The change in welfare programs from AFDC to Temporary Assistance for Needy Families (TANF) is cause for all service providers to better understand the ways they can help low income families become self-sufficient. Increased employment and training requirements, time limits, and strict sanctions for not complying with program expectations are especially great challenges for providers working with substance using and abusing parents.

Although, historically, there has been little attention paid to the overlap between substance abuse and the use of public assistance programs, new studies are emerging that examine the role of substance abuse in welfare dynamics. At the same time, some state plans are showing the way to service approaches that consider this relationship. Following is a summary of these findings.

The Overlap Between Welfare Use and Substance Use and Abuse

A small, new body of work emerging on the use of substances by welfare recipients clearly indicates that the dimensions of the problem are sizeable. Far less has been written about the dynamics of welfare use and substance use and the likely points of intervention. Least certain is the effectiveness of interventions to address the needs of women and children who are involved in welfare and substance abuse.

A report from the U.S. DHHS (1994) examines the 1991 and 1992 National Household Survey on Drug Abuse (NHSDA) to estimate the prevalence of substance use among recipients of AFDC and the degree to which that use impairs the recipient’s ability to work or participate in job training programs. This is a particularly crucial estimate in light of TANF work requirements. Approximately 4.9% of female AFDC recipients were estimated to have “significant functional impairment” (p. 2). The study found an additional 10.6% of female AFDC recipients to be “somewhat impaired.” This level of impairment applied to people who were not dependent on an illicit substance but used an illicit drug at least weekly; were dependent on alcohol but were drunk at least weekly; were dependent on an illicit drug other than marijuana but used an illicit drug less than monthly and did not use heroin; were dependent on marijuana; or were dependent on alcohol but were drunk less than weekly. When males were added, 11.2% of recipients were estimated to be somewhat impaired. These clients are likely to need “substance abuse treatment concurrent with participation in employment and training activities” (p. 2). The estimates in this report should be “regarded as conservative because of potential underreporting of both drug use and program participation” (p. 1). Taken together, these data imply that there is a significant percentage of recipients (approximately 16.4%) who will need some level of substance abuse treatment in order to meet the requirements of TANF and to provide for their families after they reach the time limits on assistance.

“...there is a significant percentage of recipients who will need some level of substance abuse treatment in order to meet the requirements of TANF and to provide for their families after they reach the time limits on assistance.”

impairment related to substance abuse”—defined as being dependent on alcohol and drunk at least once a week or as being dependent on an illicit drug other than marijuana and having used an illicit drug at least monthly or used heroin at least once in the past year (p. 2). When male recipients were also included, the rate of impairment rose to 5.2%. These individuals’ impairments were considered to be so serious that they “preclude immediate participation in employment or training activities” (p. 2).

The study found an additional 10.6% of female AFDC recipients to be “somewhat impaired.” This level of impairment applied to people who were not dependent on an illicit substance but used an illicit drug at least weekly; were dependent on alcohol but were drunk at least weekly; were dependent on an illicit drug other than marijuana but used an illicit drug less than monthly and did not use heroin; were dependent on marijuana; or were dependent on alcohol but were drunk less than weekly. When males were added, 11.2% of recipients were estimated to be somewhat impaired. These clients are likely to need “substance abuse treatment concurrent with participation in employment and training activities” (p. 2). The estimates in this report should be “regarded as conservative because of potential underreporting of both drug use and program participation” (p. 1). Taken together, these data imply that there is a significant percentage of recipients (approximately 16.4%) who will need some level of substance abuse treatment in order to meet the requirements of TANF and to provide for their families after they reach the time limits on assistance.

This is just part of the story. Looking at the overlap from another direction, the NHSDA data show that only 7% of all...
adult substance users who are significantly impaired by their use receive AFDC and 20% of women who are significantly impaired receive AFDC (p. 2). Thus, substantial numbers of impaired women do not receive AFDC—perhaps because they are working, receiving other forms of public aid, or being supported by other wage earners.

The National Center on Addiction and Substance Abuse (CASA) used the same National Household Survey on Drug Abuse (1991-1992) to estimate that among women receiving AFDC, age 18 to 44, 10% were regular users of alcohol only, 13% were users of drugs only, and 2% were regular users of alcohol or drugs (Merrill, 1994). Additionally, researchers from NIAAA (Grant & Dawson, 1996) used the National Longitudinal Epidemiologic Survey to determine the numbers of AFDC recipients who reported heavy drinking, drug use, or met DSM-IV criteria of abuse or dependence on substance. They found that among AFDC recipients, 13% were heavy drinkers, 8% met DSM IV criteria of alcohol abuse, 10% reported drug use in the previous year, and 4% met DSM IV criteria of drug abuse and/or dependence. From these results, they conclude that welfare recipients have rates of use, abuse, and dependence similar to the non-welfare population.

Other longer summaries of these studies also exist. Olson and Pavetti (1996), for instance, estimated that between 5 and 37% of AFDC recipients experience excessive or frequent drug or alcohol use (p. 27), and Young and Gardner (1997) conclude that 15% is a reasonable enough estimate for planning alcohol and other drug services to TANF clients. The Legal Action Center (1997) concludes that between 16% and 20% of welfare recipients have alcohol and drug problems.

Welfare and Substance Abuse Dynamics

Although the overlap between welfare use and substance abuse is becoming clear, the research base for understanding the dynamics of this relationship is small and unstable. We know next to nothing about the relative likelihood of going on welfare or staying on welfare because of substance abuse problems. An exception to this is a prospective study examining representative samples of AFDC and General Assistance (GA) clients in a northern California county (Schmidt, Weisner, and Wiley, 1997) who were interviewed as they applied for services in 1989 and then re-interviewed in 1995. The findings suggest that alcohol and drug problems were not significant determinants of long-term or repeat welfare use among AFDC recipients during this 6-year period. However, substance abuse was a strong predictor of repeat welfare use among GA recipients who have roughly a three times higher rate of heavy drug use and substance dependence than AFDC recipients.

Reasons for leaving welfare differed between those on AFDC and GA—as the latter were more likely to have welfare interrupted by incarceration and were much more likely than AFDC recipients to be cut off of welfare for failing to comply with bureaucratic rules. This is almost certainly true because, under AFDC, there were many fewer demands for evidence of job searches and participation in work assignments than were in place for General Assistance recipients. The increase in such demands under TANF may lead to high sanction rates for substance abusing parents with young children, leaving many more of them in the GA population, where they may not fare too well, either. Under welfare reform, then, local GA programs will often be the final “safety net” for substance abusing recipients removed from federal entitlement programs, and will have increasing numbers of families with greater financial and service needs. These increases might be mitigated by any positive impact that greater participation in work might have on reductions in substance abuse. (Unfortunately, little evidence is available to suggest that encouraging substance abusers to work has a predictable therapeutic influence on their substance use.)

Of great concern is the combined impact of substance abuse and poverty on family stability. Clarice Walker and her colleagues (1994) looked at the interactions of substance abuse, poverty, and child welfare in a study attempting to profile African-American children who entered foster care in 1986 in five major U.S. cities. Among the parents whose children entered foster care, 85% of the substance abusing parents received AFDC while only 58% of the parents who were not indicated as substance abusers received public assistance. Additionally, poverty and inadequate housing were listed as contributing factors for placement twice as often among substance abusing parents. Successfully addressing substance abuse as part of the receipt of welfare-to-work services can help reduce the need for child welfare services.

Welfare-to-Work Program Strategies to Address Substance Abuse

Although substance abuse assessment and treatment has received insufficient attention in welfare programs, there are innovative efforts to build a sensitivity to substance abuse into welfare-to-work programs. Pavetti, Olson, Pindus, and Pernas (1997) have described several innovative efforts which are summarized here. In these programs, developed under the JOBS legislation, clients have not been “screened out” because of substance abuse issues. At best, they receive assessment and referral to alcohol and other drug (AOD) services, which is likely to be the case under many TANF programs.

Chicago Commons West Humboldt Employment Training Center (ETC)

ETC is a private, community-based program designed to help welfare recipients get their GED and/or enroll in training programs to become self-sufficient. Through collaboration with other agencies, they provide a broad array of services including literacy training and GED classes, parent and child services, on-site medical care, and job-placement and career counseling. Their program begins with an 80 hour Life Skills class taught by the program’s case managers. This class also serves as an informal assessment of participants. Participants then move on to the other program opportunities, continuing to work with the program’s case managers.

Continued on page 15...
Welfare Reform: What's Happening Now?

October 1, 1997 is an historic date. It marks the one year anniversary of the end of welfare in states which were early adopters of the massive welfare changes contained in the Personal Responsibility and Work Opportunities Reconciliation Act of 1996 (PRWORA). What has been happening in those states in the first year of block-granted welfare reform? To date, little published information is available for anecdotes or vignettes, even though the policy questions are many and the issues are gravely important. One state (Maryland), however, has just released the first in what will be a series of reports tracking the post-welfare lives and experiences of a random sample of some 2000 families. The study does not focus specifically on families with a substance-abusing member or those with very young children, but its early findings are relevant to those who are concerned about the well-being of vulnerable youngsters and their families in general. It may also serve as a catalyst for similar projects in other states.

Welfare Reform the Maryland Way

Maryland’s new approach to welfare, the Family Investment Program (FIP), was designed over a period of two years with substantive input from state and local welfare administrators, state legislators, business leaders, child and welfare advocates, and state university-based researchers. Among FIP’s significant, new programmatic features are a five year lifetime limit on adults’ receipt of TCA (Temporary Cash Assistance, formerly AFDC) and termination of the entire household’s TCA benefit (i.e., full family sanction) for the adult’s non-compliance with work and child support enforcement requirements. FIP also makes welfare avoidance grants available to enable families to receive the emergency aid they need without having to become enmeshed in the welfare system.

The principles undergirding FIP are at least as dramatic a break from the past as are its program features. Gone is the traditional “one size fits all” welfare philosophy. For clients this means each is entitled to receive an individualized, up-front assessment of strengths, resources and needs. For local welfare agencies—where the true test of all reforms takes place—this means an unprecedented degree of flexibility in program design and expenditures, staff organization/use, and service delivery. While benefit levels were deliberately kept uniform across Maryland, and the state agency continues to set broad policy parameters and hold locals accountable for outcomes, the hallmark of FIP is truly local tailoring of programs to meet local needs. Local tailoring has involved both minor and major alterations, but creativity has been evident across the board. For example, one county now contracts with the local literacy council to perform parts of client assessments. In some counties, applications for welfare avoidance grants are reviewed by multi-disciplinary teams; in a number of places the “welfare office” has been transformed into a job center with computer rooms and career planning centers. Application forms which previously focused almost exclusively on the so-called “technical factors of eligibility” now place great emphasis on work history, career goals and aspirations.

FIP is anchored by knowledge gained from projects carried out via a long-standing welfare research partnership between the state’s Department of Human Resources (DHR) and the University of Maryland’s School of Social Work (SSW). In particular, findings from SSW’s ten year study of a large cohort of families documented the existence of discrete types of welfare users, each with different patterns of use over time and with varying likelihoods of being able to quickly or easily exit from the welfare rolls (Born & Caudill, 1997). These findings serve as the empirical backbone for the cohort-specific, investment-focused, locally-tailored principles of FIP. Notably, there now exists in statute what some would likely call a “rainy day” fund in which savings from cases which make early exits from welfare are deposited. These funds can only be used for the inevitable task in future years of serving families that research has shown will have the most difficulty transitioning from welfare and maintaining self-sufficiency.

Examining Reform’s Effects on Families

The agency-university research tradition enabled Maryland not only to begin operating under new federal rules on the earliest possible date (10/1/96), but also to begin studying FIP’s effects on families on day one as well. The study’s central question is: what happens over time to families who voluntarily or involuntarily cease to receive Temporary Cash Assistance? Subsidiary questions, of course, are many. Which families are leaving welfare and how do those who leave voluntarily differ from those who are terminated? How many who leave return to welfare, and what are the patterns of recidivism under the new system? What are the child welfare impacts? What types of jobs do exiting adults obtain, and what are their rates of job retention?

To insure representativeness, random samples are being drawn of cases closing in each of the first 12 months of reform. This yields a scientifically valid, statewide sample for each month and for the whole year. Monthly sampling also permits the study to account for seasonal fluctuations in exit rates. Samples for October 1996 - June 1997 have been drawn and range in size from 150 to 194, indicating that, when all cases are selected, there will be a cohort of at least 2000 families whose welfare reform experiences can be tracked over time.

Continued on page 4...
For each case, baseline data at the point of exit are collected from five administrative data systems containing individual and case-level data on public welfare, child support and employment and wages. These data provide a rich description of exiting cases and individuals in terms of: family composition, children’s ages and relationships; welfare spell lengths and reasons for case closure; and gender, ethnic background, age, age at first birth (for female payees), and employment history of household head. To date, baseline administrative data have been collected for the first nine samples (October 1996 - June 1997), a total of 1,607 families.

Follow up administrative data will be gathered at 3, 6, 12, 18 and 24 months after a family exits from cash assistance to find out, over time, such things as: how many household heads have reported earnings, and what types of wages do they command?; what types of industries hire TCA recipients?; how many return to welfare and who is at greatest risk to do so?; and how likely are children to be placed in foster care after their families leave TCA? So far, initial follow-up data have been collected on the first six months of cases (n=1,055).

These data will tell much of the story, but they will not tell all of it; administrative data simply do not provide a complete picture of families’ lives. Thus, the study will also include telephone interviews to tap into elements of families’ experiences that are not evident from administrative data bases.

The study is very much a “work in progress.” Likewise, its early findings do not represent the final answers about what happens to families once they leave welfare; they tell only what we have learned so far about who these families are and what happens to them in the first few months after leaving the rolls. Some early findings may well stand the test of time: characteristics of exiting families will not change, nor will their prior welfare use and employment patterns. Other findings, though, especially those relating to employment, earnings, job stability, household composition and, perhaps, child welfare involvement, may change markedly with the passage of time and collection of more longitudinal data.

**Findings from the First Six Months**

What have we learned thus far? First, a thumbnail sketch of the demographics of closing cases in our sample is that of a two person family, composed of a female (96%), African-American (66%), single parent (98.1%) and her one child (47.7%) who is about six years of age. Mother is about 30 years old, had her first child before the age of 21 (conservatively, 50% of the sample) and, at the time of her exit from TCA, had been receiving cash assistance for one year or less (46.2%). The large majority of adults in these exiting cases do have a demonstrated attachment to the labor force; about three-fourths of them had some paid employment in the two and one-half years just prior to their welfare exit. About two-thirds were working in the quarter immediately after their welfare case closed.

At least in the early months, we find that few cases left welfare because the agency imposed a full family sanction for non-compliance. Indeed, fewer than 5% of all closings were due to a work sanction and less than 1% were sanctioned for non-compliance with child support. We also found that, thus far, predictions about the negative impact on foster care caseloads have not come true. Of nearly 2,000 children whose records were examined, only three (siblings in the same troubled household) came into foster care within six months of the family’s exit from cash assistance. Recidivism or returns to welfare are also uncommon in FIP’s first nine months. Fewer than one in five exiting families returned to welfare; those who did return, however, tended to have younger children than those who did not.

**Implications for the Future**

It is simply too early to reach any definite conclusions about the long-term impact of Maryland’s approach to welfare reform, but a few points do seem clear. The first is that dire predictions about child welfare impacts of full family sanctions—and the prevalence of those sanctions—have not come true in the program’s first few months. Another is that the state’s cohort-specific, investment-focused, research-based approach appears to have been a wise one. The program is working as anticipated: those most likely to leave welfare quickly and remain off are those who have received aid for shorter periods of time, those who do not have young children, and those who have a fairly recent history of employment. This is both the good news and the bad news insofar as the future is concerned. It is good because savings from these cases do go into the “rainy day” fund and will be available to help those whose situations are more complicated and for whom achieving lasting independence will, without question, be far more difficult. It is bad because it unquestionably makes clear that, despite early successes, welfare reform itself is neither easy nor, in the long-run, inexpensive. The specific finding that those with younger children are more likely to return to welfare following an exit is, at this early stage, neither good news or bad. However, it perhaps should serve as an early warning signal that families with young children may need special and/or extra services in order to successfully transition to independence and remain there.

Regardless of one’s opinion about the direction of welfare policy in this country, the reality is that we have ended welfare as we knew it; we have replaced the old system with myriad state-level programs, the outcomes of which are unknown but important. In Maryland, we do not yet know the answers about welfare reform, but we do recognize the importance of beginning to ask the questions via research. To the extent that our Maryland welfare reform research experiences thus far may be instructive, persons who may wish to consider undertaking similar studies in their own states are encouraged to give us a call (410-706-5134). A copy of our interim report, *Life After Welfare*, is also available upon request.

— Catherine E. Born, Ph.D.
School of Social Work,
University of Maryland

**REFERENCE**

In 1996 the Social Security Administration notified 167,000 persons nationwide, who qualified to receive Supplemental Security Income (SSI) benefits due to a drug abuse and alcoholism (DA&A) disability, that the DA&A program would terminate on January 1, 1997. Their benefits included about $600 per month of cash and medical insurance that covered treatment for physical and emotional problems, as well as addictions. Since 1974, DA&A SSI beneficiaries also were required to attend treatment for their addiction and use money management services provided by a representative payee. Legislation in 1994 limited DA&A benefits to three years and instituted a monitoring program to check on treatment attendance. Suspecting abuses of the program, and alarmed over escalating numbers of beneficiaries, in March 1996, under Public Law 104-121, Congress changed direction and discontinued this benefits program entirely.

The 551 Study

Curious to know whether most beneficiaries would successfully reapply for SSI under another aid category, and concerned about the welfare of those who might not fare well following program termination, the Robert Wood Johnson Foundation funded a study to track a randomly selected sample of SSI DA&A beneficiaries living in four Northern California counties. The data will be incorporated into a multi-site study coordinated by the federal Center for Substance Abuse Treatment.

The Social Security Administration’s contracted Referral and Monitoring Agency mailed letters to a list of potential sample members in November 1996. Beneficiaries who were interested in participating in the study contacted an independent team of interviewers. Initial interviews were conducted face-to-face and lasted from one to two hours. Persons who participated were paid $40 to complete the interview. Interviewees were asked about their family and living situations, physical and mental health, use of alcohol and other drugs, involvement in criminal activities, experience with victimization, work situation, SSI status, experiences with the SSI program, need for health and social services, finances, and personal well-being. Following completion of the initial interviews in February, a second round of interviews was conducted between June and August 1997. Interviewees were asked mostly the same questions to gain a clear picture of how their situation had changed during the first six months following the termination of SSI benefits.

At the time of the initial interview, 43% of the interviewees indicated they had children under age 18. Twenty percent of the respondents were currently raising one or more minor children at their place of residence. The following report briefly describes the full sample from this California study of former SSI DA&A beneficiaries, then sketches with preliminary data what happened to the families raising minor children during the first six months following termination of the SSI DA&A program.

A Sample of Former SSI DA&A Beneficiaries

Only SSI beneficiaries of the DA&A program between the ages of 21 and 59, who were currently assigned to be monitored by the Referral and Monitoring Agency, were eligible to participate in the study. The entire sample of 524 persons had an average age of 43 years. Males comprised 58% of the sample. Only 45% of the sample had graduated from high school. The sample was ethnically diverse: 41% were Black, 31% were White, and 20% were Hispanic. Table 1 summarizes key features of the entire

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Full Sample (N=524)</th>
<th>Have Minor Children (N = 224)</th>
<th>Minor Children in Home (N=109)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (years)</td>
<td>43.2</td>
<td>39.5</td>
<td>38.0</td>
</tr>
<tr>
<td>Male</td>
<td>57.8</td>
<td>46.4</td>
<td>26.6</td>
</tr>
<tr>
<td>High School Graduate</td>
<td>45.0</td>
<td>37.9</td>
<td>35.0</td>
</tr>
<tr>
<td>Reside in Own Dwelling</td>
<td>52.1</td>
<td>57.1</td>
<td>73.4</td>
</tr>
<tr>
<td>Currently Married</td>
<td>9.6</td>
<td>14.8</td>
<td>18.5</td>
</tr>
<tr>
<td>Number of Children (avg.)</td>
<td>1.97</td>
<td>3.00</td>
<td>3.15</td>
</tr>
<tr>
<td>In Fair or Poor Health</td>
<td>71.2</td>
<td>66.1</td>
<td>68.8</td>
</tr>
<tr>
<td>Appealed Loss of SSI</td>
<td>76.0</td>
<td>73.4</td>
<td>66.1</td>
</tr>
<tr>
<td>Have Driver’s License</td>
<td>33.4</td>
<td>39.5</td>
<td>44.0</td>
</tr>
<tr>
<td>Have Use of Auto</td>
<td>29.4</td>
<td>43.3</td>
<td>56.0</td>
</tr>
</tbody>
</table>

1Entries in the table are percents, unless otherwise specified.
sample, then compares those characteristics for sub-samples of the persons who had minor children (N=224), and those who were raising their children under age 18 at home (N=109) at the time of the first interview. At the time benefits were terminated, the sample in general was housed, paying most of their bills, and somewhat older than the population (data not shown).

The families of the 524 persons interviewed included 1,031 offspring, of whom 671 were children, under the age of 18. Table 1 shows that respondents with minor children, particularly those raising their children, differ in significant ways from the whole study sample. The average age of persons raising minor children is 38 years, younger than the sample average of 43 years. The proportion of males drops from 58% to 27%. The proportion of persons graduating from high school declines from 45% to 35%. In contrast, the proportion of persons living in their own residence (rented, owned, or shared) increases from 52% to 73%. Few members of the study sample are currently married; however, the rates increase from 10% in the full sample to 19% of persons raising young children. On average, those with minor children at home have more children than the rest of the sample. The percent of parents raising minor children who assess their own health as fair or poor is 69%, which is very similar to the larger study sample. Health status of the study sample is much worse than that of adults in the general population, of whom 14% or less typically report fair or poor health. Surprisingly, fewer persons raising minor children pursued reinstatement of SSI benefits. People raising children were more likely to be licensed drivers and to have an automobile available for use. In summary, former SSI DA&A beneficiaries involved in raising young children at home tended to be younger and married, and to operate more independently than the larger sample.

Six Months Later: Changes in the Lives of Parents Raising Minor Children

The remainder of this article focuses on the subset of people from all four counties who are raising minor children in their households. We report on changes in the lives of respondents from the baseline survey, referring to the period just before the end of SSI benefits for drug and alcohol addiction, up to the first follow-up survey six months later (see Table 2). These preliminary data represent follow-up interviews that have been completed with 476 of the 524 people in the original sample. Of the 109 parents raising minor children, 106 have been re-interviewed and are represented in these data. Although most of the changes are small, they may foreshadow trends that will continue over the next two years.

What can this early peek at the impact of welfare reform tell us about whether predictions of policy makers responsible for welfare reform are likely to become reality? Will drug- or alcohol-addicted people, particularly those with children to raise, stop abusing alcohol and/or other drugs, find work that will support their families, and become self-sufficient? Will they cope with the loss of income, Medicaid, mandated drug and alcohol treatment, and

Table 2. Changes Six Months After Baseline for SSI Study Respondents Raising Minor Children, Preliminary Northern California Data

<table>
<thead>
<tr>
<th>Variable</th>
<th>Baseline interview (N=109)</th>
<th>6-month follow-up (N=106)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Welfare status</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Receiving SSI</td>
<td>96.3%</td>
<td>41.3%</td>
</tr>
<tr>
<td>Receiving AFDC</td>
<td>58.7%</td>
<td>60.6%</td>
</tr>
<tr>
<td>Receiving GA</td>
<td>2.8%</td>
<td>5.7%</td>
</tr>
<tr>
<td>Income</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Household Income in Past Month</td>
<td>$1,358</td>
<td>$1,241</td>
</tr>
<tr>
<td>Housing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Using Someone Else’s Place</td>
<td>23.9%</td>
<td>29.2%</td>
</tr>
<tr>
<td>Homeless Shelter or On Street</td>
<td>0.9%</td>
<td>3.8%</td>
</tr>
<tr>
<td>Children at home</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number in Household (Avg.)</td>
<td>1.97</td>
<td>2.11</td>
</tr>
<tr>
<td>Called on by CPS</td>
<td>1.8%</td>
<td>7.3%</td>
</tr>
<tr>
<td>Working</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employed at Legal Job</td>
<td>11.0%</td>
<td>19.3%</td>
</tr>
<tr>
<td>Reporting Wage Income</td>
<td>19.4%</td>
<td>29.2%</td>
</tr>
<tr>
<td>Days Worked in Last 30, if Working</td>
<td>16.7</td>
<td>13.2</td>
</tr>
<tr>
<td>Food Insecurity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>People Hungry in Past 7 days</td>
<td>15.6%</td>
<td>12.3%</td>
</tr>
<tr>
<td>Days of Hunger in Past 7</td>
<td>0.5</td>
<td>0.3</td>
</tr>
<tr>
<td>Days with No Food, Past Month</td>
<td>0.9</td>
<td>0.3</td>
</tr>
<tr>
<td>Drug use</td>
<td></td>
<td></td>
</tr>
<tr>
<td>None</td>
<td>45.0%</td>
<td>46.8%</td>
</tr>
<tr>
<td>Drinks per Day, for Drinkers</td>
<td>4.5</td>
<td>5.5</td>
</tr>
<tr>
<td>Smokers</td>
<td>75.2%</td>
<td>67.0%</td>
</tr>
<tr>
<td>Number of Cigarettes per Day</td>
<td>17.4</td>
<td>14.5</td>
</tr>
<tr>
<td>Drug Use—Days in Last 30, by Users</td>
<td>15.7</td>
<td>13.0</td>
</tr>
<tr>
<td>Health</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical Insurance</td>
<td>85.3%</td>
<td>86.8%</td>
</tr>
<tr>
<td>Drug Treatment Insurance</td>
<td>78.4%</td>
<td>45.0%</td>
</tr>
<tr>
<td>In Drug/Alcohol Treatment</td>
<td>77.1%</td>
<td>50.9%</td>
</tr>
<tr>
<td>Number of Health Problems (Avg.)</td>
<td>3.0</td>
<td>2.7</td>
</tr>
<tr>
<td>No. Mental Health Symptoms (Avg.)</td>
<td>2.8</td>
<td>2.8</td>
</tr>
<tr>
<td>Medication for Mental Illness</td>
<td>29.4%</td>
<td>30.2%</td>
</tr>
<tr>
<td>Quality of life</td>
<td></td>
<td></td>
</tr>
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<td>Life Satisfactory (Lowest=4)</td>
<td>2.4</td>
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<td>Self-esteem (Highest=5)</td>
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<td>3.6</td>
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Changes in Income and Family Composition

Although the Social Security Administration predicted that 75-80% of terminated DA&A beneficiaries would be reinstated on SSI for other disabilities (Congressional Budget Office, 1995; Sherif, 1995), in our sample, only 41%—less than half of those raising minor children—were receiving SSI payments six months after program termination (see Table 2). About two-thirds of those caring for children reported applying for SSI benefits under another disability, or appealing the SSI termination, and about two-thirds of those succeeded.

The first, most direct effect of SSI termination has been loss of income to the household. Some respondents received cash assistance from Aid to Families with Dependent Children (AFDC) or General Assistance (GA) for some adult member of the household, thus offsetting a portion of the lost income. The effect on average household income across this group was a decrease of about 9%, or $117 per month. Since AFDC is being transformed into a time-limited program, and several California counties have already limited GA benefits to three months yearly, these adjustments may prove only temporary.

Several changes in the lives of those raising children seem to be directly related to decreased income. The number of families living in someone else’s place edged upward from 23.9% at baseline to 29.2% six months later. Homelessness increased from less than 1% at baseline to 3.8% six months later.

There were a few changes in family size over the six-month follow-up period. Several children under the age of four, who may have been placed outside the home, rejoined their families. In addition, several children over the age of 18 returned to the family, perhaps to add their earnings to the household income. Whether because of the changes in family composition, or for other reasons, the percentage of respondents reporting Child Protective Services (CPS) visits increased from 1.8% to 7.3% six months later.

In addition to applying for alternative welfare benefits, reuniting with children, and moving in with family and friends, former SSI beneficiaries also responded by entering the labor market. The percent of respondents working at any legal employment increased from 11% to 19.3%, and the percent of households reporting wage income from legal jobs increased from 19.4% to 29.2%. However, the average number of days worked in the past 30 days at a legal job, decreased from 16.7 to 13.2. Perhaps those finding work did not obtain ongoing or full-time positions. Considering the health status of the sample, health and mental health conditions of the respondents (or their children) may limit ability to work or to put in longer hours.

Although hunger became more widespread in the full sample, the subset of persons raising young children reported less hunger at six months than at baseline. The proportions of persons reporting any days with insufficient food, or no food at all, and the total and average days of hunger, decreased. For about two-thirds of those reporting decreased hunger, the change may be related to multiple shifts in the family’s economic situation, such as reduced rent, increased AFDC allotments, or temporary income changes. For others, food may have become a priority in the face of uncertainty about future income adequacy.

Changes in Substance Abuse and Health

Central to the policy issues of welfare reform has been concern with drug and alcohol use. Persons with minor children at home were less likely to use alcohol or drugs than the sample as a whole. Both at baseline and follow-up, about 45% of parents reported using neither alcohol nor drugs in the past 30 days. The proportions who used either alcohol or drugs, or both, showed little change over the six-month period. Thus, six months later, termination of benefits had little effect on patterns of addiction. However, those who drank alcoholic beverages reported increased intake, from 4.5 to 5.5 drinks per day.

At the same time, both the number of smokers and the number of cigarettes smoked per day decreased. Overall, drug use appears to have declined slightly, which may be a response to reduced income and/or part of respondents’ attempts to gain and retain employment.

The major cash benefit programs—SSI and AFDC/TANF—are linked to Medi-Cal (the California version of Medicaid), so loss of income from either of these programs is likely to be accompanied by termination of health insurance as well. Following the January 1st termination date for SSI drug and alcohol disability, Medi-Cal terminations were delayed for over six months. Nevertheless, the percent of persons believing they had medical insurance coverage declined. The decline in perceived insurance coverage for drug and alcohol treatment was dramatic, from 78.4% at baseline to 45% six months later. Whether because of this, the end of a treatment mandate, or other reasons, the decline in participation in all types of drug and alcohol treatment during those six months almost exactly matched the perceived loss of ability to pay, decreasing from 77.1% at baseline to 50.9% six months later.

Health status, mental health status, and life satisfaction appear to have remained stable as people rallied to meet their changing circumstances, while self-esteem increased. However, approximately 30% of those raising minor children continued to have psychiatric medications prescribed.

Crime

One of the fears of community leaders is that welfare reform may result in increased crime as desperate people try to acquire cash for necessities of life and for the drugs to which they are addicted. In this sample of parents raising minor children, in the first six months following the end of the SSI drug and alcohol addiction disability benefit, we see no change in the amount of criminal activity likely to be associated with drug use. The SSI study will continue to monitor criminal activity, threats of violence, and victimization over the next two years.

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Looking Ahead

One Congressional goal of welfare reform is to shift the responsibility for welfare support systems to local government, particularly counties and cities. Unfortunately, the funds to maintain equivalent benefits and services may not be available at state or local levels of government. So far, the SSI DA&A reforms have resulted in reduced incomes for recipient families and may ultimately result in higher costs to local governments due to the increase in homelessness, for example.

These two waves of data on a sample of DA&A respondents suggest that welfare reform will transform the lives of former beneficiaries. Should these initial changes become trends, we expect to see shifts toward less desirable housing, continued addictive behavior, and declining household incomes, but greater participation in the labor market. In the short-run, individuals appear to be experiencing higher self-esteem. However, as income declines and health insurance disappears, the difficulties of completing the transition to mainstream living may prove overwhelming. Studies such as this, and related studies, will provide valuable insights into the impact of welfare reform on the lives of former beneficiaries, their families, and their communities.

Suggestions for Service Providers

Supplemental interviews conducted recently provide information about the perspectives of service providers on the impact of these changes in welfare benefits for former SSI DA&A beneficiaries. Preliminary findings from these interviews indicate that important services needed by families who have lost SSI benefits include: encouragement to reapply, advocacy throughout the process and in person at hearings, and assistance in documenting other mental and physical disabilities. These clients also require assistance to apply for other supportive services, e.g., TANF, Medicaid and Food Stamps, that partially offset the loss of SSI income and benefits.

Health insurance is critical for continued treatment of physical conditions, for maintaining drug and/or alcohol treatment, and for continued access to psychiatric medications. Given their poor health, former SSI recipients need assistance in determining the status of their health insurance, as well as assistance in making and keeping appointments for health care and examinations for eligibility determinations. Particularly if income support programs cannot be restored, advocates and service providers will need to work together to preserve and develop the array of housing, food, and other supportive services required by their clients.

—Jean Norris, Research Scientist; Rex Green, Senior Research Scientist; Richard Speiglman, Senior Research Scientist
Public Health Institute, Berkeley, CA

REFERENCES

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Call For Articles

The AIA Resource Center is soliciting articles for the Summer 1998 issue of The Source, which will focus on sexual abuse and its link to chemical addiction. Individuals are encouraged to submit articles that address the following: (1) the prevalence of sexual abuse histories among chemically addicted women; (2) treatment of adult survivors of sexual abuse who also have problems with alcohol or other drugs; (3) innovative strategies for assessing and treating child victims of sexual abuse. As always, an AIA program will also be featured in this issue. Interested staff from any AIA program are encouraged to submit a proposal. Articles should describe the AIA program and its activities related to the treatment of sexual abuse survivors.

To be considered for publication in this issue, please send/fax a brief (150-200 words) abstract of your proposed article to the AIA Resource Center no later than Friday, February 27, 1998. Authors of accepted articles will be notified within two weeks of the deadline. Final manuscripts should be between 1,000 and 2,500 words, and are due June 5, 1998.

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Great Starts: Helping Women Establish Drug-Free, Self-Sufficient Lives for Themselves and Their Children

Great Starts is a program of Child and Family Services of Knox County, Inc., a non-profit agency in Knoxville, TN. Funded by an Abandoned Infants Assistance grant through the U.S. Department of Health and Human Services' Children's Bureau, Great Starts has provided comprehensive services for drug addicted and/or HIV infected pregnant and postpartum women and their children and extended family members since 1991. Its coordinated, multi-disciplinary continuum of on-site services includes: residential and intensive outpatient alcohol and drug treatment (12-Step philosophy); medical treatment for mothers and children; educational classes in parenting, child development, relapse prevention, health and nutrition, and independent living skills; support services such as child care and transportation; group and individual therapy; and housing. These services are provided by a highly qualified team of case managers, nurses, therapists, child development specialists, independent living instructors, peer counselors, family support workers, and parent educators.

Objectives of the Great Starts Program are to:

- Prevent infant abandonment by involving diverse community organizations in the coordination and delivery of comprehensive services for drug addicted and/or HIV positive pregnant and parenting women and their children.

- Maintain and expand a continuum of multi-disciplinary treatment services in order to strengthen at-risk families and reunify mothers and children separated due to the mother's substance abuse.

- Improve the health and well-being of children born to substance abusing women.

- Enhance the independent living and parenting skills of mothers in the program so that they might establish drug-free, self-sufficient lifestyles for themselves and their children.

- Develop and implement supportive, educational and treatment services for extended family, noncustodial, foster or respite primary care givers of drug-exposed or HIV positive children.

Since 1991, Great Starts has served 170 women and 224 children. Between February 1996 and September 1997, 55 women successfully completed the program. Of those, at least 21 are gainfully employed and two are in college or technical training. Most of the remaining graduates suffer from mental impairments which prohibit them from being gainfully employed. One of the youngest graduates, who arrived at Great Starts transient and one step away from losing custody of her child, is now married and successfully employed as a certified surgical technician. Another graduate, who arrived at Great Starts without custody of her two children, her high school diploma, or her sobriety, now has all of these and is in her second year at a local community college where she is training to become an accountant.

Adjusting to Managed Care and Welfare Reform

Although Great Starts has always assisted women to gain education and employment and to become self-sufficient, the program has had to make adjustments in response to national and state policy changes. In January 1996, for instance, the program model was adapted to meet the TennCare provision of mental health services. As Tennessee's managed care provider system for the indigent, TennCare initiated payment schedules and tighter restrictions for mental health and substance abuse services, which drastically impacted all mental health patients in the state of Tennessee. Under the new TennCare guidelines, reimbursement for providers is limited to three-to-four days of services, minimal detoxification, and a lifetime capacity for provision of alcohol and drug abuse services for the specific population. Reimbursement for inpatient services has become almost non-existent.

These changes forced many treatment providers out of business, leaving an increasing number of families without services. In an attempt to meet this growing need, Great Starts revamped its program to provide a more inclusive range of services while meeting TennCare requirements. Specifically, they reduced the length of the residential treatment program from one year to six months (the maximum time allowed under TennCare), but increased the intensity of services provided during that time. They also doubled the number of families served through the residential treatment program (from 11 to 22 women with up to 48 children), and established new collaborations with community agencies to provide additional services to families in the program.

Further, in order to meet new state licensing requirements and maintain the residential services, Great Starts increased its outpatient client population. The program also revised its eligibility criteria to include women who had lost custody of their children, but for whom reunification was feasible with appropriate drug free housing and rehabilitative services, and they added comprehensive evening services.

Continued on page 10...
services to accommodate program participants who work during the day. Pregnant women who are addicted are also given priority status. As a result, Great Starts is in the process of obtaining licensure to be considered a maternity home in the state of Tennessee.

Additionally, the program revised its job readiness services by strengthening its partnership with the local vocational rehabilitation agency which now provides career counseling and job placement services to Great Starts participants. With the reduced length of residential treatment, however, women now have less sober time before entering the work force, which increases the pressures of work. Therefore, even with the support provided through Great Starts, many chemically addicted women with children will have difficulty meeting the requirements of welfare reform. The following autobiographical account of one Great Starts’ graduate’s experience illustrates the challenges and possibilities.

— Judy Pack
Project Director, Great Starts

Life Without Welfare: One Woman’s Story

I am a single mother of three children, only one of which lives with me. I have been clean and sober for almost two years, gainfully employed full-time for the past 18 months, and I am no longer receiving Public Assistance. Things have certainly changed for me in more ways than one.

When I came to Great Starts in 1995, I was at the end of my rope without hope. Life was not to be found, and the thought of being a good mother was lost. My drug use had brought me to the point that I had nowhere to turn. I truly did not want help for my addiction at that time, but as I learned more about the disease, I began to work hard on recovery.

After completing the program 15 months later, Great Starts hired me as a peer counselor on a contractual basis. When I began working, I was receiving full benefits from the Tennessee Department of Human Services. This included: AFDC ($142), Food Stamps ($226), Transitional Child Care, and TennCare (health insurance). I was also receiving rental assistance from another agency. After eight months and a dollar raise, I was cut completely off of AFDC and Food Stamps, and my rental assistance was significantly reduced. The whole idea of Tennessee’s Families First Program was to give a person enough time to become employed and get more education while learning how to become self-sufficient. I was not given enough time.

My monthly income was $960, $200 of which went for rent, not to mention other necessities such as utilities, food, clothing, transportation, child care and other household items. Giving up on luxuries was not hard because I am a strong-minded person determined to make it, but it has all been a new challenge for me. Apart from earning my own wages, I am being responsible as I have never been before. Paying bills and partial child care, and purchasing groceries without food stamps, is just a beginning. Being a single parent and trying to manage on a daily basis is sometimes mind-boggling. The most rewarding factor of being free of the system is the fact that I am managing pretty well independently, but weighing the difference of on or off public assistance is difficult.

While on public assistance, I received the “luxury” of a monthly emergency allowance, rental assistance ($0 rent), food stamps, and AFDC just to name a few. Little did I know that along with these “luxuries” came dependency. It wasn’t until I started working to pay the bills that I truly began to see and feel the “luxuries” of self-reliancy. I not only have gained self-esteem, but I have acquired valuable skills in the workforce and business world.

Taking that step out of the old and into the new is scary, but we all deserve to give ourselves a chance to reap the rewards of the positive. If anyone can vouch for being scared, believe me I can. Only by taking that one baby step forward will you be able to walk.

Support from Great Starts has helped me begin to take those steps. My self-esteem has given me the drive and ambition to succeed even further. In fact, this November, the program promoted me to a full-time employee with benefits.

The transition from public assistance to work is still hard for me and will be even more difficult for families subjected to the new, shorter time frames. In order to help families through this transition, programs need to begin preparing clients for work as early as possible. They also need to continually express the importance of a good education while taking the necessary steps to help them to further their education. Finally, programs need to support parents and give them the tools and encouragement they need to believe in themselves.

— Pamela Furgeson
As increasing numbers of non-profit organizations across the country attempt to address both the issue of welfare reform and the challenge of securing "new" funds to support program expenses, increasing attention is being directed at the issue of non-profit enterprise creation. Non-profit enterprise creation refers to the practice of non-profit organizations planning, launching and managing small business ventures which provide job training opportunities and the ability to support such training through sales revenue, as opposed to government or foundation grants. It should be stated at the outset that such a strategy is difficult and not without its own risks. However, it also appears that many non-profit organizations are finding the creation of small businesses that employ their communities of concern to be one of a number of tools to bring to bear in the fight against poverty. Viewed in this light, non-profit enterprise has increasing relevance for work in communities nationwide.

In approaching this strategy, it is critical for non-profit managers to address three levels of analysis: organizational, business and employee. At the organizational level, the following general issues must be addressed: (1) the capacity of the non-profit organization to successfully support such an effort; (2) the skill set required by non-profit managers interested in operating a "for-profit" enterprise; and (3) the funding required to support the planning and creation of a non-profit enterprise.

**Organizational Capacity**

In addressing the issue of organizational capacity, those exploring non-profit enterprise work should, at a minimum, assess the following issues: entrepreneurial management, participatory culture, and openness to change.

**Entrepreneurial Management:** Non-profits that are successful in operating these ventures are often, at the start, entrepreneurial in terms of their culture and overall approach to management challenges. If key leadership of the organization does not support the idea of operating a business venture, it will not meet with success. It also is critical that the board of directors have members to champion the idea and assist in the planning process. Informed support of the board will help assure that staff do not move too far ahead of the organizational resources the board is willing to provide.

**Participatory Culture:** While not critical to the success of the venture itself, non-profits considering the launch of a new venture are strongly advised to assess how open they are to program participants assisting in the venture development and planning process. The launch of a business can create numerous concerns on the part of staff and program participants. An organization with a history of involving both staff and program participants in the planning process will find implementation of the venture itself greatly facilitated.

**Openness to Change:** Organizations which are not, on the whole, open to change and transformation should not pursue business development efforts. Many groups often think of themselves as being "change agents." Yet when confronted with the challenges of launching a business, they find they are "conservative" and not willing to transform themselves in order to develop the skills, resources and capacity to successfully manage a revenue generating venture. It is not possible to launch an enterprise without having some effect on the sponsoring organization. Groups unwilling to deal with the changes such an activity will require are those most likely to fail at successfully managing a business venture.

**Skills**

In addition to basic organizational capacity, the organization must also have managers with the necessary skills to engage in business development activities. If the non-profit wants to succeed, it must critically assess whether current staff truly have the ability to manage a for-profit venture. While this may seem to be an obvious point, many non-profits attempt to simply add "new business development" to an existing staff position and are then disappointed when a new venture is either ill conceived or unsuccessful. If an organization does not have existing staff with the appropriate skills, clients and board members must be open to hiring new managers to operate the enterprise and provide the business acumen necessary for success. While it is sometimes possible, with proper planning, to assist current staff in "re-inventing" themselves as social entrepreneurs, the process itself can take a number of years.

**Funding**

A final planning consideration is the amount of funding required to support the feasibility study and business planning process, to say nothing of the capital necessary to successfully launch the business. At the earliest stages, it may be realistic to simply appoint a planning committee to do an initial assessment of the idea. Such a committee might explore what other groups have done, what particular market opportunities are thought to exist, and what specific questions those involved in the effort might have. Beyond that, the time soon comes when the organization must either enable an existing staff person to devote adequate time to the project or

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hire a consultant to assist staff in conducting a feasibility study. Both these steps will require financial resources to support the process.

Depending upon both the organization and the enterprise under consideration, a business planning effort can take between three months and two years. Prior to engaging on such a course, the board of directors must closely evaluate whether it has adequate resources on hand to support an adequate planning period. While there are certainly examples of groups that have succeeded at simply conducting a “back of the envelope” assessment of a business idea and then moving progressively toward its realization, most groups will require a fairly extended period of assessment and business plan development. The cost of such an effort may exceed $20,000 or more, and the organization must know how it will provide for these expenses prior to actually engaging in the planning effort. An “off again—on again” planning process can quickly dim enthusiasm and may end up costing more than simply investing up-front the necessary funds to do the job right from the beginning. When discussing resource requirements for a business planning effort, the old rule of thumb—to double the expenses and time frame—may be a good one to keep in mind because the process is inevitably more complicated than first thought and almost always involves set-backs along the way.

Beyond the Planning

Once the feasibility and planning process has been funded and successfully completed, the real work begins. Raising start-up capital is always a challenge for non-profit organizations. Many traditional sources of funding, such as government and foundation entities, are not familiar with business development and may have to be educated about the task the organization has taken on. Furthermore, a start-up business is most likely to lose funds in its first several years of operation and adequate cash flow must be available to support the enterprise as it increasingly moves toward profitability.

Non-profit organizations raising funds to support such efforts should be especially careful not to over promise the potential of the proposed venture. Market shifts, expanding demands, and the need for additional investments of limited dollars, are often difficulties encountered by the emerging non-profit enterprise. Without an informed funder (or with the presence of an ill-informed funder) the process can be extremely difficult, with staff often having to field questions from funders regarding when the project will be self-sufficient or why it is taking so long to get to scale. Staff of such efforts should attempt to raise adequate funds for complete execution of the business strategy in advance of launching the effort, lest they find themselves with a new business but no cash flow to support the process of establishing a successful enterprise.

Of greatest concern to those who serve families affected by substance abuse may be the issue of how to make the practice of non-profit enterprise relevant to the needs of very low-income women transitioning to employment. Non-profits have responded to this issue in a variety of ways, and it is important that organizations considering enterprise activity evaluate for themselves how to best deal with the unique employment and training needs of the population they serve. There is no one approach which works best and the practitioner must engage in a process of assessment, within a given market and with available resources, what approach will be of greatest relevance to those who it seeks to employ.

A Success Story

In San Francisco, for example, Juma Ventures provides transitional and supported employment to disadvantaged young people, some of whom are teenage mothers at risk of, or transitioning off of, public assistance. Juma spent over 18 months involved in a planning process which included an extensive evaluation of the employment needs and requirements of their clients. It also included the operation of several “pilot projects” which allowed participants to “experiment” with a number of possible venture ideas. Because many of their employees are encouraged to enroll in educational programs in addition to holding down a job, it was important to the managers of Juma to develop ventures which enable their employees to work on a part-time basis. The agency also needed to generate revenue to fund the provision of appropriate services to support their employees.

Therefore, Juma Ventures pursued and succeeded in securing a Ben & Jerry’s Ice Cream retail franchise. The youth that participated in the feasibility study and pilot projects that led to this enterprise creation effort felt that the corporation represented a “fun” product and reflected the values of the non-profit. In addition, ice cream vending lent itself well to the creation of part-time jobs that would provide good entry-level work experience to the agency’s target population, and market research suggested sufficient demand for an ice cream shop in the community.

Since establishing its first Ben and Jerry’s store in 1995, Juma has created three related businesses: a concession stand at a professional athletic arena, a second scoop shop, and “ice cream on wheels.” To date, these ventures are generating profit. The fourth is currently operating about 10% below and expected to break even next year. All together, these four businesses gross close to one million dollars annually. Additionally, through these ventures, Juma has employed approximately 150 clients, 74% of whom have successfully moved on to obtain other better paying jobs or are enrolled in an educational program.

Other Strategies for Assisting Low-Income Women

Whereas Juma chose to pursue a retail ice cream operation and related enterprises, other non-profits have approached the employment needs of women with children through different economic development strategies. San Francisco’s Women’s Initiative for Self Employment, for instance, assists very low-income women in planning and managing small businesses that, at least initially, employ only the owner or one other person. Programs in many cities across the United States...
support similar micro-enterprise development initiatives. Others have pursued sector-based economic development strategies that attempt to target sectors of the economy in which growth is projected. Including home day care and home health care initiatives, these approaches involve individual and business development, non-profit operated ventures, and cooperative business development efforts. In the final analysis, aspiring social entrepreneurs need to understand their local market opportunities, what community resources are available, and how best to build on both in partnership with women seeking to expand economic options for themselves.

Conclusion

Non-profit enterprise activities are gaining increasing visibility and credibility across the country. As those involved in efforts to expand economic opportunity for very low-income people search for and find new ways to pursue their goals, new lessons are being gathered and success achieved. While clearly not for everyone, it is at this point clear that for more and more communities, non-profit enterprise creation is a viable strategy to pursue in our work with those historically excluded from mainstream economy.

— Jed Emerson, Director, Homeless Economic Development Fund
The Roberts Foundation

A more detailed discussion of this topic can be found in The Roberts Foundations’ New Social Entrepreneurs: The Success, Challenge and Lessons of Non-Profit Enterprise Creation. (See Good Bets on p. 19 for ordering information.)

Advocacy on Behalf of Families Affected by HIV/AIDS

Many people are increasingly concerned about how low-income families affected by HIV infection will be able to function in an environment of decreased government assistance to needy and disabled people. There are good reasons for concern. The welfare reform law enacted in August 1996 ended the federal guarantee of cash assistance to the poor by replacing AFDC with Temporary Assistance to Needy Families (TANF). The law requires that people receiving federal TANF funds be working within two years, and it subjects recipients to a five-year life time limit on assistance. At the same time, significant cuts were made to other programs such as SSI and food stamps.

The federal welfare reform law left it up to individual states to determine how they will implement TANF and who they will exempt from the new requirements. Most states have already made important decisions regarding program eligibility, time limits on assistance, work requirements, supportive services, and child care. Many state TANF plans have been finalized, and new state welfare reform legislation has been passed. In most states, administrative authority for implementing TANF has been given to state agencies, although some have passed it on to local agencies.

Whatever the process may be in your state, it is a critical time for monitoring policy changes and the impact of these changes on vulnerable populations. It is not too late to become involved in the debate about TANF program options in your state. HIV-affected families must be given a voice in shaping welfare reform policy so that state and local officials are made aware of how their decisions will impact the lives of real people. In advocating on behalf of HIV-affected families, consider the following suggestions which are mindful of the realities facing this population.

- Some parents living with HIV or AIDS may be unable to work, yet they may not be eligible for SSI assistance. Therefore, suggest that individuals who cannot work due to HIV-related conditions be exempt from work requirements and time limits on assistance.
- Often times, people who may otherwise be able to meet TANF work require-
However, because of the high caseloads, the majority of interaction with case managers occurs through support groups. About 30% of the participant population have been identified as having current or past addictions and case managers list alcoholism as one of the most "severe and difficult" problems families face. They also have tracked participants and found that 50% of the drop-outs from their program are current substance abusers. This awareness influences the initial Life Skills training, as the case managers educate participants on drug and alcohol issues and provide referrals for treatment. However, no formal assessment for drug and alcohol issues is used, and none of the support groups offered to participants focuses on these issues. Furthermore, case managers acknowledge that even though they make referrals for drug treatment, these resources are extremely limited and hard to access in their community. Despite these limitations, staff believe that drug and alcohol issues can be overcome and do not constitute an absolute barrier to success.

Iowa’s Family Development and Self-Sufficiency Program (FaDSS): Cornerstone

As a component of the state’s JOBS program, Cornerstone provides family development services to welfare recipients at risk of long-term welfare dependence. All participants develop a Family Investment Plan (FIP). The core of the program’s services is intensive case management with frequent home visits (once or twice a month). They also provide assessment, goal setting, ongoing family support, referrals to community resources, development of community linkages, family empowerment, special needs funding, and group activities as part of their goal to develop a comprehensive system of support services for each family; the success of these services is facilitated by low (20-25 clients) caseloads.

Substance abuse is acknowledged as one of the major barriers faced by clients, and an estimated 24% and 32% of the state’s welfare recipients are current substance abusers and past substance abusers, respectively. Case managers refer clients for drug and alcohol assessment if they find it necessary or if family members request it. However, their program philosophy is that this and other barriers can be overcome by long-term, intense personal interaction with clients. Reliance on this approach is used to direct clients to residential treatment programs if substance dependence is assessed. Other than assessment and referral, no other specifically drug and alcohol targeted program components were mentioned; however their class content on breaking negative thinking patterns may help serve this end (Renwick & Krywonis, 1992).

Kenosha County, Wisconsin: Job Center Participation Support Program

The Participation Support Program (PSP) is part of a county-wide network of family oriented services that works to maximize the use of community resources. Families in the JOBS program who are experiencing barriers to full participation are referred to PSP. Referrals can originate with JOBS workers who think services may be helpful or after family stress assessments, done during the Life Skills training at the beginning of the JOBS program, indicate a high degree of risk. If the family chooses to participate, they are assigned a case manager whose caseload runs around 30-35 families. In addition to case management, participants receive a wide range of services including: recreational and enrichment incentive programs; children and youth counseling and mentoring; life, domestic, and parenting skills development; family empowerment support groups; child management skill-building groups; tutoring; and work apprenticeships.

An estimated 13% of the referrals to PSP have drug and alcohol problems. These families receive the same services as other families in PSP and are referred out for drug and alcohol treatment. (Case managers reported that it has been much harder to access these services since Medicaid has moved to a managed care system.) No formal evaluation has been done of the program’s outcomes, so there is no way to assess their success working with recipients who have substance abuse problems.

JOBS for Oregon’s Future

The JOBS program focuses on quick entry into the labor market with immediate job search and self-sufficiency planning for all applicants. To this end, the income maintenance and JOBS worker roles are combined into one case manager. In general, they estimate that most recipients stay in the JOBS program less than six months.

The case managers identify substance abuse as a major barrier faced by their clients. They report that 63% of clients report having used illegal drugs, 12% report having drug or alcohol problems, and 42% report having a family member who had a drug or alcohol problem. All recipients are mandated to participate in drug and alcohol assessment, counseling, and treatment programs if there is evidence of a substance abuse problem. Because each district in the state has flexibility as to how they implement this requirement, however, there is variation across the state. The Urban Institute study looked at a smaller rural/urban district (District 4) and the large Portland metropolitan district (District 2).

In these two districts, participants in need of intervention are identified through a number of ways. Substance abuse issues may become evident through the ongoing case management of the JOBS workers, particularly if clients are having difficulties fulfilling their employment plans. The four-week Life Skills classes that all participants begin with also provide a forum for discussion of and education about drug and alcohol use. Finally, both districts have some form of formal screening for substance use, though there is great variety in how this is done both between and within districts. For example, one office has mandatory urinalysis, while the other offices use the Substance Abuse Subtle Screening Inventory (SASSI) with clients. The SASSI is used differently throughout the districts. Some offices use it at intake, some only use it after a referral, some have case managers administer it, and some have trained drug and alcohol counselors administer the assessment. Staff report that it is hard to know the best time and way to do the screening as it often elicits a hostile reaction from clients.

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Overall, they feel that the way it is presented to clients is the most important factor—i.e., as a positive opportunity for the family rather than a punitive or invasive action.

If indicated by the assessment, drug treatment is mandatory for JOBS participants. In the smaller district, clients are referred to local providers for treatment. In Portland, two substance abuse clinicians are on-site at all JOBS and welfare offices. Once a client is referred to these clinicians, the clinician becomes responsible for assessing the severity of their substance abuse, referring the client to the appropriate treatment program, monitoring their progress, and negotiating between the JOBS case manager and the treatment program.

The JOBS program has struggled to strike a balance between client privacy and efficient use of resources (i.e., not wasting intensive job placement services on a client who is unlikely to be able to pass an employer’s drug screen). The balance they have reached is that, in programs where screening is not done for all participants but is done by referrals, a case manager cannot refer a client for assessment based on suspicion of substance abuse alone. Instead, they require such evidence of substance abuse as self-report, erratic behavior, or smelling alcohol on a client’s breath.

This review of JOBS programs can only suggest how the TANF program, with its vastly different assumptions, might operate. In our own visits and phone calls, we have learned that many agencies will use the flexibility inherent in TANF to continue somewhat abridged JOBS programs (sometimes with a greater emphasis on “work first”). AOD services and sensitivities can be built into second-tier programs for clients who do not benefit from “work first” or lose jobs quickly. Other important features are intensive case management, multifaceted programs, home visits, and persistent follow-up on treatment progress. The idea of co-locating drug and alcohol services in welfare offices, or at least having personnel specially trained to assess drug and alcohol use on-site, is also promising.

Supporting Recovering Individuals in Employment

Employment stability after the completion of drug-treatment may deteriorate markedly from one month post-discharge and onwards (Renwick & Krywonis, 1992). A number of treatment and post-treatment interventions that may help people maintain job stability have been tested. Renwick and Krywonis support a cognitive-behavioral approach to address environmental and personal barriers such as low self-esteem, negative thinking patterns, expectations of immediate gratification, negative stereotypes from co-workers, job stress, and a lack of sense of control in the workplace. They also recommend developing social support networks for recovering substance abusers and teaching them how to access these support systems to help with job maintenance. Finally, they emphasize that these approaches need to be utilized early on, even in conjunction with job search and training. This is a crucial factor for substance-abusing parents who may be mandated to participate in treatment as part of TANF job readiness activities. Treatment and work can co-occur, but each has an independent chance of relapse. There may also be an interaction that increases the likelihood of both. As such, unless treatment programs and job-readiness contracts address job maintenance, as well as placement, for substance abusing families, they may be placed at higher risk for losing benefits. As a counter measure, Siegal et al. (1996) found that enhancing substance abuse treatment with case management improved employment functioning.

These program summaries indicate some difficulties in effectively transitioning people who have substance abuse issues into mainstream welfare to work programs. One issue that all programs dealt with is how best to assess and refer clients. Do frontline workers need special training to identify clients in need of these services? Should a drug and alcohol assessment be done on all applicants? If not, how do you determine who is mandated for assessment?

Fortunately there is evidence that AOD services can make a difference for AFDC recipients. A study of the rates of parents (both recipients of AFDC and non-recipients) in California drug treatment programs during 1991-1992 looked at the outcomes, costs, and benefits for this population. Drawing on CALDATA, a large random sample of this treatment population, this analysis found that 47% of women in treatment had children in their households (Gerstein et al., 1997). Of these women, 64% received AFDC in the year before treatment. Also, 29% of the men in treatment met this parenting definition and 23% of the male parents were on welfare.

The study found significant and positive post-treatment outcomes among this population, both in the incidence and social costs of substance abuse. Among the women on AFDC, the number who had used a substance more than five times in the last year dropped 35% for crack cocaine, 42% for powder cocaine, and 48% for amphetamines. Reduction in the use of heroin (14%) and alcohol (26%) were not as great. In addition, the numbers of these women who engaged in illegal activities each year dropped 67%, the percentage hospitalized dropped 58%, and the percentage who were homeless for at least two days dropped about 61%.

Given these outcomes and the cost of three months of treatment, the authors assess that the reductions in spending on health care, transfer payments, and crime were two and a half times greater than the cost of treatment. They were not, however, able to assess the impact of treatment on employment.

Conclusions

Service providers of families involved with substance abuse and welfare will need to learn about their state and local TANF plans in order to understand the mixture of expectations, services, and sanctions that might affect their clients. Some clients may get greater access to drug and alcohol treatment, mental health services, and child care as a result of being in a service-enriched TANF program. TANF clients may be given priority access to services. They may also have a TANF case manager who can be a source of
information and assistance to programs that are providing services to divert families from involvement with the child welfare system.

At the same time, the "Gramm Amendment" of welfare reform prohibits provision of services, cash assistance or food stamps, to persons convicted of drug-related felonies after TANF implementation. This provision is already affecting many AIA clients (and other parents) who have histories of drug-involvement and who have watched, in recent years, as drug-related law violations have increasingly been classified as felonies. There is little doubt that the proportion of AIA clients who will be affected by welfare reform is very high, given that 2% of clients who will be affected by welfare Amendment of welfare reform prohibits alcohol and drug use, abuse, and dependence among welfare recipients. American Journal of Public Health, Vol. 86, pp. 1450-1454.


REFERENCES


New Resources from the AIA Resource Center

Integrating Services and Permanent Housing for Families Affected by Alcohol and Other Drugs: A Guidebook and Resource Manual

This 200 page resource manual provides guidance and suggested ways of integrating permanent housing and support services for families affected by alcohol and other drugs. It addresses the planning, development, implementation and management of permanent housing and support services for this population, and it provides ideas for resource development, an extensive list of resources, and numerous program profiles. Cost: $15 (including shipping and handling).

For more information on this manual, please contact Amy Price at amyprice@uclink2.berkeley.edu or (510) 643-8383.

Family Planning and Child Welfare: Making the Connection

This 24 minute video and accompanying training guide demonstrate for social workers methods for initiating and maintaining sensitive and supportive conversations about family planning with their clients, including those who use alcohol and other drugs. The training guide suggests interactive exercises and provides handouts, fact sheets, newsletter reprints, a list of pertinent resources and a bibliography. Cost: To be determined.

For more information on this video and training guide, please contact Jeanne Pietrzak at (510) 643-7017 or pietrzak@uclink2.berkeley.edu.
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