

# Substance Abuse and Welfare Reform

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**The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 has forced welfare officials and substance abuse treatment providers to better understand the connections between substance abuse and welfare dependency. As a result, both are thinking differently about their policies and even their missions. Little is known about the true extent of substance abuse among welfare recipients, but estimates range from 2.7% to 22%. The current system of substance abuse treatment is poorly matched both to the needs of disadvantaged mothers and to the mandates of welfare reform. To help women achieve self-sufficiency, treatment programs must focus on the needs of women, address problems that often accompany substance abuse, attend to the needs of children, and emphasize work as an outcome of treatment. Welfare agencies must also change to meet their mandates; they must improve the tools and resources they offer staff, improve access and services for families, and align agency policies with new missions. (JAMWA. 2002;57:36-37)**

Substance abuse and welfare dependency are pressing problems that are elaborately interconnected. Both are difficult and complex conditions that develop over time. Escape from both requires persistence, support, and courage. Welfare reform has forced welfare and substance abuse officials to better understand these connections. As a result, both are thinking differently about their policies and even their missions.<sup>1</sup>

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) made the most significant

changes to our welfare system since it was created in 1935. PRWORA is less a set of discrete programs than a basic shift in what we expect from government. It gives preference to individual self-sufficiency and personal responsibility over long-term income support, thereby fundamentally changing the nature of our public social service systems. As of March 2001, 5.4 million individuals were receiving welfare benefits, compared to 12.2 million in August 1996 when PRWORA was signed.<sup>2</sup>

Authority and responsibility for poverty programs shifted under PRWORA from the federal government to the states. Temporary Assistance to Needy Families (TANF) replaced Aid to Families with Dependent Children, but TANF is not a "program." Rather, it is a loose federal framework within which states construct their own TANF systems.

Welfare reform holds out the possibility of two futures for our society. On the one hand, PRWORA offers an opportunity to address long-standing problems. It gives state officials authority to set policy without requesting permission from the federal government and to use welfare funds for a variety of purposes, including many kinds of substance abuse treatment. On the other hand, PRWORA weakens the safety net for vulnerable families. It sets lifetime limits for cash assistance, imposes rigorous work requirements and, prohibits benefits for people convicted of drug-related felonies (unless state legislation overrides this provision) and who have parole or probation violations.<sup>3</sup> Substance abusers have poorer work histories than nonabusers,<sup>4</sup> and drug use is closely connected with the crimes of women,<sup>5</sup> thus substance-abusing TANF recipients are more likely than other recipients to be affected by these features.

## Substance Abuse Among TANF Recipients

We know little about the extent of substance abuse among welfare recipients.

State studies of TANF recipients have reported prevalence rates from 2.7% to 22%, depending on how "abuse" was defined and how questions were posed.<sup>3</sup> In a national survey, welfare administrators estimated that 20% of recipients had substance abuse problems.<sup>1</sup>

Welfare agencies traditionally used an informal "don't ask, don't tell" approach to substance abuse. Welfare "eligibility workers" were charged with determining financial eligibility for benefits and not with helping families achieve self-sufficiency.<sup>3,6</sup> Substance abuse treatment providers did not focus specifically on employment because welfare benefits were secure. Therefore, either substance abuse among welfare recipients was not identified or recipients who disclosed substance abuse could remain in treatment without seriously addressing work.

PRWORA changed the context for welfare and substance abuse treatment agencies alike. Welfare administrators now must address substance abuse among recipients, and substance abuse treatment programs must address the employment needs of addicts. Many welfare and substance abuse treatment agencies have started programs that reflect their shared interest in sobriety and work, but most are not satisfied with the results. In response to a survey, welfare officials reported that substance abuse among recipients was likely to affect state ability to meet TANF work requirements, and substance abuse administrators reported that treatment availability was a severe problem. Only 14 states reported having employment programs that integrated substance abuse treatment into work activities.<sup>1</sup>

## Treatment Challenges

The current system of substance abuse treatment is poorly matched to the needs of disadvantaged mothers<sup>7</sup> and to the mandates of PRWORA. But treatment providers can take steps to improve outcomes for women and reduce the likeli-

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hood that they will exhaust their welfare benefits.

First, *focus on the needs of women*. Approximately 90% of adult welfare recipients are women,<sup>3</sup> and women take different paths into addiction than men do, they experience addiction differently, and they follow different paths to recovery.<sup>8</sup> Treatment providers have to find ways to offer services that are gender specific, that respond to the multiple roles of women, and that recognize the influence of women's relationships in their addiction and in their recovery.<sup>9</sup>

Second, *address problems that accompany substance abuse among women*. A study of TANF recipients in Utah found that 42% were clinically depressed, 23% had learning disabilities, 35% had physical health problems that prevented them from working, 23% had children with severe behavior problems, and 12% had experienced severe domestic violence within the past 12 months. Moreover, this study found that 92% of all TANF families faced at least 1 of these barriers.<sup>10</sup> Treatment providers generally understand the complex stressors in the lives of substance abusers, and some have addressed these stressors by expanding the scope of their programs. But it is unlikely that a single service provider can effectively deliver the array of health, educational, employment, housing, and other services that poor substance-abusing mothers require. Therefore, many treatment programs are collaborating with other services so that, together, they can offer families a more complete range of services tailored to individual needs. These collaborative relationships are not easy to develop because agencies are governed by different values, funding streams, and legal requirements. Substance abuse treatment counselors may be reluctant to share information with housing specialists whose agencies have a "zero tolerance" policy regarding substance use among tenants. Or child welfare staff may conclude that children should be placed in foster care, even though treatment counselors may believe that placing children in care will remove all incentives for the mother to remain in treatment.

Third, *attend to the needs of children*. Children of substance abusers are dramati-

cally affected by substance abuse, and concern for their children often motivates women to enter and remain in treatment.<sup>11</sup> Children may also create triggers for relapse. Treatment programs must accommodate children by allowing them to attend treatment with their mothers, by offering developmentally appropriate on-site child care, or by developing relationships with nearby child care providers. Treatment providers also have to ensure that children's mental, physical, and educational needs are assessed and met.

Fourth, *be assertive about work as an outcome of treatment*. The US Department of Labor has reported that 70% of people who use illegal drugs are employed,<sup>12</sup> and research has shown that treatment improves work outcomes.<sup>3</sup> Many treatment providers include work-readiness activities as part of treatment, and many have hired vocational counselors. These strategies are good, but they are incomplete. TANF has specific rules about what "counts" as work and how long recipients may remain in training programs before they have to seek unsubsidized jobs. Few treatment providers have developed meaningful relationships with local work force development authorities or with other job training providers contracted to the welfare office.

### **Welfare Challenges**

When the final chapter of welfare reform is written, it will be about how well or poorly welfare agencies—not treatment agencies—met the challenge. These pressures have prompted welfare officials to seek partnerships with treatment agencies, but they can make welfare administrators seem unrealistic in their expectations of success. Welfare administrators have opportunities to move away from "don't ask, don't tell" toward a tradition of helping families overcome the problems that brought them to welfare.

First, *improve tools and resources for staff*. Welfare workers were not traditionally expected to talk to recipients about sensitive personal problems, so they were not hired with these skills nor given training to develop them. Therefore, many are uncomfortable talking with families about such problems as substance abuse. Moreover, these discussions may bring

up painful experiences in workers' own lives. Therefore, training for today's welfare workers has to start with explorations of values regarding addiction and poverty.<sup>3</sup> Workers also need factual information about addiction and recovery, they need skills to help them explore substance use with recipients, and they need time to practice and refine those skills.

Second, *improve access and services for families*. Welfare agencies can play a significant role in helping treatment succeed. For example, some states use TANF funds to pay for nonmedical substance abuse treatment, some provide space for substance abuse counselors on site, and a few have undertaken marketing and outreach initiatives to help recipients disclose substance abuse.

Third, *improve agency policies*. State officials have a responsibility to align their policies with their missions. If recipients are expected to take control of their lives, and if staff are expected to exercise judgment in working with families, official policies must reinforce and support those expectations. Therefore, officials should promote policies that allow time in treatment to "count" as work activity, they should communicate to staff and families whether substance abuse triggers a report to child protective services or whether it is only one factor that is considered before a referral is made, and they should expand treatment capacity to ensure that families have timely access to appropriate treatment.

### **Conclusion**

PRWORA ended entitlement to welfare and the federal government's role in establishing a social and economic safety net. Therefore, the federal-state partnership that characterized America's welfare system since its inception must now be replaced by partnerships within states and communities. None of these partnerships will be more challenging to develop and more important to families and to the success of welfare reform itself than those created between welfare and substance abuse treatment agencies. Neither system will succeed unless the other does. ■

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