

## **TANF Recipients' Barriers to Employability: Substance Abuse and Domestic Violence**

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*Recipients of temporary assistance for needy families (TANF) encounter a variety of expectations and sanctions. Recipients face work requirements, limited resources, and barriers to employability, including the barrier of substance use. This article addresses the sanctions that are applied to clients who do not meet expectations of the policy, barriers to employability, disparities in resources, and factors influencing referrals for substance abuse treatment for TANF clients.*

*KEYWORDS* TANF, welfare, substance abuse, employment, women, domestic violence

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996, from which temporary assistance for needy families (TANF) was born, became law with two main ideas shaping the concept of welfare provision: that states needed increased flexibility in setting welfare policy and that welfare was no longer considered an entitlement (Jayakody, Danziger, & Pollack, 2000, U.S. Congress, 2006). There were three main goals of welfare reform: replace welfare with work, decrease the number of out-of-wedlock births, and promote marriage (Horn, 2001; Jayakody et al.; Lee, Slack, & Lewis, 2004). Other authors characterized welfare reform as an effort to promote self-sufficiency (Daugherty & Barber, 2001). Regardless of the semantic differences of overall purposes noted by scholars and policy makers, the title given to the states' programs is noteworthy: Temporary Assistance for Needy Families (with emphasis on temporary).

Parents were expected to get "off the dole" and into the work force; the implementation of this expectation was left to the states to achieve a decrease in welfare rolls. Proponents of the policy posited that children would benefit

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from seeing their parents go to work for several reasons: Parents would provide a positive role model for work behavior, and parents would have increased financial resources for investing in their children (Gennetian & Miller, 2002). Critics of the policy argued against children's benefit because parents would experience increased stress as a result of employment that would negatively affect their ability to parent; additionally, children would be left unsupervised or with poor-quality day care arrangements (Gennetian & Miller). One conservative policy analyst stated, "Welfare was to be a way station, not a way of life" (Sawhill, 2001). To ensure that this way station did not become a way of life, federal guidelines placed limits on both the length of provision of assistance (total of 5 years) and on an individual's behaviors that might impede employability. These included drug use, incarceration, and unemployability due to lack of motivation or other hindrances to work (transportation, child care, etc.). A provision for domestic violence victims was also added.

In spite of these problems, TANF was declared a success. However, other factors were involved in this "success," such as an upturn in the economy and the implementation of the earned income tax credit during the same time period (Sawhill, 2001). Unarguably, caseloads declined; however, the decreases occurred on an uneven basis, thereby creating wide variations in state-to-state numbers (Dunlap, Golab, & Johnson, 2003; Sawhill).

Enrollment declines noted by state for TANF recipients were vastly different. Wisconsin and Wyoming experienced the fastest declines, measured at 89.5% and 86.9%, respectively, whereas Rhode Island and Hawaii experienced the slowest declines in enrollment, at 20.3% and 21.2%, respectively (Adkinson, 2001). Overall, TANF rates were reduced by 50% nationwide, from 1997 to 1999 (Parisi, McLaughlin, Grice, & Taquino, 2006; Seefeldt & Orzol, 2005).

In Wyoming, for example, the rate of decrease was measured at 90% from 1995 to 2008, whereas in Hawaii during the same time period, a decline of approximately 40% was noted (DHHS, ACF, 2010). Furthermore, declines in urban areas have been smaller than in non-urban areas with the exception of New York City (Dunlap et al., 2003). Complicating the analysis is that women who leave welfare often return, especially those from poor urban areas (Anderson, Halter, & Gryzlak, 2004; Chandler, Meisel, Jordan, Rienzi, & Goodwin, 2004). Many welfare-to-work participants simply leave the welfare rolls to join the ranks of the working poor whereby they earn minimum wage with few benefits provided (Danziger, Corcoran, Danziger, & Heflin, 2000; Reutebuch, 2001). Thus, uncertainty exists concerning how well women have fared after leaving welfare, even though the intent of the law—to get women into the workforce—was realized to a significant degree.

The definition of success, specific to this law, was operationalized as moving women from welfare programs and into the workforce. However, as a policy, TANF did not provide direction or "stopgaps" for determining

which women would need more assistance to effectively exit welfare programs, nor were there measures for determining who would be capable of exiting welfare in a timely and successful manner. Additionally, TANF did not provide the necessary support systems in the staggering amounts necessary to support this population (i.e., transportation, training, education, substance abuse treatment, or childcare; Davis, Mathai-Davis, Dujon, Roberts, & Buel, 2000; Lens, 2002). Caraley (2001) noted that women exiting welfare to take jobs created a need for 1 million daycare slots in addition to the already overburdened childcare facility system. Obviously, necessary and critical supportive structures were not in place to handle this unexpected requirement.

### BARRIERS TO EMPLOYABILITY

Employability decreases dramatically based on the number of barriers faced by a TANF recipient (Bilby, 2005; Chandler et al., 2004). These barriers include lack of high school diploma, drug dependence, domestic violence, and low work skills (Bilby). Comparatively, individuals with no employment barriers worked 82% the year whereas individuals with six or more barriers worked only 7% of the year (Bilby). Other researcher noted that that fewer than 40% of the participants had worked 32 hours per week or more at the time of their study (Chandler et al.).

Women with barriers to employment could benefit from added services provided by TANF case managers. The emphasis, clearly, should be placed on the most vulnerable TANF recipients who are eligible and expected to find work. Individuals with addictions (Atkinson, Lee, Dayton-Shotts, & French, 2001) or unmet psychological needs (Stromwell, 2001) and those who have very limited life/work experience that would provide the basis for job acquisition and retention should be a priority for TANF caseworkers. To help these clients, necessities must be provided: affordable housing, absence of violence in the family, presence of supportive structures such as child care or child supervision, transportation, and a supportive work environment free from oppression or discrimination wherein employers recognize critical family responsibilities (Daugherty & Barber, 2001).

Women seeking to exit welfare who found jobs often were in a "Catch 22" situation: They lived in impoverished areas that did not have available jobs and worked in suburbs that did have jobs (Cheng, 2005; Lens, 2002). These women were unable to afford housing near their places of employment, thus necessitating long commutes. The lengthy commutes yielded another problem in that there was unavailability of childcare for those who commuted several hours per day and for shift workers (Sawhill, 2001).

Rural TANF recipients often reported that if they were able to sustain reliable transportation, they would not need to receive TANF (Anderson & Hoy, 2006; United States Government Accountability Office, 2004). Though

both rural and urban women experience transportation hardships and other barriers to entering the workforce, rural women seem to fare slightly worse than urban women (Anderson & Hoy). Other problems associated with a return to the workforce have included such factors as being hired for seasonal or temporary work and the reality of being unable to survive on minimum wages (Anderson & Hoy; United States Government Accountability Office, Report to Congressional Requesters).

## SUBSTANCE ABUSE AND DOMESTIC VIOLENCE BARRIERS

For many women, returning to the workforce is a difficult goal to reach because of substance abuse problems or domestic violence factors. Several studies have addressed the issues of women who have difficulties that inhibit their ability to obtain and sustain employment (Anderson & Hoy, 2006; United States Government Accountability Office, 2004). As there were no allowances in most states for women who were actively seeking recovery from substance use disorders, these individuals were unfairly penalized as being unable to obtain or maintain employment (Kaplan, 2004; Woolis, Cyphers, & Roth, 2000).

However, in Chicago, TANF officials attempted to address substance abuse issues for recipients by providing referrals to substance abuse treatment facilities and direct service linkage for substance abuse clients (*Alcoholism & Drug Abuse Weekly*, 10/05/98). Though this intervention appears weak in terms of meeting the pressing need for treatment for most women who are poor and addicted, the effort is laudable in that it was one jurisdiction that made the effort to meet the needs of substance using TANF recipients.

For the most part, however, TANF administrators either have not seen psychiatric and substance use problems as a factor in employability or they have been unable or unwilling to establish protocols or methods to deal with these issues (Woolis et al., 2000). Some of the reasons cited by TANF administrators for not addressing the problem of substance abuse have been lack of funding, lack of knowledge of treatment options, and lack of policies for identifying and treating substance abusers (Woolis). Other issues have been inability of the organizations to meet the needs of substance-abusing clients and inadequate record-keeping systems to track substance-abusing clients (Woolis).

### Substance Abuse

Current policies that affect women who use substances vary widely state to state, with some states electing to prosecute and some states offering screen-

ing and/or treatment for such women (Roberts, 1991; Smith & Young, 2003; State Policy Documentation Project [SPDP], 2000; Dailard & Nash, 2000). None of the states currently tests all TANF-eligible women for drug use, although 10 states screen for drug use under certain circumstances (Smith & Young, 2003). Two states, California and South Carolina, stopped prosecuting pregnant drug users in the mid-1990s (Jessup, Humphreys, Brindis, & Lee, 2003; Jos, Marshall, & Perlmutter, 1995). California stopped prosecution of pregnant substance users in 1995 and now offers treatment-on-demand programs and treatment instead of incarceration programs for women desiring to become drug free (Jessup et al.). South Carolina stopped prosecuting pregnant substance abusers in 1994 based on an agreement with the Civil Rights Division of the Department of Health and Human Services (Jos et al.). However, elsewhere in the United States, since 1992 there has been an increasingly significant involvement by individual states in prosecution of pregnant women and in drug testing of women and newborn infants (Chavkin, Breitbart, Elman, & Wise, 1998).

### Domestic Violence Factors

Another social problem that restricts employability for women is domestic violence. Women in abusive relationships often “cycle” between living with abusive partners and living “on welfare” (Bell, 2003; Davis et al., 2000). Brandwein and Filiano (2000) estimate that the number of abused women is approximately 2 million annually. However, other researchers indicate that the prevalence of domestic violence involving women victims ranges from approximately 50% to 60% (Bell, 2003; Dansky, Byrne, & Brady, 1999; Najavits, Weiss, & Shaw, 1997). About 25% of abused women experience abuse on a recurring basis (Brandwein et al.) whereas prevalence estimates for domestic violence for women on welfare range from 20% to 75% (Brandwein et al.). Rates of abuse for women of color appear to be higher based on current research. For example, estimates for African American women are six times higher than those for White women (Campbell, Sharps, Gary, Campbell, & Lopez, 2002).

In a study that highlighted only African American and Latina subjects, researchers found that 41% of the women experienced abuse from partners such as slapping, whipping, or beating and 24% had experienced life-threatening abuse, such as with a gun or knife or by being choked or strangled (El-Bassel, et al., 2003). Fifty-seven percent of the women surveyed in the El-Bassel et al. study indicated that they had used substances, with the majority abusing alcohol.

Forty-two percent of the women in the El-Bassel (2003) study noted that their main economic support came from public assistance whereas 35% indicated that they had been employed within the past year. However, the majority of the women in the study did not hold a high school diploma,

so it is reasonable to assume that their wages were minimal. Similar results were noted by Sales and Murphy (2000) concerning the educational levels of abused women; they found that women were about three times more likely to have dropped out of high school as other women.

For women involved in domestic violence situations, many of whom have long histories of attempting to leave violent homes, the reality of work is that they are poorly trained or inexperienced, which ensures that the jobs they are able to find are low-paying. Thus, the cycle restarts; they are unable to support themselves and their children, and they return to their abusers (Bell, 2003; Brandwein et al., 2000; Davis et al., 2000). Approximately two-thirds of pregnant women in treatment for addictions or alcoholism have experienced violence (Burgdorf, Chen, Walker, Porowski, & Herrell, 2004; Tuten, Jones, Tran, & Svikis, 2004) whereas Hedin and Janson (2000) noted that 40% to 60% of battered women are abused during pregnancy. One study indicated that abused women were more likely to be poly-substance users, to have difficulty with relationships, and to experience comorbid mental health diagnoses than women without violent experiences (Tuten et al.). Another study indicated that 10% of abused women were problem drinkers whereas 17% were weekly drug users (Lown, Schmidt, & Wiley, 2006). The ability of women with such difficulties to reach self-sufficiency complicates efforts to achieve independence.

### A Policy to Address Family Violence

One policy effort that would assist women in achieving self-sufficiency is the Family Violence Amendment. This is a clause within TANF that allows states to choose whether to screen TANF recipients for family violence (Brandwein et al., 2000). This amendment, coauthored by the late Senator Paul Wellstone, was designed to help women who have additional barriers to obtaining employment because of family violence. The concern was that for abused women with limited skills and low employability options, the Family Violence Amendment would allow additional time and resources to seek independence. Approximately 31 states (including Puerto Rico) have implemented this amendment (Brandwein et al.). The state of Mississippi allows a 12-month exemption from work requirements for domestic violence victims (Mississippi Department of Human Service [MDHS], 2006, p. 14).

### Penalties and Sanctions for Substance Use Violations

TANF regulations require penalties or sanctions to be imposed as a result of noncompliance with program rules (Reichman, Teitler, & Curtis, 2005; Lee et al., 2004; Wu, 2008). These penalties/sanctions can range from mild to harsh, depending on the state in which a woman resides. Of 51 entities (50 states and the District of Columbia), 33 imposed a partial sanction

for violations, 15 utilized termination, and 3 used a combination of partial sanctions and termination, depending on the violation (SPDP, 2000). In 23 states, the first violation of a TANF rule could escalate to a maximum sanction; in 24 states, maximum sanctions would not be applied; and in 4 states, this was not applicable because the states encouraged individuals and families to become compliant to continue receiving benefits (SPDP). Mississippi and South Carolina were observed to have some of the most severe sanctions; first-time violators would be terminated from the program (lose all benefits) for 2 months before they could re-certify for benefits (SPDP). However, in Minnesota, a state observed to employ less-punitive sanctions, the individual/family would lose only 10% of the benefits for a period of 1 month before being allowed to re-certify for assistance (SPDP). Alabama was another state that used lesser sanctions; the policy stipulated a 25% reduction in benefits until compliance was reached, with an imposed limit of 6 months for the maximum sanction. By 2002, some states had sanctioned approximately half of their TANF caseloads whereas sanctions across the board increased approximately 30% nationwide (Lens, 2002). Several states used a progressive sanction policy that increased the penalties for individuals who continued to exhibit noncompliance with regulations (Kim, 2000; Lee et al., 2004). Regardless of the severity of sanctions or penalties, the message to women and children has been clear: Comply or pay the price.

### Attempts to Address Substance Use Needs

Several states, including New Jersey and North Carolina, have begun to address the problem of substance use and services to those who are TANF-eligible (Pollack, Danziger, Jayakody, & Seefeldt, 2002). In New Jersey, county departments of social services have implemented screening, assessment, and treatment strategies for substance users (Pollack et al.). In North Carolina, each county social service office has added a qualified substance abuse professional to screen, assess, and coordinate interventions for substance using clients (Pollack et al.). Several other states have enacted legislation to screen TANF applicants for substance use (Bone, 1997): Kansas, Maryland, Louisiana, New Jersey, Michigan, New York, and Ohio (Bone).

However, nine states "opted out" of the Gramm Amendment to provide for the needs of their citizenry in the arena of drug treatment (Dunlap et al., 2003; Pollack et al., 2002). The nine states were New York, New Hampshire, Ohio, Oklahoma, Oregon, Vermont, Michigan, Connecticut, and Kentucky (Pollack et al.). Eighteen other states created exceptions for some drug-related offenses and for those individuals who chose to participate in drug treatment (Pollack et al.). Some of the states with exceptions were Arkansas, Illinois, New Jersey, South Carolina, Utah, and Wisconsin (Pollack et al.). The state of Mississippi, though not on the Pollack list, does allow for

TANF recipients to continue to receive benefits as long they are participating in substance abuse treatment and following an established treatment plan (MDHS, 2006, p. 14). Although a few of the aforementioned states (New York, Ohio, etc.) test TANF recipients and applicants, there is an attempt to make provisions for treatment where indicated.

In addition to policies that eliminate drug users from the existing TANF rolls, several states enacted legislation to screen TANF applicants for substance use (Bone, 1997). These states included Kansas, Maryland, Louisiana, New Jersey, Michigan, New York, and Ohio (Bone). Louisiana, for example, offers only one drug treatment placement for women with children within the entire state, according to Substance Abuse and Mental Health Services Administration (SAMHSA) data (2004). The question for women in such states becomes: "How can substance abuse treatment needs be met in states with few treatment facilities?"

Finding available treatment facilities and the funding to pay for services has become increasingly difficult for women. Though there are thousands of treatment facilities within the United States, a relatively small number of these cater to the specialized needs of female substance users, and an even smaller number serve pregnant women or women with children (DASIS, 2004; Sowers, Ellis, Washington, & Currant, 2002).

### Treatment Availability for Pregnant or Parenting Clients

There are 536 residential facilities in the United States located in 35 states that specifically address the needs of pregnant women, and 203 of the 536 facilities offer placements for women with children (SAMHSA, 2004). Many of these states have only one facility whereas others have a dozen or more. Some of the states with multiple facilities include New York, Illinois, Pennsylvania, Nevada, Massachusetts, Texas, Arizona, Florida, California, and Michigan. States with only one facility included Louisiana, West Virginia, Wyoming, and Rhode Island (SAMHSA, 2004). The state of Mississippi was not included in any of the lists on the SAMHSA treatment finder Web site; however, two placements within the state are known to this writer. Medicaid is accepted at 165 facilities; however, it was indeterminable whether any of these facilities accepted women lacking medical insurance (SAMHSA, 2004). According to the SAMHSA (2004), all 536 facilities have payment assistance programs, although this option probably would not prove to be an adequate incentive to enter treatment for women lacking income.

Other barriers exist for women who need or desire treatment for substance use. For many women, substance use is a secret or solitary activity and is a problem characterized by denial (Gregoire & Sniveley, 2001; Johnson, Gerada, & Greenough, 2003). In the Johnson et al. study, researchers noted that 40% of the pregnant women who were asked about substance abuse denied it but later identified as positive on urine screens. For many



women, requesting treatment represents too large a stigma or risk of being "found out" (Gregoire & Sniveley). Childcare is a necessity for many women. Some substance-using women have noted that they would not have entered treatment if they could not take their children with them (Baker, 2000; Westermeyer & Boedicker, 2000). Other women have to endure extensive waiting periods for placement in residential treatment programs wherein children were allowed (Roberts, 1991).

An innovative approach to engaging women in treatment was attempted in the state of Washington. Case managers actively recruited pregnant women for inclusion in residential treatment programs (LaFazia et al., n.d.). Through this project, case managers traveled areas where drug abuse occurred such as city parks, jails, "teen hangouts," and known prostitution districts and visited health clinics and social service agencies to recruit pregnant drug users (LaFazia et al.). This represents an uncommon effort to engage pregnant substance users in treatment on a voluntary basis. In fact, this report (which, from the text of the article, appears to have been written around 1996, although there is no date) was the singular example of extensive recruitment documentation found.

### Treatment Program Limitations

There are fewer programs available to women (as compared to men) that offer day treatment or evening treatment and fewer programs for women lacking insurance coverage (Westermeyer & Boedicker, 2000). There are fewer gender-specific treatment programs that adequately address the needs and issues of women substance users (Baker, 2000; Hawk, 1994; Westermeyer & Boedicker).

A higher percentage of White women than African American women enter treatment while pregnant; 43% of clients were White versus 39% of African Americans and 18% of Hispanics (Hohman, Shillington, & Baxter, 2003). There has been a 15% decline in admissions for African Americans (male and female) in treatment programs though admissions for the general public increased by 3% (Center for Substance Abuse Treatment, 2009). The reason for this decline is not known; apparently, there are unknown barriers or combinations of barriers for African Americans and other people of color that require further investigation.

### CONCLUSION

In combination, the wide discrepancy in welfare roll decreases combined with both the difficulties women face in gaining employment and the difficulties they encounter in seeking treatment paint a harsh picture for their futures. Clearly, the psychiatric, substance use, or domestic violence problems of

women seeking an exit from welfare or who have exhausted their welfare benefit time limits need to be addressed by trained and knowledgeable professionals in a service delivery system that has the capacity to address a wide variation of client needs. Otherwise, women will be expected to achieve what seems insurmountable: employment in spite of overwhelming and opposing odds.

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