MDRC Congressional Testimony

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On Temporary Assistance for Needy Families
And the Hard-to-Employ
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Good afternoon. My name is David Butler. I am a vice president of the Manpower Demonstration Research Corporation (MDRC), a nonpartisan social policy research organization with offices in New York City and Oakland, California. MDRC has been evaluating welfare reform and employment and training programs across the country for almost three decades. I am here today to share what we have learned about welfare recipients and former recipients who have faced the most difficulty in making a successful transition from welfare to work — the group we call the "hard-to-employ."

I will briefly address four broad questions in my testimony: First, who are the hard-to-employ, what do we know about their characteristics, and what special challenges does this group pose for program designers and operators? Second, what have we learned from the evaluation research about how to improve employment and other outcomes for hard-to-employ populations? Third, what are the most promising program models and strategies states and localities have implemented for this population since the launch of Temporary Assistance for Needy Families (TANF)? And finally, how might TANF reauthorization address the needs of the hard-to-employ?

My main points are:

- A substantial group of unemployed adults continues to receive TANF benefits or no longer receives them but is unable to maintain stable employment. This group faces significant obstacles, including: basic skills deficiencies, mental and physical health problems, learning disabilities, and similar disadvantages. Moreover, these conditions often co-occur.

- The research suggests that many welfare recipients with characteristics that make them hard to employ will need specialized or more intensive services. There is some evidence that targeted strategies can be successful, but very few programs have been evaluated. However, what we have learned suggests that a combination of treatment, support service, and labor market strategies will be necessary to help individuals with serious barriers succeed in employment.

- There is cause for optimism. TANF has been an effective catalyst for innovation and experimentation by providing states with adequate funding and encouraging program flexibility. Many promising programs and approaches are being tried all over the country. But if welfare reform is to continue to build on the success it has achieved in reducing caseloads and moving recipients to steady work, designing and testing effective strategies for the hard-to-employ needs to be a priority. We applaud the Administration's proposal to maintain the TANF funding level and its recognition that treatment services can promote employment and should count towards participation.

- However, the three-month limit proposed by the Administration is too restrictive. Ideally, participation in treatment-related services should not have a pre-imposed time limit. Instead, an individual's progress in treatment should determine the treatment timeframe. TANF programs in Oregon and Utah have taken this more individualized approach to serving people with serious barriers. If the Senate decides that a time limit on treatment participation is necessary, we recommend a limit of between six and twelve months rather than three months. The research suggests that longer thresholds are more likely to yield better treatment and employment outcomes.

Who are the hard-to-employ?

The term "hard- to-employ" is in some ways misleading, since it suggests there is a group of people whose common and recognizable characteristics or barriers can be predictive of whether they will become successfully employed. Such labeling is simplistic and potentially self-defeating. Individuals cannot be defined by a simple set of characteristics, and the presence of barriers does not necessarily mean that someone will have difficulty moving to work. Many working people face these same barriers and succeed in the labor market. The relationship between a barrier and employment is a complex one, determined by such factors as the severity and persistence of the barrier, the number of problems someone faces, as well as an individual's counterbalancing strengths, motivations, and supports. Therefore, it is important not to operate with preconceived notions about who is, and who is not, employable or allow the term "hard to employ" to become a self-fulfilling prophecy about who will succeed. It is equally important to resist the presumption that characteristics or potential barriers really don't matter very much since everyone can find a job if they just try hard enough.

So, what *can* we say about the hard-to-employ population and how can we explain why, despite the success of welfare reform in reducing welfare caseloads and increasing employment, many families still have not made the transition from welfare to work? Several national and state surveys and studies have attempted to answer this question by examining the incidence or prevalence rates of potential employment barriers among welfare re-

cipients and other groups. While this body of research is not conclusive,[1] we can speak with some confidence about the characteristics of the hard-to-employ population and the program challenges states and localities face in trying to help them succeed in the labor market.

- **The hard-to-employ population is diverse.**

Many characteristics are associated with a reduced likelihood of employment, including physical or mental health problems; human capital barriers, such as low basic skills or lack of a GED; situational barriers, such as housing instability or transportation access; and family-related factors, such as disabled children or caretaker responsibilities. Relative to the general population, long-term welfare recipients are far more likely to face many of these barriers. In addition, these same barriers have also been identified among some groups of former welfare recipients, including those with a history of unstable employment who remain off welfare, as well as families who recycle between welfare and work. The range of barriers the hard-to-employ face suggests that "one size fits all" program strategies are not likely to be effective and that programs must be able to tailor services to meet the varied needs of their clients. Building and maintaining the capacity to address a range of different service needs — while staying focused on the employment goal — is a major challenge for programs for hard-to-employ populations.

- **Recent research indicates that individuals facing serious barriers to employment have not increasingly dominated the shrinking caseload since welfare reform.[2]**

Studies on welfare time limits by MDRC and others have found that recipients who reach time limits are not necessarily the most disadvantaged. Why is the remaining welfare caseload not necessarily more disadvantaged than it was in the past? More generous welfare earnings disregard policies have enabled recipients who take jobs to remain on the rolls, mixing work and welfare for extended periods, and the coupling of time-limits and tougher sanction policies have pushed some hard-to-employ recipients to leave the rolls. Several studies have found that sanctioned recipients who leave welfare are much more likely than other leavers or current recipients to face a variety of barriers to employment.[3] Former recipients who have left welfare but have not entered the workforce are a particularly vulnerable group that requires assistance.

- **Barriers of low education levels and mental and physical health problems have particularly high prevalence rates among welfare recipients.**

[1]Estimates of prevalence rates vary significantly from study to study depending upon data sources, methodology, and the like. In addition, these studies identify only correlations between barriers and difficulty sustaining employment. They do not tell us that the barrier is necessarily the cause of the employment problem.

[2]Zedlewski and Loprest, 1999, and Ollerich, 2001.

[3]Goldberg and Schott, 2000.

Three surveys of current and former welfare recipients conducted in 1999[4] found that 40 percent to 50 percent had less than a high school education, 20 percent to 40 percent had physical health limitations, and 30 percent to 40 percent had a serious mental health problem (primarily depression). The incidence of substance abuse problems was also significant but prevalence rates were lower in these samples — between 6 percent and 8 percent. (These rates may be understated since it is very difficult to obtain reliable information on drug use through self-report surveys.)

Each of these barriers poses challenges for program design. For example, while we know that there is an economic return to each additional year of education a student completes, the solution to low education levels is more complicated than just enrolling individuals in education programs. Adult education and GED classes can have very high dropout rates (50 percent or more), in some cases because the programs themselves are of low quality and ineffective, and in other cases because traditional approaches are not appropriate for some part of the population in need. In addition, as welfare-to-work programs have acquired more experience in identifying basic skill deficiencies, there is increasing recognition that many who are testing at low skill levels have some type of learning disability.[5] Adult learning disabilities often go undiagnosed and basic education programs are only beginning to focus on identifying learning disabilities and provide services for those afflicted with them.

The problem of depression among the hard-to-employ poses different challenges. From the medical field, there is clear evidence that medication, psychotherapy, and combinations of the two are very effective in treating depression, and as symptoms abate unemployment declines. However, identifying depression and getting people to participate in treatment services presents a significant problem. Perceived stigma, lack of knowledge, or fear prevent people from recognizing mental health problems or seeking treatment. Studies have shown that large proportions of people who start mental health treatment drop out quickly or do not follow treatment protocols. These problems are particularly common among low-income populations.

- **Many individuals face multiple barriers to employment.**

A 1999 national survey[6] found that 78 percent of welfare recipients experience one barrier to employment, 44 percent experience two or more barriers, and 17 percent experienced three or more barriers. The more barriers someone faced, the less likely they were

[4]The National Survey of American Families contains detailed national and state estimates; the Women's Employment Study collected extensive information on welfare recipients in an urban Michigan county; and MDRC's Urban Change study of welfare reform in four large cities surveyed current or former welfare recipients in high poverty neighborhoods.

[5]According to the 1993 National Adult Literacy Survey, 21 percent of the general population functions at the lowest proficiency level; the rates for persons having learning disabilities who functioned at the lowest level was 58 percent. Learning disabilities also are to be disproportionately represented among adult welfare recipients. In the Women's Employment Study (the only one of the three surveys referenced above that screened for learning disabilities), 18 percent of the sample had a learning disability compared to estimates of about 10 percent for the general population.

[6]Zedlewski, 1999.

to become employed. Moreover, certain barriers tend to co-occur. For example, the New Jersey Substance Abuse Research Demonstration (SARD) project, which targeted TANF recipients with a substance abuse problem, found that 49 percent of the sample had severe or moderate depression, 44 percent had a chronic health problem, and 32 percent had been victims of sexual abuse.[7] Traditionally, programs for the hard-to-employ have been highly specialized and not well-suited to address the needs of people with dual diagnoses or multiple problems. More integrated strategies have begun to emerge in recent years, however.

- **The severity and persistence of a condition are also critical factors in determining how a barrier will effect employment.**

Many studies have shown that the presence of barriers, alone or in combination is strongly correlated with poor employment prospects. One found that welfare recipients with a psychiatric disorder were 25 percent less likely to be working than those without a disorder.[8] The substance abuse literature has also extensively documented the connection between substance abuse and negative employment outcomes.[9] In addition, welfare recipients experiencing multiple health and behavioral barriers to employment, or experiencing one of these issues in conjunction with situational barriers, are even less likely to work. Only three percent of recipients with three or more barriers were working compared to 22 percent with one, and 50 percent with no barrier.[10]

A barrier's severity can also be an important predictor of employment outcomes. Having a disability does not significantly affect the likelihood of leaving welfare but having a severe disability does. Outcome studies in the mental health and substance abuse fields, for example, have found that severity is an important matching variable when determining the intensity and type of services required. Also, many barriers are dynamic — for example, behavioral and health disorders abate, recur, and newly emerge. The dynamic nature of these kinds of barriers and the need for ongoing problem management strategies suggest that programs are not likely to succeed as one-time, short-term interventions. Strategies are needed for continuous monitoring and assessment, gradually reducing program intensity over time but reconnecting a person to treatment during a crisis or relapse.

- **Parents' barriers can have significant effects on children.**

Numerous studies also point to negative impacts on children of being raised by a parent with health and behavioral problems. For instance, there is a great deal of evidence regarding the harmful effects of maternal depression on children. Increased rates of clinical diagnoses, impairments in psychological functioning, difficulties meeting social and academic standards, and poorer physical health have been found among the children of depressed mothers.[11] Studies also show that these children exhibit higher rates of withdrawn

[7]Morgenstern, 2001.
[8]Stouffer and Jayakody, 1998.
[9]McClellan, 1998.
[10]Zedlewski, 1999.
[11]Downey and Coyne, 1990.

(internalizing) and aggressive (externalizing) behavior.[12] Researchers have also shed light on the impact of parental substance abuse on child outcomes — between 60 percent and 80 percent of parents who are involved with the child welfare system have substance abuse problems.[13] It has also been shown that children of chemically dependent parents are more likely to develop such problems later in their own life.[14]

What have we learned from evaluations about how to improve employment outcomes for the hard-to-employ?

While relatively little is known about the effectiveness of service strategies targeted specifically to hard-to-employ TANF and former TANF recipients, a key assumption of those advocating more specialized programs has been that standard employment services are insufficient for the hard-to-employ. The research supports this.

- **Traditional welfare-to-work programs help some of the hard-to-employ but leave many behind.**

MDRC has examined the results of 20 welfare-to-work programs for a variety of subgroups and concluded that the programs increased earnings about as much for the most disadvantaged recipients (defined as long-term welfare recipients with no high school degree or recent work history) as for less disadvantaged groups. However, individuals (including nonworkers) in the most disadvantaged subgroup earned less than $1,000 per year on average, about one-sixth as much as those in the least disadvantaged group, indicating that the programs left many in the most disadvantaged group far from self sufficiency. Moreover, these programs typically did not serve people with serious physical or mental health problems. The most effective programs used a mix of job search, education, and training activities and maintained a strong emphasis on employment.[15] Results from time-limit evaluations and "make work pay" programs tell a similar story, but even the most effective programs leave many behind. These results suggest that it may make good operational sense initially to use the outcomes of someone's participation in the regular work program to determine who may need more intensive services. In fact, many TANF programs screen in this way.

- **There is some evidence that more targeted strategies can be successful.**

Evidence from several random assignment studies of supported employment for various disadvantaged hard-to-employ groups suggests that targeted strategies can increase work effort and incomes. The National Supported Work Demonstration tested a work experience model for four hard-to-employ groups, including very-long-term AFDC recipients. Participants were typically assigned to work crews and workplace demands were gradually increased over time. Revenues from the goods and services produced by participants

[12]Cummings and Davies, 1994.
[13]Young and Gardner, 1998.
[14]Kirby and Anderson, 2000.
[15]Michalopoulos and Schwartz, 2000.

helped finance the programs, as did welfare grant diversion. The supported work model had its largest impacts on the AFDC target group and impacts were particularly large for the most disadvantaged participants. Supported work was expensive — about $19,000 per program group member in current dollars — but the value of output produced by participants was also quite substantial.

Other evidence suggests that individually tailored supported-employment models can be highly effective. Extensive literature in the disability field documents the success of supported-employment models that focus on moving individuals with severe and persistent disabilities into permanent unsubsidized employment. While supported-employment programs for disabled individuals typically have not served single mothers, who are likely to have different support needs, the success of these models suggests that they may be quite adaptable to TANF clients.

In the medical field a number of controlled studies have identified efficacious mental health and substance abuse treatments for the disorders prevalent among hard-to-employ TANF recipients. Still, we know very little about the effectiveness of these interventions when they operate on a large scale as part of a multicomponent welfare reform program. An exception is the SARD random assignment study currently underway in New Jersey, which uses an intensive case management model to help TANF recipients with substance abuse problems stay engaged in treatment and move into employment. Early results are promising, indicating that the program has led to significant increases in treatment participation rates.

What kinds of service strategies are being implemented by states and localities under TANF, and what lessons are we beginning to learn from practitioners?

Since the passage of TANF, states and localities have devoted considerable energy and creativity to designing new program approaches and service strategies for the hard-to-employ. Some of the approaches build on the lessons from past welfare-to-work programs; others draw on practice from other fields such as rehabilitation and disability. While programs vary along many dimensions, most involve two core components — employment services and treatment services — that are organized and given emphasis in accordance with the population they target, the kind of barriers involved, and the program's philosophy.

- **Work-focused programs** primarily emphasize helping hard-to employ people prepare for and get jobs. Although debate continues about the extent to which up-front training or education should be emphasized in these programs, the trend has been towards structured, supported employment that focuses on quick employment. But there are different versions of supported employment, ranging from specially created worksites in the public or nonprofit sectors (based on the design of the Supported Work Demonstration), to placement in unsubsidized competitive employment with job coaching and different kinds of work supports. Many states, including Kansas, New York, Arkansas, Georgia, Minnesota, and

including Kansas, New York, Arkansas, Georgia, Minnesota, and Washington, for hard-to-employ TANF recipients with diagnosed disabilities or work limitations. These programs often involve partnerships between the state TANF agencies, the vocational rehabilitation and Workforce Investment Act systems.

- **Treatment-focused programs** are at the other end of the continuum from work-support programs. These are specifically designed to treat a particular barrier or condition, typically a behavioral health problem or a basic skills deficit. For example, individuals identified with depression would receive therapy, medication, or a combination of the two. Specialized treatment programs have been the dominant model in the substance abuse and mental health fields. However, as these programs have begun to partner more with the welfare and workforce reform systems they have begun to shift to more mixed strategies.

- **Mixed strategies** recognize that moving hard-to-employ individuals into employment often requires some mix of work and treatment-focused services. Programs characterized by a work orientation often take steps to ensure participants receive treatment for conditions that affect their employability. Modified versions of work first retain a focus on quick employment but incorporate treatment, education, and other activities with job preparation and job search. Whenever possible, these programs pursue employment-related and barrier-related activities simultaneously. But even when treatment is the sole initial focus, it is viewed as a first step toward the employment goal. Oregon and Utah are two states that have implemented modified work-first programs by including treatment activities in the employment development plan, allowing treatment services to count as TANF participation, co-locating mental health and substance abuse counselors in TANF offices, and emphasizing short-term treatment and counseling, or treatment provided concurrently with employment activities.

  A growing number of treatment-focused programs have begun to pilot more "integrated models" in which a vocational component is built into a substance abuse program. The national Casaworks demonstration and the Los Angeles Tri-Cities Mental Health programs are good examples of the integrated approach. The balance between treatment and employment services plays out differently for different conditions. Still, some barriers, such as physical disabilities, may not be amenable to treatment. And some conditions, like a bout of major depression or an incapacitating addiction, may be so severe that treatment alone should be the first course of action, at least until the client has been stabilized.

Lessons from Practitioners

As I have traveled around the country, I have been struck by how far programs have come in the last five years. These are some of the key lessons I have picked up from program staff at all levels in many different kinds of organizations:

- Helping people with barriers succeed in employment will require both support service and treatment strategies to deal with barriers, as well as labor market strategies that identify or create employment opportunities.

- The path from welfare to work is not linear. Some problems must be addressed before individuals begin work, others can be addressed while they are working, and others may not emerge until after they have begun to work.

- Because participants often face multiple barriers, programs must be prepared to use multiple strategies at different intensities and in different combinations.

- At the same time, programs cannot and need not address all of an individual's problems in order to "clear the path" to employment

- Serving people with serious barriers requires new investments in staffing, staff training and service delivery. A tough work message, the threat of sanctions and time limits, and job search assistance are not going to be enough.

- Programs need additional support services beyond those traditionally provided by welfare-to-work programs. Mental health counseling, shelters for victims of domestic violence, and substance abuse treatment are examples, and all require the formation of new partnerships across multiple agencies and community organizations.

- Reliable screening and assessment tools and protocols can help staff identify health and behavioral health barriers, but they must be easy to use and will not capture everyone in need of assistance.

- Helping to engage participants in treatment and services and linking them to employment has become a critical role for case managers. To do it well requires intensive and persistent outreach and small caseloads.

What are the implications for TANF reauthorization?

The Administration's proposal to increase the participation rate to 70 percent and increase the number of required hours of participation to 40 per week has far-reaching implications for states trying to engage hard-to-employ welfare recipients. To satisfy a work-only participation standard of 24 hours per week, states will probably have to develop a large numbers of work experience or community service jobs — a potentially costly undertaking that is unlikely to help the hard-to employ and would absorb much of the time and effort needed to strengthen programs for this population. The kinds of work experience slots that would be affordable at scale for most states will clearly not offer the structured work sites, close supervision, peer-group support, and gradually increasing job demands that were hallmarks of the successful Supported Work Demonstration. Nor will they have the positive features of the successful supportive employment approaches fa-

vored in the disability world, which are tailored to participants preferences and interests, provide workplace accommodations, job coaching, and other ongoing work supports.

In addition to these broader implications, the Administration's plan specifically allows engagement in treatment programs to count towards the participation standard, but only for three months out of every twenty-four. This provision does recognize the importance of treatment services in promoting employment for some TANF participants. By allowing engagement in these activities to count toward participation rates, states will have some incentive to work with the hard-to-employ. However, the research indicates that a three-month limit on treatment participation will be too restrictive, and for some hard-to-employ recipients is unlikely to yield positive results.

Several studies from the substance abuse field provide support for this conclusion. A national study of substance abuse treatment called DATOS followed 3,000 patients in different treatment modalities. The study concluded that a three-month treatment episode was a minimum amount for patients to derive meaningful and sustained benefits. Patients who stayed up to six months in treatment had significantly better outcomes than those receiving three or less months of treatment. In addition, studies of relapse indicate that the highest risk period for relapse decreases significantly after about six months. Moreover, one found that the odds of working were greatly increased for each month of treatment duration — recipients remaining in treatment for more than one year were almost twice as likely to work than those who only remained for three months.[16] In addition to these research results, anecdotal evidence suggests that in drug treatment programs serving substance-abusing women with children, the first three months is often spent dealing with addiction issues and detoxification. This suggests that more than three months is necessary to give these women the resiliency skills they will need to prepare them for being in recovery, holding a job, and being a parent.

As noted above, programs are now focusing more on providing integrated and concurrent treatment and employment services. When treatment alone is considered appropriate as an initial activity, the most common approach is to try to keep the length of stay as brief as possible before employment activities commence. The decision, however, about when treatment should end or employment should begin is best based on the progress of the individual client rather than any arbitrary timeframe. If a threshold must be imposed, six months would be more reasonable. It makes sense to keep people in treatment at least this long to ensure that they do not lose their jobs and cycle back onto welfare. Employers would also prefer to wait until people are most likely to remain drug-free before hiring them.

A Possible Alternative

An alternative approach might establish a goal of universal engagement for the welfare caseload, but with broader definitions of allowable activities and flexible hours requirements for a core group of recipients deemed hard-to-employ. States could define who

[16]Metsch et al., 1999

meets the “hard-to-employ standard,” with guidance from the federal government. Criteria might include: lack of success in regular welfare-to-work programs after a designated number of months, a pattern of recycling between welfare and work, documented employment retention problems, or inability to become employed as a time-limit approaches. The hard-to-employ group could also be defined as those who are diagnosed with a learning disability, mental illness, or a substance abuse problem.

Mr. Chairman and members of the Committee, thank you very much for the opportunity to testify on this important issue.

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