

**BRIEFING PAPER:**  
**MENTAL HEALTH AND SUBSTANCE ABUSE PROBLEMS  
AMONG WOMEN ON WELFARE**

Prepared by the Women's Programs Office  
American Psychological Association  
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Washington, DC 20002-4242  
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## **INTRODUCTION**

The estimates of the numbers of women on welfare who experience major depression, post-traumatic stress disorder (PTSD), anxiety disorders, panic disorders, and agoraphobia, as well as serious mental illnesses such as schizophrenia and bipolar disorder, vary a good deal. Generally, however, most reports find that poor women experience these mental health disorders at much higher rates than the general population.

In this briefing paper, we summarize recent research on the powerful and negative impact of mental health problems, such as depression, and on the high prevalence of mental health problems among poor women. We also outline a number of critical issues related to poor women and mental health, including the minimal prerequisite that women with mental health problems need to be identified before they can be referred, effective treatment for women with mental health and substance abuse problems, and the difficulties these women face in trying to locate, get, and keep a job. Those individuals with certain serious mental illnesses, such as schizophrenia, who are identified are often folded into the public mental health system. These individuals usually receive Supplemental Security Income (SSI), not Temporary Assistance For Needy Families (TANF), and Medicaid. Though these individuals are not on welfare, per se, they are poor and they too face certain serious obstacles in their efforts to find a job and keep it.

To reflect a variety of perspectives in this briefing paper, we sought input from individuals in related disciplines who provide services to or do research with poor women. Appendix A acknowledges, with thanks, the input these individuals have provided.

## **MENTAL HEALTH PROBLEMS: A SERIOUS PUBLIC HEALTH CONCERN**

Poor mental health continues to be a serious albeit largely unrecognized public health concern. Poor mental health, including depression, anxiety, panic disorders, agoraphobia, and PTSD, as well as serious mental illness, such as schizophrenia and bipolar disorder, continues to rob society of the productive work and lives of countless individuals.

Depression is a particularly prevalent mental health problem. Depression was estimated in 1990 to cost the nation from \$30 to \$40 billion in direct costs, lost work days, lost productivity, and disruption to personal and family life (National Institutes of Mental Health (NIMH), Depression Awareness, Recognition, and Treatment Campaign (D/ART), no date). Depression is associated with excessive use of health care services (Regier et al., 1988), higher medical costs, greater disability, poor self-care and adherence to medical regimens, and increased morbidity and mortality from medical illness (Katon & Sullivan, 1990; Research Agenda for Psychosocial and Behavioral Factors in Women's Health, 1996).

Depression can be debilitating and disabling. An individual suffering from depression can experience combinations of the following symptoms: sad, hopeless, discouraged feelings; loss of interest or pleasure in nearly all activities; changes in appetite or weight; changes in sleep patterns (sleeping a lot or experiencing insomnia); changes in psychomotor activity (e.g., pacing); tiredness, fatigue, and decreased energy; feelings of guilt or worthlessness; impaired ability to

think, concentrate, or make decisions; memory difficulties; thoughts of death or suicide (*Diagnostic and Statistical Manual of Mental Disorders*, 4<sup>th</sup> ed. [DSM-IV], 1994). It may very well be that what has long looked to some like dependency and a lack of motivation among women on welfare are actually symptoms of depression.

And it is women who are particularly vulnerable. Women's risk for depression is double that of men (McGrath, Keita, Strickland, & Russo, 1990). A host of biopsychosocial factors contribute to the prevalence of this illness among women, including socialization that shapes personality styles that are more avoidant and passive, pervasive violence in some women's lives, the cost of being the primary caretaker in many familial and social relationships, and possible biological factors related to reproduction. Poverty carries an added risk for depression (McGrath et al., 1990), and women are more likely to be poor than are men. According to U.S. Bureau of the Census (1995) figures, 90% of the almost 5 million adults on public assistance are women (most of the 14 million on public assistance are children).

### **PREVALENCE OF MENTAL HEALTH DISORDERS AMONG POOR WOMEN**

Until very recently, policymakers have focused little on mental health problems among women on welfare and their role as a serious barrier to employment. Nevertheless, studies have shown that mental health problems among women on welfare may restrict their ability to participate in employment and training programs or to leave welfare for employment (Danziger, Corcoran, Danziger, Heflin, Kalil, Levine, Rosen, Seefeldt, Siefert, & Tolman, 1998; Jayakody, Danziger, & Pollack, 1998; Olson & Pavetti, 1996).

Mental health problems are much harder to identify than are physical disabilities, often requiring welfare recipients to self-disclose. Depression, generalized anxiety disorder, substance abuse, and the existence of past abuse or current domestic violence and its psychological impacts are a few issues that welfare recipients may not readily reveal in interviews with caseworkers or researchers; however, evidence suggests they are highly prevalent and can discourage self-sufficiency (Olson & Pavetti, 1996).

Several large-scale surveys provide clear evidence of the rates of mental health problems and substance abuse among welfare recipients. Analysis of data from the National Longitudinal Survey (NLS) reveals that almost 90% of current welfare recipients between the ages of 27 and 35 experience one of five powerful barriers to employment, which include low basic skills, substance abuse, a health limitation, depression, or a child with a chronic medical condition or serious disability. Approximately 24% of recipients reported mental health problems (13.19% reported being depressed between 5 and 7 days a week, and 11.05% reported being depressed between 3 and 5 days of the week), compared with 11% of nonrecipients (Olson & Pavetti, 1996).

Data from the Women's Employment Study (WES), which surveyed 753 single mothers with children who were on the welfare rolls in an urban Michigan county in February 1997, showed that 85% of respondents had at least one of 14 barriers to employment, which included mental health problems. Approximately 26% of respondents reported depression, 14.6% reported post-

traumatic stress disorder, and 7.3% reported generalized anxiety disorder. These rates are considerably higher than those for women reported in the National Comorbidity Study (a survey of a representative national sample, assessing comorbidity of substance use and non-substance use psychiatric disorders), which found a 13% rate of depression, and a 4% rate of generalized anxiety disorders (Danziger et al., 1998).

In a similar study, researchers who analyzed data from a 1994-1995 National Household Survey of Drug Abuse (NHSDA) found that approximately one-fifth (20%) of welfare recipients experienced one of four psychiatric disorders (major depression, generalized anxiety disorder, panic attack, and agoraphobia), in contrast to 15% of nonrecipients who reported the same problems. Major depression and agoraphobia were the most prevalent. Eleven percent were diagnosed with depression and 5% were diagnosed with agoraphobia, compared to 8% and 2%, respectively of nonrecipients. Additionally, had the NHSDA measured additional disorders, the full extent of psychiatric disorders probably would have been much higher (Jayakody et al., 1998).

It bears noting that underreporting is a potential problem in efforts to determine accurately the prevalence of mental health problems among poor women.

### **VIOLENCE CONFERS ADDED RISK**

Violence, whether past or current, is another important part of the picture of mental health problems among welfare recipients and is a major barrier to self-sufficiency. Abused women are more likely to suffer depression, anxiety somaticization, and low self-esteem than those who have never experienced abuse, compromising their ability to leave welfare (McCauley et al., 1997).

Estimates of the prevalence of violence among women on welfare vary a good deal. However, rates are consistently higher than for women in the general population. Studies of several welfare and employment and training programs have found that at least 50% of participants receiving Aid for Families with Dependent Children (AFDC) had experienced domestic violence (Lyons, 1997, cited in Kramer, 1998).

Browne and Bassuk (1997) analyzed data from a study of 436 homeless and housed mothers receiving welfare. They found that 63% of respondents had experienced severe violence by childhood caretakers, and 42% had experienced childhood molestation. Likewise, over 60% of the total sample had experienced severe physical violence by an intimate during adulthood. An astounding 86% of all respondents had experienced physical and/or sexual abuse at some point in their lives. In addition, between 69% and 71% homeless and housed respondents reported suffering from at least one mental health disorder in their lifetime. By contrast, 47% of women in the general population report at least one lifetime disorder. Forty percent reported experiencing depression, in comparison to 21% of the general population. Likewise, respondents experienced PTSD at a rate three times higher than the general population (34.8%, compared with 12.4%) (Salomon, Bassuk, & Brooks, 1996). These researchers believe that PTSD is the primary disorder, driving secondary disorders of major depression, anxiety disorders, substance abuse, and so forth (Bassuk, Browne, & Buckner, 1996).

## **ISSUES/RECOMMENDATIONS:**

### **Issue: Mental health problems are not currently recognized as the serious public health concern they in fact represent.**

Mental health problems powerfully affect the productivity and quality of life of millions of Americans. Poor women tend to suffer from mental health problems at higher rates. Treatment helps women get well, and women who are well are more likely to get and hold jobs. Yet at neither federal nor state levels are mental health problems recognized as the serious public health concerns they are. Mental health care and insurance coverage should be equal to that for physical health coverage (Rice, 1998).

### **Recommendations:**

- Mental health care is a basic need for women and should be included in all state Medicaid health benefit packages. These benefits should be nondiscriminatory compared to medical benefits (i.e., parity), without financial requirements that bar access to clinically appropriate treatment.
- States and the managed care organizations they contract with to provide health care services are not required to integrate behavioral health care into their health plans. States have the option to contract out behavioral health care services to stand-alone companies, that is, “carving “ out mental health coverage. Integrating mental health care into overall health care plans will deliver better, more coordinated care.
- As states contract out Medicaid health coverage to managed care organizations, states need to develop and offer programs to educate both caseworkers and the women on welfare who are their clients about how best to navigate managed care, with the goal of obtaining the best quality care possible (Rice, 1998).
- Federal and state agencies should fund more research on the prevalence, treatment options, and treatment outcomes of mental health and substance abuse problems for women on welfare (Rice, 1998).

### **Issue: Women with mental health disorders are not currently being adequately identified.**

As noted earlier, poor women experience depression, anxiety disorders, panic disorders, post-traumatic stress disorder, and other mental health problems at higher rates than women in the general population, and these problems can interfere with the ability to hold onto a job. However, because neither the women themselves nor the caseworkers or other service providers may recognize their symptoms as symptoms of mental health disorders, these women may function at low levels for years without being identified as in need of mental health treatment.

### **Recommendations:**

- Caseworkers, primary care physicians, providers in family planning clinics, providers in pediatrician's offices, emergency room personnel, child support enforcement staff, housing office staff, employment office staff, and police officers (Kaplan, 1998) all need education and training on recognizing signs of possible mental health problems. It is not reasonable to expect these professionals to serve as mental health care providers. However, rudimentary training in recognizing some basic signs and symptoms, along with the resources to refer individuals for more complete assessment and/or treatment, will more effectively identify women who with some treatment may be better able to live a healthier, more productive life, including moving from welfare into the workplace.
- In welfare offices, job training offices, child support offices, housing offices, primary health care provider's offices, and hospital emergency departments, make available to all clients and patients printed information identifying the signs and symptoms of depression, post-traumatic stress, panic disorder, anxiety disorder, and other mental health problems, and ways to get help, so individuals are able to self-identify and perhaps seek treatment.
- In addition to screening tools, better integration of services, comprehensive case management, and procedures to allow immediate assessment and treatment will help identify these women and make treatment available to them (Kaplan, 1998).

**Issue: Despite the strong connection between violence - whether past or present - and mental health problems, and despite the high incidence of violence among poor women, women with histories and experiences of violence are not currently adequately being identified.**

The Family Violence Option (FVO) is intended to help domestic violence victims and survivors move from welfare to work. States have the option of implementing the FVO as part of the 20% caseload exemption for welfare recipients experiencing personal and family challenges. The FVO allows states to screen welfare participants for domestic violence victimization, provide referrals to specialized services, and provide good cause waivers from the five-year lifetime limit on TANF assistance and mandatory work requirements. However, according to a recent report done by the Taylor Institute (Raphael & Haennicke, 1998), thirty-one (31) states have implemented FVO; nine (9) states are planning to adopt FVO; ten (10) states have not adopted the FVO but have taken domestic violence into account in their state plans; and two (2) states are not adopting FVO and have not made any provisions for battered women in their state plans. In addition, indications are that the FVO as implemented is not effective in identifying and helping the women for whom it was intended.

**Recommendations:**

- Federal policy should mandate that all states adopt the Family Violence Option, and exemptions to and extensions of time limits need to be provided to all women identified with a history of abuse, as well as the experience of abuse in the recent past.

- The recommendations related to screening and identification of TANF recipients for mental health problems (outlined above) apply as well to screening for histories of violence and abuse, that is, caseworkers, primary care physicians, providers in family planning clinics, providers in pediatrician's offices, emergency room personnel, child care providers, child support enforcement staff, housing office staff, employment office staff, and police officers should all receive more education and training on recognizing signs of abuse. Information on the prevalence of violence among women and the connection between the experience of violence and current mental health problems, as well as how to get help, should be made available to women in all these settings, so they are able to self-identify.
- Better integration of services and comprehensive case management are needed to better coordinate care and connect women with the services they need.

**Issue: Treatment must be accessible.**

Women identified as needing mental health treatment can face intimidating obstacles. Along with the disabling effects of some mental health problems, logistical obstacles such as the lack of childcare and transportation, are often overwhelming and seriously interfere with getting care. Information about treatment is not enough. Getting poor women into treatment requires extensive outreach. In addition, for women in abusive situations, it may be dangerous to let an abusive partner know where they are going, that is, that they are doing something besides going to a provider for obstetrical/gynecological care.

**Recommendations:**

- Provide access to mental health treatment in locations that are convenient, including within the same facility as other services used, for example, family planning clinics, primary care provider's offices, and welfare offices.
- Provide vouchers for transportation and childcare to enable mothers to participate in the treatment programs.

**Issue: Treatment models designed for men may be less effective for women, who with their children make up the vast majority of individuals receiving TANF.**

Most recipients of public assistance are poor women and their children. Treatment models designed by men and for men are likely to be less effective for women. For example, mental health problems, including substance abuse, are often linked to past experiences of physical and sexual assault. Treatment models that do not address this critical issue will not be as successful for women. In addition, treatment facilities need to take into account the special needs of women. Women who are caring for children and who have substance abuse problems need assistance with child care to be able to take advantage of treatment.

Recent National Institute on Drug Abuse (NIDA) research indicates that drug abuse may and progress differently, have different consequences, and therefore, require different preventive and

treatment approaches for women and men

**Recommendations:**

- Effective mental health treatment for women needs to accommodate differences in patterns of substance abuse by women, the impact of violent assault and sexual abuse on the mental health of women, eating disorders, issues of discrimination (in employment and otherwise) on the basis of sex, sexual orientation, disability, ethnic and racial differences, and so forth.
- Most substance abuse facilities are inpatient treatment facilities. Inpatient or residential treatment programs for women must be structured for the women and their dependant children, including child care and other on site programs while the mothers are in treatment.
- Substance abuse treatment programs must take a holistic approach and include such programs as vocational education, parenting classes, GED, and so forth.

**Issue: Treatment models designed for middle class clients are likely to be less effective with low-income clients.**

Traditionally, the models and providers of mental health treatment have focused on middle or upper class clients. To be effective, models and providers need to take into account the needs of lower income individuals, to understand the issues people in poverty, particularly women in poverty, face daily, and to understand what options poor individuals have and do not have. Whereas social workers may have more experience in dealing with these issues, many other providers (e.g. other mental health providers, primary care physicians) do not receive adequate training in the experience and impact of poverty.

**Recommendations:**

- Education and training for all service providers (all mental health providers, primary care and other physicians and medical care providers) should include the impact of poverty on individuals, what kinds of options are typically available to poor and low-income individuals, and how the provider can identify the critical issues affecting health and respond most appropriately.

**Issue: People with dual diagnoses are dropping through the cracks.**

Services for people with dual diagnoses are not adequate. Programs addressing the needs of women on public assistance often address their problems in isolation. Clients with more than one diagnosed mental health problem (e.g., substance abuse and major depression) do not usually have access to a program that addresses these problems in combination. These clients also must negotiate separate and unrelated service delivery programs.

**Recommendations:**

- Programs need to be better coordinated. Poor women need “one stop shopping.”
- Caseworkers need training and information on all options available.

**Issue: Decisions about who qualifies for exemptions can be inconsistent.**

Decisions about who qualifies for exemptions to time limits are often made “on the fly,” by overloaded caseworkers. This can result in decisions that are inconsistent.

**Recommendations:**

- Who qualifies for exemptions should be based on consistent policies that are clear to the caseworkers and clients alike. All state programs should establish clear policies, provide documentation on the policies to caseworkers, and make the information available to clients. Even more important, caseworkers, who are often overwhelmed with frequently changing written documentation need more training on options that are available, policies regarding the implementation of exemptions, and so forth.

**Issue: As the “easy to place” clients leave TANF, leaving behind a population consisting of a higher and higher proportion of individuals with entrenched, complex, and difficult problems, the number of clients a caseworker can reasonably serve will decrease.**

Past performance expectations for caseworkers are based on experience with a very different population of clients. As “easy to place” clients move off TANF and into the workplace, the population remaining behind, those still receiving TANF, changes fundamentally and inexorably. States are experiencing these changes now (see DeParle, 1997, for a description of changes Oregon is experiencing in this regard). If unaddressed, this trend is likely to mean that poorer services will be provided to needier people, and that caseworkers may be at higher risk for violent assaults as a result. As summarized by the American Federation of State, County and Municipal Employees (1998), social service workers are at increased risk for violence in the workplace, because more depressed, unstable, and desperate people are waiting in longer lines to talk to fewer workers who have less time to dispense dwindling services and reduced benefits.

**Recommendations:**

- Caseload expectations must decrease, both to ensure that minimal standards are met in the provision of services to these clients with more complex problems and to ensure the safety of caseworkers. Caseload expectations must be at appropriate levels, which allow caseworkers to adequately assess needs, refer for appropriate help, including treatment, and coordinate services and other actions as needed.

**Issue: Women with mental health problems need flexible hours at work.**

Difficulty combining work and family responsibilities is one of the number one stressors for

working women (Swanson, Piotrkowski, Keita, & Becker, 1997). This problem is of particular magnitude for women on welfare who often have fewer resources. Flexible work hours and flexible employers are critical. In addition, women on welfare who have mental health problems and substance abuse problems need to be able to get to treatment appointments and to meet welfare program activity requirements, sometimes during working hours.

### **Recommendations:**

- Flexible employers and flexible hours will enable these women to work. Potential employers should be apprised of the importance of flexible hours, and welfare recipients should not be required to take jobs with nonflexible hours.
- Transportation and quality child care will also help in reducing the number of stressors.

**Issue: Women with drug-related felony convictions are seriously disadvantaged B help is often out of reach. These women are often wrestling with overwhelming substance abuse problems, and instead of receiving needed assistance, are declared ineligible for TANF and considered unemployable by many employers.**

Women with felony convictions of any kind are ineligible for TANF provisions. When the felony conviction is drug related, this effectively penalizes the individual for having a mental health disorder, as many of these women have serious substance abuse problems. In addition, employers often view felony convictions of any sort as automatically making a potential employee ineligible for a position. Women with felony convictions for drug abuse are thus automatically considered ineligible for employment in many cases, leaving them with fewer options for better paying jobs with health insurance coverage, mental health coverage, and flexible hours. Since substance abuse can co-occur with other problems, such as mental health problems, in poor women, this automatic prohibition functions as a double whammy.

### **Recommendations:**

- Women with substance abuse problems, with treatment, can get well and function successfully in the workplace. Education for employers is needed, to help make the distinction between a felony conviction related to a mental health or substance abuse problem and other felony convictions.
- Drug-related felony convictions should not automatically prohibit individuals from receiving assistance under TANF. Women with substance abuse problems, including those who have drug-related felony convictions, should be identified and referred for treatment, as well as be eligible for TANF assistance.

**Issue: Individuals with serious mental health problems or serious and disabling mental illnesses face special obstacles in the workplace.**

Adults with serious and disabling mental illnesses, such as schizophrenia and bipolar disorder, are

often receiving public assistance via SSI, with Medicaid. The degree to which people with serious mental illnesses can function in the workplace varies a great deal. Some may be able to function well on an ongoing basis; some may be able to function intermittently; some may be able to function in structured environments and/or with available support; some, who are older or for whom medications are not sufficiently controlling their symptoms, may not be able to function in the workplace at all. The following recommendations address the needs of adults with serious mental illness in the workplace. The recommendations addressing the need for enough flexibility in hours to allow individuals to get to treatment appointments, the problem of between-job gaps in benefits and health coverage, and the need for financial assistance for transportation to treatment appointments apply as well to adult recipients of TANF who have serious mental health problems.

### **Recommendations:**

- Exempt from time limits those people with serious mental illness who either can function in the workplace only intermittently or cannot function much at all.
- Ensure that offices providing public mental health services have flexible hours. Mental health centers that are open from 9:00 to 5:00 only cannot accommodate clients who are working those same hours.
- Eliminate “between-job” gaps in benefits and services and maintaining the benefits and services for those unable to function in the workplace at all. Ensure that all caseworkers know about waivers that will extend health coverage for SSI clients who lose their jobs. If workers are fired or laid off, it can take several months to apply for and reinstate SSI benefits. For these clients, mental health coverage for medications and therapy are critical, and the possibility of losing benefits may make these individuals less likely to want to accept a job.
- In transportation subsidies, accommodate the needs of seriously mentally ill employees, who have minimal funds, who need to not only get to work at the beginning of the day but also to appointments with mental health providers during the day.

### **Issue: The stigma of mental health problems and serious mental illness is an obstacle to success in the workplace.**

The stigma associated with disclosed mental health problems can be an obstacle to being hired and to being promoted. In a recent study, 80 British personnel directors evaluated hypothetical candidates with similar profiles, except that one candidate was described as having experienced depression. The personnel directors were much less likely to hire the candidate with depression, and almost 60% said they would never hire such a person for an executive job (Glozier, 1998). Those with serious mental illness encounter such obstacles as well. The stigma associated with mental illness often keeps individuals from seeking help. It often keeps individuals with serious mental illness from disclosing their psychiatric illnesses or histories to employers or potential employers, which keeps them from being eligible for certain protections and accommodations, for example, under the Americans With Disabilities Act.

### **Recommendations:**

- Implement public education efforts that counter the stigmas and myths associated with people with mental health problems and mental illness.
- Programs designed to move individuals with serious mental illness into the workplace should include a component that educates the employers as well.

### **Issue: Many caseworkers as well as traditional vocational rehabilitation programs can “aim low” for general welfare clients and clients with serious mental illness.**

The policies, practices, and procedures governing job placement in general and the vocational rehabilitation provided to clients with mental illness often focus on quick job placement (in any job possible). Performance standards are often based on the number of “closures” (e.g., quick employment, that is maintained for a few months). This encourages an attitude of “not reaching too high,” that is, encourages employment in low paying service sector jobs, discourages educational activities, and discourages real development of a client’s potential for professional, higher level work. Lower paying jobs are also less likely to provide adequate mental health insurance coverage.

### **Recommendations:**

- Address the policies and practices of welfare departments and traditional vocational rehab services, and the performance evaluation systems that encourage these practices, that emphasize finding any job over developing clients’ potential to “aim high.”
- Encourage education and training for caseworkers and for vocational rehabilitation workers.

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In addition to surveying recent reports and policy analyses for the development of this briefing paper, we talked to a number of individuals who work with low-income clients, do research with poor women, or otherwise work on issues related to women, welfare, and mental health problems.

We wish to gratefully acknowledge here those individuals, and to express our appreciation for the input they provided. At the same time, we wish to note that the policy recommendations contained here are those of the Women's Programs Office at the American Psychological Association and not necessarily those of the people listed.

Ellen L. Bassuk, MD  
President  
Better Homes Fund  
181 Wells Avenue  
Newton Centre, MA 02159  
617-964-3834 (phone)  
617-244-1758 (fax)  
Harvard School of Public Health

Lula Beatty, PhD  
Chief, Special Populations Office  
Office of the Director  
National Institute on Drug Abuse  
Parklawn Building, Room 11A333  
5600 Fishers Lane  
Rockville, MD 20857  
301-443-0441 (phone)  
301-480-8179 (fax)

Bob Bowman  
Government Affairs Director  
National Alliance for the Mentally Ill (NAMI)  
200 N. Glebe Road  
Suite 1015  
Arlington, VA 22203

Anne Brodsky, PhD  
Assistant Professor of Psychology  
Department of Psychology  
University of Maryland, Baltimore County  
1000 Hilltop Circle  
Baltimore, MD 21250

Angela Browne, PhD  
Senior Research Scientist  
Harvard Injury Control Research Center  
Harvard School of Public Health  
677 Huntington Ave., 4th Floor  
Boston, MA 02115  
617-432-4892  
abrowne@hsph.harvard.edu

Robert D. Coursey, PhD  
Department of Psychology  
University of Maryland  
College Park, MD 20737  
301-405-5905

Lisa Goodman, PhD  
Assistant Professor  
Department of Psychology  
University of Maryland  
College Park, MD 20737  
301-405-7197

Maxine Harris, PhD  
Executive Director  
Community Connections  
801 Pennsylvania Avenue, SE  
Suite 201  
Washington, DC 20003

Rukmalie Jayakody, PhD  
Assistant Professor  
Population Research Institute  
110 Henderson Building South,  
Pennsylvania State University, University Park, PA 16802.  
814-865-2659  
E-mail: jayakody@pop.psu.edu

Erika Kates, PhD  
Co-Chair  
WETAC  
60 Turner Street  
Waltham, MA 02154  
Senior Research Associate  
Heller School at Brandeis University

Roberta Kolp  
Direct of administration  
Green Door  
1623 16th Street, NW  
Washington, DC 20009

Alicia Lucksted, PhD  
Department of Psychiatry  
Office of Education  
University of Maryland  
701 W. Pratt Street  
4th Floor  
Baltimore, MD 21201

Sharon Miller, MSW  
Clinical Supervisor  
Community Connections  
801 Pennsylvania Avenue, SE  
Suite 201  
Washington, DC 20003

Jeanne M. Miranda, PhD  
Department of Psychiatry  
Georgetown University Hospital  
3800 Reservoir Road, NW  
Washington, DC 20007-2113  
202-687-8650 (phone)  
202-687-6658 (fax)

Pamela Perry, MA  
Program Analyst  
Women, Children, and Family's Team  
Substance Abuse and Mental Health Services Administration (SAMHSA)  
Parklawn Building  
5600 Fishers Lane  
Rockville, MD 20857  
301-443-5184 (phone)  
301-443-8964 (fax)

Susan Robinson, MS  
Research Associate  
Matrix Research Institute  
6008 Wayne Avenue  
Philadelphia, PA 19144

(215) 438 - 8200 (voice)  
(215) 438 - 8337 (fax)

Ulonda Shamwell, MSW  
Associate Administrator for Women's Services  
Substance Abuse and Mental Health Services Administration (SAMHSA)  
Parklawn Building  
5600 Fishers Lane  
Rockville, MD 20857  
301-443-5184 (phone)  
301-443-8964 (fax)

Dace Svikis, PhD  
Johns Hopkins University  
The Johns Hopkins Bayview Medical Center  
The Center for Addiction and Pregnancy  
Baltimore, MD 21224  
410-550-3020  
daceap@aol.com

Maria Woolverton  
Research Associate  
Georgetown University  
Child Development Center  
3307 M Street, NW  
Suite 401  
Washington, DC 20007  
202-687-5000