

Understanding Health-Status Barriers

THAT HINDER
THE TRANSITION FROM
WELFARE TO WORK

NATIONAL
GOVERNORS
ASSOCIATION



Health Policy Studies Division
National Governors' Association
Center for Best Practices

Understanding Health-Status Barriers That Hinder the Transition From Welfare to Work

by Sarah R. Callahan

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Preface

This report examines health-status barriers—substance abuse problems and/or mental health conditions—that some welfare recipients face in making a successful transition from welfare to work and the challenges that states face in helping recipients overcome those barriers. However, two other important health-related barriers impede welfare recipients’ ability to find and retain jobs, namely the lack of health insurance coverage and the difficulties associated with caring for children with special health care needs.

Medicaid generally is available to people receiving cash assistance. Moreover, some recipients with chronic medical conditions and disabilities qualify for Supplemental Security Income (SSI), which, in most cases, also makes them eligible for Medicaid.

Although Medicaid generally is available to people receiving cash assistance, including those combining welfare and work, there is little coverage for those with no current or recent attachment to welfare. Some will have been diverted to employment-seeking activities, foregoing an opportunity to apply for Medicaid coverage. Others will have exhausted their transitional Medicaid benefits. Still others will earn too much to qualify for Medicaid.

Many welfare recipients will be working in low-wage, entry-level positions without access to employer-based health insurance. Former welfare recipients are increasingly joining the ranks of the working poor, and the working poor are twice as likely to be uninsured as their unemployed counterparts. In 1997, 46 percent of poor parents (i.e., those with incomes below 100 percent of the federal poverty level) who were working were uninsured, compared with 23 percent of poor parents who had no earnings throughout the year.¹

These scenarios are particularly problematic for recipients and former recipients with ongoing health problems. Looking forward, these are some of the next challenges for states:

- improving the screening process for welfare applicants so that even if they are diverted to employment-seeking activities, they still have an opportunity to apply for Medicaid coverage;

- creating mechanisms to improve welfare recipients' access to health insurance, including purchasing cooperatives, premium subsidies, and high-risk funding pools; and
- finding ways to encourage employers to offer health insurance to their employees and then educating employees on the importance of taking advantage of health benefits.

Caring for children with special health care needs can also have a profound effect on the ability of their parents to obtain and keep a job. Women with special needs children are more likely to rate their own health as poor and are more likely to report they have a disability that limits or precludes their employment.² The potentially high incidence of children with special health care needs among the welfare population makes child care services especially important. However, often there is a lack of child care facilities willing or equipped to care for special needs children, making it difficult for adult welfare recipients to meet work requirements. States may want to consider exempting the parents of children with special health care needs from work requirements if appropriate child care facilities are not available. At the same time, states can work with the private sector to increase its capacity to care for these children.

These two additional health-related barriers to employment raise distinct policy issues and pose special challenges for states. Consequently, separate publications will describe emerging state best practices to enhance public and private health insurance coverage for welfare recipients making the transition to work and help parents with special health care needs children. The focus of this report is identifying and understanding the complexities of health-status barriers to employment among the welfare population.

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Executive Summary

Federal welfare reform legislation enacted in 1996 altered the nation's safety-net program for families by imposing time limits on the receipt of cash assistance and work requirements for recipients. These changes and the strong economy have brought about historic declines in welfare caseloads. However, continued state success in moving welfare recipients into jobs will depend, in part, on states' ability to address health-status barriers to employment prior to recipients reaching their time limits on assistance. Many welfare recipients face formidable challenges to self-sufficiency because of chronic medical conditions that include substance abuse problems, mental health problems, and co-occurring substance abuse and mental health problems.

There is a lack of good information on the number of welfare recipients with chronic medical conditions and even less data on the type, severity, and effect of health-status barriers to employment among this population. Welfare recipients are about five times as likely as nonrecipients to report they did not seek employment because of a medical problem.³ One of the most commonly experienced health-related limitations on work among adult welfare recipients is mental illness.⁴ Most studies estimate that between 10 percent and 20 percent of the welfare population has a substance abuse problem. Moreover, many of these conditions are not mutually exclusive. Some of the hard-to-serve welfare recipients are affected by "co-occurring disorders," such as a mental health problem coupled with a substance abuse problem.⁵

Treatment for chronic medical conditions results in higher productivity, employment, and money saved at the state level. Yet this seemingly simple "solution" is complicated by several factors. Although chronic medical conditions are treatable, they are not necessarily curable. Ongoing access to health care services to diagnose, treat, and manage these conditions is necessary to enable individuals to remain employed over the long term. However, because of traditional service delivery and financing arrangements, clients often must navigate multiple health care systems to receive treatment. In addition, some welfare

recipients may end up seeking treatment for a medical crisis in costly hospital emergency rooms because they did not seek care earlier. Often there is a lack of appropriate treatment facilities within a state.

As welfare caseloads continue to decline, it is likely that the proportion of welfare recipients with health-status barriers to work will exceed the 20 percent that states are allowed to exempt from the federal time limit on assistance. States may need to consider alternative funding sources and programs to address this issue. To facilitate these recipients' transition from welfare to work before they exhaust their welfare benefits, state policymakers can:

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- conduct studies and use screening tools to identify the type, severity, and effect of chronic medical conditions on employment among welfare recipients and refer them to appropriate treatment;
- promote interagency collaboration and education to develop a continuum of services for welfare recipients with chronic medical conditions;
- seek alternative funding sources to meet these recipients' health-related service needs;
- address health care access and capacity problems that prevent welfare recipients from getting the help they need to achieve self-sufficiency; and
- create a state-funded program to meet the needs of welfare recipients who have health-status barriers to employment.

Health-Status Barriers to Work Among Welfare Recipients

What Changes Has Welfare Reform Brought?

Sweeping federal welfare reform legislation was enacted in August 1996 to reshape the nation's income support program for the poor. The Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) converted Aid to Families with Dependent Children (AFDC), an open-ended entitlement program, into Temporary Assistance for Needy Families (TANF), an appropriated block grant. The focus of welfare policy shifted from emphasizing income security to promoting "work first." PRWORA stresses personal responsibility and self-sufficiency. Time limits, increasing work participation rates, and economic sanctions for noncompliance add a sense of urgency to involving as many recipients as quickly as possible in work activities.

Under TANF, federally funded lifetime benefits are limited to five years, and recipients are required to participate in work activities after two years. Approximately twenty states have time limits that are shorter than the federal time limit, though many states grant extensions based on recipients' circumstances (e.g., disability, domestic violence, lack of job availability, and general hardship). Twenty-eight states have work requirements that are shorter than two years.

States that do not meet PRWORA goals may be subject to a variety of penalties. For example, beginning in 1997, states had to engage 25 percent of their nonexempt caseload in work activities; this percentage increases to 50 percent by 2002. If a state fails to meet annual work participation goals, its TANF block grant may be reduced by up to 5 percent in the following year. This percentage may be increased by 2 percent each subsequent year of

noncompliance, up to a maximum of 21 percent.

Welfare reform and the strong economy have contributed to the significant decline in welfare caseloads. States are nearly three years into the implementation of PRWORA and have witnessed dramatic caseload declines; nationwide, between August 1996 and December 1998, 38 percent of families left the welfare rolls, putting the nation's caseload at the lowest level in thirty years.⁶ However, states now report that many of those who remain on the rolls or qualify for cash assistance are harder to serve because they have multiple barriers to employment. The continued success of welfare reform in moving adult welfare recipients into jobs and ultimately breaking the cycle of dependency among at-risk families depends, in part, on states' ability to help recipients overcome their multiple barriers to employment, particularly their health-status barriers.

What Are the Relationships among Welfare, Health, and Employment?

According to a report by Olson and Pavetti of The Urban Institute, four of the eight identified personal barriers to a welfare recipient's successful transition from welfare to work are specifically health-related—physical disabilities or health limitations, mental health problems, substance abuse problems, and the health or behavioral problems of children. Having a barrier to employment does not necessarily preclude employment, but it does significantly lower the incidence of continuous employment. Olson and Pavetti also found that only 11 percent of recipients who reported having one of the eight personal barriers—which also include learning disabilities, domestic violence, housing instability, involvement with the child welfare system, and low basic skills—reported being employed for a full year, compared with 27 percent of recipients who reported none of these barriers.⁷

Other studies have documented that health-status barriers to employment are common among welfare recipients.

- Welfare recipients are about five times as likely as nonrecipients to report they did not seek employment because of a medical problem.⁸
- About 10 percent of recipients report they are unable to work because of a serious medical condition, while between 16 percent and 30 percent report a health-related problem that limits the amount or kind of work they can do.⁹
- A study in California of the Greater Avenues for Independence (GAIN) program found that 41 percent of recipients were deferred from work requirements because of self-reported health problems.¹⁰
- A 1996 Michigan report on case closures because of sanctions noted that a health problem was one of the three primary reasons recipients gave for failing to meet program work requirements.¹¹

Local job counselors in eight counties in Minnesota found that in cases in which sanctions

were imposed, recipients were three times as likely to report a family health problem than in cases in which sanctions were not imposed.¹² This statistic is not surprising and echoes historical data. An analysis of data from the Disability Supplement to the 1994 National Health Interview Survey found that 40 percent of families on AFDC in 1994 had an adult, a child, or an adult and a child with a long-term, functional limitation. Of these families, almost one-half had an adult with a disability, about one-quarter had one or more children with a disability, and slightly more than one-quarter had both an adult and a child with a disability. Program and caseload data also indicate a high proportion of recipients with children who have health or behavioral problems.¹³

What Is the Nature of the Health-Status Barriers?

Welfare recipients, like the general population, have both acute and chronic medical conditions. Many acute conditions, such as a broken limb or severe cold or flu, may temporarily disrupt employment but are not permanent barriers to work. With more severe acute conditions, the disruption in employment may be longer, but it is expected that the situation will not recur nor require long-term medical management. For example, the removal of an inflamed appendix disrupts employment but does not require long-term medical management. Typically, acute medical conditions do not jeopardize recipients' continued successful employment so long as they have public or private health insurance coverage that provides access to health care.

The health-status barriers that present the greatest challenges to welfare recipients are the long-term, persistent medical conditions. These chronic medical conditions can vary greatly in type and severity. They include physical conditions, such as diabetes, asthma, and hypertension. They also include behavioral conditions, such as substance abuse and mental health problems

Sometimes a person may have two or more chronic conditions simultaneously. People

with these “co-occurring” conditions require long-term management by medical professionals to ensure the conditions are controlled. Medical management can include daily medication (e.g., insulin for diabetes or antiseizure medication for epilepsy) or prolonged therapy (e.g., continuing counseling for a substance abuse problem or a mental illness). Those with more severe conditions may experience limitations in some of the following functional activities:

- seeing, hearing, speaking, lifting, carrying, using stairs, and walking;
- getting around the house, getting in or out of a bed or chair, bathing, dressing, eating, and using the toilet;
- going outside the house, keeping track of money and bills, preparing meals, doing light housework, taking prescription medicines in the right amount at the right time, using the telephone; and
- maintaining employment.

However, many chronic conditions are not severe and are characterized by the need for varying levels of less intensive care (e.g., ranging from short-term, residential substance abuse treatment services to weekly support meetings within the community). Chronic medical conditions are not “curable” in the traditional sense, so access to health care must be sustained after employment.

What Is the Prevalence of Chronic Medical Conditions?

Numerous studies report significant rates of chronic medical conditions among the unemployed and the welfare population. Because chronic medical conditions can pose significant barriers to employment for some welfare recipients, states are beginning to quantify the scope of this problem. For example:

- Iowa found that about 12 percent of its caseload is chronically and physically ill.¹⁴
- In Minnesota cases in which sanctions were imposed were four times as likely to report substance abuse problems and two times as likely to report mental health problems than in cases in which sanctions were not imposed.¹⁵
- Through screening and assessment tools, New Jersey found that between 32 percent and 36 percent of its caseload has a substance abuse problem.¹⁶
- In 1998 an Oregon survey indicated that 75 percent of the state’s remaining TANF caseload reports slight to severe mental health problems, 50 percent reports substance abuse problems, and 17 percent reports physical health problems that prevent recipients from seeking or retaining employment.¹⁷

These surveys and reports point to two broad categories of chronic medical conditions that present the most formidable health-status barriers to employment among welfare recipients—substance abuse and mental illness.

What Are the Challenges for States?

States confront several challenges in their continuing efforts to ensure the success of welfare reform. Because states will be facing a welfare caseload that has a higher incidence of chronic medical problems, a major challenge is identifying those conditions. This requires diagnosis as well as delivery of the proper array of health care services to treat and manage recipients’ chronic medical conditions. Further, people with chronic conditions often need support services, such as child care and transportation to appointments.

Substance Abuse Problems

Substance abuse is a medical condition that impedes welfare recipients from obtaining and retaining jobs. Without intervention, recipients with substance abuse problems are likely to exhaust their welfare benefits. Most studies find that between 10 percent and 20 percent of the welfare population has a substance abuse problem, based on varying definitions of what constitutes a problem.

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What Constitutes Substance Abuse?

Depending on the substance, a sizable number of users are able to hold jobs.¹⁸ This is particularly true for most consumers of alcohol.

What distinguishes substance use from substance abuse is the level of habitual use of the substance. Obviously, the higher the level of use, the greater the impact on a user's ability to find and hold a job. "Substance use" is defined as occasional alcohol, tobacco, or drug use and implies the use of substances for non-medical purposes. "Substance abuse" is defined as regular, sporadic, or intensive use of higher doses of drugs, alcohol, or tobacco that leads to social, legal, or interpersonal problems.¹⁹ "Substance dependence or addiction" is defined as uncontrollable substance-seeking behavior involving the compulsive use of high doses of one or more substances and resulting in substantial impairment of functioning and health.²⁰ Substance addiction is a chronic, primary, and relapsing disease. Tolerance and acute withdrawal symptoms are characteristics associated with addiction.

Who and How Many Are Affected?

In 1995 the National Center on Addiction and Substance Abuse at Columbia University estimated that one in four female AFDC recipients abused or were addicted to alcohol and drugs.²¹ The U.S. Department of Health

and Human Services estimated in 1994 that 5 percent of adult women receiving AFDC had a significant functional impairment related to substance abuse, and 11 percent were somewhat impaired.²²

Reports from some states are beginning to illuminate the scope of the substance abuse problem among welfare recipients.²³

- Kansas has projected, based on experience from an employment project with the Cessna company, that between 20 percent and 50 percent of its welfare caseload would fail a drug screen.
- New Jersey found that 34 percent of women who answered positively to two or more questions regarding substance use and abuse had been on welfare for five years or longer.
- North Carolina found that 33 percent of adults living in households with phones and deemed in need of comprehensive treatment had received AFDC, SSI, or Food Stamps and/or had no health insurance through a 1995 survey by the Research Triangle Institute with support from the Center for Substance Abuse Treatment.
- Oklahoma has projected, based on a review of existing literature, that between 5 percent and 30 percent of its caseload has an alcohol or drug problem.

- Oregon has reported that between 50 percent and 60 percent of its welfare caseload has an alcohol- or drug-related problem.

Variations in the estimates of welfare recipients with substance abuse problems may be because of the vagaries of self-reporting as well as the effectiveness of the screening and assessment tool being used and the skills of the people administering the tool. As states embark on more screening, better data will become available. Although there is no research documenting the prevalence and severity of substance abuse within the general welfare caseload, preliminary research conducted by the CASAWORKS program indicates that 63 percent of state welfare administrators estimate that between 20 percent and 40 percent of TANF recipients need substance abuse treatment.²⁴

What Are the Treatment Options and Benefits?

Substance abuse treatment services typically include assessment and diagnosis, medication management, detoxification, outpatient or ambulatory services, residential services, and case management. Research indicates that the treatment of substance abuse can be effective in reducing substance use and increasing employability. The National Treatment Improvement Evaluation Study (NTIES) found reductions in substance abuse regardless of the amount of time spent in treatment or the amount of treatment received. In addition, the treatment had lasting benefits, with significant reductions in drug and alcohol use reported a full year after the conclusion of treatment.²⁵

Other studies demonstrate that treatment results in higher productivity, employment, and money saved at the state level. Moreover, substance abuse treatment often results in savings in acute medical care, such as emergency room services; increased productivity; and decreases in the use of other health care services.²⁶

Treatment facilitates self-sufficiency and improves the quality of people's lives. In the

NTIES study, clients reported increases in employment and income, as well as improvement in their mental and physical health, one year after treatment. In an evaluation of outpatient substance abuse services, Oregon found that clients who completed treatment earned 65 percent more than clients who did not receive treatment, and those completing treatment were 45 percent less likely to be arrested and 50 percent less likely to be investigated for child abuse.²⁷

Identifying and referring people into treatment for substance abuse problems have a significant impact on their ability to work successfully. For example:²⁸

- A Florida treatment program for pregnant and postpartum women and their children found a 76-percent increase in employment and school enrollment after treatment for substance abuse.
- Minnesota found a 64-percent increase in employment among public aid recipients after treatment.
- A study in Ohio showed a significant increase in work-related outcomes, such as decreases in absenteeism among former welfare recipients receiving treatment, as well as a 15-percent decrease in welfare payments.

The research clearly indicates that substance abuse is one of the most prevalent medical conditions that can serve as a barrier to long-term employment. It also suggests that identifying welfare recipients' needs and arranging for treatment are effective in helping them surmount this barrier.

What Are the Service Delivery Challenges And Opportunities?

Identifying the Needs of Substance-Abusing Welfare Recipients

It is important to understand the specific nature and severity of the welfare recipient's substance abuse problem. Various types of abuse result in different behavior patterns, different treatment needs, and different impacts on employability. Each substance abuser can

have his or her own treatment protocols. Unfortunately, many states lack good information on the type and severity of substance abuse problems among welfare recipients. Consequently, a first step for states is to undertake a targeted survey to better identify the type and severity of substance use and abuse within this population. This survey can be short and confidential to reduce costs and increase response rates.

Some states are developing broader assessment tools to screen for multiple potential problems, including substance abuse. For example, Illinois used CAGE as an initial screening instrument for approximately two years.²⁹ However, the Illinois Department of Human Services is revising its service delivery tools and incorporating a behavioral-based, ten-question substance abuse screen that will replace CAGE. The department believes this new tool will increase the identification of substance abuse problems, improving the ability of local offices to address this barrier among TANF families. Kansas uses the CAGE questionnaire, an additional question on drug use, and American Society of Addiction Medicine criteria. Other commonly used screening tools include the Substance Abuse Subtle Screening Inventory and Addiction Severity Index.

Coordinating Fragmented Delivery Systems

After estimating the general incidence of substance abuse and identifying welfare recipients in need of treatment, the next step is to get the substance abuser the appropriate treatment. However, recipients with substance abuse problems often face additional obstacles to receiving adequate treatment because services traditionally have been provided outside the mainstream health care delivery system. Many states have separate agencies and separate providers delivering substance abuse treatment services.³⁰ This fragmentation increases the difficulty in seeking and receiving services because the recipient must learn to negotiate a second behavioral health care system.

To respond to this challenge, many states are coordinating service delivery agencies, tapping into the existing network of providers to help screen, assess, and treat this population. Some states have begun collocating counselors specializing in substance abuse with eligibility workers in welfare agencies. For example, in Ohio substance abuse counselors are situated in welfare offices for screening and referral to avoid developing parallel service tracks for the same population. States also are recognizing that welfare eligibility workers require additional training to identify, screen, and refer recipients who need substance abuse treatment prior to, or concurrent with, their seeking employment. Staff cross-training efforts are underway in some states. For example, Oregon orients TANF caseworkers on substance abuse issues. Workers refer recipients identified as potential candidates for treatment to specific local facilities. Failure to comply with treatment may result in the loss of welfare benefits.

Overcoming the Stigma of Substance Abuse

Substance abuse is a chronic medical condition, so there is always a risk of relapse that will trigger the need for treatment. Like other chronic conditions, long-term control of a substance abuse problem requires managing the condition medically; promoting behavior modification; and living with the possibility of a flare-up or, in the case of substance abuse, a relapse. Yet, in contrast to people with other medical conditions, society is less tolerant of relapses in substance abuse. For example, people with diabetes who can help control their disease by changing their behavior (e.g., through diet, exercise, and compliance with medication) enjoy considerable latitude from their employer if they have to miss work for reasons related to their diabetes. However, an employer may be less understanding when a recovering alcoholic or other type of substance abuser wants to leave work to see a physician, visit a therapist, or attend a twelve-step meeting. This stigma and disapproval discourages recipients from admitting a problem and seeking treatment.

States can begin to address this problem by educating TANF caseworkers and potential private-sector employees about the disease of addiction and the success of treatment. This could lessen some of the stigma and

disapproval that discourages substance abusers from admitting their problem and seeking treatment. It could also increase the likelihood that recipients will obtain treatment over their lifetimes and sustain employment.

Mental Health Problems

Mental health problems include a range of mental and emotional conditions. They can significantly impair a person's ability to perform major life activities, such as dressing, sleeping, working, and communicating. States and researchers are finding a high incidence of mental health problems among welfare recipients.

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What Constitutes a Mental Health Problem?

The most common forms of mental health problems are anxiety disorders, depressive disorders, and schizophrenia. "Anxiety disorders" are characterized by severe fear or anxiety associated with particular objects or situations. They include panic disorder, phobias, obsessive-compulsive disorder, and post-traumatic stress disorder. "Depressive disorders" also are known as mood disorders or affective disorders and are characterized by disturbances or changes in mood, usually involving either depression or mania (elation). More women than men seem to suffer from these disorders.³¹ Seemingly fragmented thoughts and difficulty in processing information characterize "schizophrenia." Of the three most common mental illnesses, schizophrenia occurs least often.

The types of mental health problems and their symptoms, intensity, and duration vary from person to person and even for a person over time. Symptoms often can be minimized through medication or therapy but can last a lifetime. Some people need minimal or occasional assistance, while others need more intensive and continuous medical and social supports to maintain the level of functioning necessary for employment. Typically, a mental health problem surfaces in people between the ages of fifteen and twenty-five, the prime years for educational and vocational training.³²

Who and How Many Are Affected?

A few states have collected data on the rate of occurrence of mental health problems among welfare recipients, though it is likely that more recipients require mental health services than actively seek and receive them. Oregon estimates that 75 percent of its welfare clients have mental health problems, ranging from those who are "clinically" diagnosable to those with low levels of depression.³³ Utah reports that in cases in which sanctions have been imposed, one of the contributing factors was a mental health problem.³⁴ The California Department of Social Services estimates that 21 percent of TANF recipients have a diagnosable mental health or substance abuse disorder.³⁵ Based on data collected from 2,609 single mothers in 1994 and 1995, researchers at Pennsylvania State University found that 23 percent of single mothers on welfare had a psychiatric disorder, compared with 17 percent of single mothers not on welfare.³⁶

Long-term welfare recipients are more likely to experience mental health problems that impair their ability to find and retain employment than is the general population or than are recipients who receive cash assistance for a shorter period. There is no information disaggregating the incidence rate for different types of mental illness within the welfare population. To estimate the probable incidence rate, one must infer from national studies on the general population. However, it is likely that the incidence rates for the welfare population,

especially long-term recipients of cash assistance, are much higher.

Anxiety disorders are the most common mental health problem, affecting 15 percent of members of the general population some time during their lifetimes. Depressive disorders occur in nearly 8 percent of people during their lifetimes, with schizophrenia affecting about 2 percent.³⁷ Most episodes are of relatively short duration; less than 7 percent of adults suffer from mental health problems that last “at full diagnostic levels” for more than a year. Nearly 3 percent of the adult population experiences a serious mental illness over the course of a year, and 3 percent of children ages nine to seventeen experience a serious mental illness during a six-month period.³⁸

What Are the Treatment Options and Benefits?

Mental health problems can be treated. In recent years, advancements in biomedical technologies have enabled greater study of brain disorders, and advancements in medications have resulted in effective therapies for conditions such as anxiety disorders and schizophrenia. The treatment success rate is 60 percent for schizophrenia, 80 percent for bipolar disorder (i.e., manic-depressive illness), and 65 percent for major depression. These rates are greater than the treatment success rate for heart disease.³⁹ Unfortunately there are not many studies demonstrating the impact of mental health problems on employability, particularly for welfare recipients.

What Are the Service Delivery Challenges And Opportunities?

One troubling aspect of people with mental health problems is that often they do not receive treatment for their condition. The National Institute of Mental Health estimates that only 20 percent of the 30 million people suffering from mental illnesses seek treatment.⁴⁰ Like services for substance abuse problems, mental health services traditionally have been separated from the mainstream health care delivery system and are not covered

to the same extent as regular medical care.⁴¹ In addition, the identification of those needing treatment through a screening or referral process will bring into focus the capacity problems confronting states. For the single parent, there are few residential mental health treatment facilities for adults that can accommodate children.

Many of the opportunities to improve the delivery of services that were identified in the previous chapter on substance abuse problems also apply to the mental health arena. These include coordinating fragmented state agencies and mental health providers as well as educating welfare personnel and employers on the mental health problems experienced by many hard-to-serve welfare recipients and the benefits of treatment.

One disincentive for employed former welfare recipients seeking treatment—the limited coverage of mental health problems under private health insurance plans—has begun to be addressed. The Mental Health Parity Act requires aggregate lifetime limits and annual limits for mental health benefits to equal those of medical and surgical benefits, though it does not establish a definition of “medical necessity.” The law covers mental illness (i.e., “mental health services” as defined under the terms of individual plans), not substance or chemical dependency. It applies only to employers who offer mental health coverage, and it does not mandate coverage. Employers with fewer than fifty employees are exempt from these requirements, and an employer whose costs increase by 1 percent or more may be exempted from the parity implementation. The federal law also does not preempt existing state parity laws.

Since the federal mental health parity law was signed into law, activity has moved to the states. In 1997 thirty-four states introduced mental health parity legislation, and nine states passed such legislation. (Six states passed legislation between 1991 and 1996.) In 1998 nine states passed parity legislation; eight states have legislation pending.⁴²

Co-Occurring Disorders

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Research on people in treatment and responses to household surveys suggest that a person who has a mental health or substance abuse problem has an increased likelihood of developing multiple disorders.⁴³ Although there is no study to document the trend, there is a growing recognition that a large number of people have concurrent, multiple health problems, commonly referred to as “dual diagnosis or co-occurring disorders.” For example, people can have a mental health and substance abuse problem. The National Comorbidity Survey and other studies have shown that people with mental disorders are at least twice as likely to abuse alcohol and drugs as are people without mental disorders.⁴⁴ Adults who experience a major depressive episode also are more likely to report past-year use of illicit drugs and alcohol.⁴⁵ Unemployment, multiple hospitalizations, and failures in mental health or substance abuse treatment are very common among people with co-occurring disorders.⁴⁶

What Constitutes a Co-Occurring Disorder?

Starting in the 1980s, the term “dual diagnosis” or “co-occurring disorder” was used to describe patients with co-occurring mental health and substance abuse disorders. Four relationships between co-occurring disorders may occur:

- one disorder may directly cause another disorder;
- one disorder may indirectly lead to another disorder;
- two or more disorders may develop independently from different causes but affect each other; and
- an independent factor may lead to the development of both a mental health and substance abuse problem.

In addition, a client may experience three or more disorders and the relationship between the pairs may differ.⁴⁷ For example,

the co-occurrence of depression, low self-esteem, anxiety, and panic is common.

Who and How Many Are Affected?

It is estimated that 10 million people have co-occurring substance-related and mental disorders in any given year, including the homeless and the institutionalized. Studies of those with disorders have found that 56 percent had two or more disorders (e.g., substance abuse and two primary mental health diagnoses).⁴⁸

- Of those with co-occurring mental health and substance disorders, 52 percent of those with a lifelong history of alcohol abuse or dependence also had a lifelong mental disorder; 36 percent also had a nonalcohol drug use disorder.
- Of those with a lifelong history of illicit drug abuse, 59 percent had a lifelong mental disorder, and 71 percent also had a lifelong alcohol use disorder.

Co-occurring disorders are a growing concern, especially among those managing the welfare rolls. A welfare recipient's situation may contribute to the use of substances and foster depression. For example, Utah reports an increase in the number of recipients experiencing depression and a substance abuse problem.⁴⁹ Unemployed adults and adults not in the labor force because of a disability, retirement, or homemaker or student status report higher rates of panic attack and agoraphobia (i.e., a generalized irrational fear) than do adults working full time.⁵⁰

What Are the Treatment Options and Benefits?

The dual-diagnosis population presents unique service delivery and financing challenges because of historical patterns of using separate agencies and funding streams to provide treatment. In the past, systems were set up to treat people with a single disorder, not those with co-occurring disorders. Consequently, special accommodations must be made to assist these individuals.

Practitioners use three different approaches to treat those with co-occurring disorders—sequential, parallel, or integrated.⁵¹ Sequential or serial treatment is the traditional approach for this population. Each disorder is treated in a discrete manner, one at a time. Parallel or collaborative treatment treats each disorder separately but simultaneously. An integrated approach treats all disorders simultaneously. The sequential and parallel approaches are the most common approaches, primarily because they follow the fragmented and categorical service delivery and financing arrangements.

One of the pitfalls of sequential treatment is that people receiving treatment for one diagnosed disorder may have another undiagnosed disorder. Therefore, while one condition improves, the other(s) can worsen and even lead to greater end use of high-cost services, such as hospitalization. If two co-occurring disorders are successfully diagnosed and a parallel treatment approach is used, the burden is often on the client to negotiate multiple systems of treatment and multiple service

agencies. This problem is compounded if services are provided at different locations and could lead clients to limit or stop treatment, especially if transportation is an issue. Typically, coordination of the treatment plans—for example, for a mental health problem and a substance abuse problem—is the exception, rather than the rule.

Significant outcome data are not yet available to show that the integration treatment approach is the most effective, but the limited data suggest the promise of this approach. In a recent study of forty-seven patients with schizophrenia and substance abuse disorders, individuals were randomly assigned to either integrated outpatient treatment or nonintegrated outpatient treatment. Those in the integrated program were more likely to remain in the treatment program, and participants experienced fewer hospitalizations, increased sobriety, and decreased psychiatric symptoms during the first eight months of the study.⁵²

Although an integrated approach that treats all disorders simultaneously may be most effective, significant hurdles must be overcome before this approach can be widely implemented. These hurdles include separate funding streams, agency turf issues, and differing treatment philosophies in mental health and substance abuse that originated before the 1960s but persist today at the federal, state, and community levels.

What Are the Service Delivery Challenges And Opportunities?

Recipients with co-occurring disorders have multiple problems that do not fit clearly into the existing service categories and service boundaries of many public and private agencies. Moreover, other factors make coordinating treatment difficult. For example, this population often experiences differing onsets of the co-occurring disorders; the median age of onset of mental health problems is fifteen, while the median age of onset of substance abuse problems is twenty-one.⁵³

People with co-occurring disorders have a greater tendency to relapse than do those

experiencing a single health-related problem.⁵⁴ They tend to become circulating patients, moving from crisis to treatment to recovery to relapse and entering and reentering the same facilities—emergency rooms, jails, and treatment facilities—through a revolving door. Chemical dependency and many mental health disorders are chronic, relapse-prone conditions. Short-term therapies are not likely to have long-lasting effects.

Few people with co-occurring disorders receive the full array of treatment they need. Moreover, the treatment they receive is likely to be general medical attention, rather than

specialized mental health or substance abuse treatment. More than 40 percent of those with three or more disorders have never received any specialized mental health or substance abuse treatment.⁵⁵

To meet welfare recipients' needs for specialized health services, states can reorient traditional treatment programs, promote agency and funding coordination, and cross-train staff. States can also address other client needs, such as for medical care, housing, and vocational training, to help ensure successful treatment for co-occurring disorders and increase this population's employability.

Next Steps for States

Numerous welfare recipients face formidable challenges to self-sufficiency because of chronic medical conditions that include substance abuse problems, mental health conditions, and co-occurring disorders. Many behavioral health problems can be treated so that people experiencing these problems can find and keep jobs. However, treatment rarely leads to a cure; medical management may be needed over a lifetime, and there is always a possibility of relapses or acute episodes. Health-status barriers hinder the transition from welfare to work for many welfare recipients. For this reason, they will need access to ongoing health care services and other supports to promote the self-sufficiency envisioned under welfare reform.

As welfare caseloads continue to decline, it is likely that the proportion of welfare recipients with health-status barriers to work will exceed the 20 percent that states are allowed to exempt from the federal time limit on assistance under PRWORA. To facilitate recipients' transition from welfare to work before they reach their time limit on assistance, state policymakers can:

- conduct studies and use screening tools to identify the type, severity, and effect of chronic medical conditions on employment among welfare recipients and refer them to appropriate treatment;
- promote interagency collaboration and education to develop a continuum of services for welfare recipients with chronic medical conditions;
- seek alternative funding sources to meet these recipients' health-related service needs;
- address health care access and capacity problems that prevent welfare recipients from getting the help they need to achieve self-sufficiency; and

- create a state-funded program to meet the needs of welfare recipients who have health-status barriers to employment.

Conduct Studies and Use Screening Tools

Currently, there is limited information about the type and severity of chronic medical conditions affecting the welfare population. Moreover, the impact of health-status barriers on recipients' ability to find and retain jobs is not well documented. States can conduct studies and use screening tools to determine the nature and scope of chronic medical conditions that may affect welfare recipients' ability to work.

Information about the health-status service needs of welfare recipients can be used to develop a continuum of care that will enable most of them to find and retain jobs. Screening and assessment also are important to provide another point of identification. For some recipients, this may be the first time their health-status barriers to employment are identified. It is important to identify recipients with chronic medical conditions and refer

them to appropriate treatment as early as possible.

Promote Interagency Collaboration and Education

State governments employ people with different backgrounds and training who work in agencies that may have different missions, funding sources, provider types, delivery systems, and treatment philosophies. People with chronic medical conditions, particularly those with mental health and substance abuse problems, have difficulty arranging treatment because often they must negotiate a separate behavioral health system with its own providers and programs.

States can coordinate the efforts of multiple service agencies to help screen, assess, and treat this population. One strategy is to collocate counselors specializing in substance abuse and mental health with welfare eligibility workers to facilitate the identification and referral of recipients with health-status employment barriers to appropriate treatment. Alternatively, TANF caseworkers could receive additional training to identify, screen, and refer recipients who need treatment for health problems prior to, or concurrent with, their seeking employment. It also is important to educate health and welfare personnel on the chronic medical conditions that could hinder the transition from welfare to work and the benefits of treatment.

Collocating services would facilitate integrated treatment and management of chronic medical conditions. An interim strategy is to identify a primary caseworker to help welfare recipients with multiple health-status barriers to employment navigate the multiple service systems.

Developing the capacity to integrate service data that reside in separate management information systems within the state also is a critical step. Information sharing can facilitate the use of integrated treatment approaches and the tracking of welfare recipients with chronic medical conditions.

Seek Alternative Funding Sources

States are encouraged to blend public- and private-sector funds to meet the health-related service needs of welfare recipients with chronic medical conditions. To develop a continuum of care, states can investigate funding sources, such as categorical and block grant mental health and substance abuse funds and tobacco and liquor taxes that support health care initiatives. In addition, states can pursue direct care grants from private foundations.

States can also consider using welfare funds to address the needs of recipients with health-status barriers to employment. Federal TANF funds cannot be used to assist a family in which the adult recipient has received assistance for five years. States may exempt up to 20 percent of their caseload from this federal lifetime limit on assistance in instances of hardship or domestic violence. Generally, TANF funds must be spent on benefits or services for “needy” families, including a broad array of services to help individuals become ready for work. Although federal funds cannot be used to provide medical services, they can be used for case management as well as for nonmedical services related to substance abuse or mental health treatment, such as counseling and the housing costs of residential treatment.

To receive the full amount of their TANF block grant, states must meet a “maintenance-of-effort” (MOE) requirement. MOE funds can be used for medical services that are not Medicaid-reimbursable. This can help bring partners to the table, such as community mental health providers, who may otherwise have their own service delivery priorities. MOE funds can also serve families in a separate program to which federal time limits do not apply. This could help address recipients’ health-status barriers to employment before they move into the state’s main TANF program.

Address Health Care Access and Capacity Problems

PRWORA delinked eligibility for Medicaid from eligibility for cash assistance. As a result,

some welfare applicants and recipients may qualify for Medicaid but are not enrolled in the program. They may confuse the new time limits on cash assistance with Medicaid eligibility or think that sanctions imposed for non-compliance with work requirements affect the receipt of Medicaid benefits. State outreach and enrollment strategies, which have boosted the participation of children and pregnant women in Medicaid, can be targeted to welfare applicants and recipients to increase their participation in the program. Without coverage, those with chronic medical conditions may end up accessing health care services through costly hospital emergency rooms or fail to receive treatment.

States will also need to address capacity problems, especially in substance abuse treatment services. There is a shortage of substance abuse residential treatment services for adults and a lack of specialized substance abuse outpatient services. In fiscal 1994, the federal government estimated that fewer than half of the nearly 4 million Americans who needed treatment for chronic and persistent drug problems received treatment.⁵⁶ One reason may be that those requiring treatment were not diagnosed and refused to seek help for fear of consequences. Another reason may be that treatment facilities were not available.

There also is a lack of facilities that offer different types and levels of treatment, including facilities to treat the increasing number of

people with co-occurring disorders; facilities that can accommodate women who require treatment and have children; and age-appropriate facilities, such as those offering specialized services for adolescents. For example, pregnant women who use illicit drugs and other substances tend to decrease use during pregnancy, but their substance use then increases dramatically following childbirth.

The lack of appropriate treatment facilities misses a valuable opportunity to break the cycle of addiction. According to *The Chicago Tribune*, at least 600,000 women with children receiving public assistance require, and would benefit from, alcohol and other drug-related treatment. The evidence suggests that the majority of these women do not get treatment. One strategy is to increase the number of residential treatment centers that serve women with children.

Create a State-Funded Program

States may want to consider creating a state-funded program for recipients who have chronic medical conditions and may require more time than is allowed under welfare reform legislation. Such a program could count participation in treatment as participation for purposes of a work requirement and offer services and supports, such as counseling and treatment, to enable recipients to successfully transition from welfare to work.

Endnotes

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5. National Alliance for the Mentally Ill, web site, at <<http://www.nami.org>> (1999).
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7. Olson and Pavetti, supra note 3.
8. Ibid.
9. Ibid.
10. Ibid. There are no provisions for deferrals in CalWORKS, California's welfare reform program.
11. State of Michigan web site, at <http://www.mfia.state.mi.us/sanction/part_b.htm> (1999).
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13. Olson and Pavetti, supra note 3.
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15. Kramer, supra note 2.
16. Annette Riordan, coordinator, Substance Abuse Treatment Project, New Jersey Department of Human Services, comment at National Governors' Association forum, Washington, D.C., 25 June 1998.
17. Lydia Lissman, assistant administrator, Oregon Adult and Family Services Division, comment at National Governors' Association forum, Washington, D.C., 25 June 1998.
18. Although the term "substance abuse" is usually associated with illegal drugs, it also includes the inappropriate use of legal substances, such as alcohol, prescription drugs, and over-the-counter drugs. However, there is little evidence that the abuse of prescription or over-the-counter drugs is a major problem for the welfare population. Consequently, the focus of this chapter is the abuse of alcohol and illegal drugs.
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22. Olson and Pavetti, supra note 3.
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24. Diana D. Woolis, "Substance Abuse and Welfare Reform," presentation during National Governors' Association conference call, 15 June 1999.
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26. Nancy K. Young, *Alcohol and Other Drug Treatment Policy Choices in Welfare Reform* (Rockville, Md.: Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment, 1996).
27. Jason DeParle, "Newest Challenge for Welfare: Helping the Hard-Core Jobless," *New York Times*, 20 November 1997.
28. Young, *supra* note 26.
29. Developed by John Ewing, M.D., founding director of the Bowles Center for Alcohol Studies, University of North Carolina at Chapel Hill, CAGE is an assessment instrument for identifying alcoholics. The assessment consists of four questions: Have you ever felt you should Cut down on your drinking? Have people Annoyed you by criticizing your drinking? Have you ever felt bad or Guilty about your drinking? Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover (Eye opener)?
30. If this fragmentation were just a public-sector problem, then one policy option would be to integrate the medical and substance abuse delivery systems. Unfortunately, this pattern of separation also is reflected in the way that private managed care health plans organize benefits. Substance abuse services often are bundled together with mental health services and provided as distinct "carve-out" benefits by a company other than the one providing physical health benefits.
31. National Institute of Mental Health, National Institutes of Health, at <<http://www.nimh.nih.gov/publicat/numbers.cfm>> (1999).
32. Center for Psychiatric Rehabilitation, Boston University, "What is Psychiatric Disability and Mental Illness?," at <<http://www.bu.edu/sarpsych/reasacom/whatis-psych.htm>> (1999).
33. Lissman, *supra* note 17.
34. Mary Pannunzio, supervisor, program and policy design, Utah Workforce Services, comment at National Governors' Association forum, Washington, D.C., 25 June 1998.
35. Jo Weber, chief, Work Services and Demonstration Projects Branch, California Department of Social Services, communication with author, 26 July 1999.
36. "Mental Ills Affect Welfare Moms," *Daily News (Philadelphia)*, 24 August 1998.
37. Center for Psychiatric Rehabilitation, *supra* note 32.
38. Richard E. Hegner, *Mental Health Parity: Unresolved Issues Affecting Employers, Consumers, and Insurance Coverage* (Washington, D.C.: National Health Policy Forum, 1997).
39. National Alliance for the Mentally Ill, *supra* note 5.
40. Hegner, *supra* note 38.
41. Similarly, managed care has diverted the provision of mental health services to a separate category of behavioral health providers. Further, the effort to move clients into less-intensive, less-expensive modalities of treatment may have had the unintended effect of leaving clients with fewer treatment options. As people are diverted from high-cost treatment options, such as inpatient hospitalization, to less-intensive treatment options, such as residential or day treatment, existing facilities may be overwhelmed by the increased demand for services, leaving clients with limited options for treatment.

42. National Alliance for the Mentally Ill, *supra* note 5.
43. National Advisory Council, Substance Abuse and Mental Health Services Administration, “Improving Services for Individuals at Risk of, or with, Co-Occurring Substance-Related and Mental Health Disorders” (draft report presented at a meeting hosted by the National Health Policy Forum, Washington, D.C., April 14, 1998).
44. *Ibid.*
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46. National Advisory Council, Substance Abuse and Mental Health Services Administration, *supra* note 43.
47. *Ibid.*
48. *Ibid.*
49. Pannunzio, *supra* note 34.
50. U.S. Department of Health and Human Services, *supra* note 45.
51. *Ibid.*
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53. *Ibid.*
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55. National Advisory Council, Substance Abuse and Mental Health Services Administration, *supra* note 43.
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