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Welfare Reform: Advocacy and Intervention in the Health Care Setting

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SYNOPSIS

Welfare reform has drastically altered the lives of poor families in the US. In its wake, many former recipients are not receiving whatever transitional benefits and other safeguards to which they remain entitled under federal and state laws. Families are losing access to Medicaid and are not receiving the child care assistance or Food Stamps for which they continue to be eligible. Ill-served by stringent time limits and work requirements, lack of child care assistance, and lack of training and educational opportunities for the development of skills that will lead to better jobs, families need help to navigate the complexities of the new welfare system. Boston Medical Center's Department of Pediatrics has instituted a welfare screening project to educate families about their rights under welfare reform and assist them in advocating for themselves and their children.

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In 1996, President Clinton signed legislation designed to "end welfare as we know it." The stated goal of "welfare reform" legislation was to help families become self-supporting and leave poverty behind. Advocates for the poor who opposed the passage of this legislation argued that welfare reform eliminated the "safety net" and failed to provide the necessary support for families to escape from poverty. They were concerned that without public assistance many families would suffer poverty, hunger, homelessness and poor health. Although the federal legislation provides mandates for certain programs, there is considerable latitude for states in designing the details of new regulations and welfare systems.

Three years after the implementation of "welfare reform," national and state political leaders have declared that the policy is a resounding success. They cite large declines in welfare caseloads and an increase in employment among former recipients. President Clinton proudly announced at a national forum on welfare-to-work in August 1999 that "[t]he welfare rolls have been cut in half; they're at their lowest level in 32 years. ...[W]elfare reform, with its new emphasis on work, has been the single most important factor in reducing the rolls."[1]

One way to quantify the effects of welfare reform is to count the number of families receiving assistance. But the actual effects on poor families will only be revealed by collecting data on indicia of family well-being: health status, employment status, poverty level, and hunger.

Poverty Adversely Affects Children's Health

Welfare reform is a critical issue for medical providers and public health professionals. The deleterious effects of poverty on health have been well-established by a myriad of research studies.[2–5] The child poverty rate is already unacceptably high in the United States. In 1998, 20.6% of children under the age of six lived in poverty.[6]

Poor children are at significantly greater risk than non-poor children for health problems, including asthma, injuries, lead poisoning, physical abuse and neglect, and developmental and behavioral problems.[3] The incidence of asthma is rising, particularly among poor urban children.[7,8] Recent reports highlight the harmful effects of poor housing on child health.[9] Poor children are also at risk for the effects of trauma resulting from witnessing violence, since studies have shown that up to 60% of welfare recipients are victims of domestic violence.[10] Health problems, once acquired, are more severe for poor families than for the non-poor.[11]

A welfare reform policy that has the potential to increase the numbers of families living in poverty should be closely monitored by both medical and public health professionals. Given what we know about the effects of persistent poverty on health, medical providers and public health professionals need to be advocates for social policies that will reduce the health risks for poor families.

Declining Poverty or Declining Caseloads?

What do declining caseloads really signify? Do they mean more people are working, and therefore better off financially? Or do they mean that welfare rules are so complex and restrictive that even families who may be eligible are not receiving assistance? Reports about the effects of welfare reform from community-based monitoring projects, advocacy groups, private research institutions, and service providers highlight increasing hardship and privation for many families leaving welfare.[12–19] Many jobs that former recipients take do not pay a living wage. Indeed, full-time employment at minimum wage translates into 64% of the 1999 federal poverty level for a family of four.[20] Many families do not end up receiving the transitional support services (child care, Medicaid, Food Stamps) to which they are entitled.[21] Many are sanctioned for failure to meet work or other requirements and are ultimately cut from the welfare rolls not because they got jobs but because they could not or did not follow the rules.[12,13,17,18] What is happening to these families?

At Boston Medical Center (BMC), an urban hospital that serves a diverse patient population and is the largest provider of free care in Massachusetts, the medical staff, long cognizant of the impact of poverty on their patients' health status, has anticipated how welfare reform might change that picture.[2]

In May 1999, BMC instituted a welfare screening intervention in the pediatric primary care clinic. The goals of the intervention are threefold: to provide information about the welfare program and local resources to families who need it; to provide advocacy to families on welfare issues; and to collect simple data on how families affected by the reforms are faring. Before describing BMC's program we will first give an overview of the federal and Massachusetts welfare reform laws and some early findings of their effects on families. We will then describe the on-going intervention in BMC's pediatric clinic.

THE END OF WELFARE AS WE KNEW IT—FEDERAL AND STATE LAWS

The federal welfare law, the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), was signed by President Clinton on August 22, 1996, as the fulfillment of his campaign promise to "end welfare as we know it." The legislation cut $55 billion in federal funds over six years, funds previously allocated to welfare, Food Stamps, and disability income support.[22] PRWORA eliminated the federal entitlement to welfare (Aid to Families with Dependent Children [AFDC]) and replaced it with a capped block grant program (Transitional Aid to Needy Families [TANF]), in which states would have considerable discretion over program implementation and spending, with no assurance of additional federal money for caseload increase or economic downturn.[23]

The conversion from entitlement to a block grant means that families who previously qualified for welfare benefits based on income are no longer automatically eligible for cash assistance but must meet certain work and behavior requirements. (See "Highlights of the Federal TANF Block Grant Requirements" on p. 543.) Most of the provisions of the law were implemented as of July 1, 1997.

Many of the federal reforms were prompted by demonstration programs implemented in 43 states, including Massachusetts, that had received waivers of then-existing legal requirements.[23] Most state "experiments" had barely been implemented, much less evaluated by 1996, and the short- and long-term impacts of their individual components remain unknown. As continues to be the case today, the success of welfare reform programs created prior to the passage of the 1996 federal law was mainly measured by declining caseloads.

KEY PROVISIONS OF THE FEDERAL LAW

Federal welfare reform is a complex scheme of requirements, sanctions, and limitations for recipients of assistance. The most significant and potentially harmful features of the new block grant program are its work participation requirements, time limits, and eligibility restrictions. Welfare recipients must work a certain number of hours per week, with few exceptions. States have a financial incentive to move recipients into any type of job, including state-mandated unpaid community service, through monetary performance bonuses for moving welfare recipients into jobs at a fast rate. There is a five-year lifetime limit on the receipt of federal TANF benefits, and states may impose even stricter time limits. Massachusetts, for example, provides for only 24 months of time-limited benefits in a five-year period.

PRWORA permits states to deny welfare benefits to children born to a woman while she is receiving welfare. It continues to make receipt of benefits contingent on paternity identification and cooperation in obtaining child support. States may deny most benefits to certain immigrants for five years after arrival. (A subsequent amendment to PRWORA created a Family Violence Option that permits, but does not require, states to allow a waiver of time limit and work requirements for people experiencing domestic violence who meet specific state and federal standards and procedures.)

Despite the strings attached to the TANF block grant, states can tailor most requirements based on individual circumstances and can even create new support programs for low-income families. Though states are required to maintain their state spending at 75% to 80% of 1994 levels ("maintenance of effort"), states may use funds that were formerly restricted to cash assistance to pay for other services formerly funded with state dollars, or to create new programs. A recent *New York Times* article quoted Minnesota governor Jesse Ventura as saying that the state budget goal was to "[r]eplace state spending with federal dollars."[24] The drop in welfare caseloads means that states have "extra" federal dollars to spend as they see fit—whether or not any new services are offered to the poor. As families move into the workforce, newly identified needs such as day care and transportation could be met by federal or state funds.

THE MASSACHUSETTS WELFARE PROGRAM—"ANY JOB IS A GOOD JOB"?

Welfare recipients in Massachusetts experienced the effects of welfare reform prior to the passage of the federal legislation. On February 10, 1995, Governor Weld signed Chapter 5 of the Acts of 1995, a welfare reform package. This legislation changed the name of the executive agency charged with administering the program from the Department of Public Welfare to the Department of Transitional Assistance (DTA). The federal and state funds it disbursed, formerly AFDC, were renamed Transitional Aid to Families with Dependent Children, or TAFDC. Eligibility restrictions such as the "family

HIGHLIGHTS OF THE FEDERAL TRANSITIONAL AID TO NEEDY FAMILIES (TANF) BLOCK GRANT REQUIREMENTS

- Five-year lifetime limit on federal benefits
- Family cap (option for states to deny welfare benefits to children born to a woman who is receiving welfare or has received it in the past)
- Work requirements (recipients must work a certain number of hours per week unless exempt)
- Mandatory paternity identification
- Cooperation with state efforts to secure child support
- Teen parent living arrangement and school attendance rules

cap" (denying benefits to children born while the recipient parent was receiving benefits); "learnfare"(requiring recipients to provide documentation of child school attendance); "shotfare" (requiring recipients to provide documentation of child vaccinations); and "workfare" (requiring recipients to work at least 20 hours per week within 60 days of receiving benefits) became effective as of November 1, 1995. The 24-month time limit became effective on December 1, 1996.

EXEMPTIONS, WAIVERS AND EXTENSIONS IN THE MASSACHUSETTS LAW

Many current welfare recipients are not subject to the full brunt of Massachusetts welfare reform because they qualify for exemptions from eligibility requirements, waivers of mandates, or extensions of the time limit. Of greatest potential impact are exemptions from the work requirements and/or time limit that may be granted in seven specific situations, if other requirements are met. Families eligible for exemptions include:

- caregivers with a child under age two (who is not a family cap child);
- caregivers who are taking care of a disabled child or relative;
- caregivers who are disabled and meet certain standards;
- caregivers who have a child living with them who is closely related but not biological if the caregiver is not receiving benefits her/himself;
- women in the last four months of pregnancy or the first three months after birth of a "family cap" child;
- teen parents complying with school and living rules; and
- caregivers age 60 and over.

In addition, Massachusetts adopted the Family Violence Option, which grants temporary waivers from the time limit and work requirements for domestic violence if lengthy documentation is submitted and the impact of the violence on the victim and family is demonstrated sufficiently.[25] Under DTA policy, domestic violence waivers of the time limit are not deemed timely until the 22nd month of the family "time clock."[26] Between November 1, 1998, and September 2, 1999, 219 applications for domestic violence waivers were filed, of which only 87 (39%) were approved.[26]

The experience of Margarita (not her real name) illustrates the reality behind the numbers. Margarita sought assistance from BMC's welfare screening project in June 1999. She had been told by her welfare caseworker that she was not eligible for a domestic violence waiver if her batterer was incarcerated, a fact that had no bearing on her eligibility under the regulations. She was told this verbally instead of receiving a written notice that would have informed her of her right to appeal a denial of a domestic violence waiver.

Exceptions from the "family cap" rule are granted by DTA when the mother can document that a child was conceived due to rape, incest, or sexual assault, or in the case of "extraordinary circumstances" or domestic violence. Extensions of the time limit for up to six months may also be given in very limited circumstances. These are made at the discretion of the Commissioner, and as of this writing no decision-making standard has been promulgated. A total of 5975 extension requests have been filed; 382 have been approved as of September 1999, while more than 4100 have been denied and 1493 are pending.[26] Individuals terminated from welfare or denied an exemption, extension, or waiver may challenge that determination and request an administrative hearing.

The special rules outlined in the statute are intended to protect recipients who are unable to enter the workforce due to disability or some other limiting circumstance. However, poor training of DTA caseworkers together with overwhelming caseloads have resulted in eligible clients being denied benefits despite eligibility for exemptions, waivers, or extensions.[13,16] Indeed, as Claire McIntire, the Commissioner of DTA, stated in December 1998, "[DTA] is in the jobs business, not the extension or waiver business."

AVAILABILITY OF TRANSITIONAL BENEFITS IN MASSACHUSETTS: MEDICAID, FOOD STAMPS, AND CHILD CARE

For Massachusetts welfare recipients who are either ineligible for or denied an exemption or extension, access to "transitional" child care vouchers, Medicaid (MassHealth), and Food Stamps are likely to be the most important public benefits available once recipients are terminated from welfare. Child care and transitional health insurance are available to former beneficiaries if they apply and comply with the rules concerning termination (for example, undergoing an exit interview). Eligibility for various categories and durations of these benefits depends on the reason for termination as well as on income levels. Thus it is critical that recipients have the correct information about benefits available in their circumstances and that DTA maintains accurate records on each family's situation.

MASSACHUSETTS: MISINFORMATION AND BAD REGULATIONS DRIVE THE LOSS OF BENEFITS AND INCREASED HARDSHIP FOR FAMILIES

Unfortunately, there is growing evidence from many states that widespread lack of information, misinformation, and carelessness by caseworkers are causing eligible families to fail to receive assistance. (See "The Effects of Welfare Reform: National Findings," on p. 545.) In Massachusetts, advocates report that welfare workers have been trained to emphasize searching for work and have encouraged families to leave welfare before their time limit has been reached.[13,16] Moreover, DTA workers are not affirmatively screening for domestic violence or other employment barriers and fail to review possible exemptions.[13,17] Many recipients are unaware of the existence of domestic violence waivers and exemptions for disability.[13,17]

In April 1999, DTA interviewed families who left the welfare rolls before the 24-month time limit was reached.[32] As in national studies, DTA found that the rate of Food Stamp usage was unexpectedly low among both the families who stayed off welfare and those who had returned to the rolls, despite a reported increase in food insecurity for 40% of those who left welfare.[32] Only 6.5% of families interviewed were receiving Food Stamps despite much wider eligibility. Ten percent of adult respondents reported having gone hungry for up to ten days or more. The study also found that many families did not know about subsidized child care (although 100% were eligible, only 40% knew of the program). Naturally, for parents and caregivers who are working but not using child care vouchers, earnings that would otherwise be spent on food or rent must be used for child care.

Of the 210 families interviewed one year after they left welfare, 71% reported that someone in the household was working. For those working full-time, the average weekly earnings were $323. It is important to note that the study tracked only families who left welfare before their time-limited benefits were up. Of greater concern is the families who, in the wake of the time limits, were forced off the welfare rolls regardless of whether a household member was employed.

The only follow-up mechanism for families who lose assistance is a program instituted in February 1999 by DTA and the Massachusetts Department of Public Health to follow up on selected families after benefits have been terminated.[33] Families are referred to the Follow-up, Outreach and Referral (FOR) Families Program for assessment and referral. However, under the FOR Families Program, professionals evaluate families only *after* families have lost all cash benefits, and *if* the families can be found.

Other studies in Massachusetts conducted by local academic and social service groups using surveys, focus groups, and interviews with present and former welfare recipients and affected community members depict consistent concerns with both the implementation and the practical effects of welfare reform. For example, education and training cannot be substituted for the work requirement in Massachusetts, making it difficult for many women to obtain anything other than minimum-wage employment, which is insufficient to lift their families out of poverty. Non-English-speaking families are particularly vulnerable, as they may face more difficulty finding employment and understanding complex welfare regulations. A recent study at BMC found that welfare recipients caring for chronically ill children did not understand program rules.[34] Compounding these difficulties is a severe, statewide shortage of safe, affordable, accessible child care.[35] The results are multiplying signs of distress such as rising hunger, serious health concerns, and homelessness as well as demands on social service agencies.[12–19]

POVERTY AND CHILD HEALTH—ADVOCACY IN THE HEALTH CARE SETTING

The mission at Boston Medical Center (BMC) is to meet the health needs of low-income and vulnerable

THE EFFECTS OF WELFARE REFORM: NATIONAL FINDINGS

The evidence is growing that welfare reform has not only reduced access to cash assistance but has also significantly decreased access to subsidized health care and nutrition benefits. The practical effect of welfare reform has been to create additional uninsured and hungry families due to the failure of states to inform beneficiaries of their continued eligibility for Medicaid and Food Stamps.[21] Moreover, welfare workers frequently do not provide families with correct information about continued eligibility for cash assistance or eligibility for benefits designed to make the transition to work easier, or about exemptions from requirements.[13,16,21]

Data from recent studies show that thousands of people have lost Medicaid, their only source of health insurance, as a result of welfare reform.[27,28] This reality contributes to the overall instability of a family transitioning off of welfare benefits into the workforce.

PRWORA divorced Medicaid from welfare receipt by providing that families who are not eligible for cash assistance are still eligible for Medicaid if they meet the income eligibility standards that were in effect in the state just prior to creation of the block grant program. Moreover, PRWORA continues the guarantee of one year of Transitional Medicaid Assistance that had existed under prior law, both for families voluntarily leaving welfare and for those terminated from public assistance due to time limits. In fact, the federal government budgeted $500 million to the states to conduct outreach to recipients and provide information and training to caseworkers regarding the de-coupling of Medicaid and welfare.[28]

The Food Stamp Program is the key element in US policy to reduce hunger, and it constitutes a significant support benefit for poor families. Nevertheless, PRWORA has had a negative impact on food security through its deliberate, direct limitation of eligibility and reduction of benefit levels as well as through the unintended effect of eligible families disenrolling or not knowing they were eligible for Food Stamps. Food Stamp participation dropped from 27.5 million in 1994 to 18.5 million in 1999.[29] Food security is defined as access to enough food for an active, healthy life. Food insecurity occurs when access is limited or uncertain. Hunger—the inability, even occasionally, to obtain enough food—is a severe form of food insecurity. Federal officials believe that in addition to more restrictive eligibility requirements, aggressive local welfare workers have created barriers to enrollment by discouraging families from seeking assistance.[30,31] The Center on Budget and Policy Priorities recently issued one of the first major studies to incorporate pre- and post–welfare reform data.[21] The findings clearly demonstrate that the documented drop in Food Stamp participation between 1995 and 1997 was not due to increased earnings, but rather to a failure of families to receive the means-tested benefits for which they were eligible. President Clinton, recognizing this problem, launched a Food Stamp Initiative in July 1999 designed to ease eligibility requirements, encourage states to adopt simpler application procedures, and educate the public about continued eligibility.

populations through an integrated delivery system that is committed to honoring patients' ethnic, religious, and cultural differences. BMC pediatricians found that while existing health services could help break the link between poverty and poor health, helping families meet their basic needs through legal advocacy and system reform would also lessen poverty's effects on children's health. With that in mind, the Pediatrics Department created the Family Advocacy Program (FAP) to help clinicians improve their patients' health. BMC is uniquely situated to provide such services: as the largest provider of free health care services in Massachusetts, it sees more poor people than any other hospital in the state.

Founded in 1993, FAP provides legal services to low-income families who receive health care at BMC and its affiliated health centers. Staffed by three attorneys, FAP provides direct representation to families on issues that impact children's health, including income support, disabilities, and family violence. It also provides training and case consultation to BMC and neighborhood health center staff on relevant legal issues. In turn, FAP draws on the clinical and community expertise of health care providers to increase the effectiveness of its legal work.

In 1998, FAP received a grant from the city of Boston to use the health care setting to assist families that have lost or will lose benefits under welfare reform. The grant award was premised in part on the outcome of focus

groups of welfare recipients who cited health care providers as one of the most credible sources of welfare–related information. As part of the grant, FAP trains health care providers and others on welfare issues, is available for case consultation and referrals, and provides direct legal representation to families.

FAP also works closely with BMC's Family Help Desk to ensure that parents who are seeking referrals for services have access to these resources. Begun in 1997, the Family Help Desk is a collaboration between the BMC Pediatrics Department and Project Health, a volunteer organization founded by Harvard University undergraduates. The Family Help Desk provides information, advice, and advocacy on a host of issues including health care, cash assistance, domestic violence, housing, and community resources for families. It is staffed by undergraduates from Harvard University and operates for four hours each weekday at a desk located in the hallway outside the pediatric clinics. Families may approach the Desk on their own, or may be referred there by a provider. Students make referrals to programs and services using information collected in research binders and may make phone calls on a family's behalf; a log is kept, and follow-up calls are made to families to provide additional assistance. FAP and the Help Desk work in concert: the Director of FAP is one of the mentors of the Help Desk and FAP attorneys provide weekly case consultation to students; the Help Desk in turn makes referrals to FAP.

While several informal studies conducted in the BMC pediatric setting have revealed high proportions of current and former welfare recipients in the patient population, the number of current and former recipient families approaching or referred to the Help Desk or FAP for assistance was actually fairly low. The reasons for this are documented in many of the local studies, and readily apparent to anyone working with the welfare recipient community: there is a palpable sense of hopelessness on the part of many families who lose benefits. Frequently people don't realize that they may continue to be eligible for partial assistance, Food Stamps, or child care vouchers. They assume that if the cash assistance ends, they are no longer eligible for other supports. More important, the profound lack of knowledge regarding one's own welfare "time clock" is astounding—recipients often don't know when they will lose benefits and therefore don't know what services they might need.

SCREENING PROJECT

Armed with the anecdotal knowledge that as many as 40% of all BMC families were current or former recipients of welfare and therefore possibly entitled to transitional benefits, FAP set out to devise a welfare screening tool that would allow the Family Help Desk and FAP to approach families in a pro-active way, ascertain their welfare status, and provide information about their rights under welfare reform. In partnership with the Harvard School of Public Health Master's in Public Health Program, FAP developed a screening tool in the form of a structured interview to be used by the Help Desk students, with the following goals:

- to identify former welfare recipients who were not receiving the transitional assistance to which they were entitled;
- to identify former recipients who may have been eligible for an exemption from the time limits or work requirements and thus to have benefits reinstated through legal advocacy;
- to inform current welfare recipients of the transitional and exemption provisions of the law (including job-related services) in anticipation of their reaching the time limit in the future; and
- to collect information on the well-being of families at risk due to welfare reform.

The health care setting imposed several restrictions on the survey questions and methods. First, the interview needed to be short in order to accommodate the family's main purpose in being at the hospital, that is, the child's appointment with the nurse or pediatrician. Second, the survey needed to be sensitive to an individual's reluctance to disclose the personal and stigmatizing fact of welfare enrollment, particularly to a stranger and with others present in the waiting room. Third, the survey tool had to be understandable to people with varying levels of education. Fourth, because the survey was also being designed for possible use at local health centers, the format needed to be flexible and adaptable for use by providers or support personnel in other settings. Finally, as with any in-person interview, the survey had to flow from one question to the next in a manner both easy to follow for the questioner and rational to the respondent.

In developing the survey tool, we reviewed data routinely collected by the Family Help Desk as a guide to identifying primary issues of concern to families. The issues identified in March 1999, for example, were: housing and homelessness (79 out of 104 families), child care (17 families plus 22 more asking for summer camps) and food programs (33 families). BMC pediatricians, Help

Desk students, and FAP staff reviewed the screening tool, and a final version was completed in April 1999.

FINDINGS BASED ON THE PILOT SCREENING—MAY 1999

In May 1999, FAP implemented a pilot screening schedule and students began administering the survey. A student would be available on a rotating basis in the waiting room in the pediatric primary care clinic for at least two hours per day to conduct interviews. Each screen took approximately 10 minutes to complete. The student tracked the number of people she or he approached, the number of current and former recipients, and the number of people requesting services. During busy periods, such as school vacations, the environment of the waiting room would not allow for semi-private interviewing. When students were not able to conduct screenings, they distributed flyers inviting families to stop by the Help Desk. FAP developed a flyer listing welfare exemptions in commonly understood terms as well as "Tip Sheets" on welfare-related issues such as child care, disability and the family cap. The Tip Sheets were designed to be used in conjunction with the screening interview.

Parents and caregivers who were screened and completed the questionnaire were referred to FAP for legal advocacy when appropriate. Students conducting the screening unanimously agreed that families' willingness to respond to the screening tool increased significantly when they were told that they would be given information about services that might help them. Students also reported that it was useful, when asking particularly sensitive questions about domestic violence, to give the recipient the reason for the question: "You may be entitled to an exemption; that's why I am asking you about domestic violence." Some of the major findings of the pilot screening period were:

- It is possible to successfully discuss sensitive issues, such as welfare enrollment or domestic violence, in the environment of a pediatric waiting room during normal business hours provided that there is adequate physical space for the screener to sit next to the parent or caregiver and speak quietly and confidentially.
- A key factor in placing parents at ease is to provide an introduction to the interview that identifies the screener as working with the clinicians and places the screening in the context of improving the Help Desk service.
- Crafting the language of the interview is important both with regard to appropriate literacy level and to colloquialism, particularly when information is being imparted about complex legal rules with many qualifications against a background of rampant misinformation.
- When seeking to elicit information on receipt of government assistance, which is sensitive in addition to being complex, words should be chosen that are respectful and take into account diverse situations; for example, using the word "caregivers" instead of "parents."
- Keeping a log on how many individuals are approached, how many respond that they are neither current nor former welfare recipients, and how many affirm this status but refuse to be interviewed is useful.

FINDINGS BASED ON THE INITIAL IMPLEMENTATION OF THE SCREENING—JUNE AND JULY 1999

During June and July 1999, approximately 25 screening sessions were run. A total of 150 families were approached, and 39 families, or 26%, reported being current or former (within the previous 12 months) recipients. Of the current recipients, 43% reported being aware of the 24-month time limit. Of those current recipients who were aware of the time limit, only one knew the date that she would lose benefits. If these percentages based on a small sample accurately reflect statewide or national figures, then this is cause for concern, since such families cannot plan for the future or self-identify for programs. One-third of current and former recipients had no identified child care provider. In response to inquiries about a series of issues, current and former recipients reported problems with housing (43%), health (35%), employment (32%), and food security (18%).

The screening has enhanced the Help Desk's ability to provide services to families and has helped to streamline legal referrals from the pediatrics department to FAP. The welfare screening is part of an overall effort by the department to provide accurate information to families. To that end, the Help Desk is developing a touch-screen computer kiosk that will enable families to access information during hours that the Desk is not staffed.

The implications of these preliminary data are plain: first, current and former recipients don't have the information they need in order to understand how laws and regulations impact their lives. Second, poverty continues to pervade the fabric of these families' lives whether they are working or not. The case of Angel is emblematic of how the new welfare system affects children and their caregivers:

Angel (not her real name) is the single mother of two daughters, Kari, 8, and Jenna, 6 months. A welfare

recipient for the first several years of Kari's life, Angel left welfare to become a day care provider. She was employed for almost two years then was fired after she missed work due to complications of her pregnancy with Jenna. After she was denied unemployment, she applied for TAFDC for herself and her children. DTA determined that Jenna was a "family cap" baby and therefore not eligible for benefits. The direct effect of that determination was that Angel did not receive a $90 increase in her grant when Jenna was born, she did not receive the "crib and layette" payment, and, most important, she was told to return to work three months after Jenna was born. If Jenna had not been family cap, Angel would have been exempt from the work requirements until Jenna was five or she ran out of time-limited benefits. Angel was referred to FAP when she was threatened with a sanction for not complying with the work requirement when Jenna was 4 months old. She tried to comply, but could not find day care for Jenna. FAP began to investigate the case and quickly determined that, in fact, DTA had miscalculated and Jenna was not a family cap child. The result? Retroactive benefits for Jenna (enabling Angel to pay her mother back money she had borrowed), and an immediate exemption from work and time limits. Where is Angel now? Enrolled in a day care providers class to obtain her license to be a home provider. She hopes to be off TAFDC by the end of the year—long before her exemption runs out.

Meanwhile, DTA, like welfare agencies in most other states, has no mechanism in place for tracking families terminated from or voluntarily leaving welfare or for evaluating the results of the reforms.

Welfare As We Now Know It

Welfare reform has had a considerable impact on the lives of low-income families nationwide. Between the passage of PRWORA in 1996 and March 1999, the number of welfare recipients nationally has declined by 40%.[36] Massachusetts' caseload closely tracks the national trend: 53,584 families have left welfare since 1995, either voluntarily or by termination due to the time limit or sanction, a 52% decline.[37] While some families are undoubtedly doing well, there are consistent reports that many families are in crisis, experiencing hunger and homelessness.

There are interventions that health care institutions can and should undertake to provide information, and if possible, advocacy, for current and former welfare recipients. The BMC project demonstrates that accurate information can be made available in a medical setting, thus enabling some families to advocate for themselves. Indeed, advocacy and education about welfare reform can take place in a variety of family-focused settings. One can imagine screenings being conducted, and accurate information being provided, at schools, food pantries, and day care centers nationwide.

Simple programs or interventions such as the welfare screening interview will permit health care institutions to systematically assess the relationship of welfare issues to the health and well-being of the populations they serve. Data generated can be used for various purposes, including promoting changes or expansion of services offered either within the institution or the community and educating providers about the social stressors of poverty. Data collected could also empower providers to become involved in the political process by writing editorials or organizing direct appeal to the state legislature and governor.

Welfare "reform" is here to stay. Many efforts to assist families and monitor the effects of the changes are being undertaken by a variety of organizations as well as by the federal government. However, current monitoring efforts are not as coordinated as they could be, and therefore their impact is lessened. Moreover, the research findings that have become available have not coalesced into an interdisciplinary advocacy agenda for reform of the policies that clearly are not working and to press for the immediate needs of poor families. Part of the reason for this gap in advocacy is the sheer complexity of the laws and regulations.

Health care services alone cannot address the roots of many health problems suffered by the poor. It is important, therefore, that health care providers not only address immediate health needs but find ways to advocate for and work toward the implementation of just social policies that will promote the health and well-being of their patients. Our experience demonstrates that with the advocacy and assistance of health care providers, poor families will be better equipped to meet the challenges of welfare as we now know it.

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References

1. White House (US). Retrieve documents by category: search "welfare-to-work": remarks by the President at National Forum on Welfare to Work; 1999 Aug 3 [cited 1999 Nov 2]. Available from: URL: **http://www.pub.whitehouse.gov/retrieve-documents.htm**
2. Geltman P, Meyers A, Greenberg J, Zuckerman B. Welfare reform and children's health. Arch Pediatr Adolesc Med 1996;150: 384-9.
3. Aber JL, Bennett NG, Conley DC, Li J. The effects of poverty on child health and development. Annu Rev Public Health 1997;18:463-83.
4. Marmot M. Improvement of social environment to improve health. Lancet 1998;351:57-60.
5. Wilkinson R. Income distribution and life expectancy. BMJ 1992;304:165-8.
6. National Center for Children in Poverty. New Census data show that child poverty rate continues to lag behind other key economic indicators [press release]; 1999 Sep 30 [cited 1999 Nov 2]. Available from: URL: **http://cpmcnet.columbia.edu/dept/nccp**
7. Platts-Mills T. Rise in asthma cases. Science 1997;278:1001.
8. Sears M. Epidemiology of childhood asthma. Lancet 1997;350:1015-19.
9. The Doc4Kids Project. Not safe at home: how America's housing crisis threatens the health of its children. Boston: Boston Medical Center; 1998 Feb.
10. Unitarian Universalist Service Committee. Is it reform? report of the Welfare and Human Rights Monitoring Project: national report 1998–99. Cambridge (MA): Unitarian Universalist Service Committee; 1998.
11. Parker S, Greer S, Zuckerman B. Double jeopardy: the impact of poverty on early childhood development. Pediatr Clin North Am 1988;35:1227-40.
12. Dodson L, Joshi P, McDonald D. Welfare in transition: consequences for women, families and communities. Cambridge (MA): Radcliffe College; 1998.
13. Cahill S. Tip of the iceberg or bump in the road? the initial impact of welfare reform in Dorchester. Boston: Massachusetts Human Services Coalition; 1999 Mar.
14. Friedman D, Douglas E, Hayes M, Allard M. A policy brief: Massachusetts (T)AFDC case closings October 1993–August 1997. Boston: McCormack Institute of Public Affairs; 1998 May.
15. University of Michigan Poverty Research and Training Center. Barriers to the employment of welfare recipients. Ann Arbor: The Center; 1999.
16. Children's Defense Fund, National Coalition for the Homeless. Welfare to what? early findings on family hardship and well-being. Washington: Children's Defense Fund, National Coalition for the Homeless; 1998 Nov.
17. Massachusetts Law Reform Institute Documentation Project and Family Economic Initiative. A closer look at the thousands of families losing benefits under the Massachusetts time limit. Boston: Massachusetts Law Reform Institute; 1999 Apr.
18. Leonard M. We need to stand together. Boston: Dudley Street Neighborhood Initiative; 1999 Feb.
19. Moore S, Selkowe V. The growing crisis among Wisconsin's poorest families: a comparison of welfare caseload declines and trends in the state's poverty population—1986–1997. Milwaukee: Institute for Wisconsin's Future; 1999 Jun.
20. Department of Health and Human Services (US). Annual update of the HHS poverty guidelines. Fed Registr 1999 Mar 18;64:13428-30.
21. Primus W, Rawlings L, Larin K, Porter K. The initial impacts of welfare reform on the incomes of single mother families. Washington: The Center; 1999 Aug.
22. The Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Pub. L. No. 104-193, (August 22, 1996).
23. Department of Health and Human Services (US), Administration for Children and Families. Welfare: Temporary Assistance for Needy Families [cited 1999 Nov 2]. Available from: URL: **http://www.acf.dhhs.gov/programs/opa/facts/tanf.htm**
24. DeParle J. States struggle to use windfall born of shifts in welfare law. The New York Times 1999 Aug 29; Sect. A:1.
25. Good Cause Waivers Due to Domestic Violence, 106 CMR 203.110 (January 12, 1998).
26. Massachusetts Department of Transitional Assistance, Massachusetts Law Reform Institute Freedom of Information Act Request, September 2, 1999.
27. Ellwood M, Ku L. Welfare and immigration reforms: unintended side effects for Medicaid. Health Affairs 1998;17(3):137-51.
28. Schott L, Mann C. Assuring that eligible families receive Medicaid when TANF assistance is denied or terminated. Washington: Center for Budget and Policy Priorities; 1998.
29. Department of Agriculture (US). Food Stamps. Clinton Food Stamp Initiative [cited 1999 Nov 2]. Available from: URL: **http://www.fns.usda.gov/fsp/clintoninitiative/default.htm**
30. Abt Associates. What makes caseloads grow or shrink in the Food Stamp program? testimony before the Senate Committee on Agriculture, Nutrition, and Forestry. Cambridge (MA): Abt Associates; 1998 Apr 23.
31. Department of Agriculture (US). Household food security in the United States 1995–1998 (advance report—summary) [cited 1999 Nov 2]. Available from: URL: **http://www.fns.usda.gov/oane/menu/published/fsp/files/fsecsum.htm**
32. Massachusetts Department of Transitional Assistance. How are they doing? a longitudinal study of households leaving Welfare under Massachusetts reform. Boston: MDTA; 1999 Apr.
33. Tshibangu J. FOR Families Program [cited 1999 Nov 2]. Available from: URL: **http://www.state.ma.us/dph/network/ffp.htm**
34. Smith L, Wise P, Wampler N, Bauchner H. Knowledge of welfare reform among families with chronically ill children [abstract]. Boston: Boston University School of Medicine; 1999 May.
35. Adams G, Shulman K. Child care challenges: Massachusetts. Washington: Children's Defense Fund; 1998 May [cited 1999 Nov 2]. Available from: URL: **http://www.childrensdefense.org/childcare/challenges**
36. Department of Health and Human Services (US), Administration for Children and Families. ACF data and statistics: Welfare: caseloads: caseload comparison since the signing of the Welfare law: Aug. 1996 vs. March 1999: change in Welfare caseloads since enactment of new Welfare law [cited 1999 Nov 2]. Available from: URL: **http://www.acf.dhhs.gov/news/stats.htm**
37. Massachusetts Department of Transitional Assistance. DTA Today. Welfare reform: chapter 5: where we've been and where we're headed [cited 1999 Nov 2]. Available from: URL: **http://www.state.ma.us/dta/dtatoday/reform/welfarereform-chapter5.htm**