UNDERSTANDING FAMILIES WITH MULTIPLE BARRIERS TO SELF SUFFICIENCY

Final Report

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EXECUTIVE SUMMARY

This report summarizes results of the study entitled,"Understanding Families with Multiple Barriers to Self Sufficiency." The study was commissioned by the Department of Workforce Services (DWS) to address the situation of families who may be at risk due to Utah's three-year lifetime limit on cash assistance under the Family Employment Program. The purposes of the study were a) to describe families who face severe, persistent, and multiple barriers to self-sufficiency, including incidence and prevalence of mental illness, substance abuse, and physical disabilities and the extent to which families face one or more of these characteristics; b)to discuss the extent to which traditional interventions are effective in reducing barriers to self-sufficiency, and c) to address the probable effects of time limits on cash assistance to families who face barriers to self-sufficiency.

Study methods included multiple types of data collection and analysis. Data were obtained from Utah Department of Workforce Services, focus groups with front-line agency staff, and comprehensive interviews with long-term welfare dependent families. Client interviews included clinically relevant measures of mental health and health conditions including clinical depression, anxiety disorder, post-traumatic stress syndrome, child behavior problems, learning disabilities, substance abuse and domestic violence.

Findings from all three sources of data suggest that long-term welfare families face severe, persistent and multiple barriers to self-sufficiency. A striking percentage of study participants scored positively for clinical depression (42.3%), Generalized Anxiety Disorder (6.7%), Post-traumatic stress syndrome (15.1%), learning disability (23%), physical health problems that prevent work (34.9%), poor work history (30.4%), severe child behavior problems (23%), severe domestic violence within the last 12 months (12.3%)

The vast majority of families (92.3%) faced at least one substantial barrier to self-sufficiency. The most commonly reported number of barriers was three (26.1% of families reported three barriers.) Thirty-seven percent of the families faced four or more barriers to self-sufficiency. The likelihood of having a mental health, health, work, or family barrier to self-sufficiency was much higher for the long-term group than for all Utah welfare recipients, and much higher than would be probable in the general U.S. population.

Assessment measures for long-term welfare recipients are not adequate to determine which recipients

are most at risk for long-term dependence. Employment counselors report that often a recipient is on assistance for a year or more before there is recognition of serious barriers to self-sufficiency. Also, more collaborative, empowering and aggressive treatment methods are necessary to help recipients become self-sufficient within the three-year limit.

SUMMARY OF KEY FINDINGS

- The presence of a mental/emotional problem history is a key factor in distinguishing short- and long-term Family Employment Program (FEP) participants.
- FEP employment counselors see long-term recipients as distinctive in that they: have limited work and educational experiences, have impaired intellectual functioning, are manipulative and lacking in self-discipline, and have severe mental health problems.
- Although FEP employment counselors are concerned about the impact of lifetime limits on clients, they worry that they will lose credibility if the limits are eliminated.
- Long-term welfare clients consume a disproportionate amount of employment counselors' time and energy.
- Up to a point, long-term welfare clients look like most members of the Utah population. They are primarily Caucasian and female, average 34 years old, and are likely to be members of the LDS faith.
- When personal histories are examined, long-term welfare clients are considerably different from most members of the general public and most other welfare recipients: Over half reported that they had been physically or sexually abused before the age of 1, 12.3% had experienced severe domestic violence in the year prior to our interview, over one-fourth had been convicted of a crime, over half had a physical disability or health problem that limited their activities, one-fourth screened positively for a learning disability, and nearly half had been the subject of a CPS referral.
- The reasons for going on and off welfare have been remarkably consistent for these long-term clients. About half went on welfare because of pregnancy or a change in family circumstances and about one-third have gone off welfare because they found employment.
- Long-term clients have considerably higher levels of mental health and health problems, and more family and work barriers than do other welfare recipients, or the general public.
- Long-term clients have not only severe and persistent barriers, but multiple barriers to self-sufficiency.
- Respondents were generally positive in their response to self-sufficiency activities and the assistance they received from their employment counselors; however they were unlikely to discuss two important barriers with FEP staff. These were a spouse or partner's objection to their working and the presence of a substance or alcohol problem.
- Three types of barriers: health/mental health, work/education, and family are, individually and in combination, important predictors of client's welfare histories and employment status.

Recommendations for policy and practice are as follows:

1. **Rapid, accurate assessment is necessary** if the DWS staff is going to identify barriers to self-sufficiency, and work to create a plan which will move clients to self-sufficiency within the required time limit. Employment counselors have noted that they lose valuable time working with clients to help them become self-sufficient, because it takes as long as a year to understand the client's problems. Rigorous assessment should take place upon application for assistance in order to target families that will need specialized services.

2. **Aggressive service delivery, focused on employment must be offered during the client's three years on assistance.** Some of the barriers facing these families are intractable. For example, well-established child behavior problems, severe mental illness, and addiction present situations in which the likelihood of a permanent "cure" is often low. So employment supports must take these as "givens" in clients' lives. A practical approach would address client change (by shoring up coping abilities) and improve environmental

supports (by mobilizing formal and informal resources). Clearly the goal of this aggressive service delivery must be to create permanent supports that will sustain these troubled people in productive employment.

3. **DWS should work in conjunction with other public agencies that provide services to long-term clients**. The majority of long-term clients are involved in multiple systems -- child welfare, substance abuse services, juvenile justice and/or mental health services. Because of the severe consequences of reaching the time limit, agencies should work together to help stabilize families and help them find the means to become self-supporting. Services may include family counseling, substance abuse or mental health counseling, medication, and job training. It is a disservice to Family Employment Program (FEP) clients to present them with differing treatment methods and goals which may work at cross-purposes. Client privacy and confidentiality are important, but agencies must find a way of working together, through case conferencing or shared electronic systems to support FEP families in their efforts to become self-sufficient.

4. **The 20% hardship extension should be reviewed annually during the program's first years of operation, keeping in mind the possible need for an increase to be applied to the period between 3 and 5 years as allowed by federal law**. The percentage of clients who are long-term and have multiple barriers has historically been over 40% of the current total caseload. The clients left on the caseload face more difficult and intractable challenges than those who leave. Holding the extension rate at 20% may not be adequate for the number of clients who need longer-term support.

5. **Long-term maintenance plans should be developed for FEP participants whose cases are closed upon reaching the three-year lifetime limit.** This study describes in detail the multiple, severe and persistent barriers faced by long-term families in public assistance. Many of these barriers represent chronic conditions which may be treated and controlled, but never cured or solved. All families who reach the 3-year time limit have shown good faith effort in keeping their part of the self-sufficiency plan. Otherwise they would have been terminated from the program for non-participation. Yet, for these families ongoing assistance (however minimal) may be necessary. Therefore, when cases close at three years clients should not simply be terminated from FEP. Instead, Employment Counselors and others who have knowledge of the case should collaborate in the preparation of a maintenance plan. The plan might involve memoranda of understanding between DWS, other public agencies, and employers or potential employers.

6. **A mentoring and resource center should be established for terminated clients.** All clients who need ongoing services will not be included within the hardship exemption. For those who are terminated from cash assistance due to the time limit, ongoing non-cash resources should be offered. This ongoing support could be work-related, provide crisis and emergency emotional and instrumental support, and provide a network of positive reinforcement which may otherwise be missing from the client's support network. The mentoring and resource center might be staffed by DWS employment counselors with the help of community volunteers.

7. **The Department of Workforce Services should establish statewide guidelines for determining client eligibility for hardship extensions.** It is important that clients and employment counselors understand the criteria for meeting the hardship extension requirements, so that they may work within those guidelines from the start of the client's tenure on assistance. Focus groups with front-line staff in different areas of the state demonstrated that offices in different locations have varying definitions of "hard-to-serve families" and varying explanations for their behavior. Local discrepancy in policy is a good idea to some degree -- as a way to respond to local employment and community conditions. However, neither local offices nor individual workers should bear the burden of deciding who is eligible for exemption from the 3-year time limit.

8. In addition to considering the **allocation** of extension slots, the DWS must consider how clients are expected to **exit from their extension status**. This might be accomplished through the negotiation of individual deadlines. Such deadlines might extend from a few months to several years, depending on a client's situation. Clearly state-wide guidelines must be in place to ensure that clients in similar situations receive similar extensions.

UNDERSTANDING FAMILIES WITH MULTIPLE BARRIERS TO SELF-SUFFICIENCY

FINAL REPORT - FEBRUARY, 1999

BACKGROUND

This is the final report of progress on Contract FY985064 between the Utah Department of Workforce Services and the Social Research Institute of the Graduate School of Social Work, University of Utah. It presents results of the study entitled, "Understanding Families with Multiple Barriers to Self Sufficiency" The study was commissioned by the Department of Workforce Services to address the situations of families who may be at risk due to Utah's three-year lifetime limit on cash assistance. The study was required by the 1997 General Session of the Utah State Legislature in HB0269, sponsored by Senator Lloyd Frandsen. Text of the portion of the bill requiring the study is as follows:

(1) "Before September 30, 1998, the **Department of Workforce Services shall complete a study regarding the characteristics of families receiving cash assistance** under Title 35A, Chapter 8, Employment Support Act, **who face severe, persistent, and multiple barriers to self sufficiency.**

This study shall identify:

(a) the number, demographic characteristics, and health status of these families;

(b) the incidence and prevalence of mental illness, substance abuse, and physical disabilities as barriers to self-sufficiency, including the extent to which families face one or more of these characteristics;

c) the extent to which traditional interventions, services, and supports are effective or ineffective in reducing barriers to self-sufficiency;

(d) policy recommendations for reducing barriers to self-sufficiency;

(e) the probable effects of time limits on cash assistance to families who face barriers to self-sufficiency and those who do not; and

(f) such other issues as the department considers appropriate.

(2) The department, in accordance with Title 63, Chapter 56, Utah Procurement Code, shall contract with an organization to conduct this study. Proposals for the study shall be sent to a nationwide pool of applicants, and the organization selected shall have demonstrated expertise and experience in evaluating large and complex social policy issues.

(3) The department shall send a copy of the study to the legislative interim committee that has oversight responsibility for the Department of Workforce Services."

REVIEW OF LITERATURE

In 1996, Dr. LaDonna Pavetti testified before Congress that 70% of the current public assistance caseload has received welfare for more than 24 months and 48% have been dependent on public assistance for more than 60 months. Meyer and Cancian (1996) found similar results from current caseload data, reporting that 90% of those receiving assistance will eventually spend more than 24 months on welfare, and 76% will remain on assistance for 5 years or more.

Duncan, Harris, & Boisjoly (1997) used a national data bank of information on welfare recipients to create a picture of who is most likely to reach the federal lifetime limit of 5 years. Duncan et al. showed those at-risk for reaching the time limit were young, non-married single parent mothers with young children. Of those most likely to reach the time limits, 54% started receiving welfare before age 22, 97% of mothers had very young children when they first used welfare, 60% entered welfare as a result of a non-marital birth, and 75% were never married at the point of first enrollment.

In addition to family characteristics, school and labor market experiences influenced ability to leave welfare for work. Those most likely to be affected by time limits had little education or work experience. Sixty-seven percent of those who had been on assistance for longer than 5 years had never graduated from high school, and 55% had no prior work experience. A projected 63% of those likely to reach the 5 year time limit will not have graduated from high school and 50% will have no labor market experience (Meyer & Cancian, 1996).

Other studies have examined the characteristics of those more likely to be welfare dependent. Factors often associated with dependence on welfare include age, number of children, education, and limited work experience (Blank , 1989; Harris, 1996, 1993, 1991; Pavetti, 1997; Peterson, 1995; and Spalter-Roth, Burr, Hartmann, & Shaw, 1995). Younger welfare recipients with smaller families, who finished high school and had work experience were more likely to leave welfare through work. Education was shown to be a critical factor as graduating from high school increased the chances of welfare exit by 75% (Harris, 1991). High school graduates were more likely to leave welfare and to remain self-supporting. Other factors such as welfare benefit level and marriage or cohabitation with a working partner also influenced the probability of leaving welfare (Blank, 1989; Harris, 1996). Using a national data base, Pavetti, Olson, Pindus, & Pernas (1996) found factors related to increased likelihood of working included absence of disabilities, job availability, not having toddlers or infants, family supports (child support or earnings from other sources), and greater human capital (past work experience and high school diploma).

Researchers have also uncovered personal and family characteristics of recipients who are more likely to leave welfare for work. Recent literature has expanded knowledge about personal and family challenges faced by welfare recipients. Olson and Pavetti (1996) identified eight obstacles that may affect a recipient's ability to transition from welfare to work. These barriers included physical disabilities and/or health limitations, mental health problems, health or behavioral problems of children, substance abuse,

domestic violence, involvement with the child welfare system, housing instability, low basic skills, and learning disabilities. Ninety percent of current recipients between ages of 27 and 35 experienced one out of five potential barriers to employment (low basic skills, substance abuse, a health limitation, depression, a child with a chronic medical condition or serious disability). Furthermore, 50% of all recipients experienced at least one of the following: depression 5-7 days a week, a health limitation that prevented work, concern that one is an alcoholic, repeated use of crack or cocaine, or extremely low basic skills. Using three different national databases, Loprest and Acs (1996) determined the degree to which barriers to work affected families on welfare. Approximately 30% of families receiving welfare had either a mother or child with some level of functional limitation. Nineteen percent of parents had a work limitation due to health conditions. Seven percent of women on welfare were confined to bed due to health reasons for more than 30 days in the previous year, and 4% were in the hospital for more than 5 days. One-fifth of parents reported a work-related limitation, with 11% indicating a serious disability preventing one or all work related functions. Disability of a child also influenced the probability that a parent would work. Sixteen percent of children had some limitation in age-appropriate activity.

New attention is being paid to other, hidden barriers to work activity. Substance abuse, family violence, and mental health are very difficult to assess. Yet decreasing caseloads bring a greater concentration of clients with these hidden barriers. A recent study conducted in Massachusetts identified the number of victims of domestic violence among welfare recipients (Allard, Albelda, Colten, & Cosenza, 1997). Twenty percent of women on welfare reported being abused by a current or former husband in the previous year, and 65% had been abused sometime in their lives. These figures were based on a narrow definition of abuse. When the definition was expanded to include verbal or emotional abuse, isolation from family or friends, and being deprived of control over possessions, the number reporting abuse within the prior year increased to 70%. Brandwein (1996) found Utah welfare clients are over-represented among victims of domestic violence. A review of 1994-1996 police reports revealed 30% of known domestic violence victims had accessed public welfare.

While single barrier studies explain the depth of a single problem, other broader caseload research helps identify the most common barriers to work. Clients, eligibility technicians, and case managers from Alaska outlined their perceptions of barriers faced by those on welfare (1992). Clients indicated the primary reasons they were on welfare included: inability to get a job (17%); jobs that don't pay enough (14%); poor job skills (13%); and wanting to stay home with children (12%). Lack of medical insurance if employed (9%), lack of child care (9%) and transportation (4%) were also mentioned. Eligibility technicians had a different explanation than clients as to why people were on welfare. They cited preference to be on welfare (23%), poor job skills (22%), and inability to get jobs (14%) as the most prevalent reasons for dependence. Case managers indicated poor job skills (45%), inability to get jobs (10%), preference for welfare (10%), and jobs that don't pay enough (8%) as the primary reasons for welfare use.

While the Alaska study asked respondents to list the **primary** barrier to work, researchers evaluating Michigan's Project Zero asked 700 clients to identify **all** the reasons that prevented them from working (Diefenbach, 1996). According to clients: lack of child care (37%), lack of transportation (19%), personal medical condition (18%), and lack of education or training (13%) were among the most notable barriers to work. A separate analysis was conducted, sampling only those who worked less than 20 hours a week. This provided additional information about those who work little or not at all. When these clients were asked about their barriers to work, lack of education (48%), lack of transportation (39%), and lack of child care (38%) were among the most routinely mentioned. Mental limitation (19%) and physical limitation (14%) were also mentioned by these clients.

Utah conducted an evaluation of barriers to work faced by welfare clients. Lack of jobs (44%) and lack of education (44%) tied for the most frequently reported barriers to work. Transportation (38%), children's health (37%), lack of job skills (36%), medical problems (28%), caring for an infant (26%), and individual illness (20%) were also reported by recipients (Office of Family Support, 1996).

Several studies have been conducted examining non-participation by welfare clients. Researchers in Michigan found most common reasons for non-participation were transportation (61%), child care (54%), and health problems (26%) (Coleville, Moore, Smith, & Smucker, 1997). In Iowa, clients identified several barriers preventing participation in self-sufficiency activities. The top three consisted of: serious personal issue or respondent's health (30%); lack of transportation (28%); and lack of child care (20%) (Franker, Nixon, Losby, Prindle, & Else, 1997). In Utah's non-participating caseload, lack of transportation (55%) was the most frequently cited barrier. About half of the 55% who indicated lack of transportation lived in areas with public transportation. Non-participating welfare clients were significantly more likely to list lack of transportation as a barrier to work compared to participating clients ($p=.002$). After lack of transportation, common barriers included: lack of good jobs available (50%); lack of job skills (36%); medical condition (34%); and lack of medical coverage if employed (Derr, 1997).

In conclusion, the majority of the research conducted on those most likely to reach the lifetime limits focuses on family characteristics, educational background, and work experience. However, many welfare clients are affected by other challenges. The unique feature of this study is its comprehensive consideration of the situations faced by long-term welfare recipients. In addition to broad-ranging descriptive information, the study asked recipients for their own perceptions of the impact of diverse barriers and program components on their ability to achieve self-sufficiency.

METHOD

This study involved data collection and analysis from three sources: a) administrative data from the Department of Workforce Services PACMIS data set, b) focus groups with Department of Workforce Services front-line staff, and c) interviews with long-term welfare recipients. All three parts of the study contributed to a description of the multiple, severe and persistent barriers to self sufficiency. However, each source of data carried its own set of questions, assumptions and methodology, and each will be described separately.

Administrative Data

The report of caseload information was based on statewide data for families subject to the three-year time limit and receiving cash assistance. Data were collected in November, 1997, from the Department of Workforce Services PACMIS data system. Data consisted of demographic information about recipients, welfare history, and "risk factors", or barriers to self-sufficiency as recorded by employment counselors.

Focus Groups

Employment Counselors from the Utah Department of Workforce Services participated in focus groups to identify characteristics of hard-to-serve families, outline effective strategies for moving these families into employment, and discuss the 36 month time limit on cash public assistance. Seven focus groups were conducted in rural and urban areas. Between 8-12 employment counselors from each area were invited by local agency supervisors to participate in a two hour discussion. Employment counselors were chosen based on their experience with the hard-to-serve and proficiency in the areas of eligibility and/or self-sufficiency.

Client Interviews

In-depth, in-person interviews were conducted with a random sample of 325 welfare recipients. The sample was stratified geographically, and rural recipients were over-represented in order to assure useful data from areas of the state with differing economies and client populations. The 325 client interviews represent a 63% response rate from the randomly selected sample. Interviews were conducted by a group of trained social workers and graduate students. Letters were sent to the clients describing the study, and listing a toll-free number which the client could call to set up an interview time. If clients did not respond to the initial letter, their address was re-checked, and either a postcard sent, a telephone call, or a home visit made. The entire sample received at least two postcards, three phone calls (if they had a telephone) and three home visits before they were considered unable to locate.

The interviews were conducted either in the client's home or a location convenient to the client. The duration of the interviews was between one and three hours long. Clients were paid from $20.00 to $40.00 for a completed interview.

The survey instrument included questions on demographics, education, family income, housing, transportation, family characteristics, child care, family background, employment history, welfare history, family health, access to health insurance, self-sufficiency program participation, barriers to work, social support networks, self-esteem/self-efficacy, and domestic violence. In addition, clinically relevant measures of child behavior, individual health, learning disabilities, substance abuse, depression, anxiety disorder, and post-traumatic stress syndrome were obtained.

RESULTS

Administrative Data

Length of Time on Program

As shown in Table 1, a sizeable percentage of cases as of June 1998 were on assistance for 36 months or longer. The proportion of long-term cases is usually high in measures of current caseload, because those who remain in the population for a long time are over-represented at any point in time (Duncan, 1984). Table 1 represents the workload of Division of Employment Development staff. Of current cases, 43% have been on cash assistance (including regular Aid to Families with Dependent Children and the Single Parent Employment Demonstration) for 36 months or longer. This group of long-term clients could be described as "hard-to-serve", and is more than twice than the 20% of long-term clients allowed by current regulation.

Table 1

Length of Time in the Program: June 1998 Caseload *

Months	N	%
0-12	2024	31.0
13-35	1758	26.6
36+	**2836**	**42.9**
TOTAL	6618	100.0

*Current open AF cases. Length of time is cumulative from July, 1988.

Examination of caseload over time shows that the percentage of long-term clients (on assistance three years or more) has remained consistent. From January 1996 to June 1998, the percentage of current open AF cases has varied from 42.4% to 45.4%. In this period of dramatic change in policies and programs, over 40% of the caseload has been made up of people who were on the program for at least three years.

Now the FEP is on the verge of a deadline for long-term clients. In January of 2000 the first group will reach their lifetime limit on cash assistance. State law will allow DWS to award extensions to no more than 20% of the caseload. This figure represents less than half of the proportion that has historically been made up of clients who would have exceeded the three year time limit.

The 20% extension allowance will be adequate only if one assumes radical change in at least half of the state's long-term welfare clients. Families that have "used up" their three years on public assistance must remain self-supporting and never apply for cash assistance again. Several factors might contribute to these changes. The existence of the lifetime limit per se might serve as a powerful motivating force, spurring long-term clients to become self-sufficient. Programmatic changes within the DWS, such as the establishment of employment support programs might also contribute. Utah's economy may continue to grow dramatically, producing jobs that will permanently sustain these families. Whether these factors will be sufficient to accomplish the necessary changes remains to be seen.

Factors Associated with Length of Time on Assistance

Table 2 shows the relationship between risk factors reported by employment counselors on the USSDS and PACMIS data systems and clients' length of time on public assistance. Employment counselor data reported for this system would tend to under-report true levels of recipient risk factors for a number of reasons. Although important for self-sufficiency planning, risk factor data are not essential for eligibility determination, and may not be officially recorded or updated with the same rigor as income and family composition information. Also, risk factor data may be recorded at the beginning of the caseworker's relationship with the client, before a relationship is formed in which the caseworker is able to accurately assess the participant's risk profile. And, some participant risks are hidden, never coming to light during the participant's stay on public assistance, and thus never recorded. Given the limitation of probable under-reporting, Table 2 shows number and percent of risk factors reported by length of time on cash assistance. Risk factors are ranked by raw number for total caseload (N = 8519).

Table 2

Risk Factors and Length of Time on Assistance

Factor	1 Year (n=2546) #	1 Year (n=2546) %	2-3 Years (n=2334) #	2-3 Years (n=2334) %	3+ Years (n=3639) #	3+ Years (n=3639) %	Total (n=8519) #	Total (n=8519) %
Child Support Not Collected	1605	63.0	1679	71.9	2558	70.3	5842	68.6
Lacks Transportation	750	29.5	648	27.8	961	26.4	2359	27.7
No Recent Work History	604	23.7	609	26.1	1138	31.3	2351	27.6
Never Married Parent	708	27.8	679	29.1	924	25.4```	2311	27.1
Mental/Emotional Problem	269	10.6	381	16.3	775	21.3	1425	16.7
History	277	10.9	319	13.7	513	14.1	1109	13.0
Family Violence	184	7.2	254	10.9	555	15.3	993	11.7
Chemical Dependency History	366	14.4	273	11.7	310	8.5	949	11.1
Pregnancy or Temp. MED.	82	3.2	121	5.2	381	10.5	584	6.9
Prob.	130	5.1	168	7.2	218	6.0	516	6.1
Behavioral Problem Children	163	6.4	140	6.0	147	4.0	450	5.3
Received PA as a Child	93	3.7	106	4.5	246	6.8	445	5.2
Homeless	93	3.7	101	4.3	229	6.3	423	5.0
Physical Handicap/Chronic	77	3.0	79	3.4	201	5.5	357	4.2

Med.	77	3.0	67	2.9	121	3.3	265	3.1
Family Illness	134	5.3	60	2.6	62	1.7	256	3.0
SSA or SSI Applic. for	52	2.0	60	2.6	116	3.2	228	2.7
Disability	40	1.6	52	2.2	94	2.6	186	2.2
Incapacitated Person	25	1.0	32	1.4	84	2.3	141	1.7
Language Barrier	27	1.1	18	.8	45	1.2	90	1.1
Learning Disability	12	.5	18	.8	20	.5	50	.6
Teen Parent	10	.4	9	.4	28	.8	47	.6
Protective Service Referral								
Illiterate or Functionally SO								
Foster or Group Plcmt Age 0-5								
Disabled/Mentally Retarded								

Child Support Not Collected and Lacks Transportation rank as the most frequently reported risk factors for the total caseload, and as one of the most-often reported factors reported for each of the three groups. However, there is no sizeable difference between the percent of recipients within each group for whom these risk factors were reported. Lack of child support and transportation problems are perpetual and pervasive issues for public assistance recipients in Utah (Janzen, 1997; Derr, 1997) and nationally (Diefenbach, 1996; Fraker, Nixon, Losby, Prindle, & Else, 1997); however, they do not appear to be risks which distinguish long-term from other recipients.

Other risk factors do differentiate long-term and other recipients. These are the factors that appear at a significantly higher rate for long-term recipients (3 years or more). They include: (in order of percentage difference between 3+ years and 1 year groups):

1. mental/emotional problem history (10.7% difference)
2. chemical dependency history (8.1% difference)
3. no recent work history (7.4% difference)
4. behavioral problem children (7.4% difference)
5. family violence (3.2% difference)
6. physical handicap/chronic med. (3.1% difference)
7. family illness (2.6% difference)
8. SSA or SSI applic. for disability (2.5% difference)
9. protective service referral (1.3% difference)
10. learning disability (1.2% difference)
11. teen parent. (1% difference)

The greatest risks for long-term dependence, may be those that show at least a five percentage point difference between the 3+ year and 1 year groups. These factors include mental/emotional problem history, chemical dependency history, no recent work history, and behavioral problem children

To further clarify the differences between long-term and other recipients, Table 3 (below) shows risk factors for two groups: those who had been on assistance 1-5 years, and those with five or more years on assistance.

Table 3

Risk Factors and Long-term Dependency

Factor	1-5 Years # (n=6452)	%	5+ Years # (n=2067)	%	TOTAL # (n=8519)	%
Child Support Not Collected	4404	68.3	1438	69.6	5842	68.6
Lacks Transportation	1814	28.1	545	26.4	2359	27.7
No Recent Work History	1665	25.8	686	33.2	2351	27.6
Never Married Parent	1804	28.0	507	24.5	2311	27.1
Mental/Emotional Problem History	935	14.5	490	23.7	1425	16.7
Family Violence	832	12.9	277	13.4	1109	13.0
Chemical Dependency History	650	10.1	343	16.6	993	11.7
Pregnancy or Temp. MED. Prob.	798	12.4	151	7.3	949	11.1
Behavioral Problem Children	340	5.3	244	11.8	584	6.9
Received PA as a Child	396	6.1	120	5.8	516	6.1
Homeless	368	5.7	82	4.0	450	5.3
Physical Handicap/Chronic Med.	292	4.5	153	7.4	445	5.2
Family Illness	279	4.3	144	7.0	423	5.0
SSA or SSI Applic. for Disability	217	3.4	140	6.8	357	4.2
Incapacitated Person	191	3.0	74	3.6	265	3.1

Language Barrier	226	3.5	30	1.5	256	3.0
Learning Disability	160	2.5	68	3.3	228	2.7
Teen Parent	127	2.0	59	2.9	186	2.2
Protective Service Referral	84	1.3	57	2.8	141	1.7
Illiterate or Functionally SO	56	.9	34	1.6	90	1.1
Foster or Group Plcmt Age 0-5	36	.6	14	.7	50	.6
Disabled/Mentally Retarded	34	.5	13	.6	47	.6

The long-term group were more likely to report experiencing factors in almost all risk categories. Those risk factors which are five percentage points or higher difference between groups were as follows (in order of difference)

1. mental/emotional problem history	(9.2 points difference)
2. no recent work history	(7.4 points difference)
3. chemical dependency history	(6.5 points difference)

These data suggest that long-term recipients are distinctive in their likelihood of experiencing mental/emotional problem history, chemical dependency history, no recent work history, and children's behavior problems. These factors present the greatest likelihood of differentiating long-term from other recipients of cash assistance in Utah. Use of these risk factors as indicators of probable long-term assistance is validated by other studies that show long-term participants to be physically impaired, at risk of substance abuse and mental health problems, having young children and/or children with behavior problems, and to have limited or no work experience (Meyer & Cancian, 1996; Olson & Pavetti, 1996). These factors, in addition to demographic data, information on formal and informal support networks, physical and family health, service receipt and satisfaction, and external barriers were included in the survey instrument developed by SRI, and administered to a random sample of long-term recipients.

Risk Factors as Predictors of Length of Time on Assistance

The descriptive data described above suggest that risk factors clearly differentiate long- and short-term recipients. However, these data do not reveal the relationship between risk factors and duration of assistance, nor do they indicate the relative importance of each factor. If a recipient enters a public assistance program with a certain "risk profile", can it be predicted that the recipient is or is not likely to remain on assistance for a long period of time? To answer this question, a multiple regression was conducted to determine the strength of risk factors as predictors of length of time on assistance.

Table 4 shows the results of the multiple regression analysis, designed to determine risk factors that are significantly associated with length of time on assistance. The risk factors are listed in order of their effect on length of time on assistance. A positive beta indicates that the risk factor is positively associated with length of time on assistance. So, validating the length-of-time data shown in Tables 2 and 3, the risk factors of behavioral problem children, mental/emotional problems, no recent work history, chemical dependency, SSA or SSI application for disability, family illness, physical handicap/chronic medical problem, and protective service referral are predictive of a longer stay on assistance. A negative beta indicates that the risk factor is associated with a negative, or shorter, length of time on assistance. Pregnancy or temporary medical problem, language barrier, homelessness, years of education and never married parent are associated with a shorter length of stay on assistance. That is not to say that these factors are **advantages,** but that in the context of the welfare population they may be less problematic than others risk factors.

Table 4

Risk Factors Influencing the Length of Time on Welfare (*N* = 7911)

Factor	B	*R*	R^2	*t*	*p*	*F*	*p*

Behavioral Problem	.11	.14	.020	9.67	<.0001	52.02	<.0001
Children	.08	.18	.032	7.45	<.0001		
Mental/Emotional Problem	-.09	.20	.041	-8.46	<.0001		
History	.09	.22	.050	8.03	<.0001		
Pregnancy or Temp. MED.	-.09	.24	.056	-8.51	<.0001		
Prob.	.07	.25	.061	6.56	<.0001		
No Recent Work History	-.07	.26	.066	-6.35	<.0001		
Language Barrier	-.07	.26	.070	-6.36	<.0001		
Chemical Dependency	.04	.27	.074	3.64	.0003		
History	.04	.28	.076	3.81	.0001		
Homeless	.04	.28	.077	3.37	.0007		
Years of Education	.03	.28	.078	2.81	.0050		
SSA or SSI Applic. for	-.03	.28	.079*	-2.72	.0066		
Disability							
Family Illness							
Physical Handicap/Chronic							
Med							
Protective Service Referral							
Never Married Parent							
* Adjusted $\underline{R}^2$ = .077							

It is important to note that the overall effect of the risk factors in Table 4 is minimal in predicting length of stay on assistance. The Adjusted $\underline{R}^2$ is just .077, which means that although important, the combined effect of all risk factors in Table 4 accounts for only 8% of variability in length of time on assistance. It is likely that factors not included in the analysis, such as age, family characteristics, and gender, and environmental factors such as regional unemployment rate may influence length of time on assistance. These variables, in addition to the risk factors in the analysis, were explored in the survey of long-time recipients.

FOCUS GROUPS

Focus Group Participants (Employment Counselors)

The majority of focus group participants were female (77%). Almost half (48%) had a four year college degree and 15% earned a Masters degree. Three-fourths of those involved in the focus groups worked at the Office of Family Support prior to the creation of the Department of Workforce Services. The average age of the workers was 41 years old and they had about 6½ years of experience in human service work.

Focus Group Discussions

Focus groups provided information about the hard-to-serve from front-line employment counselors' point of view. Data from focus groups are summarized in three major areas. These areas included a) definition of hard-to-serve families; b) strategies for moving these families into employment; and c) worker thoughts regarding the welfare time limits.

Defining Hard-to-Serve Families

Employment Counselors identified challenges and behaviors associated with long-term welfare clients. They described the long-term clients as having few years of schooling, little vocational skill, and limited work experience. One worker explained, "Usually when a person drops out of school maybe they dropped out at 10th grade you can ask them, 'When did you really drop out of school?' Well, it was about 7th or 8th that's where their mentality is - even though they're 40."

In addition, long-term welfare recipients had limited work experience. They seem to find jobs, but have a difficult time sustaining employment. "They have lots of stops and starts," according to one DWS worker. Typically, they are fired from employment or they leave without proper notice. This attitude is reflected in the following statement, "They don't have the education or the discipline to work for long periods of time at a job...They go to work, they are there a few days, a few weeks, and they decide they don't want to go anymore."

Employment counselors also talked about how many of their clients are impaired in general intellectual functioning.

> I had a person I couldn't get into vocational rehabilitation because when voc rehab tested her she tested out at 2.7 in both reading and math or intellectual skills, which means the 7th month of the 2nd grade. This woman is 42 and has a child. Vocational rehab couldn't even take her because she wasn't at a high enough level for them to rehabilitate...I'm trying to get her on SSI and SSI seems to think there should be something she should be able to do. What? She has never held a job for more than 3 weeks.

Not only did Employment Counselors discuss the limited employment and educational experiences, but they also talked about the deficits in life skills among many of the long-term welfare recipients. Workers

spoke about how the families are always in crisis. They lack problem solving skills to deal with life challenges.

> It’s kind of self-defeating behaviors in the people...They have all these barriers. They are always so overwhelmed with their problems. They just won’t see beyond their problems to see there is a solution...I have never seen so many tragedies. That’s one thing I have found...There are so many personal tragedies in these people’s lives. They are kind of out of control. They don’t know how to manage personal relationships or their situation.

Some employment counselors described the clients as manipulative and lacking in self-discipline. Other counselors talked about their lack of parenting skills. One employment counselor pointed out a different social orientation among the long-term clients. "I tell clients you need to dress more appropriately for an interview and they don’t know what I’m talking about. ‘What’s wrong with this tank top?’ Well, your tattoos are showing and you have an earring in your eyebrow...It’s a hard thing to talk about with people."

Another characteristic which the employment counselors described was severe mental health problems. Depression, Bipolar, Post-Traumatic Stress Disorder, low self-esteem, and poor locus of control were all mentioned as challenges among these parents. Substance abuse was also discussed. Employment Counselors speculated that about 60-70% of this population struggled with chemical addictions. Domestic violence relationships were also cited by workers as a serious challenge for hard-to-serve families. Further, employment counselors frequently talked about the lack of emotional or extended family supports among the welfare recipients. Overall, they had serious and persistent barriers to work and few resources other than DWS services.

Worker Variability in Attitudes Towards the Hard-to-Serve

Employment counselors varied in their general attitude towards hard-to-serve clients. Differences emerged in the amount of depth they used to examine and explain client behavior. For the most part, there were differences in attitude toward clients between geographic locations, and individual worker’s attitudes were congruent with others at their office. While there were similarities among defining the hard-to-serve, general attitudes and treatment modalities differed among offices.

Some employment counselors described clients as lazy, unmotivated, manipulative, and impulsive. One worker explained, "They are really impatient. They come in and want their assistance today. They kind of live their lives for today. They don’t want to pay their dues for anything." Another said, "There is such a dependency on the old check coming they will say or do almost anything." These workers tended to offer harsh, punitive approaches to encourage client participation. For example, immediate termination for nonparticipation and more strict work policy. Employment counselors with this framework looked at client behavior rather than examining deeper explanations of conduct.

Other employment counselors recognized the surface behavior, but attributed the behavior to some deeper level of dysfunction, for example lack of motivation may reflect depression, manipulation may be a result of a personality disorder, lack of follow through - possible substance abuse. One worker described long-term welfare recipients, "...I have people that have severe mental health problems. When you meet with them you can tell. I wouldn’t hire this person if they came and applied for a job with me because there is something inherently unique about their personality." Employment counselors with this orientation suggested client-centered approaches to moving the hard-to-serve off assistance. Successful services included in-depth assessments, home visits, and substance abuse treatment. Transportation, child care, transitional Medicaid, and Food Stamps were outlined as crucial needs by workers with this orientation.

One office went even deeper in describing the underlying roots of client behavior. Their discussion centered around unstable family life during childhood and other early traumas. They described client health and mental health problems, substance abuse, domestic violence, and other related dysfunctions as aftermaths of childhood deficits and trauma. An employment counselor explained what she saw among long-term welfare recipients,

> Substance abuse, Post-Traumatic Stress Disorder, childhood traumas, domestic violence, lack of social skills, lack of self-esteem, not believing in themselves. Sometimes they are a little suicidal... I think the traumas they have been through really pull them down and they are stuck. And they don’t know how to get unstuck. And, I think they really want to. I think the system has conditioned them to be dependent upon the system and now we’re trying to change that and deep down I think people want to succeed.

Opinions regarding reasons for long-term dependence tended to vary between local offices but not within offices. That is, workers who attributed dependence to laziness and manipulation clustered within certain offices, and workers who attributed dependence to mental health issues or previous trauma tended to cluster in other offices.

Moving Hard-to-Serve Families into Employment

Working with long-term welfare recipients is a formidable task for employment counselors. The severity

and types of challenges the families face require a substantial amount of workers' time and agency resources. With the Utah time limit of 36 months for financial assistance, the families must secure employment before their 36 month lifetime limit elapses. DWS employment counselors identified agency and staff resources, support services that would help long-term welfare recipients become self-sufficient. Workers talked about conducting thorough client assessments, specific employment plans, boosting support services, and increasing treatment resources.

Thorough Client Assessment and Specific Employment Plans

The types of problems exhibited by hard-to-serve clients were difficult to detect. Employment counselors explained that they needed time to build a relationship of trust with clients. Once trust is built, clients feel comfortable disclosing concealed barriers to employment with their worker. Knowledge assists an employment counselor in creating targeted and reasonable treatment plans for clients.

> The more information you have the easier it is to make the correct employment plan...You get away from this revolving door...[of a new client situation means a new self-sufficiency plan]. Because every time you do that you really step back about three months. Every time you change a plan or every time you change a case manager you might as well step back three months in time because you're starting over. The more information you have up front I'm hoping equals less starting over.

These families have not only multiple barriers to work, but they are severe. Time to thoroughly assess clients was repeatedly mentioned. One worker explained,

> To deal with people with multiple barriers you have to look at barriers exponentially. Every barrier you add you can just plan on your time exponentially increasing or your need or your energy or your stress level. If there was one change the Department would make, it's give us enough time to work with the hard-to-serve. That's one of the key issues. I think we can deal with them. I think we can help them.

With the increasing concentration of hard-to-serve clients, employment counselors are limited in time and resources to manage their caseloads. In addition, many workers lack the expertise and time to conduct an in-depth assessment. Home visits, mental health assessments, drug and alcohol screens, and other information gathering services were cited by employment counselors as useful tools in creating a self-sufficiency plan. Another helpful activity mentioned by workers was case staffing. One worker explained the value of these meetings, "Somebody will say something like a behavior of one of their clients. And somebody will say, you know maybe it's drugs or alcohol and it will flash — that's what it is! That's why she's not doing this or this. That really helps. Just to hear what other clients are doing or what they aren't doing." While case staffing are productive, they require more time and effort to coordinate than is currently available to employment counselors.

Support Services and Treatment Resources

Transportation, transitional Medicaid, Food Stamps, and child care were all support services discussed by Employment Counselors. These services were described as critical in keeping clients in employment. In addition to support services, treatment resources were repeatedly mentioned as a need within the Department of Workforce Services. Substance abuse treatment, mental health counseling, and DWS Social Workers were brought up in the focus groups as valuable resources.

Welfare Time Limits

Focus group participants were asked how the 36 month time limits will affect welfare recipients. According to employment counselors, most clients approaching the time limits don't believe their cases will really close. The lack of a future orientation is one of the characteristics of the long-term welfare recipients identified by employment counselors. One worker explained, "A lot of our clients have no comprehension of long-term. What's going to happen in a few years, what's going to happen in six months, or the consequences. They're interested in what is here, what is now, what is today. They aren't even thinking about what's going to happen next month."

Workers expressed concern about what will happen to families once time limits expire. One worker explained,

> I have one in particular on my case. I don't see any job she could ever have. She doesn't qualify for social security because she is mentally above their limits. But socially and functionally I don't know of a job she could hold. I don't even think she could ever be a greeter at Walmart...She just can't do anything. She has been raised in a very dysfunctional home. She's been a victim of abuse — sexual abuse and physical abuse. She doesn't know how to function in society. She just sits and stares off into space. I had her tested. She did graduate from high school, but vocational rehabilitation tested her to see what they could help her with and she was on like a 2nd grade reading level and lower than that in math. Her social skills were real low, but yet her IQ average with SSI was right at the cutoff limit for them so she will not qualify for Social Security...I don't know what will happen to her

> (when she reaches her time limit), because I don't know how she can provide for herself. It's those people I have a great concern. What's going to happen to her? What's going to happen with her child?

Another predicted life for these families after case closure,

> You're going to see a lot of suicides. You'll see overflows in the homeless shelters. I'm starting to see a trend where people are starting to group up where you see 2 or 3 clients under one roof...You'll see an increase in CPS (Child Protective Service) referrals. A big increase in CPS referrals. We're already seeing that on our caseloads...A lot of our cases have closed because there's no eligible children because they are in foster care. In effect what we save on one hand will be eaten up in another system to maintain these folks.

Even though Employment Counselors were concerned about the welfare of these families, there were serious reservations about what would happen if the time limits were reversed. Workers indicated they would lose credibility if the time limits were extended. One worker explained,

> It's almost a credibility issue for us, because we're telling them come on three years lets get going and then the legislature whips off that three years. That right there just says you're nothing. How can that give us credibility to help these people and say, 'you know we're not using this as a threat but as a warning tool.' I'm hoping our credibility is still there.

Rather than repealing the time limits, employment counselors wanted more time and resources to work with clients during the 36 months on the program. Employment counselors called for a caseload reduction in order to work intensively with hard-to-serve clients. Workers also emphasized the importance of informing clients that employment services continue after grant termination. While there are potential repercussions of case closure on families, worry was expressed over the ramifications to the agency if time limits are not carried out. Overall, the challenge was described as weighing the dysfunctions of clients with the loss of agency credibility if the time limits are repealed.

Conclusions

Overall, employment counselors were aware of many of the challenges among long-term welfare recipients and their families. Frequently mentioned were lack of education, limited work experience, few vocational or life skills, low aptitudes and severe mental health problems However, frustration was expressed as the workers lack the time to conduct thorough assessments and to work effectively with these families.

Some workers attributed long-term dependence to lack of motivation and manipulation of the system, but others saw underlying causes for dependence, such as previous trauma and/or mental health problems. Opinions regarding reasons for long-term dependence tended to vary between local offices but not within offices. That is, workers who attributed dependence to laziness and manipulation clustered within certain offices, and workers who attributed dependence to mental health issues or previous trauma tended to cluster in other offices.

Limited agency resources for services such as substance abuse treatment and mental health screens were mentioned by employment counselors. Overall, because of the long-term dependence on welfare and the severity of challenges, employment counselors agreed that long-term families require more intensive services than the current system allows. Employment counselors felt that most families could become self-sufficient within the 36 month time limit, but only if additional resources were committed to the agency.

CLIENT INTERVIEWS

For the purposes of this study, hard-to-serve clients were defined as those who had been on assistance a total of 36 cumulative months or more at the point in time when the sample was drawn. A comprehensive interview instrument was created to gather information in order to describe hard-to-serve clients. Following are categories included in the interview instrument:

Interview categories:

- Demographics
- Education
- Family Income
- Housing
- Transportation networks
- Phone/computer access
- Family of origin background
- Family characteristics
- Employment history
- Self-sufficiency Program Participation
- Criminal history
- Welfare history

- Marital and long-term relationships
- Child Care
- Access to health insurance
- **Individual** and family **health**
- Barriers to work
- Social support networks
- **Child behavior**
- **Learning disabilities**
- Self-esteem/self-efficacy
- **Clinical depression**
- **Clinical anxiety disorder**
- **Post-traumatic stress syndrome**
- **Substance abuse**
- Domestic violence
- Traumatic life events
- Mental health services
- Current and future financial outlook

Description of Respondents

The total sample consisted of 325 Family Employment Program (FEP) recipients, most (87%) of whom had received welfare for at least three years. The remaining 41 respondents had been on the program for under a year. They were included in the sample to permit a rough comparison of long-term and short-term recipients, and to set the stage for a longitudinal examination of different cohorts of welfare recipients.

Long-term Recipients

Table 5 profiles the average long-term welfare recipient from the study.

Table 5

Profile of the Average Long-term Welfare Recipient

Characteristic	%
Caucasian	74.0
Female	97.0
34 years old	
Member of Latter Day Saints	46.0
2.5 children	
Child age 9.5	
12 years of education	
On assistance total of 88.6 months	
At last job worked 32.8 hours/week	
At last job earned $7.71/hour (Median = $6.25)	
NOT offered health insurance through employer at last job	59.3
Physically or sexually ABUSED before age 18	56.0

The 284 long-term recipients interviewed were on average 34 years old, with a range from 17 years to 68 years of age. The vast majority of those in this group (97%) were female. Most (74%) were Caucasian. A majority of respondents indicated they were members of a religion (72%), and the most frequently represented religious faith was Latter Day Saints. Slightly under half (46%) of these respondents indicated they were members of the LDS faith.

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Education

On average, respondents had completed 12 years of school, with a range from 6 to 20 years of education. The educational distribution is bi-polar, with half (50%) of the group reporting that they had a high school diploma, and nearly a third (32%) reporting they had neither a diploma nor a GED. Forty-five long-term recipients reported they were still attending school. This represents 16% of the sample.

Education was significantly associated with work status. Among respondents who had completed high school or a GED, 39% were employed at least 20 hours per week. This compares to 26% for those who had not completed high school or GED. This difference was statistically significant (p=.023). Clearly, education barriers are associated with a significantly reduced probability of working at least 20 hours per week.

Housing

Nearly half (43%) of long-term respondents received government housing assistance. The most common type of assistance received was a unit in public housing. Respondents reported that they had lived in their current residence for an average of 38 months. Most (57%) reported that they had moved at least once in the past two years.

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Transportation

Most respondents in this group (75%) reported holding valid driver's licenses, and a comparable number (74%) reported that they had a car. Half (50%) of the group reported their car was their main source of transportation. Although most of this group (61%) reported that public transportation was available in their area (generally within 2 blocks of their homes), the next most common source, used by 16% of the group was family members and friends. Nearly half of the sample (47.5%) reported that lack of transportation had (at least sometime) prevented them from working. Among these, half (49.2%) reported that lack of transportation had prevented them from working sometime in the past year.

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Family of Origin Background

The most common configuration in the families of origin for these respondents was a two-parent home. A majority (67.6%) reported having grown up with both parents. The second most common configuration was a single-parent home headed by their mother. Just under a fourth (22.2%) of the sample reported having grown up in this type of home. The remainder grew up in foster care or group homes (2.8%), single parent homes headed by fathers (.7%), or other situations (6.7%). Over half (51.4%) reported that their fathers had finished high school or had a GED, and almost one fifth (18.7%) reported their fathers completed college. A majority (63.3%) reported their mothers had finished high school or had a GED, and just under a tenth (9.7%) reported their mothers had finished college. Just over half (51.2%) reported their mothers were teenagers when they had their first children. Most (54.8%) reported they had felt either very or somewhat neglected as children, yet a vast majority (80.5%) felt either very or somewhat nurtured as children. Forty-four respondents (15.5% of the sample) reported that their family had been investigated by Child Protective Services, and 15.9% reported having spent time in foster care or a group home.

Client Family Characteristics

Partners and Spouses: Table 6 displays the marital status of participants. The most common marital status reported by this group was divorced. Nearly half (42.6%) were divorced, compared to a quarter (23.9%) who had never been married and were not living with a partner. One tenth (11.3%) were separated, and 9.5% were married. One in ten (10.2%) were living with someone but unmarried.

Table 6

Marital status of Participants

Status	n	%
Divorced	121	42.8
Never been married	68	24.0
Separated	32	11.3
Living together unmarried	29	10.2
Married	27	9.5
Widowed	6	2.1

Just over half of the sample (56.1%) reported that they were involved in a serious relationship, either with a spouse or with a significant other. In most of these cases respondents were evidently not living with this person. Although most (72.9%) reported that their partner or spouse was supportive of their working, a significant number (21.1%) reported that he/she was not supportive. Roughly half (55.6%) of the sample reported that their partners or spouses had steady employment.

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Children

Respondents in this sample reported having an average of 2.5 children, with a range from 0 to 10. This is lower than the average number of children per household in Utah, which is 2.87 (Mangum, Weathers, Kasten Bell, & Lazerus, 1998). The mean age of the oldest child in this sample was 11.5 years, while that of the youngest child was 7.2 years.

Over one third (35.6%) of the sample reported that at least one of their children had a physical disability or medical condition. Among these, over half (57%) were taking medication for the condition, and roughly the same proportion (54%) were receiving treatment. Almost one-third (29.5%) reported having at least one child with a learning disability. Among these 17% were taking medication, and 79% were in a special class in school. Just under one fourth (23.9%) reported having at least one child with a mental health condition. Among these 32% were taking medication, and 54% were in treatment. Finally, 11%

reported that at least one of their children had been in foster care. A striking 46.3% of the sample reported that child protective services had investigated their family for abuse and/or neglect.

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Employment History

The vast majority (98.9%) of the sample had worked for pay. Only three respondents reported that they had not. On average, respondents reported that they had been employed at 10 jobs. Nearly half (43%) of these respondents reported they were employed. On average, respondents had been in their current jobs for 15.3 months, with a range from 1 month to 20 years. Most (71%) had been in their current jobs for one year or less. Most felt fairly positive about their jobs. Over half (52.4%) felt they could be promoted, and almost three-quarters (71.4%) expected to be at their current jobs for at least six months. Almost half (46.7%) expected to be in the same job for at least two years. This is despite the fact that when asked about the longest period they had been in one job in the past five years respondents averaged 18 months. Indeed, the mean time on one job (18.2 months.) was exceeded by the mean duration of unemployment for the same period (27.4 months.).

Respondents seldom reported having worked at a job that offered health insurance. Under one quarter (22.2%) reported having health insurance in their current jobs, and only 4.6% reported having coverage for the entire family. Similarly, only 8.3% of those employed reported that they were eligible for participation in a pension plan.

Criminal History

Just over one fourth of the sample (26.9%) reported that they had been convicted of a crime. Among these, most (65.8%) had served time in jail. Most respondents who had spent time in jail did not feel that this influenced whether employers would hire them. When asked, 55.3% said "no," and 39.5% said, "yes" they did think their criminal records influenced their prospects of being hired.

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Welfare History

On average, respondents in this study had been on welfare 2.9 separate times, with a range from one to 15 times. They had spent an average of 88 months (7.3 years) on welfare in their lives, ranging from 1 to 336 months (28 years). On average, respondents first applied for welfare at the age of 22 years, but they ranged in age from 13 to 59 when they first applied.

Respondents were asked to reflect on six recent episodes on welfare. Questions addressed the reasons they went on welfare, the reasons their cases were closed, and the duration of the episode. Two themes emerged in these data. First, the reasons for going on and going off of welfare appear to be remarkably stable. About half of clients go on welfare because of pregnancy or a change in family circumstances, and about one-third leave welfare because they found a job. Second, the duration on welfare seems to have increased with each subsequent episode on welfare. Table 7 summarizes the reasons clients went on welfare for each episode.

Table 7

Why Clients Went on Welfare

Episode	Current Episode		Episode B[a]		Episode C[b]	
	n	%	n	%	n	%
Pregnancy	60	21.2	52	27.1	52	42.6
Change in relationship	58	20.5	38	19.8	25	20.5
Lost Job	49	17.3	30	15.6	13	10.7
Health problems	34	12.0	18	9.4	7	5.7
No child support	16	5.7	9	4.7	3	2.5
Other	66	23.3	45	23.4	22	18.0
TOTAL	283	100.0	196	100.0	122	100.0

a: Episode B is the most recent episode on welfare
b: Episode C is the second most recent episode

With respect to their current episode (not the first for the majority -- 72.5% -- of the sample) the most common reason for going on welfare, reported by 23.2% of the sample was "other", which mostly referred to change in family circumstances such as child returning home, child's health or discontinuation of public housing. The next most common reason, reported by 21.2%, was a pregnancy. This was followed by "change in a relationship," the reason given by 20.4%. Finally, 17.3% of the group reported a job loss led to this welfare episode, and 5.6% said it was caused by a lack of child support. With respect to the two previous episodes, the most common reason given for going on welfare was pregnancy. For the second most recent episode, with 67.6% of the sample reporting, pregnancy was the reason given by 27.1% of those responding. For the third most recent episode, with 43% of the sample reporting, pregnancy was again the most common reason, mentioned by 41.8% of those who responded.

Reasons for case closure were also consistent, as shown in Table 8. Finding a job was the primary

reason given for case closure, and the proportion giving this reason remained fairly steady between most recent, and second-most-recent episodes.

Table 8

Why Clients' Cases Closed

Episode	Current Episode n	Current Episode %	Episode B[a] n	Episode B[a] %	Episode C[b] n	Episode C[b] %
Still on welfare	221	81.3	2	1.0	1	.9
Got a job	21	7.4	76	39.6	43	37.1
Case closed involuntarily	6	2.2	20	10.4	13	11.2
Didn't want to participate	5	1.8	9	4.7	5	4.3
Married/other relationship	4	1.5	27	14.1	24	20.7
Other	15	5.5	58	30.2	30	25.9
Total	272	100.0	192	100.0	116	100.0

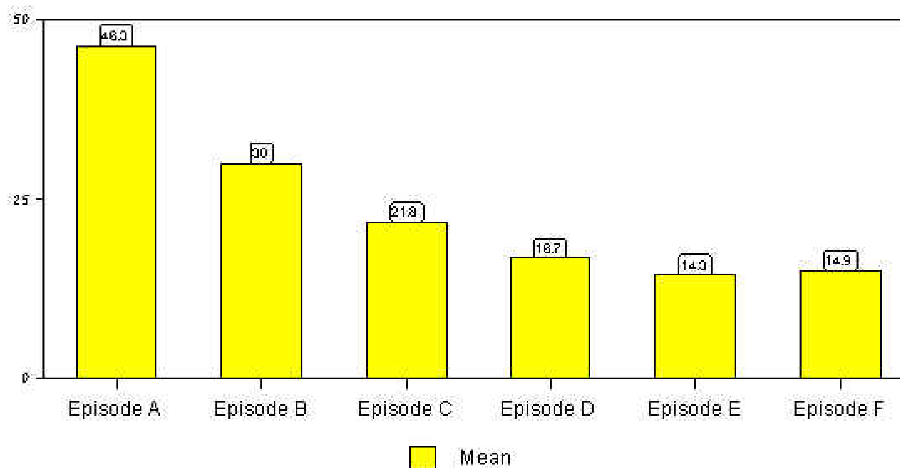
a: Episode B is the most recent episode on welfare

b: Episode C is the second most recent episode

A small number of individuals interviewed (13.2% of the sample) reported that their cases were closed. For these, the primary reason for case closure, reported by 77.7% of those whose cases were closed, was finding a job. The second most common reason, reported by 22.2% of those whose cases were closed, was involuntary closure. This was followed by choosing not to participate (18.5%) and marriage (14.8%). Most respondents (67.6%) reported on reasons for closure of their most recent welfare episode. Again, finding a job was the primary reason given. This was the response for 40% of those whose cases had been closed. The next most common reason was "other," given by 30.5%; followed by marriage (14.2%), involuntary closure (10.5%), and choosing not to participate (4.7%). Under half (40.8%) of the sample reflected on their second most recent episode. Finding a job was the most common reason, given by 37.1%, followed by "other" (25.9%), marriage (20.7%) involuntary closure (11.2%) and choosing not to participate (4.3%).

Respondents were asked about the duration of their welfare episodes. Figure 1 shows the results for the past six episodes. The mean duration for the current episode was 46 months (3.8 years). The mean for the second most recent episode was 30 months (2.5 years), and the mean for the third most recent was 22 months (1.8 years). Although the number who had experienced 4th, 5th, and 6th most recent episodes on welfare diminished considerably, this pattern of previous episodes being shorter continued until the 6th most recent episode. For the fourth most recent the mean duration was 17 months (1.4 years); for the fifth most recent, 14 months (1.2 years). The pattern breaks on the 6th most recent episode. With 9 respondents reporting, the mean duration was 15 months (1.3 years).

Figure 1



Note: Episode A = Current episode

Episode B= Second most recent episode

Episode C = Third most recent episode

Episode D = Fourth most recent episode

Episode E = Fifth most recent episode

Episode F = Sixth most recent episode

Self-Sufficiency Program Participation

Respondents were asked whether they had a "self-sufficiency or employment plan."

Most (87.3%) reported that they did. A few (12%) reported that they did not, but half of these (53.4%) reported having "an agreement with your worker about what activities you would participate in." This left only 13 individuals who either didn't know whether they had a plan or not or who maintained that they did not have a plan.

Respondents were asked about their participation in nine specific program activities. Over one fourth (27.8%) reported that they were not participating in any program activities.

Table 9
Self-Sufficiency Activities

Activity	N	"Very helpful"	"Somewhat helpful"	"Not very helpful"
Job search	156	28.3	42.9	28.8
Personal / family counseling	72	59.7	27.8	12.5
College program	55	65.5	27.2	7.3
Job training program	46	52.2	28.2	19.6
GED	42	57.1	26.5	14.3
Parenting classes	34	64.7	26.5	8.8
Alcohol / drug treatment	18	94.4	5.6	00.0
English as a second language	2	100.00	00.0	00.0
Other	39	69.2	25.6	5.2

As shown in Table 9, by and large, program activities were well-received by respondents, with over half of those participating reporting they were "very helpful." Activities in which only a few respondents participated received the highest ratings. Alcohol and drug treatment involved only 18 individuals, but nearly all (94.4%) of these reported it was very helpful. Only 2 participated in English as a Second Language (ESL) activities, but both found them very helpful. Only one of the activities examined was the exception to this general rule. The most common activity, job search, was described as "very helpful" by less than a third of participants (27.6%). Another 42.9% reported it was "somewhat helpful," and under a third (28.8%) reported it was "not very helpful." These respondents reported frequent contacts with the local office. When asked whom they would call if they had a question about their benefits, the majority (85.4%) either gave a specific name (9.6%) or indicated they would call an eligibility (17.4%), self-sufficiency (42%) or general caseworker (85.4%). Over half (57.3%) had contacted the office with a question sometime in the past two weeks, while very few (3.6%) had not been in contact within the past six months. Similarly, over half (56%) reported that they had at least one conversation with their employment counselors about going to work within the month prior to the interview.

Non-participation

About one fifth of the sample (21.8%) reported that they had $100 deducted from their financial assistance benefit for non-participation in self-sufficiency activities. When these respondents were asked to describe the reasons for this non-participation, the most common one was "other" which for the most part, were clients who "had not turned their paper work in". This was the reason given by over half (66.7%) of those responding. The second most common reason, given by 14.5%, was a mental health problem. This was followed by children's health or behavioral problems (12.5%), and lack of transportation (10.4%). Nearly half of the respondents who were non-participants (48.1%) reported that their employment counselors had helped them resolve the issues that led to their non-participation. Among the remaining, 51.9%, most (76%) reported that they had told the employment counselors about the problem but had not received help to resolve it. About one fifth of long-term respondents (19.6%) reported that their case had been closed for non-participation.

Child Care

Just under one-fourth of the sample (23.9%) reported that at least one of their children attended child care. As shown in Table 10, the vast majority (88%) of these were paid for or subsidized by the child care subsidy. The most common type of child care, used by nearly half (42.6%) of those in child care was a preschool or child care center. The next most common arrangement, used by 22.1% of the group, was care in a relative's home.

Table 10
Child Care Arrangements

Arrangement	n	%
Preschool/child care center	29	42.6
Relatives' home	15	22.1
Licensed care provider	11	16.2
Non-licensed care provider home	5	7.4
Client's home	2	2.9
Other	6	8.9

n general, respondents reported that they were satisfied with their child care arrangements. As shown in Table 11, nearly half (48.5%) rated the arrangement as "very good," another third (33.8%) rated it as "good," and 13.2% rated it as "adequate." Only two respondents among the 68 who used child care rated their arrangement as "poor."

Table 11
Child Care Quality

Rating	n	%
Very good	33	48.5
Good	23	33.8
Adequate	9	13.2
Poor	2	2.9
Don't know	1	1.5

The most common way respondents found their child care arrangements was through referral from a friend or relative. 39.7% reported using this approach, while 14.7% reported that their child care was located in their neighborhood, and 10.3% located child care through a state office. Although most (82.3%) reported that it was relatively easy to locate child care, a significant number (13.2%) reported quite a few problems, and a few (4.4%) reported very serious problems.

Problems with child care often interfere with employment. Nearly one third of this group (29.9%) reported that they had lost a job or quit a training activity because of problems with child care. Most of those who had this experience (71.8%) reported it had occurred within the past 48 months, and nearly half (41.2%) reported it had occurred in the past year. Indeed, nearly a third (33.7%) of those who had this experience reported that it had happened more than once.

Table 12 shows child care concerns reported by respondents

Table 12
Child Care Concerns

				Effect on Work[k] (%)		
Concern	n	Yes	%	1	2	3
Concerned about the quality of child care	108	55	50.9	11.5	55.8	32.7
Child care costs too much	110	40	36.4	12.5	45.0	42.5
Couldn’t find child care to go to work	110	37	33.6	54.1	32.4	13.5
Unable to work because of child care problems	110	34	30.9	44.1	38.2	17.6
Child care was not dependable	110	28	25.5	10.7	71.4	17.9
Caretaker would harm children	110	28	25.5	25.0	64.3	10.7
Didn’t have relatives to help with child care	109	28	25.7	35.7	39.3	25.0
Care provider was too far	109	11	10.1	9.1	45.5	45.5
Didn’t find a provider who would accept children with special needs	110	10	9.1	70.0	30.0	00.0

[a] 1 = Prevents work, 2 = Affects work, 3 = Does not affect work

Physical Health

Individual health: Respondents were asked a number of questions regarding their physical health and their capacity to become employed based on their health. Respondents were asked to rate their health from excellent to poor. About one quarter (24.6%) rated their health as excellent or very good, while almost half (40.1%) rated their general health as fair or poor. Over half (53.2%) reported presence of a physical disability or health problem, and 59.9% reported they were taking medication for their condition. Table 13 presents data from questions regarding health problems, and their effect on the respondent's ability to work.

Table 13

Self-Reported Physical Health

Physical Condition	Respondents Reporting Condition		Condition Prevented Work[a]	
	#	%	#	%
Physical Disability/Health Problem	151	53.2	52	34.9
Learning Disability	56	19.8	11	20.8
Alcohol/Drug Addiction	29	10.2	7	23.3
Mental Health Problem	93	33.0	40	44.0
Children's Health Condition	88	31.0	20	22.7

[a] Percent of those who reported the condition

When asked if their health interfered with specific activities, 38.4% answered that their health interfered a lot with vigorous activities, 12.0% reported that their health interfered a lot with moderate activities, 27.5% reported a lot of difficulty climbing several flights of stairs, and 26.9% reported a lot of difficulty walking more than one mile. Table 14 shows the degree to which poor health limited participants from accomplishing various tasks.

Table 14

Degree to Which Health Limits Activities

Activity	Degree to Which Health Limits Activity: A Lot		Not at All	
	#	%	#	%
Running, Lifting heavy objects	109	38.4	69	24.3
Moving a table, pushing a vacuum cleaner	34	12.0	194	68.3
Lifting or carrying groceries	39	13.8	182	43.7
Climbing several flights of stairs	78	27.5	124	43.7
Climbing one flight of stairs	25	8.8	189	66.5
Bending, kneeling, stooping	48	16.9	143	50.4
Walking more than one mile	76	26.9	142	50.2
Walking several blocks	52	18.4	176	62.2
Getting up in time for work or appointments	44	15.5	185	65.4

As activities became more strenuous, more respondents reported that their health prevented them from accomplishing the activity. The most difficult was vigorous activity, such as running or lifting heavy objects, with over 38% of respondents reporting that their health interfered a lot with vigorous activity. The activity which was least difficult for respondents was climbing one flight of stairs, with only 9% of respondents reporting their health interfered a lot with that activity.

Physical Health was an important predictor of work and welfare outcomes. For example, self-reported health status (ranging from "poor" to "excellent") was associated with working 20 or more hours per week. Among respondents who described their health as poor, only 9% were working, compared to 50% of those reporting excellent health and 40% of those who described their health as "very good." This relationship was statistically significant ($p=.002$). Physical health (as measured through the SF-36) was also associated with time on assistance and number of episodes on welfare ($p<.05$).

Family health

Regarding their family's health, and the degree to which the health of family members affected their ability to work, respondents reported high rates of family health problems. Thirty-one percent of the subjects reported that their children had a physical, learning or mental health condition which required much of their physical or emotional energy. Of those who answered yes, 22.7% reported that the child's health condition prevented the respondent from working. Seventeen

percent reported that their spouse or partner had a health problem, disability or addiction, and of those answering yes to this questions, over half (54%) reported that their spouse or partner's health problem required a great deal of their physical or emotional energy. Sixteen percent reported that their spouse or partner' s health problem prevented them from working.

Barriers to Work

Respondents were questioned about 21 potential barriers to work. They were asked first, whether they had experienced the barrier; second, whether it prevented, affected, or did not affect their working; third, how they could resolve it; fourth whether they had talked to their employment counselors and fifth, whether their employment counselor was able to help overcome the barrier. Responses are summarized in the Table 15 below:

Table 15
Barriers to Work

Barrier	% Experiencing	% Prevents Work	% Affects Work	% Doesn't Affect Work	% Talked With Employment Counselor	% Helped
Lack of job skills	52.1	50.3	45.5	4.1	70.0	48.9
Lack of education	48.8	45.5	48.5	6.0	82.9	52.0
Wages too low	46.1	22.7	60.9	16.4	55.0	25.0
Physical disability/medical Condition	45.6	68.5	29.9	1.6	80.0	56.7
Lack of transportation	45.2	57.3	18.7	4.0	62.0	66.7
Child health/behavior	42.3	58.5	40.7	.8	59.4	60.7
Lack of good jobs	38.0	43.1	43.1	13.7	58.3	34.7
Choose to stay w/children	36.7	75.5	18.6	5.9	50.0	52.6
Mental health condition	35.2	59.4	40.6	0.0	68.2	64.4
Caring for infant	34.5	73.5	25.5	1.0	53.3	66.7
Spouse/partner objected	28.6	77.5	21.3	1.3	26.9	46.7
Family illness	23.6	70.8	23.1	6.2	63.8	55.6
Lack of medical coverage if employed	22.9	19.4	53.2	27.4	46.2	50.0
Lack of child care	22.2	67.7	29.0	3.2	73.1	24.3
Alcohol/drug use	18.4	40.8	44.9	14.3	45.2	38.9
Homelessness	15.5	83.7	7.0	9.3	54.3	45.0
Difficulty reading/writing	12.7	28.6	54.3	17.1	7.1	47.1
More than 3 children	11.7	58.1	38.7	3.2	45.5	37.5
Criminal record	9.6	54.2	41.7	4.2	48.0	41.7
Caring for elderly relative	9.5	54.2	20.8	25.0	50.0	44.4
Language barrier	3.2	55.6	44.4	0.0	12.5	100.0

With respect to these barriers, we asked four questions:

1. What barriers are most and least often reported by long-term welfare recipients?

2. What barriers are most and least often seen as "preventing" work?

3. What barriers are most and least likely to be discussed with employment counselors?

4. With what barriers do respondents feel employment counselors have been most and least helpful?

Most and least commonly experienced barriers

Lack of job skills was the most often-reported barrier, experienced by 52% of respondents in this sample. It was followed by lack of education (48.8%); physical disability or medical condition (45.6%); lack of transportation (45.2%) and child health or behavioral problem (42.3%). The least common barriers were: language barrier (3.2%); caring for an elderly relative (9.5%) and criminal record (9.6%).

Barriers most and least often seen as preventing work

Those who experienced each barrier were asked about its effect on their ability to work. Although it was not a common barrier, homelessness was seen by 83.7% of those affected as preventing them from working. It was followed by a spouse or partner objecting (77.5%) choosing to stay with children (75.5%) and caring for an infant (73.5%).

Barriers least often seen as preventing work included: lack of medical coverage if employed (19.4%); wages too low (22.7%); and difficulty with reading or writing (28.6%).

Barriers most and least likely to be discussed with employment counselors

Respondents who experienced these barriers were asked whether or not they had discussed the situation with their employment counselors. Those most likely to be discussed included: lack of education (82.9%); mental health condition (80.0%), lack of child care (73.1%), and lack of job skills (70.0%).

It is important to note that over half of those experiencing these barriers reported that they had discussed the situation with their employment counselors. There were a few exceptions. Barriers unlikely to be discussed included: language barrier (12.5%), a spouse or partner objecting to the respondent working (26.9%), having more than three children in the home (45.5%), and alcohol or drug problems (45.2%).

Barriers with which employment counselors were most and least helpful

Again, it is important to note that with most of these barriers at least half of respondents who talked with their employment counselors reported that this was helpful. This was especially the case with the following barriers: language barrier (100%), mental health condition (64.4%), caring for an infant (66.7%), and child health and behavior problems (60.7%).

In some situations; however, less than half of those who reported discussing the barrier with their employment counselors found it helpful. Barriers in this category included: lack of child care (24.3%), wages too low (25.0%), lack of good jobs (34.7%), and presence of more than three children in the home (37.5%).

One striking finding was the low probability that a respondent would discuss a spouse or partner's objections in light of the fact that most of those who experienced this barrier reported that it did prevent them from working. Further, most of those who discussed this with their case workers reported that this was not helpful.

Support Networks

Social support was defined as both instrumental (concrete, tangible) and emotional (nurturing, non-tangible) support (Belle, 1982). Subjects were asked about their instrumental and emotional support networks, at both the interpersonal and community levels. Three general questions regarding social support were addressed: a) did respondents receive either or both emotional and instrumental support? b) did respondents receive either or both interpersonal and community levels of support? and c) did respondents give as much or more support than they received? It has been suggested in other studies (Belle, 1982) that many poor women are involved in social networks which are more draining than they are supportive. That is, many poor women provide more emotional and instrumental support than they receive. They end up with a "support deficit" which may be related to their financial dependence and adds to the stress of everyday life. Questions were asked to determine level of support given as well as received.

The majority of respondents in the study reported receiving both emotional and instrumental support. Emotional support was measured by questions which asked if there was someone the respondent could count on to give encouragement, who really understands you, who you could call if you were upset, and someone they could count on to listen to them. Over 75% of the respondents answered yes to each of the four questions. The lowest positive response (78.9%) was for the question, "Does someone really understand you?"

Instrumental support was measured by questions which asked if the respondent had someone who would run errands for them, would lend them money, would watch their children on a regular basis or in an emergency, or would lend their car or give a ride if needed. Positive responses for instrumental support were fewer than for emotional support, but at least half of the respondents answered yes to each of the instrumental support questions. The most frequent positive response (92%) was for the question of watching children in an emergency. The least frequent positive response (51%) was for the question of watching children on a regular basis.

Regarding the question of receipt of interpersonal and/or community support, respondents were clearly more dependent on interpersonal sources of support. Only 23% of respondents answered that they received support from community organizations. Of the 64 respondents who reported receiving community support, 27% reported receiving community emotional support (mental health therapy or counseling) and 22% reported receiving food from a community source. Other community sources of support were money, child care, and a place to stay.

Data collected for this study did not support previous studies which suggest that poor women maintain a "support deficit". For every question, both emotional and instrumental, respondents reported receiving more support than they gave. When asked a general question of "Is there anyone who counts on you for

any source of support?", 88% of the respondents answered yes. (Multiple barrier Interviewers speculated that the respondents may have been referring to their children, and not other adults, as intended in the study.) However, for each specific question relating to whether or not the respondent gave support, for all but one question ("Is there someone who counts on you to give encouragement"), respondents reported receiving more support than they gave.

Regarding source of support, the most frequent source of support reported was family member (37%), followed by friend (13%). Of those who reported a source of support, 75% said that their closest support was employed. A small percentage (4.6%) reported having no sources of emotional or transactional support.

Child Behavior Problems

Three sub-scales from the Child Behavior Checklist were completed for the oldest child in each family. The mean age for these children was 11, with a range from 4 to 18. The group was evenly divided between boys (50.7%) and girls (49.3%). A total of 47 problem behaviors were examined, in relation to aggressive behavior, delinquent behavior, and anxious behavior.

Table 16 below shows Behavior disorders among children.

Table 16
Behavior Disorders Among Children of Long-Term Welfare Recipients

Group	Borderline Level	Clinical Level	Combined
Aggressive Behavior			
Boys 4-11	3.8%	7.6%	11.4%
Boys 12-18	4.5%	11.4%	15.9%
Girls 4-11	6.2%	6.2%	2.4%
Girls 12-18	2.3%	7.8%	10.1%
Delinquent Behavior			
Boys 4-11	2.3%	4.5%	6.8%
Boys 12-18	6.8%	5.3%	12.1%
Girls 4-11	6.2%	4.7%	10.9%
Girls 12-18	4.7%	7.8%	12.5%
Anxious Behavior			
Boys 4-11	5.3%	6.1%	11.4%
Boys 12-18	6.8%	7.6%	14.4%
Girls 4-11	3.9%	6.2%	10.1%
Girls 12-18	3.9%	5.4%	9.3%

Nearly one-fourth of this sample reported severe child behavior problems. In fact, 23.2% of the sample reported CBC scores for their oldest children in the "clinical" range, a point at which professional intervention is strongly advised. These children were evenly divided among boys (50%) and girls (50%).

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Client Learning Disabilities

The "Payne" scale was used to identify clients with potential learning disabilities. This scale consists of a series of nine questions about problems, such as "working with numbers in a column","filling out forms ", "mixing up arithmetic signs", and "difficulty spelling words you know". Nearly one fourth of the group (22.9%) scored in a range that suggests they should be screened for learning disabilities.

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Self-esteem and Self-efficacy

The Rosenberg Self-esteem scale was used to measure how respondents felt about themselves and their adequacy compared to other people. A self-efficacy scale was used to measure whether respondents felt they were capable of solving problems and accomplishing goals. Answers from both scales are measured from ten to forty, with ten being a low amount of self-esteem or self-efficacy, 40 being high, and 25 as the mid-point..

The mean score for the self-esteem scale was 27.8, with a median of 28. The mean score of the self-efficacy scale was 30.9, with a median of 31. Both scores are midway between the mid-point and the high score, and indicate moderate levels of self-esteem and self-efficacy.

Mental Health

Several mental health measures proved to be significantly associated with welfare outcomes. For example, respondents who screened positive for the presence of an anxiety disorder were less likely than those who did not to be working 20 or more hours per week. Among those who did screen positive for anxiety, only 11% were working; compared to 37% of those who did not. This difference was statistically significant (p=.020). In order to see whether the presence of *any* mental health disorder was associated with work outcomes we created a dichotomous measure that indicated whether the respondent had screened positive for anxiety disorder, post-traumatic stress disorder (PTSD), or depression. Results were in the predicted direction. The presence of a mental disorder was associated with a reduced likelihood of working 20 or more hours per week. Among those who screened positive for these disorders, 31% were working, compared to 40% of those who did not. This difference only approached statistical significance, however (p=.114). There was a weak relationship between the presence of depression and number of episodes on welfare. Those who screened positive for depression averaged 2.3 episodes, compared to 2.0 for those who did not (p=.165).

Clinical Depression

Two scales were used to measure depression. The Center for Epidemiological Studies Depression Scale (CES-D) is a continuous scale used to measure risk of clinical depression. The CES-D does not provide a clinical diagnosis, but provides reliable information as to risk of depression. A score of 16 or above is generally used to indicate risk of clinical depression. In addition to the CES-D, a scale comprised of questions from the Diagnostic Statistical Manual of Disorders (DSMIII) was used. The DSM scale is a dichotomous scale indicating presence or absence of a clinically relevant level of chronic depression. A majority, (56.7%) of the respondents measured at risk of depression, and a large percentage (42.3%) scored positively for clinical depression.

Clinical depression is far more serious than normal sadness or "the blues". It is a chronic condition of abnormal sadness which causes marked functional impairment, disabling physical symptoms, and disabling psychological symptoms. Clinical depression may cause reduced capacity to experience pleasure, excessive irritability, or negative thinking which can lead to self-defeating or suicidal behavior. Clinical depression may also include abnormal ability to concentrate or indecisiveness, and/or abnormal thoughts of death. As can be seen in Table 17, the long-term welfare group is much more likely to be clinically depressed than either the total Utah welfare population or the U.S. general population.

Generalized Anxiety Disorder

A scale created from the DSMIV was used to measure presence or absence of a clinically relevant measure of generalized anxiety disorder (GAD). GAD is chronic, excessive anxiety about a number of events or activities. A person suffering from GAD finds it difficult to control the worry. It may be associated with other symptoms such as restlessness, fatigue, irritability and/or difficulty concentrating. GAD causes clinically significant distress or impairment in social, occupational or other important areas of functioning. Nineteen respondents (6.7%) scored positively for presence of GAD. As shown in Table 17 this is more than double the rate of GAD in the general U.S. population

Post-Traumatic Stress Disorder

Questions based on the DSMIV were used to create a scale measuring post-traumatic stress disorder (PTSD). PTSD is exposure to a traumatic event in which the person witnessed or experienced events that involved actual or threatened death or serious injury. The person persistently re-experiences the event through recollection or dreams. The person with PTSD may make efforts to avoid thoughts or activities associated with the trauma. The person may also possibly have feelings of detachment, restricted range of affect, or diminished interest in participating in activities. As shown in Table 17, 15.1% of the long-term welfare population suffered from PTSD, almost twice the rate in the general U.S. population.

Substance Abuse

Respondents were asked a series of questions about their use of alcohol or drugs, whether they had ever considered decreasing alcohol or drug consumption, whether a friend or family member had ever suggested they decrease alcohol or drug consumption, and whether alcohol or drug consumption had ever interfered with their job As shown in Table 17, long-term welfare recipients measured almost double the rate of alcohol and drug abuse as the total Utah welfare population, and considerably higher than the rate for the general U.S. population.

Drug use was significantly associated with work status. One in five respondents (19.6%) reported having a drug problem. Among these, only 24% were working at least 20 hours per week, compared to 38% of those who did not report a drug problem. This difference was statistically significant (p=.05). Drug use was also associated with the number of episodes on welfare. Those reporting a drug problem averaged

2.6 episodes, compared with an average of 2.0 for those who did not. (P=.051).

Domestic Violence

Respondents were asked a series of questions regarding violence involving a spouse or partner. The questions were adapted from The Women's Employment Study by the Survey Research Center of the University of Michigan, and are based on a legal definition of domestic violence. Respondents were asked about their experiences with domestic violence as adults, and in the twelve months prior to the interview.

The majority of respondents reported being involved as a victim of domestic violence in their adult lives. Seventy-nine percent reported that a spouse or partner had pushed or grabbed them. Seventy-three percent reported that a partner had threatened to hit them. Sixty percent reported that a partner had slapped or kicked them. Fifty-eight percent reported that a partner had thrown something at them. Of these incidents, which for our study were not considered "severe" domestic violence, the most commonly reported as having occurred in the last 12 months was being pushed or grabbed, with 20% reporting they had been pushed or grabbed by a partner within the last 12 months.

Over half of the respondents (62%) reported having called the police because of domestic violence. Almost half (42%) reported having been harassed at work, 36% reported having to stay home from work because of domestic violence, and 37%had seen a doctor because of domestic violence. Almost half the sample (49%) had tried to get a restraining order against a violent partner, and 17% of the sample had tried to obtain a restraining order within the last 12 months. Almost one quarter, (21%) reported that their current partner had committed an act of domestic violence against them. The mean age of respondent at which any act of domestic violence had first occurred was 21.8, with a median age of 20 years.

An additional variable of "severe" domestic violence was created by combining incidents of being hit with a fist, hit with an object, beaten, choked, threatened or used a weapon against you, and/or forced you into sexual activity against your will. As shown in Table 17, 73.6% of the sample had been a victim of severe domestic violence in their adult lives, and 12.3% had been a victim of severe domestic violence within the last 12 months. This is considerably higher than the rate of domestic violence for either the total Utah welfare population, or the general U.S. population.

Barriers in Combination

Clearly long-term welfare respondents struggle with persistent and severe barriers. How do they compare with others? Table 17 compares long-term welfare recipients where possible, to the Utah welfare population, and the United States population. These figures illustrate the difficulties faced by the long-term welfare population.

Table 17

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Prevalence of Long-term Predictive Barriers to Work

Barrier	Sample 3+ Years N = 284 %	Utah Welfare Population (July, 1998) N=7951 %	General U.S. Population %
Mental Health			
CES-Depression	56.7%		
DSMIII Depression	42.3%		10.3%**
Generalized Anxiety Disorder	6.7%	15.0%*	3.1% **
Post-Traumatic Stress Disorder	15.1%		7.8%***
Learning Disability (Payne)	23%		

Education (No diploma or GED)	32%	37.5%	7.8%
Work History (In last 5 yrs, never worked more than 6 months at one job)	30.4%		
Physical health problems (Which prevent work)	53.2% 34.9%	11.9%*	
Physical health problems - child	42.2%		
Severe Domestic violence within the past 12 months **Severe Domestic violence** ever as an adult	12.3% 73.6%	12%*	3.3%
Drug abuse	19.6%	10.2%*	2.5%**
Alcohol abuse	20.1%		0.8%**
Severe child behavior problems	23%	6.1%	
Child Protective Service referral	46.3%	1.5%*	

*Not a clinical diagnosis -- data obtained from DWS administrative data "risk factors"

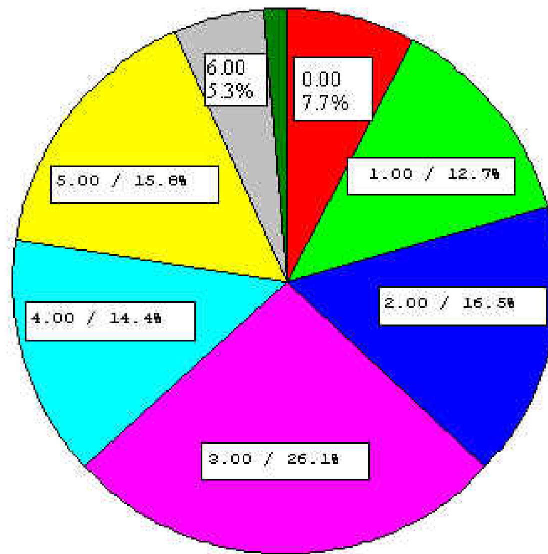
**12-month prevalence in representative U.S. sample, The National Comorbidity Study, (1994) , Kessler, R., Ann Arbor MI: The University of Michigan

***Lifetime prevalence in representative U.S. sample, Posttraumatic Stress Disorder in the Nation Comorbidity Survey, (1995), Kessler, R. Et al, Archives of General Psychiatry, 32

Figure 2 shows the percent of respondents by number of barriers. Figure 2 indicates that most respondents reported not only severe barriers, but multiple barriers. The most frequently reported number of barriers was three (26.1%). Five percent of the sample had six or more barriers.

Figure 2

Number of Barriers Experienced by Long-Term Welfare Recipients (N=284)



In order to more clearly understand the program and policy implications of the results, barriers were divided into work/education, health/mental health, and family barriers. Figure 3 shows the constellation of barriers, and indicates proportion of respondents experiencing each type of barrier. The most common configuration, experienced by 40.5% of respondents, was a combination of personal health or mental health barriers and family problems. The second most common situation was experienced by the 19.4% of respondents who had all three types of problems. Finally, in the third most common situation, 13.0% of respondents reported having personal health and/or mental health barriers. The high prevalence of individuals with health and mental health or family barriers suggests a need for aggressive interventions focused in these areas. As we indicated in the executive summary, these interventions would probably involve collaborative efforts of multiple public agencies.

We then set out to determine which constellations of barriers had a significant impact on a respondents' likelihood of achieving self sufficiency. To do this, three variables were created to measure three outcomes: whether or not a participant was working; the duration of the respondents' current episode on welfare, and the number of welfare episodes the respondent had.

The "employment" variable divided respondents into two categories: those who were currently working 20 or more hours per week, and those not working 20 or more hours per week.

Figure 3
Constellations of Barriers(N=284)

Work/Education
2.1% (6)

7.4%
(17)

Health/Mental
Health
13.0% (37)

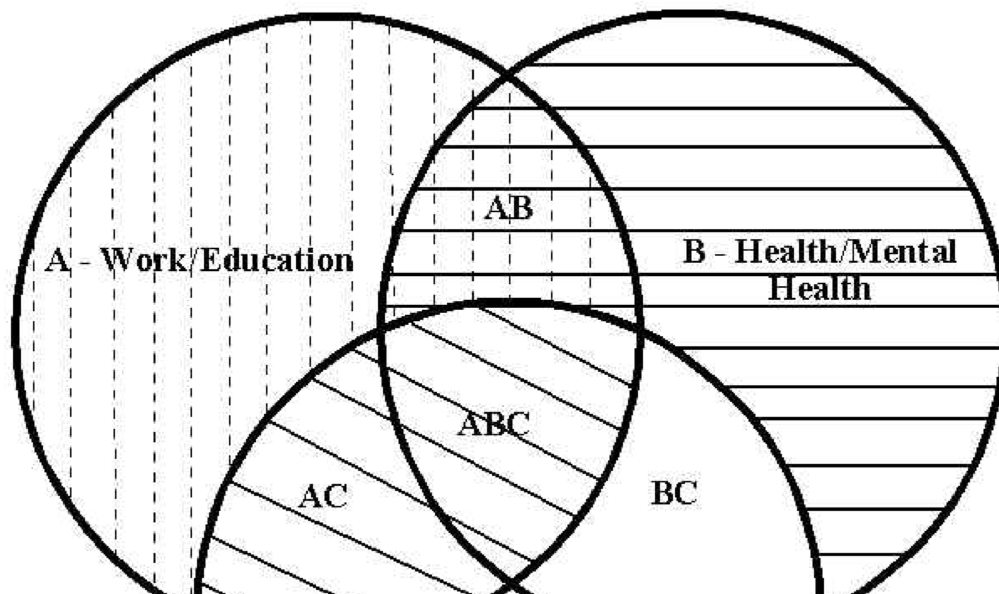
19.4%
(55)

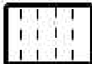
2.8%
(8)

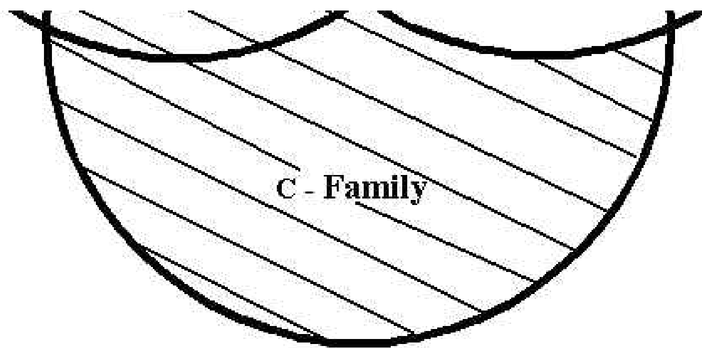
40.5%
(115)

Family
7.0% (20)

Figure 4
Relationship Between Barriers to Work and Number of Episodes, Duration of Current Employment, and Employment Status







Although there is no required number of hours which a Utah welfare recipient must work in order to be considered "fully participating" in their self-sufficiency plan, the federal guideline is 20 hours per week. Thus, the arbitrary division between 20 and less than 20 hours of employment per week. The "duration" measure was an interval scale indicating the number of months in the respondent's current welfare episode. The "episode" measure was another interval scale, ranging from 1 to 6, and indicating the number of time the respondent reported having been on welfare.

Figure 4 shows relationship between these outcome measures and the constellations of barriers presented in Figure 3. Results are striking in that all but one of the situations identified were significantly associated with at least one of the outcome measures.

Those who had both education barriers to work (no high school or GED) AND health barriers (self-reported) had a reduced probability of working. Among those with this combination, 25% were working 20 or more hours per week, compared to 39% of those who did not have both barriers. This difference was statistically significant (p=.029).

Family barriers were associated with the number of episodes on welfare. Those with family barriers averaged 1.9 episodes, and those without averaged 2.2. This difference was statistically significant (p=.028).

The presence of all three types of barriers (family, education, health/mental health) was associated with number of episodes. Those with all three barriers averaged 2.4 episodes, while others averaged 2.0. This difference approached statistical significance (p=.059).

Family barriers and education barriers combined also increased episodes on welfare. Those with both averaged 2.3 episodes, compared to 2.0 for the rest of the sample. This difference approached statistical significance (p=.063).

Health alone wasn't associated with duration or number of episodes. It was associated with employment status (see above). Health plus education did predict employment status. Among those with these two barriers, 25% were working 20 or more hours per week, compared to 39% of the rest of the sample. (P=.029).

The relationship between number of barriers and employment is also illustrated in Table 18. At zero barriers, the percent of those working 20 or more hours per week is almost double those not working. As the number of barriers increases, the percent of participants not working 20 or more hours per week increases (in relation to the percent with that number of barriers.) As the number of barriers increases, the difference between the two groups becomes more distinct. This table shows that number of barriers is significantly related to number of hours worked per week, and that more barriers are related to less hours worked.

Table 18

Number of Barriers for Two Groups: Currently Working 20+ Hours/ Not Currently Working 20+ Hours (N = 284)

Number of Barriers	Long-term recipients **NOT** currently working 20+ hours/per week (n = 184) %	Long-term recipients **CURRENTLY WORKING** 20+ hours/week (n = 100) %	TOTAL (N = 284) %

0	2.8%	4.9%	7.7%
1	7.0 %	5.6 %	12.7%
2 - 4	37.4%	19.8%	57.2%
5 - 8	17.7%	5.0%	22.7%
Total	64.8%	35.2%	100.0%

$^{2} = 18.947$, $p. <$ **.015**

SUMMARY OF KEY FINDINGS

The presence of a mental/emotional problem history is a key factor in distinguishing short- and long-term Family Employment Program (FEP) participants.

FEP employment counselors see long-term recipients as distinctive in that they: have limited work and educational experiences, have impaired intellectual functioning, are manipulative and lacking in self-discipline, and have severe mental health problems.

Although FEP employment counselors are concerned about the impact of lifetime limits on clients, they worry that they will lose credibility if the limits are eliminated.

Long-term welfare clients consume a disproportionate amount of employment counselors' time and energy.

Up to a point, long-term welfare clients look like most members of the Utah population. They are primarily Caucasian and female, average 34 years old, and are likely to be members of the LDS faith.

When personal histories are examined, long-term welfare clients are considerably different from most members of the general public and most other welfare recipients: Over half reported that they had been physically or sexually abused before the age of 18, 12.3% had experienced severe domestic violence in the year prior to our interview, over one-fourth had been convicted of a crime, over half had a physical disability or health problem that limited their activities, one-fourth screened positively for a learning disability, and nearly half had been the subject of a CPS referral.

The reasons for going on and off welfare have been remarkably consistent for these long-term clients. About half went on welfare because of pregnancy or a change in family circumstances and about one-third have gone off welfare because they found employment.

Long-term clients have considerably higher levels of mental health and health problems, and more family and work barriers than do other welfare recipients, or the general public.

Long-term clients have not only severe and persistent barriers, but multiple barriers to self-sufficiency.

Respondents were generally positive in their response to self-sufficiency activities and the assistance they received from their employment counselors; however they were unlikely to discuss two important barriers with FEP staff. These were a spouse or partner's objection to their working and the presence of a substance or alcohol problem.

Three types of barriers: health/mental health, work/education, and family are, individually and in combination, important predictors of client's welfare histories and employment status.

POLICY AND PRACTICE RECOMMENDATIONS

The profile of FEP clients with "multiple, severe, and persistent" barriers to self-sufficiency shows a group of families with, by and large, very serious barriers to self-sufficiency, and barriers which come from multiple directions. It is the double jeopardy of severe and multiple barriers, combined with lack of resources which puts families at risk of long-term dependence. Also, over time, there is an increasing percentage of clients with multiple problems in the welfare caseload. As the total caseload has decreased in size, the percentage of long-term, multi-problem families has increased. It demonstrates that clients with more barriers are more vulnerable to dependence on welfare. Based on findings of this study, recommendations for working with Utah long-term welfare families are as follows:

1. **Rapid, accurate assessment is necessary** if the DWS staff is going to identify barriers to self-sufficiency, and work to create a plan which will move clients to self-sufficiency within the required time limit. Employment counselors have noted that they lose valuable time working with clients to help them become self-sufficient, because it takes as long as a year to understand the client's problems. Rigorous assessment should take place upon application for assistance in order to target families that will need specialized services.

2. **Aggressive service delivery, focused on employment must be offered during the client's three years on assistance.** Some of the barriers facing these families are intractable. For example, well-established child behavior problems, severe mental illness, and addiction present situations in which the likelihood of a permanent "cure" is often low. So employment supports must take these as "givens" in clients' lives. A practical approach would address client change (by shoring up coping abilities) and improve environmental supports (by mobilizing formal and informal resources). Clearly the goal of this aggressive service delivery must be to create permanent supports that will sustain these troubled people in productive employment.

3. **DWS should work in conjunction with other public agencies that provide services to long-term clients**. The majority of long-term clients are involved in multiple systems -- child welfare, substance abuse services, juvenile justice and/or mental health services. Because of the severe consequences of reaching the time limit, agencies should work together to help stabilize families and help them find the means to become self-supporting. Services may include family counseling, substance abuse or mental health counseling, medication, and job training. It is a disservice to FEP clients to present them with differing treatment methods and goals which may work at cross-purposes. Client privacy and confidentiality are important, but agencies must find a way of working together, through case conferencing or shared electronic systems to support FEP families in their efforts to become self-sufficient.

4. **The 20% hardship extension should be reviewed annually during the program's first years of operation, keeping in mind the possible need for an increase to be applied to the period between 3 and 5 years as allowed by federal law**. The percentage of clients who are long-term and have multiple barriers has historically been over 40% of the current total caseload. The clients left on the caseload face more difficult and intractable challenges than those who leave. Holding the extension rate at 20% may not be adequate for the number of clients who need longer-term support.

5. **Long-term maintenance plans should be developed for FEP participants whose cases are closed upon reaching the three-year lifetime limit.** This study describes in detail the multiple, severe and persistent barriers faced by long-term families in public assistance. Many of these barriers represent chronic conditions which may be treated and controlled, but never cured or solved. All families who reach the 3-year time limit have shown good faith effort in keeping their part of the self-sufficiency plan. Otherwise they would have been terminated from the program for non-participation. Yet, for these families ongoing assistance (however minimal) may be necessary. Therefore, when cases close at three years clients should not simply be terminated from FEP. Instead, Employment Counselors and others who have knowledge of the case should collaborate in the preparation of a maintenance plan. The plan might involve memoranda of understanding between DWS, other public agencies, and employers or potential employers.

6. **A mentoring and resource center should be established for terminated clients.** All clients who need ongoing services will not be included within the hardship extension. For those who are terminated from cash assistance due to the time limit, ongoing non-cash resources should be offered. This ongoing support could be work-related, provide crisis and emergency emotional and instrumental support, and provide a network of positive reinforcement which may otherwise be missing from the client's support network. The mentoring and resource center might be staffed by DWS employment counselors with the help of community volunteers.

7. **The Department of Workforce Services should establish statewide guidelines for determining client eligibility for hardship extensions.** It is important that clients and employment counselors understand the criteria for meeting the hardship extension requirements, so that they may work within those guidelines from the start of the client's tenure on assistance. Focus groups with front-line staff in different areas of the state

demonstrated that offices in different locations have varying definitions of "hard-to-serve families" and varying explanations for their behavior. Local discrepancy in policy is a good idea to some degree -- as a way to respond to local employment and community conditions. However, neither local offices nor individual workers should bear the burden of deciding who is eligible for extension of the 3-year time limit.

8. In addition to considering the **allocation** of extension slots, the DWS must consider how clients are expected to **exit from their extension status**. This might be accomplished through the negotiation of individual deadlines. Such deadlines might extend from a few months to several years, depending on a client's situation. Clearly state-wide guidelines must be in place to ensure that clients in similar situations receive similar extensions.

Case Illustration

Following is a description of an actual interview respondent who is quite typical of long-term recipients. She faces severe challenges to employment, and challenges which are both family, and health-related. She also has experienced early, severe and multiple sources of trauma. All names and identifying information have been changed to protect the confidentiality of the respondent.

"Ann" is a 32-year old divorced white LDS female with two children, Dean and Hannah, ages 8 and 5, respectively. Chronic back problems from a vehicle accident limit vigorous and moderate activities, such as lifting heavy objects and walking more than one mile. Ann frequently experiences memory loss and migraine headaches following neurosurgery to remove a tumor. Depressive symptoms have been present for more than 50 weeks and Ann attributes these symptoms to several issues–treatment and surgery for the tumor, abuse of her daughter (Hannah) by a male person in the community, and her personal experiences of childhood trauma and violent domestic abuse from her ex-spouse.

The depressive symptoms coupled with her chronic back pain intensifies as Ann's concern for the safety and well-being of Hannah grows. She describes the effects on her family after discovering that a babysitter physically and emotionally abused Hannah when she was an infant and then a male person sexually molesting Hannah a few years later. Hannah responds, as if being violently terrorized, when certain parts of her body are touched in specific ways. While interviewing Ann, I had the opportunity to observe the family and came to understand how extremely difficult it is to be a parent of a child with severe behavior problems.

Typically, this interview would have been completed within 1½ hours, especially with young children present at the time of the interview. Hannah exhibits a high level of hyperactivity and lack of concentration to perform daily tasks appropriate for her stage of developmental development. Ann's constant supervision and prompting is needed throughout the interview at intervals of three to five minutes. During the interview, Ann remains composed and firm in her initial direction that the children are to clean their rooms. Hannah runs from room to room, out into the yard, and back into the house. She makes herself a peanut butter sandwich and leaves it face down on the carpet. Hannah antagonizes her older brother, swears, pouts, screams, and cries. Within the first hour of the interview, I observed Hannah throwing the cat onto the floor, having several temper tantrums, hugging and kissing her mother, and offering me a drink of water and some of her cereal. By the end of the interview, the closet, drawers, and bookshelves are empty. Everything has been tossed onto the floor. The bathroom floor is covered with water about a ¼ inch deep. Some of Hannah's toys and clothing have been thrown out of the bathroom window. Ann describes this scene as just *slightly* out of the ordinary and continues to maintain her composure.

Ann witnesses her daughter's struggle with the effects of the abusive situations and her frustration magnifies with thoughts and feelings on her experiences of physical, emotional, and sexual abuse. She describes her feelings as a young pre-teen who never received support or acknowledgment for her artistic accomplishments from her mother. Instead she received insults and criticism for her work, appearance, and friends. Her mother would constantly tell her what to do, how to do it, and when to do it. Eventually her parents divorced and Ann, nearly an adult, found love and support from her father. She states that the harm to her self-esteem had already been done and before age 18 had married an abusively violent man. He would threatened to kill her every time she tried to leave him. He threw knives at her; beat her with his fists, boot, and other objects; and threw hot cooking oil on her. After the divorce, he began stalking her for years. She was always looking out for him. The last time he caught her, he strangled her until she passed out.

Despite Ann's experiences she is determined and motivated to attain self-sufficiency. After a total of 42 months on welfare assistance, Ann graduated from college and knows this will lead to better employment opportunities. Presently, she is a clerk earning $7 an hour. She qualifies as a computer technician earning $12.55 an hour from the same employer, but has been unable to find child care to accommodate night shift work. Ann states that she can deal with her physical and mental health needs, the political powers that control the hiring process at work, and even the oppression and discrimination from legal authorities who refused to investigate and charge the man who fondled Hannah. She described her thoughts when legal advisers refused to act on her accusation because she is a welfare recipient and stands to gain financially from such a case. A child advocacy group stated that charges will be made only if *someone else* makes a similar charge against the same man.

Ann places her problems into a different kind of perspective, one that she can manage. She has faith that these perpetrators will face their own judgment someday. For now, she has more important issues to be

concerned with–like helping Hannah clean her room.

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Footnotes:

[1] Where possible, study findings were compared to measures of the Utah welfare population and the general U.S. population. See Table 17 of this report.

[2] Rural areas: Moab/Price, Logan, and Roosevelt/Vernal. Urban areas: Clearfield, Provo, and Salt Lake. Two focus groups were conducted in the Salt Lake Area.

[3] This data is point-in-time current open AF cases. Length of time on assistance is cumulative from July of 1988.

[4]Clinically relevant measures of bolded categories were used in the instrument.

[5]It is important to note that people of color are over-represented in this sample when compared to their proportion of the total Utah population. The U.S. Census Bureau (1998) reported that 93.9% of the state's population is Caucasian.

[6] Health/mental health barrier consisted of positive scores on any of the mental health diagnoses, physical health or substance abuse. The work/education barrier consisted of an education or work history barrier. A family barrier consisted of child physical health barrier, domestic violence barrier, child behavior barrier, or a protective service referral.