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▶ A practical clinical trial of coordinated care management to treat substance use disorders among public assistance beneficiaries.

Morgenstern J., Hogue A., Dauber S. et al. Request reprint

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Further demonstration from a US research team that relatively intensive case management support does help welfare applicants overcome substance use problems, but in this case only those not already managed through substitute prescribing.

Abstract This US study was designed as a practical clinical trial maximising real-world applicability while maintaining research integrity. It was implemented in partnership with a large city welfare agency. Participants were 421 substance using single adults and adults with dependent children applying for welfare benefits. They were selected from 1519 such applicants on the basis of their reporting a substance use problem and being motivated to receive treatment. Initially they had been identified by welfare workers using a standard screening questionnaire. Depending solely on where the next assessment slot was available, the workers transferred substance users for further assessment at one of the two offices in the study.

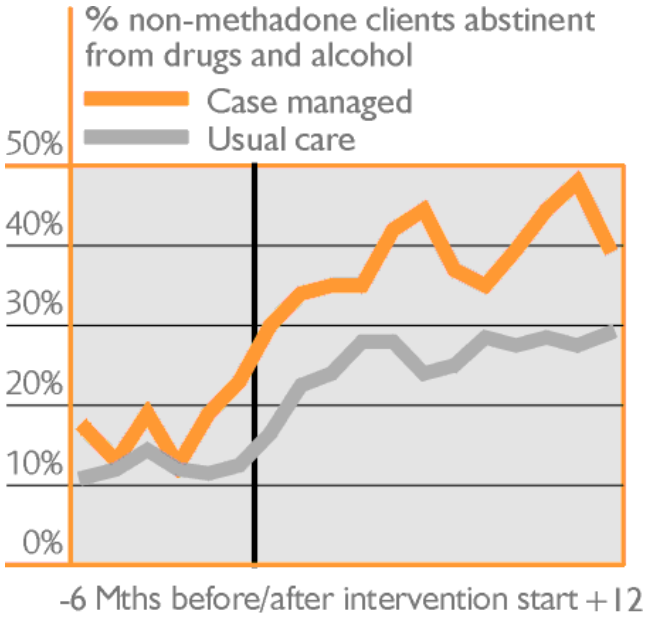
One of the offices offered usual assessment and care services: assessment by an addiction counsellor focused on substance use problems in relation to employability, followed by allocation to a generic welfare worker whose role was to assess eligibility for welfare payments and deal with non-compliance with the welfare system's requirements. They also referred the beneficiary to services, but only during infrequent meetings limited by a large caseload.

At the other office, more rounded and detailed assessments were conducted by a multidisciplinary team. After referring applicants to a range of services to meet identified needs, they transferred them to case managers. Their role was to maintain intensive contact with the beneficiary and with the agencies providing them with services, and to ensure that these agencies matched the individual's needs and performed acceptably. In the usual care option, quarterly reassessments focused on welfare system requirements, but in the case management option the focus was on client progress and adjusting the

service mix accordingly.

All 108 applicants who were in methadone maintenance treatment during the study were already in this treatment at the time they applied for benefits, and generally simply continued. Beyond these existing methadone patients, there were few if any heroin dependent applicants who might benefit from initiating treatment. Welfare case workers had more latitude to initiate or change other sorts of substance use treatments.

Diagnostic interviews found that about 6 in 10 of the sample met criteria for substance dependence, mainly in respect of cocaine, alcohol or heroin, and another fifth for substance abuse. Psychological problems and criminal justice involvement were common. About 1 in 6 had some degree of responsibility for dependent children.



As intended, over the year of the follow-up period, case managed clients saw their case workers more often than their counterparts in usual care. Especially during the first three months, they also received a broader range of services. However, this was entirely due to greater service access among clients not already in methadone maintenance. When usual care was replaced with relatively intensive and proactive case management, these non-methadone clients were significantly more likely to be in (drug-free) substance use treatment and to get help with medical, employment, mental health and basic needs. They also achieved significantly higher rates of abstinence from alcohol and illegal drugs ▶ chart. Once other influences had been taken in to account, for every four people who were abstinent during any given month in the follow-up period, another three achieved this with the help of more intensive case management. This advantage emerged early in treatment and was sustained throughout the follow-up period. In contrast, and just as with services received, abstinence rates among clients already in methadone treatment were not increased by case management.

Four in ten of the non-methadone clients were already in treatment, and largely were applying for benefits to help pay for it. Given this, the researchers argued that not only did their study demonstrate the value of case management for welfare applicants, but also for poor clients in publicly funded treatment in general.

FINDINGS The study deliberately selected the most promising candidates for substance use treatment. Its results cannot be assumed to generalise to the bulk of welfare applicants identified by front-line welfare workers as potentially hindered by their substance use, but who do not have a serious problem, have one but are unwilling to acknowledge it, or are not motivated to tackle it. More information on the sample can be found in an earlier report.

Findings were line with a sparse evidence base suggesting that increased provision/ receipt of welfare and medical services improves outcomes from addiction treatment. Lack of impact among methadone-maintained patients was expected because at the start of the study they were already in a treatment which entailed regular clinical and counselling contacts, leaving in this respect little for case managers to improve on. Had case managers been able to initiate methadone treatment, the picture might have been reversed, with greater impacts among those introduced to methadone programmes. It does however remain puzzling why the methadone patients in the study did not access the social, medical and welfare services made available through the case managers, services generally underprovided by US methadone programmes. Despite intensive case management contact, for these patients the status quo applied. The assumption may have been that simply turning up for methadone was sufficient engagement with treatment, and/or that patients on methadone could not take advantage of reintegration opportunities. Certainly the US requirement for long-term supervised consumption would constrict vocational and employment opportunities.

The same research team had recently conducted a similar study among substance-dependent mothers applying for benefits for families in need. Those offered case management were over twice as likely to be abstinent during any particular month in the two-year follow-up period, and across this period were 68% more likely to be in full time employment.

These two studies from in and around New York are at odds with the general picture reported recently in a review of studies of case management for drug users. Across 11 studies which randomly allocated clients to case management versus 'usual care', case management did improve access to services, but there was no statistically significant impact on illegal drug use. Results varied substantially from study to study, suggesting that effectiveness depends on the circumstances. One of the few reviewed studies which did report significant impacts on drug use was the study described in the previous paragraph. The authors argued that their studies may have bucked the generally negative trend because the interventions they tested were robust, well resourced by the providing authority, and there was a clear divide between these services and those provided to comparison groups. Other factors include whether services are so easily accessible that case management is unnecessary, or so hard to access that case management cannot help (or not until new systems/resources have been developed), and the type and intensity of the case management model. Evidence is strongest for the strengths-based model which focuses on the client's strengths, abilities and assets, and puts them in control of setting goals and obtaining resources to achieve those goals.

Government-backed legislation currently being debated in Britain would introduce a welfare-to-work model closer to the US model, in particular making welfare benefits for

problem drug users conditional on engaging with and making progress in the rehabilitation plan agreed with (or determined by) their employment adviser. There is though as yet no commitment to provide intensive case management support. Without this, the risk is that problem substance users and their families will be disproportionately subject to sanctions for non-compliance rather than make progress in their recovery. Even if Britain did adopt a case management model, the UK caseload may react differently to the applicants in the featured study. The US sample was dominated by cocaine users and it was among these and other non-opiate users (mostly drinkers) that positive effects were noted. All or nearly all the heroin dependent applicants in the sample were among the group on methadone who did not profit from case management. In contrast, at least initially in Britain, heroin users are likely to form the bulk of welfare applicants considered appropriate for treatment. If they are already in treatment, the featured study suggests that it will take a highly intensive, resource-rich and ambitious case management programme to take them further along the road to reintegration and employment. If they are not already in treatment, it may be because they are unable or unwilling to take up the treatment opportunities currently available. Again intensive work may be needed to overcome these obstacles. Such UK evidence as there is suggests that drug users not already in treatment will be among the welfare applicants least likely to comply with requirements in response to threats of benefit cuts.

Thanks for their comments on this entry in draft to Nicola Singleton of the UK Drug Policy Commission. Commentators bear no responsibility for the text including the interpretations and any remaining errors.

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