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ABSTRACT

Substance use by welfare recipients is frequently mentioned as an important barrier to well-being and social performance. This article uses nationally representative cross-sectional data and Michigan-specific panel data to summarize trends in substance use among Aid to Families with Dependent Children (AFDC) and Temporary Assistance to Needy Families (TANF) recipients. It also examines the prevalence of substance dependence within the welfare population. Although almost 20 percent of welfare recipients report recent use of some illicit drug during the year, only a small minority satisfy criteria for drug or alcohol dependence, as indicated by the short-form Composite International Diagnostic Interview. Illicit drug use and dependence and alcohol dependence are more common among women receiving welfare than among women who do not. For mothers who used cocaine, 59 percent received AFDC/TANF for at least 5 years and 75 percent experienced some period of welfare receipt. Drug use is a risk factor for welfare receipt. The article concludes by considering policy responses to substance use disorders following welfare reform. (Contains 52 references and 9 endnotes.) (SM)

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Abstract

Substance use by welfare recipients is frequently mentioned as an important barrier to well-being and social performance. This article uses nationally representative cross-sectional data and Michigan-specific panel data to summarize trends in substance use among AFDC/TANF recipients. It also examines the prevalence of substance dependence within the welfare population. Although almost 20 percent of welfare recipients report recent use of some illicit drug during the year, only a small minority satisfy criteria for drug or alcohol dependence, as indicated by the short-form Composite International Diagnostic Interview, CIDI-SF. The article concludes by considering policy responses to substance use disorders following welfare reform.

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Substance Use Among Welfare Recipients: Trends and Policy Responses

The 1996 Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA), PL104-193, changed the nature and purpose of public aid. It transformed the 60-year-old entitlement to cash assistance under Aid to Families with Dependent Children (AFDC) into a discretionary program of transitional cash assistance, Temporary Assistance for Needy Families (TANF). The 1996 act and related legislation also made important changes in Food Stamps, Supplemental Security Income (SSI), Social Security Disability Insurance (SSDI), and other forms of public aid.(Weaver 2000)

PRWORA also increased work expectations for welfare recipients and time-limited cash aid. Both of these changes have forced researchers and program administrators to confront the great variation in the ability of recipients to move from welfare to work. Such heterogeneity is now important given the sharp welfare caseload reductions of the late 1990s. As the most job-ready recipients leave welfare, the proportion of remaining recipients who face significant employment barriers may have increased (Blank and Schoeni 2000; Danziger et al. 2000, Danziger and Seefeldt forthcoming). These recipients may include high school dropouts, mothers without prior work experience, teen and never-married mothers, and mothers with very young children, since these characteristics are associated with longer welfare stays (Blank 1997; Duncan et al.

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2000; Moffitt and Pavetti 1999). Given that, they may be more likely to confront the 60 month federal time limit.

Some welfare reforms target users of illicit substances, even though they are a small proportion of all welfare recipients. However, many citizens, policymakers, and welfare administrators consider such use a threat to well-being and social performance. This article focuses on these issues.

We first summarize provisions of the 1996 welfare reform law and other legislation pertinent to substance users and review the known prevalence of drug and alcohol use among welfare recipients and their consequences. We distinguish drug and alcohol use from abuse and dependence. Then we present empirical results on trends in illicit drug use from nationally representative cross-sectional data from the National Household Survey on Drug Abuse and recent panel data on welfare recipients in Michigan. We describe the changing prevalence of substance use and dependence among recipients and consider the feasibility of policies such as chemical drug testing to detect and assess substance use. We conclude with a discussion of the limitations of current studies and their policy implications.

Welfare Reform, Other Policies, and Their Effects on Substance Users

The 1996 welfare reform includes several provisions that target the use or sale of illegal substances. These provisions were designed to improve states' capacity to detect and address the misuse of alcohol, prescription drugs, or other

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substances. Welfare reform also includes provisions that limit or remove eligibility for income-eligible individuals convicted of drug-related crimes.

Section 902 of welfare reform also authorized states to use chemical testing to screen new TANF applicants or to otherwise detect illicit substance use.(Public Law 104-193, 1996) Some states are contemplating such testing, though Michigan appears to be the only state that has attempted to implement suspicionless, population-based testing.

The 1996 "Gramm Amendment" (No. 4935) imposed a lifetime ban on Food Stamps and TANF aid to individuals with felony convictions for illegal drug possession, use, or distribution occurring after August 22, 1996. States were, however, allowed to modify or revoke the TANF ban. Currently, 27 states have passed such legislation.[1] Although drug-related felonies generally involve the distribution rather than use of illicit drugs, some drug-users supplement their income through drug sales and are therefore potential objects of Gramm Amendment restrictions. Other programs, such as "one strike and you're out" rules defined by the Department of Housing and Urban Development (HUD), allow the eviction of public housing tenants involved in drug-related crimes.

Outside the realm of AFDC/TANF, Congress limited the ability of substance users to obtain federal disability payments for drug-related ailments. In 1996, more than 200,000 individuals received SSI or SSDI payments based upon diagnoses of "drug and alcohol addiction," the so-called DA&A classification.

This classification was abolished by Public Law 104-121, and individuals for whom drug addiction or alcoholism were material to eligibility determination were removed from the disability rolls (Davies et al. 2000). Between December 1996 and January 1997, 103,000 recipients lost disability assistance (Schmidt et al. 1998; Davies et al. 2000; Swartz et al. 2000).

Many researchers and program administrators suggest that alcohol and drug use are widespread and important barriers to self-sufficiency. However, the nature and severity of these problems are rarely described in specific terms. During the legislative debate leading to the enactment of TANF, many commentators suggested that drug users face substantial obstacles to becoming self-sufficient within the five-year lifetime limit on federally-funded cash aid. According to Joseph Califano (1995), "all the financial lures and prods and all the job training in the world will do precious little to make employable the hundreds of thousands of welfare recipients who are addicts and abusers." In similar fashion, the Legal Action Center (1995) concluded that "welfare reform is doomed to fail if it does not address the needs of individuals with alcohol and drug problems."

These statements echoed similar anxieties among welfare administrators and caseworkers. In one survey, 65 percent of state and local welfare program directors stated that drug and alcohol treatment services were extremely important in getting recipients to leave welfare (Legal Action Center 1995). A second study

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of 25 state AFDC offices identified substance abuse as a frequently cited functional impairment that prevents recipients from leaving welfare and completing job training programs (U.S. Department of Health and Human Services 1992).

The Prevalence of Substance Use Among Welfare Recipients

Because drug use is often covert, its true prevalence within the welfare population is imperfectly known. Most data (including the data sets analyzed for this paper) are based on self-reports. Deceptive or inaccurate responses are therefore important concerns (National Institute of Drug Abuse 1997). Because welfare receipt and substance use each bring social stigma, they are often underreported. Existing data from persons who have close contact with the health care delivery system suggest that under-reporting is widespread among pregnant women and among clients of substance abuse treatment programs. (Magura and Kang 1996; National Institute of Drug Abuse 1996).

Drug use, drugs of choice, and the prevalence of drug use disorders also vary across different subgroups in the welfare population. For example, cocaine use is more prevalent among African-American women than among non-Hispanic whites, while alcohol and marijuana use are more diffusely spread among low-income women (Vega et al. 1993).

For both of these reasons, prevalence estimates of drug use and drug-use disorders (defined below) among welfare recipients vary widely due to

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differences in study methodologies and across sample populations. Although published estimates suggest that between 6 and 37 percent of welfare recipients experience some drug use disorder, the population under study and the definition of disorders varies widely. Analyses of nationally representative data suggest that less than 20 percent of AFDC recipients use illicit substances in a given year (Metsch et al. 1999; Jayakody et al. 2000). While the differences are not always large, most general population studies find higher rates of drug problems among welfare recipients compared to nonwelfare groups (Schmidt and McCarty 2000).

Measures of alcohol abuse and dependence are especially difficult to obtain within public assistance populations. The literature review conducted by Laura Schmidt and Dennis McCarty (2000) suggests that approximately 12 percent of AFDC recipients report some problem drinking. Although the cited studies used different datasets and different definitions of problem drinking, only one study (which used the National Household Survey of Drug Abuse) found statistically significant differences between welfare populations and a non-welfare comparison group.

Many published studies analyze data drawn from the National Household Survey of Drug Abuse (NHSDA), an annual, weighted and stratified cross section, which includes extensive data regarding the frequency, duration, and personal consequences of drug and alcohol use. Because the NHSDA asks the

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survey respondents about receipt of public aid, it allows researchers to examine national trends within the AFDC/TANF and the overall U.S. population.[2]

The NHSDA also includes information on psychiatric disorders that are based on the short form of the Composite International Diagnostic Interview (CIDI-SF). This instrument produces probabilities of caseness for psychiatric diagnoses that are consistent with criteria established by the American Psychiatric Association's (1994) *Diagnostic and Statistical Manual of Mental Disorders* (DSM). Under DSM criteria, individuals with the most serious substance-related symptoms are classified as dependent. Those suffering less severe but also significant drug-related symptoms are classified as substance abusers. The short-form is used because selected diagnoses can be implemented in approximately 7 minutes, compared with more than one hour for the full CIDI (Kessler et al. 1998).

Pilot testing indicates high concordance between diagnostic classifications made using the CIDI-SF and the full CIDI, particularly among individuals who satisfy criteria for psychiatric disorders within the CIDI-SF (Kessler et al. 1998; Nelson et al. 2001). CIDI-SF items correctly classify between 77 and 100 percent of cases diagnosed with disorders based on the full CIDI; they correctly identify between 94 and 99 percent of cases identified to have no disorder based on the full CIDI (Kessler et al. 1998; Nelson et al. 2001). More than 90 percent of individuals for whom the CIDI-SF indicates illicit drug dependence or other

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psychiatric disorder satisfy criteria for disorder in the full CIDI (Nelson et al. 2001).

The data examined in this paper and in most published literature are based upon DSM-IIIR criteria, the diagnoses that were in effect when the relevant surveys were being carried out (American Psychiatric Association 1987). The most recent guide to current practice and to many surveys now in the field is the DSM-IV. Validation studies indicate strong agreement between DSM-IIIR and DSM-IV criteria for substance dependence, with poorer agreement in the area of alcohol abuse and marijuana use disorders (Rounsaville et al. 1993).

Within the DSM-IV, substance abuse is defined as "a maladaptive pattern of substance use, leading to clinically significant impairment or distress," defined by at least one of the following patterns over the previous year: (1) An individual's recurrent use results in failure to fulfil major work, school, or home obligations; (2) An individual repeatedly uses a substance in physically hazardous situations; (3) An individual experiences recurring substance-related legal problems; (4) An individual continues substance use despite persistent or recurrent social or interpersonal problems that are caused or worsened by such use.(American Psychiatric Association 1994)

Individuals are classified as substance dependent if they satisfy three or more of these more significant criteria : (1)The individual develops tolerance, defined as either experiencing a need for markedly increased amounts to become

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intoxicated or to obtain desired effects, or experiencing markedly diminished effects with continued use of the same dose; (2) The individual experiences withdrawal symptoms or needs to take the substance (or a similar one) to avoid these effects.; (3) The individual repeatedly consumes the substance in higher doses or over a longer period than intended; (4) The individual has a persistent desire or attempts unsuccessfully to reduce or to halt substance use; (5) The individual spends a great deal of time attempting to obtain the substance, to use the substance, or to recover from its effects; (6) The individual eliminates or curtails important activities due to substance use; (7) The individual persists in substance use despite clear knowledge that such use causes or aggravates physical or psychological problems (American Psychiatric Association 1994).

The 1992 National Longitudinal Alcohol Epidemiologic Survey (NLAES) is another data source for examining substance use among welfare recipients; this survey also provides information on DSM-IV diagnostic criteria. Bridget Grant and Deborah Dawson (1996), using NLAES data, find that 9.7 percent of female AFDC recipients had used illicit drugs during the past calendar year, and 12 percent had engaged in heavy drinking, defined as consuming more than 1 ounce of ethanol per day. They find that 3.3 percent of recipients satisfied DSM-IV criteria for drug abuse or dependence, and 7.3 percent satisfied criteria for alcohol abuse or dependence.[3]

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Rukmalie Jayakody, Sheldon Danziger, and Harold Pollack (2000) use 1994 and 1995 NHSDA data to examine the prevalence of several mental health problems and substance use within the welfare caseload. They report that 19 percent of recipients had at least one of four DSM-III-R psychiatric disorders (major depression, agoraphobia, panic attack, and generalized anxiety disorders) within the previous year and 21 percent had used an illegal drug (mostly marijuana) in the past 12 months.[4] Excluding marijuana, 10 percent of welfare recipients had used some other illegal drug during the past year, with 6 percent using cocaine or crack. They report that 9 percent were alcohol-dependent, compared with a prevalence of 5 percent among non-recipient single mothers.

Consequences of Illicit Drug Use for Welfare Receipt

Even when drug use is known, it is difficult to evaluate the consequences for the user or for others that flow from this behavior. A woman may use alcohol or an illicit drug without suffering tangible adverse effects.

The causal impact of drug use on welfare receipt and welfare dependence has been the subject of several analyses. Using data from the National Longitudinal Survey of Youth (NLSY), Robert Kaestner (1998) finds that drug use during the year prior to the survey--especially marijuana use--was positively related to future welfare receipt. He also finds that substance users account for only a small fraction of welfare recipients. Eliminating drug use was predicted to

reduce welfare participation by only 3 to 5 percent. Jayakody, et al. (2000) obtain similar results from the 1994/95 NHSDA.

Both Kaestner and Jayakody et al. acknowledge the difficulties of attributing causality based on available data. Although drug users appear to experience worse social and economic outcomes than non-users, these differences may not be attributable to drug use. Drug use is often a marker for unobserved characteristics and circumstances that are also associated with poor outcomes. For example, adverse experiences, such as childhood trauma or experiences of violence, may lead some women both to seek welfare and to initiate or to increase their substance use. Both unobserved heterogeneity and simultaneity can produce upward-biased estimates of the effects of drug use on welfare receipt.

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

Jayakody et al. (2000) suggest that multivariate analyses of welfare dependence may overstate the causal impact of drug use. They note that tobacco -- a legal and cheap non-intoxicant, whose major health effects occur in later life— should, in theory, have little causal impact on household composition, welfare

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dependence, or other economic outcomes of young mothers. However, smokers differ from nonsmokers in important ways. For example, depression is repeatedly identified as an obstacle to smoking cessation among women (Frohna et al. 1999).

Because tobacco use is likely to play little or no causal role, any observed association between smoking and welfare receipt probably reflects the unobserved circumstances and traits associated with smoking. Controlling for standard confounders, Jayakody, et al. (2000) find a large and statistically significant association between tobacco use and welfare receipt. Moreover, the associated point estimate of tobacco use was larger and more statistically significant than that of marijuana use. Among licit and illicit substances, only cocaine use (in either crack or powder form) was more powerfully associated with welfare receipt.

Trends in Substance Use

Previous research details the extent of illicit drug use among welfare recipients during the early- and mid-1990s. However, these patterns may have changed in recent years. As TANF caseloads have fallen, the proportion of drug users among those remaining on welfare may have increased because more-advantaged recipients have left the rolls more quickly.

Figure 1, drawn from the 1990-1998 NHSDA, displays prevalence trends during the 1990s among unmarried women between the ages of 18 and 54, classified by whether or not they received welfare. These data end in 1998, the

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last year of data that was available when this manuscript was submitted. Thus, we do not have prevalence trends in 1999 and 2000, a period of further declines in welfare caseloads. However, Fall 1999 prevalence data from the Women's Employment Study (discussed below) indicate similar prevalences of marijuana and other illicit substance use.

The top, triangle-marked line in Figure 1 indicates the percentage of welfare recipients who report any illicit drug use in the previous 12 months. These data are self-reported and presumably reflect some under-reporting of drug use (Magura and Kang 1996; National Institute of Drug Abuse 1997). The asterisk-marked line displays the prevalence of illicit drug use among women who did not receive public aid. Drug use in 1998 is much more common among welfare recipients than among non-recipients (21.3 vs. 12.5 percent). However, the trend is similar for the two groups -- between 1990 and 1998, drug use fell from 29.8 to 21.3 percent of welfare recipients, and from 22.7 to 12.5 percent of nonrecipients.

The two trend-lines at the bottom of the figure show similar patterns in the use of illicit drugs other than marijuana. We show these trends because casual marijuana use may have less significant consequences than those of other illicit drugs.

Illicit drug use among welfare recipients was lower at the end of the 1990s than at the beginning of the decade, even though the caseload fell dramatically. The similar trends in self-reported use among recipients and non-recipients

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provide no evidence of post-reform increased prevalence of drug use among TANF recipients. Although the prevalence of substance use increased among welfare recipients between 1997 and 1998, this increase was not statistically significant, and the 1998 prevalences are about the same as they were in 1996.[5]

Although about 20 percent of recipients report using illicit drugs within the previous year, the consequences of such use remain poorly understood. Existing studies suggest that only a minority of illicit drug users satisfy CIDI-SF criteria for drug dependence. Table 1 explores this issue in greater detail, by showing the prevalence of illicit drug and alcohol dependence among unmarried women ages 18-54 within the 1998 NHSDA.

Alcohol dependence is more common among welfare recipients than among non-recipients, 7.5 compared to 4.6 percent, but this difference is not statistically significant. This finding is consistent with Schmidt and McCarty's (2000) review; they show positive, but generally statistically insignificant, differences in the prevalence of problem drinking between welfare recipients and the general population.

Illicit drug dependence is about twice as common among TANF recipients as among non-recipients, 4.5 compared to 2.1 percent, and the difference is significant. However, only about one-fifth of recipients who report illicit drug use meet criteria for dependence, as indicated by the CIDI-SF (Kessler et al. 1998; Nelson et al. 2001).

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Pollack et al. (2002) examined the prevalence of substance use and dependence among respondents in the first three waves of the Women's Employment Study (WES), a panel study of single-mothers in one urban Michigan county. Respondents were African-American or white U.S. citizens between the ages of 18 and 54, who were receiving TANF in February 1997. A random sample of 753 eligible women was drawn with equal probability from an ordered list of administrative records for all active cases in the county. Women were initially interviewed between September and December 1997 (86 percent response rate), and were re-interviewed during Fall 1998, and again during late 1999 or early 2000 (response rates of 92 and 91 percent, respectively).[6]

WES measures alcohol and drug use and dependence and selected psychiatric disorders (major depression, generalized anxiety disorder, social phobia, post-traumatic stress disorder) using the CIDI-SF. The first two WES waves yielded prevalence estimates that were quite close to national NHSDA prevalence estimates among TANF recipients (Jayakody et al. 2000; Pollack et al. 2002).

Table 2 shows the prevalence of drug dependence and other DSM-III-R psychiatric disorders among 626 respondents in the third WES wave. Respondents are classified in the first four columns by their work participation and welfare receipt in the survey month. Consistent with earlier epidemiological findings, illicit drug dependence was also rare among all WES respondents, 3.2

percent. Among the 194 women who continued to receive TANF (columns 2 and 3), 4.0 percent met CIDI-SF criteria for drug-dependence.

Whereas illicit drug dependence was rare, many respondents satisfied CIDI-SF criteria for the other DSM-III-R psychiatric disorders measured in WES.[7] About 28 percent of all respondents met criteria for alcohol dependence or another psychiatric disorder (last column, sum of rows 3 and 4). Drug users were more likely than non-drug-users to satisfy criteria for one of these other disorders.

Table 2 also shows a strong distinction in the extent of drug dependence between working and non-working respondents, independent of welfare receipt. Michigan's benefit rules allow recipients to combine TANF receipt with paid employment. For example, a single mother with two children can earn up to about $800 per month before she becomes ineligible for TANF. Nonworking respondents (columns 3 and 4) displayed a higher prevalence of illicit drug dependence. Among the 401 respondents who had worked at least 20 hours per week in the month prior to the survey (columns 1 and 2), about 16 percent reported illicit drug use during the previous year. Only 3 of these respondents, less than 1 percent, were drug-dependent. In contrast, 17 of the 225 respondents who had worked less than this amount, about 7.5 percent, were drug dependent. As we discuss below, the distinction between working and nonworking recipients has implications for states that might implement drug testing of recipients.

Screening and Assessment of TANF Recipients for Substance Use and Dependence

Within the WES and the NHSDA, approximately one-fifth of TANF recipients report drug use and a small percentage satisfy CIDI-SF criteria for dependence. Yet, most welfare agencies do not have systematic methods for screening and assessing recipients for these problems (Derr et al. 2001; Nakashian and Moore 2001). Data from several states indicate that less than 5 percent of recipients (in some cases less than 1 percent) are referred for substance abuse treatment services (Morgenstern 1999).

Given public concerns about drug use among welfare recipients, some states have examined the possibility of chemical drug testing. Beginning October 1, 1999, Michigan implemented mandatory testing in three local welfare offices (Family Independence Agency 1999). All applicants and a sample of continuing recipients were required to provide urine tests as a condition of eligibility for aid. Recipients testing positive for illicit drugs remained eligible for TANF but were subject to progressive sanctions if they failed to comply with a mandated treatment plan (Family Independence Agency 1999). During the short period of program operation, about 8 percent of 258 tested recipients tested positive for illicit drug use. All but 3 of these recipients tested positive for marijuana only. Testing was halted by a restraining order in November 1999, and the case remains under litigation (Family Independence Agency 2000).

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Long-term welfare receipt may be another important risk factor for substance use disorders that could be used as a specific category for screening and assessment by the welfare office. Pollack et al. (2002) analyzed 1998 data from the National Longitudinal Survey of Youth. Respondents ranged in age from 33 to 41 years of age. Only 1.1 percent of women used cocaine in the past month, but among cocaine users, 45 percent received AFDC/TANF for at least 5 years. Among women with children who used cocaine in the past month, 59 percent received AFDC/TANF for at least 5 years and 75 percent experienced some period of AFDC/TANF receipt. Whether this association is causal remains unclear, as cocaine use may be a marker for other traits that are also associated with long-term welfare receipt.

Although substance dependence is rare in the overall caseload, the need for substance abuse treatment and related services appears high within identifiable subgroups. For example, in one county in New Jersey, 49 percent of sanctioned recipients met screening criteria for a substance use disorder (Morgenstern et al., 2001a).

The Center on Addiction and Substance abuse and the American Public Human Services Association (1999) surveyed the states and identified diverse innovative programs that address drug abuse and dependence. They outline five key factors that influence the success of state policies: "collaboration among

agencies, capacity of organizations to meet new challenges, availability of funds and resources, and control and participation at the local level."

Oregon and Utah screen or assess many recipients for illicit drug disorders, alcohol abuse, and other mental health problems (Kirby, et al. 1999; Johnson and Meckstroth 1998; National Governors Association 1999). Wickizer (2001) summarizes treatment practices in Washington state that assist substance users in transitioning from TANF to paid employment. North Carolina has placed Qualified Substance Abuse Professionals (QSAPs) in every county Department of Social Service office to identify, assess, and coordinate interventions for substance abuse disorders among TANF recipients. (Center on Addiction and Substance Abuse/American Public Home Services Association 1999). Michigan's pilot testing program, which remains under court challenge, included an assessment component designed to address abuse and dependence, and mental health concern and to identify pertinent treatment options for affected recipients.

Limitations of Current Research

Like many studies of employment barriers among welfare recipients, this paper has limitations. Most obvious is the lack of current data to evaluate fully the effects of the 1996 reforms. Nationally representative data end in 1998; Michigan data for 2001 are not yet available. It is possible that substance use and dependence are more prevalent within the smaller TANF caseload of 2001 than they were in the late 1990s.

Existing literature also relies on self-reported data (Magura and Kang 1996), often collected in surveys that were not specifically designed to examine the special circumstances of welfare recipients. An Institute of Medicine (2000) committee, concerned with HIV prevention, examined the ability of nationally representative surveys to examine substance abuse and other risk behaviors and concluded that the surveys do not provide adequate coverage of the small, but important, populations experiencing greatest HIV risk. It also criticized epidemiological surveillance systems for relying on existing clinical and administrative data systems, which neglect drug users. Such criticisms are pertinent to available data regarding welfare recipients.

The NHSDA, a main dataset used in this article, has similar limitations. Comparisons of self-reported adolescent use between NHSDA and the Monitoring the Future study suggest that NHSDA under-reports use (Gfroerer et al. 1997). NHSDA does not fully implement DSM-III-R or DSM-IV dependence criteria, and was not designed to allow prevalence estimates of DSM-III-R abuse (Epstein and Gfoerer 1995).

Although the NHSDA interview response rate is high, approximately 80 percent, the survey does not cover institutionalized populations. Approximately 20 percent of past-month crack users and 20 percent of past-year heroin users are found within the non-household population (Substance Abuse and Mental Health Services Administration 1995).[8]

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Non-response concerns are particularly acute regarding extremely-poor women, such as near-homeless individuals or those experiencing severe drug-related or psychiatric disorders. Data are also limited regarding current or former criminal offenders who are income-eligible for TANF but who may not actually receive cash aid.

Because it used different questions in its early years, the NHSDA survey design does not allow construction of consistent time-trends for drug or alcohol dependence as defined by DSM-III-R or DSM-IV criteria.[9] National studies, such as the 1992 NLAES and WES, do provide diagnoses that are consistent with DSM criteria.

Policy Implications

Despite weaknesses in available data, the research summarized and the data presented in this article have implications for policymakers and researchers. Consistent with public concerns, illicit drug use and dependence are more common among women receiving welfare than among women who do not. Drug use is a risk factor for welfare receipt, even after controlling for race, educational attainment, region, and other potential confounders. Alcohol dependence also appears more prevalent among women receiving welfare than among those who do not, though this effect is smaller and more ambiguous than is the case for drugs.

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However, public concerns seem to have overstated the prevalence or severity of illicit drug use within the welfare population. NHSDA and WES results indicate that less than 20 percent of recipients report using any illicit drug during the past year. If all welfare recipients were to stop using illicit drugs, the size of the welfare population would show little decline (Kaestner 1998).

Among those remaining on the TANF rolls, drug dependence seems to be an obstacle to employment, though the causal impact of dependence is poorly understood. By the 1999 wave of WES, 6.4 percent of nonworking TANF recipients and 8.6 percent of nonworking nonrecipients satisfied CIDI-SF criteria for drug dependence. In contrast, less than 1 percent of respondents who were working at least 20 hours per week satisfied these criteria. Although most drug users do not satisfy criteria for dependence, within both the WES and the NHSDA, more than half of TANF recipients who used drugs within the previous year satisfied CIDI-SF criteria for some DSM-III-R psychiatric disorders.

Existing research highlights the potential value of the welfare system as a mechanism to assist mothers with drug use disorders. Many women who use illicit drugs have received cash aid. Long-term welfare recipients account for a large fraction of recent cocaine users and account for a significant proportion of those who report other illicit drug use. Identifying and helping TANF recipients with drug use disorders might have major implications for public health--whether

or not these services have a large impact on welfare receipt or economic self-sufficiency.

Some policymakers and researchers have expressed concern that declining caseloads have led to a high prevalence of drug use among recipients who remain on the caseload. So far, available data do not support these concerns. Although there is some evidence that TANF recipients have become a more disadvantaged group along a number of characteristics related to health and mental health (Danziger et al. 2000; Lichter and Jayakody 2002, Danziger and Seefeldt, forthcoming), it is not clear that substance use is a major contributor in defining the "core group" of recipients remaining on the rolls. In addition, the prevalence of illicit drug use among welfare recipients declined during the 1990s. Although welfare recipients are more likely than non-recipients to use drugs, changes in drug use prevalence have been quite similar in the two groups.

The above results highlight the challenges of competing strategies to detect mental and behavioral health problems among welfare recipients. This is a major policy concern because many states have yet to establish systematic procedures and data collection systems to identify, assess, and to treat these problems.

If drug testing is used as a form of screening, many recipients likely to test positive will be casual drug users who do not satisfy diagnostic criteria for dependence. Urine tests (rather than other methods such as hair assay) compound

these problems because urine tests have a longer detection period for marijuana than they do for other illicit substances (Vega et al. 1993). Although widespread testing might deter substance use, it might also deter heavy users and those who are drug-dependent from applying for welfare, an ambiguous outcome from a policy perspective (Hammett et al. 1998).

If a concern is to identify recipients who might fail an employer drug test, a more specific strategy of chemical testing would be to scrutinize only nonworking recipients, sanctioned recipients, and those who display specific signs associated with substance abuse and dependence. Although nonworking WES recipients report similar prevalence of illicit drug use to those reported among working recipients, failing employer drug screens may be less problematic for those who have already found employment. Additionally, nonworking recipients are more likely to satisfy CIDI-SF criteria for dependence (see Table 2).

Our results suggest that welfare offices using chemical tests should also utilize social and psychological assessments to identify other psychiatric disorders. Stationing addiction counselors in welfare offices and using specialized and experienced caseworkers to assess clients with potential substance use disorders are additional strategies to improve the sensitivity of existing systems (Morgenstern et al. 2001b).

The experience of former SSI recipients affected by welfare reform is also relevant to policy discussion about TANF recipients. James Swartz et al. (2000)

surveyed 204 randomly selected former SSI recipients in the Chicago area who lost benefits based on their DA&A classification. One year post-disenrollment, about half reported monthly legal earnings below $500 and received no cash public aid. Compared with working former recipients, the unemployed/underemployed had five times the likelihood of drug dependence and were substantially more likely to experience severe mental illness. This study suggests caution when implementing policies that would simply remove substance-dependent recipients from the TANF rolls without providing additional services.

The emergence of substance use among welfare recipients as a widely cited problem should remind advocates, policymakers, and researchers that the data do not speak for themselves. Substance abuse and dependence are barriers to self-sufficiency, but so are poor education, lack of transportation, physical and mental health problems, and many other difficulties that are more common among welfare recipients.

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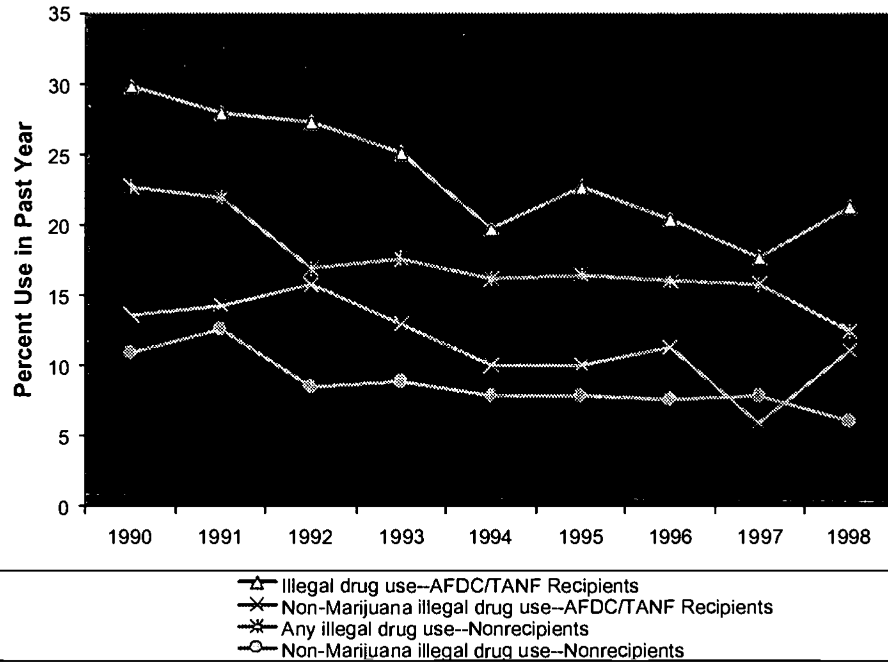

Figure 1: Illicit Drug Use Among AFDC/TANF Recipients and nonrecipients 1990-98. Source: 1990-98 National Household Survey of Drug Abuse

	Unmarried women age 18-54 who received TANF in past year	Unmarried women age 18-54 who did not receive TANF in past year
Alcohol Dependence	7.5 percent	4.6 percent
Illicit Drug Dependence	4.5 percent	2.1 percent***

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

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

Table 2: Drug Use, Psychiatric Disorders and Illicit Drug Dependence, within Previous 12 Months, Respondents Classified by Work/Welfare Status, Fall 1999. Source: Pollack et al. 2002.

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

[2] In validation studies, Reuter, et al. (2001) find that the reported prevalence of AFDC/TANF receipt within NHSDA closely tracks average program caseloads,

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as reported in administrative data. This suggests that NHSDA provides relatively good coverage of trends in the number of welfare recipients.

[3] Although NLAES data are only available for 1992, NLAES has several advantages over the NHSDA, including higher response rates, and more explicit implementation of the abuse and dependence criteria discussed above (Grant 1997). NHSDA does not allow inference of DSM-IIIR criteria for abuse.(Epstein and Gfoerer 1995)

[4] The 1994 and 1995 NHSDA were based upon DSM-IIIR definitions, though for implementation reasons the NHSDA combines items to approximate five of the nine DSM-IIIR criteria and defines a person as dependent who satisfies two of the five criteria. Epstein and Gfoerer (1995) provide further descriptive statistics and validation details.

[5] From the opposite perspective, Reuter, et al. (2001) find that relative trends in welfare takeup rates were similar among substance-using and non-substance-using women over the same period.

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[6] Comparisons of respondents with non-respondents using administrtive records find little evidence of attrition bias, with only small differences between the February 1997 universe of cases and the 632 respondents interviewed in the third WES wave (analyses available from the authors).

[7] Although WES results are based upon DSM-IIIR criteria, rather than DSM-IV, there is close agreement between DSM-IIIR and DSM-IV disorders among substance users (Poling et al. 1999).

[8] Only a small portion of welfare recipients are institutionalized in Medicaid-funded residential substance abuse treatment facilities.

[9] We thank a referee for noting the difficulty of inferring dependence from NHSDA survey responses.

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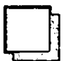

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