study (Gutman et al., 2003).

In later US research, Meara (2006) found that women with substance use disorders receiving TANF had higher rates of unemployment, less work experience, and lower earnings when in work than other TANF recipients. A further 2008 study of individuals claiming welfare assistance in an urban US county found that 70% of individuals who screened positive for substance use reported multiple barriers to work, with at least one of these barriers classified as 'severe'. Only 5% reported no other barriers to work beyond substance use (Morgenstern et al., 2008).

Together, this evidence suggests that welfare policy interventions targeted at improving the socio-economic outcomes of those with problematic substance use are likely to **require a broad focus on the multiple and diverse barriers to work** faced by these individuals.

Some US studies show little relationship between substance use and barriers to work, or economic hardship more generally (Schmidt et al., 2007; Crew & Davis, 2006). However, these studies do not distinguish between recreational users and those with substance use disorders, including both in their research populations.

Policy approaches in welfare systems internationally

Internationally, policy approaches relating to substance use and substance use disorders among welfare recipients include conditional approaches (through the application of obligations and/or sanctions), and unconditional approaches.

Examples of approaches and policy proposals across countries highlight conflicting views on substance use and its relationship to welfare dependence, and differences in the degree to which drug use and dependence is seen as requiring a health-oriented versus a sanction-oriented response. In some countries, benefit receipt is made conditional on participation in treatment.

In the **US**, the 1996 welfare reform of assistance for low-income families (mainly sole mothers) permitted drug testing, allowed states to deny benefits to adults convicted of drug felonies, and allowed states to terminate benefits to illicit drug-using women (along with others) who violated programme requirements or failed to find employment (Pollack & Reuter, 2006). Following a series of legal challenges (which continue in some states), at least 15 states have passed legislation regarding drug testing or screening for public assistance applicants or recipients. Some states use screening tools to detect drug use before referring to drug testing or treatment. Welfare recipients who test positive in drug tests may lose access to benefits for a period, or may only retain or regain access if they comply with a substance abuse treatment plan (NCSL, 2017). Other legislative changes implemented as part of welfare reform affected Supplemental Security Income or Social Security Disability Insurance payments, removing eligibility based on a primary diagnosis of 'drug and alcohol addiction' (Jayakody et al., 2004). Only 35% of those affected could re-qualify for disability assistance based upon other conditions (Hogan et al., 2008).

In **Canada**, substance abuse is classified as a disability which means people diagnosed with substance use disorder can qualify for disability benefits (Brucker, 2007). Policy in Ontario departed from this approach for a period. However the courts reinforced the view that substance abuse disorders are a disability.⁶ A mandatory drug testing and treatment policy for Ontario welfare recipients was proposed but not implemented. Concerns about effects were raised by academics and health experts (see MacDonald et al., 2001).

In **Australia**, the Federal Government has proposed a two-year trial of random drug testing of 5,000 Newstart and Youth Allowance recipients for illicit drugs, as part of wider welfare reforms. Those testing positive will be placed on 'Income Management' for 24 months (which involves having parts of their welfare payments quarantined for essential items, and limits on cash withdrawals). Further positive tests will have a range of consequences, including a medical assessment with possible referral for treatment funded through a dedicated 'Treatment Fund'. This proposal requires a legislative change, which is currently being sought (AGDSS, 2018).

In the **UK**, the current focus is on encouraging substance users to voluntarily engage with recovery services. A recent independent review recommends a number of changes, including moving away from a 'recover first/find work second' approach and towards viewing employment and other meaningful activity (including volunteering) as an essential element of recovery (Black, 2016). An earlier proposal to use welfare benefits as a mechanism to compel people to address drug or alcohol addictions was abandoned in 2010 due to concerns about its likely effectiveness. A report by the Social Security

⁶ See http://www.acbr.com/fas/Supreme_Court_rules_addiction_is_disability.htm

Advisory Committee was critical of the plan and recommended that it should not proceed as it was outlined. Key concerns were the expectation that clients undertake mandatory drug testing and treatment, the possible adverse effects of use of sanctions on vulnerable people, and mismatch with common patterns of recovery and relapse for affected people (Social Security Advisory Committee, 2010).

Viewed in the context of policy approaches in other countries, **New Zealand** has elements of both conditional and non-conditional approaches: clients with work obligations are required to undertake and pass any pre-employment drug test requested by an employer or training provider; at the same time, people with a drug dependency that affects their ability to work can receive benefit payments for this reason. There is no requirement in the New Zealand system to participate in treatment in order to qualify for or continue to receive income support.

Up-to-date information on policy settings **non-Anglophone countries** is less readily available. The following is largely based on policy reviews prepared **before 2010**.

In **Norway**, access to Sickness Benefit was only available for those with co-morbid mental health problems and conditional on getting treatment for substance abuse problems. Those who were disabled could receive a benefit called Temporary Benefit for up to four years while they took steps to improve their capacity for work. But they would need to have prospects for improved work capacity: if that was not the case then they could be eligible for a Disability Pension. If they refused to undertake relevant training or receive treatment their benefit would be stopped. Numbers of recipients of these payments with substance abuse problems were low (Harris, 2008), vulnerable drug users being largely excluded from the health and welfare systems. Norway is currently considering proposals to take a more health-oriented approach (Daly, 2018).

In **Sweden**, there were no specific requirements placed on welfare recipients with substance abuse problems. The focus was on social re-integration through alcohol or drug treatment (Harris, 2008). Problem drug users could qualify for sickness or invalid benefits, but only if the substance use disorder reduced their capacity to work. If work capacity was reduced at least by 25% for a time-period of at least one year and vocational rehabilitation measures were exhausted, any insured person could be granted activity compensation, always temporary (age 19-29), permanent sickness compensation (aged 30-64), or temporary sickness compensation (aged 30-64) (Brucker, 2009).

In **Germany**, welfare recipients could be required to undergo rehabilitation. Those with substance abuse problems who were not in work could receive welfare payments if another rehabilitation attempt was unpromising, functional limitations precluded employment and permanent medical conditions were diagnosed. In awarding benefits, no distinction was made as to which substance was abused (eg dependence on a legal drug like alcohol, an illegally obtained prescription drug like barbiturates, or an illegal drug like heroin) (Brucker, 2009). Welfare recipients with substance abuse problems were not subject to mandatory drug testing and although drug rehabilitation could not be imposed on anyone without their consent, there was pressure arising from the fact that those who did not make such application would lose their entitlement to sickness benefit if they did not undergo such rehabilitation (Harris, 2008).

Welfare recipients in the **Netherlands** were required to look for work and participate in treatment if required. Citizens could qualify for disability benefits if they had a substance use disorder that diminished their capacity to work. Recipients with a substance use

disorder were required to do their best to get well and find a job, or participate in a work re-integration-type programme, or face termination of their benefit. Recipients with a substance use disorder were required to participate in a detoxification or treatment programme. The benefit agency paid for, and decided, the type and intensity of treatment (Brucker, 2009).

Evidence on the effects of drug testing obligations and sanctions

There is very little evidence on the effects of drug testing obligations for welfare recipients, or associated sanctions. Research from the US following the introduction of the 1996 welfare reform provides some relevant information on drug testing policies that share some similarities with New Zealand's current approach. However, there are no studies that convincingly estimate the distinct causal impact of drug testing obligations and sanctions within the broader set of welfare reform changes. In addition, these studies have a number of limitations, and given the unique nature of the US welfare system it is not clear how applicable these findings are to the New Zealand context.

Additional considerations in interpreting the available evidence base are the limitations of drug testing instruments, and the implications these have for the effectiveness of drug testing policies:

- **Common drug-testing instruments do not produce reliable estimates of drug use.** Detection of drug use depends not only on substance use but also on other factors such as the characteristics of each drug, individual metabolism, and cut-off levels. Common urinary drug testing is more likely to identify marijuana users compared with people using harder drugs, such as cocaine or heroin, as these drugs exit the body's system within several hours or days. In comparison, marijuana can remain in the body for weeks after use. Most drug tests also only identify the presence of a substance in the body, and do not distinguish between use of illegal drugs and the legitimate use of certain prescription and over-the-counter drugs (ASPE, 2011; Crew and Davis, 2003).
- **Results cannot distinguish between occasional substance users and those with a substance use disorder.** Drug tests detect recent drug use, but provide no information about frequency of use, impairment or treatment needs. Many individuals who are likely to test positive will be casual drug users who do not satisfy diagnostic criteria for dependence. For example, a University of Michigan study of a drug-testing programme found that the majority of those who tested positive were casual users with no classifiable underlying addiction (Pollack et al. 2002).
- **A positive drug test cannot establish whether or not a person is intoxicated or impaired.** It cannot differentiate between drug use that has no impact on workplace safety or productivity and problematic drug use causing intoxication or impairment at the workplace (NZ Drug Foundation, 2011).

Welfare receipt

The introduction of drug-testing provisions in the US welfare reform had a primary goal of reducing welfare dependence. Research indicates that following welfare reform there were significant declines in the proportion of substance users receiving welfare assistance. However no studies estimate the causal impact of drug testing policies.

Between 1996 and 2001, the proportion of low income substance-using mothers on welfare reduced from 54% to 38%, compared with a much smaller reduction in the proportion of low-income mothers who were not substance users on welfare. A concerning possible interpretation of this caseload decline is that an increased proportion of low-income women who used substances were becoming 'disconnected' from welfare without gaining economic self-sufficiency (Pollack & Reuter, 2006). Substance use was

more common among welfare recipients who were sanctioned for failing to comply with TANF rules than among those who were not sanctioned (Meara, 2006).

A lack of research comparing welfare use reductions between states with varying policy approaches to substance users means **it is not clear how much of the caseload decline can be attributed to the use of drug testing** and associated obligations for mandatory treatment and/or sanctions affecting benefit eligibility, versus alternative policy approaches and/or wider welfare reform changes to eligibility and work incentives.

Evaluations of state-specific policies that imposed drug testing obligations and sanctions following welfare reform all report **low numbers of drug test failures, suggesting that any expected effects from the use of benefit sanctions would be relatively small**. Data from an 18-month period over 2013-2014 examining similar drug testing programmes in Arizona, Missouri, Utah and Tennessee reported that, across the four states, 847 recipients tested positive and lost their benefit eligibility out of a total 200,000 tests conducted (Butler, 2017). Similar results were found in an earlier evaluation of Florida's pilot drug testing programme for TANF recipients, with 5% testing positive for substance use (Crew and Davis, 2003).

Beyond loss of eligibility for assistance payments for recipients who fail drug tests, drug testing obligations and sanctions may also have ex-ante impacts on welfare receipt if they **deter individuals from applying for welfare assistance** in the first place. Deterrence may extend beyond individuals' concerns about the impact of substance use on benefit eligibility to wider fears of government intervention. As noted by Pollack & Reuter (2006, p.2025), "identified parental substance abuse and dependence — and sometimes mere use — is a strong criterion for child protective intervention. Such rules may have deterred some income-eligible mothers from applying [following welfare reform]." There is no research that estimates the scale of such possible effects.

There has been no research on the effects of New Zealand's drug testing policy on welfare receipt. Qualitative research conducted by Malatest International (2014) on MSD client perceptions of the 2013 welfare reforms found that some clients initially held concerns about the new drug testing policy (for example, thinking that all clients would be drug tested before being eligible for the benefit). However, this research did not examine whether such concerns impacted applications for assistance, or led to exits from benefit.

Employment and earnings

Addressing substance use as a (perceived) barrier to employment is another primary goal of welfare policies imposing drug testing obligations and sanctions. **Research in this area is also very limited, and no studies address the causal impact of the policy on employment and earnings.**

Evaluation of Florida's TANF drug testing pilot found little difference in the employment participation and earnings of those who tested positive for substance use and those who did not (Crew & Davis, 2003; 2006).

A study looking at the employment of TANF recipients with substance use disorders pre- and post-welfare reform found that this group increased their levels of employment and earnings following welfare reform's introduction. However employment rates were still lower than those for recipients without substance use disorders (Meara, 2006). This study did not isolate the contribution of drug testing policies to these outcomes.

Qualitative research exploring how drug users interact with the welfare system in the UK suggests that the **use of benefit sanctions to improve the employment participation of substance-using welfare recipients is unlikely to be effective** without the simultaneous provision of intensive case management, improvement of access and availability to treatment services, and employer-focused interventions (Bauld et al., 2012).

Substance use and participation in treatment services

There is some evidence to suggest that welfare reform in the US **may have reduced substance use and increased participation in treatment services**. However the contribution of drug testing obligations and sanctions policies is unclear.

Exploiting changes in welfare policy across states and over time and using a 'difference-in-differences' framework applied to a range of data sets, Corman et al., 2013 estimate that welfare reform reduced illicit drug use among women at risk of receiving welfare. The authors suggest TANF drug testing and work incentive policies affected drug use through multiple channels, and that welfare bans for drug felonies and other TANF drug policies do not appear to have been the main contributing factors.

Pollack and Reuter (2006) found that substance-using mothers receiving TANF assistance were more likely to receive treatment services than comparable mothers outside the welfare system following welfare reform. However, the researchers also note that this impact cannot be wholly attributed to the introduction of drug-testing and/or mandatory treatment obligations because, in some states, participation in treatment services fulfilled individual work requirements, providing an added incentive to enter treatment. Medicaid secured through TANF may have expanded access to treatment.

Other research from settings outside welfare benefit policy indicates that **mandatory treatment obligations and sanctions have little effectiveness**. A systematic review of the literature found limited scientific literature evaluating compulsory drug treatment. The available evidence does not, on the whole, suggest improved outcomes related to compulsory treatment approaches, with some studies suggesting potential harms (Werb et al., 2016).

Qualitative research exploring the treatment journeys of welfare recipients with substance use disorders indicates that the effectiveness of mandatory treatment may be limited by the complexities of access and participation in treatment services (Bauld et al., 2010).

Child outcomes

An important concern raised with the application of sanctions to drug users in the US was the impact on children in welfare dependent households (Drug Policy Alliance, 2011). To date, however, there has been no rigorous evaluation of welfare drug testing policies on child outcomes. General research on the effect of benefit sanctions that reduce family income (such as those that could result from drug testing obligations) have been shown to increase the risk that children experience food insecurity and are admitted to hospital (Skalicky & Cook, 2002). Analyses of the potential impacts of drug testing welfare recipients have also suggested negative impacts on child wellbeing due to "parents refus[ing] to apply for benefits knowing they will face drug testing, or may refuse to complete treatment" (ASPE, 2011, p.8).

Service delivery culture and public perception of welfare recipients

Critics of drug-testing obligations and sanctions have highlighted the potential for such policies **to undermine the case manager-client relationship**. As noted by MacDonald et al. (2001, p. 6): "Case managers are generally more effective when they build a trusting relationship with the client. Drug testing has the potential to undermine this relationship by creating an adversarial environment, which could be counterproductive to the joint goal of obtaining employment." There has been no rigorous research to date exploring such potential effects.

A further concern raised by critics of drug-testing policies has been the potential for these policies to **exacerbate existing stigma associated with welfare receipt**. Such stigma could prevent or deter individuals in hardship from applying for assistance, present a barrier to recovery, or negatively impact employer perceptions of welfare recipients as potential employees (Macdonald et al., 2001; Wincup & Monaghan, 2016).

Alternative approaches

There are a number of alternative policy approaches that could be considered as ways to improve the outcomes of welfare recipients who use drugs or have substance use disorders.

- Improving access to drug and alcohol services for all New Zealanders with problematic drug and alcohol use (NZ Drug Foundation, 2011), and changing the legal response to personal use and possession as a mechanism for reducing drug-related harm and shifting towards a more health-focussed approach (New Zealand Law Commission, 2011).
- Promoting more integrated collaboration across the benefit and health systems, to improve employment outcomes for substance users and others with long-term health conditions (Black, 2016).
- Working with employers to improve access to employment opportunities (Black, 2016; NZ Drug Foundation, 2011).
- Improving work incentives. A US longitudinal study found that the Earned Income Tax Credit was effective in improving both earnings and the number of hours worked among TANF recipients who were drug users (Montoya & Brown, 2006).
- Using educational programmes and vocational training to improve employability and help individuals achieve paid employment. Programmes and training of this type for the unemployed have been shown to enhance health and social functioning, as well as increasing the success of substance-related addiction treatments (Henkel, 2011).
- Moving away from a 'recover first/find work second' approach and towards viewing employment and other meaningful activity (including volunteering) as essential elements in recovery (Black, 2016). An approach that could be made more widely available is Individual Placement and Support (IPS), where intensive employment support is integrated with mental health treatment. IPS has been shown to be effective for people with severe mental health disorders and is available within District Health Board mental health and addiction services in some but not all areas of New Zealand (Lockett et al., 2018). It is currently being piloted as part of an integrated model of Police and Health activity to reduce methamphetamine demand in Northland.

- Intensive case management. In the US, experimental evaluation of CASASARD, an intensive case management programme for substance-dependent TANF recipients in New Jersey, found positive impacts on participants' employment, treatment access and participation, and reductions in substance use (see box below). Trialling this approach in New Zealand could be considered.⁷

CASASARD: Intensive Case Management for substance-using welfare recipients

The National Center on Addiction and Substance Abuse (CASA)'s Substance Abuse Research Demonstration (CASASARD) in New Jersey sought to test an intensive case management approach for substance-dependent TANF recipients (mostly single mothers), involving outreach services, screening, assessment, services to enhance motivation and increase engagement in treatment, treatment provision, coordination of support services, monitoring and advocacy, aftercare follow-up, peer support, relapse monitoring and crisis management.

CASASARD was designed as a **randomised controlled trial**. TANF recipients who were identified as having a substance use disorder through screening and assessment who gave informed consent to voluntarily participate in the study⁸ were randomly assigned to either the intensive case management service, or to the usual level of care (involving primarily screening and assessment).

Evaluation of CASASARD found that, when compared with TANF recipients who received the usual care approach, those who received intensive case management:

- received **significantly more time and services from their caseworkers**
- achieved rates of initiation, engagement and retention in **outpatient substance abuse treatment that were two to three times as great** as for TANF recipients who received usual care
- achieved **significant reductions in substance use**, with participants almost twice as likely to be completely abstinent from substance use after 12 and 24 months in the study
- showed **increased employment rates over time** and were more than twice as likely (22% vs. 9%) to be employed full-time after two years (CASA 2009).

⁷ In the UK, Adults Facing Chronic Exclusion (ACE) Pilots focused on intensive one-to-one support from 'key workers'. A key aim of the pilots was to stabilise the circumstances of the clients with whom they worked (eg through addressing issues such as homelessness and substance abuse) which was seen as a necessary prerequisite to improved employability. Evaluation of ACE recommended a 'key worker' approach to negotiate access to services, in which one practitioner takes responsibility for personalised casework, supported by enhanced integration of support services (Cattell et al., 2011).

⁸ Participation in screening was mandatory, and occurred as part of TANF benefit eligibility determination.

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