

November 30, 2001

TANF Reauthorization Ideas
Office of Family Assistance
5th Floor East
Aerospace Building
370 L'Enfant Promenade, SW
Washington, D.C. 20447

Dear Sir or Madam:

The undersigned organizations thank you for the opportunity to submit comments about the Temporary Assistance for Needy Families (TANF) program and changes the Administration should propose to improve the program. Our comments focus on changes to eligibility and funding for benefits (“assistance”) and services (“non-assistance”) that would improve the success of families with parents whose alcoholism, drug dependence, and/or criminal records are barriers to self-sufficiency.

TANF recipients with alcohol and drug problems and criminal justice histories 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.

Addiction Among Welfare Families

Most national studies have indicated that 10 to 20 percent of adult welfare recipients have alcohol and drug problems. (As a comparison, 4.5 percent of American women reported past month drug use and 2.1 percent reported heavy alcohol use in 1995.¹) These studies were conducted before the implementation of TANF, however, and it is not clear whether they are generalizable to the current caseload.

More recent studies have also found an elevated prevalence of addiction in TANF caseloads. In February 2001, Multnomah County, Oregon, found that 13 percent of TANF applicants screened positive for having an alcohol or drug problem.² An Alameda County, California, study estimated that 10 to 22 percent of TANF recipients in 1998 had an alcohol or drug problem.³

¹ Substance Abuse and Mental Health Services Administration. *Substance Use Among Women in the United States*. Rockville, Maryland: SAMHSA, 1997, p. 2-18.

² “Six-Month Report of A&D Activity Within AFS, Multnomah County,” unpublished data, February 2001.

³ R. S. Green, L. Fujiwara, J. Norris, S. Kappagoda, A. Driscoll, and R. Speiglmán, “Alameda County CalWORKs Needs Assessment: Barriers to Working and Summaries of Baseline Status.” Berkeley, California: Public Health Institute, February 2000, p. 8.

Key Findings on the Cost-Effectiveness of Alcohol and Drug Treatment for Welfare Families

Studies have shown that alcohol and drug treatment programs provide effective and cost-effective services, despite limitations in funding. Specifically, current treatment capacity can meet only about half of the demand – even less for low-income women.

Programs serving women with children, including women on welfare, have demonstrated many positive outcomes, including increased employment and earnings and decreased use of public assistance. Key findings include:

- The benefits of treating welfare recipients in California exceeded costs by more than two and one-half times.⁴ 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.⁵
- 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 \$265.⁶
- 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.⁷

⁴ D. R. Gerstein, R.A. Johnson, and C.L. Larson, "Alcohol and Other Drug Treatment for Parents and Welfare Recipients: Outcomes, Costs, and Benefits." Washington, DC: Department of Health and Human Services, 1997, p. 39.

⁵ 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.

⁶ 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.

⁷ 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.

Criminal Records Among TANF Recipients

Few studies have examined whether individuals involved in the criminal justice system are receiving welfare assistance (either before their incarceration or while on parole or probation) or whether those receiving welfare assistance are or have been involved in the criminal justice system.

A 1997 study found that many mothers in State and Federal prisons received welfare benefits before being incarcerated. A total of 41 percent of mothers in State prison and 33 percent of mothers in Federal prison reported receiving welfare before being incarcerated.⁸

A study in Alameda County, California, found that 20 percent of adult TANF recipients had been convicted of a crime, about 10 percent had been convicted of two or more crimes, and 10 percent had been convicted of a felony since the age of 18.⁹ The study did not report on the nature of the convictions.

Many women involved in the criminal justice system have alcohol and drug problems and will need treatment and other services to make the transition to employment.

Effectiveness of Employment Programs for Ex-Offenders

Findings from evaluations over the last 20 years indicate that employment programs for ex-offenders have increased their employment and earnings and reduced their recidivism. Key findings include:

- A study of New York City's Wildcat program, "Supported Work," which provided jobs and job training to chronically unemployed former heroin addicts and criminal offenders, demonstrated increased employment and pay for recovered addicts and lower arrest rates among those employed in both the experimental and control groups.¹⁰

⁸ Christopher J. Mumola, "Incarcerated Parents and Their Children." Washington, DC: Bureau of Justice Statistics, August 2000, p. 10.

⁹ R. S. Green, *et. al., op. cit.*, p. 37.

¹⁰ L. N. Friedman, *The Wildcat Evaluation: An Early Test of Supported Work in Drug Use Rehabilitation*. Rockville, Md.: National Institute on Drug Abuse, 1978. The project had financial support from the US Department of Labor, National Institute on Drug Abuse, Ford Foundation, Law Enforcement Assistance Administration, and New York City Department of Employment.

- A 1988 study of the effectiveness of Illinois prison programs found that those who obtained vocational training and education had higher employment and fewer arrests.¹¹
- An evaluation of the Texas Project Re-Integration of Offenders (RIO) program, which helps parolees find jobs, reported that 69 percent of participants found employment, compared with 36 percent of a matched control group. During the year after release, 23 percent of RIO participants returned to prison, compared to 38 percent in the control group, which saved the State \$15 million in 1990.¹²

Recommendations for TANF Reauthorization

TANF recipients with alcohol and drug problems and/or criminal justice histories need supportive services, including treatment and vocational training, to make the expected transition to work. If they do not receive these services, they may not be able to meet their TANF work requirements and may be more likely to have 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, these families could experience greater poverty and deprivation – even dissolution.

Without continued success in moving TANF recipients to work, States could face penalties for not meeting their work participation requirements or for having too many families on assistance for more than 60 months. States could also face supporting these individuals and their families in State-only welfare programs¹³ or in other, more expensive systems supported by State dollars, such as criminal justice and foster care.

Together, these negative effects – on TANF recipients and State and local governments – could erode the success of welfare reform, as well as other Federal and State poverty reduction initiatives.

¹¹ D.B. Anderson, *et. al.*, “Correctional Education A Way to Stay Out: Recommendations for Illinois and a Report of the Anderson Study.” Illinois Council on Vocational Education, 1988.

¹² P. Finn, “Job Placement for Ex-Offenders: A Promising Approach to Reducing Recidivism and Correctional Costs,” *NIJ Journal*, July 1999.

¹³ A study in one California county found that addiction was 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.

Recommendations on Benefits and Services

Recommendation #1. Maintain current levels of funding for the TANF program to provide both cash benefits (assistance) and supportive services (non-assistance), especially in light of the effects of the September 11th terrorist attacks.

Maintaining the TANF program’s current level of funding will allow States to continue to provide assistance to those who need it during the current economic downturn. It will also give States a secure source of funding to begin and expand initiatives to provide services (“non-assistance”) to help TANF recipients address barriers to self-sufficiency.

Several States, for example, are using TANF funds to identify low-income adults with alcohol and drug problems and refer them to treatment, including Illinois, Kansas, Kentucky Maryland, Minnesota, New York, New Jersey, North Carolina, Oregon, Tennessee, and Utah. At least one other State, New York, has begun to allocate TANF funds to programs to help divert appropriate individuals from prison into treatment and welfare-to-work services.

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

The Federal law lists 12 activities that can satisfy an individual's work requirement and count toward the State's minimum work participation rate.¹⁴ Alcohol and drug treatment is not on the list.

Including treatment in the definition of work that can count toward a State’s participation rate will help States both to engage TANF recipients in a broader range of work preparation activities and move addicted recipients to sobriety and work while and still meeting their Federal participation rates. The 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. Repeal Medicaid’s ban on reimbursement for residential alcohol and drug treatment services.

A key 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 will not cover prenatal care – either inside or outside the facility – for a

¹⁴ §407(d).

woman in a residential alcohol or drug treatment program with 16 or more treatment beds.¹⁵ 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 core treatment services.

States are not currently allowed to use TANF funds for “medical services,”¹⁶ with the TANF final rule leaving it up to States to define the term.¹⁷ While this gives States flexibility, the lack of a clear definition has left some State welfare directors reluctant to invest TANF in core alcohol and drug treatment services, such as counseling (covered in some State Medicaid plans) for fear of being penalized for misuse of funds.¹⁸ This is problematic for States that are doing active outreach and screening because they will find more people needing treatment but will not be able to increase core treatment slots.

Left as is, the ban acts as an unnecessary barrier to TANF investment in alcohol and drug treatment. Change would enhance State flexibility, as well as help close the treatment gap for women with children.

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

The law currently 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. Financial incentives should also be used to encourage States to implement initiatives that focus programmatic energy on improving work-related outcomes for TANF recipients with alcohol and drug problems and or criminal justice histories. 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.

¹⁵ 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.

¹⁶ §408(a)(6).

¹⁷ Preamble language, 64 *Federal Register* 17840 (April 12, 1999).

¹⁸ Personal communication from welfare officials in several States and localities.

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.

Both children and young parents in TANF families should have access to 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.”¹⁹ But more is needed, including family-based services, which are identified as key for child and adolescent prevention programming.²⁰

Funding should be directed 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 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.

¹⁹ §912(b)(2)(G).

²⁰ National Institute on Drug Abuse. Preventing Drug Use Among Adolescents: A Research-Based Guide. Rockville, Maryland: NIDA, 1997.

Recommendations on 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 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.²¹ The ban applies to convictions where the conduct and the conviction occurred after August 22, 1996, and lasts for the person's lifetime.

If a State does not "opt out," no one is exempt from the ban, not even pregnant women 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.

Federal action to end the ban or narrow it would replicate action taken by a majority of States. A total of eight States (and the District of Columbia) have opted out completely – Connecticut, Michigan, New Hampshire, New York, Ohio, Oklahoma, Oregon, and Vermont. Another 19 States – including Florida, Illinois, Iowa, Maryland, Washington, and Wisconsin²² – have narrowed the ban's scope, most commonly by exempting individuals in treatment (or who are on a waiting list for treatment or have finished treatment or achieved recovery).

Left unmodified at the Federal level, the ban reduces access to alcohol and drug treatment in 24 States. In fact, a 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.²³ (Treatment programs, particularly residential programs, have traditionally relied on a family's welfare and food stamps to help fund room and board.)

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. Repealing it gives them the means, as well as the incentive, to stay in treatment.

²¹ §115, as amended by §5516 of the Balanced Budget Act of 1997 (P.L. 105-33).

²² Legal Action Center, *Getting to Work: How TANF Can Support Ex-Offender Parents in the Transition to Self-Sufficiency*. Washington, DC: LAC, 2001. Kentucky has since enacted legislation to narrow the ban.

²³ A. Noble and E. 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 sanctions for recipients who are in treatment or willing to enter treatment.

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.

Providing incentives for welfare recipients with alcohol and drug problems to enter and stay in treatment will 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.

Recommendation #10. Codify current Medicaid procedures for ensuring enrollment for eligible individuals who are leaving prison and jail.

Current HHS policy²⁴ states that incarcerated individuals must be returned to Medicaid enrollment immediately upon their release unless the State determines they are no longer eligible. Few States, however, seem aware of this requirement. A 2001 study found 46 States and two territories have policies that require termination of Medicaid supports for people in jail, meaning that these individuals must complete the Medicaid application process again when released and wait for a decision and benefits.²⁵

²⁴ Letter from Secretary of Health and Human Services Tommy G. Thompson to Representative Charles L. Rangel, October 1, 2001.

²⁵ C. Brown, “Jailing the Mentally Ill,” *State Government News*, April 2001, p. 28.

Many women leaving prison and jail reunite with children (whom they left with relatives) and would likely continue to be eligible for Medicaid. Many also having pressing medical conditions – such as mental illness, HIV, and alcohol and drug problems – that if left untreated would decrease their chances of working and achieving self-sufficiency.

Thank you for your attention to our comments. For questions or information about these comments, please call Gwen Rubinstein at the Legal Action Center at 202-544-5478.

Signed,

Association of Alcoholism & Addiction Programs of Washington State, Seattle
California Association of Alcohol and Drug Program Executives, Sacramento
California Association of Addiction Recovery Resources, Sacramento
Center for Community Corrections, Washington, DC
Colorado Association of Alcohol and Drug Service Providers, Denver
Connecticut Association of Nonprofits, Hartford
Drug and Alcohol Service Providers Organization of Pennsylvania, Harrisburg
Florida Alcohol and Drug Abuse Association, Tallahassee
Gateway Foundation for Women, Sacramento
International Community Corrections Association, LaCrosse, Wisconsin
Iowa Substance Abuse Program Directors' Association, Iowa City
Legal Action Center, Washington, DC
Mid-Plains Center for Behavioral Healthcare Services, Grand Island, Nebraska
National TASC, Washington, DC
North Carolina Association for Behavioral Health Care, Raleigh
Ohio Council of Behavioral Healthcare Providers, Columbus
Outreach Project, Richmond Hill, New York
Research & Policy Reform Center, Washington, DC
Tarzana Treatment Centers, Tarzana, California
Tennessee Association of Alcohol and Drug Abuse Services, Nashville
The Sentencing Project, Washington, DC