

Barriers to Independence Among TANF Recipients: Comparing Caseworker Records and Client Surveys

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ABSTRACT. Survey-based studies reveal the prevalence of employment barriers among Temporary Assistance to Needy Families (TANF) recipients. However, the extent to which welfare caseworkers are aware of, and therefore able to address, particular barriers is unknown. This study compares survey data with electronic case records to measure the rate of agreement in barrier identification, and finds that although agreement rates are high, barriers were more likely to have been documented by caseworkers for certain subgroups of recipients. It is suggested that welfare agencies

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consider using validated scales and measures to assess some barriers in order to increase the likelihood of identifying and removing barriers to work for more recipients, particularly in light of new, more stringent work participation requirements.

KEYWORDS. Barriers, TANF, assessment, employment

INTRODUCTION

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 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 (Gais et al., 2000; Orlin et al., 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 work-mandatory TANF clients' skills be done, exploring such issues as reasons for applying for aid, job readiness, skills, needs, and potential barriers to employment (Personal Responsibility and Work Opportunity Reconciliation Act of 1996, 1997).

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 an unprecedented numbers of clients to leave welfare for work, notwithstanding the difficult personal circumstances that 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 economic downturns (Boushey and Rosnick, 2003). Today's TANF clients, while not predominantly hard to serve, are at least different to serve than were clients in past years (Ovwigbo, 2001). Finally, work participation and other work-related federal performance

expectations have been significantly increased. As of Oct. 1, 2006, the 50% caseload work participation requirement includes families in Separate State Programs. Many states have used Separate State Programs to serve difficult-to-employ families, such as those headed by a disabled adult, so that they would be excluded from the participation rate calculation (Deficit Reduction Act of 2005, 2006).

In this changed environment it is important to revisit the subject of barrier identification and client assessment. The most basic reason to do so is because effective case management and program administration requires good information. It is also true, of course, that decisions made by case managers based on barrier identification/client assessment impact customer and program outcomes. The present study examines 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 revealed to and/or identified by those clients' caseworkers in welfare agency files.

Barriers to Employment: Do Clients & Caseworkers Agree?

The few studies of the congruence, or lack thereof, between worker and client perceptions of work impediments pertain to the issue of domestic violence. All 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).

When administrative data do not indicate that the customer is a victim of domestic violence, it is generally concluded that the welfare agency "missed" detecting this barrier or the customer chose not to disclose it. In other words, barrier prevalence rates calculated from client survey or interview-based studies are typically considered the "gold standard." However, it is important to note that the extent to which survey data provide an *accurate* estimate of the prevalence of barriers depends largely on the methods used to collect the data, how barriers are measured and how the sample is selected.

Measuring Employment Barriers Among Welfare Recipients

Table 1 summarizes the recent literature on the prevalence of employment barriers, as determined through survey-based research, including

TABLE 1. Prevalence of barriers to work among TANF recipients

Barrier	Prevalence Rates	References	Measurements
Logistic & situational barriers			
Child Care	16.7% – 42.0%	Hauan & Douglas, 2004; Norris & Speigman, 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			
Physical Health	10.6% – 35.7%	Danziger, 2002; Hauan & Douglas, 2004; Norris & Speigman, 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

child care, transportation, housing instability/eviction, physical and mental health, child's health, substance abuse, and domestic violence. The table aptly illustrates that prevalence estimates 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 studies, 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 child care problems and about one-quarter had transportation problems (Hauan & Douglas, 2004).

This type of direct questioning measurement may be appropriate in some instances, especially in regard to human capital barriers (education, work experience, and job skills). However, more sophisticated measures may be needed to identify sensitive issues (e.g., mental health) that recipients may not be aware of or may be hesitant to disclose.

In addition, the "one direct question" approach does not yield much information regarding 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, but 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 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 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 10 (30.2%) sample members had a transportation barrier (Danziger & Seefeldt, 2002).

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 social work, 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). One implicit assumption of these types of studies is that the mere presence of a problem will interfere with a person's ability to work and leave welfare. In general, analyses conducted using these types of scales reveal higher prevalence rates than direct questions. For example, in a Maryland study, 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 (Ovwigbo et al., 2004). However, validated scales do not always produce higher prevalence rates. In the same study, almost three out of 10 respondents self-reported a physical health barrier (28.6%), but only one-fifth (20.9%) scored in the lowest quartile of physical functioning.

As demonstrated, variations in measurement techniques can lead to quite different conclusions about the prevalence of specific barriers to employment among welfare recipients. The same would be true in case management as well. For program administrators, the important question is whether the techniques used by case managers are sensitive enough to identify factors that interfere with welfare recipients' abilities to obtain and maintain employment and financial self-sufficiency. The agency can only hope to address these problems if they are accurately identified, and clearly the most efficient course is to identify them up front, before clients have been placed in activities that are inappropriate for their situations.

The present study further explores the issue of barrier identification among welfare recipients. We address two research questions:

1. To what extent do clients' reports of barriers in a research survey correspond with caseworkers' documentation in their welfare case records?
2. Is there a relationship between caseworker documentation of reported barriers and client characteristics?

METHODS

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 U.S. Department of Health and Human Services (Ovwigbo et al., 2004). Originally, 1,146 participants were randomly selected from the universe of single-adult Temporary Cash Assistance (TCA, Maryland's TANF program) 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 and were stratified on jurisdiction (Baltimore City versus non-Baltimore City cases).

For the purposes of this study, we include only 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 paper are weighted to represent the true proportion of Baltimore City and non-Baltimore City cases in the June 2002 caseload.

Data Sources

For the present study, data come 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-documented employment barriers and welfare participation.

Survey data are based on interviews conducted using the TANF Caseload Survey Instrument¹ 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). Survey questions covered a variety of topics, including family composition, employment history, job training, education, earnings, and employment barriers. We group reported barriers into two categories: (1) personal and family challenges, including physical and mental health, chemical dependence, and domestic violence; and (2) logistical and situational challenges, which included transportation, child care, and unstable housing. Specific questions and scales used to measure these barriers are presented in Table 2.

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?

(Continued)

TABLE 2. (*Continued*)

Barrier	Description of Measure
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 records and case narratives provide information about cash assistance program participation and caseworker documentation of employment barriers. The Client Automated Resource and Eligibility System (CARES), maintained by the Maryland Department of Human Resources, supplies individual and case-level program participation data for cash assistance, food stamps, medical assistance, and social services programs. Also in CARES, caseworkers can access a free-form space in which they 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. CARES narratives are a rich source of information about family circumstances and challenges (Ovwigbo, 2001).

Narrative Coding Procedure

Case narratives were examined for personal/family and logistical/situational challenges or barriers recorded by the caseworker including 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 in the narrative during the sampled time period, the barrier was coded as "yes," and if there was no mention, that barrier was coded as "no." For example, the following text was marked as indicating a child mental health barrier:

Client returned verification that she is needed in the home to care for her child who was diagnosed with bipolar disorder. Mother is needed in the home to supervise & work with mental health providers to stabilize her child's mood & behavior.

We specifically chose the broadest definition possible, considering a barrier identified if it was mentioned in the narrative text, even if there was not an explicit statement that the problem interfered with the client's ability to work. This decision was based on the assumption that caseworkers would only document issues that were relevant to the client's eligibility and work participation.

For coding, the 819 narratives were separated into 40 sets of 25 narratives and one set of 19. Each set, except the first and the last, overlapped the sets before and after by five cases each, for a total of 10 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, and the first author then made the decision as to how to code the case. The agreement rate for each set of 25 narratives, calculated as $(\# \text{ of comparisons} - \# \text{ of discrepancies}) / (\# \text{ of comparisons})$, ranged from 92% to 100%, with an overall average of 98%.

Analysis

Data were analyzed using descriptive statistics to summarize sample members' information. Kappa and phi coefficients were used to evaluate agreement between survey and administrative identification of barriers. Finally, chi-square and analysis of variance tests were used to test for differences between groups of survey disclosers and recipients with caseworker-documented barriers.

RESULTS

We first examine the extent to which survey and administrative data 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).

Self-Indicated Barriers

The first set of analyses concerns agreement between client survey and agency administrative data (i.e., narratives) 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 3.

As illustrated in the first column of Table 3, child care was by far the most common self-reported employment barrier in the research interview. Almost two-fifths (37.0%) of TANF caseheads in our sample said 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 10 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 (3.2%) as employment barriers when directly asked about these matters. Approximately one in 10 (8.3%), however, did tell the research interviewer that they had been diagnosed with a substance abuse problem.

The second column of Table 3 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, 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 childcare (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 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 10 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, but 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. Overall, the rank ordering of barriers in the surveys and the case narratives is not statistically significant (Spearman $Rho = 0.350$, NS).

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

TABLE 3. Self-reported barriers compared to caseworker notes (N = 819)

Barriers	Indicated by respondent	Noted by caseworker	Agreement rate	Kappa	% noted by caseworker when indicated by respondent	Phi
Logistic & Situational						
Child Care	37.0%	10.1%	65.2%	0.166***	19.5%	0.230***
Transportation	25.8%	2.0%	74.6%	0.054**	4.7%	0.118**
Housing-Eviction	4.4%	6.5%	91.1%	0.134***	22.2%	0.137***
Housing-Instability	13.9%	4.5%	84.7%	0.102***	10.5%	0.124***
Personal and Family Barriers						
Physical Health						
Payee	28.6%	15.5%	76.4%	0.331***	35.9%	0.356***
Child	15.3%	6.3%	84.6%	0.235***	21.6%	0.263***
Other family member	11.0%	0.7%	89.4%	0.091***	5.5%	
Mental Health						
Payee	16.1%	4.5%	83.5%	0.140***	12.9%	0.176***
Child	16.4%	2.5%	84.6%	0.146***	10.4%	0.229***
Chemical Dependence						
Alcohol	NA	NA	NA	NA	NA	NA
Alcohol - Ever Diagnosed	2.2%	0.5%	90.8%	0.088***	5.9%	0.113**
Drugs	3.1%	8.9%	91.4%	0.236***	52.0%	0.273***
Drugs - Ever Diagnosed	7.3%	8.9%	97.6%	0.387***	48.3%	0.389***
Any	3.2%	9.4%	90.8%	0.220***	50.0%	0.252***
Alcohol or Drugs - Ever Diagnosed	8.3%	9.4%	90.1%	0.350***	47.1%	0.388***
Domestic Violence	8.0%	2.8%	91.2%	0.190***	15.2%	0.220***

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.

researchers. Thus, the final four columns in Table 3 provide various measures of the agreement between the self-reported survey data and the administratively recorded case narrative data. The third column presents the percent of total cases where the survey data and the administrative data agree either that the client did not have a particular barrier, or that she did. Regardless of the specific barrier, the two sources of data coincided in the majority of cases (mean rate of agreement = 85.4%). 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%). The lowest agreement rates were observed for the three barriers most commonly self-reported by clients in the survey data: childcare (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 that occur very infrequently and for those that are very common. The fourth column addresses this problem by presenting coefficient kappa, which indicates if the agreement rate is significantly better than chance. The kappas for all barriers are statistically significant at the $p < .01$ or $p < .001$ level.

The last two columns of Table 3 provide additional assessments of the correspondence between the self-reported survey data and the administrative data. The percentage of cases in which the worker documented the barrier in the case narrative for clients who had reported that same barrier in the research interview 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? The answer to this question varies dramatically, depending on the barrier being considered. The greatest degree of congruence between clients’ self-report of a barrier to work and caseworkers’ documentation of that barrier is found in the area of substance abuse/use, with a problem noted 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.

Phi coefficients assess the relationship between survey self-reports and administrative assessments for each barrier. All coefficients are statistically significant from zero, indicating that there is a statistically reliable relationship between clients' self-reports in the survey and their case-workers' determination that a barrier exists. The highest correlations are found for drug use and any substance abuse diagnosis.

Researcher-Assessed Barriers

As discussed previously, some researchers have used validated scales or measures, in addition to 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.

In Table 4, we present data on the degree of agreement between barriers assessed during the interview using scale measures and barrier identification as noted in the electronic agency case narratives. Similar to the preceding table, Table 4 includes prevalence rates for each barrier as calculated from the survey scale data and the case narratives, along with four indicators of agreement between the two data sources. As was true for the self-reported barriers, we find statistically significant relationships between the researcher-defined barriers and caseworker-documented 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. In about 80% of cases, 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. Using the scale-based definition, one-fifth (20.3%) of TANF payees were deemed to have a physical health barrier to employment; this is noticeably less than the almost three in 10 who, in direct questioning, self-reported that their own health problems had interfered with their ability to work. In more than eight out

TABLE 4. Assessment from survey scale data compared to caseworker notes (N = 819)

Barriers	Assessed in the interview	Noted by caseworker	Agreement rate	Kappa	% noted by caseworker where interview was "yes"	Phi
Logistic & Situational						
Housing-Instability	20.0%	4.5%	80.7%	0.149**	12.8%	0.205***
Personal and Family Barriers						
Payee Physical Health	20.3%	15.5%	82.7%	0.406***	42.8%	0.417***
Payee Mental Health	28.4%	4.5%	71.4%	0.070**	8.2%	0.114**
Chemical Dependence						
Alcohol	1.6%	0.5%	97.9%	-0.008	0.0%	-0.009
Drugs	3.7%	8.9%	91.3%	0.259***	50.0%	0.286***
Any	5.0%	9.4%	90.0%	0.247***	42.5%	0.257***
Domestic Violence	21.7%	2.8%	77.9%	0.075***	6.8%	0.131***

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

of 10 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 by the scale-based definition.

In contrast, an analysis of mental health findings shows the opposite trend. Using the scale-based measure, not quite three out of 10 (28.4%) payees in our sample met the definition for a mental health barrier. In contrast, only 16.1% of clients had self-reported via direct questioning that their mental health had impeded their ability to work. The agreement rate between the scale-based “diagnoses” and the case narratives was about seven out of 10 (71.4%). This was more than 10 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 case narratives, compared to 12.9% for those who self-reported a mental health problem.

Few TANF payees met the scale-based definition for alcohol (1.6%) or drug (3.7%) dependence. Given these very low prevalence rates—and being 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, about one in five clients (21.7%) was assessed in the research study as having experienced domestic violence 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 10 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%).

The coefficient kappas presented in the fourth column of Table 4 indicate that agreement rates are significantly greater than chance, except for alcohol dependence. Consistent with the findings for self-report barriers, we find that narratives are most likely to note “true positives” for payee health and substance use/abuse problems. Finally, the last column shows that there is a statistically significant relationship between the survey data and administrative data for all researcher-defined barriers except alcohol dependence.

Demographic Characteristics and Barrier Identification

The previous sections have shown 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, consistent with prior research and 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 noted in those same clients' agency files.

Particularly in this era of heightened work participation requirements for hard-to-employ groups and enhanced program performance expectations, it is important to understand what factors might account for the discrepancy between survey and administrative data on clients' potential barriers to employment. Thus, our final analyses compare the characteristics of three client groups: (1) those reporting at least one barrier² 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 5 presents payee and case characteristic data for our three client groups. 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 more likely to have 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 in 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 federal lifetime TANF limit of 60 months.

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

TABLE 5. 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%	96.2%	98.7%	96.8%
Age***				
Less than 25	43.8%	22.1%	48.6%	35.3%
Age 25 – 34	36.2%	36.0%	26.4%	34.2%
Age >= 35	19.9%	41.9%	25.1%	30.4%
Mean*** (Standard deviation)	28.10 (8.29)	32.72 (9.09)	28.47 (9.50)	30.17 (9.15)
Race**				
African American	81.7%	75.0%	89.9%	80.4%
White	9.5%	16.3%	6.4%	11.9%
Other Race	8.9%	8.7%	3.7	7.8%
Residence**				
Baltimore City	62.8%	60.8%	75.7%	64.5%
Marital Status**				
Never Married	84.5%	81.8%	94.3%	85.2%
Age at First Birth***				
Less than 16	11.2%	9.3%	12.6%	10.7%
16 to 20 Years	52.9%	36.9%	51.8%	45.6%
21 Years and Older	35.8%	53.8%	35.6%	43.7%
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) ¹ ***	1.49	1.08	1.51	1.32
Currently employed ² ***	27.7%	16.8%	35.5%	24.5%
	(85)	(59)	(56)	(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.

*Administrative data for Maryland UI-covered employment during the four quarters between July 2001 and June 2002.

²Survey response between August and October 2002.

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, 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 suggests that 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 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 may not be totally congruent with common perceptions about urban welfare caseloads. 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 urban caseworkers and caseworkers in the suburban and rural areas. These findings also reflect the fact that the types of actual and potential employment barriers examined in this study were simply less common among urban (Baltimore City) TANF recipients (see also, Ovwigho et al., 2004).

Finally, age of the youngest child in the assistance unit is the only demographic variable of those studied on which all three groups differ. 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.

DISCUSSION

In this paper we examine the much discussed but perhaps not terribly well-understood topic of barriers to employment among TANF recipients. Using a unique data set, we consider the nature and extent of barriers self-reported by clients or researcher-assessed during telephone interviews. For the same clients, we also evaluate the extent to which the case narratives written by their welfare caseworkers mentioned the same barriers. This topic is particularly timely because of the advent of more stringent client work participation definitions 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 the services needed to ameliorate the problem.

There are several important limitations to the analyses presented here. Our study sample is limited to families receiving welfare in Maryland in June 2002. Because of variations in state welfare policies, our findings may not generalize to welfare populations in other states.

Although the survey response rate was quite high, it is possible that survey respondents differ from non-responders in ways that have important implications for the results presented here. Using administrative data, we have found that clients who participated in the survey are quite similar to non-respondents. However, we did find statistically significant differences on three demographic characteristics—age, race, and marital status. Non-respondents were, on average, one and one-half years older than respondents. Non-respondents were also more likely to be Caucasian and, according to the administrative data, more likely to be married.³ Readers may wish to keep these differences in mind when considering study findings, but we do not believe they negate or diminish the value or utility of our findings.

A final limitation of note is the electronic caseworker narratives. As mentioned previously, caseworkers are required to document certain pieces of information in the case narrative and permitted to enter other information as they choose. While it is programmatically important for caseworkers to identify client barriers to employment and to document this information as it relates to decisions they make regarding the case, it is quite possible that some barrier information may be known, but not recorded in the electronic case record. We also have no way to know which factors, if any, motivated a client's decision to disclose or withhold the existence of an employment barrier to her caseworker, versus the survey researcher.

Limitations notwithstanding, this study provides new information on a very important topic. First and foremost, we learned that, in general, there is a good deal of correspondence or agreement between survey-identified 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, and agency policies and practices regarding assessment. 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 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 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. These findings suggest that perhaps caseworkers are more thorough in their assessment of at-risk TANF clients, as defined by meeting agency work and time-limit requirements.

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. Thus, it may be difficult to target in-depth assessments to those who need additional services except by accurate screening of every client.

Overall, these findings are encouraging because they 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. A remaining question for further research is how customers' outcomes may differ depending on caseworkers' knowledge of their barriers. For example, are customers who reveal barriers to survey researchers, but not their welfare caseworkers, at higher risk for sanctioning? Do customers whose barriers are known to their welfare caseworkers achieve better employment outcomes than those for whom barriers are not detected?

As indicated previously, 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 suggest a few areas worthy of further attention and consideration.

The first is that recent changes to work participation requirements included in TANF reauthorization increase the importance and need for workers to be able to move customers quickly and efficiently into appropriate work activities. Theory suggests that accurate identification of clients' employment barriers is necessary for achieving this goal, and thus it would be wise for agencies to review and refine existing client

assessment, barrier detection, and barrier removal protocols and processes. 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 caseworker 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.

Secondly, there are certain key areas where the quality of information obtained during the frontline assessment process could be enhanced or improved by the use of validated scales or measures. Mental health, alcohol dependence, and domestic violence appear to be topics on which the use of such measures might be particularly beneficial. Administrators faced with the daunting task of moving families from welfare to work should explore the possibility of using short, easy-to-administer, validated scales. They may also wish to consider the option of partnering with subject-matter experts. We believe the value of these types of approaches is evidenced by the data showing that the detection of barriers is better for physical health and drug use/abuse. For both of these issues, welfare agencies in the study state rely on subject-matter experts and validated scales to determine if a barrier exists or not.

Finally, our results clearly demonstrate that many challenges remain for welfare agencies and the families they serve. As we move into the next phase of welfare reform, it will be critical for administrators to find creative ways of addressing barriers to employment and assisting clients on their journey from welfare to work.

NOTES

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

2. 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. We excluded evictions, alcohol and drug diagnoses, and other researcher-defined barriers to avoid duplication.

3. We chose not to use weights to adjust for these differences. The use of weights, in essence, would make these observed differences disappear, but could introduce other, unknown differences. Thus, in our view, the benefits do not outweigh the risks.

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