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Hard-to-Employ Parents

A Review of Their Characteristics and the Programs Designed to Serve Their Needs

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Low-Income Working Families

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ABSTRACT

Many low-income parents with personal challenges that make work difficult (sometimes called the "hard to employ") seek help from the Temporary Assistance for Needy Families (TANF) program, but many do not. The most effective TANF programs offer cash assistance along with services that alleviate barriers and help clients find jobs. Other federal-state programs offer help by providing either generic employment services or specialized services that address particular challenges. Hard-to-employ parents probably fare best when they enroll in TANF and receive a holistic set of supports. A redesigned system should marshal all program resources to provide an integrated system that addresses barriers and supports work simultaneously.

HARD-TO-EMPLOY PARENTS

A Review of Their Characteristics and the Programs Designed to Serve Their Needs

Historically, antipoverty efforts in the United States sought to improve the well-being of children and their families by providing cash assistance (or "welfare"), primarily through the Aid to Dependent Families with Children (AFDC) program. The 1990s saw a major transformation in this focus toward new goals of limiting dependency and promoting work. A major part of this change was the replacement of AFDC with the Temporary Assistance for Needy Families (TANF) program in 1996, with its requirements and incentives for work and time limitations on benefit receipt.

Many families that turned to AFDC and now turn to TANF for assistance have personal challenges that make employment difficult without specialized services to address those challenges. TANF's work focus and the needs of many TANF families have expanded the discussion of the safety net for hard-to-employ parents to include other federal and state programs that have traditionally addressed physical and mental health problems and skill challenges, including the workforce development system, vocational rehabilitation, mental health, substance abuse, and domestic violence services.[1] The discussion also includes the Supplemental Security Income (SSI) program, which provides cash assistance payments to those with severe disabilities.

This array of support programs especially comes into focus with the recent reauthorization of the TANF program. New federal rules, passed as part of the Deficit Reduction Act (DRA) of 2005, require states to increase the shares of their TANF caseloads participating in work activities and limit the amount of barrier-removal activity that can count as work activity. States must meet a 50 percent work participation rate that applies to nearly all adults on TANF, including those often referred to as "hard to employ." This group generally includes parents with poor mental or physical health, substance abuse issues, learn-

ing disabilities, language barriers, limited work skills, other substantial barriers to work, and combinations of these barriers.

States will need to marshal all program resources to address barriers to employment and move a greater share of hard-to-employ parents into work activities. The reauthorization of TANF presents a timely opportunity to review how the entire set of safety-net services works for hard-to-employ parents. This review addresses four key questions:

- Who are the hard to employ, and how many need specialized services?
- How do states' choices about the structure of their TANF programs affect hard-to-employ parents on welfare?
- What other service programs potentially address the needs of hard-to-employ parents? And how much do other federal cash assistance programs for people with disabilities fill the gap? Does TANF serve as an effective gateway to other services and disability benefits?
- Now that fewer low-income families enroll in TANF than under the prior welfare system, do we need to think harder about ways to connect families to a broader set of nonwelfare support services?

This paper begins by describing the general caseload size and characteristics of hard-to-employ parents with welfare experience and those that remain outside this cash assistance program. The distinction between hard-to-employ parents with and without a recent welfare connection is important because families outside TANF often do not receive services that address barriers to employment. Next, the paper describes how states' TANF programs approach the needs of hard-to-employ parents. While it is impossible to fully understand or describe the nuances of 50 different state programs, national program data and surveys of states' approaches help generally describe some key variations in program characteristics. The paper then describes other safety-net service programs that support adults with employment challenges and how these programs typically coordinate with TANF in varied ways. It concludes with implications for thinking about how the safety net for hard-to-employ parents could be improved.

Who Are Hard-to-Employ Parents?

Numerous studies have focused on parents' characteristics associated with labor market difficulties in the context of welfare reform, and a few have examined hard-to-employ parents that do not enroll in welfare. Human capital liabilities (low education levels and limited work experience) and personal liabilities (poor physical and mental health) are associated with lower employment rates. Other individual and family characteristics that often act as barriers to employment include language barriers, chemical dependence, learning disabilities, a criminal record, experiencing domestic violence, having an infant or a child with a significant disability, lack of transportation or child care to support work, and unstable housing. Many studies find the presence of multiple barriers most significantly predicts low employment levels.

The distinction between hard-to-employ parents with and without a recent welfare connection is important because families outside TANF do not receive TANF services that address barriers to employment. Researchers do not fully understand why some hard-to-employ, poor families do not participate in welfare. New TANF rules may discourage them from applying for TANF, making it so difficult that they drop out during the application process. Work participation requirements also can make it difficult to

sustain participation once families gain eligibility. Increased stigma associated with welfare may also discourage families from participating.

Numerous studies point to reasons families do not seek help from government programs. Zedlewski and colleagues (2006) summarize this literature and show that many individuals lack knowledge about program eligibility or misunderstand the rules, others perceive that the benefits do not outweigh the cost of participation, and some families choose not to seek government help as a matter of pride or a desire to avoid the stigma of participation. In general, programs with complex rules that require detailed documentation of family circumstances and requirements for participation discourage participation.[2]

We do know that a smaller share of families potentially eligible for benefits actually participates than did before 1996. Recent estimates show that less than 50 percent of families eligible for TANF assistance actually participated in the program in 2004, considerably lower than the 85 percent pre–welfare reform participation rate in 1995 (U.S. Department of Health and Human Services [HHS] 2006).

The low TANF participation rate means that many low-income parents with barriers to employment must either find appropriate services on their own or cope without any help. Parents without help face a greater danger of economic instability for their children and less hope for addressing their mental and physical health issues and eventually finding work. The discussion below describes the characteristics of families that do seek help through the TANF program and those without a recent welfare history.

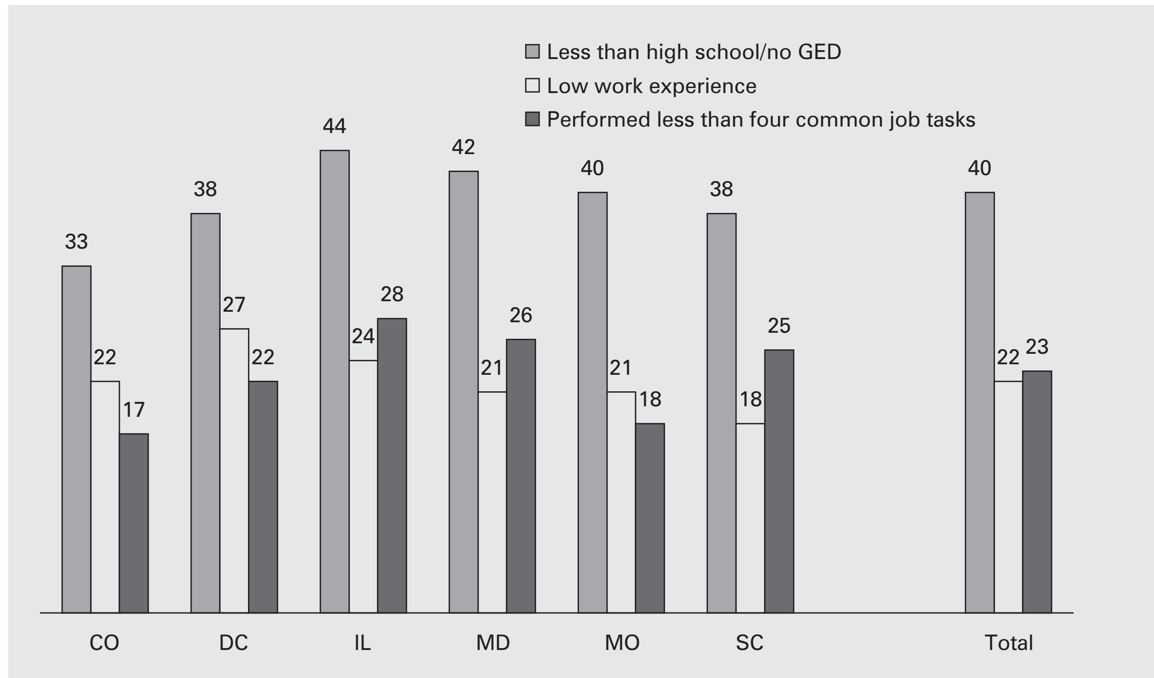
Families on TANF

A recent set of surveys in five states and the District of Columbia, sponsored by HHS, measured the prevalence of barriers among welfare recipients.[3] The synthesis of the findings shows that welfare recipients commonly have significant human capital and personal liabilities (Hauan and Douglas 2004). For example, 40 percent of the recipients in these six sites had not completed high school or a GED (figure 1). About one in five had low work experience (defined as working less than half their adult years), and about one in five failed to perform at least 4 out of 10 common job tasks. Three in 10 welfare recipients reported mental health problems, and 2 in 10 reported physical health problems (figure 2). While human capital deficits showed little variation across the sites, the share of recipients with health problems did vary. Four out of 10 recipients in Colorado, for example, reported having mental health problems, compared with 2 out of 10 recipients in the District of Columbia and Maryland.

These surveys also showed the prevalence of many other barriers to employment among welfare recipients. Relatively small numbers (fewer than 1 in 10) have chemical dependence, obvious learning disabilities, severe domestic violence experience, or criminal records. However, nearly one in three families reported having a special-needs child. Over half reported neighborhood problems such as unemployment, drugs, crime, or rundown buildings and yards, and a fifth reported that they experienced unstable housing. Human capital deficits and health problems all were significantly and negatively associated with employment. Unstable housing also presented a significant barrier to employment.

Other studies confirm the high levels of barriers to employment among TANF recipients using national samples. The U.S. Government Accountability Office (GAO) (2001), for example, finds that 44 percent of TANF recipients have physical or mental impairments, a proportion almost three times as high as among adults in the no-TANF population. Acs and Loprest (2007) report that recent data from the Survey of Income and Program Participation (representing 2003) and the Current Population Survey (2005) con-

FIGURE 1. Prevalence of Human Capital Liabilities among TANF Recipients in 2001–02 (percent)



Source: Hauan and Douglas (2004).

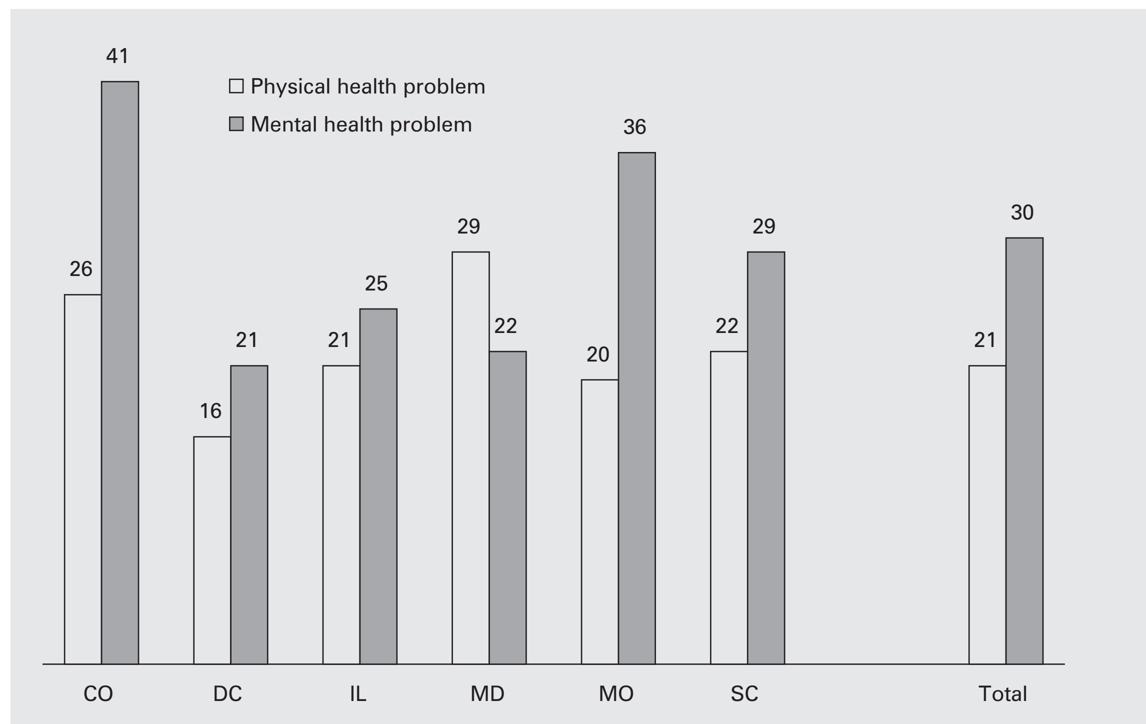
tinue to indicate that 40 percent of recipients have less than a high school degree and about 25 percent report a health condition that limits work.

Families Outside TANF

One group of hard-to-employ families outside TANF that has received recent attention is those not connected to work, welfare, or cash disability benefit programs. These families, often called "disconnected," have the most severe barriers to employment. Loprest and Zedlewski (2006) provide the only data that compare low-income families with and without a recent connection to welfare and show the subsets of both groups that are disconnected. Their data show the prevalence of barriers in 2002 for a nationally representative sample of low-income families, generally defined as families with incomes below 200 percent of the federal poverty level (table 1). Their results for current welfare recipients show similar levels of barrier prevalence to the studies discussed above. The authors' study shows that over 8 in 10 disconnected families have had no recent connection with welfare.

Loprest and Zedlewski (2006) document that disconnected families, especially those that recently left welfare, have the highest incidence of employment barriers.[4] A large share of disconnected families have limited work experience (52 percent for those never on welfare and 42 percent of the disconnected that recently left welfare), higher than the rates for current welfare recipients (29 percent) and much higher than for connected, recent welfare leavers (4 percent). Disconnected families recently connected to welfare have somewhat higher levels of other employment barriers relative to disconnected families with no welfare experience, perhaps indicating that those with the most severe needs more often turn to the TANF program for help. The authors' study also shows that barriers to employment among the disconnected and families on welfare substantially exceed rates for the general low-income population.

FIGURE 2. Prevalence of Personal Liabilities among TANF Recipients in 2001–02 (percent)



Source: Hauan and Douglas (2004).

The incidence of multiple barriers to employment perhaps best summarizes the differences across these family groups. Disconnected families have the highest incidence of multiple barriers to employment—69 percent of those with recent welfare experience and 56 percent of those with no welfare history—higher than rates for current welfare recipients. Connected families with no welfare history and those with recent welfare history have the lowest incidence of multiple employment barriers. Still, about one in three of these low-income families report multiple employment barriers.

TANF and Hard-to-Employ Parents

Many parents with the most severe employment barriers and low incomes turn to TANF for help. All TANF programs offer some cash assistance to parents who meet income, asset, and immigrant eligibility tests. Documented TANF rules, however, indicate the tremendous variation in TANF programs across the country. Thus, it can be instructive to review some broad categories of rules that affect hard-to-employ parents who enroll in TANF.

The TANF policies particularly salient to the hardest to employ parents include screening and assessment for barriers, exemptions from work requirements, sanctions for those not complying with requirements, and time limits. While it is impossible to fully understand how these policies play out on the ground, this paper draws upon secondary information from a few sources to draw a rough picture of how the process works. The U.S. Government Accountability Office (2001) completed a survey of 600 county welfare offices to understand their approaches to those designated as hard to employ because of a physical or mental health problem. The Urban Institute's Welfare Rules Database tracks state welfare

TABLE 1. Barriers to Work among Low-Income Families with Children by Recent Connection to TANF, 2002

Barrier	Currently on welfare	Never on Welfare		Recently on Welfare	
		Disconnected	Other	Disconnected	Other
No work in 2+ years	28.5	52.2	21.9	41.6	4.2
Less than high school education/no GED	41.4	33.9	24.7	59.4	26.7
Spanish speaking	10.9	22.6	21.6	5.4	4.6
Health limits work	25.2	21.8	8.1	29.4	15.9
Poor mental health	24.4	24.1	10.2	34.0	26.9
Age of youngest child <1	18.3	17.5	12.0	14.6	14.4
Child in family receives SSI	7.6	8.5	2.9	6.0	5.0
No car, not in metropolitan area	4.9	8.6	3.3	16.3	8.5
Multiple barriers	50.4	55.7	31.0	68.8	29.3

Sources: 2002 National Survey of America's Families; numbers calculated from Loprest and Zedlewski (2006), tables 10, 11, and 20.

Notes: Sample defined as current or last year's income below 200 percent of the federal poverty level and income not above 250 percent of the poverty level in either year, to provide comparable sample for no welfare families. Disconnected defined as no earnings in past year by either parent, no TANF, and no government disability benefits received by the parents.

policies using information abstracted from caseworker handbooks and subsequent reviews by state agencies.[5] States' TANF administrative data reports to the federal government provide a few measures that indicate the share of hard-to-employ adults on TANF. Finally, a recent survey by Loprest and colleagues (forthcoming) of 17 states and three local welfare offices provides some updated information about states' current policies toward the hard to employ and how policies might change in the future as a result of welfare reauthorization.

Assessment for Barriers to Employment

Parents applying for welfare generally are asked whether they have conditions that prevent employment, but states vary in how they gather this information. The GAO (2001) finds that most TANF agencies say that they screen applicants for physical and mental health impairments, and many screen for learning disabilities. Yet, over three-quarters of TANF agencies use "self-disclosure" to identify conditions or impairments that would preclude work. Individuals usually must provide medical verification once a barrier has been disclosed. To a lesser extent, welfare offices use structured screening tools to identify barriers, and these tools vary considerably in content and intensity. In 2001, only 12 percent of the offices in the GAO survey relied on a more formal, standardized screening tools, and the remaining 11 percent of county offices relied on caseworkers' observations to identify verbal or behavioral cues that indicate impairments.

Many TANF offices prefer, at least initially, to use a "labor market screen" (that is, requiring participants to engage in job search) to avoid costly assessments that may not effectively identify who can find work. The lack of up-front assessment and the difficulty of identifying some types of barriers mean that some parents with significant impairments must comply with TANF work requirements before receiving any services that address their specific employment challenges. Initial screeners often do not uncover all impairments, especially hidden disabilities that may be unknown to recipients but still interfere with work. Also, recipients are sometimes reluctant to identify impairments because they fear it could lead to negative repercussions.

While most offices rely on self-disclosure of impairments at the time of application for TANF benefits, a more formal assessment may occur later for enrollees who show difficulty finding employment or complying with other TANF rules. Three-quarters of TANF agencies report that they eventually assess enrollees with participation difficulties for physical or mental health impairment or learning disabilities. Although most of these assessments are conducted by caseworkers, the GAO survey indicates that 32 percent of local offices use medical professionals, 10 percent use state vocational and rehabilitation specialists, and 4 percent use certified social workers.

Loprest and colleagues (forthcoming) identify some of the challenges states face in assessing TANF applicants for barriers to employment. Michigan, for example, reported that about half of adults that left TANF under its strong work-first policy returned within 12 months. In 2007, Michigan began implementing a new statewide program with up-front assessment and intensive services to address barriers. Washington, a state that has relied heavily on screening and assessment tools in the past, recently implemented a new comprehensive assessment program that requires all TANF applicants to be assessed by multiple service agencies (including the community college system, economic development, employment services, and the Department of Social and Health Services). An early evaluation of the New York City WeCare program that includes comprehensive assessments, on the other hand, shows that hard-to-employ parents can find it difficult to complete processes requiring multiple assessment appointments (Kasdan with Youdelman 2007).

Exemptions from Work Requirements

Hard-to-employ parents with identified barriers may or may not be exempt from TANF work requirements or participation in barrier removal services. States' TANF program rules indicate that most states exempt some TANF recipients with illness or disability from work requirements. However, 15 states allowed no such exemptions in 2005 (table 2).[6] The GAO (2001) finds that about 63 percent of local offices exempt TANF recipients with impairments from work requirements.[7] Some states that exempt TANF recipients with illness or disability assign them to a separate state program (SSP) to exclude these individuals from the federal work participation calculation and usually work participation. At least through fiscal year 2006, SSPs were funded with state dollars that count toward their maintenance-of-effort (MOE) requirements.[8]

In 2005, states classified about 10 percent of their adult TANF caseload as exempt because of illness or disability, and less than 3 percent of the adult caseload was in a SSP because of disability (table 3). States' exemption rates vary considerably around these averages. Eight states (Idaho, Illinois, Iowa, Montana, Ohio, Oklahoma, Utah, and Wisconsin) report that they either do not allow exemptions from work requirements for illness or only allow exemptions for "good cause" reasons and classify 1 percent or less of their caseloads as disabled.[9] In contrast, eight states (Delaware, Michigan, New Hampshire, Oregon, Pennsylvania, Texas, Vermont, and West Virginia) classify about 20 percent or more of their regular TANF caseloads as disabled. Five additional states (Connecticut, Maryland, Nebraska, South Carolina, and Virginia) have relatively large SSPs for adults with disabilities. Given the similarities in prevalence of barriers among welfare recipients across individual states discussed earlier, it is likely that these outcome differences reflect states' TANF policies.

An exemption from work requirements may or may not mean that these adults receive services to address their barriers to employment. Some states encourage those with substantial health impairments to apply for federal disability benefits, and some local offices help these clients through this lengthy application

TABLE 2. State Policies Affecting the Hard to Serve, 2005

State	Ill or Incapacitated:[a] Exempt from work requirements	SSP	Full Sanction: First:	Last:	First time limit (months)
Alabama	X	O		X	60
Alaska	X			X	60
Arizona				X	60
Arkansas	X			X	24
California	X				60[b]
Colorado	X[c]			X	60
Connecticut	X	X		X	21
Delaware	X	O		X	36
Dist. of Col.	X	X			—
Florida		O	X	X	48
Georgia	X[c]	X		X	48
Hawaii	X	O	X	X	60
Idaho			X	X	24
Illinois		O		X	60
Indiana	X	X		X	24[b]
Iowa		O	X	X	60
Kansas			X	X	60
Kentucky	X[c]			X	60
Louisiana			X	X	24 of 60
Maine	X[d]	X			—
Maryland	X	X	X	X	60
Massachusetts	X	O		X	24 of 60
Michigan	X		X	X	—
Minnesota	X[d]	X		X	60
Mississippi	X		X	X	60
Missouri	X	X			60
Montana				X	60
Nebraska	X	X	X	X	24 of 48
Nevada	X	X	X	X	24
New Hampshire	X	O			60
New Jersey	X	X		X	60
New Mexico	X			X	60
New York	X	X			—
North Carolina			X	X	24
North Dakota	X[c]			X	60
Ohio			X	X	36
Oklahoma			X	X	60
Oregon				X	24 of 84
Pennsylvania	X			X	60
Rhode Island	X	X		X	60[b]
South Carolina	X	X	X	X	24 of 120
South Dakota	X			X	60
Tennessee	X	O	X	X	18
Texas	X		X	X	12, 24, or 36[e]
Utah		O		X	36
Vermont	X	O			—
Virginia	X	X	X	X	24

TABLE 2. (continued)

State	Ill or Incapacitated:[a] Exempt from work requirements	SSP	Full Sanction: First:	Last:	First time limit (months)
Washington	X	O		X	—
West Virginia	X	O		X	60
Wisconsin		O			60
Wyoming		X	X	X	60
Total number of states	36	16	19	43	

Source: Welfare Rules Database and comments from selected states.

O = states that have a separate state program but report less than 1% of the caseload as exempt due to disability.

a. These data do not indicate the variation in how states define illness or disability.

b. The time limit applies only to the adult in the unit; children continue to receive benefits.

c. The state does not consider these groups technically exempt, but they may meet the state's criteria for good cause for noncompliance or deferral.

d. Caseworker manuals and Welfare Rules Database report no exemptions from work requirements, but state reports a significant share in exempt due to disability, as shown in table 3.

e. Time limits vary by recipient's education and work experience.

process. Exempt individuals may receive mental health services, medical services to address physical health issues, or education to address learning disabilities. TANF adults may be referred to local service providers or receive more intensive case management that connects them with providers. Some states and local welfare offices also offer but do not mandate work participation services for parents exempt because of illness or another serious barrier to employment. Procedures vary tremendously across states and local welfare offices. The GAO (2001) reports that 43 percent of counties offer some services to recipients with health impairments to move them toward employment. We do not know, however, what share of parents with particular barriers actually receives services.

Sanctions

Sanctions that reduce or eliminate benefits for failure to comply with work participation activities can present a greater risk for hard-to-employ parents than for other recipients. States use sanctions to motivate clients to participate in program activities and hold them accountable for their actions. Recipients with undisclosed mental health problems, substance abuse, learning disabilities, or unreported domestic violence may find it difficult to conduct the required job search activities, show up for appointments on time, or even participate in such barrier-removal activities as mental health counseling. The risk increases in states that impose full-family sanctions after the first incidence of noncompliance. While states may try to avoid applying sanctions to those with serious impairments, lack of accurate identification of barriers can lead to sanctions for hard-to-employ parents, particularly in states that require participation of everyone or have very narrow exemption criteria.

State sanction policies vary, with 19 states using full-family sanctions (loss of the entire benefit) for the first failure to comply with requirements (see table 2). Most other states use partial sanctions that eliminate only the adult portion of the benefit for the first compliance failure and then apply a full-family sanction after more than one compliance failure. Only seven states (California, Maine, Missouri, New

TABLE 3. Share of the Caseload in High-Risk Categories, 2005

State	Total caseload[a]	TANF exempt: disability (percent)	SSP exempt: disability (percent)	Time limited and extended[b] (percent)	TANF/SSP cases in sanction[c] (percent)	Total percent of caseload
Alabama	11,074	13.3	0.8	1.1	9.4	24.6
Alaska	3,301	10.5		3.5	2.9	17.0
Arizona	24,325	8.7		0.1	0.9	9.8
Arkansas	4,311	15.6		0.1	13.0	28.7
California	284,981	9.7	0.0	6.4	14.7	32.0
Colorado	10,282	16.5		0.7	1.0	18.2
Connecticut	15,915	1.3	17.6	0.4	1.8	21.2
Delaware	3,105	21.3	0.0	0.0	2.5	23.7
Dist. of Col.	13,828	3.3	2.6	21.2	23.2	50.3
Florida	22,502	1.5	0.0	1.1	13.9	16.5
Georgia	16,773	0.0	1.2	1.3	1.6	4.1
Hawaii	8,691	0.0	0.0	0.0	27.6	27.6
Idaho	516	0.0		0.0	0.0	0.0
Illinois	20,293	0.0	0.0	0.0	2.1	2.1
Indiana	27,647	11.0	1.5	0.0	3.5	16.1
Iowa	16,747	0.5	0.1	1.3	4.8	6.7
Kansas	12,702	2.2		5.3	0.0	7.4
Kentucky	18,175	8.0		1.0	7.4	16.4
Louisiana	5,744	9.5		1.1	0.0	10.6
Maine	8,952	11.9	5.4	11.6	2.3	31.1
Maryland	16,370	3.7	12.3	11.6	1.1	28.7
Massachusetts	31,734	0.0	0.3	0.1	61.5	61.9
Michigan	53,048	30.5		17.4	0.0	47.9
Minnesota	23,186	5.6	1.2	10.3	4.9	22.0
Mississippi	8,651	7.8		0.6	0.8	9.2
Missouri	35,013	3.3	7.9	1.1	3.2	15.4
Montana	3,197	0.1		0.1	4.7	5.0
Nebraska	6,368	2.0	27.7	9.4	0.1	39.2
Nevada	4,222	0.8	3.2	0.2	0.0	4.2
New Hampshire	4,402	26.8	0.2	4.0	7.4	38.3
New Jersey	32,510	11.8	1.5	11.2	5.8	30.4
New Mexico	12,019	18.0		0.0	6.1	24.1
New York	131,895	11.0	6.2	4.9	11.4	33.5
North Carolina	14,637	14.3		0.2	2.3	16.8
North Dakota	2,221	4.3		0.2	3.3	7.8
Ohio	39,450	1.0		0.7	0.1	1.8
Oklahoma	5,392	1.1		1.9	0.0	3.0
Oregon	10,852	29.7		0.0	4.7	34.4
Pennsylvania	70,824	19.4		13.5	3.8	36.6
Rhode Island	10,425	11.8	1.9	16.4	3.7	33.8
South Carolina	10,369	4.0	25.6	0.0	2.2	31.7
South Dakota	1,006	0.0		0.4	0.9	1.3
Tennessee	53,389	4.3	0.1	0.0	15.9	20.2
Texas	41,434	20.7	0.0	0.0	0.3	24.4
Utah	6,019	0.2	0.0	1.8	2.8	4.8
Vermont	3,936	21.2	0.4	0.0	4.8	26.5
Virginia	36,682	0.5	21.4	0.0	0.0	21.9

TABLE 3. (continued)

State	Total caseload[a]	TANF exempt: disability (percent)	SSP exempt: disability (percent)	Time limited and extended[b] (percent)	TANF/SSP cases in sanction[c] (percent)	Total percent of caseload
Washington	37,534	5.6	0.3	12.1	5.7	23.8
West Virginia	7,567	19.5	0.2	0.0	5.5	25.2
Wisconsin	9,532	0.9	0.1	4.3	13.6	18.9
Wyoming	69	0.1	8.7	0.0	13.6	22.4
U.S. total	1,267,379	9.6	2.8	5.3	9.2	26.8

Source: National TANF database as of April 6, 2005, with corrections for SSP exempt from California and Texas.

a. The total caseload is calculated as the sum of all families on TANF and in separate state programs, minus families with no adult, plus families with a parent in the household but not included in the unit that are in sanction status. Note that sanction data for child-only units are not available for Colorado, Hawaii, Maryland, Montana, Nebraska, Oklahoma, or Wyoming.

b. Percent of heads of household or spouses with over 60 months countable toward the federal time limit.

c. This column includes child-only units in sanction and adult recipients in sanction/waiver status. Note that sanction data for child-only units are not available for Maryland, Montana, Oklahoma, or Wyoming.

Hampshire, New York, Vermont, and Wisconsin) and the District of Columbia never impose full-family sanctions.

The treatment of noncompliance is far more complicated than implied by these simple sanction rules. Individual caseworker discretion can play an important role in deciding whether and when to initiate a sanction. Also, some states with full-family sanctions specifically exempt individuals in SSPs because of physical or mental illness (such as South Carolina). Still other states have extensive due-process procedures before applying sanctions.

Although researchers do not have readily available statistics on the number of cases closed because of full-family sanctions, states do report the share of the adult caseload with partial sanctions.[10] Most states list fewer than 10 percent of families as sanctioned, with a few exceptions (table 3). The District of Columbia, Hawaii, and Tennessee all report about one-quarter of their caseloads as sanctioned, and Massachusetts reports 62 percent sanctioned.

Some local welfare offices deal with the risk of sanctioning hard-to-employ parents through procedures that try to reconcile or reconnect sanctioned parents. Once they reconnect with sanctioned parents, they may assess the parent for special needs. The GAO (2001) reports that 60 percent of local TANF offices make at least two attempts to contact sanctioned recipients, and 40 percent make one attempt. About one-quarter of the offices making two contacts schedule in-person, follow-up meetings, and 15 percent conduct in-home visits. Loprest and colleagues (forthcoming) discuss strategies to reconnect with sanctioned adults in Maryland and Los Angeles County. Maryland has an intensive reconciliation process using multiple methods to reach out to clients with sanctions, including home visits. Los Angeles recently began an intensive outreach to sanctioned parents, including home visits, in response to the large share of its caseload in sanction status.

Despite efforts by some states to avoid sanctioning hard-to-employ individuals or have them come back into compliance once sanctioned, a 2003 research review found sanctioned recipients are more likely

than nonsanctioned recipients to have challenges that make them harder to employ and more likely to return to TANF (Pavetti, Derr, and Hesketh 2003). Goldberg and Schott (2000) cite several studies showing that health problems and disabilities are a major cause of noncompliance and TANF sanctions. Also, Goldberg (2002) reports that certain states disproportionately sanction recipients with disabilities or other barriers. Polit, London, and Martinez (2001) and Cherlin and others (2001) find that the likelihood of sanctions increases with the number of health barriers.

Time Limits

Time limits present another risk for parents that find it difficult to obtain employment. While federal rules limit federal TANF assistance to a maximum of five years, 19 states have chosen shorter time limits (table 2). At the other extreme, 8 states either have no time limit or some guarantee of indefinite benefits for children.[11] Shorter time limits pose greater risks for parents with impairments who generally need more time to move into jobs. Also, the GAO (2001) finds that 27 percent of local welfare offices exempt some parents from work requirements but not time limits. These parents may face the greatest challenge because the clock is ticking even though they typically are not engaged in work participation activities.

Nearly all states allow for some time-limit exemptions or extensions.[12] Federal rules allow states to exempt 20 percent of the adult caseload from the federal five-year time limit. Since child-only cases constitute over 40 percent of the caseload, on average, and they are exempt from time limits, the effective exemption allows states, on average, to exempt one-third of parents from the time limit. States may apply this exemption to those initially designated as disabled, and they may exempt individuals finding employment difficult on a case-by-case basis.

States can use a liberal time-limit extension policy to mitigate the effects of tough work participation policies for hard-to-employ families. In practice, however, states granted relatively few extensions to time limits in 2005 (table 3). On average, only 5 percent of adults subject to time limits had their time limits extended. Important exceptions include the District of Columbia, Maine, Maryland, Michigan, New Jersey, Pennsylvania, Rhode Island, and Washington, all of which have granted extensions to over 10 percent of their TANF caseloads.

Implications of the Deficit Reduction Act

States' current policies and approaches toward hard-to-employ parents may change as a result of the DRA. While the DRA maintains a 50 percent work participation requirement for adults on TANF, the new law changes how states must calculate their work participation rates.[13] DRA requires most adults to be included in the rate calculation, including adults exempt owing to a disability, in SSPs, and in sanction status.[14] DRA also limits the amount of barrier-removal activities that can count toward work participation. Generally, clients can receive a maximum of six weeks of job-readiness assistance each year, including such assistance as mental health counseling designed to address barriers.[15] Adults can only receive a lifetime total of 12 months of vocational educational training. Some additional job training, such as completion of a GED program, can count as a noncore activity, limited to 10 out of 30 hours per weekly work requirement. States have until the end of fiscal year 2007 to submit changes to their current TANF plans, but the new participation rate requirements will be effective for fiscal year 2007.

States that on average have over a quarter of their caseloads in exempt, time-limit-extended, and sanction statuses generally will find it difficult to meet these new requirements (table 3). Some states have

much larger shares of their caseloads in these categories than others. Also, these statistics do not reflect all hard-to-employ parents, nor do they reflect the increase in the hard to employ that has occurred in some areas. New York City, for example, reports that the share of its caseload considered "able-bodied" declined from 63 percent in 1999 to 39 percent in 2006.[16] While the 50 percent work participation requirement still allows states to exempt hard-to-employ parents, it places much more pressure on states to move more parents into paid jobs quickly. Success likely will vary depending on the strength of the local labor market and the ability of local offices to quickly connect parents without significant impairments to paid work opportunities.

States may employ other strategies to meet the new requirements. The survey of states conducted by Loprest and others (forthcoming) indicates that some states no longer will continue to exempt hard-to-employ parents from work activities. More states will try to combine work requirements with barrier-removal activities or stabilization activities. Respondents discussed the challenges associated with this shift in strategy, because mental health counselors and educators traditionally focus on addressing impairments and deficits rather than strategies that also support clients' work activities. Also, many TANF programs do not have staff trained to combine these services. Some states noted they would focus more on clients' SSI applications, to ensure that those with substantial health impairments enroll in federal disability benefits and leave the TANF caseload more quickly. Some states mentioned the need to add resources to services for the hard to employ, especially mental health counseling, to help them learn how to better manage impairments as they move into the labor market.

Beyond TANF: Other Services for Hard-to-Employ Adults

Hard-to-employ parents can benefit from an array of employment services to help them prepare for, find, and retain employment. Parents may access these services directly or be directed to these services through their TANF participation. These services include the public workforce development system authorized by the Workforce Investment Act (WIA) of 1998 and the vocational rehabilitation (VR) program for employment-related services. Parents may also need mental health, substance abuse, and domestic violence services for assistance with addressing specific barriers. While these services do not focus directly on employment, they can provide a way to stabilize barriers and enable an adult to work.

Each program and service system has its own mission, population focus, and challenges. While these systems provide services that can benefit low-income hard-to-employ parents, this group is not the sole (or even main) clientele for their services. This means there may be special challenges in using these services for hard-to-employ parents. Also, these programs traditionally have not focused on accessing income supports for clients and their families while receiving services. With the exception of WIA programs in some states, these service systems for the most part have not had close links with TANF programs. TANF program requirements regarding work participation and time limits often conflict with the goals of these other service programs and may not be understood by service providers. Also, the organization of these services typically occurs locally, and it varies tremendously within states as well as across the nation. This section provides an overview of the common elements in these systems across communities and discusses how they generally interface with TANF.

Workforce Development System

The public workforce development system, authorized by WIA in 1998, aims to provide a seamless, one-stop service delivery system of employment assistance for all job seekers, regardless of income, and to all

employers. WIA serves a broad group including youth, the general adult population, and dislocated workers. Originally authorized through 2003, WIA operates under a continuing resolution while congressional debate over the specific parameters of a reauthorized program remains unresolved.

There are currently more than 3,000 one-stop centers across the country.[17] WIA was developed in response to concerns over the duplication and inefficiencies associated with the fragmented patchwork of employment and training programs that had marked the nation's workforce development system. WIA's guiding principles include streamlined services to simplify and expand access, individual empowerment, universal access to core employment-related services (e.g., self-directed and assisted job search services, labor market information), increased accountability through performance measures, engaging the private sector, and enhanced state and local flexibility.

In addition to core employment services, WIA provides other services (called "intensive" services) and training to those unable to obtain employment through core services. These additional services include comprehensive and specialized assessments, development of an individual employment plan, case management, and training for those who have been unsuccessful in their job search and would benefit from training. In keeping with the priority WIA places on state and local flexibility, there is no standardized eligibility process for accessing these additional services and training, and this leads to considerable variability in who receives them across areas.

More than a dozen "mandatory partner" programs must participate in and share in the costs of the WIA workforce development system. With the exception of VR services, the mandatory partners are not solely focused on the hard to employ. TANF is not a mandatory partner, but about half of all states have chosen to make TANF or the TANF work program a mandatory partner.

In fiscal year 2005, WIA federal appropriations included about $1 billion for youth activities and about $900 million each for adults and dislocated workers.[18] Funds flow through the U.S. Department of Labor, and states need not match the federal funds. Mandatory service partners contribute to WIA's funds. Partners usually provide in-kind staff resources and sometimes help for infrastructure costs. Partner organizations often face their own funding constraints, and the requirement that partners should pay for the costs of the one-stop infrastructure generally has been an ongoing source of tension.

WIA gives public assistance recipients and other low-income individuals priority for intensive and training services, but they are not the sole recipients of these services. For example, in 2003, about 68 percent of adults that used WIA funding to pay for training were low income, and just 14 percent were public assistance recipients. In addition, the resources available to the public workforce development system under WIA fall short of needs (Osterman 2007). Funds available for training particularly are limited. The GAO (2005) estimates that 235,000 poor adults received training under local workforce programs in 2003, and this number has fallen over time.

Despite WIA's stated priority on serving low-income and public assistance recipients, several factors work against hard-to-employ parents gaining access to noncore services and training. WIA programs must meet performance standards that focus on unsubsidized employment and retention or face significant financial penalties. The performance measures do not adjust to reflect any additional costs or difficulties associated with serving clients with multiple barriers. Consequently, there is a significant disincentive to provide WIA-funded services (noncore services and access to training) to the hard to employ, especially those with significant disabilities (Bader 2003; Timmons, Fesko, and Hall 2003; GAO

2002). Although WIA partners vary across localities, many WIA programs are not closely connected and coordinated with barrier alleviation services in the community (such as mental health and substance abuse) and do not fund these services themselves. Instead, despite the fact that hard-to-employ individuals could in fact benefit from WIA intensive services and training, many may only receive basic core services or get referred to partners (such as TANF and VR) for other services without further coordination or collaboration. In addition, an important focus of WIA programs is engaging and serving private-sector employers, and this focus poses a tension with promoting work for those with employment challenges.

WIA and TANF interactions. Both TANF and WIA allow significant variation in the design and implementation of welfare and workforce systems, leading to considerable differences in how these two systems intersect across the country. Many states maintain separate administrative structures but contract with the workforce system for various employment services for TANF clients. In addition, at the local level, a variety of mechanisms may be used to coordinate one-stop and TANF services such as co-location of staff, outstationing WIA staff at the TANF agency, coordinated service planning, cross-training, and leveraging funding so a client can be enrolled in WIA intensive services or training while receiving supportive services through TANF (Werner and Lodewick 2004).

A few states have integrated all or part of their TANF and workforce development programs. For example, Utah and Wisconsin have consolidated all TANF welfare and workforce functions into a single agency. Florida consolidated all WIA and TANF employment functions but retains a separate agency to administer TANF eligibility and cash benefits. (Wisconsin also integrated VR in its consolidated workforce administrative structure, but this is uncommon.) Oregon, Minnesota, and Texas, among others, also have highly integrated systems. Consolidated administrative structures foster, but do not guarantee, increased access to services for both TANF and non-TANF individuals (Ranghelli, Patel, and Greenberg 2003).

In other states, there is little to no local coordination between TANF and WIA, and the two generally operate in separate program and funding silos. For example, in Virginia, a state with a strong work-first focus and generally minimal collaboration between WIA and TANF, only 6 percent of TANF work program participants tracked for a two-year period received intensive services through the one-stop system, and only 4 percent participated in WIA funded skills training.[19]

TANF program rules and approaches to serving their hard-to-employ clients may also impede participation of TANF clients in WIA services. States with a strong work-first emphasis and few additional supports for TANF clients with multiple barriers to employment usually do not provide the opportunity to participate in WIA intensive or training services. Their programs focus on helping all TANF clients find immediate employment rather than education or training, whether funded by WIA or other sources (Werner and Lodewick 2004).

Vocational Rehabilitation Services

The Vocational Rehabilitation program, authorized under the Rehabilitation Act of 1973, serves individuals with disabilities diagnosed by licensed health care professionals. The disability must be a barrier to employment and require VR services to secure or regain employment. VR services include, but are not limited to, an eligibility determination and needs assessment, vocational counseling, vocational training, personal assistance services, supported employment, transportation related to other VR services, and job-placement services.

The concepts of "informed choice" and "order of selection" shape VR program design and organizational culture. VR seeks to place individuals in jobs commensurate with their strengths, resources, priorities, concerns, and capabilities. Informed choice ensures that consumers can choose among available service options and activities throughout the rehabilitation process. Order of selection requires that VR agencies first serve individuals with the most significant disabilities when resources are more limited than demand for services.

In fiscal year 2006, the federal appropriation for VR state grants was $2.7 billion. Funds are distributed to the states based on per capita income and population through the U.S. Department of Education.[20] In fiscal year 2005, the VR program assisted about 1 million individuals. States claim that the program can meet the needs of only a small percentage of eligible individuals. One estimate claims that only about one in twenty who could benefit actually receives services. As a result of limited funds, many state VR agencies implement the order-of-selection system, which offers VR services only to individuals with the most significant disabilities.

As a mandatory partner in the WIA one-stop system, VR often equips the one-stop centers with assistive technology, provides accessibility assessments, and co-locates VR counselors to provide initial eligibility assessments, technical assistance, and advice to one-stop staff on disability-related issues (Salzman 2006). One-stop career centers can offer services to those with less significant disabilities in need of employment assistance who may not be eligible for VR services. They can also provide an additional resource for VR eligibles not interested in VR services and for those not served because of VR's "order of selection" rule. VR clients can also benefit from additional employment assistance resources (e.g., job listings, labor market information, and workshops on interviewing skills) available through the one-stop career centers.

VR is often viewed as the partner that does not fit well within the one-stop career centers (Barnow and King 2003; D'Amico and Salzman 2004). VR programs must comply with the Rehabilitation Act requirement that VR staff and funds be used only for VR eligibles and not non-VR clients. This requirement limits the involvement of VR staff in the one-stop centers (Drew, McGuire-Kuletz, and Alan 2001; Timmons, Fesko, and Hall 2002). Also, WIA's funding constraints and performance standards often lead states to limit intensive and training services. People with disabilities often need training that ultimately costs more and lasts longer than these limits allow. The WIA one-stop system model does not provide the wide array of accommodations and other supports that people with disabilities often need (Holcomb and Barnow 2004).

VR and TANF interactions. Some states and local TANF programs have established partnerships with VR to help them address the needs of some hard-to-employ TANF clients. At first glance, VR seems to fit the needs of hard-to-employ TANF parents. VR's specialized expertise in serving people with disabilities and its focus on helping clients move to employment and self-sufficiency closely align to TANF program needs.

The most common VR and TANF partnerships co-locate TANF and VR staff (often within the one-stop center or outstationed on an itinerant basis at the TANF agency) to provide initial VR assessments for eligibility, training on how to identify disability, and using TANF dollars to pay for VR comprehensive assessment services or VR counselors who carry specialized caseloads of TANF recipients with disabilities. VR funding and rule constraints, however, limit the ability of TANF agencies to pay for VR staff and constrain a potentially effective strategy for serving at least some hard-to-employ parents with certain types of disabilities.

Both TANF and WIA have had mixed success tapping into the VR system on behalf of hard-to-employ clients. Conflicting philosophy and programmatic priorities often make coordination with VR difficult. The basic TANF framework of time limits and required participation in activities, often combined with a strong work-first focus, runs counter to the typical VR program environment with voluntary participation guided by client empowerment and informed choice. VR more traditionally serves clients with a longer timeframe for rehabilitation and return to work. In addition, VR does not target and has less experience serving a long-term poverty population. Hard-to-employ TANF recipients often face more complex problems than VR typically handles, including multiple barriers and issues related to poverty. While many VR clients have severe disabilities, they often have greater financial and family or support resources and more significant work experience (Holcomb and Thompson 2002).

Services Focused on Particular Barriers

Other federal and state programs that focus on particular personal challenges also can play a role in supporting work among low-income parents. Some parents need mental health, substance abuse, and domestic violence services. These services are financed through a complex array of federal block grants, Medicaid, private insurance, state funds, and local funds. Community social-service nonprofit organizations also provide some of these services. Access to services can vary tremendously depending on where parents live, with stronger networks of services generally more available in urban than rural settings.

Mental health services. While parents with mental health issues sometimes need counseling and other services to stabilize their condition before work becomes viable, it can be difficult to connect with these services. Mental health services encompass a complex and fragmented set of service and treatment options delivered in various settings. Both public and private sources fund these services through the primary medical system (physician offices, health clinics, emergency rooms, etc.) or through the "specialty mental health services" system. This specialty system includes residential and community-based options. Appropriate treatment and service settings depend on the specific mental health condition and the severity of the problem. The public mental health system largely focuses on low-income individuals but is characterized as fragmented and underfunded. Medicaid plays an important role in paying for mental health services for the low-income population, including services and prescription drugs.

Mental health services can be required for acute conditions or long-term chronic conditions. The most intensive treatment settings include inpatient psychiatric hospitalization and residential programs for individuals with serious mental illness.[21] These settings include state-funded psychiatric hospitals, psychiatric wings of general hospitals, or private residential treatment programs. The use of psychiatric residential programs has declined over time in favor of treatment in community settings. For example, the percent of state mental health agency expenditures on inpatient mental hospital treatment has fallen over the past two decades from 63 to 28 percent, while the percent of expenditures on community mental health has grown from 33 to 69 percent (NASMHPDRI 2006). Partial hospitalization or day-treatment programs offer intensive services while allowing the individual to continue to live in the community.

Outpatient treatment services are the most common form of intervention, encompassing a broad array of specific treatment approaches for individuals or groups. Services can be provided by specialized mental health professionals (e.g., psychologists, psychiatrists, psychiatric nurses, and psychiatric social workers) in service settings devoted to mental health services or by general health practitioners that provide a range of health services. Voluntary support networks such as self-help groups and community organizations

providing supports that extend beyond formal treatment are also a part of the mental health system. In addition to the primary medical system, individuals can receive services through private mental health practices, public community-based mental health services centers, and social service organizations.

Public mental health service centers or clinics provide mental health services mainly to low-income populations, often using sliding-fee scales based on patients' income. These are funded in part by the Community Mental Health Services block grant to states (in fiscal year 2006 about $400 million from the U.S. Department of Health and Human Services), Medicaid, and state funds. Access to and availability of these services vary tremendously across states and communities.

An array of community social-service nonprofit organizations also provides mental health services, sometimes to specific populations, such as homeless individuals, ex-offenders, or at-risk youth. These organizations are more likely to provide mental health counseling and less likely to have psychologists or psychiatrists on staff. They may serve clients through contracts with public agencies, such as TANF programs, as well as having an independent client base (Derr, Hill, and Pavetti 2000).

There has been enormous critique of public mental health services in this country. While the Surgeon General's report on mental health concluded that "a range of treatments of documented efficacy exists for most mental disorders"(HHS 1999), many barriers to accessing treatments still exist, especially for low-income individuals. Insurance plans, including Medicaid, can limit the type or length of treatment available, especially under managed care options. In addition, limited public funding for mental health services reduces access. Increased reliance on Medicaid funding in public health systems may be reducing options for those not covered by Medicaid. Treatments that have proven effective are often unavailable in community-health settings owing to higher costs, lack of appropriate service providers, or other reasons. One report suggests that public mental health systems are so underfunded relative to demand that they focus on serving those "most in need" at the expense of preventative or stabilizing services (Bazelon Center 2001). In addition, the continued stigma of mental illness keeps many individuals from seeking help.

Substance abuse services. As noted earlier, some parents with employment barriers have substance abuse issues. This can be one of the most difficult employment challenges; often parents do not want to admit that they have a problem, and many do not seek help. Parents who enroll in TANF and have substance abuse issues get identified more often than parents outside TANF. State TANF offices in turn usually refer individuals to the local substance abuse service system to stabilize this problem. TANF may also require that individuals in treatment participate in work activities.

Most professionals acknowledge that treatment of substance abuse takes time and is a very individual process. Services to help individuals overcome abuse and dependence of alcohol or drugs vary by the intensity of individuals' needs and where they are in the treatment process. Also, there is a high co-occurrence of substance abuse and mental health problems, and efforts have been promoted to serve this population (Pollack et al. 2002). The federal Substance Abuse and Mental Health Services Administration (SAMHSA) has identified as one of its highest priorities the improvement of treatment and services for individuals with co-occurring mental and substance abuse disorders.

Alcohol and drug treatment services include assessment and diagnosis; medication management (including brief office or clinic visits supervised by licensed physicians using FDA-approved medications, such as methadone); detoxification (management of individuals while they withdraw from alcohol or drugs); short-term outpatient addiction counseling provided by certified professionals; extended counseling

and continuing care by certified professionals (including ongoing support services around maintaining abstinence, family counseling, or obtaining other social services); partial hospitalization for those needing intensive, structured, ongoing counseling and medical management; short- or long-term residential services for those with even more intensive structured needs; and case management services (including help in obtaining other social services).[22] These services are provided in a variety of settings including hospitals, public and private clinics, nonprofit social-service agencies, and public agencies.

The need for these services also exceeds the supply, especially for low-income individuals. Estimates for 2002 indicate that 22 million Americans age 12 and older have a substance use disorder (9.4 percent of the population), but only a small proportion obtains treatment. An estimated 3.5 million people age 12 or older (1.5 percent of the population) received some kind of care for a problem related to the use of alcohol or illicit drugs in the 12 months before being interviewed in 2002. More than half of those in treatment (2.0 million) received care at a self-help group (Office of Applied Studies 2003). The lack of treatment capacity explains part of the gap (Legal Action Center 2002).

Public sources (local, state, and federal government) pay for about two-thirds of substance abuse treatment services. Of all public expenditures on substance abuse treatment in 2001, 50 percent came from state and local government funds, not including Medicaid. Medicaid pays for an additional 25 percent of publicly funded substance abuse treatment services, and Medicare and other federal sources pay for the remainder (SAMHSA 2005). The variation in the organization of services across communities reflects the high percentage of funding by state and local systems.

Domestic violence services. Services needed by women experiencing domestic violence vary from emergency housing to legal services to therapy. Available services vary across communities. In the late 1990s, an estimated 1,800 programs nationwide served women experiencing domestic violence, including 1,200 shelters (Burt, Zweig, Schlichter et al. 2000). In most communities, private nonprofit agencies run these shelters and supportive services for victims of domestic violence with funding from private and public sources, including local, state, and federal funds.

Following the implementation of new national programs and funding in the 1990s, there has been a growing movement toward coordinated community approaches (Burt, Zweig, Schlichter et al. 2000). These approaches try to effectively combine the efforts of law enforcement, prosecution, the courts, health care, and social service agencies. The services provided can include hotlines, shelters, support groups, individual and group therapy, legal advocacy, social service referral and advocacy, transitional housing, and other support services.

In initial debates over welfare reform, some raised concerns that work requirements could put some women at risk of abuse from their partners. In response, the federal government allowed states to implement a family violence option (FVO), which includes screening recipients for domestic violence, providing referrals to services, and exempting them from program requirements if necessary. All but a few states have adopted the option, although actual waivers granted under the option have been limited (Tolman and Raphael 2000).

Barrier-Alleviation Services and TANF Interactions

There are numerous challenges for TANF programs in interfacing with service systems that address particular barriers. Although mental health, substance abuse, and domestic violence services face their own challenges in providing services, they share many common issues around the interface with TANF.

The first challenge for TANF programs in connecting recipients with these service systems is identifying individuals who need these services. Unlike physical health problems, these barriers often will not be self-reported by recipients to TANF workers. This could be because the recipient does not define herself as having the problem or she does not want to reveal the problem due to stigma, fear of losing her children, or personal safety. Parents with challenges who go to the TANF office are usually seeking cash assistance, not help in dealing with specific barriers. While individuals who directly seek out mental health, substance abuse, or domestic violence services often need screening and assessment services, they have already identified themselves as having a problem.

Use of appropriate screening and assessment tools is one part of addressing this issue, and a number have been developed and implemented in TANF settings (Thompson, Van Ness, and O'Brien 2001). How screening occurs is also important. Screening and assessment that takes place in a service provider setting (for example, a clinic, hospital, or shelter) usually has specifically trained personnel using appropriate tools and experienced with the given population. Some TANF programs have moved to co-locating counselors in TANF offices who are expert in dealing with one or more of these barriers to carry out screening and assessment. Other programs have moved sensitive assessment around need for domestic violence services outside the TANF eligibility process altogether to be completed by domestic violence advocates (Burt, Zweig, and Schlichter 2000).

Another challenge is how to connect recipients with identified needs to services in the community. Referrals to resources outside the TANF program with minimum follow-up or guidance often fail. Unlike programs such as TANF with a well-defined process for access, these service systems may have multiple providers and entry points in a community. Without formal partnerships, it may not always be clear where to refer TANF clients for services. The complexity of these systems can pose difficulties for recipients trying to navigate them without guidance. In addition, limited resources and overburdened systems mean it is often difficult to gain access to needed services.

Lack of understanding about TANF client needs and TANF program rules, particularly around work requirements, sanctions, and time limits, also exists. This can mean that even those TANF recipients who find their way into these service systems can face conflicting requirements or systems that fail to meet their needs within the parameters of TANF program rules.

Given these difficulties, many TANF programs have moved toward more direct connections to service systems for hard-to-employ recipients. These include co-location of counselors in TANF offices, funding of services through contracts with community organizations that allow more TANF oversight, development of program models that are specifically for TANF recipients and are TANF-funded, and more intensive case management and follow-up of recipients that are referred to services.

One difficulty for service providers in partnering with TANF is the need to track client participation in services. This may be even more important under new DRA requirements. Not only may this be a new burden for service providers, it can bring up significant issues of confidentiality and how to communicate information across partners while protecting these rights.

Multiple barriers faced by many recipients present another challenge for these service systems. Some TANF programs now recognize the need to address individuals' multiple barriers and to find program partners that can address multiple issues. For example, the coordinated approach in some communities for those who have experienced domestic violence seeks to provide housing, counseling, legal, and some-

times work services. Some providers of substance abuse services also offer housing and mental health counseling services. However, for the most part, providers have a primary service focus. TANF programs often must create programs to address these multiple barriers or create ways to coordinate across different service systems, including hiring intensive case managers to coordinate services for clients with multiple barriers.

Finding ways to combine efforts to address and alleviate barriers while preparing for work perhaps presents the toughest challenge for TANF programs. Federal work requirement rules and time limits demand program models that can combine services to address barriers with services that prepare individuals for work. Traditionally, many providers of services around these barriers have not been explicitly involved in work readiness, especially for women with children. This has been changing, and some examples of programs that address barriers and work have emerged (for example, see Morgenstern and Blanchard 2006 on substance abuse). Nonetheless, program administrators in the Loprest and others (forthcoming) survey frequently mentioned the difficulty of combining these services as one of their greatest challenges.

Disability Cash Benefits for Those with Severe Health Barriers

The broad safety net for individuals with barriers to employment acknowledges that some adults cannot work because of a physical or mental disability and recognizes these individuals' need for cash assistance. Two major public programs potentially offer benefits to low-income parents unable to work due to disability. The means-tested Supplemental Security Income (SSI) program provides benefits to low-income adults, children, and elderly, and the Social Security Disability Insurance (SSDI) program provides benefits to adults with disabilities and work histories in covered employment.[23] Individuals cannot receive both TANF and SSI benefits, but TANF often serves as a gateway to the SSI program for low-income parents.

Both SSI and SSDI require that an individual has a medically determined disability expected to last at least 12 months or result in death, and the disability must prevent engagement in "substantial gainful activity."[24] TANF recipients with disabilities more often apply for SSI than SSDI because they typically have low incomes, limited assets, and limited work histories. However, low-income individuals can also qualify for a small SSDI benefit if they have enough work history and a supplemental state-funded benefit in addition to the federal SSI benefit.

Low-income adults with health impairments have a strong incentive to apply because SSI benefit levels considerably exceed TANF benefits. The SSI benefit guarantees an income of approximately 75 percent of the poverty level for an individual, and some states supplement this minimum. In contrast, the median TANF benefit in 2005 provided an income of about one-third of the federal poverty level for family of three. When a parent qualifies for SSI, the children remain on TANF receiving a child-only grant worth about two-thirds of the full TANF benefit. Wamhoff and Wiseman (2006) calculate that families could on average have increased their income by 115 percent ($552 a month) in 2003 by transferring one adult from TANF to SSI. States also have an incentive to enroll TANF beneficiaries with disabilities in these programs because federal monies (through the Social Security Administration) cover most of the benefit cost. Also, when these individuals leave the TANF caseload, states no longer face the challenge of engaging these individuals in work-preparation services.

Qualification for cash disability benefits is difficult, and the application process is complex and lengthy.[25] Applicants must provide documentation to establish impairment, and SSI also requires detailed infor-

mation on income and assets. The burden of gathering this information and providing contacts falls mostly on families. The assessment of disability status is complex and time intensive. The state Disability Determination Service (DDS) reviews the information submitted to SSA and decides whether the applicant meets the disability eligibility requirements. The initial DDS assessment takes about 100 days, and about 37 percent of initial SSI applications are approved, although approval rates vary considerably across states (National Academy of Sciences [NAS] 2005).

About one-third of the claims denied initially by the DDSs are appealed. This process usually requires the assistance of an attorney to help claimants assemble a complete case record. Legal fees for TANF recipients applying for SSI may be paid by the TANF office, often through contracts with legal services offices. Other low-income applicants may get help directly from the local legal services office. Applicants who appeal wait an average of more than a year from the time they are denied until their case is decided, with successful cases receiving benefits retroactive to the time of application. Judges approve 61 percent of appealed claims (NAS 2005). A small share of cases denied at this level can go on to an additional appeal.

In 2006, SSA began implementing new procedures across the country to shorten the time between application and final approval (including new medical-vocational experts to make more accurate and timely decisions). It is too soon to know, however, how much the new procedures will shorten the wait.

SSI and TANF interactions. Researchers do not have good national statistics on the share of TANF clients likely to have disabilities severe enough to qualify for SSI. In part this comes from the difficulty of estimating who could meet the complex SSI disability criteria. We do know, however, that there is significant overlap between the TANF and SSI adult populations. Wamhoff and Wiseman (2006), using administrative program data, estimated that 13 percent of all TANF/SSP cases in 2003 lived in households that included an adult SSI recipient. They also found that 13 percent of SSI awards to women age 18–64 (about 34,000) went to recipients "associated with TANF" (those who had federally funded income based on need at the time of SSI application).[26] Nadel, Wamhoff, and Wiseman (2004) estimated that one in three adult women receiving SSI benefits in 2002 (about 250,000 women) had some previous association with TANF.[27]

States and local offices vary in how they connect TANF recipients with disabilities to SSI. Some simply refer candidates to the program and suggest that they apply. Other offices take a more activist approach by helping clients fill out the applications and monitoring their progress through the process. Loprest and others (forthcoming) report that an increasing number of TANF offices are taking a more active approach to helping recipients apply for SSI, including contracting with local legal services offices to help applicants through the process or hiring specialists to work in TANF offices, usually through performance contracts. New York City, for example, uses this second approach and claims a 50 percent success rate in gaining approvals for clients referred to SSI. Similarly, Maryland assigns likely SSI candidates to its Disability Entitlement and Advocacy Program that pays contractors to pursue SSI awards.

Some TANF programmatic factors can complicate the connections between TANF and SSI. TANF allows recipients to have higher levels of assets than the SSI program, limiting some individuals' ability to move from TANF to SSI even if they meet disability criteria.[28] Also, some state TANF programs allow eligibility for immigrants in the United States less than five years, but the SSI program prohibits eligibility. In addition, Loprest and colleagues (forthcoming) suggest that the long and complex SSI application process presents unique challenges to TANF recipients. Applicants typically are exempt from any

work activity during the waiting process because work participation could disqualify them for disability benefits. Those eventually denied benefits have lost time that could have been used for additional training or barrier stabilization. The DRA requires that SSI applicants be included in states' work participation rate calculations, intensifying the need for quick resolution of SSI applications.

Summary and Implications

Many low-income parents with children have significant impairments that make it difficult to work. Some of these parents turn to TANF for help, but many do not. The best TANF programs offer temporary cash assistance to these parents, along with connections to services that alleviate barriers, and eventually help in finding work. Other federal-state programs that focus on work either provide more generic employment services (WIA) or specialized services for those with severe disabilities (VR). Programs that address particular barriers to employment, including mental health, substance abuse, and domestic violence services, often do not connect these services to work, nor do they particularly focus on the special needs of parents. Finally, SSI provides long-term cash assistance for adults with severe physical and mental health diagnoses. Parents not enrolled in TANF can seek help from these separate service and safety-net programs, or, more likely, try to make it in the labor market without help.

Given TANF's focus on low-income parents and their children, it is natural to review the safety net for hard-to-employ parents through the lens of this program. All TANF programs embrace the goal of moving parents to work as their primary mission, and they vary tremendously in their success at integrating all the services required by hard-to-employ parents to move to employment. States' philosophies and approaches to the needs of hard-to-employ parents vary across the country. Some believe that hard-to-employ parents fare best when required to work immediately like everyone else. Others exempt parents with physical and health disabilities from work participation and time limits, expecting to continue some cash assistance for some of these families indefinitely. Most states fall between these two extremes.

It is difficult to understand fully the implications of these disparate approaches for hard-to-employ parents on TANF. Information pieced together in this paper from states' TANF program rules, program outcome data, specialized surveys of state and local welfare offices, and outcome studies highlights some of the challenges and the variability in outcomes. Common reliance on individuals to identify their own employment barriers rather than professional assessments means that hard-to-employ parents can struggle for years to find employment before getting the services they need. In many cases, these individuals lose benefits as a result of sanctions or time limits. Exemption policies that exclude individuals with significant mental or physical health issues from program requirements can mean that parents languish on the TANF program without getting appropriate barrier-removal or work services.

TANF may partner with other programs that offer services to help hard-to-employ parents find and retain work. WIA employment services aim to help all low-income adults find work, and VR focuses on helping adults with severe disabilities find appropriate jobs. While WIA typically limits the amount of time an individual can spend in training supported through WIA funds, core employment services are available to everyone for as long and as often as needed. VR programs tend to provide client-oriented services without restrictions on the time spent in employment services. Limited funding means that WIA training assistance and VR programs serve only a fraction of individuals that need services. TANF programs can and sometimes do transfer money to pay for these services, but TANF's emphasis on work and time limits can conflict with these programs' strategies. TANF may also connect hard-to-employ parents with local mental health, substance abuse, and domestic violence service systems. These programs

focus on these primary services, and TANF programs must add the work services component that will comply with TANF rules. For parents with severe disabilities, TANF programs refer them to federal disability benefits. Some programs help parents through this long and complex application process.

Hard-to-employ parents outside TANF can access employment or barrier alleviation services directly, and they can apply for disability benefits on their own. However, most of these programs do not understand the particular challenges of parents trying to cope simultaneously with the care of their children, mental or physical health issues or other barriers, and the pressure to find work. Also, numerous studies document the difficulty of applying for disability benefits without legal assistance. The prevalence of multiple barriers among these parents points to the need for intensive case-management services that tailor barrier stabilization and work services to particular individuals' needs.

Parents disconnected from work and welfare represent the most extreme cases requiring work services. The consequences of not being connected to TANF along with the lack of any other alternative system that integrates critical services can be significant. Parents may struggle indefinitely with their physical and mental health issues and never connect solidly with the labor market. We do not know how often these families receive help through other public programs such as WIA, VR, or services that address specific barriers. The limits of these programs, however, suggest that individuals may have difficulty accessing services that combine barrier alleviation with employment services. State TANF programs increasingly find that parents with substantial barriers need intensive case management services to help them navigate the maze of potential services to address often multiple issues (Loprest et al. forthcoming). Given the current structure of the safety net for hard-to-employ parents, low-income parents seldom have access to intensive case management services outside TANF.

This review leads to the clear conclusion that we fail to offer an integrated system of supports for hard-to-employ parents. These parents probably fare best when they apply for welfare, but many fall through the cracks in TANF programs. The review does not lead to simple answers. Instead, it leads to some broad questions:

- How should we provide access to services for hard-to-employ parents? Must they apply for welfare to get coordinated services? Should we expect TANF programs with fixed block grant funds to solve the complex problems of all hard-to-employ parents?
- How much should the public invest in services for hard-to-employ parents? Are we willing to spend enough on mental health, substance abuse, and domestic violence so all who need services can receive them?
- How can we better connect work with services aimed at barrier alleviation and stabilization? Do we need more specialists who can bridge these services? Do we need more intensive case management services?
- Should we expect paid work to be feasible for all those with serious physical and mental health problems? Or do we also need a better, more accessible disability benefit program that allows individuals to combine some paid work with a guarantee of some cash income support?

We can only begin to answer these questions by initiating a conversation with the leaders representing the different aspects of the safety net serving hard-to-employ adults. This will be challenging since each operates with funding from a different federal agency. As we have shown, the federal departments of

Labor, Education, and Health and Human Services as well as the Social Security Administration all play a role in the current safety-net system. States must administer the broad variety of programs within the funding and program constraints defined by these federal agencies. The structure naturally leads to silos and a lack of coordination of services for the hard to employ.

The reauthorization of welfare presents the right time to think more holistically about the safety net for hard-to-employ parents. States are thinking about how they will meet tougher work participation requirements without harming hard-to-employ families. Changes in program guidelines that facilitate partnerships across TANF, employment services, and barrier alleviation service programs coupled with sufficient funding for these services will be required. Improvements in access to disability benefits for the subset of parents with severe disabilities that reduce the need for legal aid and speed up benefit decisions would help.

Reform will require leadership at the federal level with strong support from the nation's governors. It will require thinking outside traditional program boundaries. Understanding effective system changes may require experimentation with new delivery mechanisms in the states. It will also take time and money. Finally, program reforms should increase access to services for all hard-to-employ parents regardless of whether they choose to participate in welfare.

This review calls attention to the need for rethinking the system of supports for hard-to-employ parents. A move to action will require innovative thinking about how a system could be designed that meets the needs of all hard-to-employ parents. A blueprint for system reform will require consideration of current funding levels compared with needs for services; the roles of federal, state, and local governments; and analysis of state initiatives that show particular promise. Most important, it will require thinking about how a system could be designed that responds to the needs of parents who want and need to work but need help in achieving this goal.

NOTES

1. Other state and local adult education programs and the community college system are also important to hard-to-employ parents with literacy issues and education deficits. This paper, however, focuses primarily on those programs and systems supported largely by federal funds. It also includes domestic violence services since they can be critical for supporting some hard-to-employ parents.
2. Lurie (2006), for example, observed the TANF application process in local offices in four states. She concluded that the application requirements in states with strong "work first" programs in her sample discouraged entry among hard-to-employ families.
3. A major advantage of these surveys was they all used the same survey instrument and measures of barriers. This consistency greatly facilitates comparison of results across studies.
4. Other location-based studies also find that TANF recipients with barriers are more likely to become disconnected than TANF recipients without barriers. See Turner, Danziger, and Seefeldt (2006) and Moore, Wood, and Rangarajan (2006).
5. The Welfare Rules Database is available online at http://anfdata.urban.org/wrd.
6. Some states with no general exemption for illness or disability do exempt for "good cause." Also, some states indicate no general exemption for illness or disability but categorize TANF recipients as disabled in the statistics they report to the federal government. Finally, three states (Illinois, Minnesota, and Kansas) that do not allow exemptions for illness or disability specify that they assign activities appropriate to the health of the applicant (per the Welfare Rules Database). The formal program rules only provide a general sense of differences across states and cannot capture individual caseworker decisions or local variability in application of formal state rules.
7. The GAO sample was designed to be representative of all welfare offices, not all welfare recipients.
8. As discussed later, TANF reauthorization requires individuals in SSPs funded with state MOE dollars to be included in states' work participation calculations beginning in fiscal year 2007.
9. Massachusetts and Hawaii also classify less than 1 percent of their caseload as disabled.

10. Partial sanctions usually lead to "child only" TANF cases because only the children receive benefits. (In some places with short sanction periods such as New York City the case may never move to the child-only designation.) In 2005, over 40 percent of the approximately 2 million families on TANF were child-only, and 44 percent of the child-only cases included a sanctioned parent (HHS 2006).
11. Two states, California and Rhode Island, are listed in table 2 as having a 60-month time limit that applies only to the adult in the unit. Benefits continue indefinitely for the children.
12. From the Welfare Rules Database, 2005.
13. See the Center on Budget and Policy Priorities and the Center for Law and Social Policy (2007) for a thorough discussion of the changes in federal TANF rules included in the DRA.
14. Parents caring for infants less than 12 months old or family members in their household with disabilities still are exempt from the participation-rate calculation.
15. The Interim Final Rule says that any hours of barrier-removal activities or job search during a week use up one of the limited weeks of participation.
16. Unpublished data supplied by New York City staff, April 2007.
17. By law there must be one full-service one-stop center in each of 600 local workforce areas across the country. Some local areas have satellite centers and informational centers in addition to one full-service center.
18. Data from U.S. Department of Labor, Employment and Training Administration, 2006.
19. Joint Legislative Audit and Review Commission, *Self-Sufficiency among Social Services Clients in Virginia,* House Document No. 33 (Richmond, VA, 2006).
20. Federal funds flow through the Department of Education. The number of individuals receiving services includes only those with specific rehabilitation plans; other individual receive counseling and guidance. Direct services accounted for $1.7 billion of total expenditures, guidance accounted for $1.2 billion, and other expenditures such as administration and facility costs accounted for the remainder. States must match 21 percent of the federal dollars (Wittenburg and Favreault 2003).
21. This section is based on chapter 2 of "Mental Health: A Report of the Surgeon General," 1999.
22. This section is adapted from Legal Action Center (2002).
23. Adults who experience the onset of a disability on the job may also qualify for workers' compensation (WC). Veterans Administration (VA) benefits cover individuals with disabilities who have been honorably discharged from the military. Private-sector employees may also be covered by private disability insurance (PDI) as an employment benefit. These sources of disability income are less likely to apply to low-income parents because they require significant connection to the labor market or military experience.
24. The SSI program also provides benefits for low-income seniors (over age 65) regardless of disability status.
25. Wamhoff and Wiseman (2006) estimate that about half of SSI awards to TANF applicants were completed within one year, one-quarter were only completed in the second year, and one-fifth took more than two years.
26. These authors point out that administrative data systems make it impossible to calculate directly the number of TANF adults who transfer to SSI. In particular, SSA data systems cannot identify adults in states' SSPs as TANF recipients.
27. Nadel and colleagues calculated this association using the SSA 10 percent Master Beneficiary File. In this study, a previous association with TANF could occur because they were receiving TANF at the time of the most recent SSI application, at the time of a prior application, or at some point when the applicant was living with an SSI applicant or recipient.
28. SSI allows recipients to have a maximum of $2,000 in financial assets. TANF has updated its asset test to allow low-income families to accumulate more savings for emergencies. While states' asset tests vary, median allowable financial assets were $10,000 in 2005 (per the Welfare Rules Database).

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