CalWORKs Project

California Work Opportunities and Responsibility to Kids

Number 3: June 2002

POLICY AND PRACTICE BRIEF

The overall number of children exposed to serious threats is alarmingly high. For example, 26% of mothers report their children did not always get needed dental care.

MULTIPLE RISKS THREATEN CHILDREN OF TANF RECIPIENTS WITH ALCOHOL OR OTHER DRUG, MENTAL HEALTH, OR DOMESTIC VIOLENCE ISSUES

RESULTS IN BRIEF

This Brief presents strong evidence that children of TANF parents who have serious alcohol and other drug (AOD), mental health (MH), or domestic violence (DV) issues face substantially more threats to their well-being than do children in families which do not face these situations. We measured 49 potential threats to child well-being in a population of 579 randomly selected female head of household TANF families from two California counties one year after exposure to welfare reform. Children whose mothers had serious AOD, MH, or DV issues had a higher number of threats to basic safety net needs, including insufficiencies in food, housing, income, and medical care. Problems in accessing good-quality child care were also disproportionately higher among these families. Mothers in our sample who had MH or DV issues expressed significantly more frustration in raising their children and reported lower amounts of social support than those without these issues. And parents who face MH or AOD issues had more complaints about their children's behavior and reported significantly lower performance in school in comparison with families who do not face these issues. Overall 15% of the study sample participants confronted a very high total number of threats to child well-being (greater than 14). Roughly twice as many families with AOD, MH, or DV problems (28–30%) had more than 14 threats. These rates were five to six times as high as the 5% rate for those without any AOD/MH/DV condition. In order to mitigate the effects of these conditions on child well-being, TANF reauthorization legislation should mandate screening for AOD/MH/DV issues as well as permit AOD/MH/DV services to be counted as allowable work activities for up to a year. Family-oriented AOD/MH/DV services—that also respond to needs of children—are in short supply and will need specialized funding through TANF.

Three-quarters of TANF recipients are children. The ultimate goal of the 1996 welfare reform legislation—the Personal Responsibility and Work Opportunity Reconciliation Act—was to improve the well-being of families by assisting poor parents to become economically self-sufficient. Proponents argued that when parents engage in work rather than welfare their children would benefit. Opponents of the PRWORA expressed serious concerns that the time limits and emphasis on "work first" (rather than education and training) would be detrimental to children, particularly in hard economic times or in families with parents who face serious obstacles to employment. Research on these issues to date is limited and far from conclusive. (For a summary of existing findings see the Child Trends report listed in the *Resources* section at the end of this report.) As welfare reform legislation comes up for reauthorization six years following its enactment, provisions that may affect the well-being of children in the family remain a matter of concern. And—as shown in this Brief—a number of *new* provisions are needed to help TANF families in which a parent faces AOD/MH/DV issues.

OVERALL STATUS OF CHILDREN IN STUDY FAMILIES

We measured 49 potential "threats" to child well-being in our random sample of 579 TANF families with a single female head of household. Some of these threats are direct, such

RESPONDENT WITH AOD NEEDS:

"I HATED MYSELF. I HATED WHAT I WAS DOING TO MY KIDS. I JUST HAD ENOUGH. I PROBABLY NEVER EVEN WOULD HAVE TRIED OR EVEN GOT TO THAT POINT [GETTING OFF DRUGS] IF IT WEREN'T FOR MY KIDS."

The Research

This report summarizes California information from two rounds of intensive research interviews in 1999 and 2000 with a random sample of women in Kern County who had received TANF cash aid for at least one year, and a random sample in Stanislaus County who just were applying for TANF. Participants were required to be: Age 18–59, fluent in English or Spanish, and a female head of the household (relative-caretakers and two-parent families were not eligible). In Kern County, a total of 273 of 287 (95 percent) Round I respondents were re-interviewed in Round II. In Stanislaus County, 306 of the original 356 respondents (86 percent) were re-interviewed, yielding a total sample of 579 respondents who were present in both interview rounds.

as food deprivation; others are indirect, such as lack of social support for the parent; and still others reflect school and behavioral characteristics of a "focal child" selected for study at random in each family. The overall rates for many of the 49 items in our sample are alarmingly high:

- 29% had no home of their own (so had to live with someone else)
- 23% had to cut the size of meals or skip meals
- 14% regularly leave a child under 13 alone due to lack of child care
- 45% said friends had provided little support in the prior year
- In 27% of the families at least one child lives separate from his/her mother
- 19% of children age 7–11 were in special education classes, and 19% had been expelled or suspended during the prior year
- 29% of youth aged 12–17 were in special education classes, and 20% had run away, had been in trouble with the law, were using drugs or drinking, had become pregnant or impregnated someone else, or were involved with a bad crowd or gang

As prominent as these threats are in the general TANF sample, they are consistently even higher for the children living in TANF families with mothers who have serious AOD, MH, or DV issues.

Impact of AOD, MH, and DV Issues on Children

How we define AOD/MH/DV service needs among TANF parents

In this *Policy and Practice Brief* we have used the following definitions of those who "need" AOD, MH, or DV services.

- AOD – a diagnosis of dependence or abuse, employment problems because of AOD (flunking a drug test or being fired), or coming to the interview under the influence.
- MH – a measure of symptom severity equivalent to that for a broad reference group of patients starting treatment at outpatient clinics.
- DV – physical injury; having been choked or beaten; subject to stalking; threats by the abuser to kill the woman or himself or threats to kidnap the children or call CPS; abuser actively interfering with employment; or, Post Traumatic Stress Disorder resulting from adult abuse.

We added those who actually sought and used or thought they needed professional services for an AOD, MH or DV condition (even if they did not meet the above criteria). Our measurement of AOD, MH, and DV issues thus includes objective criteria *and* self-perceived need for

services. Using these definitions, at the Round II interviews, we classified 13% as having a need for AOD services, 33% for MH services, and 22% for DV services. The results in the rest of the Brief are categorized by these three groups compared to the 54% who had no AOD, MH, or DV need for services.

What we found

A great deal of existing research indicates that parental , substance abuse, domestic violence or mental health problems have deleterious effects on the children (see the *Resources* section). Studies also reveal that the cumulative impact of multiple risk factors is far more consequential than any particular risk factor in harming children—and that poverty is a proxy for many such risk factors. Our findings substantiate these patterns for this TANF population.

Table 1 below summarizes the results for each of five risk categories that our 49 measures covered. A **black symbol** means that those with each condition are statistically different from those without (we are 95% sure such a difference is not due to chance); a **white symbol** means the association was not statistically significant. Statistical tests were applied to the sum of measures (for each respondent) in each category.

Table 1: Statistically significant associations between AOD/MH/DV status and child well-being measures

RISK CATEGORIES	Participants with AOD Needs N=76	Participants with MH Needs N=192	Participants with DV Needs N=127
SAFETY NET (21 measures covering housing, utilities, food insecurity, medical care, resources)	●	●	●
CHILD CARE (8 measures)	●	●	●
PARENT SUPPORT & FRUSTRATION (7 measures)	○	●	●
CHILD STATUS (living away from mother, placed out of home,or serious disability)	●	●	●
SCHOOL PERFORMANCE & PROBLEMATIC BEHAVIOR (7 measures)	●	●	○

How our findings are presented. For each risk category we discuss the results and show a graph of one measure as illustrative of the risk category. In each graph we show the overall percentage of the sample experiencing that particular threat to child well-being and, for contrast, the percentage experiencing it in the 54% of the sample who did not report any AOD, MH or DV needs during the year (N=318). The bars for AOD, MH, and DV are not mutually exclusive; 11% of the sample overall experienced two or more types of AOD/MH/DV needs during the year. All measures are based on the mother's self-report regarding herself and her family.

AOD/MH/DV and safety net needs

Families in which mothers have AOD/MH/DV service needs report far more threats to the material well-being of their children than do mothers without those issues. Families in which the mother has one or more of these needs experience more housing inadequacies (including lack of utilities or phone), more food insecurity, less access to needed health care, and greater income deprivations.

Housing and utilities. We asked seven questions about housing, encompassing homelessness, number of moves in the year, neighborhood safety, whether utilities had been turned off, and lack of a phone.* Inadequate housing was statistically associated with all three conditions, and lack of utilities was associated with MH and DV.

Figure 1 shows that while only 2% of women with no AOD/MH/DV needs were homeless on the street or in shelters during the year, 10% to 13% of women with AOD/MH/DV needs were.

Hunger. Food insecurity was measured by whether a family reported having to use a food bank, having skipped or cut down the size of meals in the past year, or by a parent *or* child having been hungry because the family just could not afford food. Food insecurity was statistically associated with all three AOD/MH/DV conditions.

* The time periods for the questions varied, from the past 60 days to the past one year.

Figure 1: Homeless on street or in a shelter during the year—by AOD/MH/DV service need

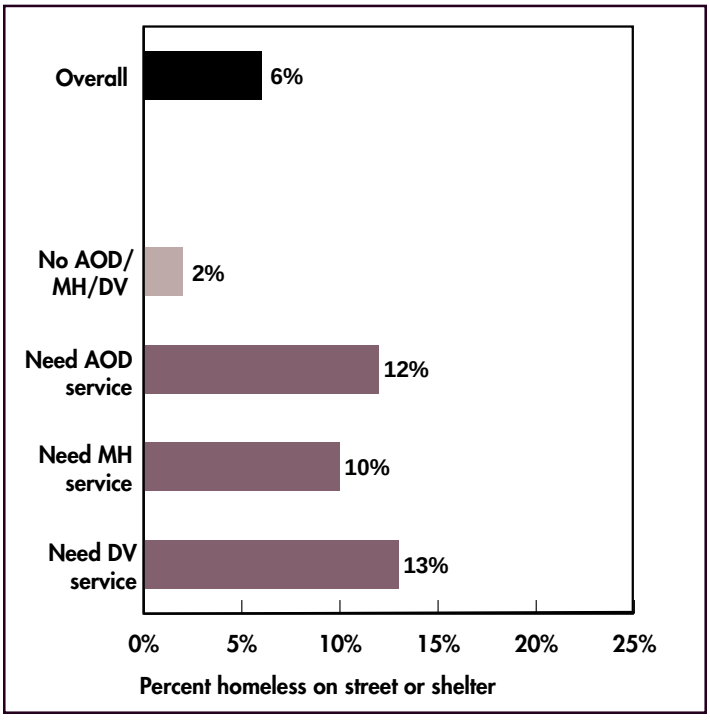


Figure 2 portrays the group differences in those depending on food banks.

Medical care. Lack of a medical safety net was determined by whether any child was not covered by medical insurance and by how frequently each child received needed medical and dental care. Inadequate medical care correlated with all three AOD/MH/DV conditions.

Figure 3 presents the most critical of these measures—whether medical care was *not* received by children in the family "all of the time." One fifth of participants with MH and DV needs reported lack of consistent care—double that reported by those with no AOD/MH/DV needs.

Family financial resources. Inaccessibility to food stamps in the prior month, lack of child support in the year, accumulating debt greater than $1,000, earning less than $5,000 (in 1999) in annual income, earning much less in 1999 than 1998, and the mother's lack of medical insurance for three months or more were counted as resource-related threats to child well-being. AOD/MH/DV needs were significantly associated with these measures.

Figure 2: Had to use food bank in previous year—by AOD/MH/DV service need

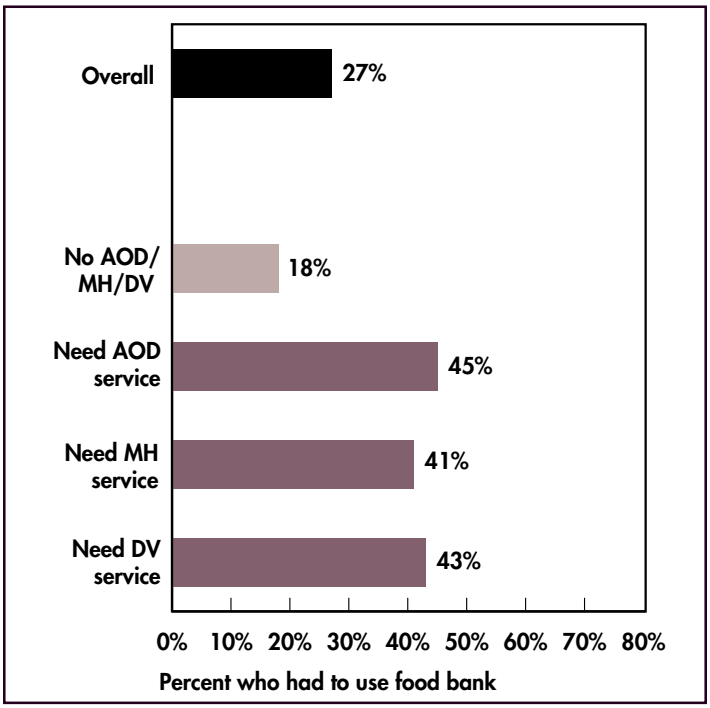
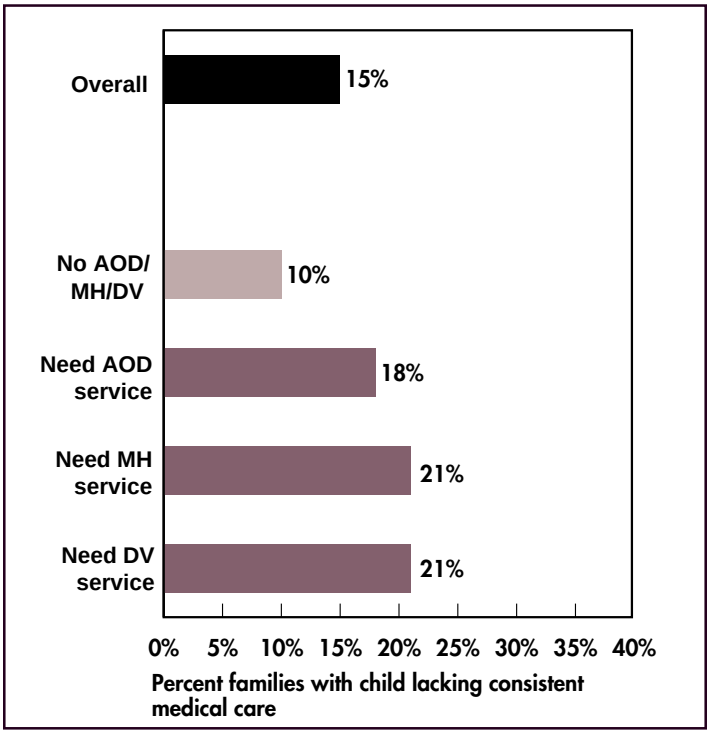


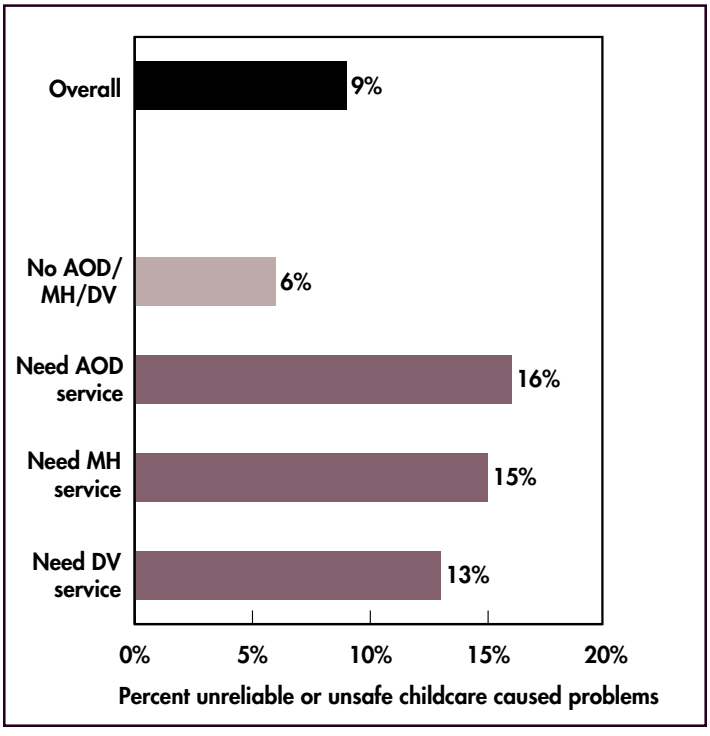
Figure 3: Families in which a child in the family did not receive needed medical care "all of the time"— by AOD/MH/DV service need



AOD/MH/DV AND THE ADEQUACY OF WORK-RELATED CHILD CARE

Beyond its necessity for employment, child care also directly affects the well-being of children. We measured whether children under 13 were regularly left alone; whether work-related child care was very difficult to obtain; whether the quality of the child care was poor; whether the youngest child had had more than two regular child care arrangements in the prior year; and whether preschool children did *not* have access to Head Start or other center-based child care (which is associated with better developmental outcomes). Having AOD, MH and DV needs was associated with these measures in the aggregate and with most of the measures individually. Figure 4 shows the results for women who reported that in the past year

Figure 4: Respondents who report unreliable or unsafe child care caused work problems in previous 12 months—by AOD/MH/DV service needs

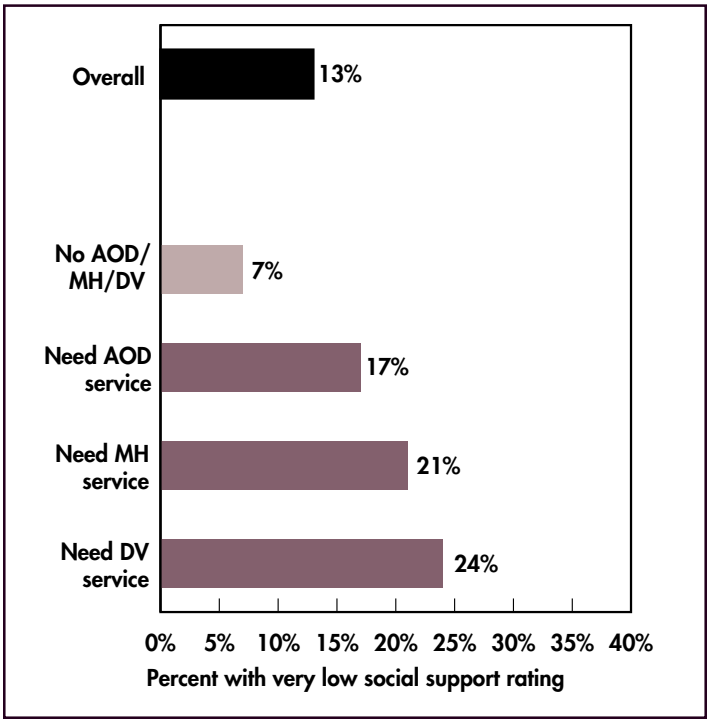


unreliable or unsafe child care had caused them problems finding a job, caused absenteeism or lateness, or caused them to quit or be fired. More than twice as many women with AOD/MH/DV service needs reported these problems in comparison to participants with no AOD/MH/DV service needs.

AOD/MH/DV and Parental Stress and Social Support

Measures of parental stress included feelings within the past month by mothers that their children were much harder to care for than most children, that their children's actions bothered them a lot, that they felt angry with their children, and that they were giving up more of their lives to meet their children's needs than they had expected. Additional stress indicators were having a child under two years of age and caring for four or more children.

Figure 5: Very low social support reported by mother—by AOD/MH/DV service needs

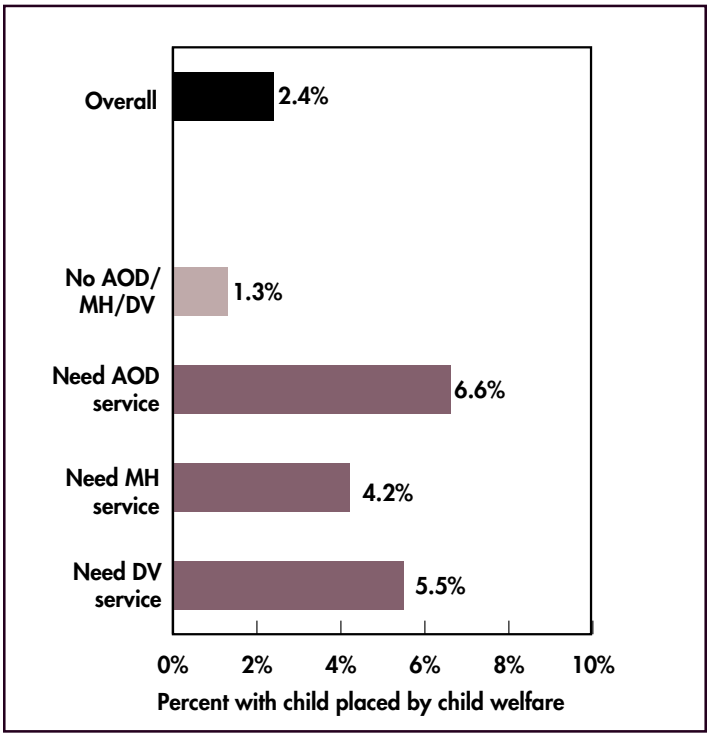


A scale measured the availability of emotional, personal, financial, and decision-making help. The existence of marriage-like relationships of at least a year, and assistance provided specifically by friends and by welfare/employment staff, were additional measures of social support.

Mothers with DV and MH conditions expressed significantly more frustration and received less support in connection with their children than those without these conditions.

Figure 5 shows that two to three times as many women report very low social support if they have AOD/MH/DV service needs than if they do not.

Figure 6: One or more child placed in foster care by child welfare—by AOD/MH/DV service needs



AOD/MH/DV and Child Status

For a variety of reasons, including neglect or abuse, children may reside away from their mother. Children may also have a significant physical or emotional disability which limits their activities and therefore requires special care from the parent. Families where the mother has AOD/MH/DV service needs are more likely to have children in these difficult situations than when the mother does not have such needs.

Figure 6 shows the percentage of mothers reporting that at the time of the interview one child or more had been placed in a foster home by child welfare. Although the overall rate is fairly low (2.4%), respondents with AOD/MH/DV service needs were three to five times as likely as those without such needs to have had a child placed in foster care. The rate was particularly high among those with AOD needs.

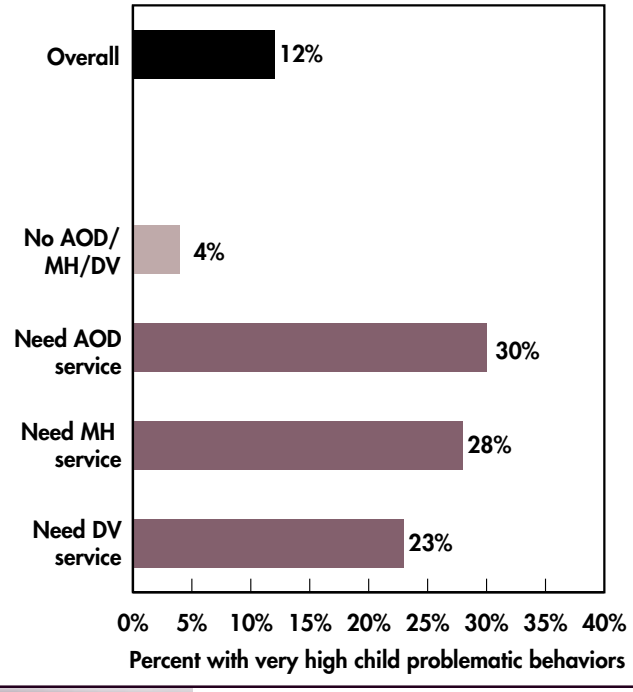
AOD/MH/DV and Child Behaviors and Schooling

This *Brief* presents outcomes for 282 families with a "focal child" between the ages of 7 and 17.

We measured five problematic behaviors and six school-related indicators, including whether the parent was contacted by the school about the child's performance, whether the child was held back a grade, whether the child was in special education, or was suspended or expelled. Taking these measures in the aggregate, the children of

mothers with AOD and MH service needs were significantly different from those without. Figure 7 shows the percentage of focal children age 7–17 in each group with very low (bottom 12% overall) behavior scores. In comparison with women who do not have AOD/MH/DV needs, those who do report very low scores six to seven times more often.

Figure 7: Very high scores on child behavior difficulties, age 7–17 —by AOD/MH/DV service needs



Based upon the findings of this research every effort needs to be made to identify and serve TANF families in which a parent suffers from AOD/MH/DV issues.

AOD/MH/DV and the cumulative threats to child well-being

The best predictor of poor developmental outcomes among children is often the *total* number of risk factors to which they are exposed. In this study we have measured 49 potential threats to children. The study population exhibited a range of two threats to as many as 29—the mean is 9.8. All three of the AOD, MH and DV subgroups experienced significantly more threats than did those without these issues.

The 15% of families with the highest number of risks (above 14.3 threats) were defined as having a "very high" number of threats.

Figure 8 compares the percentage in each subgroup with a very high number of threats—that is, over the 14.3 threats threshold.

Roughly twice as many families in the AOD (28%), MH (29%), and DV (32%) groups had more than 14.3 total threats as did the group as a whole. And the rates were five to six times as high as the 5% rate for families without any AOD/MH/DV condition.

Recommendations

The lives of a substantial minority of parents and children receiving TANF are precarious and excruciatingly difficult. AOD, MH and DV issues exacerbate an already difficult situation for a disturbingly large percentage of families. At present they must rely on a welfare system that is "reformed" but does not yet provide compassionate and helpful services for all TANF participants. This section presents recommendations to respond more effectively to the needs of TANF participants with AOD/MH/DV needs.

Policy changes

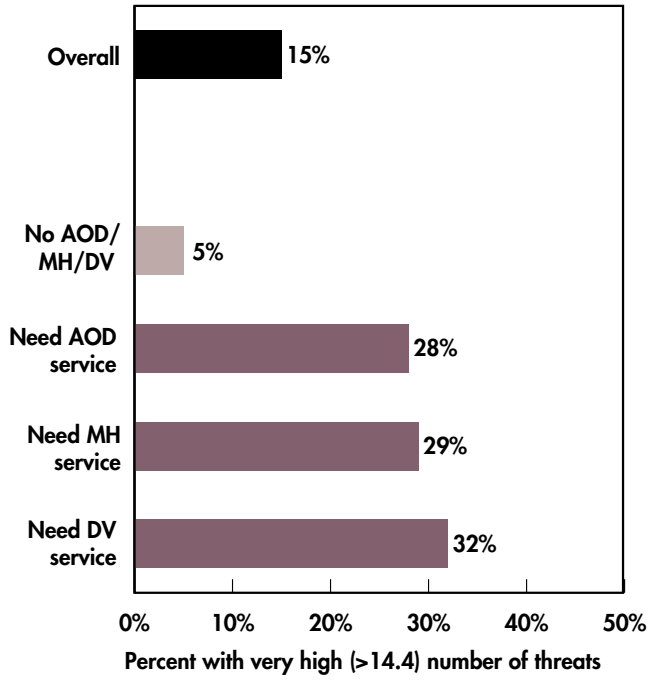
TANF reauthorization must be accompanied by enhanced and strengthened services to help diminish parental AOD, MH, and DV problems

- All TANF programs should be required to screen, assess, and provide services to recipients with serious AOD, MH, and DV issues.
- Hours spent receiving services for AOD, MH, and DV issues should count as allowable work activities for as long as necessary.
- The 60-month time clock should be suspended during any months in which a recipient is receiving AOD, MH, or DV services to overcome barriers to employment.

Practice changes

- *TANF programs should have a family focus.* Intake questions should consider the well-being of children. Referrals should be made for assessments and services when problems with children are identified. TANF caseworkers should determine whether the family is involved with other agencies and initiate linkages with those other agencies when possible, particularly for families involved with Child Protective Services.
- *AOD, MH, and DV programs that serve TANF parents also should encompass the needs of their children.* Given the high likelihood of threats to child well-being in these families, these programs should provide a range of general support services for children. These can include educational, recreational, and/or more therapeutic support activities. These programs also should ensure that any children with suspected problems receive thorough assessments and referrals to services. Ideally these general and specialized services for children could be obtained at the same program that serves the parents, or close collaborations should be formed with programs that provide the needed services for the children.

Figure 8: Women with a "very high" number (more than 14.3) threats to children in their families—by AOD/MH/DV service needs



- AOD and DV residential programs serving TANF recipients should include women and their children, and special programming should be designed to meet the children's needs.
- Close linkages need to be developed between TANF and child welfare programs, particularly in view of the higher likelihood of child placement among women with AOD problems.

RESPONDENT WITH MH NEEDS: "The 10-year-old doesn't want to learn in school. They're constantly calling from school for her. Then she did this, she did that, she don't want to learn, she don't want to listen, she's fighting, she's always doing something bad in school."

The CalWORKs Project

CalWORKs (California Work Opportunity and Responsibility to Kids) is California's implementation of the federal Temporary Assistance to Needy Families (TANF) program. The CalWORKs Project is a collaborative effort of the California Institute for Mental Health, Children and Family Futures, and the Family Violence Prevention Fund. Funding from the California Department of Social Services, voluntary contributions from California counties, the David and Lucile Packard Foundation, the California Wellness Foundation, and a grant from the National Institute of Justice support the Project's work. Additional information about the Project and products from the Project are available at **www.cimh.org** or by calling (916) 556-3480.

CalWORKs Project

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RESPONDENT WITH AOD NEEDS: "I wanted to tell them that I was an addict and I was in recovery but I didn't know how. I was afraid of what would happen if I did. But they worked with me on it. And I kept in touch with my TANF worker and saw her periodically, and they developed a plan for me, and then it's just worked out good."

Resources

Moore, K. A., M. J. Zaslow, C. Emig, and H. J Scarupa. April 2002. *The Unfinished Business of Welfare Reform: Improving Prospects for Poor Children and Youth, Perspectives from Research*. Child Trends. Available: **http://www.childtrends.org/**. [Effects of welfare reform on children.]

Sameroff, A. J., R. Seifer, A. Baldwin, and C. Baldwin. 1993. Stability of intelligence from preschool to adolescence: The influence of social and family risk factors. *Child Development 64:* 80–97 [Impact of multiple risks].

Lennon, M. C., J. Blome, and K. English. April 2001. *Depression and Low-Income Women: Challenges for TANF and Welfare-to-Work Policies and Programs*. Research Forum on Children, Families and the New Federalism, National Center for Children in Poverty, Mailman School of Public Health, Columbia University. Available: **www.researchforum.org.** [Effects of parental depression on children.]

Young, N. 1997. Effects of alcohol and other drugs on children. *J Psychoactive Drugs 29*(1): 23–42. [Effects of parental AOD on children.]

The Future of Children: Domestic Violence and Children. Volume 9, Number 3, Winter 1999. Eleven articles, recommendations and a bibliography. Available: **http://www.futureofchildren.org/pubs-info2825/pubs-info.htm?doc_id=70473**. [Effects of witnessing family violence on children.]

Chandler, D., J. Meisel, and P. Jordan. 2002. *Policy and Practice Brief #1: Mental Health, Domestic Violence and Substance Abuse: Need for and Use of Services Among Adult Female TANF Participants*. California Institute for Mental Health. Available: **www.cimh.org/calworks**.

Chandler, D., J. Meisel, and P. Jordan. 2002. *Policy and Practice Brief #2: Impact of Alcohol and Other Drugs, Mental Health Problems and Domestic Violence on Employment and Welfare Tenure*. California Institute for Mental Health. Available: **www.cimh.org/calworks**.