Work Requirements and Well-Being in Public Housing

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Abstract

- *Objectives: Work requirements in public housing are highly controversial, and little is known about their impacts. We examined how implementation of a work requirement paired with supportive services by Charlotte Housing Authority has impacted residents' overall well-being. Although the policy might improve well-being by increasing household income, it might also engender stress through greater housing precarity.*
- *Methods: This mixed-methods study analyzes data from 126 resident surveys conducted before and after work requirement implementation, interviews with 48 residents, and household-level administrative data. Survey and administrative data capture changes in income and health between 2010 and 2014. Interviews provide qualitative insights on changes in health, household income, and overall well-being.*
- *Results: We find that residents want to work and report both positive and negative effects associated with the work requirement. Resident interviews suggest increases in household income led to a reduction in overall stressors. Negative impacts include cuts in or elimination of Medicaid and Supplemental Nutrition Assistance Program benefits (more commonly known as food stamps). Self-rated health did not improve.*
- *Conclusions: We find work requirements—when implemented with case management and opportunities to complete work-related activities in lieu of employment—are associated with both positive and negative impacts. We urge public housing agencies implementing similar policies to carefully monitor and evaluate not only changes in household income and evictions but also welfare supports and the health and well-being of all residents in households affected by the policy.*

Introduction

Poverty and minority status can exacerbate individuals' risk for physical and mental disabilities (Adler and Rehkopf, 2008). Public housing residents, therefore, 64 percent of whom are classified as very low-income and 45 percent of whom are African-American, are at especially high risk for poor health. Furthermore, many public housing residents live in negative social environments (for example, high crime and socially isolated) that can further lower well-being (Bennett, Smith, and Wright, 2006). One study found that public housing residents were three times more likely to report fair or poor health and twice as likely to be diagnosed with chronic health conditions compared with Black women nationally.[1] In addition, 29 percent of public housing residents reported poor mental health (Manjarrez, Popkin, and Guernsey, 2007).

This article addresses the question: What are the impacts on the well-being of residents when public housing agencies (PHAs) require work-able (that is, nonelderly[2] and nondisabled) residents to have a job in order to remain in their housing? In theory, a work requirement could improve well-being by increasing household income (Danna and Griffin, 1999; Stronks et al., 1997). However, work requirements could also reduce well-being by increasing stress and housing precarity (Bowie and Dopwell, 2013; Hasenfeld, Ghose, and Larson, 2004; Starkey et al., 2012).

Currently, only eight PHAs—all participants in the U.S. Department of Housing and Urban Development (HUD) Moving to Work (MTW) demonstration program—have implemented work requirements for some or all of their work-able residents (Webb, Frescoln, and Rohe, 2014). As of March 2018, requirements range from 20 hours per week of work for a single household member to 30 hours for all work-able adults in the household (HUD, 2017). Although all policies have been implemented with case management supports and protections for residents who find compliance difficult, failure to comply results in eventual eviction in all but one agency (HUD, 2017).

The MTW demonstration encourages participating PHAs to implement innovative policies and programs to help residents achieve self-sufficiency, among other statutory goals.[3] To do so, MTW agencies can seek waivers from standard HUD regulations and to combine various funding streams into a single, flexible account. MTW agencies have the funding and regulatory flexibility to implement not only policies to structure resident behaviors, such as work requirements, but also policies to support those behaviors, including case management, transportation, childcare assistance, and tuition reimbursement. Together, these supports could increase well-being by connecting public housing residents to employment, education, healthcare, and other resources.

Well-being is a multidimensional concept that encompasses physical, mental, emotional and social functioning (ODPHP, n.d.). To achieve a state of well-being, one must be sufficiently healthy and resourced to meet the basic needs of the family, while also being able to engage with family, friends, and community. This article seeks to expand our understanding of public housing work requirements by examining how well-being, examined through changes in household income and

[1] The Manjarrez, Popkin, and Guernsey (2007) study compares outcomes of African-American women, as 88 percent of adults in the HOPE VI Panel Study sample were women and 90 percent were Black.

[2] The U.S. Department of Housing and Urban Development defines *elderly* as people age 62 and older.

[3] These other goals include increasing housing options and achieving cost efficiencies.

self-rated health, is affected by Charlotte Housing Authority's (CHA's) work policy. To date, work requirements in public housing have attracted little research attention; these studies have primarily focused on the economic impacts on public housing residents and have not addressed the impacts on broader indicators of well-being. For example, an evaluation of CHA's work requirement found a statistically significant and positive impact on residents' employment status without a corresponding increase in evictions (Rohe, Webb, and Frescoln, 2016). Placing these findings in the broader context of resident well-being is crucial to understand the impact of work requirements.

Background

This article examines the effects of a work requirement implemented by CHA on the well-being of affected residents. CHA manages roughly 3,300 public housing units and 8,500 housing choice vouchers. Admitted to MTW in 2007, their program comprises several major initiatives including rent reforms, expanding its housing portfolio, and a work requirement, which only applies to work-able residents in 5 of its 15 public housing developments.

CHA's work requirement mandates that all work-able households—those households with at least one nondisabled adult age 18 to 61—maintain 15 hours per week of employment. In lieu of employment, residents may complete preapproved work-related activities for up to 12 months. Beginning in fall 2011, CHA has provided voluntary case management to residents at all 5 work-requirement sites. CHA notified affected residents in fall 2013 that work requirement enforcement would begin in January 2014.[4]

Case managers work with property managers to monitor compliance. Sanctions for noncompliance include—

- Initially, noncompliant residents are placed on a 2-month improvement plan that requires them to meet with case managers and either obtain employment or complete "work-related activities." Approved work-related activities include documented job searches, training or licensure programs, and some educational activities.
- Continued noncompliance results in loss of one-half the household's subsidy. In most cases, this loss means that rent would be reassessed from the minimum $75 to between $360 and $450 per month for a two- to three-bedroom unit.
- If noncompliance continues for more than 6 months, the household loses its entire subsidy.
- Households are evicted if they cannot pay the higher rents or if they remain noncompliant for 1 year.

Prior evaluations of CHA's work requirement indicate broad resident support for, and compliance with, the policy (Rohe et al., 2013; Rohe, Webb, and Frescoln, 2016). Most residents believe the work requirement is fair. Among work-able respondents to a 2012 survey, 87 percent of those in the work requirement sites and 80 percent of those in the non-work-requirement sites thought so

[4] Enforcement of the policy was delayed due to high unemployment resulting from the 2010 recession.

(Rohe et al., 2013).[5] Administrative data suggest that the policy has not increased evictions; since enforcement began in May 2014 and September 2016, only two households have been evicted (Rohe, Webb, and Frescoln, 2017).

Although case management alone was not successful at increasing employment, when paired with a work requirement, residents' employment increased significantly (Rohe, Webb, and Frescoln, 2016). Analysis of administrative data in December 2012 (15 months after case management began) indicated 51 percent of residents were employed. One year later, slightly prior to enforcement of the work requirement, 58 percent were employed, and a year after enforcement began, wage employment rose to 88 percent. After another year, the number of residents employed was 93.9 percent (Rohe, Webb, and Frescoln, 2016).

Methods

CHA implemented the work requirement in 5 of its 15 family public housing sites, thereby allowing for a natural quasi-experimental design. Residents living in the 5 work requirement sites are the treatment group, and the comparison group is composed of work-able residents living in the other 10 family public-housing sites.

Given how little we know about public housing work requirements, we used mixed-methods and convergent analysis (Creswell, 2015)—which involves separate analysis of each type of data, then comparison of the results to seek areas of convergence or divergence in the findings—to investigate the impacts of the policy on well-being. This approach improves our understanding by leveraging the advantages of both quantitative and qualitative methods (Caracelli and Greene, 1997; London, Schwartz, and Scott, 2007).

Data for this study include survey responses, CHA administrative data, and longitudinal interviews with residents. Surveys were mailed to all heads of household in CHA's 15 nonelderly public housing sites in July 2010 (response rate 75 percent) and September 2014 (response rate 53 percent). Survey data include responses to questions about physical and mental health and food security. Quantitative analysis is limited to those work-able respondents who responded to both the 2010 and 2014 surveys (25 treatment and 101 comparison cases). Administrative data for each household include the head of household's age, the number of children, disability and elderly status, and household income.[6]

Semi-structured interviews were conducted with work-able residents subject to the work requirement in January 2014, September 2014, and November 2015 and with residents in the non-work-requirement (comparison) sites in September 2016. Interviewees in the treatment group were randomly selected from residents living in the five work requirement sites in January 2014 (n = 15). The interview

[5] Mail-out/mail-back surveys were sent to the head of household in all CHA public housing units. Among those living in the work-requirement sites, the response rate was 57.5 percent, and it was 52.8 percent among residents in the comparison sites.

[6] The income variable used is the Total Household Income in HUD's Multifamily Tenant Characteristics System. Work-able households living in CHA housing have their incomes verified biennially, unless they are a minimum renter, in which case the household is required to report an increase in income within 30 days. Due to these policies, the Total Household Income may not be the household's actual income at the time the variable was taken in June 2011 and December 2014.

samples for September 2014 (n = 14) and November 2015 (n = 15) include this original sample, as well as additional randomly selected individuals. Fifteen heads of household were interviewed more than once across the three periods. Residents placed on improvement plans or a subsidy sanction were oversampled to ensure that we heard their perspectives.

The comparison interviews were drawn from work-able residents who had been living in the comparison family public housing sites in December 2013 and who were still living in CHA public housing in September 2016. The sample was matched with work-able residents living in the work-requirement sites in December 2013 based on age, whether dependent children were living in the home, household income, and whether the head of household had a high school diploma or general educational development (GED) certificate.

We asked all interviewees about their household composition; health; employment experiences; educational background; participation in education, job training, or life skills programs; and receipt of welfare benefits such as Medicaid and the Supplemental Nutrition Assistance Program, or SNAP (hereafter, food stamps). We also asked how working outside the home affects their families, their views on the work requirement and, if applicable, experiences with case managers and sanctions. Interviews were recorded, transcribed, and analyzed using deductive coding.

Results

Due to limitations related to sample size, results are suggestive of trends rather than causal inferences. Summary statistics are presented for all work-able survey respondents living in public housing without the work requirement (comparison) and in the five work requirement sites (treatment). As exhibit 1 shows, the sample is largely composed of African-American females. Work requirement respondents were slightly younger (average 42 versus 47 years), were more likely to have children (80 versus 61 percent), and were better resourced—56 percent had reliable access to a car, and 84 percent had a high school diploma or GED.

Median household income increased between 2010 and 2014 for both groups (exhibit 2). Median income among comparison group members was lower than that of the treatment group in 2011 ($1,812 versus $7,540) and in 2014 after the work requirements were implemented ($3,204 versus $10,826). The resulting change in median income from 2011 to 2014 was $1,392 for the comparison group versus $3,286 for the treatment group.

The 2014 survey of households living in the work requirement sites asked what, if anything, the head of household had done in response to the work requirement. Of respondents, 52 percent indicated they had looked for a new job, 37 percent said they had found a new job, and 22 percent said they were working more hours. The Total Household Income data within the Multifamily Tenant Characteristics System data are reflective of these survey results. Reported wage employment increased from 48 to 60 percent among residents in the work requirement sites between 2011 and 2014.

Although household income increased, food insecurity rose among households subject to the work requirement from 60 percent in 2010 to 76 percent in 2014. The increase is consistent with what heads of household said during interviews—that their food stamps were cut as household income rose.

Exhibit 1

Demographic Characteristics of Treatment and Comparison Groups

2014	Public Housing Comparison (N = 101)		Work Requirement Treatment (N = 25)	
	Mean	Std. Dev.	Mean	Std. Dev.
% Female[a]	98	—	96	—
% Black or African-American[a]	98	—	100	—
Age head of household[a]	46.99	9.89	42.04	9.18
% Dependent child in home[a]	61	—	80	—
Total number children in home[a]	1.38	1.50	1.84	1.68
% Reliable access to car[b]	42	—	56	—
% High school diploma or GED[b]	52	—	84	—

GED = general educational development certificate.
Sources: [a]Charlotte Housing Authority (CHA) Tenant Directories (December 2014); [b]2014 survey of CHA public housing residents

Exhibit 2

Income Characteristics of Treatment and Comparison Groups

	Public Housing—Comparison (N = 101)					Work Requirement—Treatment (N = 25)				
	2011		2014			2011		2014		
	Median	Std. Dev.	Median	Std. Dev.	Change	Median	Std. Dev.	Median	Std. Dev.	Change
Median household income[a]	$1,812	$5,183	$3,204	$6,011	$1,392	$7,540	$6,187	$10,826	$8,016	$3,286
	%		%		Change	%		%		Change
Households with wage any income[a]	20		36		16	48		60		12
Households with total income ≥ $1,000/ month[a]	9		17		8	28		40		12
Households minimum renter[a]	69		50		– 19	36		24		– 12
Food ran out sometimes or often[b]	67		65		– 2	60		76		16

Sources: [a]June 2011 and December 2014 Multifamily Tenant Characteristics System reports; [b]2010 and 2014 surveys of Charlotte Housing Authority public housing residents

Low-income and minority populations have worse health outcomes than the general population, as our survey results confirm (exhibit 3). On average, our respondents estimated their health to be "good" (1 is poor, 3 is good, and 5 is excellent), but overall self-rated health worsened slightly within both the comparison (3.21 to 2.91) and treatment (3.84 to 3.04) groups between 2010 and 2014. In the comparison and treatment groups, 45 and 40 percent of respondents, respectively, reported having at least two chronic diseases in 2014, including asthma, hypertension, diabetes, or an autoimmune or inflammatory disease such as lupus, fibromyalgia, or arthritis.

Exhibit 3

Health Characteristics of Treatment and Comparison Groups

	Public Housing—Comparison (N = 101)					Work Requirement—Treatment (N = 25)				
	2010		2014			2010		2014		
	Median	Std. Dev.	Median	Std. Dev.	Change	Median	Std. Dev.	Median	Std. Dev.	Change
Self-rated health	3.21	1.19	2.91	1.14	– 0.30	3.84	0.90	3.04	1.14	– 0.80
CES-D (score ≥ 10 is depressed)	9.13	6.22	10.28	6.63	1.15	8.60	5.85	10.44	5.99	1.84
BMI (≥ 30 obese in AA women)[a]	32.78	9.01	33.99	9.35	1.21	32.95	10.09	35.18	9.67	2.23
	%		%		Change	%		%		Change
Two or more chronic diseases	20		45		25	12		40		28
Physical health limited accomplish-ments	52		54		2	40		64		24
Physical health limited activities	46		44		– 2	28		44		16
Emotional health limited accomplish-ments	49		46		– 3	32		48		16
Anxiety affected activities	42		39		– 3	24		40		16

AA = African-American. BMI = body mass index. CES-D = Center for Epidemiologic Studies Depression.
[a]New studies account for different ranges of healthy and unhealthy BMI in non-White populations (Wagner and Heyward, 2000).
Source: 2010 and 2014 surveys of Charlotte Housing Authority public housing residents

Survey data indicate that respondents' poor health impacts their daily living in multiple ways and most measures of health worsened for those in both the treatment and comparison groups. Self-rated health, depression, body mass index, and the number of chronic diseases heads of household reported all increased. Although not statistically significant, reported anxiety increased more among the treatment than the comparison group between 2010 and 2014.

Work Requirements and Income Changes

Based on resident surveys and interviews, CHA work requirement impacted household income in four key ways. First, for some, the policy provided the impetus and support to secure wage employment. Although the perception that public housing residents do not want to work is

common (Falk, McCarty, and Aussenberg, 2014; Mead, 1986), nearly every resident we spoke with in the treatment and comparison groups wanted to work and believed that other work-able residents should as well. One woman living in a work requirement site shared, "[I think the work policy is fair, because] it pushes me to go out and do things I should already do, things I should've already done … job research, working on resumes, etc." Despite this support, many also expressed fear about what would happen to them if they were unable to find work, "For the people who are looking—it's hard. You can't make people hire you. You can't make people give you a chance."

Many interviewees in the treatment sample told us that case managers provided the support needed to obtain wage employment. A mother of two who was unemployed when she moved into a work-requirement site explained, "I think it is a good stepping stone if you do what you are actually supposed to do. 'Cause they have a lot of resources for you to accomplish the things you are trying to accomplish. …I would say my best experience is my case worker." Another praised her case manager for encouraging her to complete Certified Nursing Assistant (CNA) training. She now has a job she enjoys that pays $14 per hour.

Second, the work requirement seems to have affected education, which in turn affects income, in two very different ways. Some residents said the case management helped them return to school to obtain certifications, such as a CNA, enabling them to earn more. Others, however, stated that the policy was impeding their educations (particularly completion of GED). Although less commonly expressed, frustration with case managers was mostly related to enforcement of the policy, such as requiring parents with dependent children and inadequate childcare to work in low-wage, dead-end jobs. A mother of three without a GED who had been sanctioned for not meeting the work requirement said she did not find the case manager helpful, because "they pushing you to find any kind of job. You know what I mean? It's not fair, because they're not thinking about it long term. I mean working at McDonald's is not a long-term job."

Third, households that transitioned from unemployment or underemployment talked about having their welfare supports reduced. Many in the work requirement sites told us that their welfare benefits had been reduced as their wage incomes increased. Several expressed frustrations similar to this one: "The more you make, the more they take." One resident explained, "I have a temp job making $8 per hour. They cut my food stamps from $333 down to $65 so that's not incentive to work."

Reductions in welfare benefits are especially acute for most interviewees, as their jobs did not pay enough for families to live independent of welfare. An interviewee living in a work-requirement site shared a common sentiment. When asked about her ability to become economically self-sufficient, she said, "The biggest problem with me, is trying to find a decent paying, permanent job… because you can't survive off of eight, nine, even ten dollars." Another work requirement interviewee stated, "I'm doing way better than I was before but that's just because I'm working hard to get what I want. Other than that, no, I still feel like I'm at the bottom. I'm not getting anywhere."

Finally, parents pointed to the tradeoffs of increased employment on their family—more income but also less family time. Nearly all interviewees discussed working in the context of their parenting role. Many in the work-requirement sites told us that the increased income resulting from changes in employment had improved the overall well-being of their families, because they felt

less financial pressure and could afford to do a little bit more than meet basic needs: "I feel like it's a stress when I'm not working, because I do not like bill collectors and then I don't like them to turn my stuff off. Then my kids… when they [are] going on field trips, 'Momma, we just need five dollars… OK, I can give you five dollars to go on the field trip.' But when I'm not working, it makes me feel bad."

All but three of our interviewees were single mothers, and each addressed the challenge of balancing work and parenting. The lack of affordable and reliable childcare directly impacted their employment. One told us, "My biggest challenge is being a single mom. I mean, I have so much on me. If… one of the kids gets sick, I'm the only one to go get them." Another recounted turning down a fast food management position because she did not have affordable childcare.

Interviewees across all sites told us the security provided by living in public housing had a positive impact on their overall well-being. Not only did it provide shelter, but it also helped them stabilize financially. One shared, "If it wasn't for the rent being adjustable I know I probably would have been evicted a long time ago." Another articulated the role that public housing played in her ability to plan for self-sufficiency goals: "Being a single mother of four and just going to school, the housing authority is very beneficial to me. I need to establish a career and work on it until I'm able to move out on my own."

Work Requirements and Health Outcomes

As both survey results and resident interviews evidenced, the baseline physical and mental health of CHA's work-able public housing residents is very poor. Although health measures generally worsened within both groups, individuals living in the work-requirement sites reported diminished health in all measures.

Both groups reported high rates of depressive symptomatology; depression negatively impacts physical health and reduces capacity for employment (Ross and Mirowsky, 1995; Wells, Stewart, and Hays, 1989). Interviews with work-requirement residents suggest much of this condition is situational—the demands of being a single mother and struggling financially—but it was exacerbated by trauma events, poor health histories, or the inability to afford healthcare. A 35-year-old mother of three who did not have health insurance and was relocated to one of the work-requirement sites after a serious domestic violence incident, told us, "They said I got high blood-pressure. I'm anemic. I know I'm depressed, so I guess I'd just say 'good.' When I'm not at work I sleep a lot. I'm sad, I mean, I just feel like down, depression, sad. I don't want to be bothered."

The way a work requirement interacts with other welfare benefits, such as food stamps and access to Medicaid, is of significant concern given the health challenges of public housing residents. For instance, North Carolina Basic Medicaid Eligibility stipulates a mother with a single dependent cannot make more than $434 monthly to be eligible for full Medicaid benefits. If she has two children, she cannot make more than $569, and with three children, no more than $667 monthly (NCDHHS, n.d.). A household of a single parent with one child who lives in a CHA work-requirement development would make *one dollar* too much to qualify for full Medicaid insurance if working only the required 15 hours per week at minimum wage (15 x $7.25 x 4 = $435). As

such, the work requirement policy of only 15 hours a week and the qualifications for Medicaid are incongruent. Complying with the requirements for one program disqualifies a household from receiving the benefits of the other, thereby creating hardships.

Without full medical insurance for routine care, interviewees described going to the emergency room to access medication and healthcare. One woman subject to the work requirement shared, "I had to go to the ER. My blood pressure was through the roof and my head was hurting so bad. They were going to admit me if it didn't come down. I just want to be happy about something. I'm glad to be alive. I'm thankful for my health and my strength and my children and my family so I am happy about some things. But I am always depressed and sad about stuff."

Despite the challenges of reduced benefits and balancing parenting and employment, those subject to the work requirement reported feeling less stressed as a result of increased wage income. At least part of this decrease in stress resulted from feeling that they were better able to care for their families, "Me being the only parent, it's important for [my son] to see me going to work and working to get what we need."

Discussion

This article seeks to understand how a public housing work requirement paired with case management affects well-being as measured by changes in household income and self-rated health. Survey and interview data suggest CHA's public housing residents support enforcement of a 15-hour-per-week work requirement for work-able residents when implemented with case management support and opportunities for compliance through work-related activities. Despite overall support for the policy and increases in household income, interviewees reported frustrations with obtaining living wage employment, reductions in welfare benefits following marginal increases in income, a perceived PHA focus on employment over education, and deteriorations in self-reported health.

During interviews, those residents in the work-requirement sites reported that the policy had provided motivation to find work and that the case managers had offered support and encouragement. Work-requirement interviewees, who had increased their wage employment, indicated that increased wages had reduced some stressors by providing the household with a little extra money that could be used to pay down bills or purchase small "treats" such as a meal out or school pictures.

Although both employment and hours worked increased, few households reached the threshold of $1,000 monthly that Sullivan and DeCoster (2001) found would improve mental health and depression; only 17 percent of comparison households and 40 percent of treatment households met that threshold in 2014. One reason households likely did not meet this threshold was low educational attainment; only 52 percent of comparison and 84 percent of treatment heads of household within the survey sample had either a high school diploma or a GED. Several interviewees argued that the policies would be more effective if residents without a GED or high school diplomas were given a choice between obtaining a GED or wage employment.[7] Households were particularly frustrated that increases in income resulted in reductions in their food stamp benefits and Medicaid coverage.

[7] The 2016 revision of CHA's work policy requires 20 hours of work but also includes a provision for the head of household to attend educational programing and work just 15 hours.

Access to sufficient, healthy food and healthcare is of critical importance, as responses to the 2010 and 2014 surveys suggested that self-rated health worsened within both treatment and comparison groups. Reasons for this decline may include the baseline health status of the residents and the normal effects of aging.

Most of the literature suggests that wage employment improves health (Faragher, Cass, and Cooper, 2005; Ross and Mirowsky, 1995; Stronks et al., 1997), and interviewees in the work-requirement sites reported some reductions in financial stressors; however, the survey data revealed reductions rather than improvements in measures of health. The relatively brief time of the intervention and the sample size may have contributed to these results. Also, research on welfare reform indicates that low-wage employment might not be sufficient to generate health improvements (Cancian et al., 1999; Corcoran et al., 2000; Meyer and Sullivan, 2006; Scott et al., 2004).

Limitations

Our study has several limitations we hope to address in future research. First, it was dependent on a small survey sample of 126 work-able households and an interview sample of 48 individuals. Second, we would like to examine changes during a longer period following work-requirement enforcement. Finally, household income and education within the treatment and comparison groups were significantly different at baseline. Despite these limitations, this study contributes to our limited knowledge of the effects of work requirements on public housing residents.

Policy Recommendations

Only MTW agencies currently have the authority to impose work requirements. Given the limitations of this study and lack of other studies examining work requirements in public housing, we caution against expanding such policies without additional study. HUD should require any PHA proposing a work requirement to collect additional data, including changes in health and well-being for all those living in the household.

CHA's policy reflects recognition of barriers many work-able public housing residents encounter in finding and maintaining employment. Other PHAs should consider a similar policy that begins with a low employment threshold (15 to 20 hours), case management for all affected households or those that are noncompliant, and provision for engagement in "work-related activities" in lieu of wage employment. These policies have provided a safety net for residents who make good faith efforts to find employment and protection from immediate eviction for noncompliance.

One of the most significant barriers to employment was low education levels and a lack of job skills. PHAs considering implementing a work requirement should allow those subject to the policy to meet it through completion of education and job training. Partnerships with community agencies, including Workforce Investment Boards, could help residents develop employment skills and obtain marketable licensures.

PHAs should work with local public health organizations to provide additional support for improving the health of public housing residents. The health needs of this population have been

well documented, and our study provides additional evidence of the need for expanded services. Federal and state policymakers should carefully consider the way work requirements may impact access to healthcare and food.

Overall, CHA's work requirement, including case management and other services, was associated with increases in wage employment without increasing evictions. Parents described wanting to work to provide financially for their families and to serve as a role model for their children. They reported feeling less stressed when they had a little extra money to treat their families and pay their bills. Despite this, household income was not sufficient to support a move out of public housing, physical and mental health needs remained severe, and few residents made progress toward improving their educational levels. PHAs could improve the effectiveness of public housing interventions to increase family self-sufficiency and well-being by providing more job training and educational opportunities, additional health interventions, and access to case management services.

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