

**Employment Duration of African-American and White Welfare Recipients and the
Role of Persistent Health and Mental Health Problems**

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ABSTRACT

We use a panel study of Michigan welfare recipients to estimate the prevalence and persistence of health problems in the post-reform welfare population and the extent to which health problems predict low durations of employment. Rates of health problems were disproportionately high. Over 70 percent of current and former welfare recipients reported limitations in physical functioning; over 60 percent met the diagnostic screening criteria for a mental health disorder measured in the study; and 37 percent reported having a child with a health problem in at least one of four interviews conducted over a roughly 4 ½ -year period. Women who reported physical health, mental health, or child health problems at multiple waves worked fewer months over that period. There were no race-based differences in employment durations and in physical health problems, but African-Americans were less likely than whites to meet the diagnostic screening criteria for depression, to meet the diagnostic criteria for general anxiety disorder, and to report a child with a health problem. These findings suggest a reexamination of the welfare program's work participation requirements to encourage states to provide services, training, and supports to recipients.

When The Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) passed in August 1996, some analysts warned that physical and mental health problems might hinder recipients' abilities to successfully move from welfare to work. Olson and Pavetti (1996) and Loprest and Acs (1996) reported that Aid to Families with Dependent Children (AFDC) recipients had high levels of depressive symptoms and that rates of physical health problems among recipients and their children were higher than among women and children in the general population. Recent reviews of welfare-to-work research report that health problems are common among recipients and are related to employment status at a point in time (S. K. Danziger et al. 2000, Blank 2002, Lichter and Jayakody 2001, Corcoran et al. 2000).

Under PRWORA, the receipt of cash benefits is no longer guaranteed to all eligible families, but is conditioned on work and/or participation in work-related activities. Currently, most states focus primarily on providing job search assistance in welfare-to-work programs and do not systematically screen and assess participants for physical health problems and mental health problems that may constrain their ability to remain steadily employed. These programs also tend not to provide referral, treatment, and counseling services to recipients with health problems. (S.K. Danziger and Seefeldt, 2002)

A related concern is whether health problems may make it harder for African-American welfare recipients than white, non-Hispanic recipients to establish stable employment trajectories and successfully leave welfare. In the general population,

African-American women have higher rates of chronic physical health problems than do white women of the same age. On the other hand, African-American women have lower rates of depression than do white women. (S. Danziger, 2001). The existence and extent of race differences in the physical and mental health status of welfare recipients and how this affects employment outcomes has not yet been demonstrated.

In this paper we analyze data from the first four waves of the Women's Employment Survey (WES), a representative sample of African-American and white single mothers who were welfare recipients in an urban Michigan county in February 1997 and who were subsequently interviewed in Fall 1997, Fall 1998, Fall 1999/Winter 2000, and Fall 2001/Winter 2002. We investigate whether their physical health problems, mental health problems, and their children's health problems limit their ability to establish stable, long-term employment records (holding constant other characteristics such as family structure, human capital deficits, and prior experiences of discrimination). We address these questions and discuss their implications for welfare policy and research:

- What percentage of respondents reported physical health problems, mental health problems, and a child with a health problem at each of the four waves. How common was persistent reporting of these problems? Does their prevalence vary by race?
- Does the prevalence of physical health, mental health, and child health problems change over time?
- Are persistent physical health problems, persistent mental health problems, and persistent child health problems associated with lower durations of employment?

- Do African-Americans have shorter employment durations than whites? Do effects of health on employment duration vary by race?

Background

Cross-sectional studies have shown that poor health and/or depression are negatively associated with employment. Until recently, most such studies examine men only (Shortt 1996). Analysts who do examine how health affects women's employment often restrict analyses to married, middle-class white women (O'Campo and Rojas-Smith 1998; Baker et al. 1999).

Despite concerns that physical and mental health problems may be barriers to the successful transition from welfare to work, research on the health status of welfare recipients and their service needs prior to the 1996 reform is limited (O'Campo and Rojas-Smith, 1998). Olson and Pavetti (1996) and Loprest and Acs (1996) documented high rates of both physical health problems and psychological distress among AFDC recipients. Salomon, Bassuk, and Brooks (1996) found high rates of limitations in physical functioning, and of chronic medical conditions in their cross-sectional study of homeless and housed AFDC recipients. They also found that long-term welfare receipt is associated with lower levels of physical functioning among housed AFDC recipients than is short term receipt . This research shows that physical and mental health problems are common in the AFDC population, but does not link these problems either to employment or to length of employment.

The research on health of AFDC recipients could understate the health problems of recipients in the new welfare program, Temporary Assistance to Needy Families

(TANF), since welfare caseloads dropped sharply after welfare reform (Zedlewski and Alderson 2001; Blank et al. 2002). Those remaining on welfare may have more physical and mental health problems than did AFDC recipients prior to welfare reform (Lichter and Jayakody 2001; Danziger 2001).

Three recent studies – Zedlewski and Alderson 2001, Loprest 2001, Danziger et al. 2000 – examine the health status of TANF recipients in the years following welfare reform. These studies report high rates of health problems among TANF recipients. Zedlewski and Alderson (2001) report that 36 percent of a national sample of TANF recipients in 1999 reported a serious health problem. Loprest (2001) reports that women who left TANF in the year after welfare reform had fewer health problems than women who left in 1999. She suggests that health problems may be a major issue in the new caseload.

Danziger et al. (2000) investigated the associations between health, mental health and employment status at a point in time among 753 women who were TANF recipients in an urban county in Michigan in February 1997. They found that contemporaneous health problems and recent major depressive disorder were significantly associated with a lower likelihood of employment at the interview date.

Most past research on welfare recipients' health and employment examines their relationship over very short periods of time. There is little research either on the persistence of health problems among welfare recipients or on the associations between persistent health problems and employment duration. One exception, Ensminger's (1995) longitudinal study of 833 African American mothers in a Chicago neighborhood,

found that long-term AFDC recipients were more likely to report poor health, having a chronic illness, and high levels of psychological stress, than were women who had never received welfare. Ensminger speculated that poor health may be a cause of persistent welfare receipt. This suggests that persistent health problems may be associated with shorter employment durations, but neither Ensminger (1995) nor other authors have directly examined this issue

This paper uses data from the four waves of the Women's Employment Study (WES) to extend previous research. First, we examine for TANF recipients and former recipients the extent to which physical and mental health problems and child health problems persist or change over time. Advocates of PRWORA hoped that the new welfare system, by promoting work and responsibility, might lead to improvements in recipients' and their children's well-being on a wide range of dimensions, including health. Second, Blank (2002), Hershey and Pavetti (1997), Kaye and Nightingale (2000), and Corcoran et al. (2000) caution that the success of welfare-to-work policies will depend in large part on whether recipients can remain employed on a regular basis. This is one of the first studies to examine in multivariate models the correlates of the duration of TANF recipients' employment over multiple years. Third, the WES asked recipients about a more comprehensive and broader reaching set of health problems than other studies enabling us to explore whether *persistent* physical health problems, *persistent* mental health problems, and *persistent* child health problems across waves are associated with women's employment durations over a period of about 55 months. Finally, Zedlewski and Alderson (2001) found that African-American women constituted a larger

percentage of the welfare caseload in 1997 than in 1999, and speculated that African-American women may be finding it harder to remain off TANF than white women. We investigate whether there are race differences in TANF recipients' employment trajectories by running all analyses separately for African-Americans and whites.

Data

The women in the Women's Employment Survey (WES) sample were systematically selected with equal probability from an ordered list of single mothers with children who were welfare recipients in an urban Michigan county in February 1997. . In-home interviews were conducted in Fall 1997, Fall 1998, Fall 1999/Winter 2000, and Fall 2001/Winter 2002. Response rates were 86 % for wave 1 (N=753), 92 % for wave 2 (N=693), 91% for wave 3 (N=632), and 91% for wave 4 (N=577) for a cumulative response rate of 66 %. Our sample includes respondents who were present at all four interviews, were not receiving Supplemental Security Income (SSI recipients are not subject to TANF work requirements), and who had no missing data on any variables used in the analyses. This left 503 women.

The dependent variable is the number of months worked between February 1997 and August 2001. In wave 1, respondents were asked to indicate whether or not they had worked for pay for at least 20 hours in each calendar month between February 1997 and the wave 1 interview date. In waves 2, 3, and 4, respondents were asked to indicate whether or not they had worked for pay in each calendar month between the current and previous waves. We use these responses to calculate the number of months in which respondents worked over the 55 month period from February 1997 to August 2001.

Respondents were asked about their physical health status, their mental health status and their children's health status in each of the four waves. Women's physical health was assessed using items from the Physical Functioning subscale of the SF-36 (Ware, Snow, Kosinski, and Gandek, 1993). Respondents were asked a series of questions about whether their health limits their daily activities a lot, a little, or not at all in walking, lifting, climbing stairs, bending, carrying bundles, etc. Respondents who scored in the lowest age-specific quartile (based on population norms) in a wave were defined as having physical limitations in that wave. We defined a respondent as having a child with a health problem in a wave if she reported that one of her children had a physical, emotional, or learning problem that limited the child's activity. This question was taken from the National Longitudinal Survey of Youth (NLSY) questionnaires.

WES collected data on four mental health disorders: major depression, post-traumatic stress syndrome (PTSD), generalized anxiety disorder (GAD), and social phobia. Major depression and PTSD are measured in all four waves, GAD in waves 1, 3, and 4; and social phobia in waves 2, 3 and 4. The measurement of depression and other mental health disorders was based on the definition and the criteria specified in the revised third edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM-III-R) (APA, 1987).¹ Questions on mental health

¹ The diagnosis was operationalized in screening versions of the World Health Organization (WHO) Composite International Diagnostic Interview, Version 2.0 (CIDI) (WHO, 1990; Kessler et al., 2002). [GET REF] The short form CIDI is a structured interview schedule designed to be used by trained interviewers who are non-clinicians to assess the prevalence of specific psychiatric disorders (Robins et al., 1998).

disorders ask about mental health problems experienced in the 12-month period prior to the interview date. We code a respondent as having a mental health disorder in a wave if she met the clinical screening criteria for any disorder measured in that wave. We measure the presence and persistence of each of these three health problems - -physical limitations, child health problems, mental health problems - - across waves by creating sets of dummy variables that indicate whether the problem occurred at 1 or 2 waves or at 3 or 4 waves. For instance, the set of dummies for child health are: reported a child health problem at one or two waves and reported a child health problem at three or four waves. Women who never reported a child with a health problem are the omitted group.²

The WES data allows us to control for a rich set of personal characteristics when we estimate effects of persistent maternal and child health problems on employment durations. Past studies of welfare recipients' employment trajectories typically include only a few measures of personal characteristics. Our analyses also include demographic variables, such as the number of very young children, marital/cohabitation status across waves, whether the woman had a child between waves or was pregnant at wave 4, and years received welfare in her past. Human capital controls include schooling, work experience, job skills, work norms, and past experiences of workplace discrimination. We also include measures of the number of waves at which respondents had a transportation problem, the number of waves at which respondent reported having experienced severe domestic violence, and the number of waves in which she met the screening criteria for

² We experimented with using four dummy variables to pick up the number of waves at which had a health problem. The coefficients on dummies, for waves 1 and 2 were similar in magnitude and those on the dummies of waves 3 and 4 were similar in magnitude.

having either an alcohol or drug dependence problem. We describe how these control variables were constructed in Appendix A.

Research Strategy

We explore the relationships between health, mental health, child health, and employment durations by estimating equation (1) which expresses the number of months worked between February 1997 and August 2001 as a function of maternal physical and mental health problems, child health problems, demographic characteristics, human capital characteristics, access to transportation, domestic violence problems, and substance dependence.

$$(1) \text{MONS} = \mathbf{d}_0 + \sum_{i=1}^{12} \mathbf{d}_i X_i + \sum_{j=1}^5 \mathbf{g}_j \text{HC}_j + \sum_{k=1}^6 \mathbf{f}_k H_k + \mathbf{n}$$

where $Y(\text{MONS})$ = number of months worked between February 1997 and August 2001.

X = demographic, transportation, domestic violence and substance dependence measures

– race, number of children age 0-2, marital status (2 dummies), whether received welfare 7 or more years, had a child between waves or was pregnant at Wave 4, transportation problem (2 dummies); severe domestic abuse (2 dummies), substance dependence (2 dummies).

HC = human capital controls (high school dropout, has low work experience, has less than four job skills, knows 5 or fewer work norms, and perceived exposure to 4 or more different types of employment discrimination)

H = health measures - physical limitations (2 dummies), mental health problem (2

dummies), child health problem (2 dummies)

We estimate equation (1) using the left-censored and right-censored Tobit regression technique, because the distribution of *MONS* is bounded by zero on the left and by 55 on the right.

Descriptive Results

Health and Mental Health Status. Table 1 shows the health status of women and their children in our sample. (TABLE 1 about here) The first panel shows how the prevalence of physical and mental health problems changed across waves. The second panel shows the distribution of health problems across waves – i.e., the numbers of times over the four waves that a problem was reported.

Rates of mental, physical and child health problems were high at every wave. For instance, at each wave, 16 to 25 percent of women met the diagnostic screening criteria for major depression; 14 to 16 percent met the criteria for PTSD; and over 40 percent reported limitations in physical functioning. In each wave, 29 to 34 percent of women met the criteria for at least one mental health diagnosis, and over half had either a physical limitation or any mental health diagnosis.

The prevalence of physical and mental health problems at a point in time in WES typically exceeds rates found in national surveys of U.S. women of comparable ages. For example, although at each wave over 40 percent of WES women reported high levels of problems in physical functioning, only one in four women in nationally representative samples do so. About 16 to 25 percent of WES respondents met the diagnostic screening

criteria for clinical caseness of depression at each wave. This compares to 13 percent for women in the general population (Kessler et al, 1994). At each wave, 14 to 16 percent of WES women had met the criteria for experiencing PTSD *within the past year*, but the *lifetime* prevalence rate of PTSD in the general population is only 5 percent (Kessler et al, 1994). The one exception to this general rule is social phobia, where WES women have a lower prevalence within the past year, around 7 percent at any wave, than do women in the general population. The rate for women ages 18-54 in the 1990 National Comorbidity Survey is 9.1 percent (Berglund, 2003).

For the most part, maternal health problems did not lessen over time. Rates of major depression and maternal reports of children with health problems did decline somewhat across waves; but rates of PTSD, social phobia, and reports of physical limitations changed only slightly across waves. Rates of GAD actually rose between waves 1 and 4.

The persistence of physical and mental health, and child health problems among WES women are examined when we look at health problems across multiple years. Over the four and one half year period, only 30 percent never reported a physical limitation (column 7, Table 1); so seven in ten respondents met this criteria of poor health. Similarly, 44 percent were depressed, and 35 percent met the clinical screening criteria for PTSD at least once over the period. The lifetime prevalence of PTSD is only 5 percent.

The vast majority of WES women had one or more psychological or physical health problems over the period of study. Over 60 percent of women had any mental

health problem in at least one wave; almost 85 percent had either a physical or mental health problem at least once; and over 37 percent reported a child with a health problem at least once. Poor health is the rule, not the exception, among current and former TANF recipients. This is disturbing given that roughly three in four WES respondents were under age 35 years at the start of the study and that respondents who moved on to Supplemental Security Income rolls are excluded from our sample.

There was considerable long term persistence in health status across waves (Table 1, columns 7 – 8). For instance, 12 percent of respondents reported depression in two waves and another 9 percent in three or four waves. One fifth of the sample reported any mental health problem in three-four waves and one-third had physical limitations at three-four waves.

There were three significant race differences in these distributions, shown in Table 2 (TABLE 2 about here). African-Americans were less likely than whites to ever have met the screening criteria for major depression , to have met the criteria for general anxiety disorder (GAD), and have reported children with health, emotional, or learning problems. African-Americans were also less likely than whites to report any of these three problems at multiple waves. For instance, major depression occurred in 3-4 waves among 6 percent of African-Americans compared to 12 percent of whites; and child health problems were reported in two or more waves by 13 percent of African-Americans and 22 percent of whites. Rates of PTSD, social phobia, and physical limitations did not differ by race. We also ran significance tests for race differences in prevalence of these problems at specific waves (not shown in the tables). African –Americans had

significantly lower rates of depression in three out of four waves, of GAD in two out of three waves, and of child health problems at any wave.

Demographic Characteristics, Human Capital and other Control Measures. Table 3 reports the means on months worked, demographic characteristics, domestic violence, substance dependence, transportation, human capital, and discrimination measures separately by race. (TABLE 3 ABOUT HERE) On average, the WES women had worked in 38.5 months out of the 55 months between February 1997 and August 2001. African-Americans' and whites' average months worked were virtually identical.

Slightly over half the women are African-American. About half of respondents had received welfare in seven or more of the years prior to the wave 1 interview, and over half were married or cohabited with a partner at some point. More than half did not have a car or license at some point. In fall 1997, the mean number of very young children (0-2 years) was .51. Twenty-nine percent of women had either had a baby since wave 1 or were pregnant at wave 4.

There were three significant race differences on demographic characteristics. African-Americans were more likely to have received welfare for 7 or more years prior to Fall 1997, less likely to have married or cohabited, and more likely to report having no car and/or license at a wave

Current and former TANF recipients have low levels of human capital. At wave 1, about 29 percent had less than a high school diploma; 19 percent had fewer than four (out of nine) work skills; and 14 percent worked in less than 20 percent of the years between turning age 18 and the wave 1 interview. At wave 1, one in eight WES women

reported having experienced multiple instances of discrimination on past jobs. On the positive side, most recipients knew work norms; at wave 1 less than 9 percent knew five or fewer of the nine norms we measure. There were no significant race differences in human capital deficits, reports of past discrimination, or knowledge of work norms.

The majority of the sample had not experienced severe domestic violence during the survey period, but one-third reported severe violence in one or two waves and 5% reported having been abused in 3 or 4 waves. Eleven percent of the respondents reported meeting the criteria for substance dependence at one or two waves, either alcohol or drugs, and 1% were dependent at 3 or 4 waves. There were no race differences in prevalence or persistence of these problems.

Multivariate Analyses

Table 4 reports results of the Tobit regressions predicting the number of months that a woman worked over the 55 month period as a function of her demographic characteristics, access to transportation, experiences of domestic violence, substance dependence, human capital characteristics (at wave 1), discrimination experiences (prior to wave 1), health and mental health status, and her children's health status. (See Equation 1). (TABLE 4 ABOUT HERE) The first two columns of numbers in Table 4 report results for the full sample; the second two columns report results for African-Americans; and the third two columns report results for whites. The coefficients measure the increases in the number of months worked per unit increase of the independent variable, evaluated at the mean of the independent variable. Since, for the

most part, coefficients in the Tobit regression do not significantly differ by race, we begin by discussing results for the full sample and then discuss race differences.

Persistent reports of mental health problems, physical health problems, and child health problems were significantly associated with length of employment. Women who met diagnostic screening criteria for a mental health problem at three or four waves worked 5.4 fewer months, evaluated at the mean, than did women who did not meet the diagnostic criteria for a mental health problem in any wave. Women who reported impaired physical functioning at three or four waves worked 4.7 fewer months than did women who never reported impaired functioning. Women who reported a child with a health problem in one or two waves worked 3.5 fewer months, and women who reported a child with a health problem in three or four waves worked 9.1 fewer months than did women who never reported a child with a health problem.

Two demographic variables were associated with employment duration. Women who had lived with husband or partner at 3 or 4 waves worked in fewer months, and women who had a baby between waves or who were pregnant at wave 4 worked in fewer months. The coefficient on the race dummy was tiny, positive and insignificant. Race had no effect on employment duration.

Consistent with cross-sectional WES analyses, a lack of either a car or license mattered for employment. A lack of car or license at three or four waves was associated with 8.8 fewer months of work.

Two human capital measures and perceived discrimination were significantly associated with employment duration. Women who had fewer than four job skills at

wave 1 accumulated 8.9 fewer months of work. Women who had low work experience at wave 1 accumulated 5.9 fewer months of work. Women who reported multiple experiences of discrimination prior to wave 1 worked 4.0 fewer months. Neither domestic violence nor substance dependence were significant for employment duration in these models.

We tested for race differences in Tobit coefficients to see whether the effects health, mental health, child health, demographic characteristics, human capital, and other control measures on the number of months worked varied significantly by race. When several dummy variables were used to represent a factor (e.g., the two mental health dummies), we tested whether the coefficients on the full set of dummies differed significantly by race. There were two significant race differences out of fifteen tests. Living with a husband or partner was associated with fewer months of work for whites but not for African-Americans. Lack of knowledge of work norms had a large, negative, significant coefficient for African-Americans (-5.9) and a large, positive, insignificant coefficient for whites (7.2).

Summary and Discussion

Like previous researchers, we find that the prevalence of health problems among current and former TANF recipients and their children at a point in time is higher than among women and children of similar ages in the general population. Unlike previous researchers, we also examine health problems over multiple years. When viewed over a roughly five-year period, the prevalence of health problems in this vulnerable population is considerably higher than that reported in analyses using shorter time periods. Over

two out of five women met the diagnostic screening criteria for clinical caseness of major depression at one or more of the four WES waves, and almost 35 percent met the criteria for PTSD. Over 60 percent met the diagnostic screening criteria for one of the following four mental disorders – major depression, PTSD, GAD, or social phobia – at one or more interviews. Fully 70 percent reported limitations in physical functioning at one or more interviews. The vast majority – 85 percent – had a mental health or physical health problem at one or more waves. About 38 percent reported a child with a health problem in at least one wave. Health problems were the rule, not the exception, in this sample of current and former TANF recipients.

A second difference between this study and previous research is that we examine the extent to which health problems persist or recur over time. Large minorities of current and former TANF recipients reported health problems at multiple waves. For example, 38 percent met the diagnostic criteria for a mental health disorder at multiple waves, and more than half reported limitations in physical functioning at multiple waves. Almost half had a mental health and/or physical health problem in three or more waves. One hope of welfare reform was that TANF's emphasis on reducing dependency and encouraging work would lead to improvements in family well-being over time. But, with the exception of depression, overall rates of physical health and mental health problems among WES women remained high even five years after respondents were first observed on the welfare rolls.

This study is the first to examine relationships between persistent health problems and employment durations in the post-PRWORA welfare population. We show that

persistent physical health problems, mental health problems and child health problems each are associated with lower employment durations over a 55 month period. These findings are compelling given the young age of our sample (75 percent are less than 35 years old at the start of WES) and given that women who received SSI or other disability income were dropped from this analysis.

When estimating effects of health problems on work duration, we controlled for prior job skills, extent of prior work experience, past experiences of discrimination, and access to transportation, because in previous research, we have shown that many of these factors are associated with employment at a point in time. They are also associated with months worked over the 55 months from February 1997 to August 2001.

One goal of this study was to estimate whether the prevalence of health problems in the welfare population was higher for African-Americans than for whites, and if so, to estimate whether this resulted in lower employment durations for African-Americans. In fact, prevalence of rates of health problems was roughly equal for African-Americans and whites – with three exceptions: African-Americans were less likely to experience depression, to experience GAD, and to report a child with a health problem. There were no race differences in employment durations. Both African-Americans and whites averaged about 38-39 months of work over the study period.

The relatively high rates of physical health problems, mental health problems, child health problems, and prior discrimination as well as the low levels of work experience and low levels of job skills among TANF recipients and ex-recipients are of concern given that all these factors are associated with shorter employment durations.

Current state welfare programs typically focus either primarily or exclusively on job search and pay little or no attention to factors that could influence employment retention, including health and mental health needs, employer discrimination, and human capital development of recipients. More attention needs to be paid to physical and mental health deficits, child health deficits, discrimination and human capital deficits, and how they can prevent women from establishing stable employment records. This is particularly important given that work requirements are likely to increase in the welfare re-authorization, current unemployment rates are high, and no additional funds are allocated to the states to provide services, training, or support to address these issues.

One implication of our research is that recipients and their children should be systematically screened for health problems during TANF intake interviews and referred for health services or counseling. Treatment of such problems, if effective in improving recipients' and their children's health, could improve these individuals' quality of life and could potentially increase the probability of their meeting TANF work requirements and succeeding in building a strong work history over the long run. And, given that these problems recur or persist, or can begin at various intervals, screening and treatment may need to occur at multiple points in the welfare-to-work process.

The prevalence and effects of health barriers for women expected to move from welfare to work also suggests a re-examination of TANF's work participation requirements. PRWORA currently allows women up to two years' time, or less at state option, in which to begin fulfilling work requirements. Michigan, for example, effectively requires this participation to occur immediately if the women are not granted

exemptions from work requirements. The temporary exemptions are allowed for illness, having a child less than 3 months old, caring for a sick family member, or, if under age 18 and still enrolled in high school or GED classes. Michigan and other states could expand the categories of problems for which exemptions are allowed.

On the other hand, current federal law allows states to count a specific array of activities as meeting the work participation requirements, such as working, looking for work, or participating in short term training or public service employment. States are not precluded from defining these activities more broadly to include activities to diagnose and treat these problems. States could count activities to resolve barriers such as getting needed care, training, etc., as meeting participation requirements and allow a certain number of these mandated participation hours to be met by addressing/resolving barriers to employment.

Another health-related concern raised by these findings is health insurance. If women with physical and mental health problems move into low wage jobs without health benefits, their access to health and counseling services may be severely hampered. Women who work while still receiving welfare remain on Medicaid, and women who leave welfare for work are eligible for a transitional year of Medicaid. But when that transitional year ends, what happens to women whose jobs do not provide health benefits or who cannot afford to pay for the health insurance provided by their employers? Currently only thirteen states extend Medicaid coverage beyond one year (Blank, 2002).

Job skills and past work experience at wave 1 strongly predicted employment durations of current/former recipients in our sample. Human capital improvements via

education and training programs for TANF recipients could have a large impact on future work stability. Allowing education and training to count as meeting requirements for work participation could increase the skills of TANF recipients.

Our findings with respect to discrimination experiences in the workplace also have implications for policies and programs. While we find few differences in barriers to work or in the work stability of African-American and white current and former recipients, we find that prior experiences of perceived discrimination at the work place on the basis of race, gender, or welfare receipt are associated with shorter employment durations. Although the measure of perceived discrimination, and our findings must be interpreted with caution, workplace discrimination based on such stereotypes is not addressed in current programs promoting employment. If confirmed by further research, our findings imply the need for anti-discrimination policies directed to employers, as well as to individual workers.

Finally, we add several policy cautions. Many states are experimenting with short time limits for TANF recipients. Time limits may especially penalize recipients who are not work ready because of physical health, mental health child health problems and/or human capital deficits. In other words, many who remain on the rolls and do not successfully leave for work may lose benefits due to these problems. In addition, these women may be especially targeted by sanctions policies. Reducing their benefits for noncompliance to work requirements may put their vulnerable health and safety at risk and further reduce their long-run employability.

Recent policy discussions as welfare reform reauthorization loomed but failed to pass in 2002 did not result in increased funding or policy language that would encourage states to increase services to address the multiple barriers that we find associated with the work success of TANF recipients. For example, the House Bill H.R. 4700 increased the proportion of recipients who must be enrolled in work requirements to 70% and increases the number of hours per week that they must comply with work requirements to 40 hours per week. While there is some flexibility in what can be counted as meeting work requirements, such demands on state programs prohibit their ability to assess, refer, and monitor the receipt of services by large numbers of recipients (see also Fremstad et al, 2002). In contrast, more consistent with our study findings, the Senate Finance Committee proposal had explicitly allowed states to provide rehabilitative services and count them as work, but for only a limited portion of a recipient's time on TANF, 3 of 24 months. Given current state fiscal problems, it is unlikely that state legislators will expand services to promote the work and well-being of welfare recipients.

Appendix A

Demographic controls include dummy variables indicating race, number of children age 0-2, whether pregnant between waves and whether pregnant at wave 4, and number of waves at which respondent was married/cohabitating. Welfare history was measured by a dummy variable indicating whether respondent had received welfare for seven or more years as of wave 1 (the mean years of welfare receipt in the sample was 7). Transportation problems are measured by set of dummy variables indicating the number of waves at which respondent did not have a license and/or access to a car.

Domestic violence was assessed with a modified version of the Conflict Tactics Scale, (Straus 1979). Domestic violence problems are measured by a set of dummy variables indicating the number of waves at which a respondent reported having experienced severe abuse. Severe abuse is defined as having experienced one or more of the following in the 12 months prior to the wave interview; being hit with a fist, being hit with an object that could hurt, being beaten, being choked, being threatened with or hurt by a weapon, being forced into sexual activity against her will.

Substance dependence is based on diagnostic screening batteries for 12-month prevalence of either alcohol or drug dependence, using the Composite International Diagnostic Interview derived from the national Comorbidity Survey (Kessler et al, 1994). “Dependence” on drugs or alcohol is more restrictive than a use or abuse measure, because the respondent has to meet criteria of likely needing treatment and having functional impairment due to her use of substance (see also Jayakody, Danziger, & Pollack, 2000).

Schooling is measured by a dummy variable indicating if the respondent lacks a high school diploma or GED. A second dummy variable measures the skill content of all jobs held by the respondent prior to Fall 1997. Based on a set of work skills adapted from Holzer (1996), a respondent was coded as having low work skills if on previous jobs she had performed fewer than four of nine listed tasks, such as having written letters or memos, filled out forms, used math, worked with electronic machines, talked with customers, worked with computers, supervised people etc. We measure low work experience by a dummy variable indicating respondent has worked less than 20 percent of time since turning age 18. We classified a woman as not knowing work norms by a dummy variable that indicates that she did not know at least five of a set of nine norms adapted from Berg, Olson and Conrad (1991). (See Danziger et al., 2000 for more detail on these measures).

The measure of employment discrimination experience is based on self-reports of discrimination. Women were asked whether they had experienced any of 5 types of discrimination on jobs held prior to fall 1997 – losing pay or promotion, firing, hiring,

disparaging remarks, or general discrimination – on the basis of race, sex, or welfare status. They were also asked about sexual harassment. These questions were modeled in those used by Bobo (1995). A dummy variable indicates women who reported four or more of these 16 types of discrimination.

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TABLE 1. Mental Health and Health Status (N=503)

Mental Health and Health Characteristics	Prevalence at				Never	One Wave	Two Waves	Three to Four Waves
	wave 1	wave 2	wave 3	wave4				
	(1)	(2)	(3)	(4)				
Major Depression	25.1%	15.5%	17.7%	17.7%	55.5%	24.5%	11.5%	8.6%
Post Traumatic Stress Disorder	15.7%	13.7%	14.1%	14.7%	65.2%	18.3%	10.9%	5.6%
Generalized Anxiety Disorder	6.4%	NA	9.9%	9.9%	79.5%	15.7%	3.8%	1.0%
Social Phobia	NA	7.6%	6.8%	7.0%	85.3%	9.9%	3.0%	1.8%
Any Mental Health Problem	34.2%	28.6%	33.6%	31.8%	38.2%	23.5%	18.1%	20.2%
Physical Limitations	44.9%	45.3%	40.7%	42.1%	29.6%	18.7%	18.1%	33.6%
Any Mental Health Problem or Physical Limitation	59.4%	57.7%	55.5%	55.7%	15.3%	17.3%	18.5%	48.9%
Child Has a Health Problem	21.3%	16.3%	12.7%	14.1%	62.4%	20.5%	9.7%	7.4%

Note: Sample includes only respondents who were interviewed at all four waves, and who had no missing values on any of the analyzed variables in the Tobit regression (Table 4),and excludes 40 cases who reported receiving SSI/disability at wave 2, wave 3, or wave4.

TABLE 2. Mental Health and Health Status by Race (N=503)

Mental Health and Health Characteristics	African-American (N=283)				Whites (N=220)			
	Never (1)	One Wave (2)	Two Waves (3)	Three to Four Waves (4)	Never (5)	One Wave (6)	Two Waves (7)	Three to Four Waves (8)
Major Depression	56.9%	24.4%	13.1%	5.7%	53.6%	24.6%	9.6%	12.3%
Post Traumatic Stress Disorder	65.4%	18.7%	11.3%	4.6%	65.0%	17.7%	10.5%	6.8%
Generalized Anxiety Disorder	83.0%	12.7%	2.8%	1.4%	75.0%	19.6%	5.0%	0.5%
Social Phobia	86.6%	9.9%	1.8%	1.8%	83.6%	10.0%	4.6%	1.8%
Any Mental Health Problem	39.6%	25.1%	17.3%	18.0%	36.4%	21.4%	19.1%	23.2%
Physical Limitations	29.0%	20.5%	16.3%	34.3%	30.5%	16.4%	20.5%	32.7%
Any Mental Health Problem or Physical Limitation	15.9%	17.7%	18.7%	47.7%	14.6%	16.8%	18.2%	50.5%
Child Has a Health Problem	65.0%	21.6%	7.4%	6.0%	59.1%	19.1%	12.7%	9.1%

Note 1: See Note in Table 1 for sample description.

Note 2: We checked for black/white difference on the distribution of health problems across waves.

The black/white differences in the distribution of major depression were significant at the 5% level.

The black/white differences in the distribution of generalized anxiety disorder and child health problem were significant at the 10% level.

TABLE 3. Work Outcomes, Demographic and Human Capital Characteristics

	<u>All Rs</u> (N=503)	<u>Blacks</u> (N=283)	<u>Whites</u> (N=220)
<u>Work Outcomes</u>			
Mean Number of Months Worked Between Feb. 1997 and Aug. 2001 (55 months)	38.50	38.74	38.20
<u>Demographic Characteristics</u>			
Race (w1)			
African-American	56.3%		
White	43.7%		
Mean Number of Rs' Children in HH at W1			
Age 0 - 2 years	0.51	0.52	0.50
Pregnant at W4 or Had a Baby since W1	29.2%	27.2%	31.8%
Received Welfare for 7+ years	47.9%	54.4%	39.6%
Living with Husband or Partner at			
One or Two Waves	28.8%	29.3%	28.2%
Three or Four Waves	27.0%	15.9%	41.4%
Never	44.1%	54.8%	30.5%
<u>No Car/License at</u>			
One or Two Waves	27.2%	29.7%	24.1%
Three or Four Waves	24.7%	31.1%	16.4%
Never	48.1%	39.2%	59.6%
<u>Human Capital Characteristics (W1)</u>			
Less than High School Education	28.8%	29.7%	27.7%
Fewer than 4 Job Skills	18.7%	20.5%	16.4%
Low Work Experience	13.7%	12.4%	15.5%
Knows 5 or Fewer Work Norms	8.8%	10.3%	6.8%
Experienced Discrimination	13.1%	14.8%	10.9%
<u>Domestic Violence at</u>			
One or Two Waves	31.3%	32.6%	29.6%
Three or Four Waves	5.2%	4.3%	6.4%
Never	63.6%	63.1%	64.1%
<u>Alcohol or Drug Dependence at</u>			
One or Two Waves	11.3%	11.0%	11.8%
Three or Four Waves	1.0%	1.1%	0.9%
Never	87.7%	88.0%	87.3%

Note 1: See Table 1 Note for sample description.

Note 2: We tested for black/white difference on distributions of the measures above.

Differences on these sets of variables were significant at the 1% level:

Living with husband or partner, No car/license, and Received welfare for 7+ years.

TABLE 4. Tobit Regressions Predicting # of Months Worked Between Feb. 1997 and Aug. 2001

	<u>ALL</u>		<u>BLACK</u>		<u>WHITE</u>	
	<u>B</u>	<u>SE</u>	<u>B</u>	<u>SE</u>	<u>B</u>	<u>SE</u>
<u>Demographic Characteristics</u>						
African-American	1.1539	1.558				
# of Children Age 0 - 2	-1.4470	1.207	-2.1410	1.570	-0.6746	1.851
Pregnant at W4 or Had a Baby since W1	-7.5570 *	1.719	-6.1401 *	2.296	-8.1693 *	2.589
Received Welfare for 7+ years	-1.1076	1.627	-2.0663	2.191	0.1062	2.434
Living with Husband or Partner at						
One or Two Waves	0.2159	1.743	2.920	2.236	-5.3504 **	2.796
Three or Four Waves	-3.3867 **	1.842	0.2691	2.738	-6.9464 *	2.477
<u>No Car/License at</u>						
One or Two Waves	-2.3033	1.771	0.2907	2.377	-4.0273	2.734
Three or Four Waves	-8.7623 *	2.109	-7.502 *	2.575	-8.2170 *	3.811
<u>Human Capital Characteristics</u>						
Less than HS Education	-2.1731	1.710	-0.514	2.295	-3.0626	2.560
Fewer than 4 Job Skills	-8.8626 *	2.081	-7.5311 *	2.734	-9.6916 *	3.195
Low Work Experience	-5.8596 *	2.298	-8.8974 *	3.293	-2.6627	3.095
Knows 5 or Fewer Work Norms	-1.7135	2.575	-5.904 **	3.213	7.2055	4.483
Experienced Discrimination	-4.8606 *	2.145	-3.671	2.736	-5.8740 **	3.436
<u>Any Mental Health Problem at</u>						
One or Two Waves	-1.4562	1.650	-1.6806	2.184	-1.5710	2.447
Three or Four Waves	-5.4054 *	2.357	-8.0845 *	3.351	-2.8570	3.290
<u>Physical Limitations at</u>						
One or Two Waves	-1.1068	1.820	-2.5257	2.565	-0.8073	2.546
Three or Four Waves	-4.6767 *	1.927	-5.6033 *	2.656	-4.6222 **	2.748
<u>Child Has a Health Problem at</u>						
One or Two Waves	-3.4769 *	1.614	-3.0805	2.186	-3.8115	2.344
Three or Four Waves	-9.0834 *	2.874	-5.082	4.141	-13.2864 *	4.008
<u>Severe Domestic Violence at</u>						
One or Two Waves	1.3165	1.702	-0.350	2.245	2.6689	2.597
Three or Four Waves	4.6473	3.391	1.0433	4.933	7.2001	4.687
<u>Alcohol or Drug Dependence at</u>						
One or Two Waves	-0.2836	2.528	-1.0704	3.540	1.2234	3.523
Three or Four Waves	-3.6411	7.405	0.619	9.584	-8.9956	11.562
Constant	55.0307 *	2.321	55.825 *	2.842	56.2293 *	3.430

N

503

283

220

Note 1: We checked for significance of Black/White differences in Coefficients. The coefficients on "Living with Husband or Partner at one or two waves", "Living with Husband or Partner at three or four waves", and "Knows 5 or Fewer Work Norms" were significantly different for Blacks and Whites at the 5% level.

Note 2: * $p < .05$ and ** $p < .01$