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Facilitating the Welfare-to-Work Transition for Women with a Mental Health Work Barrier

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Shawna J. Lee

SUMMARY. Since the 1996 PRWORA welfare reform act requiring workforce participation in order to receive services, evidence has emerged that many welfare recipients experience mental health work barriers. Yet, little is known about effective approaches for assisting women with a mental health work barrier in the welfare-to-work transition. This paper addresses this gap by first surveying the empirical research on mental health work barriers among welfare recipients. Second, I propose a comprehensive service provision model to identify and assist

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welfare recipients with a mental health barrier. Third, I review outcome data from several promising intervention strategies.

KEYWORDS. TANF, mental health, barriers to employment, intervention model, innovative programs

Following the 1996 welfare reform law, the number of women receiving welfare declined by more than half, which corresponded with a large increase in workforce participation among current and former welfare recipients (Blank, 2001; Lichter & Jayakody, 2002). Yet, recent research indicates that many female welfare recipients face numerous work barriers, including mental health problems like depression, anxiety, and PTSD, to full workforce participation. Women with mental health work barriers are at increased risk of unstable work situations, lower levels of work and earnings, and decreased well-being, when compared to women with fewer or no work barriers (Corcoran, Danziger, Kalil, & Seefeldt, 2000; Danziger et al., 2000a). In addition, there is concern that many women with the skills to leave welfare early on did so, leaving behind those recipients with the most work barriers and least employment skills (Gardiner & Fishman, 2000; Pavetti et al., 2001; Lichter & Jayakody, 2002). Such a shift would result in a welfare caseload that is increasingly disadvantaged, pointing to the need for innovative approaches that can help women who remain on the welfare rolls to reduce work barriers or adjust better to difficult circumstances (Danziger & Seefeldt, 2002). This paper briefly reviews the extent of mental health work barriers among female welfare recipients, proposes a model to provide services for welfare recipients with a mental health work barrier, and examines several promising intervention approaches that can facilitate the welfare-to-work transition among women with a mental health work barrier.

PREVALENCE OF MENTAL HEALTH WORK BARRIER

Welfare populations are high in both prevalence and incidence of mental health problems (e.g., Olson & Pavetti, 1996; Ahluwalia, McGroder, Zaslow, & Hair, 2001; A. Brown, 2001; Coiro, 2001). Ma-

jor depression, generalized anxiety disorder (GAD), and post-traumatic stress disorder (PTSD) are common disorders among the welfare-to-work population (Danziger, Kalil, & Anderson, 2000b; Ahluwalia et al., 2001). One major study of former and current welfare recipients in urban Michigan found that one-third of the respondents met the diagnostic criteria for major depression, PTSD, or GAD (Danziger et al., 2000a).

Depression is especially common. A number of other studies substantiate the high prevalence of major depression and depressive symptoms in the welfare-to-work population (Ahluwalia et al., 2001; Brown, 2001; Coiro, 2001; Olson & Pavetti, 1996). A study conducted of a Florida welfare-to-work program found that 42% of the women reported high levels of depressive symptoms (Olson & Pavetti, 1996). Similarly, another program reported that 40% of a sample of African American participants reported symptom levels indicative of clinical depression (Coiro, 2001) and 39.5% of a multiple race sample of participants in a Maryland program met the diagnostic criteria for major depression (Vinokur, 2003). These rates are much higher than those found in a national sample in which the lifetime prevalence estimate among women for major depressive disorder was 18.6%, and the 12-month prevalence was 11% (National Comorbidity Study; Kessler, Nelson, McGonagle, Liu, Swartz, & Blazer, 1996).

While presence of mental health work barriers does not necessarily prohibit work (Coiro, 2001; Lehrer, Crittenden, & Norr, 2002; Olson & Pavetti, 1996; Zedlewski & Loprest, 2001), work effort may be hindered to the extent that barriers cause intermittent work or lower wages (Olson & Pavetti, 1996; Corcoran et al., 2000). It is documented that work levels decrease as the number of work barriers increases (Danziger et al., 2000a) and repeated episodes of high depressive symptoms are associated with greater welfare reliance (Lehrer et al., 2002).

CURRENT STATE OF MENTAL HEALTH SERVICES

Despite growing attention to mental health work barriers in the welfare population (Olson & Pavetti, 1996; Danziger & Seefeldt, 2002), there is little evidence of effective approaches for providing services to welfare recipients or low-income women in general. First, few welfare offices have a formal procedure for screening and identifying women who have a mental health work barrier. In a field study of welfare-to-work programs for welfare recipients who had difficulty finding employment,

only two of eight programs used formal assessment tools to determine the need for more intensive services (Olson & Pavetti, 1996). In a study of four states, only one state (Florida) had developed a standardized screening tool and hired outreach staff for the purpose of identifying those with a need for mental health services (Derr, Douglas, & Pavetti, 2000b; Kramer, 2001).

Second, even if a welfare recipient is identified as potentially having a mental health work barrier, treatment options in the community are often limited for disadvantaged groups. Although cognitive behavior therapy (CBT), psychotherapy, and pharmacological approaches have been demonstrated to be effective in treating mental health problems like depression (Elkin, Parloff, Hadley, & Autry, 1985; Elkin et al., 1989), low-income women and racial and ethnic minority groups are much less likely to receive treatment when compared to the general population, and treatment services may be inconsistent (Coiro, 2001; Belle & Doucet, 2003; U.S. Department of Health and Human Services, 2001; Lennon, Blome, & English, 2001).

Finally, there are few programs within the welfare system that address mental health work barriers. Most welfare-to-work programs focus on helping recipients quickly obtain employment through job search and skills training (often referred to as "work-first" programs). A review of work-first programs suggested that many recipients benefited from participating in these programs, with the notable exception of depressed participants (Michalopoulos, Schwartz, & Adams-Ciardullo, 2000). The researchers concluded that the "programs did not affect earnings for people at high risk of depression when they entered the study, and had significantly smaller effects for those at high risk than for those at low risk" (Michalopoulos et al., 2000). Another study of work-first programs indicated that participants in five of the seven programs reviewed reported *increased* depression symptoms (Ahluwalia et al., 2001).

The limited use of mental health screening and the dearth of resources for women with mental health work barriers seems to suggest a growing disconnection between the services provided via the welfare system (e.g., work-first employment programs; determination of benefit eligibility) and the needs of welfare recipients (e.g., mental health services). If one goal of welfare reform is to increase workforce participation, it is important that this disconnection be addressed and services designed to meet the needs of the many welfare recipients who experience a mental health work barrier. Welfare recipients with a mental health work barrier need to gain the concrete work and job search skills

provided by work-first programs, but in a context that takes into account mental health related issues. Thus, one challenge is to integrate mental health services into the work-first model (Derr, Douglas, & Pavetti, 2000b). A clearly articulated model for how to screen and provide services to recipients with a mental health work barrier is one strategy for integrating mental health services with employment.

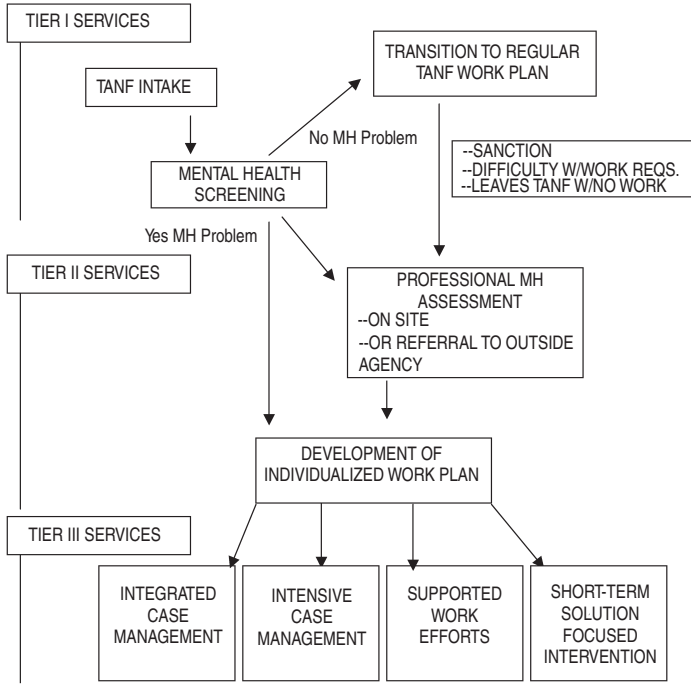
SERVICE PROVISION MODEL

A tiered approach that involves (1) mental health work barrier screening, (2) assessment and development of a work plan, and (3) mental health support services is recommended as a model to provide services to welfare recipients with a mental health work barrier (see Figure 1). In order to assist welfare recipients with mental health work barriers, caseworkers must first have the tools and training to identify women who have symptoms of a mental health problem. Thus, the first tier of service provision involves use of brief, self-report screening measures and other questions to alert caseworkers to symptoms indicating the increased likelihood of a mental health work barrier. The second tier involves mental health assessment and development of an individualized work plan that integrates employment with mental health services. The third tier puts the individualized work plan into action and identifies promising, targeted interventions and services that are believed to effectively address mental health work barriers and facilitate the transition to work.

TIER 1–MENTAL HEALTH WORK BARRIER SCREENING

In order for treatment or referral to take place, recipients requiring services need to be effectively identified through a screening procedure. Screening typically refers to simple pencil and paper tools or oral questions that are usually administered during initial intake when entering the welfare system. Screening aims to identify a potential limitation or risk of a condition through self-report (Kramer, 2001). At the Tier I screening phase, the caseworker's goal is not to make a clinical diagnosis, but rather to identify women with symptoms of a mental health work barrier that might necessitate formal assessment by a mental health professional or development of an individualized work plan. Women who indicate symptoms or problems that could be related to a mental health work barrier at Tier I screening proceed to Tier II ser-

FIGURE 1. Multi-Tiered Service Provision Model



vices. Tier II services involve referral to a mental health professional for more thorough assessment and development of an individualized work plan, possibly in conjunction with health treatment or counseling.

Following the service provision model outlined in Figure 1, women who are not indicated for a current mental health work barrier transition to the regular welfare work plan. Inevitably many women with a mental health work barrier will not report these problems at initial intake and screening. Thus, another Tier I strategy to identify women with a mental health work barrier is aggressive outreach using specialized caseworkers to investigate sanctioned cases, with the assumption that those who have been sanctioned are most likely to have barriers to work (R. Brown, 2001; Thompson & Mikelson, 2001; Derr, Hill, & Pavetti, 2000a). Aggressive outreach could also include looking for recipients

who cycle on and off welfare or who leave welfare without reporting a source of income. The specialized caseworker's main task is to assess for barriers to work and refer individuals participating in the regular welfare work plan for further professional assessment of mental health problems.

TIER II–ASSESSMENT AND DEVELOPMENT OF A WORK PLAN

Professional Mental Health Assessment

Assessment refers to the process of evaluation to determine the severity of a problem. Thompson and Mikelson (2001) suggest a number of assessment tools that caseworkers and professionals can use to identify mental health and other work barriers. Assessment is a more intense process than screening and is usually performed by a mental health professional (Kramer, 2001). As shown in Figure 1, women who show signs of a mental health work barrier at the screening phase would ideally be referred for mental health assessment, which would then facilitate development of a work plan that is specific to the work barriers identified by the assessment. However, limited resources for thorough assessment may result in directly proceeding to development of an individualized work plan with the welfare caseworker.

Co-location of mental health professionals at the welfare office site may be useful for assessment and service provision. On-site services are likely to increase client follow through with services (Derr et al., 2000b) and would make it easier for mental health professionals to communicate with welfare caseworkers. An alternative is caseworker referral to outside community mental health resources.

Development of an Individualized Work Plan

Flexibility has frequently been identified as a key issue in developing mental health services within the welfare system (Strawn & Echols, 1999; Pavetti, Olson, Pindus, Pernas, & Issacs, 1996). In this view, in order to effectively serve recipients with a mental health work barrier, caseworkers should have the flexibility to create an individualized work plan that takes advantage of available resources and is tailored to the particular needs of the client (Pavetti et al., 1996), perhaps as indicated by the mental health assessment in Tier II. Additionally, in order to be

successful over the long-term and to maintain consistency with the goals of welfare reform, work plans must meet the dual objectives of helping recipients meet their mental health needs while they also work towards employment goals (Strawn & Echols, 1999).

Numerous factors can contribute to a successful work plan for recipients with a mental health work barrier. A work plan might focus on finding a supportive work environment, connecting the recipient to mental health counseling through community resources, connecting the recipient to welfare-to-work and other programs, and can include use of a job coach (A. Brown, 2001; Dion, Derr, Anderson, & Pavetti, 1999). In sum, welfare recipient, caseworker, and perhaps a mental health professional jointly develop a work plan that makes use of the resources in community and tailors them to the needs of the recipient in a manner that facilitates employment and receipt of services that address the mental health work barrier.

TIER III–MENTAL HEALTH SUPPORT SERVICES

As noted above, there are a number of ways to create an effective, successful individualized work plan. Several types of programs that address mental health work barriers and can be integrated into the welfare system are reviewed below, including (1) integrated case management, (2) intensive case management, (3) supported work, and (4) short-term solution focused interventions. The intervention efforts in this model provide a continuum of services, from the more comprehensive (intensive case management) to the less intensive (short-term solution-focused).

Integrated Case Management

In the integrated case management model, the traditional case management tasks of income maintenance and eligibility determination are expanded to include connecting recipients with employment and training opportunities. Integrated case management also often means that the roles of determining benefit eligibility and providing employment related services are conducted by one caseworker (Brock & Harknett, 1998). The Job Opportunities and Basic Skills Training (JOBS) program evaluation included rigorous assessment of traditional and integrated case management. Results indicated that both the traditional and integrated management approaches were moderately effective, and in-

tegrated case managers more closely monitored client participation and follow through with program activities (Brock & Harknett, 1998; Scrivener, Walter, Brock, & Hamilton, 2001). Integrated case management engaged more people in the program and perhaps as a result clients experienced reduced welfare receipt compared to those in the traditional program. Both integrated and traditional case management resulted in about 10% higher earnings compared to the control group (Scrivener et al., 2001).

The JOBS evaluation is a case management model with the potential to work well for clients who suffer from mental health problems, particularly if caseloads are kept low. Integrated case management connects the caseworker more effectively with the client, potentially allowing the caseworker to successfully address clients' mental health work barriers. As with the JOBS program, integrated case management services can be specialized for clients with particular needs (Brock & Harknett, 1998). In addition, the ability to more closely monitor client participation in program activities and more seamlessly provide services through one caseworker may be helpful for clients who have difficulty managing work requirements. In JOBS, the trend toward more work and less dependency for the integrated case management clients suggests that support and resources provided through the welfare system can have positive effects for clients.

Caseworker referral of clients to outside agencies for services is another type of integrated case management. For example, caseworkers might refer clients to for-profit or non-profit agencies for employment and training, or refer clients to community mental health agencies for counseling and therapy (Derr et al., 2000b; Martinson & Holcomb, 2002). Another option is to contract with private provider mental health professionals and/or use Medicaid for treatment options. On-site treatment has the advantage of facilitating careful oversight of the client's progress, whereas off-site services that are not connected to the welfare office may be more difficult to coordinate.

Intensive Case Management

Similar in nature to the integrated model discussed above, intensive case management also utilizes a client-focused approach that involves activities such as linking clients to community services, spending more time with clients, closer coordination of services, and other activities (Ryan, Ford, Beadsmoore, & Muijen, 1999). Some models also include interdisciplinary teams and long-term client involvement (Rosenheck,

2000). In a welfare context, intensive case management can include home visits from caseworkers (e.g., Wisconsin), one-on-one counseling, and ongoing support programs (e.g., Nevada). Caseworkers in intensive case management programs carry small caseloads to allow more contact with clients, so that the caseworker is able to continually assess the services needed for meeting individual needs (Pavetti et al., 1996).

Client outcomes from intensive case management programs have been explored in a variety of contexts, including with the severely mentally ill in community health settings and with homeless mentally ill individuals (e.g., Chandler, Meisel, Hu, McGoan, & Madison, 1998). Ryan et al. (1999) reviewed psychological symptoms, life skills, and other outcomes from three intensive case management sites. Symptom levels decreased and social functioning improved significantly for individuals at two sites. Mowbray and colleagues (2000) provide support for the effectiveness of an intensive case management model that also focused on job attainment (Project WINS). The treatment groups engaged in significantly more competitive work than the control group, with evidence of higher community functioning (Mowbray, Bybee, & Collins, 2000). Additionally, those who received a moderate or substantial amount of service increased the odds of working by almost five times, more than doubled the likelihood of working more than ten hours per week, and increased the odds of work-related activity such as seeking work (Mowbray et al., 2000).

One innovative intensive case management program is the CASA WORKS demonstration project, which used a multi-service approach aimed at decreasing substance abuse problems among low-income women, many of whom were involved in the welfare system. CASAWORKS was innovative because it also addressed the disconnection between treatment and employment services in welfare agencies and substance abuse treatment programs (McLellan et al., 2002; Morgenstern et al., 2002). Initial reports show that CASAWORKS participants reported significantly reduced substance use, increased employment and decreased welfare dependence. As well, there were significant increases in working at least part-time, number of mean days worked, and earned income (McLellan et al., 2002; Morgenstern et al., 2002).

Although the CASAWORKS program was not administered as a part of the welfare system and was focused primarily on substance abuse treatment, with mental health as a secondary area of interest, it provides a model for intensive case management that could be adapted for women with a mental health work barrier. First, mental health and substance abuse problems often co-occur (Danziger, Kalil, & Anderson,

2000; Morgenstern et al., 2002; Jayakody, Danziger, & Pollack, 2000) and many of the relevant issues may overlap. If the intensive case management model and services provided by CASAWORKS were adjusted to address mental health concerns, and involve coordination of services specific to mental health treatment, this would likely also facilitate positive employment outcomes for women with a mental health work barrier.

Supported Work Efforts

A variety of approaches broadly falling under the domain of supported work efforts have gained increased attention. Pavetti and colleagues (2001) identified four forms of supported work efforts that have been used with welfare recipients who have difficulty transitioning to steady employment, due to work barriers that may include but are not limited to mental health problems. The goal of paid work experience is to provide employment opportunities to those with limited previous employment experience. Businesses employ individuals that would otherwise not be employed and provide on-site supervision. Supervision ends when people transition into the work force (Pavetti et al., 2001). Supported transitional publicly funded job programs also provide temporary paid work experience. However, such programs occur through non-profit organizations, government agencies, or private sector businesses, usually through individual placements. Program participants receive the same type of on-site supervision that other employees receive. Programs may be subsidized by welfare-to-work grants or TANF funds. Assessment and case management usually occur when people enter the program, and participants receive some modest job search assistance and post-placement support (Pavetti et al., 2000). Supported transitional structured programs provide a "more forgiving" work environment that is intended for people who may be expected to have greater difficulties in the competitive labor market. Wages are often subsidized by public funds (Pavetti et al., 2001). Generally this is a more intensive model that the previous two. Finally, supported competitive employment participants go directly into competitive employment but with intensive case management and on-site vocational training. This is type of program is typically used for the seriously disabled, with the goal of placement into competitive employment as quickly as possible (Pavetti et al., 2001).

Flexible work environments might include a less demanding work environment that provides flexible work hours and leave schedule, periodic breaks, and stress-reducing work situations (Kramer, 2001). In one

supported employment program, participants received services like gradual introduction to complex or demanding work, on-site work support, and small work crews (Gardiner & Fishman, 2000). An evaluation found that in comparison to a control group, supported employment participants had increased work outcomes. In particular, those with large barriers to work (e.g., no work experience) did especially well in the supported work program (Gardiner & Fishman, 2000). Supported employment may be particularly suited for women with a mental health work barrier because participants in these programs often receive more structured, ongoing support as they transition to the work force. And although supported employment is not specifically targeted to facilitate treatment of mental health problems, supported employment services can include assessment of work barriers and more extensive case management services (Pavetti et al., 2001).

Short-Term Solution-Focused Intervention

Short-term solution focused interventions combine elements of work-first programs with life skills development using a workshop format. The goal of such programs is to help participants increase job search mastery and gain skills like job interviewing and communication. Yet, unlike some work-first interventions, there is a focus on learning these skills in a supportive context that promotes positive coping strategies and peer support. It is proposed that a short-term, solution-focused intervention that helps women build mastery and coping in the job search process will provide skills that are also relevant to coping with a mental health work barrier and improving employment outcomes.

There are a number of advantages to short-term solution focused interventions. They are likely to be more cost-efficient than intensive case management and supported work efforts. Short-term interventions integrate provision of mental health services in a manner that is compatible with the work-first model, and in many ways they may be appropriate for women with a mental health work barrier. While low participation in more intensive treatment services is likely attributable in large part to lack of availability of such services (Lennon et al., 2001), it is also important to take into account the fact that the same structural barriers hindering work effort, like lack of transportation and child care, may also contribute to women's inability to take advantage of treatment services that are available in the community. Short-term programs may be more

manageable for women who have few resources and little time to participate in other kinds of treatment services.

One promising short-term employment intervention is Winning New Jobs (WNJ), a week-long workshop consisting of five four-hour sessions. A rigorous evaluation of the intervention using a recently unemployed working- and middle-class sample demonstrated that the program was highly effective at increasing participants' job-search motivation and job-search self-efficacy. Furthermore, symptoms of depression and financial strain were reduced and employment outcomes improved (Caplan, Vinokur, Price, & vanRyn, 1989; Vinokur & Schul, 2002). The reem- ployment and mental health benefits of JOBS were obtained almost exclusively by those who were at high-risk of experiencing depression resulting from job loss (Vinokur & Schul, 1997), which suggests that a short-term intervention can be an effective way to prevent the onset of depression.

Some preliminary evidence suggests that the positive results mentioned above may extend to the welfare participants in WNJ. Results evaluating a series of WNJ workshops that took place through the welfare offices of an urban center show very high levels of mental health work barriers among workshop participants, with 39.5% of the respondents meeting the diagnostic criteria for major depression and 19.7% reporting generalized anxiety disorder (Vinokur, 2003). Yet, at the four-month follow-up to participation in the WNJ workshop, respondents reported a significant decrease in depressive symptoms, and 43% reported being employed at the current time (Vinokur, 2003). In sum, although the evidence is preliminary and conclusions should be drawn with caution, data obtained from a group of mostly female welfare applicants suggests that positive mental health and employment outcomes can result from a short-term solution focused intervention like WNJ.

CONCLUSION

Given the heterogeneous nature of the welfare population and the high prevalence of mental health work barriers in the welfare population, it is important to identify a model for the provision and integration of multiple levels of services that assist women with a mental health work barrier in the welfare-to-work transition. This paper elucidates a tiered approach that involves (1) mental health work barrier screening, (2) assessment and development of a work plan, and (3) mental health support services (see Figure 1).

Tiers I and II include mental health work barrier screening and assessment, referral to mental health services, and development of an individualized work plan. Tier III identifies a number of specific intervention approaches to assist women with a mental health work barrier in the transition to work. Integrated and/or intensive case management approaches are the most comprehensive services and involve awareness of community resources and careful coordination with those resources (Scrivener et al., 2001). Supported work efforts (Pavetti et al., 2001) are promising, but in isolation they may not adequately address the problems presented by a mental health work barrier. Supported work efforts provided in conjunction with some of the other services outlined in the Tiered model that are directed at the mental health problem would facilitate meeting treatment and work objectives. Short-term solution-focused interventions are an emerging new approach for addressing mental health work barriers in the welfare system. Short-term solution-focused programs approach the job search process in a manner that builds client efficacy and mastery. Clients are able to gain skills and increase job search motivation a supportive environment. Such interventions also help women gain coping skills that assist with the mental health work barrier that inhibits work. An ideal scenario is one in which a variety of resources are available to assist women in treating mental health problems throughout the transition to work and beyond, in order to optimally facilitate the dual objectives of helping recipients meet their mental health needs while they also work towards employment goals.

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