

**Making Welfare Reform Work Better:**

**Improving TANF Program Results  
For Recipients With Alcohol & Drug Problems**

**Recommendations for TANF Reauthorization**

*September 2001*

### *Acknowledgments*

This paper was written by Gwen Rubinstein, the Legal Action Center's director of policy research in the Washington, D.C., office. It is part of a series of papers exploring issues at the intersection of welfare and addiction produced by the Center's Arthur Liman Policy Institute.

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## *Executive Summary*

Since the creation of the Temporary Assistance for Needy Families (TANF) program, welfare caseloads have dropped significantly. Studies have indicated an elevated prevalence of alcohol and drug problems among welfare recipients both before and after implementation.

TANF recipients with alcohol and drug problems need treatment and other supportive services to make the expected transition to self-sufficiency. Numerous studies have demonstrated that treatment helps low-income mothers achieve recovery, decrease their use of welfare, and increase their earnings. But current treatment capacity can meet less than half of the need for services.

The TANF reauthorization process, required in Fiscal Year (FY) 2002, gives Federal policy makers an opportunity to examine the law's effects and consider how best to help States address remaining barriers to self-sufficiency among TANF recipients. This paper recommends changes in Federal law in two areas to help address addiction-related barriers to employment.

For funding of benefits and services, Congress should:

- Maintain current levels of funding for the TANF program to provide both supportive services and cash benefits.
- Add alcohol and drug treatment to the list of defined work activities that count toward an individual's work requirement and toward a State's participation rate.
- End Medicaid's ban on reimbursement for residential addiction treatment services.
- Exempt alcohol and drug treatment from the definition of "medical services" to allow States to improve their use of TANF funds for treatment.
- Create a "promote treatment" initiative that provides financial incentives for States to expand assessment, referral to treatment, and treatment services for TANF recipients and custodial and non-custodial parents of TANF-eligible children.
- Create a "promote prevention" initiative to provide alcohol and drug prevention services for parents, particularly teen parents, and children in TANF families who are at risk.

For eligibility, Congress should:

- End the ban on TANF assistance and food stamps for individuals with drug felony convictions, or narrow the ban so it does not apply to those in treatment or recovery.
- Add exceptions to the TANF and Medicaid sanction provisions for recipients who are in treatment or willing to enter treatment.
- Exempt individuals in alcohol and drug treatment – or on a waiting list to receive treatment – from the Federal time limit.

## ***Background***

The American welfare system changed dramatically on August 22, 1996, with the signing of the “Personal Responsibility and Work Opportunity Reconciliation Act” (PRWORA).<sup>1</sup> The law ended the individual entitlement to cash welfare and replaced it with a block grant to States (Temporary Assistance for Needy Families, or TANF), imposed a five-year lifetime limit on benefits, and required welfare recipients to work to receive benefits or face sanctions, including a loss of benefits.

Since then, welfare caseloads have dropped significantly. Between January 1997 and June 2000, the number of individuals receiving welfare declined 49 percent and the number of families receiving welfare declined 46 percent.<sup>2</sup> Some State caseloads have dropped by more than half.

Studies conducted both before and after the implementation of TANF indicate that between 10 and 20 percent of adult welfare recipients have alcohol and drug problems. For comparison, 4.5 percent of American women reported past month drug use and 2.1 percent reported heavy alcohol use<sup>3</sup> in 1995.<sup>4</sup>

TANF recipients with alcohol and drug problems need support services, including treatment, to make the expected transition to work. Yet current treatment capacity can meet only about half of the demand – even less for low-income women.

If TANF recipients with alcohol and drug problems cannot receive timely and appropriate treatment for their addiction, they may not be able to meet their TANF work requirements and may be more likely to have their benefits sanctioned (including having their benefits reduced or cut off) or reach their time limit without being able to work and take care of their family. Faced with a loss of benefits and a lack of employment, welfare families affected by addiction could experience greater poverty and deprivation – even dissolution.

Data are beginning to bear out the relationship between addiction and sanctions. A study of families leaving welfare in Boston, Chicago, and San Antonio found that families facing sanctions were more likely to report alcohol and drug involvement than other families.<sup>5</sup> Another study, of all

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<sup>1</sup> Public Law 104-193. All other references in this paper are to this law, unless otherwise noted.

<sup>2</sup> “Change in TANF Caseloads,” web site of the Administration for Children and Families. Retrieved from <http://www.acf.dhhs.gov/news/stats/caseload.htm> on June 4, 2001.

<sup>3</sup> Defined as drinking five or more alcoholic drinks on five or more days at least once in the past 30 days.

<sup>4</sup> Substance Abuse and Mental Health Services Administration. *Substance Use Among Women in the United States*. Rockville, Maryland: SAMHSA, 1997, p. 2-18.

<sup>5</sup> Research Forum on Children, Families, and the New Federalism, “Three-City Findings Reveal Unexpected Diversity Among Welfare Leavers and Stayers.” New York: Mailman School of Public Health, Columbia University, 2000, p. 3.

sanctioned clients in one New Jersey county, found that 49 percent met criteria for an alcohol or drug problem.<sup>6</sup>

Cash welfare and food stamp benefits have historically been available to support room and board for women entering residential alcohol and drug treatment. Without continued access to these funds, treatment programs may be forced to reduce services or caseloads.

Without continued success in moving TANF recipients to work, State and local governments could face penalties for not meeting their work participation requirements (which rise to 50 percent in FY 2002) or for having too many families on assistance for more than 60 months. State and local governments could be faced with supporting these individuals and their families in State-only welfare programs<sup>7</sup> or in other, more expensive systems supported by State dollars, such as criminal justice and foster care.

Together, these negative effects – on TANF recipients, alcohol and drug treatment providers, and State and local governments – could erode the success of welfare reform, as well as other Federal and State poverty reduction initiatives. The TANF reauthorization process, required in FY 2002, is an opportunity for Federal policy makers to re-examine how the law is working and adjust it to meet diverse and changing needs in the caseload.

With the TANF reauthorization process in mind, this paper:

- Discusses the estimated prevalence of alcohol and drug problems among TANF recipients and its implications.
- Reviews research on the cost-effectiveness of alcohol and drug treatment for women with children who are receiving welfare.
- Provides recommendations for changes in the TANF law at the Federal level to promote policies that help TANF recipients with alcohol and drug problems make a successful transition into recovery, off welfare, and into jobs.

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<sup>6</sup> Jon Morgenstern, *et. al.* *Research Notes – Specialized Screening Approaches Can Substantially Increase the Identification of Substance Abuse Problems Among Welfare Recipients.* New York: Mt. Sinai School of Medicine, January 2001, p. 2.

<sup>7</sup> In fact, a study in one California county found that alcohol and drug problems were a stronger predictor of repeat use of general assistance than of Federal welfare assistance. L. Schmidt, C. Weisner, and J. Wiley, “Substance Abuse and the Course of Welfare Dependency,” *American Journal of Public Health*, Vol. 88 (1998), pp. 1616-1622.

### *Alcohol and Drug Problems Among Welfare Families*

Several studies<sup>8</sup> using Federal data from the early 1990s indicated that a number of adults receiving welfare had alcohol and drug problems. A U.S. Department of Health and Human Services (HHS) study, using 1991 and 1992 data, estimated that 5.2 percent of adult recipients of AFDC had significant alcohol- and drug-related functional impairments (compared to 2.6 percent not receiving AFDC) and another 11.2 percent were somewhat impaired (compared to 9 percent not receiving AFDC).<sup>9</sup> Another study, based on 1991 data, reported that 20 percent of welfare recipients abused or were addicted to alcohol and drugs.<sup>10</sup>

State and local studies have also noted an elevated prevalence of addiction in welfare caseloads – both before and after the implementation of TANF. In February 2001, Multnomah County, Oregon, found that 13 percent of its welfare applicants screened positive for having an alcohol or drug problem.<sup>11</sup> An Alameda County, California, study estimated that 10 to 22.3 percent of county welfare recipients in 1998 had an alcohol or drug problem.<sup>12</sup>

Yet treatment resources for these families are significantly limited. A significant treatment gap, resulting from an inadequate investment of public funds, exists for childless women and those with children, who are the majority of TANF recipients. Nationally, treatment capacity for women can meet only 41 percent of need, compared to 47 percent for men. In addition, only 48 percent of women receiving welfare who need treatment can actually receive it.<sup>13</sup>

Individual States face the same limitations. Washington State estimated that 78 percent of low-income adults, including 30,000 welfare and 20,000 Medicaid recipients, needed treatment in 1994

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<sup>8</sup> Most studies indicate that between 10 and 20 percent of welfare recipients have alcohol and drug problems. Differences among study estimates have been attributed to differences in measurement, methodology, and definitions used.

<sup>9</sup> U.S. Department of Health and Human Services. “Patterns of Substance Use and Substance-Related Impairment Among Participants in the Aid to Families with Dependent Children Program (AFDC).” Washington: U.S. Department of Health and Human Services, December 1994, p. 20.

<sup>10</sup> National Center on Addiction and Substance Abuse at Columbia University. “Substance Abuse and Women on Welfare.” New York: CASA, June 1994.

<sup>11</sup> “Six-Month Report of A&D Activity Within AFS, Multnomah County,” unpublished data, February 2001.

<sup>12</sup> R. S. Green, L. Fujiwara, J. Norris, S. Kappagoda, A. Driscoll, and R. Speigman, “Alameda County CalWORKs Needs Assessment: Barriers to Working and Summaries of Baseline Status.” Berkeley, California: Public Health Institute, February 2000, p. 8.

<sup>13</sup> A. Woodward, J. Epstein, J. Gfroerer, D. Melnick, R. Thoreson, and D. Wilson, “The Drug Abuse Treatment Gap: Recent Estimates,” *Health Care Financing Review*, Volume 18 (1997), pp. 5-17.

but did not receive it.<sup>14</sup> In a 1999 study, half of the States reported that limited financial resources led to shortages in long-term residential care, detoxification, outpatient services, and short-term residential care in the public treatment system.<sup>15</sup>

### *Cost-Effectiveness of Alcohol and Drug Treatment for Welfare Families*

Numerous studies have shown that alcohol and drug treatment programs provide effective and cost-effective services, despite limitations in funding. Programs serving women with children, including women on welfare, have demonstrated many positive outcomes. Most important, for welfare programs, treatment has been shown to increase employment and earnings and decrease reliance on public assistance, especially in the long term.<sup>16</sup>

Key findings include:

- The benefits of treating women with children on welfare in California exceeded costs by more than two and one-half times.<sup>17</sup> The authors of the study considered this ratio an underestimate because post-treatment employment and earnings data were deflated by a recession in the State at the time of the study.
- An Oregon study found that treatment completers received 65 percent higher wages than those who didn't complete treatment, with the difference due to improved earning power and an increase in the number of weeks worked. Increases were recorded in all treatment modalities, but highest in methadone maintenance.<sup>18</sup>
- The Oregon study also found that treatment completers dramatically decreased their use of food stamps in the three years after treatment. Individuals who completed methadone

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<sup>14</sup> Washington State Department of Social and Health Services, "Chemical Dependence Among DSHS Clients: A Departmental Problem." Olympia: DSHS, October 31, 1996, p. 10.

<sup>15</sup> National Center on Addiction and Substance Abuse at Columbia University. "Building Bridges: States Respond to Substance Abuse and Welfare Reform." New York: CASA, April 1999, p. 73.

<sup>16</sup> Some studies have reported short-term treatment-related increases in welfare and food stamp use, particularly in residential programs, as a result of eligibility work done by programs to maximize funding available to support a client's treatment (including room and board).

<sup>17</sup> D. R. Gerstein, R.A. Johnson, and C.L. Larison, "Alcohol and Other Drug Treatment for Parents and Welfare Recipients: Outcomes, Costs, and Benefits." Washington: U.S. Department of Health and Human Services, 1997, p. 39.

<sup>18</sup> M. Finigan. "Societal Outcomes & Cost Savings of Drug & Alcohol Treatment in the State of Oregon." Salem: Office of Alcohol and Drug Abuse Programs, Oregon Department of Human Resources, 1996, p. 16.

treatment, for example, reduced their food stamp costs by \$877, compared to non-completers, who increased their food stamp use by \$153 over the three-year study period.<sup>19</sup>

- A Washington State study found that indigent clients who completed treatment worked more and earned more than those who did not. Treatment completers earned an average of \$403 per month, compared to non-completers, who earned an average of \$265.<sup>20</sup>
- The National Treatment Improvement Evaluation Study (NTIES) found that women treated in Federally funded treatment programs increased their employment and decreased their use of welfare. The number who reported being employed in the year after treatment increased 25 percent. Income rose modestly, up 6 percent, while the number receiving public assistance decreased 8 percent.<sup>21</sup>
- A Minnesota study reported that among clients treated with public funds, 41.2 percent were employed full time after treatment, compared to 23.1 percent before.<sup>22</sup>

### ***Recommendations for TANF Reauthorization***

Many families remaining in the TANF caseload have one or more barriers to self-sufficiency. While States have begun to address some of these barriers, including addiction, additional flexibility and secure funding will allow States to work more effectively to help these families succeed at recovery and work. The remainder of this paper recommends changes in Federal law to help States address alcohol and drug problems among TANF recipients.

### **Recommendations on Funding for Benefits and Services**

*Recommendation #1. Maintain current levels of funding for the TANF program to provide both supportive services and cash benefits.*

According to some studies, individuals remaining on the TANF caseload have multiple barriers to employment and require a range of services to make the transition to work. Some States have begun innovative programs, including using TANF funds, to provide those services.

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<sup>19</sup> *Ibid.*, p. 17.

<sup>20</sup> T. Wickizer, J. Joesch, D. Longhi, A. Krupski, and K. Stark. *Employment Outcomes of Clients Receiving Alcohol and Drug Treatment in Washington State*. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1997, p. viii.

<sup>21</sup> Center for Substance Abuse Treatment, "Women In Treatment – National Treatment Improvement Evaluation Study." Rockville, Maryland: CSAT, 1997.

<sup>22</sup> C. Turnure, "Implications of the State of Minnesota's Consolidated Chemical Dependency Treatment Fund for Substance Abuse Coverage under Health Care Reform." Testimony to the Senate Labor & Human Resources Committee, March 8, 1994, p. 5.

Several States and localities are using the TANF program to identify low-income adults with alcohol and drug problems and refer them to treatment, including using TANF funds to support these initiatives. The most common approach is to require TANF recipients to be screened for alcohol and drug problems and to participate in treatment, if needed.

North Carolina has allocated TANF funds to support Qualified Substance Abuse Professionals (QSAPs), alcohol and drug clinicians who are co-located in county welfare agencies to screen and assess TANF recipients for problems and connect them with treatment.<sup>23</sup> In Hamilton County, Ohio, TANF funds are supporting screening and assessment services provided by Recovery Link, a provider services organization.<sup>24</sup> Some of the other States that have adopted similar policies are Illinois, Kansas, Kentucky Maryland, Minnesota, New York, New Jersey, Oregon, Tennessee, and Utah.

States need a secure source of funding to begin and expand these kinds of initiatives for TANF recipients. Maintaining the TANF program's current level of funding will help ensure that States can establish and increase funding for services for low-income parents with multiple barriers to employment, including alcohol and drug problems. Without services, these parents may not be able to make the expected transition into recovery, off welfare, and into work. Maintaining current levels of funding will also ensure the availability of income support for low-income families still needing it.

*Recommendation #2. Add alcohol and drug treatment to the list of defined work activities that count toward an individual's work requirement and toward a State's participation rate.*

The Federal law lists 12 activities – including unsubsidized employment, on-the-job training, and community service – that can satisfy an individual's work requirement and count toward the State's required minimum work participation rate.<sup>25</sup> Alcohol and drug treatment is not on the list.

Work and work training are integral parts of most alcohol and drug treatment programs, including programs for women with children, and should be defined as a work activity in the TANF statute. In most treatment programs, clients receive vocational services and begin to work as they progress in their recovery. In a 1998 study of 20 women's treatment programs, more than half (60 percent) required work and vocational training as a part of treatment, with three-quarters (75 percent) providing work and vocational training concurrently with treatment.<sup>26</sup>

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<sup>23</sup> North Carolina Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services. WF/SA Initiative Reporting Information, August 2000.

<sup>24</sup> Personal communication with local treatment providers and county welfare and alcohol and drug officials.

<sup>25</sup> §407(d).

<sup>26</sup> Legal Action Center. *Steps to Success: Helping Women with Alcohol and Drug Problems Move from Welfare to Work*. Washington: LAC, 1999, p. 11.

Including treatment in the definition of work that can count toward a State’s participation rate will help States engage TANF recipients in a broader range of work preparation activities and still meet their Federal participation rates. This change will also help TANF recipients better coordinate their treatment and work requirements – since they will be able to perform them in the same program.

*Recommendation #3. End Medicaid’s ban on reimbursement for residential alcohol and drug treatment services.*

A key Federal barrier to alcohol and drug treatment for TANF recipients is the Medicaid program’s “Institutions for Mental Diseases” (IMD) exclusion. IMDs are inpatient treatment facilities (including non-hospital residential programs) with more than 16 treatment beds for individuals with “mental diseases,” with addiction being included in the definition of “mental disease.”

The exclusion prohibits reimbursement for any service provided in an IMD or for any service provided to an IMD patient in a non-IMD setting for individuals between the ages of 22 and 64. For example, Medicaid would not cover prenatal care – either inside or outside the facility – for a woman in a residential alcohol or drug treatment program with 16 or more treatment beds.<sup>27</sup> For facilities under 16 beds, treatment can be covered by Medicaid, but not room and board.

Excluding addiction from the definition of “mental disease” would significantly increase access to residential treatment for women with children, who are the majority of TANF recipients, increasing their likelihood of achieving recovery and moving from welfare to work.

*Recommendation #4. Exempt alcohol and drug treatment from the definition of “medical services” to allow States to improve their use of TANF funds for treatment.*

Under the law, States are not allowed to use TANF funds for “medical services,” with the exception of “pre-pregnancy family planning services.”<sup>28</sup> The TANF final rule leaves it to States to “differentiate between [services] that are medical and those that are not.”<sup>29</sup> While this gives States flexibility, the lack of a clear definition has left some State welfare directors reluctant to use TANF funds for alcohol and drug treatment for fear of being penalized for misuse of funds.<sup>30</sup>

States need clearer Federal guidance that TANF may be used to fund a wide range of alcohol and drug treatment services. Adding a statutory exception for certain treatment services – such as non-hospital, non-physician, or non-pharmaceutical services – would provide that clarity.

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<sup>27</sup> Beds for children in women’s residential treatment programs do not count toward the 16-bed limit. Memo from Acting Medicaid Bureau Director Rozann Abato to HCFA regional administrators, June 23, 1993.

<sup>28</sup> §408(a)(6).

<sup>29</sup> Preamble language, 64 *Federal Register* 17840 (April 12, 1999).

<sup>30</sup> Personal communication from welfare officials in several States and localities.

Without a clearer definition, the ban acts as an unnecessary barrier to TANF investment in alcohol and drug treatment, which the TANF final rule acknowledges as “programmatically sound and reasonably calculated to achieve TANF goals since it may help clients make successful transitions to work and provide for a stable home for TANF children.”<sup>31</sup> Change would enhance State flexibility, as well as help close the treatment gap for women with children, particularly for non-medical residential treatment services, which are not covered by Medicaid (see Recommendation #3, above).

*Recommendation #5. Create a “promote treatment” initiative that provides financial incentives for States to expand assessment, referral to treatment, and treatment services for TANF recipients and non-custodial parents of TANF-eligible children.*

Currently, the law gives States financial incentives to reduce non-marital births, meet work participation requirements (through a reduction in the “maintenance of effort” requirement), achieve high levels of performance on TANF goals, and other outcomes deemed nationally desirable. Creating a “promote treatment” initiative within TANF would give States incentive to meet two related national policy goals: moving people from welfare to work and closing the treatment gap (a goal articulated by the White House Office of National Drug Control Policy<sup>32</sup>).

Incentives built into the TANF program would encourage States to implement initiatives that focus programmatic energy on improving work-related outcomes for TANF recipients with alcohol and drug problems. States would not be required to participate (so this would not be an unfunded mandate) but could be eligible for supplemental funding or matching funding if they did.

Ideally, enough funding would be available for States to evaluate their efforts and disseminate best practices. This would help other States and the Federal government understand how best to craft and implement policies to help TANF recipients with alcohol and drug problems make the transition into recovery, off welfare, and into work.

*Recommendation #6. Create a “promote prevention” initiative to provide alcohol and drug prevention services for parents, particularly teen parents, and children in TANF families who are at risk.*

For adolescents, alcohol and drug use is associated with a range of negative health and social outcomes, including risky sexual behaviors that can lead to unplanned pregnancy, HIV/AIDS, and long-term welfare participation for the entire family. Risks can be even higher for adolescents whose parents have alcohol and drug problems, because they are statistically more likely to develop alcohol and drug problems themselves.

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<sup>31</sup> Preamble language, *op. cit.* Also emphasized in a September 22, 2000, “Dear Colleague” letter co-signed by the Departments of Health and Human Services and Labor.

<sup>32</sup> Office of National Drug Control Policy. *National Drug Control Strategy 2000 Annual Report*. Washington: ONDCP, 2000, p. 55.

Both children and young parents in TANF families should have access to alcohol and drug prevention and early intervention services designed specifically for them. These services can help young parents reduce their alcohol and drug use so they can finish school, work, and take care of their children. These services can also help children avoid alcohol and drugs and the related health and social problems that can lead to reliance on welfare. In turn, this will decrease welfare and child welfare caseloads and costs, as well as build healthier individuals, families, and communities.

The law currently funds abstinence education, which is required to include a component that teaches adolescents how “alcohol and drugs can increase their vulnerability to sexual advances.”<sup>33</sup> But more is needed, including family-based services, which are identified as key for child and adolescent prevention programming.<sup>34</sup>

Congress should direct funding to the Center for Substance Abuse Prevention (CSAP) (part of the Substance Abuse and Mental Health Services Administration, or SAMHSA), the lead Federal agency on prevention, for this purpose. The program should require evaluation (including identification of model practices) and be coordinated with other prevention activities for these families administered by the Administration for Children and Families (ACF), other agencies in the Department of Health and Human Services, the Office of Juvenile Justice and Delinquency Prevention (OJJDP), and the Department of Education.

### Recommendations for Eligibility

*Recommendation #7. End the ban on eligibility for TANF assistance and food stamps for individuals with drug felony convictions, or narrow the ban so that it does not apply to those in treatment or recovery.*

Under the 1996 Federal welfare law, individuals with drug felony convictions are not eligible for TANF assistance and food stamps, unless the State they live in enacts legislation to opt out of or narrow the ban.<sup>35</sup> The ban applies to convictions where the conduct and the conviction occurred after August 22, 1996, and lasts for the person’s lifetime. The ban is limited to drug offenders and does not apply to violent – or non-violent – non-drug offenders.

If a State does not “opt out,” no one is exempt from the ban, not even pregnant women, people with HIV/AIDS, or individuals participating in treatment. The ban is permanent and continues regardless of an individual’s successful job history, participation in drug treatment, or abstinence from drug use.

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<sup>33</sup> §912(b)(2)(G).

<sup>34</sup> National Institute on Drug Abuse. Preventing Drug Use Among Adolescents: A Research-Based Guide. Rockville, Maryland: NIDA, 1997.

<sup>35</sup> §115, as amended by §5516 of the Balanced Budget Act of 1997 (P.L. 105-33).

Federal action to end the ban or narrow it would replicate action taken by a majority of States. A total of eight States have opted out completely – Connecticut, Michigan, New Hampshire, New York, Ohio, Oklahoma, Oregon, and Vermont.<sup>36</sup> Another 18 States have narrowed the scope of the ban, with the most common modification being to exempt individuals who are in treatment (or on a waiting list for treatment or have finished treatment or achieved recovery). These States include Florida, Illinois, Iowa, Maryland, Washington, and Wisconsin.<sup>37</sup>

Left unmodified at the Federal level, the ban reduces access to alcohol and drug treatment in 24 States. Alcohol and drug treatment programs, particularly residential programs, have traditionally relied on a family's welfare and food stamps to help fund room and board.

A 1998 survey of 20 women's programs found that welfare and food stamps accounted for an average of 7 percent of total funding.<sup>38</sup> Another study (of eight women's residential programs in California) found that providers reported that their loss in monthly revenue ranged from none to 25 to 30 percent.<sup>39</sup>

Left unmodified, the ban also acts as an impediment to recovery for individual women because it denies them support as they are leaving treatment and re-entering the community. Lifting it gives them the means, as well as the incentive, to stay in treatment.

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<sup>36</sup> The District of Columbia has also opted out.

<sup>37</sup> Legal Action Center, *Getting to Work: How TANF Can Support Ex-Offender Parents in the Transition to Self-Sufficiency*. Washington, DC: LAC, 2001.

<sup>38</sup> Legal Action Center, *Steps to Success*, *op. cit.*

<sup>39</sup> Amanda Noble and Elaine Zahnd, "The Gramm Amendment to Welfare Reform: Problems for Women's Residential Treatment Providers and Their Clients." Davis: University of California, January 2000.

*Recommendation 8. Add exceptions to the TANF and Medicaid sanction provisions for recipients who are in treatment or willing to enter treatment.*

The law requires States to reduce or end benefits for TANF recipients who are not complying with their work requirements,<sup>40</sup> with exceptions for women with a child under age 6 who cannot find appropriate child care. It also allows, but does not require, States to terminate Medicaid for individuals, except pregnant women,<sup>41</sup> who do not comply with their work requirements.<sup>42</sup>

Some TANF recipients with alcohol and drug problems who are trying to become self-sufficient through treatment may have difficulty complying with their work requirements, either because their addiction interferes with their ability to work or because their treatment schedule conflicts with their work or training schedule. Ending their eligibility for TANF and Medicaid virtually ensures that they will not be able to make the transition to recovery and self-sufficiency.

Those who are in treatment – or on a waiting list to receive treatment – should be able to retain their TANF and Medicaid so they can continue to afford treatment. Without it, they may not be able to learn the recovery and vocational skills they need to achieve self-sufficiency.

*Recommendation #9. Exempt individuals in alcohol and drug treatment – or on a waiting list to receive treatment – from the Federal time limit.*

Without treatment, few welfare recipients with alcohol and drug problems will be ready to work when they reach their time limit on Federal assistance. Unfortunately, in many communities, individuals needing treatment and willing to enter it cannot – because it is not available. Treatment is even less available for women with children, because they need programs that can provide child care and other child-specific services.

Providing incentives for welfare recipients with alcohol and drug problems to enter and stay in treatment will also help them become ready to work. Exempting TANF recipients in alcohol and drug treatment from the Federal time limit gives them incentive to enter treatment and to stay in treatment. It also gives States more flexibility to engage TANF recipients in treatment as a work-promoting activity for as long as necessary, regardless of whether the State has reached its 20 percent hardship exemption maximum.

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<sup>40</sup> §407(e).

<sup>41</sup> §114.

<sup>42</sup> A total of 13 States have adopted Medicaid sanctions, according to: Center for Law and Social Policy and Center on Budget and Policy Priorities, “States’ Implementation of Selected Medicaid Provisions of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996,” January 2000, p. 40.

### ***Conclusion***

A significant number of TANF recipients have or are at risk of developing alcohol and drug problems and need treatment, prevention, and other services to make the expected transition to self-sufficiency. Numerous studies have demonstrated that treatment helps low-income women with children achieve recovery, decrease their use of welfare, and increase their earnings. But current treatment capacity can meet less half of the demand for services.

The 1996 Federal welfare law increased States' flexibility over their welfare programs. A few States have used their new flexibility to implement policies and programs that successfully address alcohol and drug problems as employment barriers among TANF recipients.

Federal policy makers should use the TANF reauthorization process as an opportunity to expand State flexibility to help meet the needs of the hardest-to-employ TANF recipients, including those with alcohol and drug problems.

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