BARRIERS TO INDEPENDENCE AMONG TANF RECIPIENTS: COMPARING CASEWORKER RECORDS & CLIENT SURVEYS

PAMELA CAUDILL OVWIGHO, PHD
RESEARCH DIRECTOR

CORRENE SAUNDERS, BA
RESEARCH ANALYST

CATHERINE E. BORN, PHD
PRINCIPAL INVESTIGATOR

JUNE 2005

UNIVERSITY OF MARYLAND
SCHOOL OF SOCIAL WORK
525 WEST REDWOOD STREET
BALTIMORE, MD 21201

ACKNOWLEDGEMENTS

The authors would like to thank Kathy Patterson, Tamiko Myles, and Nikol Shaw for their work in coding all of the electronic case narratives for this report. We would also like to thank Dan Kott, Rennert Kane, and Jamie Haskel for their assistance in the collection and processing of the administrative data that was utilized.

This report was prepared by the Family Welfare Research and Training Group, School of Social Work, University of Maryland, 525 West Redwood Street, Baltimore, Maryland 21201 with support from its long time research partner, the Maryland Department of Human Resources. The survey data for this report comes from a study funded by the Office of the Assistant Secretary for Planning and Evaluation (ASPE), U.S. Department of Health and Human Services (Reference Grant No. 01ASPE367A) and awarded to the Maryland Department of Human Resources, on which the Family Welfare Research and Training Group was a subcontractor.

For additional information about the report or the study, please contact Dr. Catherine Born at the School of Social Work (410.706.5134, cborn@ssw.umaryland.edu). For more information about welfare reform in Maryland, please contact Mr. Richard Larson at the Department of Human Resources (410.767.7150, rlarson@dhr.state.md.us or welfarereformer@prodigy.net).

TABLE OF CONTENTS

LIST OF TABLES

EXECUTIVE SUMMARY

As states prepare for the reauthorization of the Temporary Assistance to Needy Families (TANF) program and the likely increased work participation requirements it will include, they are taking a closer look at the characteristics and circumstances of families receiving welfare today. There is also interest in reviewing current assessment protocols and practices to ensure that they are able to adequately and accurately identify barriers to employment which may interfere with clients' movement from welfare to work.

There is a wealth of empirical data examining the prevalence of common barriers to employment, such as a lack of child care and physical health problems, among welfare recipients. Studies have also explored the relationship of these barriers to welfare and employment outcomes. However, the literature has been conspicuously silent on one very important piece of the puzzle: the correlation between the presence of barriers as reported by clients to survey researchers and the identification of those same issues as employment barriers in clients' welfare agency files.

The present study addresses this important question by combining data from a telephone survey of a random sample of Maryland TANF customers receiving benefits in June 2002 (n = 819) with data from their case logs maintained by front-line welfare caseworkers. We compare employment barriers identified in the survey interviews to those documented by welfare caseworkers. We also explore whether discrepancies between the two sources are related to payee or case characteristics.

The goal of our project is <u>not</u> to find fault with front-line caseworkers or to suggest there are problems with their work. Rather, our intent is to provide empirical data that can help us all better understand the areas where clients' perceptions of employment barriers (as disclosed to survey researchers) and caseworkers' perceptions (as documented in case files) match and areas where discrepancies seem to exist.

In sum, our analyses revealed several important findings:

First, and foremost, we learned that, in general there is a good deal of correspondence between survey-generated identification of barriers and worker-documented employment barriers.

For all barriers except alcohol dependence, there was a statistically significant relationship between the survey data and the case narrative data. Raw agreement rates averaged 86.4%. Highest rates of agreement were found concerning evictions (91.1%), domestic violence (91.2%) and chemical dependency (90.8% to 97.6%). Lowest rates of agreement were observed for the three barriers most commonly self-reported by clients in the survey: child care (65.2%); transportation (74.8%); and payee physical health (76.4%).

The overall level of agreement is particularly remarkable for two reasons. First, there are a host of factors ranging from individual client characteristics and preferences to agency policies and practices that may influence whether clients choose to disclose the

presence of a particular barrier and/or whether the caseworker inquires about a particular topic during the intitial assessment and ongoing case management.

Second, for most barriers examined in this study, there is no one generally-accepted definition or measurement technique used by both researchers and welfare agencies. In fact, choice of a measurement approach is strongly influenced by one's goal. For researchers the goal has typically been to measure the prevalence of a particular problem or issue. For welfare caseworkers, the goal is a more limited and practical one: to identify those issues which interfere with this client's ability to work at this time.

On the other hand, the administrative data generally indicate lower prevalence rates for employment barriers than customers reported in their telephone interviews with researchers. These differences may arise from clients and workers having different views on whether or not a problem rises to the level of actually impeding or preventing the client from working.

The data revealed higher self-reported rates than caseworker-documented rates for all employment barriers examined here except evictions and chemical dependence. The largest discrepancies were found for child care (37.0% survey vs. 10.1% case narrative) and transportation (25.8% survey vs. 2.0% case narrative). These lower rates may arise from a variety of factors, including customers' willingness to disclose information to TANF workers, agency policies and practices regarding assessment, and the like. We also strongly suspect that some of the discrepancy in rates arise from different perceptions of the severity of various problems. In particular, anecdotal data suggests that, because Purchase of Care is available to pay the child care costs for welfare recipients and resources are available for identifying providers, welfare caseworkers do not generally see child care issues as employment barriers.

We also find that the degree of agreement between survey data and administrative data varies depending on the type of barrier and the way in which the barrier is measured (i.e., self-report vs. validated scale).

In general, problems or potential barriers identified via client self-report survey responses are more likely to be documented in agency case narratives than are problems such as mental health that were identified in the survey through the use of validated scales or measures. Notable exceptions are payee physical health and drug dependency, perhaps reflecting caseworkers' reliance on subject area experts (i.e. health care providers and addictions specialists) for assessment and verification of these types of issues.

In terms of client demographics, the general theme of our findings is that TANF recipients with administratively-documented employment barriers have a different profile than clients with no barriers or barriers revealed only in the survey. In particular, our findings regarding differences in employment and welfare history suggest that TANF caseworkers are generally identifying and documenting barriers among those who appear to be having the greatest difficulty in making the transition from welfare to work.

We find that on average those with agency-recorded barriers are older, began childbearing at an older age, have older children, and are more likely to be Caucasian. They are also less likely to be working, had worked fewer quarters in the past year, and had accumulated significantly more months toward the TANF time limit. Clients with survey-noted, but not administratively-noted barriers more closely resembled those who had no employment barriers indicated in either data source. In fact, the only noticeable difference between these two groups appear to be more related to clients' perception of barriers or problems, than to differences in disclosure or caseworker knowledge.

While generally encouraging, our results do suggest a few areas worthy of further attention and consideration:

1. **Universal engagement and increased work participation requirements increase the importance and need for workers to be able to accurately identify clients' employment barriers. It would be wise for policy-makers and program managers to review and refine existing client assessment, barrier detection and barrier removal protocols and processes.**

2. **There are certain key areas where the quality of information obtained during the front-line assessment process could be enhanced or improved by the use of validated scales or measures rather than reliance on client self-report. Mental health, alcohol dependence and domestic violence appear to be topics on which the use of such measures might be particularly beneficial.**

Although overall agreement rates between survey and administrative data are quite high across all barriers examined in this study, the percentage of "true positives" (i.e., those for whom a particular barrier was reported or assessed in the interview and documented in the case narrative) is generally low, never reaching more than 52% for any barrier. There are any number of possible explanations for why these discrepancies might exist. In particular, they may arise from the differing perceptions of clients and workers not about the existence of a particular problem, necessarily, but about its severity. That is, there is at least a suggestion in these data that clients may view themselves as being more impaired or impeded in their ability to work than workers do. It is beyond the scope of this paper to examine how these perceptual differences might affect welfare-to-work outcomes, but it seems reasonable to speculate that they do exert some degree of influence. To avoid misunderstanding and mutual frustration, it might be prudent to insure that, as part of the assessment process, clients are fully-informed about the purpose and results of the assessment and its implications.

Study findings also indicate that there are certain areas where front-line assessment protocols could be enhanced and the resulting profile data and case management/planning improved by the use of validated scales or measures, rather than reliance on client self-report data. Mental health, alcohol dependence and domestic violence, in particular, appear from this study to be topics on which the use of such measures could be beneficial.

3. More research is needed on the relationship between measures of employment barriers and TANF clients' actual employment and welfare utilization outcomes.

Despite the large body of empirical research documenting the prevalence of various employment barriers among welfare recipients, there is surprisingly little research on the relationship between these barriers and customers' actual welfare-to-work experiences, particularly in the post-PRWORA era. Much of the research that is available suffers from design problems that limit its usefulness in assessing causality. For example, some survey-based studies use employment status at the time of the interview as their "outcome" and try to predict this outcome based on client self-report of employment barriers at that time or in the previous year. Because the timing of the outcome and the predictors is confounded, it is impossible to determine if the barrier caused the current employment situation.

Our knowledge of the relationship between employment barriers and client outcomes would be greatly strengthened through the use of prospective, longitudinal studies. Of particular policy and program interest would be studies that link multiple sources of data on customers' self-reported barriers, caseworkers' documentation of barriers, and welfare outcomes. The next report in this series will do just that by examining the relationships among client self-report, caseworker documentation, and risk of sanctioning for non-compliance with work activities. As policy makers and program managers retool their TANF programs to best serve the welfare-to-work transition needs of a diverse caseload, empirical data from studies such as these can be invaluable in assessing options and choosing strategies.

INTRODUCTION

Despite continued uncertainty about when the Temporary Assistance to Needy Families (TANF) program will be re-authorized, there is little doubt that increased work participation requirements will be a feature of the final legislation. In preparation for this reality, states have begun to take a closer look at the characteristics and circumstances of families receiving welfare today. Existing client assessment policies and protocols have also come under review because of the heightened work requirements and the prevailing philosophy of universal engagement. In particular, there is interest in making certain that assessment practices and protocols are able to adequately and accurately identify barriers to employment which, if not uncovered and addressed, may prevent or at least interfere with the goal of moving clients from welfare to work.

To date, the literature on employment barriers has relied almost exclusively on client self-report to survey researchers. However, there is little information about the extent to which these same issues are known to clients' front-line welfare caseworkers and, if so, whether workers view them in the same way (i.e., as barriers severe enough to interfere with the ability to work). Moreover, while some studies have been able to link clients' self-reports of the presence of certain barriers with less positive welfare or employment outcomes, little research attention has been paid to the relationship between caseworker knowledge or perception of employment barriers and client outcomes. In short, while there is a wealth of empirical data examining the prevalence of common barriers to employment among welfare recipients, the literature has been conspicuously silent on one very important piece of the puzzle: the correlation between the presence of barriers as reported by clients to survey researchers and the identification of those same issues as employment barriers in clients' welfare agency files.

The present study begins to fill these gaps in the literature by utilizing a unique data set that combines client survey research data with agency administrative data, including case logs maintained by front-line welfare caseworkers. Specifically, the study compares employment barriers identified in survey interviews with TANF clients to those barriers documented by their welfare caseworkers and explores whether discrepancies between the two sources are related to payee or case demographics. The two central research questions addressed in the study are:

1. What is the correspondence between survey data and caseworker notes in the documentation of employment barriers?

2. Are there demographic differences among TANF clients who report no employment barriers, those for whom barriers have been identified and documented by their TANF workers, and those who disclose the presence of barriers to survey researchers, but whose agency records do not indicate the presence of barriers?

It is important to state unequivocally that the goal of this project is <u>not</u> to find fault with front-line caseworkers or to suggest there are problems with their work. Rather, our intent is to provide empirical data that can help us all better understand the areas where

clients' perceptions of employment barriers (as disclosed to survey researchers) and caseworkers' perceptions (as documented in case files) match and areas where discrepancies seem to exist. Ultimately, our goal is a practical and important one: we aim to provide information that can be used to enhance the tools available to workers in trying to identify barriers accurately and adequately and, in so doing, facilitate their ability to effectively carry out their case management functions and help clients successfully transition from welfare to work.

BACKGROUND

There are myriad differences between today's cash assistance program, Temporary Assistance to Needy Families (TANF) and its predecessor, Aid to Families with Dependent Children (AFDC). Perhaps the most fundamental of these is the change in the key task of local welfare agencies and their staff: from determining eligibility for income maintenance program benefits to assisting clients to become economically independent through employment (Orlin, Matto, Alstein, Born & Caudill, 1997). In other words, while AFDC was largely concerned with *check management,* TANF is primarily concerned with *case management*. This latter orientation is evidenced by the federal requirement that an initial assessment of all non-exempt TANF clients' skills be done and, in Maryland, that up-front assessments be done for all clients, exploring such issues as reasons for applying for aid, job readiness, skills, needs and potential barriers to employment.

The primary goal of assessment in the TANF era has been and remains to identify and remove barriers to work. A large body of empirical literature documents that potential barriers such as lack of childcare, lack of reliable transportation, and domestic violence are not uncommon among TANF recipients (see, for example, Danziger & Seefeldt, 2002; Hauan & Douglas, 2004; Pavetti, 2003; Zedlewski, 2003). However, the booming economy during welfare reform's early years, coupled with the reforms themselves, made it possible for unprecedented numbers of clients to leave welfare for work, notwithstanding the difficult personal circumstances which some families no doubt faced. The situation is somewhat different today. Industries in which low-income women, including TANF clients, typically find work have been slow to recover from recent downturns. Today's TANF clients, while not predominantly hard-to-serve, are at least different-to-serve than were clients in past years. Finally, work participation and other work-related federal performance expectations have been or soon will be significantly increased.

In this changed environment it is important to revisit the subject of barrier identification and thus, indirectly, the subject of client assessment. The most basic reason to do so is because effective case management requires good information. It is also true, of course, that decisions made by case managers based on barrier identification/client assessment have important impacts on customer and program outcomes. The present study, as noted previously, takes a look at one important, but little understood piece of the barriers-to-employment puzzle: the extent to which employment barriers perceived by clients and revealed to survey researchers correspond to barriers identified by those clients' workers and documented in welfare agency files. Despite the many surveys that have been done and measures that have been created for assessing employment barriers among TANF clients, there is little to no published research on the correlation between survey-documented barriers and case record-documented barriers. The remainder of this chapter reviews literature related to this important question.

Client Disclosure to Welfare Caseworkers

There are a host of factors ranging from individual client characteristics and preferences to agency policies and practices that may influence whether clients choose to disclose the presence of a particular barrier and/or whether the caseworker inquiries about a particular topic during the initial assessment and ongoing case management process. From the clients' perspective, several considerations may influence their decisions to reveal or not reveal certain information to the welfare agency. These factors include a lack of self-awareness or willingness to admit the presence of a particular problem or issue, their degree of comfort or rapport with the caseworker, and the perceived risks and benefits of revealing the information (U.S. Department of Health and Human Services, 2001). All else equal, it seems reasonable to expect that clients will be less likely to share information or admit to issues that may lead to a decrease in benefits or possible investigation by Child Protective Services. On the other hand, all else equal, they will more likely reveal problems that have the potential to exempt them from certain program requirements or which they think can be addressed through welfare agency resources.

Caseworkers may also be less likely to inquire about certain issues than others. Some may not have the training and skills necessary to assess sensitive issues such as mental health, drug dependency, or domestic violence (Bane & Ellwood, 1994). Regardless of their training, caseworkers may not feel comfortable or may not believe that addressing these issues is part of their job duties. Moreover, the value that caseworkers place on client-provided information about possible barriers and the options they have for dealing with particular barriers in case management may also vary. It is quite possible, to illustrate, that the client and her worker both agree that a certain problem exists, but differ in their perception of whether or not that problem is severe enough to preclude or interfere with the client's ability to work. Moreover, some caseworkers may believe that everyone - whether on welfare or not - faces challenges in balancing work and family and that recipients need to work out life problems on their own. Alternatively, even if caseworkers believe a particular issue is a problem or potential barrier, there may be a lack of resources available in the community to address it. With nowhere to direct the client for help, caseworkers may be reluctant to pro-actively seek to elicit information regarding a particular problem.

Accurate assessment of and information about clients' employment barriers is obviously critically important to the success of workers' and clients' joint efforts to move the latter from welfare to work. Unfortunately, the field knows little about the congruence or lack thereof between worker and client perceptions of work impediments. The very limited literature that does exist on the subject pertains to the issue of domestic violence and all studies have reached the same general conclusion. Despite surveys that consistently find a high incidence of domestic violence among cash assistance recipients, very few women disclose family violence to their TANF caseworkers (Hetling & Born, 2002; Hetling, Saunders & Born, 2004; Lennert, 1997; Raphael & Haennicke, 1999; Tolman & Raphael, 2000). The present study expands this literature by comparing interview and administrative data on the prevalence of a variety of potential employment barriers.

Measurement & Prevalence of Barriers in Client Surveys

In the few studies that have examined caseworker knowledge of welfare recipients' employment barriers (specifically, domestic violence), prevalence rates of those barriers calculated from client survey or interview-based studies are generally considered the "gold standard." That is, if the administrative data do not indicate that the customer has a particular barrier or problem, it is generally concluded that the welfare agency "missed" detecting this barrier or the customer chose not to disclose it. However, it is important to note that the extent to which survey data can provide an accurate estimate of the prevalence of barriers depends largely on the methods used to collect the data, including how barriers are measured and how the sample is identified.

Table 1, following this discussion, summarizes the recent literature on the prevalence of employment barriers addressed in the present study including: child care; transportation; housing instability/eviction; physical and mental health; child's health; substance abuse; and domestic violence. The table aptly illustrates that estimates of the prevalence of specific employment barriers from client surveys vary widely, depending largely on how they are measured.

Typically barriers are measured by asking welfare recipients directly about the types of struggles they face. Prominent national studies, such as The National Survey of American Families (NSAF) and the Current Population Survey (CPS) utilize direct questioning to examine some types of barriers. In the Office of the Assistant Secretary for Planning and Evaluation (ASPE) funded TANF caseload survey, customers were asked directly if "X" (e.g., child care, transportation, etc) had been such a problem in the previous year that it interfered with their ability to work or participate in training activities. Findings from these types of questions indicate that about one-third of customers had childcare problems and about one-quarter had transportation problems (Hauan & Douglas, 2004).

While this type of direct questioning measurement may be appropriate in some instances, especially regarding human capital barriers (education, work experience, and job skills), more sophisticated measures may be needed to identify sensitive issues (e.g., mental health) that recipients are unlikely to either be knowledgeable of or to disclose. In addition, the "one direct question" approach does not yield much information on the severity or degree of the barrier or whether it is short-term or long-term. For example, in the ASPE funded TANF caseload survey, one customer may have answered that child care problems had interfered with her ability to work in the previous year because the day care center closed early three times in one week. In contrast, another customer may have answered yes to the same question because she has a child with special needs and no care providers in her area can take special needs children. Both would be coded in the survey as having a child care barrier, although the second customer's problem is clearly more severe and long-term than the first customer's and, all else equal, probably much more likely to impede her transition from welfare to work.

A second, arguably less subjective, measurement approach defines the existence of a particular barrier based on clients' responses to questions related to the presence or

absence of specific resources or events. For example, in the Women's Employment Study, welfare recipients were identified as having a transportation problem if they either did not have access to a car and/or did not have a driver's license during both waves of the survey (fall 1997 and fall 1998). By this definition, about three out of ten (30.2%) sample members had a transportation barrier (Danziger & Seefeldt, 2002). Similarly, the TANF caseload survey defined clients as having unstable housing if they had moved at least twice and/or been evicted within the past year; on average, about one-quarter of current TANF recipients had this barrier by this definition, with a range from 13% in Washington, DC to 31% in Colorado (Hauan & Douglas, 2004). In general, these types of composite measures have not been tested as predictors of welfare and employment outcomes (see Nam, 2005 for one exception).

Finally, some studies utilize previously validated scales or tests within the context of a survey. Specifically, researchers have begun to include in-depth measures from the fields of psychology and medicine to assess physical and mental health, alcohol and drug abuse, domestic violence, and other barriers that may be difficult to observe and for recipients to directly disclose. Examples of these types of measures include the Physical Functioning Scale of the Medical Outcomes Study Short-Form Health Survey (SF-36), the Kessler K-6 Non-Specific Psychological Distress Scale, and the Alcohol and Drug Dependence Scales of the Composite International Diagnostic Interview Short-Form (CIDI-SF). In general, analyses conducted using these types of scales reveal higher prevalence rates than direct questions. For example, in the federally-funded Maryland TANF caseload survey, 28.9% of respondents scored in the clinical range for either depression or serious psychological distress, but only 16.2% indicated that a mental health issue had interfered with their ability to work or participate in work or training activities (Ovwigho, Born, Ferrero, & Palazzo, 2004). However, validated scales do not always produce higher prevalence rates. In the same study, more clients reported that their health had interfered with work or training activities in the past year than scored in the lowest quartile of the standardized measure. Almost three out ten respondents self-reported a physical health barrier (28.6%), but only one-fifth (20.9%) met the researcher-defined criteria of having self-reported fair or poor health and scoring in the lowest quartile of physical functioning.

Table 1. Prevalence of Barriers to Work Among TANF Recipients

Logistic & Situational Barriers			
Barrier	**Prevalence Rates**	**References**	**Measurement**
Child Care	16.7% - 42.0%	Hauan & Douglas, 2004; Norris & Speiglman, 2003	need more child care; child care problem prevents participation in work, education, or training
Transportation	20.0% - 36.0%	Danziger, 2002; Hauan & Douglas, 2004	no car or license; transportation problems caused to leave job or prevented from taking a job or attending education or training
Housing	13.0% - 31.0%	Hauan & Douglas, 2004; Wood & Rangarajan, 2004	moved in with others, moved at least twice, evicted, lived in an emergency shelter, homeless
Personal & Family Barriers			
Barrier	**Prevalence Rates**	**References**	**Measurement**
Physical Health	10.6% - 35.7%	Danziger, 2002; Hauan & Douglas, 2004; Norris & Speiglman, 2003; Zedlewski, 2003	self-reported health status, health interferes with work; health limits daily activity; Physical Functioning scale of the Medical Outcomes Study Short-Form Health Survey
Mental Health	16.1% - 41.0%	Danziger, 2002; Hauan & Douglas, 2004; Moffitt, Cherlin, Burton, King & Roff, 2002	major depression (Brief Symptom Inventory); post-traumatic stress disorder; generalized anxiety disorder, social phobia, non-specific psychological distress
Child Health	5.7% - 36.0%	Danziger, 2002; Hauan & Douglas, 2004; Zedlewski, 2003	receiving SSI on behalf of child; child has a health, learning or emotional problem;
Substance Abuse	1.0% - 13.1%	Chandler, Meisel, & Jordan, 2003; Danziger, 2000; Hauan & Douglas, 2004; Pollack, Danziger, Jayakody, & Seefeldt, 2002	self-reported substance dependence or abuse diagnosis; self-reported use of or need for services; related employment problems; under influence during interview; Substance Dependence Scales
Domestic Violence	1.6% - 70.0%	Danziger, 2002; Hauan & Douglas, 2004; Moffitt, Cherlin, Burton, King & Roff, 2002	Conflict Tactics Scale, past year, lifetime

Summary and the Present Study

As demonstrated, variations in measurement techniques can lead to quite different conclusions about the prevalence of specific barriers to employment among welfare recipients. Table 1 shows that the widest range exists in the measure for domestic violence (1.6% to 70%), most likely because of differences in the types of questions asked and how the barrier was defined (i.e., "in the past year" vs. "ever in your lifetime"). Furthermore, barrier rates derived from the Women's Employment Study tend to be somewhat lower across most barriers, than in other studies, perhaps because of a focus on the persistence of barriers over several years rather than a cross-section of a particular sample at one point in time. On the other hand, despite similar questions and barrier definitions in each of the six state studies funded through ASPE, prevalence rates are consistently lower for the Washington, DC sample and consistently higher for the Colorado sample, indicating that even with an established measurement tool, results can vary.

METHODS

This chapter describes the methods used in our study including the sample, the various types of data, and techniques used for comparing reported and identified barriers.

Sample

The sample used in our analyses was drawn from a broader study of employment barriers sponsored by the Office of the Assistant Secretary for Planning and Evaluation (ASPE) of the US Department of Health and Human Services (Ovwigho, et al., 2004). Originally, 1,146 participants were randomly selected from the universe of single-adult Temporary Cash Assistance (TCA) cases active in June 2002 (N=15,867). Cases were eligible for selection if they had one adult and at least one child included in the welfare grant. The sample was stratified on jurisdiction (Baltimore City versus non-Baltimore City cases). For the purposes of this study, we chose to only include those cases in which the payee took part in a telephone survey that was conducted between August and October 2002 (n=819, 71.5% response rate). In addition, all data presented in this report are weighted to represent the true proportion of Baltimore City and non-Baltimore City cases in the June 2002 caseload.

Data

In the present study, we combine data from a variety of sources. Information concerning client-reported and researcher-defined employment barriers is drawn from client surveys conducted as part of the original TANF caseload study. State administrative systems provide data on caseworker-identified employment barriers and welfare participation. The following sections describe each of these data sources in more detail.

Survey Data.

Survey data used in this report are based on interviews conducted using the TANF Caseload Survey Instrument[1] during the months of August through October 2002. Interviewers utilized computer-assisted telephone interviewing (CATI) to conduct the survey, which averaged 35 minutes in length and was completed only in English and only with sample members (no proxies were used). Questions in the survey covered a wide variety of topics, including family composition, employment history, job training, education, earnings, and employment barriers. Reported barriers were grouped into three categories: 1) human capital deficits, including education, work experience, and job skills; 2) personal and family challenges, including physical and mental health, learning disabilities, criminal records, language barriers, chemical dependence, and domestic violence; and 3) logistical and situational challenges, which included transportation, child care, unstable housing, and neighborhood characteristics. Specific questions and scales used to measure these barriers are presented in Table 2, on the next page.

[1] This instrument was developed by Mathematica Policy Research, Inc. (MPR) with input from six ASPE grantees who participated in the original study.

Table 2. Measurement of Barriers from Survey Data

Barrier	Description of Measure
Child care	In the past 12 months, was child care or lack of child care ever such a problem that you could not take a job or had to stop working, or could not attend education or training activities?
Transportation	In the past 12 months, was transportation ever such a problem that you could not take a job or had to stop working, or could not attend education or training activities?
Housing	During the past 12 months, was your housing situation ever such a problem that you could not take a job or had to stop working, or could not attend education or training activities?
Housing (Researcher Defined)	Defined as having unstable housing if moved 2 or more times in the past year or was evicted.
Eviction	Respondent reported having been evicted at least once in the past year.
Payee Physical Health	During the past 12 months, was your physical health ever such a problem that you could not take a job or had to stop working, or could not attend education or training activities?
Payee Physical Health (Researcher Defined)	Physical Functioning Scale of the SF-36; Defined as having a physical health problem if self-rated health as fair or poor AND physical functioning score was in the lowest quartile by age and gender.
Payee Mental Health	During the past 12 months, was your mental health ever such a problem that you could not take a job or had to stop working, or could not attend education or training activities?
Payee Mental Health (Researcher Defined)	6-item K6 Non-Specific Psychological Distress Scale; World Health Organization Composite International Diagnostic Interview Short-Form (WHO CIDI-SF) for a Major Depressive Episode; Defined as experiencing nonspecific psychological distress OR having major depression
Child's/Other Family Member's Health	Does your child have a health, behavioral or other special need? Do have an elderly, disabled, or sick family member or friend you are caring for? During the past 12 months, was this ever such a problem that you could not take a job or had to stop working, or could not attend education or training activities?
Alcohol/Drug Dependence	During the past 12 months, was your use of alcohol/drugs ever such a problem that you could not take a job or had to start working, or could not attend education or training activities? Have you been diagnosed as having a drug or alcohol use problem in the past year?
Alcohol/Drug Dependence (Researcher Defined)	WHO CIDI-SF for alcohol dependence and for drug dependence; Defined as having alcohol/drug dependence if reported having 3 or more of the 7 symptoms of the CIDI-SF for alcohol dependence or drug dependence.
Domestic Violence	During the past 12 months, was your relationship with a current or past husband, boyfriend, or partner ever such a problem that you could not take a job or had to stop working, or could not attend education or training activities?
Domestic Violence (Researcher Defined)	16-question Conflict Tactics Scale for interpersonal violence (modified version); Any moderate or severe threats or violence within the past year.

Administrative Data.

Traditional administrative records and unique case narratives from Maryland automated data systems complement the survey data and provide information about cash assistance program participation and caseworker identification of employment barriers. Data are drawn from data systems used for programs under the purview of the Maryland Department of Human Resources. Our earlier report describes these systems in detail, particularly in relation to program participation (Ovwigho, et al., 2004). New to this study is the use of caseworker logs or case narratives within the Client Automated Resource and Eligibility System (CARES). The next sections describe this data source and the coding procedure.

CARES Case Narratives.

In CARES, caseworkers can access a free-form space in which they can narrate their interactions with case members. While some case aspects must be documented in the case narrative (e.g., verifications requested), caseworkers are free to enter any information they feel relevant. In fact, CARES case narratives have been shown to be a rich source of information about family circumstances and challenges (Ovwigho, 2001).

Narrative Coding Procedure.

The narratives were examined for both personal/family, and logistical/situational challenges recorded by the caseworker. These challenges, or barriers, include child care, transportation, housing, physical and mental health of the client and the client's children, chemical dependence, and domestic violence. Each narrative was read by one of three coders who carefully examined the information recorded within the time frame for this study (July 2001 to December 2002). This time frame was based on the fact that most of the survey questions concerning these barriers referred to the year before the interview. In addition, we wanted to ensure that the narrative period included at least one time frame when the client was likely to meet with her caseworker. Because all sample members were receiving assistance in June 2002 and cases are typically certified for six months, all clients met with their caseworkers at least once between January and December 2002.

Coders were given a standard set of instructions, and a pre-test was conducted in which the three coders all coded the same set of ten narratives and came to consensus on their ratings. In short, if mention was made of any of the specific barriers during the sampled time period, the barrier was coded as "yes", and if there was no mention, that barrier was coded as "no". Table 3, following, highlights some examples of narrative text that was coded as indicating specific barriers.

Table 3. Examples of Barrier Coding in Case Narratives

Topic	Narrative Example
Child care	Customer applying for assistance for herself and one child age 4. TCA was sanctioned in 11/00 due to customer's non-compliance with work activity...needs to be current before customer can receive cash assistance. No income or assets reported. Customer reported employed as of three weeks ago. She quit due to daycare problems.
	Customer seen for WOMIS; customer has barrier - child care. She needs someone to take six-year-old to and from school. Also needs care for eleven-month-old, two-year-old, and four-year-old all day, and eight-year-old after school. Customer given number to Child LOCATE [*local child care referral agency*] prior and did locate two such persons. Customer completed child care application. Customer given appointment for next month because customer had nursing assistant license but it expired. Customer allowed work exemption for one month for barrier removal.
Transportation	Client in to reapply for TCA/FS for self and 2 children. Client states she is unemployed and last worked 2 weeks ago. Client states she stopped/voluntarily quit due to transportation difficulties.
	Returned telephone call to client from phone # left on worker's voicemail, which states she doesn't understand reason for denial. Advised her of reason; She states she did bring in Absent Parent information, but did not go to [*work activity*] due to illness and a car accident taking her means of transportation.
Housing Instability	Customer has moved to a new district - Received the rental verification form incomplete, after requesting it several times. Customer is evasive about her living arrangement and since telephone number is not active, we are unable to verify legitimacy of her address. Rent amount not allowed. Case set up for transfer to new district.
	Customer in today to inquire about housing assistance and apply for TCA. Customer had requested that her case be closed two months ago due to employment. Since then, customer has moved to a different county and then returned. Upon her return, there were no positions available at her place of employment. Ms. L has been conducting a job search, as well as finding permanent housing. Ms. L is receiving assistance through section 8, as verified through a telephone call to landlord.
Eviction	Client in the office today to apply for eviction assistance. The client is stating that she does not have an eviction notice, she was living with her father and unable to pay the rent and the father put her out. The client is stating that the son is staying with her daughter and she is sleeping in her van. The client did apply for a job with [*local retail store*] and is waiting on an answer, at this time the client is homeless.
	Ms. S kept the TCA/FS application appointment today. Ms. S had lived at the same sect. 8 house for 20 yrs. and she was evicted last week. She is now living with her parents in private housing.
Physical health	Client in for redetermination appointment for TCA and FS for self and three children. She was in a few months ago and submitted all required info. She is currently under doctor's care for depression, sleep disorder and breathing problems. She applied for SSI but was denied and has reapplied.
	Customer came to discuss work opportunity. She provided a 12 month medical which would exempt her from participating in a work program.
Child's Physical Health	Customer in office applying for TCA for herself and her 2 children – 4 yrs old and 2 yrs old. Ms. Z reports she is no longer employed last worked over one year ago. States due to child's illness and her needing to provide care for him she lost her job. Reports she has applied for SSI for 2 yr old several weeks ago.
	Customer in office for TCA/FS redetermination appointment Household consists of customer, son X, son Y who just started receiving SSI, and son Z who is 21 yrs old and not working. Customer states she is limited in her availability to work because her son Y who is on SSI has a seizure disorder. Medical evaluation form requested (questions added about whether customer is needed in the home and whether she can leave the home to work).
Mental health	Psychological evaluation came back for Ms B. Per DORS [*Maryland's Division of Rehabilitation Services*] representative, Ms B. may be too disabled to work with DORS. She will let worker know the status when determined. Evaluation indicates Ms B has a history of bipolar disorder and a history of drug abuse. She appears to be in remission for the drug/alcohol use.

Topic	Narrative Example
	Customer in to agency to apply for TCA. Household consists of customer and two children – 4 years and 8 months old. Customer's son was killed in a house fire six months ago. She blames herself and is dealing with the grief and the guilt. A grief counselor suggested that she spend as much time as possible with her own mother and that is why she took the job in the school cafeteria where her mother works.
Child's Mental Health	Customer in office for TCA/FS redetermination interview for self and 4 children. The 15 yr old had been off the case because he had been in custody of juvenile services. Customer states he has returned home and is adding him back on the case today.
	Client returned verification that she is needed in the home to care for her daughter who was diagnosed with bipolar disorder and mother is needed in the home to supervise and work with mental health providers to stabilize her daughter's mood and behavior.
Alcohol Abuse	Wage form received from employer…Ms. K was fired for falling asleep while working. Received notice that Ms. K admitted to a substance abuse problem--alcohol. She has been referred to the health department for assessment.
	Customer in office to discuss work activity as scheduled. Reassessment completed. Customer is now routed to [*Substance Abuse assessment*] and must return for a new plan. Several times customer has come to office appearing to be intoxicated. In addition to that, customer continuously fails to participate at [*work activity location*] with one of the reasons being customer failed to comply with urine test. Further, another staff member had to intervene when customer came in appearing to be intoxicated and incoherent.
Drug Abuse	Customer participated in full substance abuse assessment today. Worker reports that customer presented for urinalysis screen at the health department yesterday. Customer agreed to enter outpatient treatment. Case to be assigned to treatment. Customer was instructed to attend orientation where she will get her group assignment. Customer understands that if she has future positive urinalysis screens, she will be referred to a more intensive drug treatment group.
	Customer did not return call - mailed another pre-sanction letter w/appointment date and time. If she does not show this time, process 501 [*1st offense full-family work sanction*]. Notice received stating customer was admitted in methadone maintenance & she is able to work….No show for appointment today - referred to worker for 501 closing. Per previous narration customer was to be permanently ineligible for Food Stamps due to possession of controlled dangerous substance & prostitution.
Domestic violence	Client into agency to apply for TCA & FS for herself and one child. Zero resources. Client is currently residing in shelter under their domestic violence program. Client was employed, but states that she stopped working two months ago. Client is exempt from work requirements due to domestic violence exemption.
	Customer did not show for mental health appointment. Worker received call from customer stating she would like to go to a shelter due to violence. Worker contacted shelter and took customer over there today.
Other barriers - caring for others in the home	Ms. W has provided the letter from the doctor stating that she is needed in the home to care for her mother. The customer is exempt from work requirements at this time.
	Customer is in for TCA/FS interview. Claims no income or assets, lives with fiance. Fiance receives SSI. Was working at until five months ago when she had to leave work to take care of her fiance.

Inter-Coder Reliability.

For coding, the 819 narratives were separated into forty sets of 25 narratives and one set of nineteen. Each set, except the first and the last, overlapped the sets before and after by five cases each, for a total of ten cases out of 25 and 200 cases out of the total sample of 819, a total quality control set of 24.4%. Each set was coded by one of the three coders. The like cases in the quality control sets were compared and if a discrepancy was found by the quality control checker, the narrative was re-read to find a justification for a "yes" answer. The Project Director then made the decision as to how to code the case. The Project Director also calculated the coder agreement rate for each set of 25 narratives. This was calculated as (# of comparisons – # of discrepancies) / (# of comparisons). The agreement rate between the three coders ranged from 91.85% to 100.00%, with an overall average of 97.89%.

Analysis

Data were analyzed using descriptive statistics. Specifically, frequency tables were created to summarize sample members' information, and measures of central tendency (mean, median, and mode) were used to describe sample members' characteristics and trends. Chi-square and analysis of variance tests were used to test for differences between groups of survey disclosers and caseworker-identified recipients with barriers. Finally, the Spearman Rho correlation coefficient was used to evaluate agreement between survey and administrative identification of barriers. The next chapter summarizes our findings.

FINDINGS: COMPARING CASE NARRATIVES AND SURVEY DATA

In this chapter we present findings related to our two research questions:

1. What is the degree of correspondence between survey data and caseworker notes in the identification of barriers to employment?

2. Are there demographic differences among TANF clients who report no employment barriers when surveyed, those for whom these same barriers have been identified and documented by their TANF workers, and those who disclose barriers to survey researchers, but whose agency records do not indicate those barriers?

We begin our discussion by looking at the extent to which survey data and administrative data do and do not agree, depending on whether the barrier was identified by clients' responses to simple direct questioning (i.e., self-reported) or by their scores on a more sophisticated measure or scale (i.e., researcher-assessed).

Correspondence of Survey Interview & Administrative Case Narrative Data

Self-Reported Barriers.

The first set of analyses concerns the degree to which client survey data and agency administrative data (i.e., narratives) match for barriers where the survey response was elicited through obvious, direct questioning. A typical question of this type would be "during the past 12 months, was your physical health ever such a problem that you could not work or had to stop working, or could not attend education or training activities?". Results are shown in Table 4, which follows this discussion.

As illustrated in the first column of Table 4, in the survey research interview child care was by far the most common self-reported employment barrier. Almost two-fifths (37.0%) of TANF caseheads in our sample told the research interviewer that child care had been such a problem in the past year that it had interfered with their ability to work. Physical health and transportation problems were also not uncommon. Almost three of ten payees (28.6%) said their own health had been problematic and about one in four (25.8%) reported transportation was an employment barrier for them. Not surprisingly, very few clients disclosed alcohol or drug use as employment barriers when directly asked about these matters. Not quite one in ten (8.3%), however, did tell the research interviewer that they had been diagnosed with a substance abuse problem.

The second column of Table 4 shows the percentage of TANF clients for whom each of these same problems was documented in the agency's administrative records (i.e., case narratives). Overall, Table 4 shows that the case narratives indicate markedly lower barrier prevalence rates than the self-reported survey data. Nonetheless, although the rates were lower, the two most commonly identified problems in the administrative data were payee's physical health (15.5%) and child care (10.1%), the same 'top two' self-reported problems, though in reverse order, from the research survey.

Interestingly, the administrative data indicate a higher prevalence than the self-reported survey items for two particular barriers: evictions and substance abuse. Although it was self-reported as a problem by only 4.4% of survey respondents, eviction was documented as an issue in 6.5% of clients' case narratives. In terms of substance abuse, nearly one in ten case narratives indicated a drug abuse problem (8.9%) or any type of substance abuse problem (9.4%). These rates are nearly three times higher than the rate of self-disclosure during the research interview. Notably, these rates are comparable to the percentage of clients (8.3%) who indicated during the research interview that they had, at some point in time, been diagnosed with an alcohol or drug problem.

Because caseworkers are largely dependent on what clients report to them, it is especially vital to know if clients are effectively communicating their self-perceived barriers to workers as they are to survey researchers. Thus, the final three columns in Table 4 provide various measures or indicators of the agreement or lack of agreement between the self-reported survey data and the administratively-recorded case narrative data. The agreement rates in the third column of the table refer to the percent of total cases where the survey data and the administrative data agree either that the client did not have a particular barrier within the last year, or that she did. Table 4 shows that, regardless of the specific barrier, the two sources of data coincided in the majority of cases (mean rate of agreement=86.4%). Highest rates of agreement were found among evictions (91.1%), domestic violence (91.2%), and all of the chemical dependence measures (range from 90.8% to 97.6%). Curiously, the lowest agreement rates were observed for the three barriers most commonly self-reported by clients in the survey data: child care (65.2%); transportation (74.6%); and payee physical health (76.4%).

These high rates of agreement appear heartening at first glance, but must be interpreted with caution because these "raw" agreement rates are strongly influenced by the overall prevalence of the barrier. That is, agreement rates will be higher by chance for barriers which occur very infrequently and for those which are very common. For example, if none of the case narratives documented alcohol problems, the agreement rate would be 97.8%, that is, all cases (100%) minus the 2.2% of clients who reported an alcohol abuse diagnosis in the survey.

Because of the mathematical relationship between prevalence rates and raw agreement rates, the last two columns of Table 4 provide a better assessment of the actual correspondence between the self-reported survey data and the administrative data. The fourth column presents the percentage of cases where the worker documented the barrier in the case narrative for clients who had reported that same barrier in the research interview. These figures provide an estimate of the measurement sensitivity of the case narratives - that is, for each barrier, how often do caseworkers identify a problem or barrier that the client has self-reported to others?

As the fourth column in the table shows, the answer to this question varies dramatically, depending on the barrier that is being considered. The greatest degree of congruence between clients' self-report of a barrier to work and caseworkers' determination that said barrier exists is found in the area of substance abuse/use. The administrative data document a substance use/abuse barrier in about half the cases (50.0%) where this

was self-reported as an employment barrier in the research survey. Payee health was noted as a barrier in about one-third (35.9%) of cases where the client told the research interviewer it was an employment impediment. Child care, eviction and child health issues were each documented as barriers in about one-fifth of cases where these had been self-reported as interfering with work or training.

Finally, the last column in Table 4 displays Spearman Rho coefficients for the relationship between survey self-reports and administrative assessments for each barrier.[2] All coefficients are statistically significant from zero, indicating that there is a statistically reliable relationship between clients' self-reports in the survey and their caseworkers' determination that a barrier exists. The highest correlations are found for drug use and any substance abuse diagnosis.

[2] Spearman's Rho is a product-moment correlation coefficient, similar to Pearson's r and interpreted in the same way. Spearman's Rho is used when cases are ranked on two variables, as is the case here.

Table 4. Self-Reported Barriers Versus Caseworker Documentation

Barriers	Indicated by Respondent	Documented by Caseworker	Agreement Rate	% of Survey 'yes' w/Admin 'yes'	Spearman Rho
Logistic & Situational					
Child Care	37.0%	10.1%	65.2%	19.5%	0.226***
Transportation	25.8%	2.0%	74.6%	4.7%	0.120**
Housing-Eviction	4.4%	6.5%	91.1%	22.2%	0.162***
Housing-Instability	13.9%	4.5%	84.7%	10.5%	0.151***
Personal and Family Barriers					
Physical Health					
Payee	28.6%	15.5%	76.4%	35.9%	0.376***
Child	15.3%	6.3%	84.6%	21.6%	0.283***
Other family member	11.0%	0.7%	89.4%	5.5%	0.153***
Mental Health					
Payee	16.1%	4.5%	83.5%	12.9%	0.218***
Child	16.4%	2.5%	84.6%	10.4%	0.204***
Chemical Dependence					
Alcohol	NA	NA	NA	NA	NA
Alcohol - Ever Diagnosed	2.2%	0.5%	90.8%	5.9%	0.181***
Drugs	3.1%	8.9%	91.4%	52.0%	0.248***
Drugs - Ever Diagnosed	7.3%	8.9%	97.6%	48.3%	0.371***
Any	3.2%	9.4%	90.8%	50.0%	0.230***
Alcohol or Drugs - Ever Diagnosed	8.3%	9.4%	90.1%	47.1%	0.376***
Domestic Violence	8.0%	2.8%	91.2%	15.2%	0.235***

Note: The data for self-reported alcohol problems are not presented because only one respondent reported that alcohol interfered with her ability to work in the past year.
**p<.05, **p<.01, ***p<.001*

Researcher Assessed Barriers.

As discussed previously, some researchers have used validated scales or measures, rather than simple direct questioning to assess employment barriers among TANF recipients. Many welfare agencies, too, recognize the importance of scientifically sound measures and are beginning to include various scales in their client assessments or to refer clients to subject matter experts for screening and assessment.

The use of more sophisticated measures or scales may be particularly appropriate for sensitive or complicated topics such as physical health, mental health, substance abuse and domestic violence. These measures can be advantageous over direct, self-report items, too, because the determination that a problem does or does not exist is not based on the client's admission, but on the client's score across several, often more subtle, items. Moreover, when validated instruments or scales are used, one can have a greater degree of confidence in the results obtained.

The survey instrument used in this study contains a number of validated, widely-accepted scales. In this section of the chapter and in Table 5 which follows, we present data on the degree of agreement between barriers assessed during the interview using scale measures and barrier identification as documented in the electronic agency case narratives. Similar to the preceding table, Table 5 includes prevalence rates for each barrier as calculated from the survey scale data and the case narratives, along with three indicators of agreement between the two data sources. As was true for the self-reported barriers presented earlier in this chapter, we find statistically significant relationships between the researcher-defined barriers and caseworker-defined barriers for all categories except alcohol dependence.

For the first set of barriers, logistical and situational challenges, survey respondents were asked several questions related to their housing experiences over the past year. Based on the methodology of the Women's Employment Study (WES), researchers defined a sample member as having unstable housing if she reported moving more than two times, or being evicted at least once, within the past 12 months. In about 80 percent of cases (80.7%), there was agreement between the researcher-assessed and caseworker-assessed finding (i.e., that this was or was not a barrier). This is a somewhat lower rate of agreement than was found for the direct, self-report questions regarding housing problems that interfered with work or training, but a slightly higher percent of survey disclosers whose housing problems were known to the agency worker and documented in the case narrative (12.8% vs. 10.5%).

Personal and family challenges assessed in the survey through use of validated measures include payees' physical health, mental health, chemical dependence and domestic violence. Physical health was assessed both through self-reported health status and a series of questions about physical functioning from the SF-36 Health Survey. A health problem was adjudged to exist if the respondent self-rated her own health as either fair or poor *and* her physical functioning score was in the 25th percentile or less for her age and gender. Using this definition, one-fifth (20.3%) of TANF payees were deemed to have a physical health barrier to employment; this is noticeably less than the 28.6% or almost three in ten who, in direct questioning, self-reported that their

own health problems had interfered with their ability to work. In more than eight out of ten cases (82.7%), there was agreement between the research finding and the case narrative. Moreover, health problems were documented in case narratives for more than two-fifths (42.8%) of clients 'diagnosed' with a health problem using the research measures.

In contrast, an analysis of mental health findings shows the opposite trend. Survey researchers classified clients as having a mental health problem based on responses to items from the K-6 Nonspecific Psychological Distress Scale which indicates possible severe mental illness, or if their responses to a series of questions based on the CIDI-SF scale for major depression exhibited three or more of seven possible symptoms. Using this measure, not quite three out of ten (28.4%) payees in our sample met the definition for a mental health problem. In contrast, only 16.1% of clients had self-reported via direct questioning that their mental health had impeded their ability to work or take part in training. The agreement rate between the scale-based 'diagnoses' and the case narratives was about seven out of ten (71.4%). This was more than ten percentage points lower than the rate of congruence between case narratives and clients' self-reported mental health problems (83.5%). Only 8.2% of those who met the scale-based definition of a mental health issue were documented as having this problem or barrier in the electronic narratives (compared to 12.9% for those who self-reported a mental health problem).

Likely alcohol and drug dependence were assessed in the survey using questions from the CIDI-SF and respondents were classified as dependent if they reported three or more of seven symptoms. Even using these valid measures, few TANF payees met the definition for alcohol (1.6%) or drug (3.7%) dependence. Given these very low prevalence rates - and mindful of the mathematical relationship between prevalence rates and raw agreement rates - it is not surprising to find that the overall agreement rate between the survey and case narratives was rather high. Case narratives documented a substance-related problem for half of those clients who scored positive on the drug dependence scale. However, alcohol problems were not identified as an issue in the case narratives of any individuals whose CIDI-SF score indicated likely alcohol dependence.

Finally, using a series of 16 female-directed questions regarding moderate and severe violence, as well as physical and coercive threats, in the context of romantic relationships, about one in five clients (21.7%) was assessed in the research study as having experienced at least one incident within the past year. There was agreement (i.e., presence/absence of the problem) between case narratives and survey data in almost eight out of ten cases (77.9%). However, consistent with previous studies on this topic, less than 10% of those who were assessed with a domestic violence issue in the research study were documented as having this problem in the case narratives (6.8%).

Table 5. Researcher Assessment Versus Caseworker Documentation

Barriers	Assessed in the Interview	Documented by Caseworker	Agreement Rate	% Documented by Caseworker where Interview was 'yes'	Spearman Rho
Logistic & Situational					
Housing-Instability	20.0%	4.5%	80.7%	12.80%	0.213***
Personal and Family Barriers					
Payee Physical Health	20.3%	15.5%	82.7%	42.80%	0.428***
Payee Mental Health	28.4%	4.5%	71.4%	8.20%	0.133***
Chemical Dependence					
Alcohol	1.6%	0.5%	97.9%	0.00%	-0.010
Drugs	3.7%	8.9%	91.3%	50.00%	0.257***
Any	5.0%	9.4%	90.0%	42.50%	0.229***
Domestic Violence	21.7%	2.8%	77.9%	6.80%	0.155***

*p<.05, **p<.01, ***p<.001

In sum, our findings are mixed and, in a research context, somewhat difficult to interpret. However, these less than clear-cut research findings probably are an accurate reflection of the 'real world' of front-line welfare agency practice. Our mixed findings about the agreement or lack of agreement between and among client self-reports of barriers to work, researcher-assessed problems, and problems documented in electronic agency notes clearly speak to just how complex and difficult it can be to identify all of the obvious and not so obvious problems that might be affecting a given client. Moreover, front-line staff also faces the arguably more difficult challenge of assessing if a given problem rises to the level where it truly is a barrier to the client's ability to seek or maintain employment.

In terms of front-line practice these data suggest there may be fairly large proportions of TANF cases where clients' perceptions of their situations and workers' perceptions of those situations are quite different, clients perhaps often perceiving themselves as more impaired by barriers in their quest for independence than do their caseworkers. Child care problems and personal physical health problems, for example, were the two most commonly-indicated problems or barriers in both the self-reported survey data and the agency case narratives. However, these were recorded as barriers in the administrative data in only one-third (35.9%) and one-fifth (19.5%) of cases where the client had self-reported this as a barrier to work in the survey research interview. There are many possible reasons for these observed differences, including clients' lack of disclosure of the problem to the worker. Worker-client differences in perception of the severity of the problem vis-a-vis the client's being able to work, however, no doubt explain at least part of the difference. It is beyond the scope of this paper to explore how these perceptual differences might affect client cooperation with work program requirements and/or welfare-to-work outcomes, but it would seem reasonable to speculate that they do exert some degree of influence in both spheres.

Study findings also seem to indicate that there are certain areas where front-line assessment protocols could be enhanced or improved by the use of validated scales or measures, rather than reliance on client self-report data. Mental health, alcohol dependence and domestic violence, in particular, appear to be topics on which the use of such measures could be beneficial.

Demographic Characteristics and Barrier Identification

The preceding discussion demonstrates that the extent to which survey and administrative data agree varies depending on the type of potential employment barrier being assessed. Findings also indicated that, using both direct client self-report and validated scales, the results of survey research interviews with clients yield more barriers than are known to and/or documented in those same clients' agency files. Not all problems, certainly, are necessarily severe enough to prevent someone from being able to seek, obtain or maintain work. Moreover, as research on the topic of domestic violence has consistently shown, there are some problems that clients seem unwilling or reluctant to share with their TANF caseworkers.

Nonetheless, in this era of heightened work participation requirements and enhanced program performance expectations, it is important to try and understand what factors might account for the discrepancy between survey and administrative data on clients' potential barriers to employment. Research has shown that welfare reform has played out differently for different types of clients and in different locales. Thus, in addition to variability based on barrier type, it is especially important to consider if there are any systematic relationships between the demographic characteristics of clients and the disclosure/assessment/administrative documentation of potential barriers to work. Thus, in this section of the report we compare the characteristics of three client groups: (1) those reporting at least one barrier[3] in the caseload survey, but with no barriers indicated in the case narrative (n=306), referred to as the survey group; (2) those for whom at least one barrier was documented in the case narrative, regardless of disclosure in the survey (n=354), referred to as the narrative group; and (3) those for whom no barriers were reported in the survey or recorded in the case narrative (n=159). The main focus of the discussion will be on comparisons between the survey and narrative groups, although we will also make comparisons between those who reported at least one barrier and those who reported none.

Table 6, following this discussion, presents payee and case characteristic data for our three client groups. As seen in the far right-hand column of the table, the typical respondent in our sample is a 30 year old (mean = 30.17 years), African-American (80.4%), woman (96.8%), who has never married (85.2%). Almost half of the women (46.5%) had only one child included in the assistance unit and, on average, the youngest child in the assistance unit was about five years of age at the time of sample selection (June 2002). The typical payee in our sample had worked for 1.32 quarters,

[3] Groups were based on calculations for the following barriers only: child care, transportation, housing instability, payee physical health, other family member health, payee mental health, child mental health, alcohol problem, drug problem, and domestic violence. Excluded were evictions, alcohol and drug diagnoses, and other researcher-defined barriers.

or about four months, in the previous year. In terms of welfare use, payees had received TCA during most of the preceding year (8.46 months out of 12 months) and had received 27 months of cash assistance benefits that counted toward the 60 month limit. At the time of the research interview, which took place between August and October 2002, approximately one out of four respondents (24.5%) were employed.

There are statistically significant differences among the three barrier groups on all variables except gender and welfare receipt in the previous year. Payees with a barrier recorded in the administrative data (i.e., the narrative group) are, on average, older, began childbearing at a later age, have older children, are less likely to be African American and less likely to have never been married than are payees in either of the other two groups (survey group, no barriers group). Clients whose case narratives indicated the presence of at least one barrier also had worked fewer quarters in the past year, on average, were less likely to be employed at the time of the research interview and had used about half of the months available to them under the 60 month time limit.

In contrast, on a number of demographic variables considered in the study, clients reporting no barriers and clients reporting barriers in the survey (but with no barriers recorded in the case narrative) had a similar profile. In both groups, clients were more likely to be African American and to have never been married. Clients in these two groups were also more likely to be working at the time of the survey, to have worked in more quarters in the past year, and to have used six or seven months fewer of their 60 lifetime months of TANF benefits.

On three of the demographic variables examined, however, the patterns are different: number of children in the assistance unit, age of the youngest child, and place of residence. In terms of number of children, Table 6 shows that clients with no reported or documented barriers are much more likely to have only one child in the assistance unit. Roughly three-fifths (57.6%) of no barrier clients had only one child on the TANF case, compared to just over two-fifths among clients with a survey-reported barrier, but no barrier noted in the case narrative (44.3%) and clients with an administratively-indicated barrier (43.5%). This particular finding would appear to suggest that perceived and actual employment barriers are more common among those with more children, but also that there is no relationship between the number of children on the TANF case and the likelihood that actual or potential barriers will be disclosed to or detected by the welfare caseworker.

The observed pattern with regard to Baltimore City versus non-Baltimore City residence is an interesting one that is consistent with findings from other of our research studies, but may not be totally congruent with common perceptions about the Baltimore City caseload. In this study we find that clients with no self-reported barriers in the survey were significantly more likely to reside in the City (75.7%) than were clients with survey-identified barriers (62.8%) or barriers recorded in the agency case narrative (60.8%). This finding can best be interpreted as indicating that there is no systematic difference in barrier identification/documentation between Baltimore City caseworkers and caseworkers in the 23 counties. Instead, these findings reflect the fact that the types of actual and potential employment barriers examined in this study are simply less common among Baltimore City TANF recipients (see also, Ovwigho, et al., 2004).

Finally, the results show that age of the youngest child in the assistance unit is the only demographic variable of those studied on which all three groups differ. As mentioned previously, the average age of the youngest child is not quite six years (5.78 years) among payees whose case narratives contain documentation of at least one barrier to employment. The average age of the youngest child among payees with no barriers noted in the survey or case narrative is about one year less (4.85 years), while clients having at least one survey-indicated, but no administratively-indicated barrier have the youngest children, on average (4.30 years). Related to this last finding it should be noted that about one-fifth (20.3%) of the survey group had a child under the age of one year during the time of our record review. This may partially explain why they were less likely to have a barrier recorded in the case narratives than in the surveys. In general, single parents with a child under one year of age are exempt from work activities and thus, in these cases, it is conceivable that workers might not necessarily have assessed and documented employment barriers during the time frame covered by this study.

Table 6. Demographic Characteristics of Barrier Groups

	Survey Disclosure (n=306)	Case Narrative (n=354)	No Barriers Reported (n=159)	Total (n=819)
Female Gender	96.5% (295)	96.2% (341)	98.7% (157)	96.8% (793)
Age* **				
Less than 25	43.8% (134)	22.1% (78)	48.6% (77)	35.3% (289)
Age 25 – 34	36.2% (111)	36.0% (127)	26.4% (42)	34.2% (280)
Age >= 35	19.9% (61)	41.9% (148)	25.1% (40)	30.4% (249)
Mean*** (Standard deviation)	28.10 (8.29)	32.72 (9.09)	28.47 (9.50)	30.17 (9.15)
Race**				
African American	81.7% (250)	75.0% (266)	89.9% (143)	80.4% (658)
White	9.5% (29)	16.3% (58)	6.4% (10)	11.9% (97)
Other Race	8.9% (27)	8.7% (31)	3.7 (6)	7.8% (64)
Residence**				
Baltimore City	62.8% (192)	60.8% (216)	75.7% (120)	64.5% (528)
Marital Status**				
Never Married	84.5% (256)	81.8% (287)	94.3% (150)	85.2% (693)
Age at First Birth***				
Less than 16	11.2% (29)	9.3% (29)	12.6% (17)	10.7% (76)
16 to 20 Years	52.9% (138)	36.9% (115)	51.8% (71)	45.6% (323)
21 Years and Older	35.8% (93)	53.8% (168)	35.6% (49)	43.7% (310)
Mean*** (Standard deviation)	20.54 (4.81)	23.04 (6.49)	20.39 (4.88)	21.60 (5.75)
Employment				
Number of Quarters Worked in Past Year (Mean)[4] ***	1.49	1.08	1.51	1.32
Currently employed[5] ***	27.7% (85)	16.8% (59)	35.5% (56)	24.5% (200)
Number of Children*				
1	44.3% (135)	43.5% (154)	57.6% (91)	46.5% (381)
2	35.3% (108)	34.4% (122)	21.9% (35)	32.3% (264)
3 or more	20.5% (63)	22.1% (78)	20.6% (33)	21.2% (174)
Mean (Standard deviation)	1.90 (1.14)	1.89 (1.04)	1.71 (1.02)	1.86 (1.08)
Age of Youngest Child***				
Less than 12 months	20.3% (62)	15.3% (54)	17.6% (28)	17.6% (143)
1 to 4 years	46.6% (142)	37.1% (130)	49.7% (78)	43.1% (350)
5 to 9 years	20.7% (63)	28.0% (98)	13.0% (20)	22.4% (182)
10 to 18 years	12.4% (38)	19.5% (68)	19.7% (31)	16.9% (137)
Mean*** (Standard deviation)	4.30 (4.05)	5.78 (4.71)	4.85 (4.63)	5.05 (4.50)
Months of TCA Receipt Out of the Past 12 (Mean)	8.41	8.69	8.03	8.46
Months of TCA Counted toward 60-month Limit (Mean)*	24.72	30.65	23.72	27.09

Note: Sums vary slightly due to weighting *p<.05, **p<.01, ***p<.001

[4] Based on administrative data for Maryland UI-covered employment during the four quarters between July 2001 and June 2002.

[5] Based on survey response between August and October 2002.

CONCLUSIONS

In this report we have examined the much-discussed, but perhaps not terribly well-understood topic of barriers to employment among TANF recipients. Using a unique data set, we looked at the nature and extent of barriers self-reported by clients or researcher-assessed during telephone interviews. For the same clients, we also examined the extent to which the case narratives written by their welfare caseworkers did or did not mention the same barriers. This is a timely topic to explore because of the imminent advent of more stringent client work requirements and heightened program performance expectations for states. It is also an important subject because, when all is said and done, welfare-to-work efforts and outcomes take place at the retail level, one client at a time.

To enhance the likelihood of welfare-to-work success, individual TANF workers simply must have accurate, reliable data about clients' situations and be able to make informed judgments about the existence and severity of any barriers to employment and services needed to ameliorate the problem. Today's environment of universal engagement - where every adult TANF recipient is expected to do something - makes accurate assessment all the more important.

What did we learn from this investigation? First and foremost, we learned that, in general, there is a good deal of correspondence or agreement between survey-generated identification of barriers and worker-documented employment barriers. For all barriers except alcohol dependence, there was a statistically significant relationship between the survey data and the case narrative data. This finding is particularly notable because, for most barriers examined in this study, there was no one generally-accepted definition or measurement technique used by both researchers and welfare agencies at the time of our research.

On the other hand, the administrative data generally indicate lower prevalence rates for employment barriers than customers reported in their telephone interviews with researchers. These lower rates may arise from a variety of factors, including customers' willingness to disclose information to TANF workers, agency policies and practices regarding assessment and the like. In particular, it seems likely that clients and workers may have different perceptions of the severity of various problems, that is, differing views on whether or not a problem rises to the level of actually impeding or preventing the client from working.

We also found that the degree of agreement between survey data and administrative data varies depending on the type of barrier and the way in which the barrier is measured (i.e., self-report vs. validated scale). In general, problems or potential barriers identified via client self-report survey responses are more likely to be documented in agency case narratives than are problems such as mental health that were identified in the survey through the use of validated scales or measures. The one notable exception is physical health, which may reflect welfare caseworkers' reliance on medical documentation from qualified health care providers.

In terms of client demographics, the general theme in our findings is that TANF recipients with administratively-documented barriers to employment do have a different profile than clients with no barriers or barriers revealed only in the survey. Those with agency-recorded barriers, in general, are older, began child-bearing at an older age, have older children, and are more likely to be Caucasian. They are also less likely to be working, had worked fewer quarters in the past year, and had accumulated significantly more months toward the TANF time limit. Intriguingly, clients with survey-noted, but not administratively-noted barriers more closely resembled clients who had no employment barriers indicated in either the survey or the administrative data. In fact, the only noticeable differences between these two groups were found in employment status at the time of interview, number of children, age of youngest child and residence. Moreover, these differences appear more related to the clients' perception of barriers or problems than to differences in disclosure or caseworker knowledge.

Overall, the above findings "as is" are encouraging because they do generally indicate that TANF caseworkers are identifying and documenting barriers among those who appear to be having the greatest difficulty in making the transition from welfare to work. As indicated in the background chapter, however, the goal of this project was to provide empirical information on areas where survey data and administrative data about clients' barriers to work match, areas where discrepancies exist, and areas where there may be need for further policy, program, or protocol enhancement. The data presented in this report suggest a few areas worthy of further attention and consideration.

1. **Universal engagement and increased work participation requirements increase the importance and need for workers to be able to accurately identify clients' employment barriers. It would be wise for policy-makers and program managers to review and refine existing client assessment, barrier detection and barrier removal protocols and processes.**

2. **There are certain key areas where the quality of information obtained during the front-line assessment process could be enhanced or improved by the use of validated scales or measures rather than reliance on client self-report. Mental health, alcohol dependence and domestic violence appear to be topics on which the use of such measures might be particularly beneficial.**

Although overall agreement rates between survey and administrative data are quite high across all barriers examined in this study, the percentage of "true positives" (i.e., those for whom a particular barrier was reported or assessed in the interview and documented in the case narrative) is generally low, never reaching more than 52% for any barrier. There are any number of possible explanations for why these discrepancies might exist, including client unwillingness to reveal certain issues to her worker and the worker's reluctance, for whatever reason, to inquire about certain topics. Another likely explanation, in our view, lies in the differing perceptions of clients and workers not about the existence of a particular problem, necessarily, but about its severity. That is, there is at least a suggestion in these data that clients may view themselves as being more impaired or impeded in their ability to work than workers do. It is beyond the scope of this paper to examine how these perceptual differences might affect welfare-to-work

outcomes, but it seems reasonable to speculate that they do exert some degree of influence. To avoid misunderstanding and mutual frustration, it might be prudent to insure that, as part of the assessment process, clients are fully-informed about the purpose and results of the assessment and its implications.

Study findings also indicate that there are certain areas where front-line assessment protocols could be enhanced and the resulting profile data and case management/planning improved by the use of validated scales or measures, rather than reliance on client self-report data. Mental health, alcohol dependence and domestic violence, in particular, appear from this study to be topics on which the use of such measures could be beneficial.

3. More research is needed on the relationship between measures of employment barriers and TANF clients' actual employment and welfare utilization outcomes.

Despite the large body of empirical research documenting the prevalence of various employment barriers among welfare recipients, there is surprisingly little research on the relationship between these barriers and customers' actual welfare-to-work experiences, particularly in the post-PRWORA era. Much of the research that is available suffers from design problems that limit its usefulness in assessing causality. For example, some survey-based studies use employment status at the time of the interview as their "outcome" and try to predict this outcome based on client self-report of employment barriers at that time or in the previous year. Because the timing of the outcome and the predictors is confounded, it is impossible to determine if the barrier caused the current employment situation.

Our knowledge of the relationship between employment barriers and client outcomes would be greatly strengthened through the use of prospective, longitudinal studies. Of particular policy and program interest would be studies that link multiple sources of data on customers' self-reported barriers, caseworkers' documentation of barriers, and welfare outcomes. The next report in this series will do just that by examining the relationships among client self-report, caseworker documentation, and risk of sanctioning for non-compliance with work activities. As policy makers and program managers retool their TANF programs to best serve the welfare-to-work transition needs of a diverse caseload, empirical data from studies such as these can be invaluable in assessing options and choosing strategies.

REFERENCES

Bane, M. J. & Elwood, D. T. (1994). *Welfare realities.* Cambridge, MA: Harvard University Press.

Chandler, D., Meisel, J., & Jordan, P. (2003). *Domestic violence prevalence and effects on employment in two California TANF populations.* Sacramento, CA: California Institute for Mental Health.

Danziger, S. and Seefeldt, K. (2002). Barriers to employment and the "hard to serve": Implications for services, sanctions, and time limits. *Focus, 22,* 76-81.

Hauan, S. & Douglas, S. (2004). *Potential employment liabilities among TANF recipients: A synthesis of data from six state TANF caseload studies.* Washington, DC: Office of the Assistance Secretary for Planning and Evaluation, U.S. Department of Health and Human Services.

Hetling, A, Saunders, C., & Born, C. (2004). *"Missing" domestic violence victims in welfare caseloads: The discrepancy between survey and administrative disclosure rates*. Baltimore, MD: University of Maryland School of Social Work.

Hetling-Wernyj, A. & Born, C. (2002). *Domestic violence and welfare receipt in Maryland: Are domestic violence victims different from other welfare recipients?* Baltimore, MD: University of Maryland School of Social Work.

Lennert, J. (1997). Like ships passing through the night: AFDC policy and battered women. *Law and Policy, 19,* 183-203.

Moffitt, R., Cherlin, A., Burton, L., King, M., Roff, J. (2002). *The characteristics of families remaining on welfare*. Background Working Paper 02-02. Baltimore, MD: Johns Hopkins University.

Nam, Y. (2005). The roles of employment barriers in welfare exits and reentries after welfare reform: Event history analyses. *Social Service Review, 3,* 268-293.

Norris, J. & Speiglman, R. (2003). *Welfare and work status under TANF: Effect of barriers to employment and implications for program planning.* Oakland, CA: Public Health Institute.

Orlin, M. B., Matto, H. C., Altstein, H., Born, C. E., & Caudill, P. J. (1997). *Client assessment on the TCA frontlines: An exploratory study.* Baltimore, MD: University of Maryland School of Social Work.

Ovwigho, P. C. (2001). *Life on welfare: Have the hard-to-serve been left behind?* Baltimore, MD: University of Maryland School of Social Work.

Ovwigho, P.C., Born, C.E., Ferrero, A., and Palazzo, C. (2004). *Life on welfare: The active TANF caseload in Maryland*. Baltimore, MD: University of Maryland School of Social Work.

Pavetti, L. (2003). Helping the hard-to-employ. In I.V. Sawhill, R.K. Weaver, R. Haskins & A. Kane (Eds.), *Welfare reform and beyond: The future of the safety net* (pp. 117-124). Washington, DC: Brookings Institution Press.

Pollack, H., Danziger, S. H., Jayakody, R., & Seefeldt, K. S. (2002). Substance use among welfare recipients: Trends and policy responses. *Social Service Review, 76,* 256-274.

Raphael, J. & Haennicke, S. (1999). *Keeping battered women safe through the welfare-to-work journey: How are we doing?* Chicago: Center for Impact Research.

Tolman, R. & Raphael, J. (2000). A review of research on welfare and domestic violence. *Journal of Social Issues, 56,* 655-682.

United States Department of Health and Human Services. (2001). *Screening and assessment in TANF/Welfare-to-Work: Local answers to difficult questions.* Washington,DC: Author.

Wood, R. G. & Rangarajan, A. (2004). *The benefits of housing subsidies for TANF recipients: Evidence from New Jersey.* Princeton, NJ: Mathematica Policy Research, Inc.

Zedlewski, S. (2003). Work and barriers to work among welfare recipients in 2002. *Snapshots of America's Families III Number 3*. Washington DC: The Urban Institute.