

**Long Term Employment 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 current and former welfare recipients to estimate the prevalence and persistence of health problems in the post-reform welfare population and their role in women's 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 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 over a 4½ -year period. Women who reported physical health, mental health, or child health problems at multiple waves worked fewer months. There were no race-based differences in employment length or in physical health problems, but African-Americans were less likely than whites to meet the diagnostic screening criteria for depression, to meet criteria for general anxiety disorder, and to report a child with a health problem. These findings suggest that the inclusion of persistent health problems as determinants of work in human capital models increases understanding of the transition from welfare to work. Policies need to reexamine welfare's work requirements to encourage states to provide services and supports to recipients.

KEY WORDS. Employment of welfare recipients, race differences, health problems

The Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996 led some analysts to warn 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 rates of depressive symptoms and physical health problems among welfare recipients and their children were higher than among women and children in the general population. Recent reviews 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).

The receipt of cash welfare is now conditioned on work and/or participation in work-related activities. Most states primarily provide job search assistance in welfare-to-work programs and do not systematically screen and assess participants for physical and mental health problems that may constrain their ability to work. These programs also tend not to provide referral, treatment, and counseling services to recipients with such problems. (S.K. Danziger and Seefeldt, 2002)

A related concern is whether health problems make it harder for African-American welfare recipients than white, non-Hispanic recipients to establish stable employment and leave welfare. In the general population, African-American women have higher rates of chronic physical health problems than do white women. The existence and extent of race differences in the physical and mental health status of welfare recipients and how this affects employment has not yet been demonstrated.

This paper uses data from 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. We investigate whether physical health problems, mental health problems, and child health problems limit their ability to establish stable employment (holding constant characteristics such as family structure and human capital deficits). 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?
- Does the prevalence of these problems persist or change over time?
- Does the prevalence or persistence of these problems vary by race?
- Are persistent physical health problems, persistent mental health problems, and persistent child health problems associated with fewer months of employment, controlling for other factors?

- Do African-Americans work fewer months than whites? Do effects of health on long term employment vary by race?

Background

Despite concerns that physical and mental health problems hinder transitions from welfare to work, research on the health status of recipients and their service needs prior to the 1996 reform was 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 recipients. Salomon, Bassuk, and Brooks (1996) found high rates of limitations in physical functioning and chronic medical conditions in a cross-sectional study of welfare recipients; they also found that long-term recipients had lower levels of physical functioning than did short term recipients. The research showed that these problems were common, but did not link them to work or to length of employment.

These early studies 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). Three studies--Zedlewski and Alderson 2001, Loprest 2001, Danziger et al. 2000 – report high rates of health problems among TANF recipients. Danziger et al. (2000) report that the prevalence rates of mental and physical health problems among 753 women who were TANF recipients in an urban county in Michigan in February 1997 were considerably higher than those for women of comparable ages in the larger population. They found that contemporaneous health problems and meeting the diagnostic screening criteria for major depressive disorder were significantly and negatively associated with employment. A recent review of several studies of TANF recipients also confirms high rates of health and mental health problems and that these problems pose employment risks (Levin-Epstein, 2003).

Most research on recipients' health and employment examines their relationship over short periods of time. There is little research either on the persistence of their health problems or on the associations between persistent health problems and long term employment. One exception,

Ensminger's (1995) longitudinal study of 833 African American mothers in a Chicago neighborhood, found that long-term Aid to Families with Dependent Children 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 terms of employment, but neither Ensminger (1995) nor others have directly examined this issue.

Past studies have not explored how health problems among TANF mothers are related to their long term employment. Nor have they addressed whether white and African American women differ in the patterns of relationships between health and work. When examining this relationship, it is important to control for likely confounding characteristics. Factors highly prevalent among welfare mothers that have been found to predict employability at a point in time include: being single, having young children, low education, low work skills and experience, long history of welfare, lack of transportation, and problems such as perceived discrimination, substance dependence and domestic violence (Corcoran et al., 2000; Danziger et al., 2000).

This study's approach (1) particularizes the established associations between socioeconomic status (SES), gender, race, and health, and (2) expands human capital models of employment for welfare women. The association between poverty (low SES) and poor physical health is well documented (Mullahy & Wolfe, 2001; Williams, 2001). Racial and ethnic disparities in health are in part due to SES differences (such as higher poverty and welfare reliance among African Americans compared with Whites) as well as differences in medical care, racism, and stress (Williams, 2002). Wheaton (2001, 221-222), describes the connection between SES and mental health: "First, social environment is both a starting point and a carrier of the fact of emotional inequality, and, second, variation in emotional functioning has specific social consequences for our institutions and our society."

We argue that models of work for women generally, and in particular, low wage women, are limited if they focus solely on human capital. According to Conrad, human capital theory predicts that a

woman's decision to work is a function of her expected wage, her nonmarket 'productivity' as reflected in number of children, marital status, and living arrangements, and her nonlabor income, such as earnings of others in the household and receipt of welfare (Conrad, 2001, 143-144). Conrad (2001) adds that good health can increase work by increasing labor market productivity. Our paper extends the human capital model to incorporate the roles of persistent mental and physical health problems in reducing employment over time as women move into work. We suspect that persistent health and mental health problems can reduce capacity and motivation to work and reduce an employer's willingness to hire and retain a woman.

This paper uses data from four waves of WES to extend past research. First, we examine for current and former TANF recipients the extent to which physical and mental health problems and child health problems persist or change over time. One hope was that welfare reform, by promoting work and responsibility, might improve recipients' and their children's well-being over many dimensions, including health. Second, Blank (2002), Hershey and Pavetti (1997), and Kaye and Nightingale (2000) caution that the success of welfare reform depends in large part on whether recipients can remain stably employed. This is one of the first studies to examine in multivariate models the correlates of time employed over multiple years. Third, WES has comprehensive information based on well-validated measures, enabling us to explore whether *persistent* physical health problems, *persistent* mental health problems, and *persistent* child health problems are associated with women's employment over a period of about 55 months. Fourth, in addition to controlling for the usual predictors of women's work in human capital models – family characteristics, education, skills, and experience - , we control for factors that may impede work among low wage women workers, such as transportation, substance dependence, experiences with job discrimination, and domestic violence. Finally, Zedlewski and Alderson (2001) found that African-American women constituted a larger share of the welfare caseload in 1999 than in 1997, and speculated that African-American women may find it harder to remain off TANF than white

women. We investigate whether there are race differences in TANF recipients' long run employment when health and other factors are controlled.

Methods and Data

WES respondents were selected with equal probability from single mothers with children who received TANF in an urban Michigan county in February 1997. Respondents were interviewed 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 present at all four interviews, who were not receiving Supplemental Security Income (SSI recipients are not required to work), and who had no missing data on variables used in the analyses. This left 503 women.

The characteristics of the original sample do not differ from the population of welfare recipients in the county. In 1997, the mean age of the sample and county caseload was 29 years of age, ranging from ages 18-54, and the proportion African American was 55% for the county and 56% for the sample. While age is comparable to that of the national TANF caseload, the national caseload has higher proportions of Hispanic families than does this Michigan county.

Our dependent variable is the number of months worked between February 1997 and August 2001. In wave 1, respondents were asked 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 other waves, respondents were asked whether or not they had worked for pay in each calendar month between the current and previous waves. We calculate the number of months in which respondents worked over the 55 month period from February 1997 to August 2001.

Respondents were asked about physical and mental health and their children's health in each wave. Physical health was assessed using standard items from the Physical Functioning subscale of the SF-36 (Ware et al., 1993). Respondents were asked whether their health limits their daily activities a lot, a little, or not at all in walking, lifting, climbing stairs, bending, carrying bundles, etc. Following

SF-36 coding, respondents scoring in the lowest age-specific quartile (based on population norms) in a wave were defined as having physical limitations. We defined “having a child with a health problem” if a child under age 18 had a physical, emotional, or learning problem that limited his/her activity.

WES collected data on four mental health disorders, replicating internationally-validated measures: major depression, post-traumatic stress syndrome (PTSD), generalized anxiety disorder (GAD), and social phobia (Kessler et al., 1994; 2002). 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 and scoring is based on 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 We code a respondent as having a mental health disorder in a wave if she met within the 12 months prior to the interview the diagnostic screening criteria for any disorder measured. We measure the presence and persistence of these problems--physical limitations, child health problems, mental health problems-- across waves by creating variables that indicate whether the problem occurred at 1 or 2 waves or at 3 or 4 waves. For instance, the 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

WES provides many personal characteristics that we employ as control measures. We include demographic 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 the respondent was married or cohabiting. We include a control for pregnancy or very young children, because welfare recipients in Michigan are exempted from work requirements only from the time of birth until the youngest child reaches three months of age; we assume that pregnancy and childcare for those aged 0-2 pose unique problems for work stability. We tried an alternative specification including the number of children aged 3-5, but this variable was insignificant in these models.

Welfare history is measured by a dummy variable indicating whether received welfare for 7 or more years as of wave 1 (the mean years of receipt in the sample). Transportation problems are measured by number of waves the respondent lacked access to a car and/or did not have a driver's license. Domestic violence was assessed with a modified version of the nationally-validated Conflict Tactics Scale (CTS, Straus, 1979); it indicates the number of waves at which a respondent reported having experienced at least one of 6 types of severe abuse in the last 12 months. Substance dependence is based on meeting the diagnostic screening criteria in the last 12 months for alcohol or drug dependence, validated in the National Comorbidity Survey (Kessler et al., 1994).

Schooling is a dummy variable indicating if the respondent lacks a high school diploma or GED. We measure skill content of jobs held prior to Fall 1997 using an instrument adapted from Holzer (1996). A respondent has low work skills if on previous jobs she had performed fewer than four of nine tasks, such as having written letters or memos, used math, or worked with computers. Low work experience is measured as having worked less than 20 percent of time since turning age 18. We classified a woman as not knowing work norms if she did not know at least five of nine norms (from Berg, Olson and Conrad (1991).

Employment discrimination is based on self-reports. Adapted from Bobo's survey research, (1995), 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. A dummy variable indicates women reported four or more of 16 types of discrimination.

Sample Description

Table 1 reports the means on months worked and control variables for all respondents and separately by race. (TABLE 1 ABOUT HERE) There are few race differences on work and control measures. The average respondent worked in 38.5 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 years prior to wave 1, 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 children ages 0-2 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.

Levels of human capital are low. At wave 1, about 29 percent had less than a high school diploma; 19 percent had used fewer than four (out of nine) work skills on previous jobs; and 14 percent had low prior work experience. At wave 1, one in eight reported multiple instances of discrimination on past jobs. On the plus side, most recipients knew work norms--at wave 1 less than 9 percent knew five or fewer of the nine norms. There were no significant race differences in human capital deficits, reports of past discrimination, or knowledge of work norms.

One third of respondents reported domestic violence in one or two waves and 5% reported abuse in 3 or 4 waves. Eleven percent reported meeting the criteria for either alcohol or dependence at one or two waves, and 1% was dependent at 3 or 4 waves. There were no race differences in these problems.

Analysis Strategy

We explore the relationships between health, mental health, child health, and time employed 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, and individual control characteristics.

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

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

X = a set of demographic, transportation, domestic violence, substance dependence measures

HC = a set of human capital controls

H = health measures

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. Tobit corrects for the limited range of possible months that women can report.

Health and Mental Health Status

Table 2 shows the health status of respondents and their children. (TABLE 2 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. Consistent with recent studies (Levin-Epstein, 2003), 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 met the criteria for at least one mental health diagnosis, and over half had either a physical limitation or mental health diagnosis.

The prevalence of these problems at a point in time typically exceeds rates found in national surveys of U.S. women of comparable ages (18-54). For example, although at each wave over 40 percent of WES women reported 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 depression at each wave, compared to 13 percent for women in general (Kessler et al, 1994). At each wave, 14 to 16 percent of respondents met the criteria for 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 pattern is social phobia, where WES women have a lower prevalence within the

past year, around 7 percent at any wave, than do women in general. The rate for women ages 18-54 in the 1990 National Comorbidity Survey is 9.1 percent (Berglund, personal communication, 2003).

For the most part, health problems did not lessen over time. Rates of major depression and maternal reports of child health problems did decline somewhat between waves 1 and 4; but rates of PTSD, social phobia, and reports of physical limitations changed only slightly and rates of GAD rose. Poor health is the rule, not the exception, even though this is a relatively young sample. Over 4 1/2 years, only 30 percent never reported a physical limitation (column 7, Table 2). Over this period, 44 percent met the criteria for depression, and 35 met criteria for PTSD at least once. The majority had one or more psychological or physical health problems over the study period. Over 60 percent had a 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.

Health problems were frequently persistent: 12 percent of respondents met criteria for depression in two waves, and another 9 percent in three or four waves (Table 2, columns 7 – 8). One in five reported a mental health problem and one in three, physical limitations, at three-four waves.

Only three significant race differences occurred in Table 3 (TABLE 3 about here). African-Americans were less likely than whites to have met the screening criteria for major depression, the criteria for general anxiety disorder (GAD), or to have a child health, emotional, or learning problem at any wave. African-American women were less likely than whites to report any of these 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 in two or more waves, 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 (data not shown). African-Americans had significantly lower rates of depression in three of four waves, of GAD in two of three waves, and of child health problems at any wave.

Multivariate Analyses

Table 4 reports results of the Tobit regressions predicting the number of months worked as a function of individual characteristics, health, mental health, and child health status. (TABLE 4 ABOUT HERE) The first two columns report results for the full sample; the second set, results for African-Americans; and the third, for whites. The coefficients measure increases in the number of months worked per unit increase of the independent variable, evaluated at the mean of the independent variable. Most coefficients in the Tobit regression do not significantly differ by race.

Persistent reports of mental health, physical health, 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 women who never met the criteria. Women who reported impaired physical functioning at three or four waves worked 4.7 fewer months than did women who never reported impairment. 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 child health problems.

Several control variables were associated with months worked. Women who had lived with a 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. Women who had fewer than four job skills at wave 1 accumulated 8.9 fewer months of work; those with 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. A lack of car or license at three or four waves was associated with 8.8 fewer months of work.

Race had no effect on months worked. We tested for race differences in Tobit coefficients to see whether the effects of health, mental health, child health, or other control measures on the number of months worked varied 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 negative, significant coefficient for African-Americans (-5.9) and a positive, insignificant coefficient for whites (7.2).

Summary and Discussion

As in previous research, we find that prevalence of health problems among current and former TANF recipients and their children is the norm and is higher than in the general population. Unlike earlier research, we examine health problems over multiple years and in the context of a broad array of other contextual factors that co-occur at high rates among welfare recipients and could impede work. When viewed over a roughly five-year period, prevalence of health problems increases. Over two out of five women met the diagnostic screening criteria for major depression at one or more waves, almost 35 percent met the criteria for PTSD. Over 60 percent met the criteria for one of 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 and 85 percent had a mental or physical health problem at one or more waves. About 38 percent reported a child with a health problem in at least one wave.

A second difference between this study and previous research is that we examine the persistence of health problems. Large minorities of current and former recipients continued to report health problems over multiple waves: 38 percent met the diagnostic criteria for a mental health disorder at multiple waves; more than half had 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 if TANF reduced dependency and encouraged work, it would lead to improvements in family well-being. But, with the exception of a decrease in the rate of depression, physical and mental health problems remained consistently high throughout waves.

This study is the first to examine relationships between women's persistent health problems and time employed after welfare reform. We show that persistent physical and mental health problems and

child health problems are associated with fewer months of employment over 55 months. These findings are compelling given the young age of our sample, the exclusion of women who received SSI from this analysis, and the wide array of control factors we included. Other studies of low wage women's labor force participation need to incorporate measures of health and mental health problems.

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 length of employment for African-Americans. In fact, prevalence rates of health problems were roughly equal for African-Americans and whites and there was no significant race difference in months worked. White and African American women obtain comparable amounts of employment experience over time both before and after their health status, human capital, and other characteristics, including experiences of prior job discrimination on the basis of race, gender, or welfare history, are taken into consideration.

The findings are limited to a sample in one Midwestern state and one urban county, particularly one with few recipients of other race and ethnic origins, such as Hispanics. Further research replicating these analyses with other samples of current and former welfare recipients is warranted. Of particular interest is whether the findings hold for women who entered the welfare rolls after welfare reform. The WES respondents were a transitional cohort on the rolls when the new law took effect and when the economy was strong. They may have different work trajectories than later groups of recipients or those in rural areas.

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 job skills, are of concern given that these factors are associated with fewer months worked. Current state welfare programs typically focus on job search and pay little attention to factors that could influence employment retention, including health and mental health needs, experiences of employer discrimination, and human capital development of recipients. More research and policy attention needs

to be paid to these problems and the processes by which they prevent women from establishing stable employment records. This is important because work requirements will likely be raised when welfare is re-authorized, and given high current unemployment rates that may reduce the hiring of welfare recipients. Of equal concern, no funding increases to states for services, training, or support to address these issues is likely to occur in the near term.

Our findings imply that recipients and their children should be systematically screened for health and mental health problems during TANF intake interviews and referred for health services or counseling. The high rates of measurable problems that do not reach the level of qualifying the women for disability, but do reduce work, impede the goals of welfare reform. Treatment of such problems, if effective in improving recipients' and children's health, could improve their quality of life and increase the probability of meeting TANF work requirements and building a strong work history.

The prevalence and effects of health barriers for white and African American 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, 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, for health and mental health care, for example.

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 participation in treatment programs. States could count activities such as getting needed care, training, etc., as meeting participation requirements and allow a certain number of mandated participation hours to be met by addressing/resolving barriers to employment.

Another concern relates to health insurance, obviously an important consideration among a group with high prevalence of health problems. If women with physical and mental health problems move into low wage jobs without coverage, their access to services may be hampered. Women who work while receiving welfare remain on Medicaid (and even this level of work, required as a condition of welfare receipt, could be compromised by having health problems); 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 insurance provided by employers? Currently only thirteen states extend Medicaid coverage beyond one year (Blank, 2002).

Finally, we add several policy cautions. Many states are experimenting with short time limits for TANF. Time limits may penalize recipients who are not work ready because of physical health, mental health, and/or child health problems. In addition, these women may be vulnerable to sanctions policies. Reducing their benefits for noncompliance with work requirements may put their health 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 address the multiple barriers associated with the work success of TANF recipients. For example, House Bill H.R. 4700 increased the proportion of recipients who must enroll in work to 70% and the number of hours per week from 30 to 40 hours. 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 (Fremstad et al, 2002). In contrast, the Senate Finance Committee proposal 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 address the range of health problems that we have documented.

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Table 1. 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 2 Mental Health and Health Status (N=503)

Mental Health and Health Characteristics	Prevalence at				Never (5)	One Wave (6)	Two Waves (7)	Three to Four Waves (8)
	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 wave 4.

Table 3 Mental Health and Health Status by Race (N=503)

Mental Health and Health Characteristics	African-American (N=283)				Whites (N=220)			
	Never	One Wave	Two Waves	Three to Four Waves	Never	One Wave	Two Waves	Three to Four Waves
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(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 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

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). 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.

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.