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The Effect of Deferred Action for Childhood Arrivals (DACA) Attainment on Risky Health Behaviors: Alcohol Consumption and Smoking

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The Effect of Deferred Action for Childhood Arrivals (DACA) Attainment on
Risky Health Behaviors: Alcohol Consumption and Smoking

by

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Abstract

This paper analyzes the effects of receiving Deferred Action for Childhood Arrivals (DACA) status on the recipients' risky health behaviors. DACA is a program which serves to provide work authorization and temporary reprieve from deportation to eligible immigrants. This study uses a difference-in-differences approach in order to compare DACA eligible individuals to DACA ineligible individuals, who are likely undocumented immigrants, before and after the program went into effect. I analyze repeated cross-sectional data from the US National Health Interview Survey (NHIS) for the period January, 2009, to December, 2016. I explore the effect of obtaining DACA on the individual's likelihood to consume alcohol and smoke in the past year. While the effects are not statistically, the results slightly imply that obtaining DACA reduces the number of days' alcohol is consumed while increasing the number of drinks consumed on those days. Furthermore, they imply that acquiring DACA increases cigarette consumption among current and daily smokers.

1 Introduction

Given the current political landscape, exacerbated by the upcoming 2020 presidential

elections, reform of the U.S. immigration system has been on the top of American minds. An

AP-NORC Center poll finds "49 percent (of American's) mention immigration as a problem

facing the nation, up from one year ago" (Riccardi). One of the biggest matters currently being

discussed is whether immigration reform should include a path to citizenship for unauthorized

immigrants already living in the country; with greater emphasis on unauthorized immigrants who

came to this country as children. Advocates of these youths have pushed forward many

variations of the Development, Relief, and Education for Alien Minors (DREAM) Act,

legislation to grant these minors citizenship, over the past years without any success. That was

until the Deferred Action for Childhood Arrivals program (DACA), was passed on June 15th

2012. Under the DACA those individuals who are approved for deferred action are granted a

renewable 2-year temporary work authorization and pardon from deportation proceedings.

Roughly 800,000 young unauthorized immigrants have received work permits and

temporary protection from deportation through the Deferred Action for Childhood Arrivals

program since its creation[1]. According to U.S. Citizenship and Immigration Services, today

nearly 690,000 of these immigrants are currently enrolled in the program. In order to be eligible

for DACA, there are certain requirements an applicant must meet. The criteria is as follows: the

individual must be under the age of 31 as of 15 June 2012, have arrived in the USA before

reaching the age of 16, and have continuously resided in the USA since 15 June 2007, up until

the time of application. The person must also have 1) been physically present in the USA on 15

June 2012 and at the time of making the request for deferred action, 2) have entered without

inspection prior to June 2012 or had his lawful immigration status expired by that date, 3) be

currently in school, have graduated from high school or obtained an equivalent degree (or have been honorably discharged from the Coast Guard or Armed Forces of the USA)[1], 4) and lastly, have no criminal records or pose a threat to national security or public safety (USCIS website).

From a public health perspective, it is known that undocumented immigrants in the United States are at risk for poor health outcomes (Hacker, 2015). Studies show that harsh immigration policies that focus greatly on deportation and / or place harsh limits on legal rights and access to social services may increase the risk of poor mental health outcomes, such as depression and anxiety, and more broadly constrain access to health care (Dee et al, 2018). The implementation of DACA however has served to address these issues and improve the lives of its beneficiaries in many ways. Previous research shows that since the implementation of DACA there has been increases in education, employment and consequently income for these individuals. Each of the aforementioned results directly correlates with improved health and well-being. Having greater economic opportunities suggest greater future aspirations for these individual which can ultimately result in a desire to invest in their short and long-term health. By eliminating the threat of deportation and providing access to employment opportunities the recipient's aspirations may rise and psychosocial stress might fall, all possibly leading to improved mental and physical health wellness.

2 Literature Review

To what extent does work authorization and temporary amnesty from deportation affect

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[1] Criminal history and honorable discharge from the military were not available in the NHIS Data (because crimes and misdemeanors are not directly queried and honorable discharges were not queried after 2010) therefore could not be taken into consideration in my study.

the school and labor market for undocumented workers? Amuedo-Dorantes and Antman explore this phenomenon thoroughly by comparing the outcomes of individuals who were eligible and ineligible undocumented immigrants before and after the program went into effect. Their research findings suggest that a lack of authorization may lead individuals to enroll in school when working is not a viable option but once they are given the opportunity to work they immediately enter the work force to fully benefit from this short-term opportunity (Amuedo-Dorantes & Antman, 2017). In other words, once employment restrictions are relaxed, the opportunity costs of higher education rise and those eligible individuals may often choose to reduce investing in schooling instead to fully benefit from their provisional opportunity (Amuedo-Dorantes & Antman, 2017). This finding is consistent with other studies in that it demonstrates that when an individual is given the opportunity to work hard without fear it allows the individual to focus and plan for a healthier more financially stable future.

Individuals that immigrate to the United States often arrive with relatively low socioeconomic status and come from countries with poorer population health outcomes than that of the United States (Filion, 2018). In the analysis of mental health problems faced by Immigrant adolescents, Filion examines what the risk of experiencing mental health problems is, given being foreign-born in American society. Citizenship, he states, represents integration into U.S. society inclusive of access to public benefits and economic opportunities that may serve as a marker for cultural assimilation. However, for foreign-born citizens their experience is vastly different, which over the long run is a determinant of their well-being (Filion, 2018).

Supporting this discovery, DACA has been able to change these effects for those DACA eligible immigrants. There have been positive descriptive studies of DACA beneficiaries that have revealed remarkable improvements in psychological well-being after the program's

implementation. Patler and Pirtle's study demonstrate the positive emotional consequences of transitioning out of undocumented status for immigrant young adults (Patler & Pirtle, 2017). In another studies, findings show that rates of moderate or severe psychological distress in the DACA-eligible group fell by nearly 40% relative to rates in the DACA-ineligible group after the program was signed into law (Venkataramani & Atheendar et al., 2017). Economic opportunities and protection from deportation for undocumented immigrants, as offered by DACA, could ascribe large mental health benefits to such individuals.

Hainmueller et al find further evidence of this in their study, where the mental health benefits of DACA extended across generations: among the children of DACA-eligible mothers. Their results show that children of Mothers' who are DACA eligible had significantly decreased diagnoses of adjustment and anxiety disorder, an abnormal and excessive reaction to a life stressor. Rates of adjustment and anxiety disorders, fell by more than half after DACA was implemented. Parents' unauthorized status is therefore a substantial barrier to normal child development and perpetuates health inequalities through the intergenerational transmission of disadvantage (Hainmueller, Jens, et al, 2017).

I contribute to this literature by examining the effects of DACA eligibility on the young immigrant's risky behaviors and decisions. The ability to pursue a more promising future allows oneself to make wiser choices and take care for their mental and physical wellbeing.

3 Research Question

With these policy implications in mind, I analyze risky health behaviors as an indication of future healthy outcomes. My analysis looks at the effect of obtaining DACA on cigarette use and drinking. The first behavior, smoking, has many well documented adverse effects.

According to the Center for Disease Control Smoking causes more harm and deaths every year

than HIV, illegal drug use, alcohol use, motor vehicle injuries, and firearm related incidents

combined. The second dependent variable is alcohol consumption, measured by how many days

and units of alcohol were consumed by the individual in the past year. Although there is an

abundant amount of literature on the schooling and labor market affects of DACA, there is very

limited to no literature that discusses or explores a significant causal relationship between DACA

and smoking or drinking habits of its recipients.

4 Methods
4.1 Data

To evaluate the effects of DACA on an individual's decision to make wholesome health

choices I used repeated cross-sectional data from the US National Health Interview Survey for

the period January, 2009 to December, 2016. The NHIS is an in person interview survey that

tracks health outcomes, behaviors, and access to care in the US civilian, non-institutionalized

population. The original cross sectional data set has a total of 806,175 observations. Although I

am unable to observe the actual participation of unauthorized individuals in the program, my

treatment group does fulfill the collection of the DACA-eligible requirements, it displays

demographic characteristics that align with the reported DACA applicants. I start off by

restricting my attention to individuals aged 19-50 as this meets the target age of those eligible for

DACA. Next I limit for those who reported Hispanic ethnicity only, this is because nearly 90%

of DACA beneficiaries were born in Central America or South America, making it a good

representation of the most likely to be unauthorized. In order to continue to acquire a better

representation of undocumented DACA eligible immigrants, I restricted my attention to non-US

citizens with at least a high school education. Further limiting to those having arrived in the

United States at an early age and residing within the country for at least 5 years. After I drop

observations that are outside the scope based on the above limiting criteria my sample is reduced

to 11,995 observations. I utilized the following equation in my statistical analysis:

$$Y_{ist} = \alpha + \beta_1 \, (DACA_t \times eligible_{ist}) + \beta_2 eligible_{ist} + \beta_3 \mathbf{Educ}_{ist} + \beta_4 YearsinUS_{ist} + \beta_5$$

$$\mathbf{Intervwyr}_{ist} + \beta_6, Ageatimm_{ijst} + \beta_7 \mathbf{Age}_{ijst} + X_{ist}\gamma$$

where the subscript i references the individual and t the year–month of the survey

$DACA_i$: a is a binary indicator for survey timing (1 if surveyed after June 2012, when the first

large wave of individuals received official notification that their cases had been approved, and 0

otherwise)

$Eligible_i$ is a binary indicator denoting whether the individual met DACA eligibility criteria (1 if

individual was DACA-eligible, 0 otherwise)

$Educ_i$: is a binary indicator denoting whether the individual met educational requirement criteria

(1 if individual had more than a high school degree or its equivalent, 0 otherwise)

$YearsinUS_i$: is a binary indicator denoting whether the individual met U.S. residence requirement

criteria (1 if individual resided in the US for at least 5 years when DACA was implemented, 0

otherwise)

$Ageimm_{ijst}$: individuals age when entered to the US

Age_{ij}: participants age in years at the time of the policy change

X_{isty}: consists of key covariates, census region of residence, gender, and year–month of

interview.

The difference-in-differences estimate is denoted by the coefficient on the product term (β1).

This estimate can be interpreted as the effect of the policy on DACA-eligible individuals before

versus after the policy change, compared with the effect on DACA-ineligible individuals. I adjusted for the complex survey design of the NHIS by using Robust Standard Errors to account for heteroskedasticity.

4.2 Robustness checks

My first robustness check limits the population from Hispanic to those of Mexican-origin only. The vast majority of DACA applicants are Hispanic (almost 3/4th of unauthorized immigrants are Hispanic) and about 60 percent of them are from Mexican-origin according to the Pew Research Center. By imposing this restriction, I end up with a sample that is more representative of the DACA population, therefore leading to a subset for comparison to the original Hispanic sample. My second robustness check ensures I account for differential time trends. It is crucial to account for age differences because habits, more precisely health habits, change over time due to things like health status and if not accounted for would result in a bias estimate. I attempted to overcome this by further restricting my sample from individuals younger than 50 years of age to individuals younger than 40 years of age and analyzing if there is a change in outcomes. Finally, my third robustness check helps me to observe if unqualified DACA immigrants shared the same health risk behaviors compared to DACA eligible immigrants. I re-estimated my models to account for only adults who had completed less than a high school education only and were not currently in school at the time of the survey to analyze if this policy had any affect on their health outcomes.

It is important to be mindful nevertheless that each of these data limitations would bias my estimates toward the null, either by deflating estimates of the intention-to-treat effect, introducing classic measurement error, or inaccurately assigning respondents to eligible and

ineligible groups.

5 Results

In my selection of an appropriate sample, I incorporated Venkataramani et al's approach from their paper "Health consequences of the US Deferred Action for Childhood Arrivals (DACA) immigration programme: a quasi-experimental study" as the basis for my sample selection. In my sample as shown in table 1, consistent with Venkataramani, I included non-citizen, Hispanic adults aged 19–50 years where I further restricted my sample to consist of only individuals who had lived in the USA for at least 5 years and had completed at least high school or its equivalent. These criteria were selected in order to conform to the DACA eligibility requirements. My departure from the authors sample selection is due to my disagreement with their classification of "unknown" and "don't know" respondents throughout my sample. These groups include individuals who either did not reply to the survey question or simply responded I did not know the answer. The authors included these individuals in their "greater than a high school education" and "non-US citizens" samples, whereas I did not include them. As such my number of respondents for the "Restrict to non-US citizen" and "Restrict to those with a >= high school education" categories are lower than in the authors study.

For comparability purposes I have conducted a similar summary statistic results as the authors in table 2. As you can see in that table my results display similar results to that of the author in every category, starting with similar number of respondents for individuals that are eligible and not eligible for DACA. My final sample contained 11,995 respondents for the self-reported health outcome and 4,342 respondents for mental health outcomes. The introduction of DACA compared with people ineligible for DACA showed no significant change among DACA-eligible individuals in terms of self-reported overall health (b=0.018, 95% CI -0.05 to 0.08) or

likelihood of reporting poor or fair health (B=0.012, 95% CI -0.0 to 0.03) similar to the findings of the author as shown in table 3. However, similar to that of the author I found that DACA-eligible individuals also experienced a reduction in K6 score compared with DACA-non eligible individuals. Given the fact I was able to achieve a similar sample size and results, I concluded this as a fair starting point for the continuation of my DACA risky health behavior analysis.

Although one might expect that DACA eligible individuals would be less likely partake in risky behaviors compared to those individuals who are ineligible, there are many factors to take into consideration. On one hand, these individual's future may now appear more secure and promising which could result in the individual becoming more astute about their health choices (resulting in little to no participation in risky behaviors). On the other hand, it may also be rational to assume that having the ability to work without the fear of being deported may reduce the pressure to take every precaution, now allowing themselves to make mistakes and take risks they would have not allowed themselves to do before (resulting in participation of risky health behaviors). These contrary thoughts illustrate themselves through my results in the subsequent paragraphs.

The relationship between DACA eligibility and alcohol consumption is displayed below in table 4. The DACA eligible variable shows that there is not a statistically significant relationship, however it still implies that obtaining DACA reduces the number of days' alcohol is consumed while increasing the number of drinks consumed on those days. The results also imply that DACA eligible individuals, who attained at least a college degree compared to those who only completed high school or less than a Bachelor's degree, drank more days in the past year. A potential reason for this could be that these individuals were still in school and therefore had more leisure time to enjoy the college party lifestyle in the past year. Finally, note that the

variable female is statistically significant, implying females are less likely to consume alcohol in terms of number of units and days in the past year.

Table 5 estimates the relationship between DACA eligibility and smoking, this is determined based on the number of cigarettes consumed in a day by current smokers and daily smokers. All results are not statistically significant, but there is a positive correlation between smoking cigarettes whether you're a current smoker or a daily smoker. This may be a result of finally allowing themselves to partake in behavior of their peers or the nervousness of being granted this temporary status followed by the uncertainty of when their temporary status might end. The results also imply that there is a negative correlation between obtaining a college degree and smoking, which can be a result of being more knowledgeable and informed of the risks associated with smoking. Finally, you can also see that the results imply there is a negative correlation between females and cigarettes usage, by current smokers as well as a by daily smokers on a daily basis. This negative correlation can be due to the social stigma attached to cigarette smoking, specifically with females.

Lastly, table 6 contains sensitivity analyses, including a falsification test to look at the data through different vantage points. The Mexican-American population and the group of individuals under the age of 40 years old were not found to be statistically significant across the previously discussed criteria of alcohol consumption and smoking. This reinforces my results above, giving me more certainty about the correlations found. The third sensitivity test looked at a population of individuals who had less than a high school education and as such were not expected to be affected by the introduction of DACA. My results corroborated this as the data showed no statistical significant across all risky behaviors; alcohol consumption, smoking for this group but yielded similar correlations.

6 Conclusion

The correlation between health and citizenship status is well-documented. Showing where this correlation comes from, and ultimately delivering results for causal pathways has been a far more challenging task. This paper used the Deferred Action for Childhood Arrivals requirements across years to isolate behavioral variation in individuals' pre and post DACA implementation. Doing so allowed me to analyze the effect of obtaining DACA on risky health behaviors as a potential causal pathway that Citizenship status, even temporary status, improves health outcomes.

The main shortcoming of this paper, despite the quasiexperimental research strategy, was the inability to include observations of individuals who I knew with certainty were undocumented immigrants and/or met all the DACA qualifications: causal of using public data. A future improvement on this study would be to expand the sample size to include current year data. An additional control could be added for President Trump being in office. His harsh immigration policies could have influenced the outlook of these individuals. It would be interesting to observe if there are any changes in DACA recipients' behavior due to Trump's border control policies, possibly effecting their family members, and his attempt to end the program.

The results, although not statistically significant, imply that individuals who receive DACA are less likely to engage in some risky health behaviors. Specifically speaking, the results report that obtaining DACA reduces the likelihood an individual is a smoker although there are signs alcohol consumption might increase in certain individuals. A significant take away from this study is that rescinding DACA might present a great threat to public mental health and it is imperative that health care providers and public health officials take an active role in offsetting

this threat. Mental health disorders cost the US healthcare system over $200 billion in 2013, making it one of the costliest diagnosis' (Roehrig, 2016). We found that the DACA program had important, positive effects on mental health outcomes. These benefits have so far been underappreciated so its crucial that we vocalize the benefits and integrate it in our immigration policies. Providing a path to citizenship through pro immigration reform offers stability and certainty to immigrants and their family members, which in turn lowers the risk of mental illness.

Tables

Table 1

Study Sample and Inclusion Cri*t*eria

2008 - 2016 NHIS			
Total Interviews	N	=	806,175
Rest*r*ict to ages 19-50	N	=	340,285
Restrict to Hispanic ethnicity	N	=	84,780
Restrict to non-US citizen	N	=	34,487
Restrict to those with a >= high school education	N	=	14,166
Restrict to those who have lived in US >= 5 years	N	=	11,995

Notes: Figure displays changes in sample size after applying each restriction. The final sample size of 11,995 reflects all individuals in the analytic sample with measures of self-reported overall health. Of this group, a randomly selected third (4,342) were administered the K6. (These results and methods were derived from Venkataramani, et al appendix paper "Health Consequences of the US Deferred Action for Childhood Arrivals (DACA) Immigration Programme: A Quasi-Experimental Study". However, upon thorough review I did not find fitting to include the unknown-do not know respondents as the referenced paper did when restricting the sample size in the category "greater than or equal to a high school education".

Table 2

Sample Statistics

	Eligible for DACA		Not Eligible for DACA	
Number of Respondents	Pre-DACA	Post-DACA	Pre-DACA	Post-DACA
Self-Reported Overall Health Outcomes	1171	1730	4,346	4,744
Mental Health Outcomes	344	536	1,690	1,772
Self-Reported Overall Health Outcomes (Likert Scale Score 1-5)	3.98 (0.93)	3.99 (0.94)	3.81 (0.98)	3.81 (0.98)
Fair or Poor Health	54 (4.6%)	87 (5%)	348 (8%)	380 (8%)
K6 Score (0-24)	2.36 (3.82)	2.14 (3.53)	2.09 (3.65)	2.10 (3.57)
Moderate or Worse Psychological (K6 Score >= 5)	69 (20%)	91 (17%)	695 (16%)	301 (17%)
Gender, Female	597 (51%)	882 (51%)	2173 (50%)	2372 (50%)
Age (Years)	23.0 (2.88)	25.0 (4.25)	36.8 (7.03)	38.09 (6.87)
Age at Immigration (Years)	5.4 (6.9)	5.0 (6.0)	21.4 (8.2)	21.6 (7.5)
Census Region				
Northeast	*117* (10%)	173 (10%)	652 (15%)	569 (12%)
North central or midwest	82 (7%)	208 (12%)	348 (8%)	474 (10%)
South	422 (36%)	571 (33%)	1608 (37%)	1803 (38%)
West	550 (47%)	796 (46%)	1738 (40%)	1945 (41%)

Notes: Data are mean (SD) or n (%) unless specified otherwise. All data are from the NHIS, 2009–16. The sample is restricted to non-citizen, Hispanic men and women aged 18–50 years who have lived in the USA for at least 5 years and who have completed at least a high school education or above. Eligible for DACA refers to individuals who were 31 years or younger as of June, 2012, and had immigrated to the USA at age 16 years or before. Pre- DACA denotes respondents interviewed before June, 2012, and post-DACA those interviewed thereafter. The K6 instrument was administered to a random subset of NHIS respondents. Descriptive statistics were weighted by NHIS sampling weights. DACA=Deferred Action for Childhood Arrivals. K6=Kessler 6 scale. NHIS=National Health Interview Survey. These results and methods were derived from Venkataramani, et al appendix paper "Health Consequences of the US Deferred Action for Childhood Arrivals (DACA) Immigration Programme: A Quasi-Experimental Study"

Table 3

Sensitivity analysis

	Self-Reported health (Likert scale score 1-5)	Poor or fair health	K6 score (0-24)	Moderate or Worse psychological distress (K6 score >=5)
Restricted to Mexican-American only				
Differences-in-differences estimate (95% CI)	0.018 (-0.05 to 0.08)	0.012 (-0.0 to 0.03)	0.019 (-0.39 to 0.43)	-0.010 (-0.05 to 0.033)
p value	0.826	0.292	0.926	0.658
Number	11,991	11,991	4,342	4,342

Notes: Differences-in-differences estimates of the effects of the DACA programme on health outcomes. For the ordinary least-squares (self-reported health) and (K6 score) models, I calculated 95% CIs with heteroscedasticity-corrected SEs. The estimates shown reflect coefficients on the interaction between binary indicators that denote meeting the eligibility criteria of age at immigration (16 years or younger) and age at policy implementation (31 years or younger) and being surveyed after programme implementation (June, 2012). All models include the main effects for meeting DACA eligibility thresholds, interview year–month fixed effects (which subsume the main effects of being surveyed after DACA implementation), and adjust for respondent age (at the time of policy), gender, fixed-effects for years living in the USA, and fixed effects census region of residence. All models use National Health Interview Survey sampling weights. K6=Kessler 6 scale. DACA=Deferred Action for Childhood Arrivals.

Table 4

Estimates of the Relationship Between DACA Eligibility and Alcohol Consumption

	Number of units	Days per week	Days in past year
DACA Eligible	0.082	-0.817	-1.00
	(-0.235)	(-0.486)	-0.992
College Degree	0.743	0.372	5.165**
	(-0.406)	(-0.486)	(-1.121)
Female	-0.596**	1.144**	-8.848**
	(-0.148)	(-0.298)	(-0.582)
R2	0.00	0.01	0.02
N	11,991	11,991	11,991

*p<0.05; **p<0.01

Notes: Differences-in-differences estimates of the effects of the DACA programme on Alcohol consumption. The estimates shown reflect coefficients on the interaction between binary indicators that denote meeting the eligibility criteria of age at immigration (16 years or younger) and age at policy implementation (31 years or younger) and being surveyed after programme implementation (June, 2012). All models include the main effects for meeting DACA eligibility thresholds, interview year–month fixed effects (which subsume the main effects of being surveyed after DACA implementation), and adjust for respondent age (at the time of policy), gender, fixed-effects for years living in the USA, and fixed effects census region of residence. All models use National Health Interview Survey sampling weights. K6=Kessler 6 scale. DACA=Deferred Action for Childhood Arrivals.

Table 5
Estimates of the Relationship Between DACA Eligibility and Smoking

	Current Smoker	Daily Smoker
DACA Eligible	0.031	0.037
	(-0.040)	(-0.032)
College Degree	-0.030	-0.038
	(-0.041)	(-0.038)
Female	-0.227**	-0.176**
	(0.028)	(0.025)
R2	0.01	0.01
N	11,991	11,991
*p<0.05;**p<0.01		

Notes: Differences-in-differences estimates of the effects of the DACA programme on smoking. Model is identical to that presented in table 4.

Table 6

Sensitivity analysis

	Alcohol Consumption			Smoking	
	Number of units	**Days per week**	**Days in past year**	**Current Smoker**	**Daily Smoker**
Restricted to Mexican American only Differences-in-differences estimate (95% CI)	-0.039 (-0.38 to 0.31)	0.019 (-0.87 to 0.91)	-0.941 (-2.69 to 0.81)	-0.006 (-0.08 to 0.07)	0.0122 (-0.04 to 0.07)
p value	0.826	0.966	0.292	0.881	0.678
Number	11,991	11,991	11,991	11,991	11,991
Restricted to younger than 40 years Differences-in-differences estimate (95% CI)	0.042 (-0.45 to 0.54)	-0.675 (-1.64 to 0.29)	-0.574 (-2.56 to 1.41)	0.036 (-0.04 to 0.11)	0.037 (-0.03 to 0.10)
p value	0.869	0.171	0.571	0.449	0.259
Number	11,991	11,991	11,991	11,991	11,991
(falsification test) Restricted to less than high school education Differences-in-differences estimate (95% CI)	0.011 (-0.34 to 0.36)	-.343 (-1.06 to 0.37)	-0.699 (-2.06 to 0.66)	0.025 (-0.03 to 0.08)	0.027 (-0.04 to 0.09)
p value	0.949	0.349	0.313	0.401	0.432
Number	29,739	29,739	29,739	29,739	29,739

Notes: Models are identical to those presented in table 4, 5, &6, except the sample is restricted as denoted.

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