New Jersey’s Welfare to Work Model:
The Substance Abuse Initiative (SAI)

The 1996 federal welfare reform legislation, which created the Temporary Assistance to Needy Families (TANF) program, transformed federal welfare programs into a capped block grant with specific work requirements and a five-year lifetime limit on federal assistance. To help recipients meet the new work requirements, the legislation allowed states to use their federal and state TANF funds to provide support services for long-term welfare recipients facing serious employment barriers, including alcohol and drug problems. In the state of New Jersey, research indicated that approximately 27% of TANF recipients tested positive for illegal drug use and that 20% had addiction problems serious enough to warrant treatment. To address this problem, New Jersey allocated approximately $20 million per year to expand treatment services for welfare recipients. The New Jersey Division of Addiction Services (DAS) in conjunction with the Department of Human Services and the New Jersey affiliate of the National Council on Alcoholism and Drug Dependence (NCADD-NJ), the state implemented a Substance Abuse Initiative (SAI) in all counties of the state.

The New Jersey SAI is unique in having developed a uniform statewide care management model, based on managed behavioral health care principles, for patient assessment, placement and care. Significantly different from for-profit managed care entities, SAI care coordinators are driven primarily by client needs. Through close coordination with the welfare caseworkers, SAI has increased access to those in need by a factor of 40. Using standardized assessment and monitoring tools, clients are moved through a continuum of care within an organized, statewide network of treatment providers. SAI care coordinators identify addiction and other related problems that impact on the recovery process, refer the client to the appropriate ASAM level of care, and through ongoing care coordination ensure that the treatment provider is adequately addressing the client’s needs. In this way the SAI ensures that issues such as housing, transportation, childcare, and other “wrap around” services that are essential ingredients to “success” for this population, receive appropriate focus and attention, along with the addiction counseling services. Although the SAI does not deal directly with mental health treatment, the high level of credentials held by the care coordinators, having at least a masters degree and in many cases a clinical license, permits screening for and preliminary assessment of mental health issues. Those clients with a psychiatric diagnosis may still be referred, and their care coordinated, if those issues are being treated and the client is sufficiently stabilized to be able to benefit from the addiction treatment. Many addiction programs previously unable to deal with this population are now doing so with the benefit and assurance of the prior screening and assessment by the care coordinators.

Client information and clinical decisions can be captured in an Information Management System (IMS). If these are integrated with outcome measures such as whether the individuals completed the welfare to work training and obtained employment, SAI will be able to derive what service clusters work best with what client characteristics and indications of what differential outcomes cost. In other words, SAI would be able to estimate what levels of service produce what results for what population at what cost. Thus, from the state’s point of view as a purchaser of services, they should be able to allocate funding to achieve a specified outcome.