Transitional Jobs Programs:
A Health Impact Assessment



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Section I: Executive Summary

STUDY PURPOSE:

The Wisconsin legislature passed the Wisconsin Transitional Jobs Demonstration Project (TJDP) as part of the 2009-11 Biennial Budget Act. The project provides low-income Wisconsin residents with job training, experience and support in re-entering the workforce, and has assisted approximately 3,900 low-income people. The WI Department of Children and Families administers the program, and the $28 million program budget comes from monies made available by the American Recovery and Reinvestment Act of 2009 (ARRA) through TANF and other TANF funds.

This Transitional Jobs program will expire on June 30, 2013.

The Wisconsin legislature will decide, in shaping the 2013-15 Biennial Budget during the spring 2013 session, whether to make the current, temporary WI Transitional Jobs Demonstration Project program permanent, eliminate it, or modify it in some way. This Health Impact Assessment was undertaken to help inform that decision.

In the last twenty years, as part of an effort to shift from public assistance to work, Transitional Jobs (TJ) programs have specifically focused on the goals of helping long-term welfare recipients establish financial independence, providing disadvantaged populations access to the labor market and, most recently, attempting to shrink the ranks of the unemployed.

Transitional Jobs programs, however, have not been analyzed for their effect on the health of program participants, their families, and their children. This question is pertinent: while health is a significant influence on workforce participation, employment can itself be a key determinant of health. The causes of poor health extend well beyond healthcare and personal health behaviors. The UW Population Health Institute model, among others, indicates socio-economic factors, including employment and income status, along with physical environments drive over half of health outcomes.[1] Improving health requires attention to these larger socio-economic factors.

Health Impact Assessment (HIA) offers an approach to looking at these potential relationships in a systematic way. The HIA of the Transitional Jobs program explores the relationship between health and employment for this population. This framework will support decision-makers' effort to both strengthen the workforce and improve the health of the population, ultimately promoting long-term employability and well-being among Wisconsin's residents.

* * *

This Health Impact Assessment (HIA) was conducted as a Demonstration Project under the auspices of the National Network of Public Health Institutes through support from the Health Impact Project (a collaboration of the Robert Wood Johnson Foundation and the Pew Charitable trusts). The HIA was conducted during the period April 2012 through January 2013.

This HIA, under national sponsorship, has two distinct audiences:

- Those interested in the potential health impacts of Transitional Jobs programs,

- Those interested in methods for conducting HIAs, particularly in the area of economic or social policy.

PARTNER AND STAKEHOLDER ENGAGEMENT: A broad range of key stakeholders, representing public and private sector agencies, participated in the conduct of this HIA. An advisory committee guided the project's scope, and the research team engaged local advocacy and community organizations, elected and state agency officials, and expert consultants during the process. The research team also made attempts to include perspectives from the business community. State agency personnel are not permitted to make political recommendations; they served in an advisory capacity only and the recommendations made in this report are not made in their name.

SCOPE AND METHOD: The health factors investigated can be viewed in the logic model below. Other effects -- "state and local fiscal effects" and "private sector effects" were considered, but dropped from analysis. This HIA adds value by focusing on the health effect of income and of social capital/social cohesion. A comprehensive literature review was conducted of both the academic literature on the health impact of employment and the grey literature evaluating transitional jobs programs.

Scope of Research: Project Logic Model

Policy Change		Immediate Outcomes / Health Indicators	Long-term Outcome
EMPLOYMENT	Income Effects Social Cohesion and Social Capital Effects	• Income and poverty status • Diet • Alcohol and tobacco use • Recidivism & incarceration • Self-efficacy • Social Capital • Family Cohesion • Children's maltreatment	Reduced Chronic Disease Improved Mental Health Reduced Domestic Violence Improved Child Well-Being Improved Birth Outcomes

The literature was augmented by survey data collected from individuals currently or previously enrolled in Wisconsin's Transitional Jobs program. Survey questions were designed specifically to explore areas where, in the literature, links from employment to intermediate outcomes was weak, mixed, or absent. The Wisconsin survey data was also used, where possible, to identify specific populations for whom the effects of the program might prove stronger or weaker. Analysis was conducted by participants' race, gender, education level, and former-offender status. This survey was fielded in partnership with the Wisconsin Department of Children and Families; DCF handled survey distribution and collection, UW-PHI conducted analysis of the data.

Survey response: Surveys were completed during October, 2012. A total of 2,520 surveys were mailed, 587 were returned undelivered, and 141 surveys were completed, for a response rate of 7.3%. The survey reports self-perceived changes in various behaviors. These responses help fill gaps in and provide insight beyond the literature. They provide valuable primary information

about the impact of the TJ experience on self-reported indicators of personal health. The responses capture the voices of actual participants in Wisconsin's TJ program, providing a rich case history to round out other evaluative measures.

KEY FINDINGS

Extensive literature has demonstrated that employment is a key determinant of health. It impacts health directly as well as indirectly by affecting other determinants of health. Full descriptions of the analysis can be found in the "Assessment" section.

IMPACT ON IMMEDIATE HEALTH INDICATORS: The literature linking employment to immediate health indicators is either mixed or not extensive. The findings are summarized in Table 1, below. The survey conducted by our HIA provides a useful supplement and case reporting specific to Wisconsin's program.

TABLE 1: STRENGTH OF LITERATURE LINKING EMPLOYMENT TO IMMEDIATE HEALTH INDICATORS AND THE DIRECTION OF EFFECT

Health Indicator	**Literature**	**Maintain TJ Program at Current Level or Expand: Direction** (effect on indicators)
A. Income	Scientifically Supported	+
B. Diet	Mixed Evidence	+/-
C. Alcohol/Tobacco	Mixed Evidence	+/-
D. Incarceration/Recidivism	Some Evidence	+
E. Self-Efficacy	Some Evidence	+
F. Social Capital	Some Evidence	+
G. Family Cohesion	Some Evidence	+
H. Child Maltreatment	Scientifically Supported	+

KEY FINDINGS FROM WISCONSIN'S TJ PARTICIPANT SURVEY: The following percentages of survey respondents reported that since starting in the TJ program their behaviors changed in ways likely to influence their own or their family's health.

Diet:

- Increased fruit and vegetable consumption: 28%
- Decreased fast food consumptions: 52%
- Increased exercise: 44%

Self-efficacy:

- At least 46% and as many as 57% reporting increases in measures such as feeling more hopeful for the future, in control of their lives, more calm and peaceful, increased confidence in applying for jobs, or less depressed and anxious.

Social Capital: Theories of social capital maintain that workers with strong social networks benefit because of the job information and influence they receive from their social ties.

- Attended religious services more frequently: 14%

- more time going to community events such as neighborhood meetings, festivals, etc.: 22%
- Got along with others better: 39%
- Communicated with others better: 45%

Family Cohesion:

- Spent more time eating meals with people in their house: 27%
- Spent more time reading with their children: 22%
- Spent more time attending children's school or sports events: 21%
- Oldest child improved grades; improved school attendance; and improved behavior in school: 15%

IMPACT ON HEALTH OUTCOMES

The likelihood, direction and magnitude of impact on health outcomes under four different policy scenarios pertaining to the Transitional Jobs Program are summarized in the Table 2 below.

TABLE 2: DIRECTION AND MAGNITUDE OF IMPACT ON HEALTH OUTCOMES

Health Outcome	**Likelihood**	**Non-renewal** of the TJ program	**Contraction** of the TJ program	**Maintain program at current level**	**Expansion** of the TJ Program
Chronic Disease *	Likely	-	+/-	++/-	+++/-
Mental Health **	Likely	-	+/-	++/-	+++/-
Domestic Violence	Likely	-	+	++	+++
Birth Outcomes	Likely	-	+	++	+++
Child Physical Health	Likely	-	+	++	+++
Child Mental Health**	Likely	-	+	++	+++

* Literature suggests that if employment involves occupational hazards physical health can be negatively impacted.

** Literature suggests that unstable employment or employment that creates work/family imbalances may have a negative impact on mental health.

IMPACTS ON SUB-POPULATIONS:

Gender: Men more frequently than women reported improved health behaviors and improvements on indicators of family cohesion.

Race: Blacks more often than whites reported improved health behaviors and improvements on indicators of family cohesion and social capital.

Education: The pattern is less distinct than in the cases of gender and race.

- Those with more than a high school education (an associates or college degree) least frequently reported improvements.

Previously Incarcerated:

- There were no noticeable differences in health indicators between those who had been incarcerated and the larger population.
- Those previously incarcerated were 9% more likely to be unemployed post-program than the larger group of survey respondents. However, this rate of 45% unemployed compares very favorably with a study finding 60% of recently incarcerated New Yorkers were unemployed in 2006.[1]

RECOMMENDATIONS

PROCESS FOR FORMULATING RECOMMENDATIONS: Three recommendations emerged directly from the analysis. Additionally, stakeholders and TJ program advocates provided ideas for legislators, state agencies, and contractors for ways to implement these recommendations. These suggestions may be viewed in the "Recommendations" section.

Recommendation 1:

- *Extend opportunities for participation in the program to the largest potential pool of eligible persons.*

The analysis revealed a host of positive health impacts, suggesting that expanding the TJ program may increase the magnitude of these health benefits.

However, simply expanding the TJ program for more people is not alone sufficient to realize lasting health benefits. The literature suggests that many of employment's positive effects on stress, children's physical and mental health, and family cohesion are undermined or even reversed when employment is unstable (and income inadequate). The literature on TJ evaluations also shows that employment wanes over time.

Recommendation 2:

- *Focus on creating lasting employment outcomes for participants after the subsidized employment ends.*

An important caveat to keep in mind: The two recommendations may, at some point become contradictory. Opening the program to the greatest number of people may draw in those with even greater barriers to long-term employment. Diminishing returns could result in a lower percentage of program recipients receiving long-term benefits, even as the absolute numbers of participants aided increases.

Recommendation 3:

- *Assure priority in the TJ program to applicants with children, while not making parenthood an eligibility requirement of the program.*

Many of the positive health impacts stemming from participation in the TJ program actually accrue to participants' families, especially children.

CONCLUDING REMARKS

Transitional Jobs programs have the potential to improve the physical and mental health of participants and their families. Further evaluation is needed to determine how long these benefits last and if they persist only under conditions of stable and lasting employment. Implementing agencies should make a priority the on-going collection of participant data on key health indicators and health outcomes.

[1] New York State Independent Committee on Reentry and Employment, Report of Recommendations to New York State on Enhancing Employment Opportunities for Formerly Incarcerated People. *sentencing.nj.gov/downloads/pdf/articles/2006/.../document03.pdf*

Section II: Introduction

Wisconsin's Transitional Jobs Demonstration project (TJDP) was passed by the legislature as part of the 2009-2011 Budget Act 28. It was intended to provide up to 2,500 transitional jobs allocated among six counties and other regions with high unemployment. Recipient eligibility was determined by several need-based and demographic criteria.

The demonstration project was later modified by Act 333, also passed in 2009, which created an enhanced demonstration project. TANF emergency funds available under the federal American Recovery and Reinvestment act (ARRA) permitted the state to eliminate the cap on the number of jobs and extend the program statewide. The program is administered by the Department of Children and Families (DCF) and can sunset when ARRA funds are no longer available. Enrollment of new participants will end on March 31, 2013 and the program itself will end as of June 30, 2013.[1]

The state thus far has invested about $24 million in the TJ project, assisting approximately 3,900 low income enrollees.[2] The 2012 DCF Agency Biennial Budget Request for 2013-2015 proposes a new Wisconsin Transitional Jobs project titled Transform Milwaukee Jobs Initiative (TJMI).[3] This proposal requests $8.75 million dollars for the upcoming biennium, creating TJMI as a permanent program to serve low-income adults in Milwaukee County. Eligibility criteria and program model would be similar to those under the expiring TJDP program, using contractors as the primary entity determining program eligibility and providing case management, job placement, and other services to participants.[4] This also provides an opportunity for DCF to build in a detailed program evaluation designed to evaluate causal impact of this program on participants.

Generally, Transitional Jobs (TJ) programs refer to government-sponsored employment programs where the state subsidizes short-term work opportunities – which can include placement and training as well as pay -- to previously unemployed individuals in either the public, private, or non-profit sectors. State sponsored employment programs go back to the New Deal when they were designed to maintain employment and economic demand. The programs of the 1960s and 70s targeted those with substantial barriers to employment and were part of a larger anti-poverty policy. In the last twenty years, as part of an effort to shift from public assistance to work, programs have specifically focused on the goals of helping long-term welfare recipients establish financial independence; providing disadvantaged populations access to the labor market; and, most recently, attempting to shrink the ranks of the unemployed.

Transitional Jobs programs, however, have not been analyzed for their role in shaping the health of program participants, their families, and their children. This question is pertinent, in that health is a significant influence on workforce participation and employment[5] [6] and the causes of poor health extend well beyond healthcare and personal health behaviors. The UW Population Health Institute model, among others, indicates socio-economic factors, including

employment and income status, along with physical environments drive over half of health outcomes.[7]

Employment is itself a key determinant of health, but employment may also have a cascading effect on many other determinants of health. On the positive side

- Secure income may positively affect nutritional intake, educational opportunities, and can offer entré to safer neighborhoods, cleaner environments, and access to health care;
- Continuous employment may reduce stress, improve confidence, and improve mental health status, which may in turn improve family and social supports and health behaviors.

On the other hand, employment could offer detrimental exposures:

- Stress in balancing work and childcare demands;
- Occupational hazards and exposures;
- Potential alienating or demeaning work environment may further detract from mental well-being or self-confidence.

Health Impact Assessment (HIA) offers an approach to looking at these potential relationships in a systematic way. The HIA of the Transitional Jobs program explores how factors seemingly outside the health arena have significant impacts on health, and the relationship between health and employment for this population. This framework will support decision-makers effort to both strengthen the workforce and improve the health of the population, ultimately promoting long-term employability and well-being among Wisconsin's residents.

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This HIA, under national sponsorship, has two distinct audiences:

- Those interested in the potential health impacts of Transitional Jobs programs,
- Those interested in methods for conducting HIAs, particularly in the area of economic or social policy.

This report explicates as much about the methods and process of conducting the HIA as it does about the subject matter itself -- Transitional Jobs – and the results of the analysis. The report is organized as follows:

Section III: Screening, provides insight into the screening process by which the project was selected. It describes the history of the Wisconsin Transitional Jobs Demonstration project and the current decision (and its alternatives) under consideration. Screening also discusses the potential to add value to the decision-making process, including potential health effects and distribution of impacts. It also considers stakeholder and decision-maker positions and the likelihood of the HIA to inform the decision in a timely fashion. Screening represents the early hopes for the project.

Section IV: Scoping, describes the process by which the research team and key advisors selected the health outcomes for analysis and describes their pathways from policy to outcome. This section essentially lays out the HIA's logic model and methodology.

Section V: Assessment, is the heart of the analysis. This section brings together baseline data, survey data from participants in the WI TJ program, and published literature to weigh the potential health impacts of a change in the current TJ program. This section takes each of the pathways identified in the scoping phase, and applies the best available evidence to evaluate the strength of the links along the pathway from employment to indicator to priority health outcome. It also characterizes these impacts according to direction of impact, likelihood, duration, and impacts on different populations.

Section VI: Recommendations and Monitoring, describes the specific recommendations to manage the health impacts identified and describes the criteria used to make these recommendations. It also makes recommendation about monitoring the impacts of the program moving forward.

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[1] Wisconsin Legislative Fiscal Bureau 2011-13 Budget Summary, Children and Families: Economic Support and Child Care, Paper #215, May 31, 2011.

[2] The $28M budget will likely be expended by program end on June 30, 2013. Angela Davis, Dept. of Children and Families, Correspondence, Jan 30, 2013.

[3] Wisconsin Legislative Fiscal Bureau 2011-13 Budget Summary .

[4] Wisconsin Department of Children and Families. Agency Budget Request 2013 - 2015 Biennium.

[5] García-Gómez, P., Jones, A.M., Rice, N., 2010. Health effects on labour market exits and entries. Labour Economics 17, 62–76.

[6] Lindholm, C., Burström, B., Diedrichsen, F., 2001. Does chronic illness cause adverse social and economic consequences among Swedes? Scandinavian Journal of Public Health 29, 63–70.

[7] County Health Rankings, University of Wisconsin Population Health Institute, accessed December 15th 2012, http://www.countyhealthrankings.org/our-approach.

Section III: Background and Screening

Why Do a Health Impact Assessment, and Why on This Topic?

HIA is formally defined as a "combination of procedures, methods and tools that systematically judges the potential and sometimes unintended effects of a proposed project, plan or policy on the health of a population and the distribution of those effects within the population". HIA identifies appropriate actions to manage those effects.
International Association for Impact Assessment
http://www.iaia.org/publicdocuments/special-publications/SP5.pdf

Health Impact Assessment (HIA) offers a flexible framework to inform proposed policies, plans or projects prior to their execution, engaging multidisciplinary, non-traditional partnerships. This multi-step process draws upon community input, uses multiple criteria, and deploys data to project the health implications of a decision on a population and the distribution of impacts within a community. Based on the synthesis of the best available evidence, HIA then disseminates recommendations or mitigation strategies to ameliorate the negative and bolster the positive elements of a proposed policy, plan or project. Finally, HIA entails monitoring and evaluating the utility and influence of the methodology on the decision-making process and health outcomes.[1]

This current HIA builds on the work of a previous analysis of a package of anti-poverty policies, one of which was a Transitional Jobs program, which was conducted by the Community Advocates Public Policy Institute in 2009.[2] This model assumed that program recipients moved from one income bracket to the next highest; it also assumed that the entire package of benefits resulted in these improvements and couldn't calculate the contribution of any single program or policy. The current HIA offers two additional dimensions:

1. It specifically considers the health impacts of the employment experience itself, independent of income. This will permit policymakers to consider whether jobs programs provide additional benefits beyond alternative methods of income support.

2. It considers health outcomes broadly to include mental health, violence and community health. Given how important work is to self-esteem and a sense of efficacy, the goal of this HIA was particularly to highlight any outcomes on mental health, and the mental health of family members which could themselves lead to improved physical health.

Transitional Jobs programs (TJ) frequently target specific populations, often the homeless, ex-offenders, and youth. Wisconsin's eligibility requirements were more general. Program renewal, however, offers policymakers the opportunity to redesign program eligibility for greatest impact. An additional goal of this HIA is to consider possible differential impacts of the program on various populations, including ex-offenders, family status, age, gender, education, and race. And this HIA considers the

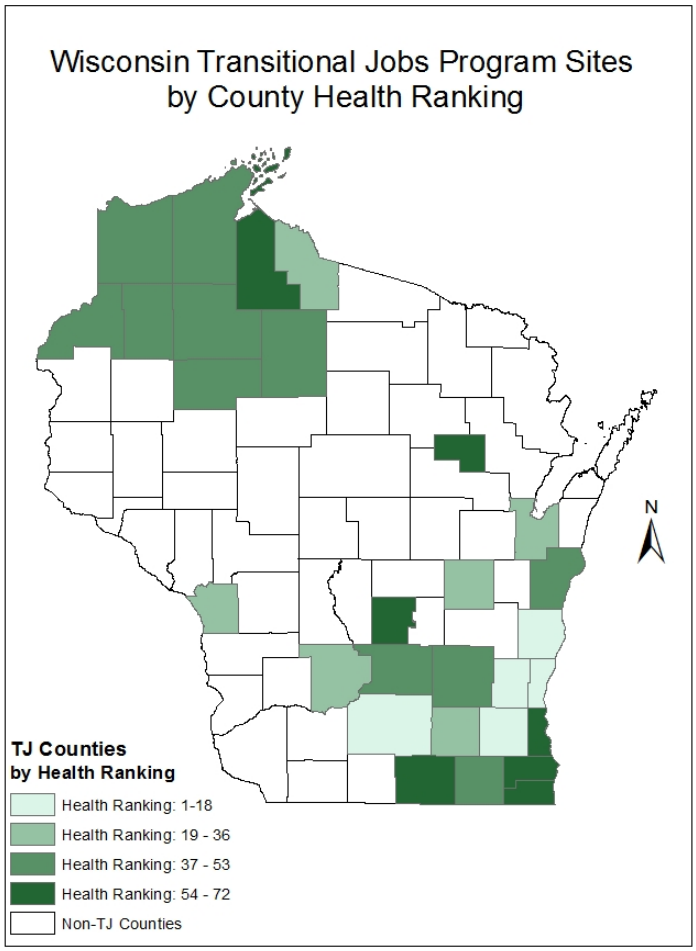
additional possibility that a transitional jobs program could also reduce health disparities by addressing key health determinants, for those of lower socioeconomic status.

Target Communities

The low-income unemployed are the population most directly impacted by the policy decision regarding program renewal. The WI Transitional Jobs Demonstration Project (TJDP) program does have foci in areas of the state with high rates of poverty and unemployment. Counties were selected because of their high unemployment rate, and these areas with high unemployment also tend to rank poorly in population health status. Indeed the map of Wisconsin counties where a TJ program exists reflects, generally, counties with health rankings at or below the median (Figure 1).

Although the Wisconsin TJDP operated in 38 counties, most of the jobs are located in the city of Milwaukee. Indeed, Milwaukee advocates and legislators were the primary force in developing and ensuring the passage of the program. Milwaukee County has an overall unemployment rate of 9.6% but, among black men, the rate is 55%.[3] Poverty among the county's children stands at 35%, while 49% of children live in single parent households. The teen pregnancy rate is twice that of the state overall (6.1 vs. 3.1 per 1,000).[4] The county ranks 70th out of 72 counties for health outcomes. Although the infant mortality rate declined to a historic low in 2011, the rate for black babies continued to climb, now standing at three times the white rate. Milwaukee's infant death rate stands among the worst in the nation, and in some neighborhoods rank among third world nations.[5]

Figure 1



The majority of TJ program participants to date have been black men and the state's largest TJ programs are in areas with concentrations of black, low-income unemployed residents. The co-occurrence of low socio-economic status, public benefit receipt, race, and unemployment, along with poor health, provide a compelling rationale to consider how employment and health interact here.

Background: Transitional Jobs in Wisconsin

The welfare reforms enacted by the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) sought to, "end welfare as we have come to know it."[6] It replaced cash "welfare," then known as Aid to Families with Dependent Children (AFDC) with "Temporary Assistance to Needy Families (TANF)", time-limited cash benefits and work requirements. The robust economy of the 1990s, however, was followed by recession, and states then faced greater challenges meeting the

requirement that at least 50% of a state's TANF case load meet work requirements. This led policy makers to seek additional ways to address persons with multiple barriers to employment. The current use of Transitional employment opportunities has been piloted and evaluated since the 1990s and changes in federal regulations governing States' use of TANF funds have allowed States to implement transitional jobs programs using federal funds.

Milwaukee's New Hope program, implemented from 1994-1997 is perhaps one of Wisconsin's most recognizable Transitional Jobs programs. Architects of that program have kept the idea of ending poverty through a package of policies – including Transitional Jobs – alive in Wisconsin and were involved in the passage of the 2009 legislation to enact the current Transitional Jobs Demonstration Project. They are joined by a broad group of stakeholders who are committed to the program's renewal and expansion. These stakeholders included the Milwaukee Transitional Jobs Collaborative (MTJC), a coalition of area members from religious, community, social service agency, work force development, and philanthropic organizations; several legislators; and a public policy institute, Community Advocates. The coalition hopes to build on the strong bipartisan support for the initial demonstration program to expand it significantly in 2013.

To date, the state has invested about $24 million in the TJ project and has assisted approximately 3,900 low income people. At the end of 2012, 1,780 of these participants had gone on to secure unsubsidized employment.[7] The Wisconsin Transitional Jobs Demonstration Project, administered through the WI Department of Children and Families, provides low-income WI residents with job training, experience and support in re-entering the workforce. This project, created as part of Wisconsin's 2009-11 Biennial Budget Act, applied emergency funds appropriated by the American Recovery and Reinvestment Act of 2009 (ARRA) through TANF. The original intent was for a two-year program, but after the 2010-2011 budget review process revealed that less had been spent than anticipated, the legislature extended the program for a third year. [8]

TJ programs often fill immediate employment and policy needs; the recession of 2008 resulted in high unemployment nationally and in Wisconsin. The Wisconsin Legislature instituted transitional jobs as one policy to address growing unemployment. Wisconsin's program is unusual among TJ programs in that job placements occurred at public, private, and non-profit work sites.

Eligibility Criteria

To be eligible for the WI TJ program participants must be: (1) between 21 and 64 years of age; those over the age of 25 must also be a parent or primary relative caregiver of a minor, (2) not receiving W-2 benefits and ineligible for Unemployment Insurance (UI) benefits; (3) previously unemployed for 4 or more weeks; (4) have a household income below 150 percent of the federal poverty level; (5) be a citizen of the US and a resident of WI; and (6) have past participation of fewer than 1,040 hours in the TJ program.

Employment and Services

The Wisconsin Department of Children and Families used an RFP process to select 17 contractors to coordinate employers and program participants for the duration of the program. Most contractors are the official employers of record (paying workers and receiving the wage reimbursements from the state), with a few exceptions in which the contractors partner with one or more subcontractors to serve as the employers of record, and provide all program services. Over 800 businesses have participated in the program.

Contractors assist participants in accessing additional services for which they are eligible (such as Medicaid/BadgerCare, FoodShare, Child Support, etc.). In the initial Orientation Phase, contractors assist in creating an employment plan, providing education/training, and offering any additional job supports necessary. During the next phase, Subsidized Work, participants work at a subsidized job (at either a Host Site or with a Work Crew). Program contractors are responsible for maintaining provider agreements with a number of employers sufficient to place all participants in their charge. After the Subsidized Work phase, participants enter the Follow-Up Phase, which lasts for up to six months. During this time, the contractor is responsible for assisting participants with the transition to unsubsidized employment and providing ongoing support.[9]

Employers participating in the TJ project are required to provide at least 20, but no more than 40 hours of employment per week at the minimum wage, although they can choose to pay more. Participating employers have 100% of workers' wages subsidized up to the minimum wage level ($7.25/hour), all federal and state taxes and workman's compensation insurance premiums. As permitted by the program, over 100 employers have chosen to provide supplemental wages so that the TJ participant can earn above the minimum wage.[10] Education and training may also be provided during the subsidized work period and workers are paid for these activities. Transitional Jobs cannot displace current workforce.

* * *

Screening: The Decision Process

The decision to conduct the Transitional Jobs HIA was jointly made by Marjory Givens, UW Health Disparities Postdoctoral Scholar; Paula Tran Inzeo, a UW-PHI Fellow and Outreach Specialist, and Elizabeth Feder, UW-PHI Associate Researcher. Paula Tran Inzeo had previous experience working with the Milwaukee TJ Collaborative and was familiar with its intent to pursue both research and advocacy in support of the program.

Salience: Researchers considered the multiple opportunities to inform the decision as an asset. First, the HIA had the potential to influence executive agencies budget processes; the Department of Children and Families (DCF) and the Department of Workforce Development (DWD) would be submitting their budgets to the Governor on September 15, 2012. The Governor would submit his budget to the legislature in early 2013. Finally,

the legislature would debate the budget and make a final decision in the spring of 2013. The new budget would be operational on July 1. There were, additionally, several possible policy outcomes that the analysis could inform:

- a decision to extend the program past its June 2013 sunset;
- a decision to expand – or to contract -- the program both in terms of participants and / or geographic reach;
- a decision to redesign the program to target particular groups of participants;
- a decision to end the program altogether.

Stakeholders: Decision makers and the political process seem open to considering the findings of the HIA. The legislation creating the TJDP was supported by lawmakers of both parties, many of whom are still in office and are presumed still interested in the program's future. Several of these legislators hold leadership positions, while one is a senior committee chair with deep experience in health policy. The Governor, after slating the program for termination in the last budget, ended up leaving the funding intact when restored by the legislature. Job creation was one of the Governor's key campaign promises and he is also extremely interested in reducing the cost of state-financed health care; thus it seems likely that he would interested in the outcome of this HIA.

Partners: The key partners in conducting the HIA are the Milwaukee TJ Collaborative, the Department of Children and Families, and the University of Wisconsin's Population Health Institute. UW-PHI researchers were the grant recipients and project leads. They have no financial or political stake in the outcome of this HIA. Similarly, the funders of the HIA, the National Network of Public Health Institutes, have no conflicts of interest to report. The other partners were invited to join the HIA advisory committee for their experience with and knowledge of the Transitional Jobs program and do have interests in the outcome of the decision. Community Advocates and other members of the Milwaukee TJ Collaborative are advocates for the TJ program who plan is to conduct a state-wide campaign to expand the program. State agency representatives also serve on the advisory committee. Their professional mandates in no way restricted the scope or findings of the HIA. They are not, however, permitted to make political recommendations. They served in an advisory capacity and the recommendations made in this report are not made in their name.

[1] Human Impact Partners, 2006. FAQ about HIA. Accessed April 12, 2012. http://www.humanimpact.org/faq#Questions
[2] Community Advocates Public Policy Institute, "Health Impact Assessment of Pathways to End Poverty," 2009
[3] Schmid, John, "Employment of black men drops drastically: UWM study of 2010 census data finds record low in Milwaukee," *Milwaukee Journal Sentinel*, January 23rd, 2012. http://www.jsonline.com/business/employment-of-black-men-drops-drastically-tf3tg7m-137932723.html
[4] County Health Rankings, University of Wisconsin Population Health Institute. Accessed December 27th, 2012. http://www.countyhealthrankings.org/#app/wisconsin/2012/milwaukee/county/1/overall
[5] Stephenson, C and Herzog, S, "Disparity in infant mortality rates in Milwaukee widens," *Milwaukee Journal Sentinel*, April 24th, 2012.
http://www.jsonline.com/news/milwaukee/milwaukee-infant-mortality-rate-drops-overall-but-disparity-worsens-sp54t7f-148680905.html
[6] Clinton, Bill, October 23, 1991. "The New Covenant: Responsibility and Rebuilding the American Community. Remarks to Students at Georgetown University." *Democratic Leadership Council*. Accessed on January 30th, 2013 from http://clintonpresidentialcenter.org/georgetown/speech_newcovenant1.php
[7] Wisconsin Department of Children and Families, Transitional Jobs Report, December 2012.
[8] The budget is $28 million for the program (which will likely be fully expended by the 6/30/13 end). Through October 2012, the program expenses were $24.2 million. The original TJ budget allocations were intended to be $34 million but changed after a regular program review as part of the biennial budget process in 2010-2011. The budget was changed to just over $25 million, due to program under-spending of monies budgeted for the program in 2009-2010…[$17.5 million was allocated for 2009-2010, with intentions that another $17 million would be allocated for 2010-2011 in the next budget process. However, since much less was spent than expected in 2009-2010, the legislature determined that less than the $17 million would be allocated for the second year of the program, setting the total budget at just over $25 million]. DCF reallocated an additional $3 million TANF dollars to TJ in May 2012, using funds (not part of the TJ "budget) that were unspent in other TANF areas as we neared the end of the state fiscal year. Angela Davis, DCF, Correspondence, January 30, 2013.
[9] Some program participants skipped the Subsidized Phase and went directly into Follow Up because either they found an unsubsidized job prior to entering the Subsidized Phase, simply declined the subsidized placement, or left the program before entering the Subsidized Phase. Agencies could either dis-enroll individuals that left the program without having subsidized employment or move them to Follow Up to continue to offer job search support or unsubsidized job supports to help them retain unsubsidized jobs. Angela Davis, DCF, Correspondence, Jan. 30, 2013.
[10] Angela Davis, DCF, Correspondence, January 30, 2013.

Section IV: HIA Scope

Partner and Stakeholder Engagement

Scoping Participants

Early in the process, a group of stakeholders was convened to participate in defining the scope of the project. People were chosen based upon their current or previous experience with Transitional Jobs (TJ) programs; expertise in poverty and social policy; or because they were in a position to affect the final decision about the program's future. Several participants met more than one of these criteria and all had a stake in the out-come of the decision. The research team also made attempts to include perspectives from the business community.

Figure 2

Scoping Process Participants

Advocacy Organizations:

- David Riemer, Community Advocates Public Policy Institute
- Raisa Koltun, Wisconsin Center for Health Equity
- David Liners, WISDOM
- Conor Williams, Community Advocates Public Policy Institute

Community Organizations:

- Nicole Angresano, United Way of Greater Milwaukee
- Ella Dunbar, Social Development Commission
- Nyette Ellis, YWCA of Milwaukee

Executive Agency Representatives

- Lisa Boyd, WI Department of Workforce Development

Participants attended a half-day meeting at which they engaged in a facilitated scoping exercise designed to identify health pathways and potential equity effects of TJ policies; assign priority to the research questions for the HIA; and identify sources of information and data. Through follow-up communications they were asked to review, inform, and finalize the HIA research. Figure 2 lists participants.

Advisors

Our key partner groups, the Milwaukee TJ Collaborative and the Department of Children and Families, provided on-going consultation throughout the project. However, the Assessment was conducted independently by UW-PHI researchers.

The pathway diagram created at the meeting can be viewed in Appendix 1. A simplified logic model is Figure 3, below.

Figure 3 Logic Model

Policy Change		Immediate Outcomes	Long-term Outcomes
EMPLOYMENT	**INCOME EFFECTS**	• Federal Poverty Level (FPL) • Disposable income • Public benefits • Debt • Improved Housing • Transportation options	Reduced Chronic Disease Improved mental health Reduced Domestic Violence Increased Child well- being Improved Birth Outcomes
	SOCIAL COHESION / SOCIAL CAPITAL EFFECTS	• Family cohesion • Civic Participation • Religious activities • Reduced stigma of poverty • Reduced referrals to child welfare / other support services • Social/environmental exposures • Recreational behaviors (drinking, smoking)	
	STATE/LOCAL FISCAL EFFECTS	• Increased budget expenditures – public funds for TJ programs • Changed state/local taxes • Reduced public funds for case management/incarceration programs • Reduced public funds for welfare programs	
	PRIVATE SECTOR / EFFECTS	• Increased number of jobs • Changed local labor market dynamics • Business growth/expansion	

After further discussions with several stakeholders, the "state and local fiscal effects" and the "private sector effects" were dropped from analysis. In some cases it would have been too difficult to access administrative data, and in others economic modeling requirements beyond available resources dissuaded us. Additionally, a survey of businesses participating in the program was already underway elsewhere. Beyond this, there remained high interest on the impact of the program on children and families and on mental health. This HIA would add value by focusing on the health outcomes of income effects and social capital/social cohesion effects.

Selecting Health Factors

From this point, a preliminary literature review was conducted of all the hypothesized pathway links from each indicator of income and social effects to each of the health outcomes. This was done in several steps: the direct pathway from employment to health outcomes; then

from employment to immediate outcome; finally from intermediate outcomes to health outcomes. The review included both the academic literature on the health impact of employment and the grey literature evaluating the transitional jobs programs. Literature was graded both by the type and by the strength of the results, irrespective of direction. Those intermediate health indicators which had strong connections to both employment and to the priority health outcomes remained for final analysis. Other health or environmental concerns related to the TJ program are presently unknown to the authors; therefore, we consider this evaluation the most thorough to date, of how the Wisconsin TJDP impacts participant health. A full discussion of scoping methods and data sources can be found in Appendix 1.

The overall research questions thus stood as follows:

- What impact do Transitional Jobs programs have on selected indicators of individual and household income?
    - How do these income effects relate to health outcomes?

- What impact do Transitional Jobs programs have on selected indicators of social cohesion?
    - How is social cohesion linked to health outcomes?

Employment status works indirectly through various intermediates to influence a workers' mental and physical health and on the education, mental health, and physical health of their dependents. The indicators selected are:

a. Income and poverty status

b. Diet

c. Alcohol and tobacco use

d. Recidivism & incarceration

e. Self-efficacy

f. Social capital

g. Family Cohesion

h. Children's maltreatment

Geographic Scope

The entire state of Wisconsin is the subject of this HIA. Although the program operated in only 38 counties, one of the proposed policy options is to make TJ jobs available to those who meet program criteria throughout the state. Pertinent literature from national as well as international sources were used to inform the study, These works were augmented by survey data collected from individuals currently or previously enrolled in Wisconsin's TJ program. Survey questions were designed specifically to elucidate where, in the literature, links from employment to intermediate outcomes was weak, mixed, or absent. The Wisconsin survey data was also

used, where possible, to identify specific populations for whom the effects of the program might prove stronger or weaker. Crosstabs analysis was conducted by participants' race, gender, education level, and former-offender status.

Evaluation of Other Transitional Jobs Programs

In the last two decades, independent evaluation organizations have done several thorough evaluations of Transitional Jobs programs. TJ evaluations have, predictably, tracked participants' employment and income over time; some evaluators have also considered receipt of public benefits, recidivism, health, and child outcomes. A review of several major TJ programs[1]informed a general understanding of how different TJ programs have been structured and their successes and limitations. This body of work was important in directing attention to relevant health indicators and outcomes for further analysis.

Programs designed to connect the difficult-to-employ into jobs demonstrate the myriad challenges of this effort. Only three of the eight rigorously evaluated programs provided evidence of employment impacts (CEO, TWC, and PRIDE); of these, only PRIDE demonstrated effects that lasted through the follow up period. (The New Hope program was not included in the review.) The general pattern the evaluations found is that employment, income, and earnings all increased during participation in the program, relative to a control group. After participants graduated from the program, however, the effects declined; members of groups randomly assigned to treatment or control groups came over time came to resemble one another in terms of employment, income, and earnings outcomes [2]

Some programs, however, demonstrate important positive outcomes beyond those of employment and earnings. The New Hope Program was started in 1994 by a group of Milwaukee and national advocates for the poor who argued that those who work should not be poor.[3] With substantial grant funding, they provided a full package of supports including income supports, child care, health insurance, and transitional work experiences. The program was rigorously evaluated for eight years after the program ended and is to date one of the more extensive longitudinal analyses of an anti-poverty program in America. Program impacts on income, earnings and employment mirrored other programs; participants experienced significant increases while they were enrolled that waned after exiting. However, researchers observed some lasting effects for the participants' children including improvement in school progress, boys' standardized test scores, positive expectations for future school performance, the quality of social relationships, and participation in extracurricular activities.[4] While parents in the participant group did note that they were more able to manage their children, the evaluators found no lasting impacts of participation on parents' material, physical, or emotional well-being.[5] Indeed, the breadth of evaluation metrics surveyed in the New Hope program motivated this health impact assessment to consider similar economic impacts (income, employment, and poverty status), health impacts (mental and physical well-being) as well as social impacts.

TJ programs can also have success for some types of people or those with particular work histories.[6] An evaluation of the CEO program for released prisoners indicated that recidivism of program participants was significantly less than the control group during the first year, especially

for those enrolled within three months of release from prison.[7] The larger Transitional Jobs Demonstration Project (TJRD) did not demonstrate the same effects on recidivism,[8]raising questions about how differences in the programs' management and/or structure might contribute to the programs' differential success.[9]

Veterans also face a number of adverse mental health outcomes and health risk behaviors, and therefore particular attention is paid to how programs serving this population affect these health outcomes. Evaluations have found that TJ programs offered through the Veteran's Affairs Department reduced homelessness and recidivism and improved treatment of alcohol and other substance use[10] and had a greater impact than a minimal but common intervention used by the Veterans Health Administration.[11]

While the literature suggests that TJ programs have limited lasting effects, there remain unanswered questions about the potential of program modifications that might improve outcomes. No evaluations tested components of program implementation, so it is impossible to determine the role of program quality or other characteristics. Mature programs (CEO), however, did have better results than TJ programs that didn't use mature programs.[12]

Modifications proposed, but untested, include providing longer-term transitional work experiences, using transitional jobs that morph into unsubsidized employment, conducting relevant and technical skill training, readjusting organizational structures to better meet program participants needs, providing improved soft job skill training, and including accompanying social services (child-care, health care, etc.).[13] Perhaps the most salient critique of these evaluated programs is that the job placement was often in a government or non-profit setting where there was little to no chance that the work experience would translate into unsubsidized employment.[14]

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[1]The programs reviewed here are those evaluated using randomized experiments or quasi-experimental designs from 1990 to the present. Other TJ programs have been evaluated, particularly at the state level, but those evaluations are descriptive, not analytical. The programs discussed here are:
Washington State's Community Jobs program, PRIDE program, TWC program, New Hope program, CEO program, the Transitional Reentry Demonstration Project, and programs for Veterans.

[2](Jacobs and Bloom, 2011). The PRIDE program had slightly more promising results; participants demonstrated a greater propensity be employed and rely less on public assistance programs. Yet, they often lost jobs quickly and in any given quarter, the group experienced a high rate of unemployment. (Bloom, Miller, and Azurdia 2007).

[3]Brock, T., Doolittle, F., Fellerath, V., & Wiseman, M. (1997). Creating New Hope: Implementation of a Program to Reduce Poverty and Reform Welfare. MDRC

[4] Huston, et al., 2008a. New Hope Project. Promising Practices Network on Children, Families and Communities. Last modified April 2010, http://www.promisingpractices.net/program.asp?programid=269

[5] Huston, et al., 2008b. New Hope Project. Promising Practices Network on Children, Families and Communities. Last modified April 2010, http://www.promisingpractices.net/program.asp?programid=269

[6] Evaluating Washington State's Community Jobs Program: Two-Year Employment Outcomes of 2002 Enrollees. 2005, Washington State Institute for Public Policy.

[7] Redcross, C., Millenky, M., Rudd, T. And Levshin V. (2012). *More Than a Job: Final Results from the Evaluation of the Center for Employment Opportunities (CEO) Transitional Jobs Program*, OPRE Report 2011-18. Washington, DC: Office of

Planning, Research and Evaluation, Administration for Children and Families, U.S. Deptartment of Health and Human Services.

[8] Jacobs, Erin, Returning to Work after Prison - Final Results from the Transitional Jobs Reentry Demonstration (May 10, 2012). Available at SSRN: http://ssrn.com/abstract=2056045 or http://dx.doi.org/10.2139/ssrn.2056045

[9]Jacobs, Erin, Returning to Work after Prison - Final Results from the Transitional Jobs Reentry Demonstration (May 10, 2012). Available at SSRN: http://ssrn.com/abstract=2056045 or http://dx.doi.org/10.2139/ssrn.2056045

[10] Kashner, T. M., Rosenheck, R., Campinell, A. B., Surts, A. et al. (2002). Impact on work therapy on health status among homeless, substance-dependent veterans: A randomized control trial. Archives of General Psychiatry, 59, 938-944.

[11]Drebing CE, Bell M, Campinell EA, Fraser R, Malec J, Penk W, Pruitt-Stephens L. Vocational services research: Recommendations for next stage of work. *J Rehabil Res Dev*. 2012;49(1):101–20. http://dx.doi.org/10.1682/JRRD.2010.06.0105

[12] Redcross C, Millenky M, Rudd T, Levshin V. 2012. More than a Job: Final Results from the Evaluation of the Center for Employment Opportunities (CEO)Transitional Jobs Program. January 2012. OPRE Report 2011-18

[13] Butler, D., Alson, J., Bloom, D., Deitch, V., Hill, A., Hsueh, J., Jacobs, et al. (2012). What strategies work for the hard to employ?: Final results of the Hard-to-Employ Demonstration and Evaluation Project and selected sites from the Employment Retention and Advancement Project. OPRE Report 2012-08. MDRC.

[14] Butler, D., Alson, J., Bloom, D., Deitch, V., Hill, A., Hsueh, J., Jacobs, et al. (2012). What strategies work for the hard to employ?: Final results of the Hard-to-Employ Demonstration and Evaluation Project and selected sites from the Employment Retention and Advancement Project. OPRE Report 2012-08. MDRC.

Section V: Assessment

The Link between Employment Status and Health Outcomes

Direct Effects

Employment status and type (e.g., temporary, permanent, seasonal, intermittent, and precarious employment) affects many health outcomes. The literature review presented here focuses on the health impacts of domestic violence/child abuse, mental health, alcohol and tobacco use, birth outcomes, chronic diseases and child/dependent physical and mental health.

Domestic Abuse

Male unemployment and intermittent is a strong individual risk factor for domestic violence perpetration on female partners.[1] [2] [3] [4] [5].[6] Underemployment or lower status employment than their partner often results in male perception of loss of power/control/status and can result in domestic violence.[7] [8] [9] [10] [11] [12] Female unemployment is one risk factor for women being victimized by their partner,[13] and domestic violence prevents women from maintaining/obtaining employment. [14] [15] [16] [17] Unemployment of both men and women increases child abuse.[18] [19] [20] [21]

Mental Health

Unemployment, as well as underemployment[22] and temporary employment,[23] [24] [25] [26] has been associated with poor psychological well-being and other mental health outcomes, [27] [28] [29] [30] [31] [32] [33] while employment has been associated with positive mental health.[34] Employment appears to improve the health of women,[35] [36] while unemployment appears to more negatively affect the mental health of men.[37] Re-employment recaptures lost mental well-being.[38] Depression can interfere with employment status, and employment has been found to reduce depression over the long term.[39] Perceived job insecurity leads to negative mental health outcomes in permanent employees,[40] [41] while perceived employability was negatively associated with negative psychological symptoms among both permanent and temporary employees. [42] Transitional jobs (TJ) participants in one study spoke more of the emotional benefits they gained from transitional work than any other benefit of the TJ program.[43]

Substance Abuse

The evidence is mixed regarding how employment status and type of employment interacts with substance abuse.[44] [45] It is not clear whether substance abuse leads to unemployment or the reverse.[46] [47] Unemployment may lead to increased substance abuse, usually stemming from psychological distress from job loss.[48] [49] [50] And substance abuse may lead

to unemployment and underemployment.[51] Underemployment can also increase substance abuse risks.[52] [53]

Birth Outcomes

Employment status affects birth outcomes, with the type of work particularly relevant for assessing likely impacts on birth outcomes.[54] [55] Stress, hours, physical exertion associated with work environments can be predictive of birth weight, size at gestational age, and pre-term birth. Employment status has only recently been examined as a determinant of birth outcomes; a study of a cohort of American women found no causal link between unemployment and low birth weight or pre-term birth[56], a finding similar to an earlier study of women in the Netherlands.[57]

Children's Health

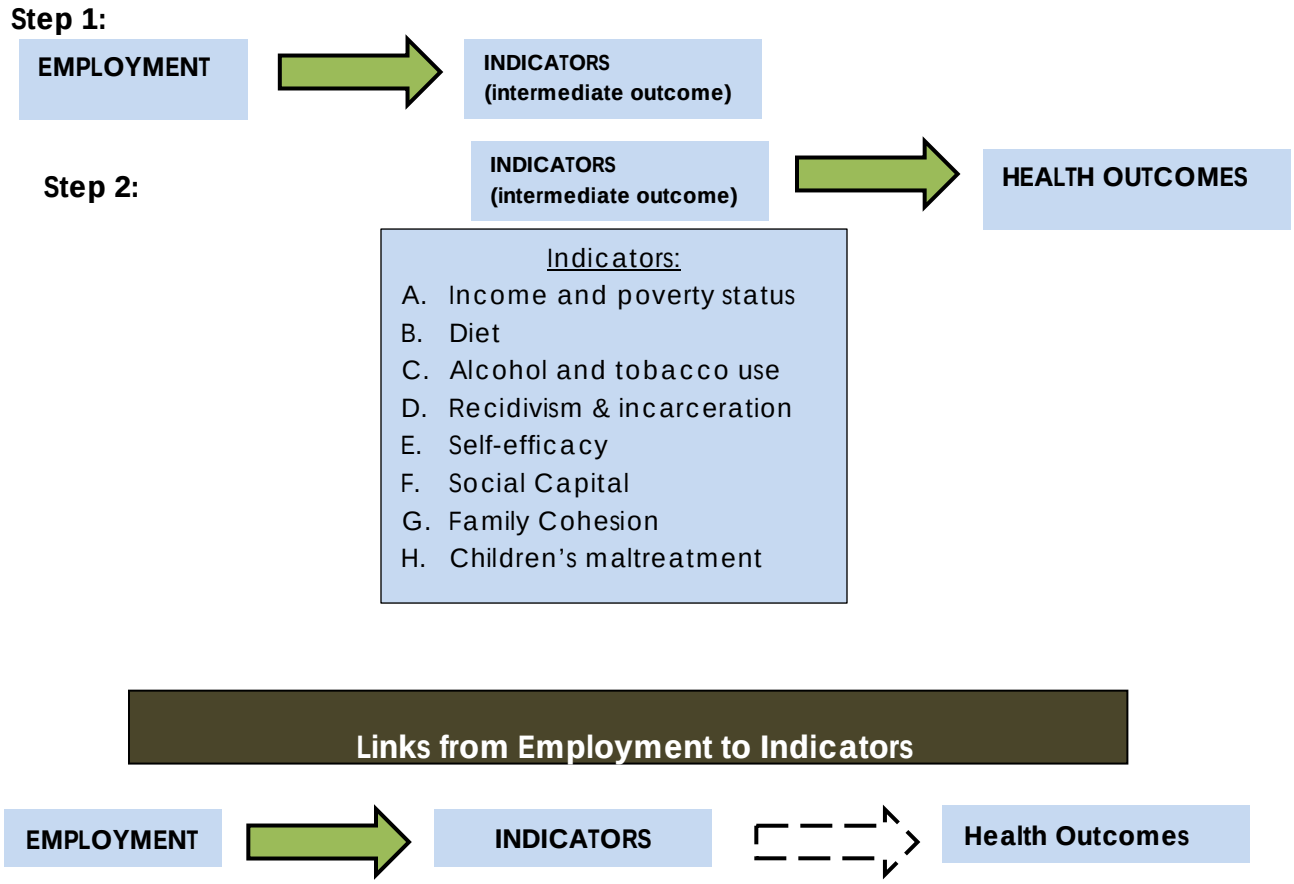
Evidence is mixed connecting parents' employment status and children's physical and mental health. The relationship appears to be bi-directional. Children's health status can impact parental employment: children with physical or mental health needs often require parents to reduce employment hours or stop working altogether.[58] Alternatively, parental employment can also influence children's health, although these effects appear nuanced. On the negative impact side, a cohort study from the United Kingdom revealed that for every additional 10 hours a mother worked while a child was under 3 corresponded to increased odds of having an overweight child.[59] Non-standard work schedules, more years with non-standard work schedules and near-poor incomes were also predictive of children being overweight.[60] Parents' labor market participation influenced Nordic children's psychosomatic and chronic illness incidence.[61] Some effects seem to be gendered: in Nordic studies unemployment among fathers, but not mothers, had negative effects on adolescents' self-reported health and self esteem.[62] [63] [64] [65] However, the bottom line is that much of the negative impact noted is mitigated by the financial support parents receive.[66]

Other Outcomes

Studies show that unemployment predicts a number of other health outcomes, even after controlling for other demographic factors. These include increased morbidity (suicide and lung cancer), [67] receipt of prescription medicines, smoking and alcohol consumption,[68] and cardiovascular risk factors,[69] Causality may, however, run the other way. For instance, although unemployment is connected in cross-sectional and longitudinal studies with poorer self-rated health status, it is possible that those in poorer health have difficulty maintaining regular employment. Similarly, unemployment may impact health status by reducing access to health care. [70] The type of employment is also relevant in determining health outcomes; work requiring more hours and eliciting more stress contributes to poor health outcomes.[71] [72]

Employment-Health Pathway

While many health outcomes are affected by employment status, the exact mechanism isn't clear. It is the primary goal of this assessment to trace the links from employment to key health outcomes as designated by key stakeholders. A two part process is used. Step One examines the strength of the links between employment and a set of intermediate outcomes. Step Two assesses these intermediate outcomes as indicators of specific health outcomes. This can be visualized as follows:



TJ Participant Survey

Literature review findings are augmented by results of a survey conducted during October, 2012 of current and former participants in Wisconsin's current Transitional Jobs Demonstration Program. The survey was designed and conducted in partnership with the WI Department of Children and Families. DCF handled survey distribution and collection, UW-PHI conducted analysis of the data. A total of 2,520 surveys were mailed, 587 were returned undelivered, and 141 surveys were completed, for a response rate of 7.3%. (The survey can be viewed as Appendix 2.)

Two factors may have influenced the return rate: first, there could be up to a two-year lag time between participating in the TJ program and being surveyed and, second, the fairly high transiency of the surveyed population. Some demographic factors can be compared to the total population of TJ participants. The survey population is older, more female, and has a higher proportion of whites and Asians than the total population. Employment status offers another point of comparison. DCF's monthly October report shows 9% of the total TJ population in a subsidized job. The same percentage of survey respondents - 9% - reported that they were

in a subsidized job. DCF reports also show that slightly less than 44% of all TJ participants to date had found unsubsidized employment.[73] Only 36% of the survey respondents reported they were *currently* employed. It is certainly possible that the survey would draw more heavily from those who remain unemployed as they may have had more time on their hands or could have been disgruntled. Alternatively, the DCF employment rate reflects those *ever* employed since leaving a subsidized job; if some percentage of the TJ participants didn't *maintain* employment, then this 8% difference could be overstated. The demographics of the surveyed population may be viewed in Table 3.

The survey reports self-perceived changes in various behaviors. Responses could be affected by the fact that some respondents participated in the TJ program a full two years ago, which presents memory challenges and recall bias.[74] That is, their status or circumstances may affect their recollection of past experience. Others respondents are currently in the initial phase of the program and are not yet in a position to know the outcome of their TJ experience.

Nonetheless, these responses help fill gaps in and provide insight beyond the literature. They provide valuable primary information about the impact of the TJ experience on self-reported indicators of personal health. The responses capture the voices of actual participants in Wisconsin's TJ program, providing a rich case history to round out other evaluative measures.

Table 3

Demographics of Survey Respondents
And selected comparisons with the total population of TJ participants

Age	20-29 yrs	30-39 yrs	40-49 yrs	50+ yrs	
	24%	37%	28%	11%	
All TJ	*49%*	*31%*	*16%*	*4%*	
Race	White	Black	American Indian	Asian/ Hawaiian/Pacific Islander	Other
	50%	42%	2%	6%	2%
All TJ	*23%*	*66%*	*2%*	*1%*	7% & unknown
Sex	Female	Male			
	59%	41%			
All TJ	*37%*	*63%*			
Parents (guardians) of minor children	Living with them	Not Living with them	Pay Child Support		
	68%	35%	34%		

Current Employment Status	In a TJ	Post TJ In job with same employer	Post TJ In job with different employer	Unemployed	
	9%	17%	19%	52%	
All TJ	*9%*	*44%*			
Incarcerated within last 5 years	Yes	No			
	21%	78%			
Veteran	Yes	No			
	4%	96%			
Education	Didn't Graduate High School	High School Degree	Associate Degree	Bachelor's Degree	
	18%	65%	12%	5%	

Baseline data on health indicators

Baseline health data does not exist for TJ participants, nor do data on their health behaviors or other indicators of their health. As a proxy, this study reports available data for Wisconsin residents with income that meets the program requirements (below 150% FPL), using these data to approximate baseline conditions. The data (presented in summary Table 4) offer a portrait of the health issues in this economic group.

The baseline data collected on the various indicators under investigation (unless otherwise noted) was collected from the Survey of the Health of Wisconsin (SHOW), a state-wide public health survey that is operated by the University of Wisconsin School of Medicine and Public Health. SHOW uses a variety of health assessments methods to capture information about the health of Wisconsin residents. These assessments include: in-person interviews, paper questionnaires, computer-assisted surveys, physical measurements and laboratory tests. SHOW measures a broad range of health information. Conditions and health-related characteristics captured in the data include high blood pressure and high cholesterol, nutrition and exercise habits, access to health care, health care utilization and other health related behaviors.

STEP 1: *Employment to Indicator*

Indicator A: Income

Employment → **Income** ⇢ **Health Outcomes**

Scientifically Supported:

Income's impact on health is well established.[75] [76] [77] Moreover, there is evidence of a graded association with health at all levels of SES, suggesting that even small increases in income may have positive health impacts.[78] However, this literature assumes a generally constant income status. The issue is whether TJ programs produce lasting income effects. The evidence is that Transitional Jobs programs appear to have minimal impact on participants' lasting income relative to a control group. Only three of the eight rigorously evaluated programs provided evidence of employment impacts and only one demonstrated income effects that lasted through the follow up period. The general pattern found is that employment, income, and earnings all increased during participation in the program, relative to a control group. After participants graduated from the program, however, the effects declined; members of groups randomly assigned to treatment or control groups came over time came to resemble one another in terms of employment, income, and earnings outcomes [79]

Indicator B: Diet

Employment → **Diet** ⇢ **Health Outcomes**

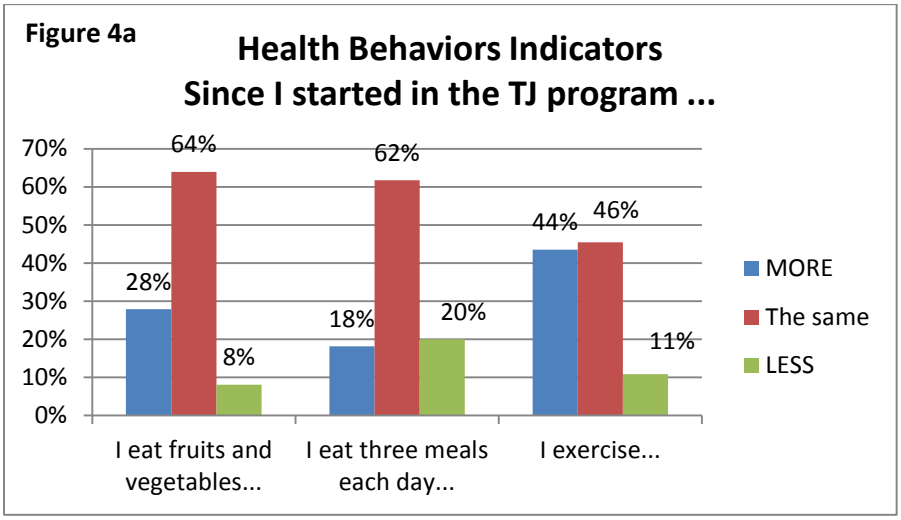
Mixed Evidence

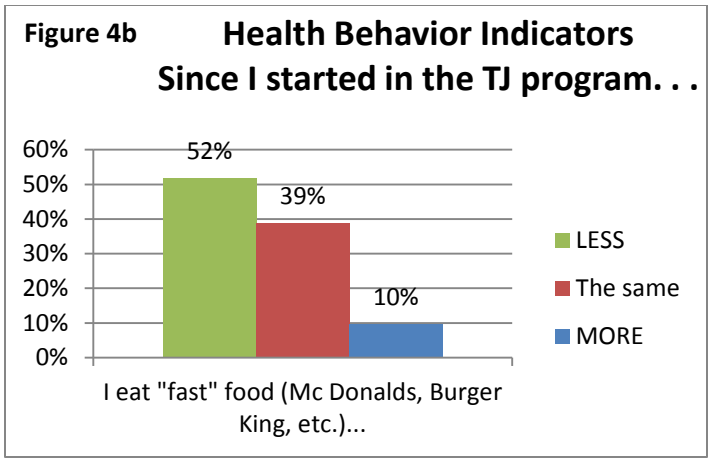
Studies have described maternal employment as having no effect on diet; working mothers neither provide fewer family meals nor encourage less healthful eating. [80] [81] [82] [83] Although studies did note increased work-life stress producing negative effects on eating, these effects (obesity) only happened when household income was greater than $33,000.[84] [85]

***TJ Participant Survey*:**

Evidence from the survey -- which speaks only to the TJ participants' habits, and not their families' -- was also mixed, but leans toward a moderate positive impact. Most people's diet remained the same, although fruits and vegetables consumption shows a net increase. Most striking was that 50% of respondents reported eating less fast food. The regularity of eating overall was not impacted.

Figure 4a



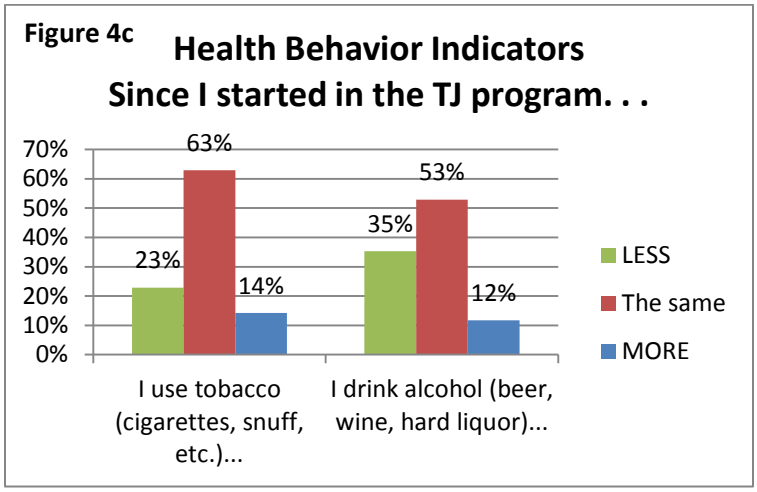


Indicator C: Alcohol and Tobacco

Employment → **Alcohol/Tobacco** ⇢ **Health Outcomes**

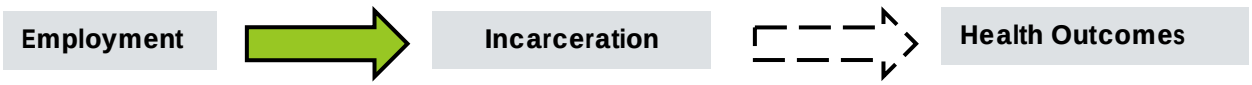
Mixed Evidence. Some studies reviewed found that alcohol abuse increases as a result of stressful life events, such as unemployment.[86] [87] [88] However, these studies have been criticized for methodological problems. .[89] Some studies found an association between unemployment and alcohol abuse, but just as many studies found no association[90] [91] or a reverse association, which they attributed to loss of income.[92] Another study concludes: "unemployment appears to have both an increasing and a reducing effect, but also no effect at all on the use of alcohol and tobacco in different populations."[93]

***TJ Participant Survey*:**
According to self-report, there was less net tobacco and alcohol use among TJ participants.



Indicator D: Incarceration / Recidivism

STEP 1: *Employment to Indicator*



Some Evidence. Studies have found that employment reduces the risk of recidivism.[94] Full time, relatively well-paid employment may be more beneficial than part time/short term, lower-paid work.[95] Transitional Jobs programs have found that participants in these programs are less likely to be arrested, be convicted, receive a technical violation, or be re-incarcerated than those who do not participate in the programs.[96]

Employer discrimination exists for hiring of ex-offenders,[97] and varies based on type of conviction offense.[98] [99] Many offenders have difficulty finding permanent, unsubsidized, well-paid employment after release because they lack job-seeking experience, a work history, and occupational skills.[100] Ongoing unemployment and lack of stability is consistently associated with high recidivism rates.[101] [102]

Indicator E: Self-Efficacy

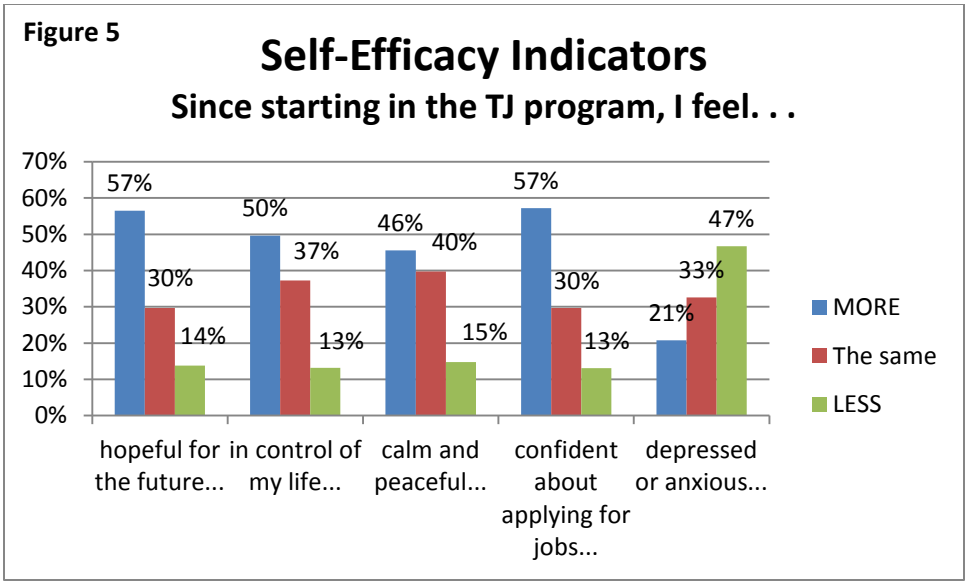
Some Evidence.

Self-efficacy refers to one's confidence in handling a wide array of situations; it is especially important in the workplace where it translates to workers' confidence in managing workplace experiences (especially for new or prospective workers). In theory, those with higher self-efficacy are more likely to exhibit the qualities of interest and persistence and to be successful in the workplace (and elsewhere). A feedback loop is established whereby achievements lead to increased self-efficacy which in turn enhance a person's performance, further strengthening self-efficacy.[103] Activities that promote self-efficacy, such as training and re-training opportunities, have been identified as important in predicting reemployment of those who have been on social assistance.[104] [105] [106]

TJ Participant Survey:

Survey participants reported strong improvement in measures of self-efficacy. Between 46% and 57% of respondents reported feeling more hopeful, calm, confident and in control of their lives.

Figure 5



Indicator F: Social Capital

Employment → **Social Capital** ⇢ **Health Outcomes**

***Some Evidence*.**

Social Capital theories maintain that workers with strong social networks benefit because of the job information and influence they receive from their social ties. In fact, 40-50% of jobs in the US are found with the help of friends and relatives.[107] Overall, those with better social networks do better in the job market.[108] The question is whether this relationship works in reverse: does employment increase workers' social networks? It appears likely. There is a strong association between workers with high social capital and political participation and union membership,[109] carpooling,[110] public employment,[111] and female labor force participation[112]. Causal models suggest that social capital also reflects social "homopily" – the tendency of similar people to become friends; this does suggests that work experiences in homogeneous work places can increase social capital.[113]

TJ Participant Survey: The TJ respondents indicated improvement on several measures of social capital, although these increases are not great. Spending time with friends decreased more than increased. This measure is difficult to analyze; spending less time with friends may indicate moving on in new, constructive ways or may mean increased isolation. Substantial numbers of respondents, however, reported improved ability to get along and communicate with others. These qualities, if not instrumental in obtaining a job, may be key to keeping one.

Figure 6a

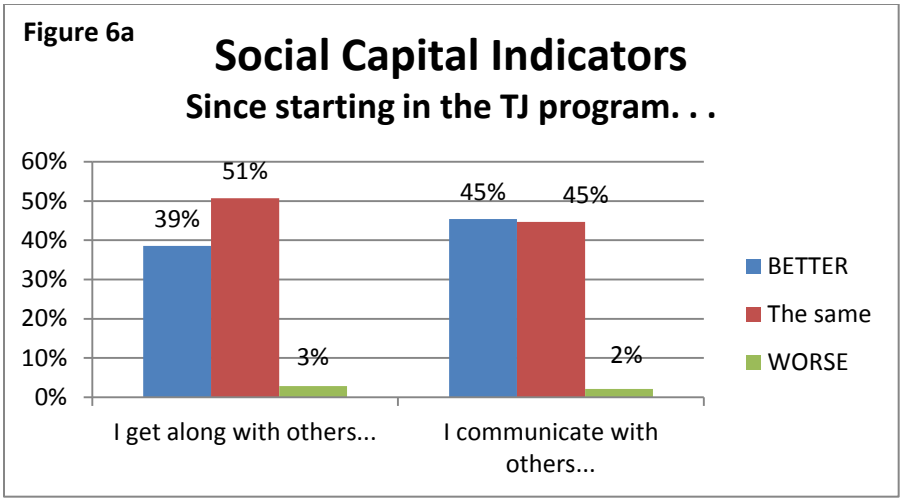
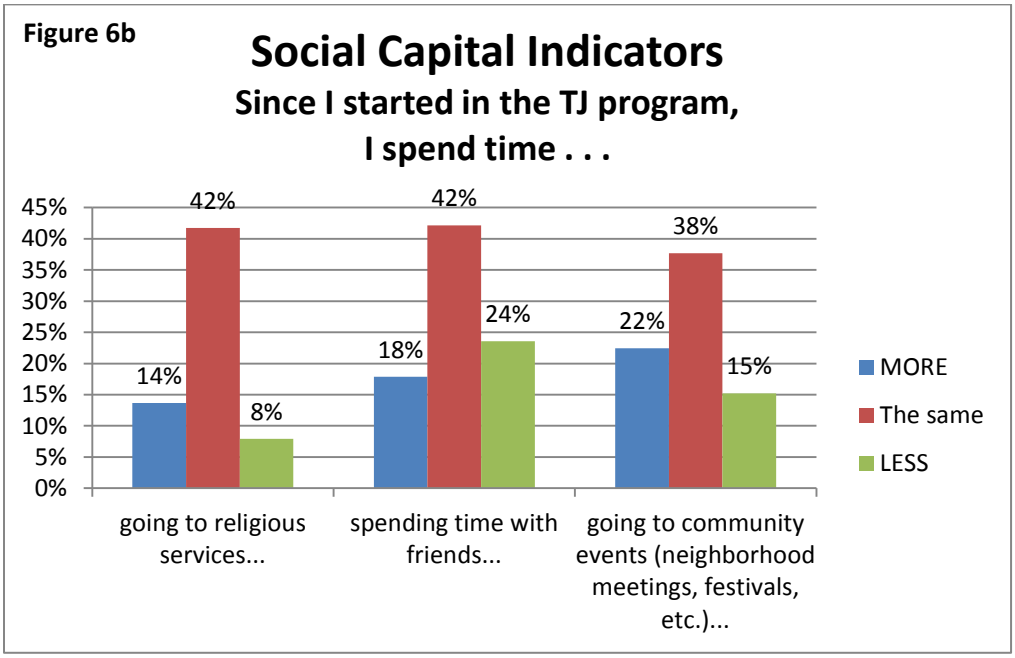


Figure 6b



Indicator G: Family Cohesion

Employment → **Family Cohesion** ⇢ **Health Outcomes**

Some Evidence. The literature review found some evidence linking family cohesion and employment status. There are a number of factors that contribute to family cohesion; in some cases, employment serves to stabilize and thus strengthen families.[114] However, when the employment does not provide stable and adequate income, or when work heavily spills over to home life, the effects are absent.[115] [116]

TJ Participant Survey:

STEP 1: *Employment to Indicator*

About one-fifth to one-quarter of the respondents reported increased engagement with children and families. The TJ Participant Survey also revealed some very positive academic effects for participants' children.

Figure 7

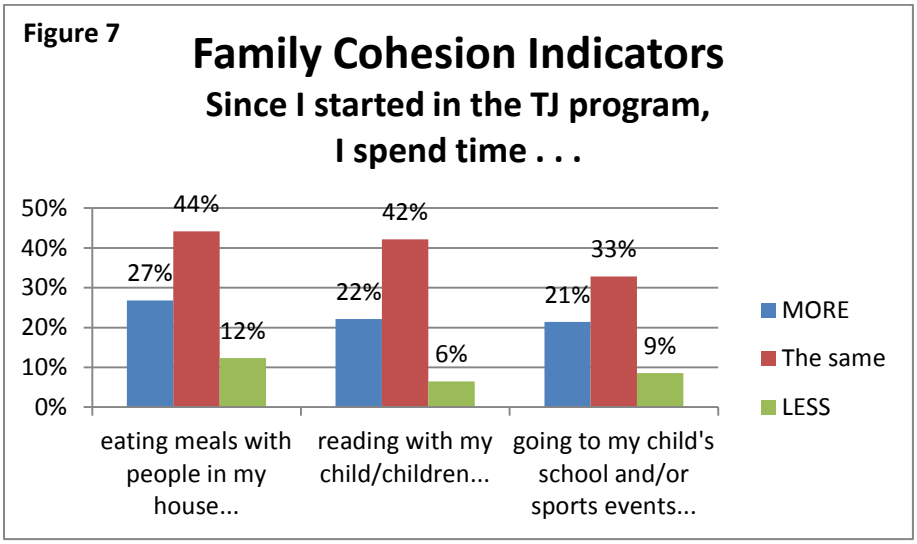


Figure 8

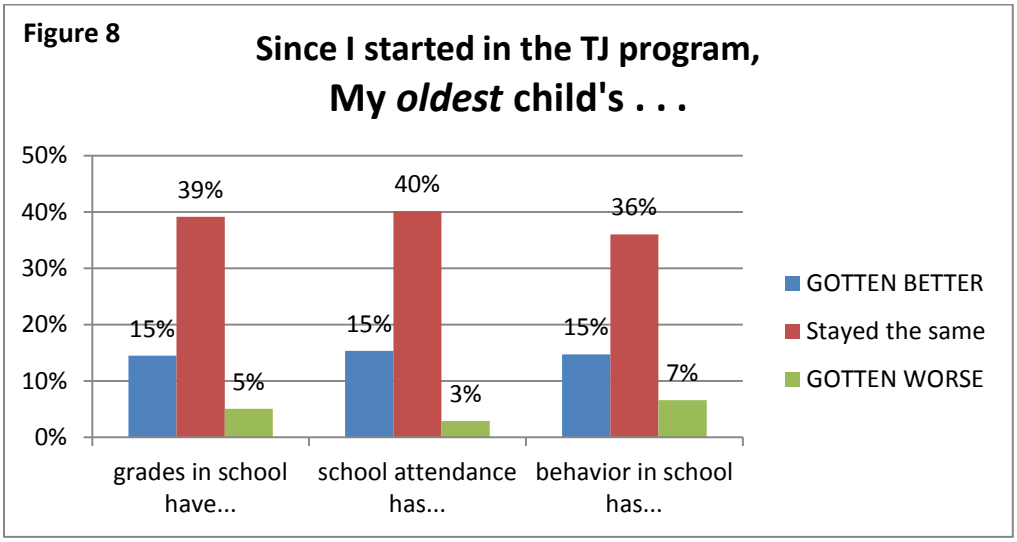
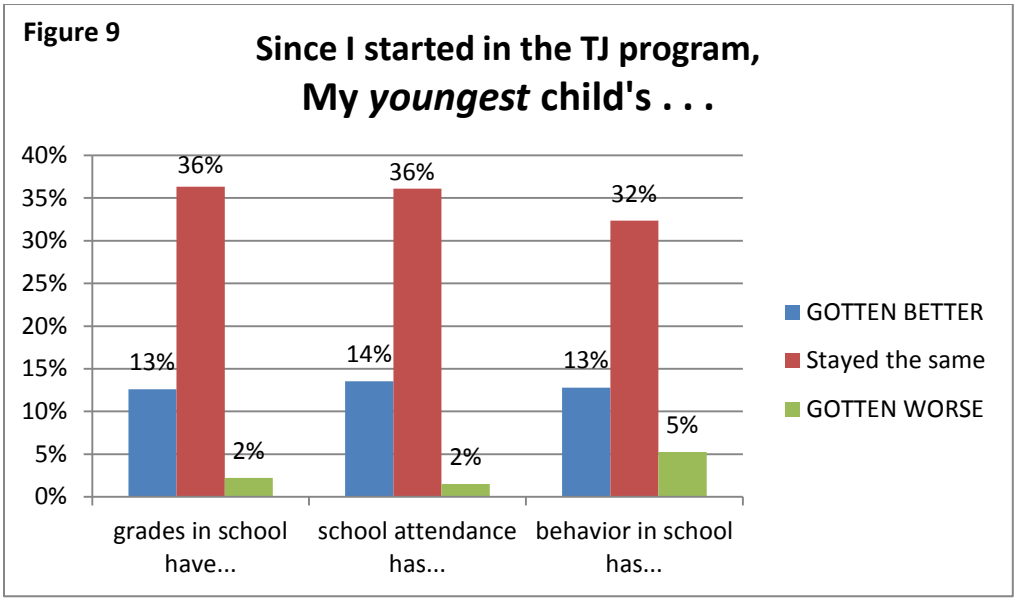


Figure 9



Indicator H: Child Maltreatment

Scientifically Supported.

Child maltreatment encompasses neglect and physical, sexual, and emotional abuse.[117] The literature review found scientifically supported evidence for a link between employment and child maltreatment. Unemployment stands among many causes and correlates of child abuse and maltreatment.[118] Unemployment of both men and women increases child abuse.[119] [120] [121] [122] The underlying causal mechanism, however, is still subject to debate. Family economic hardship and stress may either directly result in maltreatment or may work through other family characteristics associated with elevated risk for maltreatment.[123]

Summary of Employment to Immediate Health Indicators

Table 2 summarizes the strength of evidence in the literature linking employment to immediate health indicators. Additionally, it notes if the Wisconsin TJ participant surveyed indicated improvement on a particular measure. The third column presents available baseline data. Finally, the table shows the direction of change that could be expected should the TJ Demonstration Project become permanent.

STEP 1: *Employment to Indicator*

Table 4: Summary of Step 1
Employment to Health Indicator

Indicator	Literature	TJ Survey	Baseline Data	Maintain TJ Program at current level: Direction (effect on indicators)
A. Income	Scientifically Supported	NA	• 28.0% of unemployed live below 150% FPL* • 11.6% of employed live below 150% FPL*	+
B. Diet	Mixed Evidence	√	Average daily consumption of fruits and vegetables: • Unemployed below 150% FPL: o Fruit: 1.03 cups o Vegetables: 1.24 cups • Employed below 150% FPL: o Fruit: 1.05 cups o Vegetables: 1.40 cups Percent consuming 4+ fast food meals per week: • Unemployed below 150% FPL: 39.8% • Employed below 150% FPL: 41.8% Percent consuming 3 meals per day: • Unemployed below 150% FPL: 47.7% • Employed below 150% FPL: 41.2%	+/-
C. Alcohol/ Tobacco	Mixed Evidence	√	Considered heavy drinkers**: • Unemployed below 150% FPL: 11.0%* • Employed below 150% FPL: 25.9%* Current tobacco smokers: • Unemployed below 150% FPL: 44.5% • Employed below 150% FPL: 23.6%	+/-
D. Incarceration/Recidivism	Some Evidence	NA	Recidivism rates**: • at 1 year: 14.5% • at 2 years: 23.9% • at 3 years: 32.4% Faced incarceration in prior 12 months**: • Unemployed: 3.1%* • Employed: 1.1%*	+
E. Self-efficacy/ Social Capital	Some Evidence	√	N/A	+
G. Family Cohesion	Some Evidence	√	N/A	+
H. Child Maltreatment	Scientifically Supported	NA	In aggregate, the State of Wisconsin experiences 3.7 victimizations (neglect and/or abuse) per 1000 children per year.****	+

**This difference is considered significant at p<0.05*
*** Defined by the CDC as an average of 2 drinks/day for men and 1 drink/day for women*
**** Jones, M and Streveler, T. 2012, Recidivism After Release from Prison. Wisconsin Department of Justice.*
***** Wisconsin Child Abuse and Neglect Report (2011)*

STEP 2: *Indicator to Health Outcome*

Links from Indicators to Health Outcomes

This section reviews the literature linking the immediate health indicators to the health outcomes, and the strength of the link is assessed. It is organized by the eight indicators.

The indicators are:	**The health outcomes are:**
A. Income and poverty status B. Diet C. Alcohol and tobacco use D. Recidivism & incarceration E. Self-efficacy F. Social Capital G. Family Cohesion H. Children's maltreatment	• Chronic Disease • mental health • Domestic Violence • Birth Outcomes • Child Physical Health • Child Mental Health

Table 5: Evidence Rating Rubric*	
Scientifically Supported	Numerous studies or systematic review(s) with positive results
Some Evidence	Research suggests positive impacts; further study may be warranted
Expert Opinion	Recommended by credible groups; research evidence limited
Mixed Evidence	Evidence mixed
Insufficient Evidence	Evidence limited or unavailable
Evidence of Ineffectiveness	Research consistently shows detrimental or no effect

A. INCOME

Chronic Disease

Some Evidence. The evidence linking Income and Poverty and Chronic disease shows a link between the two factors; however the link appears to be rather weak. As one study notes, "In societies rich and poor, those of greater privilege tend to enjoy better health," however "privilege" has many dimensions which have different effects on health.[124] One such dimension

may lie in social capital: one study found that a reduction in social capital, which stems from income inequality, may negatively affect health.[125] Income was found to be one of three factors (along with health insurance and family background) that combined, accounted for about 30% of the "education gradient" which relates to health behaviors.[126] Finally, a systematic review of the literature found that while most studies did find a small, positive and statistically significant association between income and self-rated health (SRH), after controlling for confounders, this association was much reduced.[127]

Mental health

Scientifically Supported. The evidence clearly supports the link of income to mental health. Household income affects emotional well-being:[128] Low-SES and financial hardship are linked with depression;[129] [130] [131] lifetime mental disorders and suicide attempts are associated with low household incomes; and the risk for mental disorders increases with the occurrence of negative changes to household income.[132] [133]

Domestic Violence

Some evidence. Domestic violence has been associated in the literature with age, gender, socioeconomic status, race, culture, stress, neighborhood context, school factors, childhood experiences, peer influences, relationship factors, and psychological risk factors.[134] Both education and income have small inverse correlations with domestic violence; [135] [136] But, given the wide ranging nature of these studies and correlations, this evidence remains weak. Evidence linking domestic violence to unemployment, however, is quite strong. Unemployment leads to perceived loss of status, control, and power which all increase the likelihood of male domestic violence.[137] [138] [139] [140]

Birth Outcomes

Scientifically Supported. Strong evidence links mother's income with low birth weight and preterm birth.[141] [142] A systematic review showed that most reviewed studies found a significant association between low birth weight and income.[143] Another study found that both income and income inequality affect infant health outcomes in the United States. The health of the poorest infants, however, was affected more by absolute wealth than relative wealth. [144]

Child Physical Health

Scientifically Supported. The literature assessing income and poverty and child physical health is quite substantial and covers a variety of issues such as chronic conditions and health behaviors.

Child Mental Health

Scientifically supported. Depression and suicide attempt have been found to be associated along a gradient with income.[145] For example, household income and depressive symptoms were reported higher among children of lower-income, however, it appears that the family environment (meaning parental divorce/separation and perceived parental support) explains much of this association.[146]

B. DIET

Chronic Disease

Scientifically supported. Epidemiological and other evidence clearly concludes that many Americans have less than optimal diets and that improved nutrition could prevent chronic disease.[147] One review found substantial evidence from a variety of studies over the past several decades, including metabolic studies, prospective cohort studies, and clinical trials linking diet to coronary heart disease (CHD).[148] Another review that also looked at a variety of sources found that most chronic diseases in the world today can be linked to "inappropriate diet consumption" as well as physical inactivity.[149] Articles more specifically suggest that a higher intake of fruits and vegetables may protect against cardiovascular disease (CVD), coronary heart disease (CHD), stroke, cataract formation, chronic obstructive pulmonary disease (COPD), diverticulosis and hypertension.[150] [151]

Birth Outcomes

Scientifically supported. The literature connecting maternal diet to birth outcomes focuses on how deficiencies of certain nutrients are deleterious to the fetus. The Institute of Medicine,[152] as well as others, has extensively reviewed maternal diet affects birth outcomes.[153] [154]

Child Physical Health

Scientifically Supported. The literature finds a strong link between child dietary intake and child physical health, though usually in conjunction with child physical activity expenditures. Children who eat "empty calories" while also not expending sufficient calories through physical activity[155], and those who consume sugar-sweetened beverages[156], are more likely to be obese than other children.

C. ALCOHOL AND TOBACCO USE

Reduced Chronic Disease

Scientifically Supported. Lung cancer, almost always caused by smoking cigarettes, is the most frequent cause of cancer-related in the United States.[157] Smoking also causes other types of cancer such as cancer of the larynx, mouth and throat, esophagus, bladder, kidney, pancreas, cervix and stomach and also causes acute myeloid leukemia.[158]

Excessive alcohol consumption causes over 54 different diseases and injuries, including various cancers (mouth, throat, esophagus, liver, colon, and breast), liver diseases and cardiovascular, neurological, psychiatric and gastrointestinal chronic health problems.[159]

Tobacco use and excessive alcohol consumption are related to chronic diseases,[160] such as heart disease, stroke, cancer and diabetes, which are among the most common and preventable health problems in the United States.[161]

Improved mental health

Mixed Evidence. Studies have demonstrated that a link exists between mental health and alcohol and tobacco use and have documented that alcohol and tobacco use are higher among individuals exhibiting mental health issues.[162] [163] Also, dual substance abuse was noted in conjunction with higher rates of anxiety and affective disorders: use of tobacco was strongly associated with alcohol, cannabis and other substance abuse/dependence.[164] Smoking was specifically related to higher rates of psychosis, and smokers reported higher levels of psychological distress and disability than non-smokers/never smokers, while these differences were not explained about by demographic differences or other drug use.[165]

Domestic Violence

Scientifically Supported. Studies have found a strong relationship between intimate partner physical abuse and substance abuse as well as between parental substance abuse and child physical abuse. While many risk factors relate to partner domestic violence, women at greatest risk for injury from domestic violence include those with male partners who abuse alcohol or use drugs.[166] [167] [168] [169] Child physical abuse and sexual abuse are also significantly higher, with a more than twofold increased risk, among those reporting parental substance abuse histories.[170]

Improved Birth Outcomes

Scientifically Supported. Prenatal exposure to alcohol and tobacco results in negative birth outcome, including premature deliveries, sudden infant death syndrome, and decreased lung growth.[171] [172] [173] Birth outcomes resulting from prenatal exposure to alcohol includes infants born with significantly lower birth weights, height and head circumference and brain damage such as fetal alcohol syndrome.[174]

Child Physical Health

Scientifically Supported. Parental alcohol and tobacco use can negatively affect children's health in a number of ways, including through postnatal exposure to alcohol and tobacco[175] and through modeling which results in the increased likelihood of children using alcohol and tobacco.[176] [177]

Children of smokers are much more likely to have otitis media (ear infections), tonsillectomies or adenoidectomies, asthma, coughs, bronchitis, pneumonia and fire-related injuries as well as the longer-term effects of tobacco exposure that result in increased likelihood of lung and other forms of cancer, atherosclerosis and coronary heart disease.[178] Children of alcoholics have higher rates of hospital admissions due to injuries, poisonings and substance abuse.[179]

Finally, parental substance abuse may be the strongest factor in child substance abuse and appears to involve several mechanisms including physiology, genetics, psychology and environment.[180]

Child Mental Health

Scientifically supported. Many studies and reviews have found that parental drug use has a negative impact on children.[181] This negative impact has been particularly well documented for children of alcoholics.[182] The negative impacts include psychological consequences as well as

physical and cognitive consequences, and children of parents who abuse substances have higher rates of antisocial behavior, emotional problems, attention deficits and social isolation.[183]

D. RECIDIVISM & INCARCERATION

Chronic Disease

Scientifically Supported. Incarceration and recidivism are linked to chronic disease: more than 8 in 10 returning prisoners have chronic physical, mental, or substance abuse conditions. [184] One study on the topic found that having a more extensive criminal history was associated with higher rates of overall physical health problems.[185] The same study also found that offenders with more serious criminal histories were more likely to have received previous medical treatment in a hospital emergency room and to have received treatment for drug or alcohol abuse, though the emergency room treatment was not necessary for chronic disease treatment only.[186] Research conducted by the Urban Institute found that respondents (offenders) in their study typically had one or more chronic health conditions at the time of their release and that the majority of men and women in the study sample had chronic physical and mental health conditions at the time of their release from prison.[187]

Mental health

Scientifically Supported. There is a strong connection between mental health and incarceration and recidivism. Prison and jail populations at all levels (e.g., federal prisons, state prisons, local jails) experience much higher rates of mental health problems than does the general population. A report released by the Bureau of Justice (BOJ) demonstrates that in 2005, more than half of all prison and jail inmates had a mental health problem (meeting criteria in the DSM-IV).[188] The same report notes that among the general population, about 10% of the population in the U.S. over age 18 met these same criteria for mental health problems.[189]

Birth Outcomes

Scientifically Supported. The literature shows a connection between incarceration/recidivism and birth outcomes, though the connection may not be intuitive. Studies on the relationship between incarceration and birth outcomes have found that birth weights of infants born to mothers incarcerated at the time of birth and mothers never incarcerated were not significantly different. However, babies born to mothers incarcerated at some point other than childbirth gave birth to babies with much lower birth weights than women who gave birth in prison. [190] Another study looked at women who gave birth to children both while incarcerated and when not incarcerated found that the children born during incarceration had higher birth weights.[191] Certain aspects of incarceration (shelter, food, provision of medical care etc.) might actually be protective to infant birth weights for this particular population of women who have been incarcerated.[192] [193]

Child Mental Health

Scientifically Supported. One systematic review of forty studies on the associations between parental incarceration and children's later antisocial behavior, mental health problems, drug use, and educational performance found that the most rigorous studies did not associate

children's mental health issues with parental incarceration.[194] The meta-analysis did however find that parental incarceration is associated with children's anti-social behavior.[195]

E. SELF-EFFICACY

Chronic Disease

Scientifically Supported. Self-efficacy is linked to chronic disease management: people with greater self-efficacy are at an advantage in self-managing chronic disease and rehabilitation.[196] Self-efficacy also leads to increased healthy behaviors, thus minimizing health risks.[197] Controlled clinical trials suggests that programs teaching self-management skills, which increase self-efficacy, are more effective than information-only patient education in improving clinical outcomes.[198] [199]

Mental health

Scientifically Supported. There appears to be a relationship between self-efficacy and mental health status. One study reviewed found that adolescents with mental health issues, when using a self-efficacy scale, rated themselves more poorly than adolescents without mental health issues.[200] Another study on the topic found that empowerment, closely related to self-efficacy, was inversely related to use of mental health services.[201]

F. SOCIAL CAPITAL

Chronic Disease

Mixed evidence. Theoretically, social capital reflects social relationships that can contribute to awareness of health, health resources, and health improving behaviors. The evidence, however, connecting social capital to improvements in, or risk of chronic disease is slim.[202] [203]

Attempts at finding causal links between social capital and chronic disease risk factors and outcomes are few.[204] One study found results linking social networks with better self-reported health,[205] and an examination of social capital in the workplace found that men employed in places with higher social capital experienced reduced hypertension.[206] However, three other studies find little evidence that compiled measures of social capital contribute to better health outcomes in the UK;[207] [208] [209] To complicate the issue further, another study found two measures of social capital to have opposite influences on smoking and drinking behaviors.[210]

Mental health

Mixed Evidence. Social Capital is reported to have strong associations with health and health behaviors;[211] however, attempts at finding causal links between social capital and health outcomes are few, often suffering from the shortcomings of cross-sectional designs, recall bias,

and correlations.[212] [213] Two studies reviewing the literature relating social capital to mental health;[214] [215] affirm that social capital can contribute to better mental health in adults and children. Later evidence finds that self-rated health is predicted by neighborhood social capital even after controlling for demographics and income,[216] while social capital, and the broader concept of social cohesion, contributed to improved mental health.[217] However, the evidence that social capital mediates mental health is often obscured by demographic or income characteristics and individuals' perceptions of the social capital in their environment.[218] [219]

Child Physical Health

Some Evidence. Socioeconomic conditions[220] and measures of social capital are associated with children's general and mental health.[221] One study found that increases in social capital (indexed measure of efficacy, neighborhood cohesion, and sense of community) reduced the risk of children suffering maltreatment, itself a predictor of poor health throughout the lifespan. [222] [223] Networks within which children and adolescents exist, however, can have both health positive and health negative impacts. Peer impact, for example, may promote substance use while family attachment and youth activities may deter it. [224]

Child Mental Health

Some Evidence. Studies that have examined how social capital is reflected in children's health and educational outcomes suggest the effect is positive on behavior problems. One study finds black youth in areas with higher social capital have reduced fear of calamity and diminished depression symptoms and that higher social capital in the communities makes up for lower levels of family social support.[225]

G. FAMILY COHESION

Chronic Disease

Scientifically Supported. The family is a major source of both stress and social supports, both of which affect health.[226] A systematic review that looked at studies on family cohesion and chronic disease found that, in general, social support from family members affects chronic illness outcomes.[227] The review found that better patient outcomes were associated with family cohesion, whereas negative health outcomes were associated with behaviors that demonstrate a lack of family cohesion such as critical, overprotective, controlling and distracting family responses.[228]

Mental health

Scientifically Supported. Families that lack cohesion are characterized by conflict and aggression and/or by relationships that are cold, unsupportive, and neglectful. Studies find that family cohesion during childhood affects both childhood mental health as well as mental health over the lifespan of an individual.[229] [230]

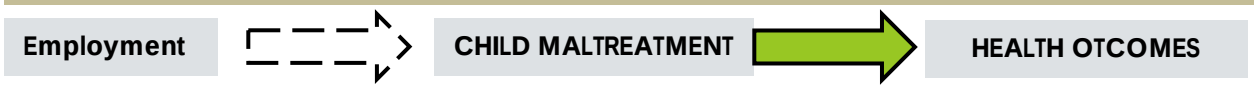
Child Physical Health

Scientifically Supported. Families that lack cohesion are characterized by conflict and aggression and by relationships that are cold, unsupportive, and neglectful.[231] This type of family environment creates vulnerabilities and/or interacts with genetically based vulnerabilities in children that can negatively affect stress-responsive biological regulatory systems, including sympathetic-adrenomedullary and hypothalamic–pituitary–adrenocortical functioning, and poor health behaviors.[232] One meta-analysis found that family is the major source of both stress and social supports, both of which affect physical health. [233] However, another meta-analysis that reviewed the literature on social support and physical health found that evidence supporting the link between social support and physical health more modest than previously thought. [234] All of the studies agree that childhood family environments play an important role in affecting physical health across the life span.[235]

Child Mental Health

Scientifically Supported: Families that lack cohesion are characterized by conflict and aggression and/or by relationships that are cold, unsupportive, and neglectful.[236] This type of family environment creates vulnerabilities and/or interacts with genetically based vulnerabilities in children that can negatively affect psychosocial functioning such as emotional processing and social competence.[237] [238] Studies find that family cohesion during childhood affects both childhood mental health as well as mental health over the lifespan of an individual.

H. CHILD MALTREATMENT



Child Physical Health

Scientifically Supported. Child maltreatment is associated with a broad range of adverse physical health outcomes, [239] as well as behaviors that increase risk for such outcomes.[240] The adverse health effects of child maltreatment manifest in childhood and in later life.[241] [242]

Child Mental Health

Scientifically supported. Without question, emotional, physical, and/or sexual abuse of children affects their mental and physical health both during their childhood and into their adult lives. One study noted that noticeably higher rates of major depression in children and adolescents are associated with child abuse and maltreatment.[243] Another study notes that among victims of child maltreatment, psychological problems are prevalent and often manifest in aggressive behaviors towards both adults and peers, present problems with peer relationships, and children who have experienced childhood maltreatment have less capacity for empathy towards others.[244] Yet another study reports that adolescents who had a history of childhood maltreatment were three times more likely to be suicidal and or become depressed in adolescence compared to adolescents who did not have a similar history of childhood maltreatment.[245]

SUMMARY: COMPREHENSIVE IMPACT ANALYSIS

This section summarizes all data collected and offers predictions about the likelihood, direction and magnitude of change under different policy scenarios. Additionally, it looks at potentially different impacts for different sub-populations of participants.

Impact Assessment: Direction and Magnitude

In Steps One and Two of this assessment, the strength of the literature for each partial pathway -- from employment to health indicator and then from indicator to health outcomes – was evaluated. In this analysis the two separate sets of evidence are combined to assess the likely impact of the TJ Program on Health Outcomes along the full pathway

A detailed discussion of the method by which this was done is available in Appendix 3.

Likelihood:

The categories of likelihood are as follows:

Table 6: Likelihood Effect Characterizations*	
Very Likely	Adequate evidence for a causal and generalizable effect
Likely	Logically plausible effect with substantial and consistent supporting evidence and substantial uncertainties
Possible	Logically plausible effect with limited or uncertain supporting evidence
Unlikely	Logically implausible effect; substantial evidence against mechanism of effect
* from: Health Impact Assessment: A Guide for Practice	

Direction and Magnitude:

A positive (+) or a negative (-) impact on each health outcome is anticipated for each of the following scenarios:

- Non-renewal of the TJ program;
- Contraction of the TJ program to serve fewer people;
- Maintain the program at its current level – this is the status quo option; or
- Expand the program to serve more people

The actual number of people affected will depend on the number of people actually enrolled in the program under each potential policy scenario. Relative magnitude of the impacts is indicated by the number of positive (+) or negative (-) signs. The more people who are enrolled, the greater the impact (either positive or negative). Although the evidence of health benefits is mixed on some individual indicators, and could result in negative benefit, on balance our analysis suggests positive health outcomes overall. Only if the program were ended altogether would there most likely be a negative health impact as no new participants would benefit from the program. Under all the other policy scenarios the health impacts would be positive. Even under a program reduced from its current size, there would be new enrollees to experience the program's health benefits, where they exist. The health impact would be larger, however, if the

program were maintained at its current level. The benefits could potentially be larger still if the program were expanded to serve more people. Additionally, positive impacts could be exponential as the families of program participants also benefit. However, positive impacts may be diluted as the program is extended to larger groups of eligible participants, as there may be qualitative differences between those in the program and those not currently participating: later entrants may face greater challenges than current participants, may be less employable, or be in worse health.

Duration:

Estimating the duration of health benefits is beyond the scope of this analysis. Evaluations of other TJ programs, however, indicate that employment and income benefits fade over time. The New Hope project suggests that benefits to families may be lasting.[246] This is an area that clearly warrants further research.

Table 2 (also found on pg. 4)

Direction and Magnitude of Impact on Health Outcomes					
Health Outcome	**Likelihood**	**Non-renewal** of the TJ program	**Contraction** of the TJ program	**Maintain program at current level (status quo)**	**Expansion** of the TJ Program
Chronic Disease *	Likely	-	+/-	++/-	+++/-
Mental Health **	Likely	-	+/-	++/-	+++/-
Domestic Violence	Likely	-	+	++	+++
Birth Outcomes	Likely	-	+	++	+++
Child Physical Health	Likely	-	+	++	+++
Child Mental Health **	Likely	-	+	++	+++

*Literature suggests that if employment involves occupational hazards physical health can be negatively impacted.

**Literature suggests that unstable employment or employment that creates work/family imbalances may have a negative impact on mental health.

Impact on different sub-populations:

An analysis of the TJ Participant Survey data found the TJ program had impacts for greater numbers of men, blacks, and those with less education. There were too few veterans to determine any distinctions. Detailed findings of this analysis may be found in Tables 7-9 in Appendix 4.

Gender

Although both men and women reported improved health behaviors and improvements on indicators of family and social cohesion, men more frequently reported improvement. This was especially true in the area of family cohesion and improved children's educational outcomes. For instance, 25% of women, but 42% of men, reported spending more time reading with their children. 20% of women increased the amount of time they spent attending school and other functions with their children; 51% of men said they spent increased time in these activities. Children's behavior in school improved for 13% of women, but improved for 38% of the men. It may be that more women engaged in these activities before starting the TJ program and thus had less room for improvement. Nonetheless, the impacts for fathers (and the benefits for their families) are notable.

Race

Results are only reported for whites and blacks; other groups were too small to determine meaningful differences. Blacks more frequently reported improvements in measures of family cohesion: 38% spent more time reading with their children, versus 25% of whites; and 46% of blacks reported increased attendance at school events, versus 19% of whites. More blacks reported that their children's grades improved (40%) than whites did (13%). Most striking is the marked improvement in indicators of social capital. Blacks reported they attended religious events more (35%) than whites (9%); attended community events more (45% versus 23%), and spent more time with friends (25% versus 19%) since starting in the TJ program.

Education

The relationship of education to outcome in this program is less distinct than in the cases of gender and race. On some measures, those with less education more often reported improvement. On other measures, those with high school degrees did so. In general, those with more than a high school education (an associates or college degree) less frequently reported improvements. This may be because a higher percentage of them were already engaging in the measured behaviors.

Previously Incarcerated

- No differences were observed in health indicators between those who had been incarcerated and the larger population.
- One very notable exception is employment status. Those previously incarcerated were 9% more likely to be unemployed post-program than the larger group of survey respondents. This would be a current unemployment rate of 45% for the surveyed

population. However, unemployment among previously incarcerated New Yorkers was 60% in 2006.[247] In this context, the TJ program appears extremely successful and placing this difficult-to-employ population.

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Section VI: Recommendations

Goals of a Transitional Jobs Program and HIA:

The Wisconsin TJ program began during an economic downturn. Some supporters saw it as a way to provide temporary jobs to large numbers of individuals who would otherwise be unemployed, or as a way to help businesses weather the economic downturn. However, the larger goal of Transitional Jobs program is to provide individuals who have employment barriers with paid employment experiences, training, and personal supports, to connect them to the labor force and then find *permanent, unsubsidized* employment. The best measures of TJ program success – and the goals for policymakers -- are

1. The number of people placed in temporary jobs and,
2. The number who find unsubsidized employment when the temporary job ends.[1]

The goal of the TJ HIA was to identify potential health impacts and to make recommendations that can increase positive health outcomes and decrease or mitigate negative health outcomes.

Identified Impacts:

On health indicators:

Positive Impacts: The analysis found that the TJ program has positive impacts on the following health indicators:

- Income
- Self-efficacy
- Social capital
- Family Cohesion **
- Recidivism
- Child Maltreatment

Possible Impacts: The literature shows mixed evidence of impacts to other health indicators, but the TJ participant survey conducted for this study show positive impacts for:

- Alcohol use **
- Tobacco use **
- Diet**
- Exercise

To health outcomes:

A comprehensive assessment of the data support the conclusions that the impact of the TJ program on the following health indicators are **LIKELY and POSITIVE:**

- Chronic Disease *
- Mental Health **
- Domestic Violence
- Birth Outcomes
- Children's Physical Health

- Children's Mental Health**

* Employment that is dangerous or with occupational hazards can negatively impact physical health.
** Literature suggests that employment that is unstable, demeaning, or creates work/life imbalance can be stressful and negatively impact these health factors.

Impacts more frequent for the following populations:

- Men / Fathers
- Blacks
- Those with less than post High School education

PROCESS FOR FORMULATING RECOMMENDATIONS: Three recommendations emerged directly from the analysis. Additionally, stakeholders and TJ program experts and advocates provided ideas for legislators, state agencies, and contractors for ways to implement these recommendations.

Recommendations:

Recommendation 1:

- *Extend opportunities for participation in the program to the largest potential pool of persons eligible.*

The analysis revealed a host of positive health impacts, suggesting that expanding the TJ program may increase the magnitude of these health benefits.

However, simply expanding the TJ program for more people is not alone sufficient to realize lasting health benefits. The literature suggests that many of employment's positive effects on stress, children's physical and mental health, and family cohesion are undermined or even reversed when employment is unstable (and income inadequate). The literature on TJ evaluations also shows that employment wanes over time.

Recommendation 2:

- *Focus on creating lasting employment outcomes for participants after subsidized employment ends.*

An important caveat to keep in mind: The two recommendations may, at some point conflict. Opening the program to the greatest number of people may draw in those with even greater barriers to long-term employment. Diminishing returns could result in a lower percentage of program recipients receiving long-term benefits, even as the absolute numbers of participants aided increases.

Recommendation 3:

- *Assure priority in the TJ program to applicants with children, while not making parenthood an eligibility requirement of the program.*

Many of the positive health impacts stemming from participation in the TJ program actually accrue to participants' families, especially children. Current use of TANF funds to finance the program requires that all participants over age 25 are parents. An alternative funding source for the program could prompt reconsideration of this eligibility requirement. The program benefits for children support a policy that focuses on parents. Such a policy, however, clearly discriminates against childless adults who are otherwise suitable for the program. A policy that balances the needs of both groups is warranted.

Implementation ideas:

For Legislators

To impact the largest number of people:

- Increase the threshold household income from 150% FPL to provide a safety net for a wider group of needy families.[2]
- Eliminate the requirement that participants be ineligible for Unemployment Insurance (UI) benefits.
- Provide additional incentives to employers who can hire large groups of workers.

To improve the employability of participants past the subsidy period:

- Impose minimal expectations on employers regarding continued employment after the subsidy ends.
- Provide additional incentives for growing industries to accept TJ workers. These should be industries where participants are not in direct competition with large numbers of displaced workers with more experience (e.g. workers from other industries, but with transferable skills). [3]
- Provide less than 100% subsidies (or phase them out over time) in order to target subsidies at employers that are more invested in workers and able to keep them at the end of the subsidy period. All attempts should be made to do this without increasing red tape for participating employers.
- Provide subsidies for higher maximum wages to open a larger pool of employment opportunities; these jobs are more likely to provide benefits and advancement opportunities. [4]
- In certain circumstances, consider providing incentives for placements that last beyond the subsidy period.

For Implementing Agencies

Research needs:

Lack of data, or of data compatible across programs, is a significant obstacle to understanding key factors of the current program that could be used in program improvement. Data

collection is a priority recommendation. The evaluation literature of other TJ programs as well as the survey participant data suggests programs may have different impacts on people based on different characteristics such as gender, previous employment history, incarceration history, etc.

- Direct contractors to collect data on key health indicators from TJ participants at the beginning and end of the program and after a suitable follow-up period.
- To assure data consistency and compatibility, require a single data collection instrument and software package.
- Conduct an evaluation of Wisconsin's program that stratifies outcomes based on sets of participant characteristics.

To improve the employability of participants past the subsidy period:

Literature suggests that the income and employment benefits of TJ programs wane over time, but also suggest that this may vary depending upon the quality/relevance of training participants receive, and the likelihood that the subsidized worker will be incorporated into the employers' unsubsidized workforce.

- Require training in skills for which there is a demonstrated market demand in the program area.
- Evaluate the program outcomes for participants based upon the sector of job placement: for-profit, non-profit, and governmental.
- Select mature contractors with good connections to employers, social services, and training opportunities in the area.

For Contractors

To improve the employability of participants past the subsidy period:

- Develop a job placement strategy that assures the best matches between employers and employees.
    - Target placements to employers that can 1): reasonably expect to continue jobs for participants, and ask for a commitment to do so, and/or 2): provide significant training opportunities in skills in demand in the local market.
    - Identify ways to leverage TJ participants' work experience into credentials, references, and work-readiness certificates.

***To mitigate negative health consequences*:**

- Check all employers participating in the TJ program for recent OSHA inspection.

- Include training and supports on work/family balance and stress management.

CONCLUDING REMARKS

Transitional Jobs programs have the potential to improve the physical and mental health of participants and their families. Further evaluation is needed to determine how long these benefits last and if they persist only under conditions of stable and lasting employment. Implementing agencies should make a priority the on-going collection of participant data on key health indicators and health outcomes.

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[1] We have relied heavily on the lessons for program design and implementation drawn from a survey of how different states structured their TJ programs using TANF emergency funds.
Pavetti L, Schott L, Lower-Basch E. February, 2011. Creating Subsidized Employment Opportunities for Low-Income Parents: The Legacy of the TANF Emergency Fund. http://www.cbpp.org/cms/index.cfm?fa=view&id=3400

[2] Ten states set income limits at or below 200% FPL and six states set limits above 200% FPL.

[3] For example, New York used the TANF EF to create training and employment opportunities for green jobs and health careers. Pavetti, Creating Subsidized Employment.

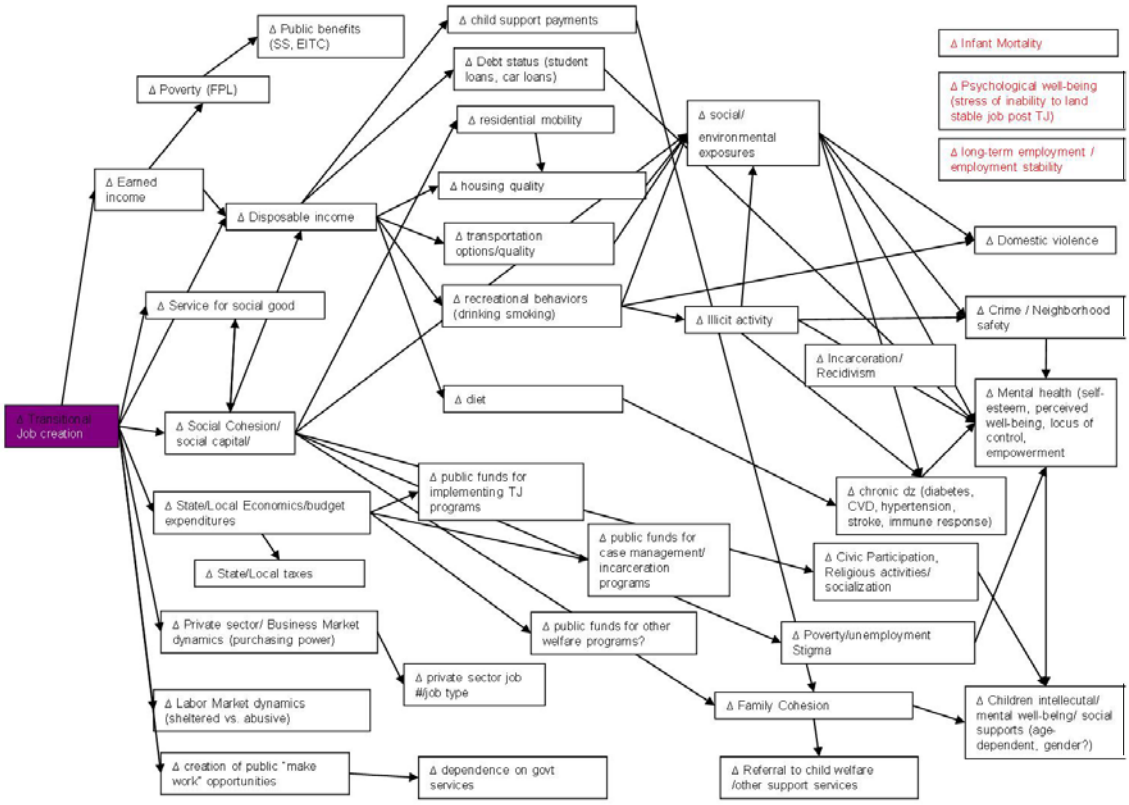
[4] Maryland created a career advancement program that uses wage subsidies to encourage employers to hire low-income individuals as trainees in entry-level jobs that have higher starting wages (usually between $10 and $12 per hour) and the potential for career growth. Pavetti, Creating Subsidized Employment.

APPENDIX 1

SCOPING METHOD AND DATA SOURCES

Search Methods:
The preliminary literature search covered the web of hypothesized pathways (Figure 10) connecting the transitional jobs program to various measures of adult and child health. Evaluations of other transitional jobs programs were examined for any indications of health outcomes as well as peer reviewed literature that more generally considered the role of employment and employment-related intermediate outcomes on various measures of health.

Figure 10



The first – and immediate pathway –investigated was how employment directly affects health. For this pathway, direct outcomes considered included the mental and physical health of participants' children; employment's dynamic in domestic violence; chronic disease; the adults' mental health; and birth outcomes. Given the high rate of infant mortality in Milwaukee, birth

outcomes was of especial interest to project stakeholders. The next set of pathways involved a two-step investigation: first, connecting employment to a direct, but intermediate outcome and then connecting that intermediate outcomes with the final health outcomes listed above.

Literature reviews for each of the pathways in the research questions were conducted using Google Scholar, PubMed, and the websites of consultants who had conducted evaluations of other TJ programs over the years (MDRC, Urban Institute, Mathematica Policy Research). Titles and abstracts of search results were read to exclude irrelevant literature; remaining literature was graded by type of research (meta-analysis, quasi-experimental design, controlled study, non-experimental program report) and by the strength of the results [irrespective of direction; strong, weak, neutral]. Citations in studies and reports deemed relevant provided additional opportunity to increase the number of relevant articles.

Figure 11 represents the results of the literature review, reflecting the ratings of the quality and strength of the evidence. Meta-analyses were given the greatest weight; non-experimental program reports were given the least. Strong evidence (two arrows up or down) indicate meta-analysis demonstrating that the effects are consistently in one direction or indicate multiple experimental evaluations have shown strong evidence. Some evidence (one arrow up or down) indicate a meta-analysis with weak effects or several experimental designs with some, but not conclusive, evidence of an effect. Arrows to the right and left indicate no meta-analyses were found and the experimental studies available demonstrate the effects were insignificant, weak, or were difficult to analyze.

Figure 11

		Strength of Relationship from Employment to Health Impacts					
				(Adult participant in employment)			
		Children's and/or Dependent's Mental Health	Children's and/or Dependent's Physical Health	Domestic Violence	Birth Outcomes	Chronic Disease	Mental Health
Employment		▲▲	▲▲	▼▼	◄►	◄►	▲▲
Intermediate	Strength of Relationship: Employment to Intermediate	Strength of Relationship from Intermediate to Health Impacts					
Income	▲	▲▲	▲▲	▲▲	▲	◄►	▲▲
Poverty	▼	▼▼	▼▼	▲▲	▼▼	◄►	▼▼
Diet	◄►	▲▲	▲▲	n/a	▲▲	▲▲	▲
Incarceration/Recidivism	▼	▼▼	n/a	n/a	▼▼	▼▼	▼▼
Alcohol and Tobacco Use	◄►	▼▼	▼▼	▼▼	▼▼	▼▼	◄►
Self Efficacy	◄►	n/a	n/a	◄►	◄►	▲▲	▲▲
Social Capital	◄►	▲▲	▲▲	▲	◄►	▲▲	▲▲
Family Cohesion	▲	▲▲	▲▲	n/a	◄►	▲▲	▲▲
Children's Maltreatment	▼▼	▼▼	▼▼	▲▲	n/a	n/a	n/a

Key: ▲▲ Strong positive connection; ▲ Some positive connection; ▼ Some negative connection; ▼▼ Strong negative connection; n/a the relationship is either not relevant or the relationship appears to be unexplored

A number of data gaps appeared in the process of conducting the literature review, particularly concerning the link between employment and intermediate health indicators.

In some instances, we elected to include relevant questions about these intermediate indicators in the survey distributed to TJ program participants to see if the program had prompted any relevant changes. Specifically, literature linking employment to individual's or a community's social capital was inconclusive or suggested non-effects; however, because social capital has been repeatedly linked to better health, participant surveys included questions asking about indicators of social capital.

In other instances, we simply excluded mention of the intermediate from further analysis and dropped it from the report. These intermediates included transportation options, individual and neighborhood housing quality, housing mobility, illegal substance use, and negative social and environmental exposures. After examining the aggregate effects of employment on these intermediate indicators, especially for those moving in and out of unemployment or those bouncing around the lower rungs of the poverty scale, we found little support for employment having some or a strong connection with them.

APPENDIX 2:
Transitional Jobs Participant Survey

These first questions ask about your experience in the Transitional Jobs (TJ) program.

1. Where are you participating/did you participate in the Transitional Jobs (TJ) program?

- ☐ Community Action, Inc. of Rock and Walworth Counties
- ☐ Forward Service Corporation (Green Bay area/Brown County)
- ☐ Goodwill Industries of Southeastern WI (Milwaukee and Kenosha) - *WorkNOW Program*
- ☐ Indianhead Community Action Agency, Inc.
- ☐ Lakeshore Consortium / Health & Human Services (Sheboygan and Manitowoc Counties)
- ☐ Milwaukee Area Workforce Investment Board
- ☐ Milwaukee Careers Cooperative
- ☐ Northwest Wisconsin Concentrated Employment
- ☐ Policy Studies, Inc. / MAXIMUS
- ☐ Racine County Human Services Dept. / Express Professionals Staffing
- ☐ Silver Spring Neighborhood Center
- ☐ Social Development Commission (Milwaukee)
- ☐ Step Industries (Milwaukee and Neenah)
- ☐ United Migrant Opportunity Services (UMOS) *U-STEP Program*
- ☐ Workforce Connections, Inc. (La Crosse)
- ☐ Workforce Development Board of South Central WI
- ☐ Workforce Resource, Inc.
- ☐ W-O-W (Waukesha-Ozaukee-Washington) Workforce Development, Inc. *T.A.P.E. (Transitioning Adults into Permanent Employment) Program*
- ☐ YWCA (Milwaukee)
- ☐ Other – Please specify:

2. What is your current employment status?

- ☐ Working in a transitional job
- ☐ Transitional job ended and now employed in a job with the **same TJ employer**
- ☐ Transitional job ended and now employed in a job with a **different employer**
- ☐ Unemployed

3. How long have you worked or did you work in your transitional job?

- ☐ Less than 1 month
- ☐ 1-2 months
- ☐ 3-5 months
- ☐ 6 months
- ☐ More than 6 months

4. Which of the following education and training activities did you participate in through the TJ program? (check all that apply)

- ☐ Career assessment
- ☐ Resume writing
- ☐ Job search strategies (e.g. networking, interviewing, looking for jobs, completing applications)
- ☐ National Career Readiness Certification (NCRC) training and testing
- ☐ Basic mathematics and/or reading skills instruction
- ☐ GED / High School Equivalency educational instruction
- ☐ English as a Second Language (ESL)
- ☐ Computer training
- ☐ Other specialized occupational skills training
- ☐ College courses
- ☐ Parenting class(es)
- ☐ Financial literacy instruction
- ☐ Other life skills instruction

5. Which of the following support services did you receive from the TJ program? (check all that apply)

- ☐ Transportation (e.g. bus vouchers, shuttle service payment, car repair or insurance aid, etc.)
- ☐ Help in getting or recovering a driver's license
- ☐ Work clothing
- ☐ Work tools (e.g. construction tools)
- ☐ Childcare assistance
- ☐ Food subsidy (e.g. food pantry, referral to FoodShare, etc.)
- ☐ Housing (e.g. shelter arrangements, rent or deposit aid, home buyer education, etc.)
- ☐ Personal counseling
- ☐ Drug/alcohol counseling
- ☐ Credit counseling
- ☐ Legal assistance (e.g., help with child support debt)

The next questions ask you to compare how things were before you started in the Transitional Jobs program and how things are now.

6. Since I started in the TJ program...

	A lot more	A little more	The same	A little less	A lot less	Does Not Apply
I eat fruits and vegetables...	☐	☐	☐	☐	☐	☐
I eat fast food (McDonalds, Burger King, etc.)...	☐	☐	☐	☐	☐	☐
I eat three meals each day...	☐	☐	☐	☐	☐	☐
I exercise...	☐	☐	☐	☐	☐	☐
I have trouble falling or staying asleep...	☐	☐	☐	☐	☐	☐
I use tobacco (cigarettes, snuff, etc.)...	☐	☐	☐	☐	☐	☐

I drink alcohol (beer, wine, hard liquor)...	☐	☐	☐	☐	☐	☐

7A. Since I started in the TJ program, my *oldest* school-age child's...

	Gotten a lot better	Gotten a little better	Stayed the same	Gotten a little worse	Gotten a lot worse	Does Not Apply
grades in school have...	☐	☐	☐	☐	☐	☐
school attendance has...	☐	☐	☐	☐	☐	☐
behavior in school has...	☐	☐	☐	☐	☐	☐

7B. Since I started in the TJ program, my *youngest* school-age child's...

	Gotten a lot better	Gotten a little better	Stayed the same	Gotten a little worse	Gotten a lot worse	Does Not Apply
grades in school have...	☐	☐	☐	☐	☐	☐
school attendance has...	☐	☐	☐	☐	☐	☐
behavior in school has...	☐	☐	☐	☐	☐	☐

8. Since I started in the TJ program, I spend time…

	A lot more often	A little more often	The same	A little less often	A lot less often	Does Not Apply
eating meals with people in my house...	☐	☐	☐	☐	☐	☐
reading with my child/children...	☐	☐	☐	☐	☐	☐
going to my child's school and/or sports events...	☐	☐	☐	☐	☐	☐
going to religious services...	☐	☐	☐	☐	☐	☐
spending time with friends...	☐	☐	☐	☐	☐	☐
going to community events (neighborhood meetings, festivals, etc.)...	☐	☐	☐	☐	☐	☐

9. Since I started in the TJ program...

	A lot better	A little better	The same	A little worse	A lot worse	Does Not Apply
I get along with others...	☐	☐	☐	☐	☐	☐
I communicate with others...	☐	☐	☐	☐	☐	☐

10. Since I started in the TJ program, I feel…

	A lot more	A little more	The same	A little less	A lot less
hopeful for the future…	☐	☐	☐	☐	☐
depressed or anxious…	☐	☐	☐	☐	☐
in control of my life…	☐	☐	☐	☐	☐
calm and peaceful…	☐	☐	☐	☐	☐
confident about applying for jobs…	☐	☐	☐	☐	☐

11. Since the TJ program, I... (check all that apply)

- ☐ Have a better sense of direction with my career planning.
- ☐ Have a current resume to use for job searches.
- ☐ Am more confident about my job search abilities.
- ☐ Have been successful in securing employment after the transitional job ended (if applicable).
- ☐ Obtained new certification or increased my certification level of the National Career Readiness Certification (NCRC)
- ☐ Improved my math or reading skills
- ☐ Earned my GED / High School Equivalency
- ☐ Increased my English language proficiency level
- ☐ Earned computer related certification(s) (e.g. Microsoft Office certification or other software certifications)
- ☐ Earned occupational skills certification
- ☐ Completed a college course
- ☐ Completed a college degree
- ☐ Increased my financial savings
- ☐ Decreased my financial debt

12. Are any other changes we have not asked about? Please tell us about them here.

The last few questions will help us get to know you a little better.

13. What is your age? ☐

14. What is your gender?

☐ Male ☐ Female

15. Are you of Hispanic, Latino, or Spanish descent?

☐ Yes ☐ No

16. Which of the following best describes you? Please check all that apply.

- ☐ White
- ☐ Black/African American
- ☐ American Indian or Alaska Native
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ Asian
- ☐ Something else, please specify: _____

17. What is your current marital status?

- ☐ Married
- ☐ Separated
- ☐ Divorced
- ☐ Widowed
- ☐ Never Married

		Yes	No
18.	**Have you ever served on active duty in the US Armed Forces, military reserves, or National Guard?**	☐	☐
19.	**Have you been incarcerated within the last 5 years?**	☐	☐
20.	**How many other persons (both adults and children) do you currently live with?**	☐	☐
21.	**How many of your children under the age of 18 are currently living with you?**	☐	☐
22.	**How many of your children under the age of 18 are not currently living with you?**	☐	☐
23.	**Do you provide child support for any of your children not living with you?**	☐	☐
24.	**How many times have you moved (changed residences) in the past year?**	☐	☐

25. What is the highest level of education that you completed before entering the TJ program?

- ☐ Bachelor's Degree or higher
- ☐ Associate's Degree
- ☐ High School Diploma or GED
- ☐ Less than High School Diploma or GED

Thank you for your time.

Please return the completed survey

By OCTOBER 18 in the postage-paid envelope provided.

APPENDIX 3

Assessing the Likelihood of Impact: Putting Steps One and Two Together

There are many ways to score impacts. We designed a method employing high quality and widely used templates. It is not intended to suggest quantitative certainty, but rather to provide transparency and internal consistency.

In Steps One and Two of the assessment, the strength of the literature for each partial pathway -- from employment to health indicator and then from indicator to health outcomes – was evaluated. Here these two separate sets of evidence are recapped and combined to make visible the full pathway.

This is done through a simple process of assigning a numerical score based upon the quality of the supporting evidence (see Table 5 below) and then adding across the pathway to produce a combined score.

To take into account the primary data collected from TJ participants themselves, additional points are added to the initial pathway scores where the survey data adds value to the published evidence. These additional points, based on the strength of the data, are as follows:

TJ Participant Survey Score	
Diet	.25
Alcohol/Tobacco	.25
Social Cohesion	.25
Self-efficacy/Social Capital	.5
Family Cohesion	.5

Table 5: Evidence Rating* (also see pg. 37)		Score
Scientifically Supported	Numerous studies or systematic review(s) with positive results	4
Some Evidence	Research suggests positive impacts; further study may be warranted	3
Expert Opinion	Recommended by credible groups; research evidence limited	2
Mixed Evidence	Evidence mixed	1
Insufficient Evidence	Evidence limited or unavailable	0
Evidence of Ineffectiveness	Research consistently no effect	0
*From: What Works for Health: Policies and Programs to Improve Wisconsin's Health, UW Population Health Institute. Level of effectiveness based on a scan of academic literature and key recommendations of leading organizations. http://whatworksforhealth.wisc.edu/ratingScales.asp		

Finally, to assess the TJ program's likely impact on each outcome, the combined scores for each outcome were added to produce a summary score which was then calculated as a percentage of the best possible score for that outcome (e.g. as if all indicators had received a 4, the highest score). That percentage was then translated into a likelihood rating, using Table 6 (see below).

Using a quantitative scale to estimate what is fundamentally a qualitative judgment has many problems. The greatest concern is that readers will interpret the numbers literally, understanding them to indicate an actual percentage likelihood that something will occur. ***The use of percentages are not intended in any way to suggest a numerical likelihood that something will happen.*** They are used only as an internal scoring method to bring consistency to disparate data.

Table 6: Likelihood* (also see pg. 45)		
Very Likely	Adequate evidence for a causal and generalizable effect	> .90
Likely	Logically plausible effect with substantial and consistent supporting evidence and substantial uncertainties	.66 - .89
Possible	Logically plausible effect with limited or uncertain supporting evidence	.50 - .65
Unlikely	Logically implausible effect; substantial evidence against mechanism of effect	< .50
*Health Impact Assessment – A Guide For Practice		

Employment Impacts on Chronic Disease (5.1)					
Step 1: Employment to Health Indicator			**Step 2: Indicator to Health Outcome**		
Strength of Evidence	**Score**	**Indicator**	**Strength of Evidence**	**Score**	**Combined Score**
Scientifically supported	4	Income & Poverty	Some Evidence	3	7
Mixed Evidence	1.25	Diet	Scientifically Supported	4	5.25
Mixed Evidence	1.25	Alcohol & Tobacco Use	Scientifically Supported	4	5.25
Some Evidence	3	Incarceration/Recidivism	Scientifically Supported	4	7
Some Evidence	3.5	Self-Efficacy	Scientifically Supported	4	7.5
Some Evidence	3.5	Social Capital	Mixed Evidence	1	4.5
Some Evidence	3.5	Family Cohesion	Scientifically Supported	4	7.5

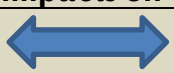
		Summary score: 44
44 of Possible 56 = .79	Impact on health outcome	**Likely**

Employment Impacts on Mental Health (5.2)					
Step 1: Employment to Health Indicator			**Step 2: Indicator to Health Outcome**		
Strength of Evidence	**Score**	**Indicator**	**Strength of Evidence**	**Score**	**Combined Score**
Scientifically supported	4	Income & Poverty	Scientifically Supported	4	8
Mixed Evidence	1.25	Alcohol & Tobacco Use	Mixed Evidence	1	2.25
Some Evidence	3	Incarceration/Recidivism	Scientifically Supported	4	7
Some Evidence	3.5	Self-Efficacy	Scientifically Supported	4	7.5
Some Evidence	3.5	Social Capital	Mixed Evidence	1	4.5
Some Evidence	3.5	Family Cohesion	Scientifically Supported	4	7.5
					Summary score: 36.75
		36.75 of possible 48 = .76	Impact on health outcome		**Likely**

Employment Impacts on Domestic Violence (5.3)					
Step 1: Employment to Health Indicator			**Step 2: Indicator to Health Outcome**		
Strength of Evidence	**Score**	**Indicator**	**Strength of Evidence**	**Score**	**Combined Score**
Scientifically supported	4	Income & Poverty	Some	3	7
Mixed Evidence	1.25	Alcohol Use	Scientifically Supported	4	5.25
					Summary score: 12.25
		12.25 of possible 16 = .77	Impact on health outcome		**Likely**

Employment Impacts on Birth Outcomes (5.4)					
Step 1: Employment to Health Indicator			**Step 2: Indicator to Health Outcome**		
Strength of Evidence	**Score**	**Indicator**	**Strength of Evidence**	**Score**	**Summary Score**
Scientifically supported	4	Income & Poverty	Scientifically Supported	4	8
Mixed Evidence	1.25	Diet	Scientifically Supported	4	5.25
Some Evidence	3.25	Alcohol & Tobacco Use	Scientifically Supported	4	7.25
Some Evidence	3	Incarceration/Recidivism	Scientifically supported	4	7
					27.5
		27.5 of possible 32 =.86	Impact on health outcome		**Likely**

Employment Impacts on Child Physical Health (5.5)					
Step 1: Employment to Health Indicator			**Step 2: Indicator to Health Outcome**		
Strength of Evidence	**Score**	**Indicator**	**Strength of Evidence**	**Score**	**Combined Score**
Scientifically supported	4	Income & Poverty	Scientifically Supported	4	8
Mixed Evidence	1.25	Diet	Scientifically Supported	4	5.25
Mixed Evidence	1.25	Alcohol & Tobacco Use	Scientifically Supported	4	5.25
Some Evidence	3.5	Social Capital	Some Evidence	3	6.5
Some Evidence	3.5	Family Cohesion	Scientifically Supported	4	7.5
Scientifically Supported	4	Child Maltreatment	Scientifically Supported	4	8
					Summary score: 40.5
		40.5 of possible 48 = .84	Impact on health outcome		**Likely**

Employment Impacts on Child Mental Health (5.6)					
Step 1: Employment to			**Step 2: Indicator to Health**		

Health Indicator			Outcome		
Strength of Evidence	**Score**	**Indicator**	**Strength of Evidence**	**Score**	**Combined Score**
Scientifically supported	4	Income & Poverty	Scientifically supported	4	8
Mixed Evidence	1.25	Alcohol & Tobacco Use	Scientifically Supported	4	5.25
Some Evidence	3	Incarceration/Recidivism	Scientifically supported	4	7
Some Evidence	3.5	Social Capital	Some Evidence	3	6.5
Some Evidence	3.5	Family Cohesion	Scientifically supported	4	7.5
Scientifically Supported	4	Child Maltreatment	Scientifically supported	4	8
					Summary score: 42.25
		42.25 of possible 48 =.88	Impact on health outcome		**Likely**

APPENDIX 4:
IMPACTS ON SUB-POPULATIONS

Statistical significances – the likelihood that the same result would happen by chance -- are not shown. In many cases, cell size was too small to accurately assess statistical significance. The results are true for *this* population and may not be replicable or generalizable to another. The observed patterns are clearly *meaningful*, if not necessarily statistically significance.

Limitations: This study was conducted without a control group. Even though participants were asked about changes since the intervention, it is not known what would have happened had the participants not received the intervention. Similarly, we don't have good baseline measures of behavior. While we would expect a regression to the mean without participation in the TJ program, we don't know the mean without a control group.

Table 7: Different Program Impact by Gender

	MORE		SAME		LESS	
Since I started in the TJ program I . . .	% Males	% Females	% Males	% Females	% Males	% Females
Spend time reading with my children	**42**	**25**	47	66	11	9
Spend time going to my child's school and/or sports events	**51**	**20**	34	67	14	13
Spend time Going to religious services	**26**	**19**	55	74	18	7
Spend Time with friends	22	19	45	56	32	24
Spend time eating meals with people in my house	**43**	**25**	43	62	13	13
Spend time going to community events	**38**	**26**	46	53	13	21
I eat fruits and vegetables	**34**	**21**	57	71	9	7
Eat less fast food	**58**	**46**	33	44	10	10
I exercise	**51**	**39**	37	47	12	14
Drink less alcohol	**44**	**26**	40	65	16	9
Oldest child: grades improved	**34**	**17**	63	71	3	12
School attendance improved	**36**	**15**	58	78	6	8
Behavior in school improved	**38**	**13**	56	72	6	15
Youngest child: grades improved	**32**	**17**	68	74	0	9
School attendance improved	**32**	**21**	68	74	0	6
Behavior in school improved	**35**	**15**	58	70	6	15

Table 8:	**Different Program Impact by Race**					
	MORE		SAME		LESS	
Since I started in the TJ program I . . .	% Whites	% Blacks	% Whites	% Blacks	% Whites	% Blacks
Spend time reading with my children	**25**	**38**	66	49	9	13
Spend time going to my child's school and/or sports events	**19**	**46**	65	41	16	14
Spend time Going to religious services	**9**	**35**	89	43	3	22
Spend Time with friends	**19**	**25**	63	39	19	36
Spend time eating meals with people in my house	**21**	**46**	66	38	13	16
Spend time going to community events	**23**	**45**	57	37	19	18
I eat fruits and vegetables	**14**	**41**	80	46	6	13
Eat less fast foods	**49**	**52**	40	36	11	12
Eat three meals a day	**10**	**23**	72	53	18	25
I exercise	**35**	**56**	55	26	10	18
Drink less alcohol	**32**	**47**	60	37	8	16
Oldest child: grades improved	**13**	**40**	79	53	8	7
School attendance improved	**14**	**39**	78	55	8	6
Behavior in school improved	**14**	**34**	75	55	11	10
Youngest child: grades improved	**13**	**37**	87	52	0	11
School attendance improved	**10**	**43**	87	54	3	4
Behavior in school improved	**13**	**37**	83	44	3	19

Table 9:	**Different Program Impact by Education**								
	MORE			SAME			LESS		
Since I started in the TJ program I . . .	< HS %	HS %	HS+	< HS %	HS %	HS+	< HS %	HS %	HS+
Spend time reading with my children	**44**	**33**	13	47	56	80	12	11	7
Spend time going to my child's school and/or sports events	20	**40**	15	60	46	77	20	14	8
Spend time Going to religious services	23	24	14	54	64	86	23	14	0
Spend Time with friends	6	**29**	6	44	47	81	50	24	13
Spend time eating meals with people in my house	**39**	**33**	18	39	55	71	22	12	12
Spend time going to community events	25	**39**	7	50	44	73	25	16	20
I eat fruits and vegetables	**32**	26	13	53	69	73	16	5	13
Eat less fast foods	6	14	67	38	41	33	56	45	0
I exercise	42	49	44	42	41	50	16	10	6
Drink less alcohol	**11**	**13**	60	33	29	40	56	58	0
Oldest child: grades improved	**31**	**24**	14	69	69	71	0	7	14
School attendance improved	**25**	**26**	14	75	67	79	0	7	14
Behavior in school improved	**25**	**28**	8	75	60	77	0	13	15
Youngest child: grades improved	**46**	16	18	54	79	82	0	5	0
School attendance improved	**46**	22	9	54	73	91	0	5	0
Behavior in school improved	**46**	19	9	54	64	91	0	14	0