

SUPPORTING SOLE-SUPPORT PARENTS ON WELFARE IN CANADA¹

by

TRACY PERESSINI, PH.D.²

Associate Professor of Sociology
Social Development Studies, Renison University College,
University of Waterloo

POLICY FUTURES: LEARNING FROM THE PAST?

Social Policy Association Conference,
University of Edinburgh,
Edinburgh, Scotland

JUNE 29 – JULY 1ST, 2009

DRAFT: NOT FOR QUOTATION.

¹ Acknowledgement: The author wishes to thank the Region of Peel, Ontario Works Division Community Programs Unit for providing funding for the Families First Program Evaluation Research Project.

² Address Correspondence to: Tracy Peressini, Social Development Studies, Renison University College, University of Waterloo. 240 Westmount Rd. N., Waterloo, Ontario Canada N2L 3G4. Tel: 519-884-4404, ext. 28602. Fax: 519-884-5135. e-mail: tperessi@uwaterloo.ca

ABSTRACT

Responding to vulnerable families through early intervention and family support is vital to building strong and inclusive communities. In general, the research literature indicates that the greater number of community-based programs and supports available to youth, the more likely they will develop pro-social behaviours (e.g. educational achievements, leadership, resistance skills, tolerance for diversity), avoid risk behaviours (e.g. gang participation and violence, substance abuse, school failure, homelessness) and contribute positively to self, family and community. This study examines the impact of children's recreational supports on family health and functioning in a mid-size Canadian city. Using data from a longitudinal case-control study of sole-support parents and their children on welfare who participated in an innovative program of intensive case management that provided targeted health, employment and recreational supports, we examine the individual and combined family effects of participation in community-based youth recreational programs. The results indicate a significant improvement in the social and emotional health and functioning of parents, children and families. The data reveal significant declines in depression, social isolation, and dysfunctional behaviour, as well as significant improvements in social functioning and activities, educational achievements and health status among youth participating in the program. Similar results in health and social functioning are observed for parents with children receiving recreational supports. Implications for promoting urban youth development programs are discussed.

Introduction

The idea of supporting families and the advent of family resource and support programs is not new (see Kagan and Weissbourd, 1994). Since the mid-twentieth century a wide variety of social service initiatives have been developed in conjunction with the anti-poverty movement to address the needs of impoverished families and children in North America. Programs such as Head Start and Legal Aid in the United States and Social Assistance (welfare), Unemployment Insurance, Worker's Compensation, Universal Health Care and post-secondary Education in Canada are just a few of the programs that were born out of this movement. The grand scale anti-poverty programs that emerged during the 1960s were due to the recognition that North American children were being lost to poverty, ill health and educational failure (Kagan and Weissbourd, 1994, p. 29). Built on the back of community-based advocacy efforts to address the growing fragmentation and breakdown of the family (e.g. increasing rates of divorce, single parenthood, teenage pregnancy, poverty and homelessness), the family support movement was one of the first to acknowledge the importance that scientific knowledge can play in helping government officials and policy makers in their efforts to build an efficient and cost-effective infrastructure of social assistance and support designed to address the needs of North America's most vulnerable and socially and economically disadvantaged: lone-parent families and their children.

Over the last decade Canadian advisory groups, government officials and policy makers have renewed their interest in and emphasized the importance of evidence-based practice in restructuring existing programs and developing new programs to respond to rising rates of poverty and childhood problems in a time of economic restraint and decline (Browne, Byrne, Roberts, Gafni and Whittaker, 2001, p. 1697). The *Families First Program (FFP)* is one such program. The FFP is modelled on a program offered as the basis of a 5 year study of different mixes of provider-initiated health and social services packages to single parents and their children on social assistance conducted by Browne et al (2001) in a neighbouring Region of Ontario, Canada. Families First is a community-based family support program that mobilizes and coordinates an array of community resources to address the health, employment, economic, childcare and recreational needs of lone-parent families and their children on social assistance. It consists of four primary social service supports/ treatment strategies: a health promotion intervention, a recreation intervention, an employment/retraining intervention and social assistance (income maintenance and/or subsidized childcare). The program is a holistic program that is also designed to address the emotional, psychological and physical health of extremely low-income parents and their children, as well as the employment challenges and barriers that sole-support parents living on a welfare-income face. Using a nested case-control design, data was collected on a total of 1,460 families (1,010 in FF and 450 OW only), with 3,268 children (1,937 in FF and 1,331 whose parents were on OW only). Parents were interviewed 5 times over two years about themselves and their children; resulting in over 14,000 completed interviews. In this paper, I describe and outline the short- and long-term impact of the program on sole-support parents and their children.

Overview of the Evaluation Research Design

The evaluation of parents participating in Families First (FF) and Ontario Works³ (OW) employed a *nested case-control* design. A nested case-control study is a type of quasi-experiment in which study participants for both the comparison and the evaluation groups are drawn from the same population and the program interventions are administered in a community setting. The evaluation uses a repeated measures design with participants being interviewed at entry, 12 months, 18 months and 24 months into the Program, and on exit from the Program⁴. Using this methodology both FF Program Parents (e.g. the “cases”) and the comparison group of OW parents (e.g. the “controls”) were drawn from all sole-support parents who have been on Ontario Works for a year or more, who have children, age 6 or older. Sole-support parents on OW meeting the program criteria were invited to participate in the FF program. Those who agreed to participate in the program were then referred to the research team and constituted the “cases” or evaluation group. Those who either didn’t meet the program criteria or who did, but refused the invitation to participate in the study, were then referred to the research team as potential comparison group (“controls”) participants.

Parents in both the FF and OW programs were administered the same comprehensive questionnaire consisting of multiple standardized measurement instruments designed to measure the mental and physical health and social functioning and well-being of diverse and marginalized populations; in this case, they were used with sole-support parents and their families in the Region of Peel, Ontario. Two questionnaires were developed for the study. The first was administered to FF and OW parents about their own health, social functioning and socio-demographic characteristics, and the second administered to parents in both groups about their children’s’ health, social functioning, behavioral problems and academic performance.

Parent and children outcomes were measured at 4 points in time over the course of the study; at entry, 12 months, 18 months, and 24 months. Finally, both sets of outcomes were measured when parents and their families left the FF program or OW.

Over the course of the research the research team conducted 14,184 interviews – 4,123 interviews with parents about themselves and 10,061 interviews with parents about their children.

³ Social Assistance or welfare in the province of Ontario, Canada is referred to as Ontario Works. Participants in OW only received the standard income maintenance and employment/retraining supports, but, none of the other treatment strategies.

⁴ The comparison group participants are interviewed as they go on Ontario Works (entry), 12 months, 18 months and 24 months on OW, and finally, they are interviewed after they have exited OW.

Response Rates

The response rate for FF parents (evaluation group) was 100% at the initial interview, 98% at the 12 month follow-up, 88% at 18 months and 84% during the final interview, with an average response rate from start to finish of 76%. The response rates for OW parents (comparison group), while lower than that of the FF cohort, were also well above what would be expected given the study design. At entry, 100% of the OW participants completed the interview, 83% the 12 month follow-up, 71% the 18 month, and 52% during the final interview, with an average response rate of 63%. The refusal/non-response rate for those in the FF program was extremely low, well below 10%.

The rate of exits for FF parents, as compared to OW parents, was quite impressive, with a 15% differential between the two cohorts, representing a savings of 15% in the costs associated with being on welfare. By 12 months into the program, OW participants were 1½ times more likely to exit OW as FF program participants. By 18 months, however, this outcome reversed itself and doubled. At 18 months, FF program participants were 3.3 times more likely to exit OW and at 24 months they were 4.2 time more likely to exit OW as the comparison group.

Measurement & Analysis

In addition to measuring the demographic characteristics, educational and employment history and background, and the health and social services usage of the parents in the evaluation, a number of standardized psychometric and health indices measuring parents' physical, psychological, and social health and functioning were also collected as part of the evaluation. In tandem, the scales and indices provide a comprehensive profile of the physical, mental and social health of the Families First Program and Ontario Works clients included in the study. These instruments also provide an assessment of the physical and behavioural limitations and problems experienced by the parents in the study. The scales and indices used are: SF-36, Brief Symptom Inventory, Duke Health Profile, and Duke Social Support and Stress Scales.

The SF-36 is a standardized method for assessing client perspectives about functional health status, well-being and other health care outcomes. It is considered to be a generic health measure that captures health-related quality of life outcomes, particularly aspects of health that are affected by disease and treatment. The SF-36 is designed to be used in the assessment of non-aged adults' physical and mental health and functioning in general, and, in particular, their behavioural functioning, perceived well-being, social and role disability and personal perceptions of health. The SF-36 is employed to assess the functional status and well-being of the parents in the study.

The BSI is a 53 item self-report symptom inventory designed to reflect the psychological symptom patterns of psychiatric and medical patients as well as community non-patient respondents. The BSI is scored and profiled in terms of nine primary symptom dimensions: Somatization (SOM); Obsessive-compulsive (O-C); Interpersonal Sensitivity (I-S); Depression (DEP); Anxiety (ANX); Hostility (HOS); Phobic Anxiety (PHOB); Paranoid Ideation (PAR); and Psychoticism (PSY).

The Duke Health Profile is a 63-item generic (not disease-specific) measure of functional health status, including: symptom status, physical function, emotional function and social function. The DUKE is composed of 11 subscales: Physical Health; Mental Health; Social Health; General Health; Perceived Health; Self-Esteem; Anxiety; Depression; Anxiety-Depression; Pain; Disability.

The DUSOCS is a 24-item instrument developed to measure respondent-reported social support and social stress. Respondents are asked to rate family members and non-family members as to the amount of support and/or stress cause by each relationship. Family members include: spouse or significant other person, children or grandchildren, parents or grandparents, brothers or sisters, other blood relatives and relatives by marriage. Non-family members include: neighbors, coworkers, church members and other friends. The scale renders summary scores for: family support, family stress, non-family support and non-family stress.

Two psychometric and health tools/instruments designed to measure the physical, psychological, and social health, as well as, academic performance of the children in the program are employed in the children's questionnaire. Together, the tools provide a comprehensive profile of the parents' perceptions of their children's health, social functioning, behavioral, and academic limitations and problems of the children in the study. The instruments used are: *The Achenbach Scale* and the *Child Health Questionnaire*.

The Achenbach Scale (CBCL) is the primary means of assessing children's: cognitive ability, academic performance, hobbies and recreational interests, social skills/competence (e.g. friendships, associations, etc.). It is a standardized instrument for assessing behavioural, emotional and psychological problems and problems with delinquency in children age 4 and older.

The Child Health Questionnaire (CHQ) is a holistic assessment tool that measures complete physical, mental and social well-being of the child. The CHQ assesses the following attributes of the children, their parents and their families: the presence and extent of physical limitations due to health-related problems; general and overall health and illness; the impact of psychological and social problems have on school work and activities with friends; psychosocial issues and problems with: self-esteem, anxiety, depression, aggression, delinquency, hyperactivity/ impulsivity and social withdrawal; the impact that the child's health and behavioral problems have on the parent and the limitations they pose; and the impact of children's health conditions on family relationships.

The data were analyzed using basic bivariate and multivariate techniques. Basic descriptive and Chi-Square tests of association were used to assess difference in the socio-demographic profiles of FF and OW parents. One-way analysis of variance and paired t-tests were employed to evaluate statistical differences across the study groups and time.

Initial & Exit Sociodemographic Characteristics of Sole-Support Parents: Families First & Ontario Works Comparisons

Table 1 summarizes the initial information on sole-support parents, presenting separate means and percentages for parents in the Families First program (evaluation group) and parents on Ontario Works (comparison group) and indicating whether or not the two groups were statistically equivalent at the beginning of the study.

The parents in the FF Program are comparable to those on Ontario Works only; which is expected as they are both drawn from the same population. The data show no significant differences across the demographic characteristics of the study and comparison group. Age, marital status, minority status, race, and ethnicity are not significantly different, meaning the two groups are equivalent. In general, participants in the study were approximately 37 to 38 years old, predominantly separated or divorced, about 45% reported being a member of a visible minority and well over ½ are non-Caucasian; with just over a third of both groups reporting being of African or West Indian descent. Just under ½ of those who participated in the research report being a person of color.

The profile of female sole-support parents in the study is quite different from females and sole-support parents in the Region of Peel in 2006 (see table 3). As compared to the general female population, female sole-support parents on welfare in Peel are twice as likely to be single, separated, divorced or widowed. The general female population in Peel is about 10 percent more likely to be Canadian Born, 5% more likely to be a member of a visible minority, and almost 25% more likely to have high school or more education than the female, sole-support parents in the study. Female sole-support parents on welfare tend to have larger families and live on two-thirds less income than female sole-support parents in the Region of Peel. The variation in income can be attributed to the disproportionately higher rates of minority and immigrant group membership, as well as substantially lower rates of education among welfare recipients in the Region of Peel.

In general, FF parent's perceptions of their own health tend to be more positive than those of the comparison group (see table 1). About one third of the FF parents report being in fair to poor health at the time of entry into the study. It is interesting to note that eight percent of the parents in the comparison group (on OW only) report being in poorer health than parents in the study group.

Table 1: Select Demographic Characteristics of FF & OW Parents by Time in the Program. Families First Program, Region of Peel, 2007. ¹

Attribute Description	Entry		FF Parents Only	
	FF Parents N=774	OW Parents N=447	Entry N=774	Exit N=506
Age: $\mu \pm \sigma$	36.9 \pm 7.2 yrs	37.9 \pm 9.0 yrs	36.9 \pm 7.2 yrs	37.1 \pm 6.1 yrs
Marital Status:				
Single/Never married	41.6	48.2	41.6	44.2
Common-law/married	3.5	3.2	3.5	3.7
Separated/divorced/widowed	54.9	48.6	54.9	52.2
Place of Birth: Canada	41.0	41.5	41.0	42.5
Outside Canada	59.0	58.5	59.0	57.5
% Visible Minority	45.5	44.3	45.5	43.3
Racial/Ethnic Background:				
Caucasian	42.2	42.8	42.2	42.7
East Indian/South Asian	6.1	7.8	6.1	5.6
West Indian/African	37.9	34.0	37.9	38.3
Asian/Oriental	8.3	8.7	8.3	7.0
Other	5.5	6.7	5.5	6.5
Education - years of schooling: $\mu \pm \sigma$	11.7 \pm 1.8	11.9 \pm 3.1	11.7 \pm 1.8	12.8 \pm 1.2
% High School or more education	52.5	58.7	52.5	51.9
% on OW for the 1st Time*	55.8	62.5	55.8	53.3
Length of Time in Evaluation: $\mu \pm \sigma$	19.9 \pm 3.2 mo.	21.1 \pm 6.3 mo.	19.9 \pm 3.2 mo.	19.9 \pm 3.2 mo.
Length of Time on OW: $\mu \pm \sigma$	29.9 \pm 37.7 mo.	31.4 \pm 76.2 mo.	29.9 \pm 37.7 mo.	30.1 \pm 33.5 mo.
% Children Living with Parents	81.4	84.6	81.4	81.3
% With Children Aged 6-11	57.9	56.1	57.9	56.8
% With Children Aged 12-17	44.5	45.3	44.5	43.3
Average Number of Children: $\mu \pm \sigma$	2.4 \pm 1.1 kids	2.3 \pm 1.3 kids	2.4 \pm 1.1 kids	2.4 \pm 1.2 kids
% With 2 or fewer children	56.5	55.2	56.5	55.3
Residential Status:				
Canadian Citizen	73.0	73.3	73.0	74.6
Landed Immigrant/Other	27.0	26.7	24.5	23.1
Language Issues (self-assessment)				
<i>Speaking English</i> Fair-Poor	12.6	17.9	12.6	12.1
<i>Reading English</i> Fair-Poor	16.7	20.9	16.7	15.3
<i>Understanding English</i> Fair-Poor	12.3	13.8	12.3	12.3
Labor Force Status:				
Working Full or Part Time	16.6	23.8	16.6	18.4
Unemployed/Looking for Work	58.7	49.9	58.7	59.6
Volunteer	2.6	3.4	2.6	2.0
Student	9.1	10.2	9.1	7.5
Disability	12.9	12.7	12.9	12.5
Average Income: $\mu \pm \sigma$	\$1277.00	\$1159.00	\$1277.00	\$1360.00
Self-Perceived Health:				
Good - Excellent	64.9	56.5	64.9	68.8
Fair - Poor	35.1	43.5	35.1	31.2

¹ *Bolded scores (shaded cells) are significantly different at $\alpha \leq .05$ across study group and time in the program.*

Health, Social Functioning & Well-Being: The Overall Impact of FF Program Participation

There is a consistent pattern of significant change for FF parents as compared to OW parents over time. FF parent's health, social functioning and well-being significantly improve as compared to OW parents over the study time period (from entry to exit). With the exception of somatisation, obsessive-compulsive, global physical scores, self-esteem, pain, and disability, FF parents social, mental, emotional and physical health significantly improve from entering the program to exiting Ontario Works.

Upon leaving Ontario Works, the FF parent's exhibit significantly improved health, social functioning and well-being, as well as a significant increase in their social support and decrease in their stress scores; as compared to those in the comparison group.

Table 2 summarizes the change in participant's scores from the time they entered the FF program to when they exited. On the majority of indicators the change in the participant's social, emotional, mental, and physical health is dramatic and significant. Not only do participants experience and significant improvement in their psycho-social and physical health functioning, but, they see significant improvement in their network of support (both formal and informal). Interestingly, participant's also experience an increase in their stress scores from entry to exit. This may, however, be a reflection of the anxiety associated with a change in life circumstances as a result of leaving Ontario Works.

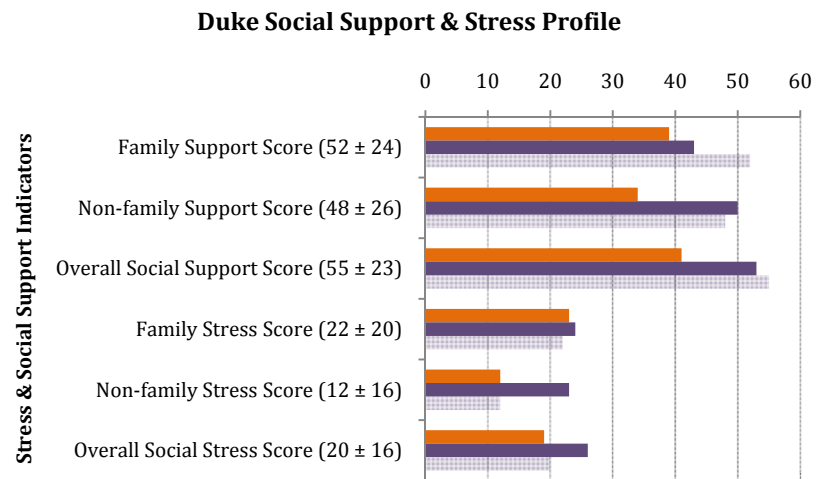
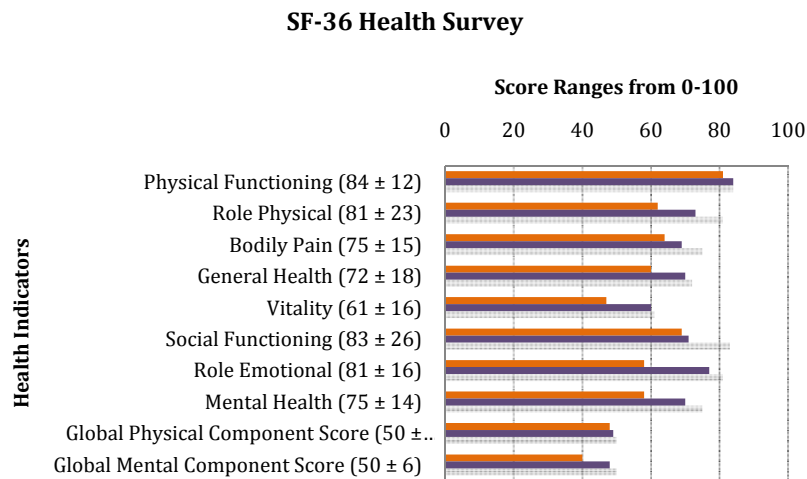
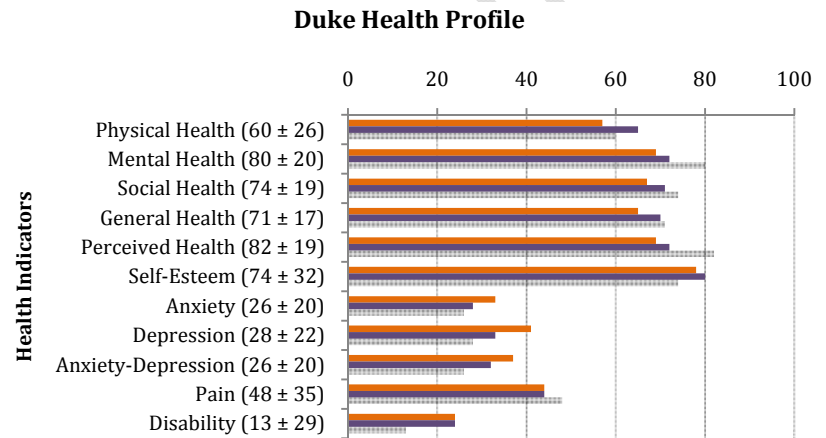
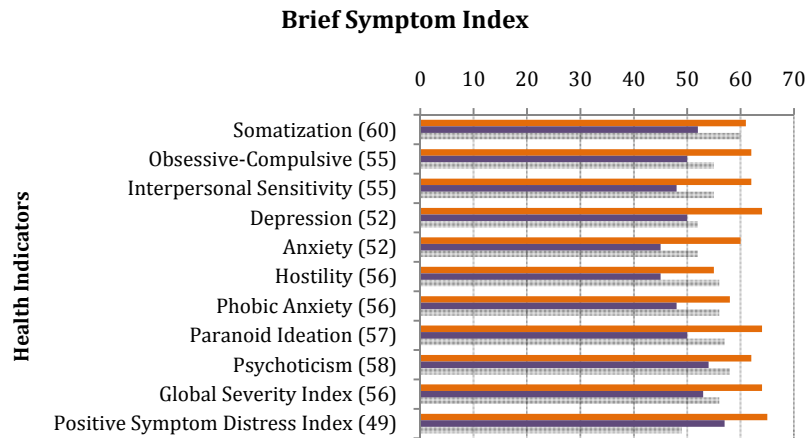
Tables 3a and 3b report the study participant's scores on the Brief Symptom Index, the SF-36 Health Survey and the DUKE Health Profile. The table summarizes the mean scores and variances for both parents in the FF program and on OW, at the outset of the study and then again after they leave Ontario Works. Based on the research design we would expect the following:

- No significant difference between FF & OW parents upon entry into their respective programs – e.g. the two groups are equivalent at the outset of the research;
- Significant differences between FF & OW parents after exiting Ontario Works;
- Significant differences for FF parents from entry to exit; and
- No significant differences for the comparison group from entry to exit.

The first two columns in table 3a-b compare the FF parents to OW parents at the start of their respective programs. No significant differences are observed across all of the health indices or in terms of social support and stress. These data demonstrate the equivalency of the two groups at the outset of the study, prior to the FF program intervention, which is the desirable outcome.

Table 2: Entry and Exit Scores by Psycho-Social Index for Parents in the FF Program, Region of Peel, 2007.

Legend: Orange = Entry Score; Purple = Exit Score; Grey = Inpatient Norm



Draft

Table 3a: Parents Responses on the Brief Symptom Index (BSI) and the SF-36 Health Survey by Study Group and Time in the Program. Families First Program, Region of Peel, 2007.¹

Health Index: BSI & SF-36 Means and Standard Deviations	Entry		Exit		FF Parents		OW Parents	
	FF N=774	OW N=447	FF N=506	OW N=209	Entry N=774	Exit N=506	Entry N=447)	Exit N=209
BSI: Brief Symptom Index								
Somatization (60)	61 ± 14	61 ± 14	52 ± 13	61 ± 14	61 ± 14	52 ± 13	61 ± 14	61 ± 14
Obsessive-Compulsive (55)	62 ± 14	62 ± 13	50 ± 13	63 ± 14	62 ± 14	50 ± 13	62 ± 13	63 ± 14
Interpersonal Sensitivity (55)	62 ± 13	60 ± 13	48 ± 13	62 ± 13	62 ± 13	48 ± 13	60 ± 13	62 ± 13
Depression (52)	64 ± 13	62 ± 13	50 ± 12	63 ± 13	64 ± 13	50 ± 12	62 ± 13	63 ± 13
Anxiety (52)	60 ± 15	60 ± 15	45 ± 15	62 ± 14	60 ± 15	45 ± 15	60 ± 15	62 ± 14
Hostility (56)	55 ± 12	55 ± 11	45 ± 12	56 ± 11	55 ± 12	45 ± 12	55 ± 11	56 ± 11
Phobic Anxiety (56)	58 ± 12	59 ± 12	48 ± 12	61 ± 12	58 ± 12	48 ± 12	59 ± 12	61 ± 12
Paranoid Ideation (57)	64 ± 14	63 ± 13	50 ± 13	63 ± 13	64 ± 14	50 ± 13	63 ± 13	63 ± 13
Psychoticism (58)	62 ± 14	61 ± 13	54 ± 12	63 ± 13	62 ± 14	54 ± 12	61 ± 13	63 ± 13
Global Severity Index (56)	64 ± 16	63 ± 17	53 ± 15	65 ± 17	64 ± 16	53 ± 15	63 ± 17	65 ± 17
Positive Symptom Distress Index (49)	65 ± 15	64 ± 14	57 ± 13	64 ± 15	65 ± 15	57 ± 13	64 ± 14	64 ± 15
[Inpatient Normative Scores in Parentheses]								
SF-36 Health Survey (Score Range 0-100)								
Physical Functioning (84 ± 12)	81 ± 24	79 ± 24	84 ± 20	78 ± 23	81 ± 24	84 ± 20	79 ± 24	78 ± 23
Role Physical (81 ± 23)	62 ± 45	57 ± 45	73 ± 38	52 ± 45	62 ± 45	73 ± 38	57 ± 45	52 ± 45
Bodily Pain (75 ± 15)	64 ± 32	61 ± 31	69 ± 25	57 ± 31	64 ± 32	69 ± 25	61 ± 31	57 ± 31
General Health (72 ± 18)	60 ± 26	61 ± 28	70 ± 22	61 ± 27	60 ± 26	70 ± 22	61 ± 28	61 ± 27
Vitality (61 ± 16)	47 ± 27	45 ± 25	60 ± 21	42 ± 23	47 ± 27	60 ± 21	45 ± 25	42 ± 23
Social Functioning (83 ± 26)	69 ± 34	73 ± 32	71 ± 31	71 ± 35	69 ± 34	71 ± 31	73 ± 32	71 ± 35
Role Emotional (81 ± 16)	58 ± 46	55 ± 44	77 ± 35	55 ± 43	58 ± 46	77 ± 35	55 ± 44	55 ± 43
Mental Health (75 ± 14)	58 ± 23	60 ± 24	70 ± 21	60 ± 26	58 ± 23	70 ± 21	60 ± 24	60 ± 26
Global Physical Component Score (50 ± 6)	48 ± 13	46 ± 13	49 ± 12	45 ± 12	48 ± 13	49 ± 12	46 ± 13	45 ± 12
Global Mental Component Score (50 ± 6)	40 ± 14	42 ± 14	48 ± 13	42 ± 14	40 ± 14	48 ± 13	42 ± 14	42 ± 14
[Adult Normative Scores in Parentheses]								

¹ *Bolded scores (shaded cells) are significantly different at $\alpha \leq .05$ across study group and time in the program.*

Table 3b: Parents Responses on the Duke Health, Stress & Social Support Profiles by Study Group and Time in the Program. Families First Program, Region of Peel, 2007.¹

Health Index: Duke Profiles Means and Standard Deviations	Entry		Exit		FF Parents		OW Parents	
	FF	OW	FF	OW	Entry	Exit	Entry	Exit
	N=774	N=447	N=506	N=209	N=774	N=506	N=447	N=209
Duke Health Profile 0= Worst Score; 100= Best Score								
Physical Health (60 ± 26)	57 ± 29	55 ± 30	65 ± 21	54 ± 28	57 ± 29	65 ± 21	55 ± 30	54 ± 28
Mental Health (80 ± 20)	69 ± 26	70 ± 25	72 ± 21	68 ± 27	69 ± 26	72 ± 21	70 ± 25	68 ± 27
Social Health (74 ± 19)	67 ± 18	66 ± 19	71 ± 12	63 ± 18	67 ± 18	71 ± 12	66 ± 19	63 ± 18
General Health (71 ± 17)	65 ± 19	64 ± 19	70 ± 11	62 ± 20	65 ± 19	70 ± 11	64 ± 19	62 ± 20
Perceived Health (82 ± 19)	69 ± 36	67 ± 37	72 ± 24	65 ± 41	69 ± 36	72 ± 24	67 ± 37	65 ± 41
Self-Esteem (74 ± 32)	78 ± 20	78 ± 18	80 ± 18	75 ± 21	78 ± 20	80 ± 18	78 ± 18	75 ± 21
Anxiety (26 ± 20)	33 ± 23	33 ± 23	28 ± 18	34 ± 23	33 ± 23	28 ± 18	33 ± 23	34 ± 23
Depression (28 ± 22)	41 ± 28	39 ± 27	33 ± 20	40 ± 27	41 ± 28	33 ± 20	39 ± 27	40 ± 27
Anxiety-Depression (26 ± 20)	37 ± 26	34 ± 24	32 ± 19	36 ± 25	37 ± 26	32 ± 19	34 ± 24	36 ± 25
Pain (48 ± 35)	44 ± 38	47 ± 40	44 ± 28	50 ± 37	44 ± 38	44 ± 28	47 ± 40	50 ± 37
Disability (13 ± 29)	24 ± 36	25 ± 37	24 ± 21	33 ± 32	24 ± 36	24 ± 21	25 ± 37	33 ± 32
[Female, Adult Primary Care Scores in Parentheses]								
Duke Social Support & Stress Profile 0=Low; 100=High								
Family Support Score (52 ± 24)	39 ± 21	37 ± 21	43 ± 21	37 ± 21	39 ± 21	43 ± 21	37 ± 21	37 ± 21
Non-family Support Score (48 ± 26)	34 ± 21	36 ± 20	50 ± 21	33 ± 20	34 ± 21	50 ± 21	36 ± 20	33 ± 20
Overall Social Support Score (55 ± 23)	41 ± 16	40 ± 17	53 ± 15	36 ± 17	41 ± 16	53 ± 15	40 ± 17	36 ± 17
Family Stress Score (22 ± 20)	23 ± 17	21 ± 17	24 ± 16	25 ± 17	23 ± 17	24 ± 16	21 ± 17	25 ± 17
Non-family Stress Score (12 ± 16)	12 ± 12	12 ± 12	23 ± 12	14 ± 16	12 ± 12	23 ± 12	12 ± 12	14 ± 16
Overall Social Stress Score (20 ± 16)	19 ± 12	17 ± 13	26 ± 12	22 ± 14	19 ± 12	26 ± 12	17 ± 13	22 ± 14
[Female, Adult Primary Care Scores in Parentheses]								

¹ Bolded scores (shaded cells) are significantly different at $\alpha \leq .05$ across study group and time in the program.

Columns 3 and 4 of table 3a-b (FF & OW exits) summarize the FF and OW parent's scores after leaving Ontario Works. These data clearly show FF parents improved social, emotional, psychological and physical functioning as a result of participating in the FF program. With the exception of social functioning (which remains constant from entry to exit), all of the indicators across the indexes for FF parents significantly differ from OW parents.

The Brief Symptom Inventory (BSI) provides a summary of participant's psychological issues and their intensity at any given point in time. As can be seen in table 2a-b there is no difference in scores on the BSI for parents in FF as compared to those on OW at the start of the program.

The BSI symptom profile for both groups is in the clinical range, with symptomatic distress levels that far exceed those of the inpatient psychiatric patient norm. The magnitude of the scores for both groups is clinical in nature and is supported by a large number of symptoms in the clinical range. Both groups of parents reported being "quite a bit" distressed for the following symptoms: feeling easily annoyed or irritated; trouble falling asleep and feeling that people will take advantage of you if you let them. The FF Parents also reported feeling "quite a bit distressed" in terms of feeling lonely, blue and having hurt feelings, while the OW parents were less likely to be lonely or blue, but, were more likely to feel that most people could not be trusted. Based on these profiles, it is clear that both groups of parents were experiencing significant psychological difficulties that required further professional evaluation.

By the time they left Ontario Works, the parents in the comparison group showed no change in their BSI clinical profile, while the FF parents demonstrated fewer and less intense symptoms of distress. Although still reporting scores in the clinical range, parents who participated in the FF program experienced significant improvement in their psychological and emotional health and functioning as compared to OW parents.

Despite this, after leaving Ontario Works, parents in the FF program report somatisation and obsessive-compulsive levels that were above average, suggesting continuing and elevated distress with somatic complaints. FF parents reported feelings of inferiority, inadequacy and self-doubt that were clinical in nature, yet, consistent with what might be expected as a result of leaving Ontario Works and having to face the uncertainties and vagaries of life after welfare. These symptoms are echoed in moderate levels of anxiety, but the observed anxiety levels could also simply be the normal anxiety level for each individual. The findings also suggest that FF parents were displaying phobic and avoidance behaviours. Again, these behavioural patterns could be consistent with the anxiety of coping with an uncertain future and life off of welfare. Finally, the FF parents continued to report Psychoticism scores in the clinical range, which are more likely a function of the intense feelings of isolation and alienation associated with leaving welfare and living alone.

Overall then, the results from the BSI both at entry and exit for both cohorts indicate clients in the Program and OW experience higher than normal levels of psychological and emotional distress. While their scores on the majority of primary symptom dimensions

included in the BSI are above the norm for a typical inpatient population, we do observe both a substantial and significant decline in these scores after they exit the program, which can be attributed specifically to their participation in the Program. Participating in the Families First program results in a significant decline in depression, anxiety, interpersonal sensitivity, paranoia and distress experienced by FF parents.

The SF-36 Health Survey is a commonly used and standardized instrument designed to offer a general assessment of an individuals' health and behavioral functioning. The sub-scores for the SF-36 identify specific dimensions of physical and psychological health, with higher scores indicating improved or superior health. In addition, the SF-36 provides us with two summary estimates of the participants' overall mental health (Global Mental Component Score) and physical health (Global Physical Component Score). The summary scores for the SF-36 for each study group are presented in Table 2a. The normative scores for the normal adult population for the SF-36 are also included in table 2a.

Once again, we note no significant entry-level differences between the study and comparison group participants. The SF-36 scores for both groups, as compared to the normal adult population, indicate that all participants in the study report poorer mental and physical health. The Global scores suggest that while there is more substantial variation across the sub-indicators of health on the SF-36, overall, the physical health of the study participants approaches that of the normative population, while their mental health scores are somewhat lower than what would be expected in the general population.

As with the BSI, the SF-36 means scores reported in table 2a clearly indicate a significant decline in the physical, emotional and social limitations they experience in terms of their activities of daily that they report at the outset of the study. Although the program participants report significant improvements in their health and social functioning, the majority of their scores are slightly lower than the normal population, indicating they are still experiencing minor limitations in physical and social functioning after exiting the program. For example, FF program participants "role-physical" score at the outset of the study indicate that they do experience some degree of difficulty with work or other daily activities as a result of physical health problems (see table 2a). At exit they report significantly diminished impediments in terms of work or other daily activities (an 11 point increase in their mean score). Yet, FF program participants display exit scores that are lower than what would be expected in the normal population; meaning that, although muted, their physical health problems persist and do limit their activities of daily living.

It should be noted that, upon exiting OW, the comparison group reports significantly greater limitations in their work and daily activities due to health problems than their FF counterparts. With the exception of social functioning, which is the same across both FF and OW parents, the comparison group parents report experiencing significantly higher activity limitations due to health problems (i.e. lower scores than the FF parents) after exiting their respective programs. Furthermore, OW parents report that, from entering to exiting social assistance, they experience greater limitations with work and physical functioning due to their health problems, pain and significant declines in their vitality.

These findings further reinforce the positive impact that participating in the FF program, particularly the health component, has. The declines in OW parents' scores on the role-physical, bodily pain and vitality dimensions of the SF-36 from entry to exit (column 4, table 2a) **reinforce the importance and necessity** of providing health supports to social assistance recipients. Comparing these scores to that of FF parents provides clear evidence of the positive, significant and, more importantly, necessary impact that the FF health supports have – especially in terms of physical health. Without the PHN supports, the physical, mental and emotional health problems of the parents persist and get worse over time.

The Duke Health Profile (DHP) is a non-specific standardized instrument measuring functional health status. Higher scores on this assessment tool indicate high functional health (e.g. no or minor health problems that affect the individuals' functional abilities or activities of daily living). As with the two previous measures, the DHP scores reported in table 2b do not differ significantly across study group. The absolute value of the reported DHP scores, as compared to the norms indicated in table 2, re-affirm the prior observations based on the BSI and SF-36 - in general both groups experience more problems with their physical and mental health than adults in the general population. Further to this observation, DHP scores for both groups indicate that, in fact, the study participants' health problems render them slightly less functional than adult women in primary care. As with the other scales, an examination of the entry and exit scores for the DHP indicate that the FF parents health significantly improved over the course of their participation in the program.

The last set of scores in table 2b summarizes the participants' scores on the Duke Social Support and Stress Profile (DSSSP). This instrument estimates the degree of stress and amount of social support that participants in the study are experiencing. The estimates are further differentiated into familial and non-familial sources of support and stress.

No significant differences are observed between the study and comparison parents at the outset of the study. Upon exiting the program, however, the OW parents report a significantly lower level of social support than their FF counterparts. While FF parents report a moderate level of social support, OW parents report a low level of social support. More importantly, while FF parents experience a significant increase in social support as a result of participating in the FF program, OW parents experience a significant decline in social support upon exiting Ontario Works. FF parents experience an increase in both familial and non-family supports over the course of participating in the program, while OW parents' familial supports remain the same and their non-familial supports decline upon exiting the programs. Overall then, the social and emotional support provided by the FF case coordinators, PHNs and ESWs act as a significant buffer against the real and perceived social isolation typically experienced by social assistance recipients.

The Duke Stress Profiles for both groups of parents indicate a similarly interesting trend in terms of family stress. While the FF parents family stress levels remain stable over from entry to exit, the OW parents family stress levels significantly increase upon exiting the program. The comparison group of parents provides us with information about natural

changes experienced by families on social assistance over time (column 4, table 2b). In this case, we observe a significant increase in family stress upon leaving social assistance; an increase in family stress that does not manifest itself for those leaving the FF program. From this we may infer that participation in FF acts as a buffer against the deleterious effects of the loss of formal supports (e.g. economic, social, emotional, recreational, child care, etc.) upon leaving the program. This is echoed in the non-family stress scores across both groups.

Discussion

These data and other data not reported here from the Families First Program Evaluation all coalesce to tell the same story about recreation: participation in recreational activities significantly improves the health, social functioning and well-being of the families, parents and children in the program. More important, the results of the program evaluation are consistent with a large body of research that has found the same thing across a wide variety of organizations, social and culture groups. Providing the opportunity to participate in a variety of recreational and leisure activities is one of the most effective ways of improving the health, well-being and functioning of Canadian families and of breaking down the barriers that impoverished children face in terms of health, educational performance and academic achievement -- all factors that translate in lifelong occupational and employment opportunities and success and long term savings to Canada's social safety net.

In addition, these findings also indicate that the effectiveness of the program lies in its holistic approach in terms of addressing all of the needs of single parent families, from the health, employment and child care issues faced by single parents, to the developmental, social and emotional needs of children in low-income families. An examination of the service effectiveness of the differential interventions suggests that each of the interventions addresses different needs across the population and across time. As clients' health and social functioning improves, they are better able to take advantage of the employment, retraining, educational supports and services available to them. In many respects, the overarching impact of the program is one of recreating community, a community in which sole-support families have a network of alliances and supports that work together and all contribute to the social, emotional, mental and physical health and well-being of not only parents, but, children as well.

From the perspective of evidence-based practice, this research reinforces the importance of subjecting programs and services to scrutiny and evaluating them as to their effectiveness. Social service workers and practitioners need to be able to determine what supports are effective and for whom. Conducting such evaluations of all programs and services, allows for the effective and efficient rationing of resources; resources.

References

- Achenbach, T.M. (1991). *Manual for the Child Behavior Checklist/4-18 and 1991 Profile*. Burlington, VT: University of Vermont, Department of Psychiatry.
- Autry, C.E. and S. C. Anderson (2007). Recreation and the Glenview Neighborhood: Implications for Youth and Community Development. *Leisure Sciences*, 29, 267-285.
- Bassuk, E.L., Mickelson, K.D., Bissel, H.D. and J.N. Perloff (2002). Role of Kin and Nonkin Support in the Mental Health of Low-Income Women. *American Journal of Orthopsychiatry*, 77(1): 39-49.
- Black, K. and M. Lobo (2008). A Conceptual Review of Family Resilience Factors. *Journal of Family Nursing*, 14(1): 33-55.
- Brown, G., Byrne, C., Roberts, J., Gafni, A. and S. Whittaker (2001). When the bough breaks: Provider-initiated comprehensive care is more effective and less expensive for sole-support parents on social assistance. *Social Science & Medicine*, 53: 1697-1710.
- Kagan, Sharon L. and B. Weissbourd (eds.) (1994). *Putting Families First: America's Family Support Movement and the Challenge of Change*. San Francisco: Jossey-Bass Publishers.
- Derogatis, L.R. (1993). *BSI – Brief Symptom Inventory: Administration, Scoring and Procedures Manual*. Minneapolis, MN: National Computer Systems, Inc.
- Evans, G.W. (2004). The Environment of Childhood Poverty. *American Psychologist*, 59(2): 77-92.
- Landgraf, J.M., Abetz, L. and J.E. Ware Jr. (1999). *Child Health Questionnaire (CHQ): A User's Manual*. Second Printing, Boston, MA: HealthAct.
- Nakhaie, M.R., Smylie, L. and R. Arnold (2007). Social Inequalities, Social Capital and Health of Canadians. *Review of Radical Political Economics*, 39(4): 562-585.
- Nettles, S. M. (1991). Community Involvement and Disadvantaged Students: A Reivew. *Review of Educational Research*, 61(3): 379-406.
- Parkerson, G.R. (1999). *User's Guide for Duke Health Measures*. Durham, N.C.: Department of Community and Family Medicine, Duke University Medical Center.
- Reupert, A. and D. Maybery (2007). Families Affected by Parental Mental Illness: A Multiperspective Account of Issues and Interventions. *American Journal of Orthopsychiatry*, 77(3): 362-369.
- Reutter, L. I., Veenstra, G., Stewart, M.J., Raphael, D., Love, R., Makwarimba, E. and S. McMurray (2005). Lay understandings of the effects of poverty: a Canadian perspective. *Health and Social Care in the Community*, 13(6): 514-530.

Rowlingson, K. and S. McKay (2005). Lone motherhood and socio-economic disadvantage: insights from quantitative and qualitative evidence. *The Editorial Board of The Sociological Review*, 30-49.

Schorr, L. B. (1999). Fighting Poverty and Building Community: Learning from Programs that Work. *American Journal of Orthopsychiatry*, 69(4): 420-423.

Statistics Canada (2007). *2006 Community Profiles*. Ottawa, Canada: Statistics Canada.

Ware, J. E. (1993). *SF-36 Health Survey: Manual and Interpretation Guide*. Lincoln, RI: QualityMetric Incorporated.

Ware, J.E., Kosinski, M, and S.D. Keller (1994). *SF-36 Physical and Mental Health Summary Scales: A User's Manual*. Boston, MA: Health Assessment Lab.