Substance Use Among Welfare Recipients: Trends and Policy Responses

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Abstract

Illicit drug use by welfare recipients has been identified as an important barrier to well-being and social performance. This paper uses nationally-representative cross-sectional data, and Michigan-specific panel data, to summarize trends in substance use among AFDC/TANF recipients. It also examines the prevalence of drug use disorders within the welfare population. Although almost 20 percent of welfare recipients report recent use of some illicit substance, our analysis indicates that only a small minority of welfare recipients satisfy screening criteria for chemical dependence. The paper concludes by considering policy responses to substance use disorders following welfare reform.

Substance Use Among Welfare Recipients: Trends and Policy Responses

The 1996 Personal Responsibility and Work Opportunity Reconciliation Act, PL104-193 changed the nature and purpose of public aid. It transformed the 60-year cash entitlement to cash assistance under Aid to Families with Dependent Children (AFDC) into a discretionary program of transitional cash assistance, Temporary Assistance for Needy Families (TANF). The 1996 act also brought important changes to Food Stamps, Supplemental Security Income (SSI), Social Security Disability Insurance (SSDI), and to other forms of public aid.

Increased work expectations and the advent of time-limited aid has forced researchers and program administrators alike to confront the great variation among AFDC/TANF recipients in their ability to move from welfare to work. Such heterogeneity is now especially important given the sharp caseload reductions of the late 1990s. Previous research indicated that high school dropouts, mothers without prior work experience, teen and never-married mothers, and mothers who enroll with very young children are more likely than other recipients to have long welfare spells and are therefore more likely to confront federal time-limits.(Blank 1989; Blank 1997; Duncan, Harris et al. 1997; Moffitt and Pavetti 1999)

Recent data also indicate that the economic tradeoffs between welfare and work have shifted for more-employable recipients.(Danziger, Corcoran et al.

2000) Partly because of low unemployment, an expanded earned income tax credit (EITC), introduction of the State Children's Health Insurance Program, increased childcare subsidies, and other assistance for the working poor, and in part because of more stringent AFDC/TANF policies themselves, recipients face increased pressure and changed incentives to enter the labor market rather than to receive cash aid. As caseloads fall, and as TANF becomes a less-favorable option for the most marketable recipients, the proportion of remaining recipients who face significant employment barriers may have increased.(Blank and Schoeni 2000)

Recipients who use illicit substances, though a small proportion of the total caseload, were subject to dramatic changes in eligibility for benefits under the 1996 welfare reforms. This paper summarizes provisions of the 1996 legislation pertinent to substance users. Then, using nationally-representative cross-sectional data and panel data on recipients in Michigan, it describes the changing prevalence of substance use and dependence among AFDC/TANF recipients. After reviewing the consequences of illicit drug use, it then considers the feasibility of policies such as chemical drug testing to detect and assess substance use among welfare recipients.

Welfare Reform Policies and Substance Users

Welfare reform included provisions to limit or remove eligibility for income-eligible individuals convicted of drug-related crimes. The 1996 "Gramm Amendment" (No. 4935) imposes a lifetime ban on Food Stamps, and TANF aid to individuals with felony convictions for illegal drug possession, use, or distribution for conduct occurring after August 22, 1996. States are, however, granted great discretion to modify or revoke the TANF ban. Currently, 27 states passed legislation to eliminate or to modify the lifetime ban of women with felony drug records.[1] Within public housing, HUD-defined "one strike and you're out" rules allow for eviction of tenants involved in drug-related crimes. Although drug-related felonies generally involve crimes connected with the distribution, rather than use of illicit drugs, many drug-users supplement their income through drug sales and are therefore potential objects of Gramm Amendment restrictions.

Section 902 of welfare reform also authorized states to use chemical testing to screen new TANF applicants or to otherwise detect illicit substance use.(PL104-193 1996) Some states are contemplating such testing, though Michigan appears to be the only state that has attempted to implement suspicionless, population-based testing.

[1] States that have eliminated the ban: Connecticut, Kentucky, Michigan, New Hampshire, New York, Ohio, Oklahoma, Oregon, Vermont. States that have created exceptions for certain drug-related felonies and for those participating in drug treatment: Alaska, Arkansas, Colorado, Florida, Hawaii, Illinois, Iowa, Louisiana, Maryland, Minnesota, Nevada, New Jersey, North Carolina, Rhode Island, South Carolina, Utah, Washington, Wisconsin.

Outside the realm of AFDC/TANF, welfare reform limited the ability of substance users to obtain federal disability payments for drug-related ailments. In 1996, more than 200,000 individuals received SSI or SSDI payments based upon diagnoses of "drug and alcohol addiction," or DA&A. Public Law 104-121 abolished the DA&A classification in federal disability programs and removed individuals from the SSI and SSDI rolls for whom drug addiction and alcoholism (DA&A) were material to the determination of disability.(Davies, Iams et al. 2000) Between December 1996 and January 1997, 103,000 recipients were subsequently removed from the disability assistance rolls.(Danziger and Kossoudji 1994/1995; Schmidt, Weisner et al. 1998; Davies, Iams et al. 2000; Swartz, Lurigio et al. 2000)

Many researchers and program administrators suggest that drug use disorders are widespread. During the legislative debate leading to the enactment of 1996 reforms, many commentators suggested that drug users would face substantial obstacles to self-sufficiency. As Joseph Califano put the argument, "all the financial lures and prods and all the job training in the world will do precious little to make employable the hundreds of thousands of welfare recipients who are addicts and abusers" (Califano 1995). In similar fashion, the Legal Action Center concluded that "welfare reform is doomed to fail if it does not address the needs of individuals with alcohol and drug problems."(1995)

These statements echoed similar anxieties among welfare administrators and caseworkers. In one survey, 65 percent of state and local welfare program directors stated that drug and alcohol treatment services were extremely important in getting recipients to leave welfare. A second study of 25 state AFDC offices cited substance abuse as a frequently-cited functional impairment that prevents recipients from leaving welfare and completing job training programs.(US-DHHS 1992).

The Prevalence of Substance Use Disorders

Because drug use is often covert, its true prevalence within the AFDC/TANF population is imperfectly known. Most data (including the data sets analyzed for this paper) are based upon self-reports in survey data. Deceptive or inaccurate responses are therefore important concerns.(NIDA 1997) Because welfare receipt and substance use each bring social stigma, they are often underreported. The validity of self-report has been scrutinized in specific populations who have close contact with the health care delivery system. Existing data suggest that under-reporting is widespread among pregnant women and among clients of substance abuse treatment programs.(Magura and Kang 1996; NIDA 1996)

Drug use, drugs of choice, and the prevalence of drug use disorders are also likely to vary across different subgroups in the welfare population. Among

low-income women, cocaine use is most prevalent among African-Americans, whereas alcohol and marijuana use are more diffusely spread.(Vega, Kolody et al. 1993)

For both of these reasons, prevalence estimates of drug use and drug-use disorders among welfare recipients vary widely due to differences in study methodologies and across sample populations. Although published estimates indicate that between 6 and 37 percent of welfare recipients experience drug-related problems,(Metsch, McCoy et al. 1999; Jayakody, Danziger et al. 2000) analyses of nationally representative datasets suggest that less than 20 percent of AFDC recipients use illicit substances in a given year.

The 1992 National Household Survey of Drug Abuse (NHSDA) indicated that 15.5 percent of AFDC recipients were impaired by drugs or alcohol.(US-DHHS 1994) Grant and Dawson (1996), using data from the 1993 National Longitudinal Alcohol Epidemiologic Survey, found that 9.7 percent of women AFDC recipients had used illicit drugs during the past calendar year, and that 12 percent had engaged in heavy drinking, defined as consuming more than 1 ounce of ethanol per day over the previous year.(Grant and Dawson 1996)

Jayakody, Danziger, and Pollack (2000) used 1994/95 data from National Household Survey of Drug Abuse (NHSDA) to examine the prevalence of several mental health problems and substance abuse in the welfare caseload.(Jayakody, Danziger et al. 2000) The NHSDA, an annual, national cross-sectional survey of

the civilian noninstitutionalized population, includes detailed information regarding psychiatric disorders, substance use, and welfare receipt. These authors report that 19 percent of recipients had at least one of four DSM-III-R psychiatric disorders (major depression, agoraphobia, panic attack and generalized anxiety disorders) within the previous year, and that 21 percent had used an illegal drug (mostly marijuana) in the past 12 months. Excluding marijuana, 10 percent of welfare recipients had used some other illegal drug during the past year, with 6 percent using cocaine/crack.

Trends in Illicit Drug Use

Previous research details the prevalence of illicit drug use among welfare recipients during the early- and mid-1990s. How have these patterns changed in recent years? As TANF caseloads have fallen, is there evidence of increased prevalence among the more-disadvantaged subgroup that remained on the AFDC/TANF rolls?

Figure 1 below shows prevalence trends among women receiving welfare over the 1990s, as captured in the NHSDA. These data end in 1998, the last year of available, nationally-representative public-use data. Although welfare rolls declined substantially between 1994 and 1998, this series fails to capture subsequent prevalence trends in 1999 and 2000, a period of further sharp declines

in welfare caseloads. Fall 1999 prevalence data from the Women's Employment Study indicated similar prevalences of marijuana and other illicit substance use.

The top trend-line in Figure 1 indicates the percentage of welfare recipients who report use of any illicit substance in the previous 12 months. The bottom trend-line excludes marijuana, indicating the percentage of recipients who used some other illicit substance during the same period. As shown, illicit drug use declined in prevalence within the AFDC/TANF population over the 1990s. The observed 1998 prevalence of 18.3 percent was markedly below the observed 1990 prevalence of 26.0 percent, though this difference was at the margin of statistical significance ($p<0.07$) given the small number of NHSDA welfare recipients in the two years.

Unpublished research by Ebener, Reuter, and Pollack (2001) indicates that prevalence trends were broadly similar among recipients and non-recipients of public cash aid. From the opposite perspective, relative trends in welfare takeup were similar among substance-using and non-substance-using women over the same period. Although the prevalence of substance use increased slightly among welfare recipients between 1997 and 1998, this increase was neither large nor statistically significant. Within the current limits of public-use data, we find little evidence of post-reform increased prevalence of substance use among TANF recipients.

Consequences of Illicit Drug Use

Even when use is known, a second complication arises in interpreting the consequences for the user or for others that flow from this behavior. A woman may consume alcohol or an illicit drug without suffering tangible adverse effects.

The causal impact of drug use on welfare dependence and welfare receipt has been the subject of several analyses, though all duly acknowledge important limitations. Using data from the National Longitudinal Survey of Youth (NLSY), Kaestner (1998) examined the effect of current drug use on future welfare participation.(Kaestner 1994; Kaestner 1998) He found that drug use during the year prior to the survey--especially marijuana use--was positively related to future welfare receipt. Yet, he also found that substance abusers account for only a small fraction of welfare recipients. Eliminating drug use was predicted to reduce welfare participation by only 3 to 5 percent. Jayakody, Danziger, and Pollack (2000) obtain similar results from the 1994/95 National Household Survey of Drug Abuse.

Both Kaestner and Jayakody *et al.* acknowledge the difficulties of attributing causality based upon available data. Although drug users appear to experience worse social and economic outcomes than non-users, these differences may not be properly attributable to drug use. Drug use is often a marker for unobserved characteristics and circumstances that are also associated with poor outcomes. For example, adverse experiences, such as childhood trauma or

experiences of violence, may lead some women both to seek welfare and to initiate or to increase their substance use. Both unobserved heterogeneity and simultaneity can produce upward-biased estimates of drug-related harm.

Econometric methods exist that might, in principle, address these concerns. One approach is to link exogenous shocks to drug markets and street drug prices to variation over time and space in outcomes among welfare recipients.(Caulkins 2001) A second method is to examine panel data to untangle temporal patterns of drug use and welfare receipt. To-date, these methods have not been applied to examine changes in drug use among welfare recipients.

Jayakody, Danziger, and Pollack (2000) provide an alternative analysis that suggests that multivariate analyses of welfare dependence overstate the causal impact of marijuana use. They note that tobacco--a legal and cheap non-intoxicant, whose major health effects occur in later life—should, in theory, have little causal impact on household composition, welfare dependence or other economic outcomes of young mothers. However, smokers differ from nonsmokers in important ways. Many women smoke to cope with the stress and loneliness that often accompany caregiving roles.(Wakefield, Gillies et al. 1993) Depression has repeatedly been identified as an obstacle to smoking cessation among women.(Frohna, Lantz et al. 1999)

Because tobacco use should play little causal role, any observed association between smoking and economic outcomes probably reflects the

unobserved circumstances and traits associated with smoking. In multivariate analysis of the 1994/95 NHSDA that controlled for standard confounders, Jayakody, Danziger, and Pollack (2000) found a large and statistically significant association between tobacco use and welfare receipt. Moreover, the associated point estimate was larger and more statistically significant than the point estimate corresponding to marijuana use. Among licit and illicit substances, only crack/powder cocaine use was more powerfully linked with welfare receipt.

A more careful analytic strategy to scrutinize drug use as an obstacle to self-sufficiency is to examine clinical measures of problem use. Drug treatment providers and epidemiologists address these questions in accordance with the *Diagnostic and Statistical Manual of Mental Disorders* (DSM).(APA 1994) Under these criteria, individuals with the most serious substance-related disorders are classified as *dependent*. Those suffering less severe, but also significant drug-related symptoms are classified as substance *abusers*.

In particular, substance *abuse* is defined as "a maladaptive pattern of substance use, leading to clinically significant impairment or distress," defined by at least one of the following patterns over the previous year:

(1) An individual's recurrent use results in failure to fulfil major work, school, or home obligations.

(2) An individuals repeatedly uses a substance in physically hazardous situations

(3) An individual experiences recurring substance-related legal problems.

(4) An individual continues substance use despite persistent or recurrent social or interpersonal problems that are caused or worsened by such use.(APA 1994)

Individuals are classified as substance *dependent* if they satisfy three or more of the more significant criteria shown below:

(1) The individual develops *tolerance*, defined as either (1) experiencing a need for markedly increased amounts to become intoxicated or to obtain desired effects, or (2) experiencing markedly diminished effects with continued use of the same dose.

(2) The individual experiences *withdrawal* symptoms, or needs to take the substance (or a similar one) to avoid these effects.

(3) The individual repeatedly consumes the substance in higher doses or over a longer period than intended.

(4) The individual has a persistent desire or attempts unsuccessfully to reduce or to halt substance use.

(5) The individual spends a great deal of time attempting to obtain the substance, to use the substance, or recover to from its effects.

(6) The individual eliminates or curtails important activities due to substance use.

(7) The individual persists in substance use despite clear knowledge that such use causes or aggravates physical or psychological problems.

Grant and Dawson (1996) provide the most extensive analysis of abuse and dependence among welfare recipients. These authors find that 3.3 percent of welfare recipients satisfied DSM-IV criteria for drug abuse or dependence, and that 7.3 percent satisfied criteria for alcohol abuse or dependence.(Grant and Dawson 1996) Similarly, Jayakody, Danziger, and Pollack (2000), using 1994/95 data, reported that 9 percent of welfare mothers were alcohol-dependent, compared with a prevalence of 5 percent among non-recipient single mothers.

No existing dataset allows researchers to construct a consistent time-series for the prevalence of substance abuse and dependence within the AFDC/TANF caseload over the 1990s. NHSDA—the only annual, nationally-representative survey that covers recent years—used different questions in 1994 from those used in later years. The 1995-98 NHSDA surveys do examine alcohol and drug dependence, and facilitate comparisons between TANF recipients and other women in the NHSDA.

Table 1 shows the prevalence of illicit drug and alcohol dependence among unmarried women ages 18-54 within the 1998 NHSDA.

Alcohol dependence is more common among welfare recipients than among non-recipients, but the difference is not statistically significant. Illicit drug

dependence is more than twice as common among TANF recipients than it is among non-recipients. However, only a small minority of recipients exhibit these symptoms. Less than half of respondents who reported illicit drug use met screening criteria for actual dependence on these substances.

Most recently, Pollack, Danziger, Jayakody, and Seefeldt (2001) examined the prevalence of substance use and dependence among respondents in the first three waves of the Women's Employment Study (WES).[2] WES is a panel study of single-mothers in one urban Michigan county. All respondents were receiving TANF cash aid in February 1997, and were interviewed in Fall 1997, Fall 1998, and Fall 1999. WES includes detailed data regarding substance use and dependence. The first two WES waves yielded prevalence estimates that were quite close to national NHSDA prevalence estimates among TANF recipients.

Table 2 below shows the prevalence of substance dependence and other DSM-III-R psychiatric disorders among 626 WES respondents in the Fall 1999 wave. Respondents are classified in the first four columns by their work participation and welfare receipt in the survey month. Consistent with earlier epidemiological findings, illicit drug dependence was also rare among all WES respondents (3.2 percent), including those still receiving cash aid (columns 2 and 3). Among the 194 surveyed women who continued to receive TANF, 4.0 percent met screening criteria for drug-dependence. Illicit drug dependence was markedly

[2] For WES details, see Danziger, Corcoran et al. 2000.

less prevalent than other psychiatric disorders. Among the 43—we have to check this #--continuing welfare recipients who reported using an illicit drug, only 7 satisfied screening criteria for illicit drug dependence.

Although dependence was rare, drug users were more likely than other recipients to satisfy screening criteria for *some other* DSM IIIR psychiatric disorder such as depression, generalized anxiety disorder, social phobia, or post-traumatic stress disorder. 53 percent of recent drug users, and 34 percent of non-drug-users, satisfied screening criteria for one of these four disorders.

A second striking feature is the strong distinction between working and non-working respondents, independent of welfare receipt. (Michigan's benefit rules, and its relatively high benefit level allow recipients to combine TANF receipt with paid employment.) About 40 percent of nonworking welfare recipients satisfied *some* DSM-III-R screening criteria for major depression or other psychiatric disorders (column 3, sum of rows 3 and 4). Nonworking respondents, both those receiving welfare and those not receiving cash aid (column 4), also displayed higher prevalence of illicit drug dependence. Among the 401 respondents who had worked at least 20 hours per week in the month prior to the survey (columns 1 and 2), more than 16 percent reported illicit drug use during the previous year. Only 3 of these respondents were drug-dependent. In contrast, 17 of the 225 respondents who had worked less than this amount were dependent on an illicit drug.

Screening and Assessment of TANF Recipients for Substance Abuse and Dependence

Within the Michigan WES study and nationally-representative data from the NHSDA, approximately one-fifth of TANF recipients report recent heavy drinking or illicit drug use, and a significant subgroup of these substance users satisfy screening criteria for substance dependence and abuse. Yet, existing screening strategies in welfare agencies identify only a small proportion of recipients who experience substance use and dependence. (Derr, Douglas et al. 2001; Nakashian and Moore 2001) Data from several states indicate that less than 5 percent of recipients (in some cases less than 1 percent) are even referred for substance abuse treatment services.(Morgenstern 1999)

Given the difficulties of screening and assessment for illicit drug use, some states have examined the possibility of chemical drug testing to detect recent illicit drug use. To-date, Michigan appears to be the only state to implement suspicionless testing of the TANF population. Beginning October 1, 1999, Michigan implemented mandatory testing in 3 local welfare offices.(Michigan Family Independence Agency 1999) All applicants, and a sample of continuing recipients were required to provide urine tests as a condition of eligibility for aid. However, testing was halted by a restraining order in

November 1999, and the case remains under litigation.(Michigan Family Independence Agency 2000)

Within Michigan, recipients testing positive for illicit drugs remained TANF-eligible, but were subject to progressive sanctions if they failed to comply with a mandated treatment plan.(Agency 1999) During the short period of program operation, twenty-one out of 258 tested recipients tested positive for illicit drug use. All but 3 of these recipients tested positive for marijuana only.

A more specific strategy of chemical testing would be to scrutinize only non-working recipients, sanctioned recipients, and those who display specific signs associated with substance abuse and dependence. Although non-working recipients report similar prevalence of illicit drug use to those reported among working recipients, results from the WES study indicate that nonworking recipients are much more likely to satisfy screening criteria for dependence.

Long-term welfare receipt may be another important risk-factor for substance use disorders. Nationally-representative cross-sectional studies, such as the NHSDA, do not describe the duration of welfare receipt. However, longitudinal datasets indicate a strong relationship between long-term welfare receipt and drug use. This relationship is especially pronounced in the case of cocaine, and in the case of women over age 30. By 1998, respondents in the National Longitudinal Survey of Youth ranged in age between 33 and 41 years of age. In this sample, only 1.1 percent of women had used cocaine in the past

month, but among cocaine users, 45 percent had received AFDC/TANF for at least 5 years. Among women with children who had used cocaine in the past month, 59 percent of mothers had received AFDC/TANF for at least 5 years; 75 percent experienced some period of AFDC/TANF receipt.

Aside from chemical testing, the sensitivity of existing systems could be improved by stationing addiction counselors in welfare offices and through the use of specialized and experienced caseworkers to assess clients with potential substance use disorders.(Morgenstern, Riordan et al. 2001) Although substance use disorders are not very prevalent in the overall caseload, the need for substance abuse treatment and related services is high within identifiable subgroups that can form the basis for screening and intervention.

Morgenstern and colleagues (2001) describe a program of targeted screening and assessment for sanctioned TANF recipients in New Jersey. In one county, 49 percent of sanctioned recipients met screening criteria for a substance use disorder. Specialized screening appeared to substantially increase the number of referrals for substance abuse assessment.(Morgenstern, Riordan et al. 2001) North Carolina has placed Qualified Substance Abuse Professionals (QSAPs) in every county Department of Social Service office to identify, assess, and to coordinate interventions for substance abuse disorders among TANF recipients.(CASA/APHSA 1999)

CASA/APHSA (1999) surveyed the states, and identified diverse innovative programs created by states to address drug abuse and dependence. These authors outline five key factors that influence the success of state policies: "collaboration among agencies, capacity of organizations to meet new challenges, availability of funds and resources, and control and participation at the local level."(CASA/APHSA 1999)

Oregon and Utah screen or assess many recipients for illicit drug disorders, but these assessments also explore alcohol abuse and other mental health problems.(Johnson and Meckstroth 1998; NGA 1999) Wickizer (2001) summarizes of treatment practices in Washington state that assist substance users in transitioning from TANF to paid employment.(Wickizer 2001)

Michigan's pilot testing program included an assessment component, designed to address abuse and dependence, and mental health concerns. Michigan's policy was also designed to identify pertinent treatment options for affected recipients. Mental and behavioral health professionals are then consulted to develop treatment plans.(Kirby 1999)

Discussion

This paper draws upon nationally-representative cross-sectional data, as well as longitudinal Michigan data, to examine the prevalence of substance use within the welfare population. Like many studies of employment barriers and hidden behaviors among welfare recipients, this paper reflects frustrating limitations that affect its conclusions.

Most obvious is the lack of current data to examine post-1996 reforms. Our nationally-representative data end in 1998, our Michigan data in 1999. TANF caseloads continued to significantly decline between 1999 and 2001, and it is possible that substance use and substance use disorders are more prevalent within the smaller population of remaining TANF families than in the late 1990s.

In addition, the existing literature is based upon self-reported data. An Institute of Medicine committee, concerned with HIV prevention, recently examined the ability of existing nationally-representative surveys to examine substance abuse and other risk-behaviors.(IOM 2000) The committee concluded that these surveys failed to provide adequate coverage of the small, but important, populations experiencing greatest HIV risk. It commented that telephone-based surveys of non-institutionalized respondents may overlook the individuals of greatest research and policy concern. It also criticized existing epidemiological surveillance systems for being overly-reliant upon existing clinical and administrative data systems which neglect drug users and others who seek limited contact with health care providers or with social service systems. Similar criticisms are pertinent to available data regarding welfare recipients.

These data problems are particularly acute regarding extremely-poor women, such as near-homeless individuals or those experiencing severe drug-related or psychiatric disorders. Data are also limited regarding current or former criminal offenders who are income-eligible for TANF but who may not actually receive cash aid. Some of these women are under legal

supervision. Some may be barred from TANF by the Gramm Amendment or related legislation; some may also receive services and economic assistance through child protective or family preservation services.(Waldfogel 2000)

The impacts of welfare reform on these subgroups of poor women are largely unknown. Hammett and collaborators describe outreach and service strategies to recruit substance users and criminal offenders into social services. Several research teams have presented analytic frameworks to improve social and medical services for criminal offenders and out-of-treatment drug users.(Hammett, Gaiter et al. 1998; Thompson, Blankenship et al. 1998; Pollack, Khoshnood et al. 1999) Most recently, a randomized trial examined the efficacy of enhanced treatment approaches for the TANF population. Preliminary results indicate that both engagement and retention in outpatient substance abuse treatment are higher within intensive interventions than they were within usual modes of care.(Morgenstern, Riordan et al. 2001)

Despite important weaknesses in available data, recent studies have several implications for policymakers and welfare researchers. Consistent with public concerns, illicit drug use and chemical dependence are more common among welfare recipients than among women who do not receive cash aid. In multiple datasets, illicit drug use is a strong risk-factor for welfare receipt, even after controlling for race, educational attainment, region, and other potential confounders. Rates of problem alcohol use are also substantially higher within the welfare population.

Among those remaining on the TANF rolls, chemical dependence may be an important obstacle to employment. By the 1999 wave of the Michigan WES, 6.4 percent of nonworking TANF recipients satisfied screening criteria for chemical dependence. Especially intriguing, more than 8 percent of nonworking *non-recipients* satisfied the same dependence criteria. Less

than 1 percent of respondents who were working at least 20 hours per week satisfied these screening criteria.

More than half of recipients who had used illicit drugs within the previous year satisfied screening criteria for one of several DSM-III-R psychiatric disorders included in the NHSDA and WES. Although few drug users appear chemically dependent, many report some adverse social, family, or economic consequences associated with their substance use.

From a public health perspective, existing research highlights the potential value of the welfare system as a mechanism to find and to assist mothers with drug use disorders. Although illicit drug use appears rare among welfare recipients, many (or most) women who *do* use illicit drugs have spent some time receiving cash aid. This pattern is especially pronounced among women over the age of 30, among whom drug use is rare, but whose use may reflect more chronic difficulties than are found in younger cohorts. Long-term welfare recipients account for a large fraction of recent cocaine users, and account for a significant proportion of those who report other illicit drug use. Identifying and helping TANF recipients with drug use disorders would have major implications for public health--whether or not these services had a large impact on welfare receipt or economic self-sufficiency.

Existing data also underscore the dangers of exaggerating the prevalence or severity of illicit drug use within the welfare population. Less than 20 percent of recipients report using any illicit drug during the past year. Aside from marijuana, less than 10 percent report other illicit drug use during the past year. Chemical dependence is far less prevalent than many other threats to well-being and self-sufficiency--depression, post-traumatic stress disorder, and physical health problems, all of which are more common among welfare recipients than among other women. Although drug use is one risk-factor for welfare receipt, the observed association is weaker than

one finds for race, region, unmarried teen pregnancy, or educational attainment. If all welfare recipients were to stop using illicit drugs, one study indicates that the size of the welfare population would show little decline.(Kaestner 1998)

Some policymakers and researchers have expressed concern that declining caseloads have led to a high prevalence of drug use disorders among the more disadvantaged recipients who remain on the caseload. So far, available data do not support these concerns. Although by tangible measures TANF recipients have become a more disadvantaged group,(Danziger, Corcoran et al. 2000; Lichter and Jayakody 2002) it is not clear that substance use is a major contributor in defining the "core group" of recipients remaining on the rolls.

The prevalence of illicit drug use among welfare recipients declined during the 1990s. Although welfare recipients are more likely than non-recipients to use illicit drugs, changes in drug use prevalence have been quite similar in the two groups. Welfare caseloads fell significantly between 1994 and 1998. However, the prevalence of illicit drug use among welfare recipients declined slightly over the same period.

The above results also speak to the challenges of competing strategies to detect mental and behavioral health problems among welfare recipients. This is a major policy concern, since existing screening and assessment strategies detect only a small proportion of recipients with substance abuse or dependence.(Nakashian and Moore 2001) Many states have yet to establish systematic procedures and data collection systems to identify, assess, and to treat these disorders.(CASA/APHSA 1999)

Because psychiatric disorders are more prevalent than illicit drug dependence among TANF recipients, screening welfare applicants and recipients for depression, PTSD, and other psychiatric disorders is likely to be more effective than chemical tests in identifying problems

that hinder the transition from welfare to work. Specific screening policies for a broad range of DSM-III-R disorders would address a much larger population than the important--but small--population of drug-dependent recipients who might be detected through chemical tests.

Moreover, many recipients likely to test positive are casual drug users who do not satisfy DSM-III-R screening criteria for dependence. Urine tests (rather than other methods such as hair assay) compound these problems because urine tests have a longer detection period for marijuana than they do for other illicit substances.(Vega, Kolody et al. 1993) In addition, widespread testing might deter substance use, but might also deter heavy users and those who are drug-dependent from applying, an ambiguous outcome from a policy perspective.(Pollack, Khoshnood et al. 1999)

Absent specific suspicion, population-based chemical testing of welfare recipients will detect some "true positives" who are drug-dependent, a greater number of "accidental positives" who use drugs but are not dependent, but who have psychiatric disorders, and a larger group of "false positives," casual users who have no apparent psychiatric (including drug-related) disorder. Chemical testing does not detect "false negatives"—the significant population of TANF recipients who satisfy screening criteria for alcohol-dependence or other psychiatric disorders, but who do not report use of illicit drugs.

The pitfalls in suspicionless chemical testing of TANF recipients are illustrated by Michigan's recent experience. Although the policy detected substance use by 21 out of 258 tested recipients (about 8 percent), only three recipients tested positive for non-marijuana illicit drug use. A more specific strategy would be to focus on non-working recipients and those displaying specific signs associated with substance abuse and dependence. Although non-working recipients report similar prevalence of illicit drug use to those reported among working

recipients, they are much more likely to satisfy screening criteria for dependence. Whichever population is tested, chemical tests should be combined with additional social/psychological assessments to identify other psychiatric disorders requiring intervention. Stationing addiction counselors in welfare offices, and the assessment of clients with potential substance use disorders by specialized and experienced caseworkers are additional promising strategies to improve the sensitivity of existing systems.(Morgenstern, Riordan et al. 2001)

Experience with drug users outside the TANF program also provides an important caution that stringent policies can cause significant hardship for severely disadvantaged recipients. Between December 1996 and January 1997, 103,000 individuals with diagnosed drug or alcohol disorders were removed from federal disability rolls. Some of them managed to receive cash assistance or health insurance through General Assistance and other state-level programs, though these heterogeneous programs were sharply curtailed during the early 1990s and have received limited policy analysis.(Danziger and Kossoudji 1994/1995; Schmidt, Weisner et al. 1998)

Swartz and colleagues(Swartz, Lurigio et al. 2000) surveyed 204 randomly selected former recipients in the Chicago area. One year post-disenrollment, only 28 reported monthly earnings of at least $500; 107 reported monthly legal earnings below $500 and received no cash public aid. Compared with working former recipients, members of the unemployed/underemployed group had five times the likelihood of drug dependence and were substantially more likely to experience severe mental illness. This experience suggests the need for caution about policies that would simply remove substance-dependent recipients from the TANF rolls without providing additional services.

Such cautionary tales are especially timely given the overall success and popularity of the 1996 welfare reforms. Welfare reform is among the most popular policy changes of recent decades.(Danziger 1999; Weaver 2000) The convergence of a strong economy and welfare reform has led to declines in welfare dependence and increased work among single mothers. Contrary to its critics' worst fears, welfare reform has not caused widespread hardship among those leaving the rolls.(Blank and Schoeni 2000) Such successes, on average, may not hold for the small subset of more-disadvantaged recipients with more significant barriers to self-sufficiency.

The emergence of substance use among welfare recipients as a widely-cited employment barrier should also remind advocates, policymakers, and researchers that the data must be interpreted through a lens of public values, policy judgments, and the known effectiveness of available interventions. Substance abuse and dependence have been documented as barriers to self-sufficiency, but so are poor education, lack of transportation, physical and mental health problems, and many other difficulties that are widespread among welfare recipients. Epidemiological data can inform decisions about resource allocation and the administration of public programs. These data cannot resolve the policy debate regarding the rights and obligations of substance users to receive public aid and/or treatment services.

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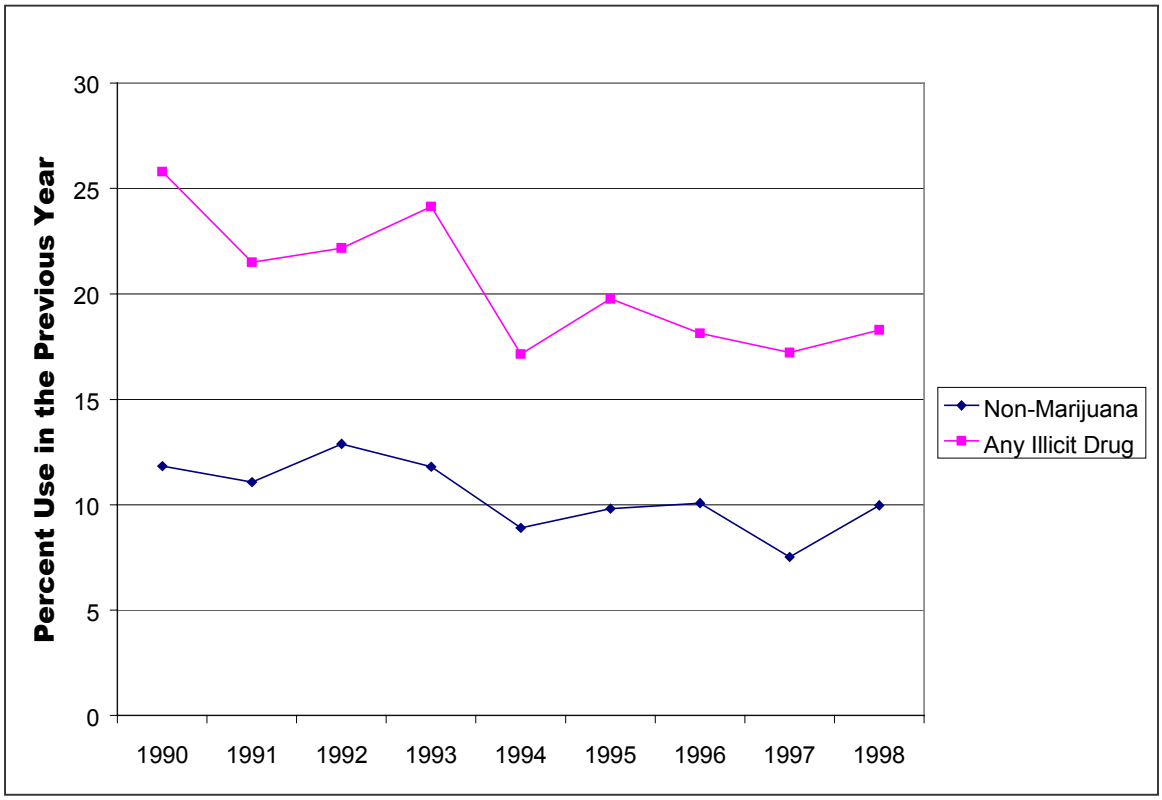


Figure 1: Illicit Drug Use Among AFDC/TANF Recipients 1990-98. Source: 1990-98 National Household Survey of Drug Abuse

	Unmarried women age 18-54 who received TANF in past year	Unmarried women age 18-54 who did not receive TANF in past year
Alcohol Dependence	7.5 percent	4.6 percent
Illicit Drug Dependence	5.4 percent	2.1 percent***

Table 1: Drug and Alcohol Dependence in 1998 National Household Survey of Drug Abuse, Authors' Tabulations. (* p<0.001 distinguishing TANF recipients and non-recipients)**

	Working 20+ hours, No TANF cash receipt (N=316)	Working 20+ hours, did receive TANF cash aid (N=85)	Not working 20+ hours, did receive TANF cash receipt (N=109)	Not working 20+ hours, No TANF cash aid (N=116)	Totals (N=626)
Illicit-Drug dependent	0.9%	0	6.4%	8.6%	3.2%
Illicit drug use within past 12 months, but no drug or alcohol dependence, and no psychiatric disorder.	9.5%	11.8%	9.2%	7.8%	9.4%
No illicit-drug dependence, but drug use within previous 12 months. Has alcohol dependence or psychiatric disorder.	4.7%	9.4%	7.3%	4.3%	5.8%
No drug dependence or recent use, but does have alcohol dependence or psychiatric disorder	19.6%	20.0%	32.1%	24.1%	22.7%
No recent drug use or dependence, no alcohol dependence or psychiatric disorder	65.2%	58.8%	45.0%	55.2%	58.9%

Table 2: Drug Use, Psychiatric Disorders and Chemical Dependence, within Previous 12 Months, Respondents Classified by Work/Welfare Status, Fall 1999.