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ABOUT THIS TECHNICAL REPORT

The main findings presented in this report are available in a much condensed version: Daniel Chandler & Joan Meisel (2002). *Need, Incidence, and Services*. Sacramento: California Institute for Mental Health. It can be obtained from the CIMH website (www.cimh.org/calworks) or by calling CIMH at (916) 556-3480, Extension 111.

This technical report will be of most interest to other researchers in the field. It contains much detail not in the condensed report (for example, the two year prevalence figures for different mental disorders and for different types of domestic violence). It also contains comparisons of a variety of different measures of particular domains. For example, mental health issues can be characterized by diagnosis and number of diagnoses, by functional impairment, or by symptom-scale scores. Results for all of these are presented here but the condensed report focuses on the symptom scores. Finally, there is more methodological information here than in the condensed report.

INTRODUCTION

Domestic violence,[1] mental health, and alcohol & other drug problems are related to welfare in complex ways. Although rates of domestic violence have been found in numerous studies to be higher than in the population at large the dynamics of how welfare may affect the situation of women suffering from abuse are little known—particularly in the era after welfare reform[2] was passed and implemented. Similarly mental health issues, particularly depression, appear to be much more prevalent among women on welfare than in comparable populations not on welfare. But the existing cross-sectional studies have not allowed us to determine whether depression is a cause or consequence of welfare use. Finally, it has been unclear the extent to which alcohol and other drug use may be situationally related to participation in welfare as opposed to being chronic conditions.

In California and other states much effort and resources have gone into identifying and serving welfare participants with domestic violence, substance abuse or mental health needs. In general, the services provided through welfare programs have identified far fewer persons that prevalence studies would suggest might need help in order to meet time limits and achieve economic independence. The CalWORKs Project six county case study found that the two most successful county programs (of the six counties) are the two which are reported on here: Kern County and

[1] Professionals often use "intimate partner violence;" and physical and emotional battery in a context of control has recently been termed "intimate terrorism." The California Department of Social Services Domestic Abuse Protocol defines domestic abuse as "assaultive or coercive behavior which includes: physical abuse; sexual abuse; psychological abuse; economic control; stalking; isolation, and threats or other types of coercive behavior occurring within a domestic relationship."

[2] The Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996 replaced the Aid to Families with Dependent Children (AFDC) program of cash assistance with Temporary Aid to Needy Families (TANF) block grants. The California legislation implementing TANF is called CalWORKs (California Work Opportunity and Responsibility to Kids).

Stanislaus county. Yet only 13 percent of the eligible CalWORKs recipients in these counties were identified and served in mental health and substance abuse programs in 1999-2000.

The focus of this report is on these two issues:

- To what extent are the conditions of domestic violence, mental health problems and substance abuse stable or changing over time?
- What is the extent and nature of services that women with these three conditions receive, if any?

This is part of a series of reports documenting the results of a longitudinal study of 882 women recipients of CalWORKs in California's Kern and Stanislaus counties. In Stanislaus respondents were interviewed immediately after they had applied for CalWORKs and were in the initial stages of welfare-to-work activities. In Kern the sample had all received cash aid for at least one year but many participants in the study had yet to begin welfare-to-work activities. Thus the samples in each county differed in their relationship to welfare. The differences are somewhat less than they seem, however, since 79 percent of the Stanislaus sample had received cash aid in the years 1996–1998. This report compares information from the first interview with that of the second interview, conducted 12 months after the first.

Details of the study sample and design are presented in the project's *Prevalence Report*[3] and are summarized in Appendix A of this report. This study is being conducted by the California Institute for Mental Health, a non-profit educational and research affiliate of the California Mental Health Directors Association, in conjunction with The CalWORKs Project—a collaboration between the California Institute for Mental Health, Children and Family Futures, and the Family Violence Prevention Fund. The focus of the Project is on the role of domestic violence (DV), mental health (MH) and alcohol and other drug (AOD) issues under welfare reform. While one concern is the extent to which these issues may be hurdles to attaining and retaining employment, we are equally concerned with their effect (in the welfare context) on children in the family, and with how best to identify and serve women having to cope with one or more AOD/MH/DV issue. A variety of other information on these topics is available at the CIMH website: www.cimh.org.

Note on Table Formatting: In general results are shown rounded to whole numbers in order to avoid a misleading sense of precision (sampling and measurement error are likely to be much more than rounding error). However, when many of the numbers in a table are under ten we present the figures to one decimal point. Unless specifically stated otherwise (which only occurs with one table), the N stands for the number in the denominator. Thus an N of 300 and a percentage of 10 would mean that the percentage represents 30 respondents.

[3] Chandler, D. and J. Meisel (2000). *The Prevalence of Mental Health, Alcohol and Other Drugs, & Domestic Violence Issues Among CalWORKs Participants in Kern and Stanislaus Counties.* Sacramento, California Institute for Mental Health.

Chapter One:

Domestic Violence Issues

I. TWO YEAR PREVALENCE RATES

A prevalence rate is defined as the number of "cases" divided by the total number of persons at risk at a given point in time or during a given time period—in this case the 12 months prior to the research interview. The rates here reflect respondent answers to questions about different types of abuse.

A. PREVALENCE OF ABUSE BY TYPE OF ABUSE

Lifetime and Round I prevalence rates for abuse were very high, even for comparable populations.[4] Rates shown here are for the 12 months prior to the first interview and the twelve months between the first and second interviews. In general, Tables 1-3 show some reduction in Round II in both sites of virtually all types of abuse. The decline in the percentage reporting *any* abuse from Round I to Round II is statistically significant in both counties. The percentages reporting *specific* types of abuse tended to be statistically significant, but only in Stanislaus.[5] Round II rates in Stanislaus remained higher than in Kern. The results are summarized below:

- Women reporting at least one type of physical abuse went from 17 to 14 percent in Kern and 25 to 19 percent in Stanislaus (not statistically significant).

- In Round I 22 Kern women (7.6 percent) reported physical injuries as a result of abuse in the prior 12 months; in Round II 18 women (6.6 percent) reported injury. In Stanislaus the comparable figures were 32 (9.0) and 34 (10.9)—one of the few instances of a seeming increase. In Stanislaus in Round II, three percent of the entire sample reported having been physically abused while pregnant during the year. None of the changes between interview rounds is statistically significant.

- Stalking changed very little in Kern (9 to 8 percent) but declined significantly (13 to 9 percent) in Stanislaus.

- Forced sex or sex under duress changed from 3 percent to 2 percent in Kern and 4 percent to 1 percent in Stanislaus (statistically significant in Stanislaus).

- The percentage of women whose partner made at least one serious threat (such as to kill the woman or call child protective services) dropped from 18 to 12 percent in Kern and from 25 to 15 percent in Stanislaus (a significant reduction in both counties).

- The percentage of women endorsing three out of the four control items went from 10 to 8 percent in Kern and 19 to 11 percent in Stanislaus (significant in Stanislaus).

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4 Op cit. *Prevalence Report*. There is one important difference between the *Prevalence Report* information and that presented here: in the *Prevalence Report* we included data from 63 Kern County CalWORKs clients who were not at that time eligible for welfare-to-work activities. Roughly 40 were ineligible due to disability and 23 were undocumented. Because rates for these study participants were quite similar to those overall the Round I rates here vary little from those in the *Prevalence Report.*

5 We tested whether the rates changed significantly using the McNemar test with an alpha of 0.05. For the effects of attrition, please see page 8.

- Seven questions were asked about whether a partner had interfered with work or training in the past year. The percentage answering at least one question positively went from 9 to 6 percent in Kern and 18 to 13 percent in Stanislaus.

- The broadest measure of abuse includes anyone with a positive response to any of the measures in Table 1 or Table 2. In Kern the percentage reporting any measure was 38 in Round I and 31 in Round II; in Stanislaus the decline from 52 to 39 was comparable in magnitude. (The reduction was statistically significant in both sites.)

Lower prevalence rates may reflect a variety of possible conditions, all of which we will explore.

- To what extent is abuse "new" vs. "sustained?" (Section II)

- How did the partner status change over the two years? (Section III)

- To what extent did women receive DV services and how effective did they appear to women who sought help? (Section V)

- To what extent do lower rates reflect differential attrition?

Table 1: Percentage of Randomly Selected Women Head of Household CalWORKs Participants in Two California Counties Who Experienced Domestic Violence Lifetime, In Year Before First Interview and Year Before Second Interview (Shaded Rows are Means)

	KERN			STANISLAUS		
	Lifetime N=287 Percent	**98-99** N=287 Percent	**99-2000** N=273 Percent	**Lifetime** N=356 Percent	**98-99** N=356 Percent	**99-2000** N=311 Percent
CONTROL						
Excessively Jealous of Other Men	63%	24%	20%	66%	34%	25%
Limited Contact with Family/Friends	43	12	9	47	20	13
Had to Know Where She Was	55	20	18	59	30	22
Prohibited Knowledge/Access to Income	17	3	2	22	11	4
Three Out of Four Control Items	39	10	8	43	19	11
STALKING						
Hung Around or Followed Outside	31	9	8	31	13	9
VERBAL ABUSE						
Called Names and Humiliated	58	18	16	58	26	24
THREATS						
Threatened to Kill Himself or Woman if She Left	36	9	4	35	12	8
Threatened to or Hurt or Abused Child	11	1	1	10	2	1
Threatened to Kidnap Child or Call CPS	27	7	5	25	11	6
Threatened With Fist	50	12	9	51	17	13
AT LEAST ONE THREAT OF FOUR	60%	18%	12%	56%	25%	15%
Mean of four threats if at least one	2.1	1.7	1.5	2.0	1.7	1.8

Table 1 continued: Percentage of Randomly Selected Women Head of Household CalWORKs Participants in Two California Counties Who Experienced Domestic Violence Lifetime, In Year Before First Interview and Year Before Second Interview (Shaded Rows are Means)

	KERN			STANISLAUS		
	Lifetime N=287 Percent	**98-99** N=287 Percent	**99-2000** N=273 Percent	**Lifetime** N=356 Percent	**98-99** N=356 Percent	**99-2000** N=311 Percent
FORCED SEXUAL ACTS						
Forced Woman into Sexual Acts	20%	3%	2%	17%	4%	1%
PHYSICAL ABUSE						
Threw Dangerous Object	38	9	6	43	13	10
Pushed Grabbed or Shoved	58	16	12	60	22	18
Slapped	46	10	5	48	12	9
Kicked, Bit, Hit with Fist	41	8	6	43	11	7
Hit With Dangerous Object	33	6	5	35	10	7
Beat up	34	6	4	32	6	5
Choked	34	6	3	33	8	4
PHYSICAL ABUSE AT LEAST ONE OF 7 ITEMS	64%	17%	14%	64%	25%	19%
Physical Abuse: Mean of 7 items, if any	**4.5**	**4.4**	**3.2**	**4.7**	**4.4**	**3.2**

Table 1 continued: Percentage of Randomly Selected Women Head of Household CalWORKs Participants in Two California Counties Who Experienced Interference by a Partner With Work, Lifetime, In Year Before First Interview and Year Before Second Interview *(Shaded Rows are Means)*

"In last 12 months, difficult to find or keep a job because partner…"	KERN			STANISLAUS		
	Lifetime N=287 Percent	**98-99** N=287 Percent	**99-2000** N=279 Percent	**Lifetime** N=356 Percent	**98-99** N=356 Percent	**99-2000** N=311 Percent
Prevented from working	16%	4%	1%	22%	8%	7%
Refused to help/went back on promises	9	4	2	14	8	4
Made hard to attend classes or program	9	3	1	8	4	3
Tried to discourage from working	10	4	2	19	9	7
Made feel guilty about working	11	5	3	15	8	5
Harassed with phone calls at job	7	2	<1	6	3	<1
Shown up at job and harassed	7	2	<1	6	1	1
Forced to go to work to support partner	NA	NA	0	NA	NA	1
INTERFERED WITH WORKING IN AT LEAST ONE WAY (OF FIRST SEVEN)	**24%**	**9%**	**6%**	**36%**	**18%**	**13%**
Mean number of ways interfered if any	**2.8**	**2.8**	**2.1**	**2.5**	**2.3**	**2.5**

Table 2: Prevalence and Type of Physical Injury in Past Year, If Eligible for Welfare to Work

	ROUND I		ROUND II	
	Kern Recipients	**Stan Applicants**	**Kern Recipients**	**Stan Applicants**
TOTAL NUMBER IN GROUP	**287**	**356**	**273**	**311**
PHYSICALLY HURT IN PAST 12 MONTHS	N=22*	N=32*	N=18	N=34
Overall	7.6%	9.0%	6.6%	10.9%
Type of physical injury in past 12 months (one person may have more than one injury)	Number reporting injury	Number reporting injury	Number reporting injury	Number reporting injury
Physical abuse while pregnant	NA	NA	4	9
Miscarriage/complications of pregnancy	1	1	0	3
Head or brain injury (skull fracture, concussion)	7	3	2	4
Spinal cord injury, broken neck or back	1	2	1	0
Broken bones, dislocated joints, broken nose	3	4	3	2
Burns, rug burns; road burns	6	4	1	4
Internal injuries.	2	2	0	2
Lacerations, knife wounds, cuts, stitches	7	4	3	6
Scratches/bruises/welts/black eye/busted lip/bites	18	31	13	24
Chipped or knocked out teeth.	1	4	0	2
Sore muscles, sprains, strains, pulls	10	17	9	17
Bleeding genitals, genital injury	0	1	0	1
Perforated eardrum, shattered eardrum	2	0	0	2
Pulled hair out	0	1	2	7
Caused blood clot	0	1	0	0
Knocked unconscious, passed out	1	3	0	3
Deprived of food	0	0	0	1

* We did not ask whether physical abuse occurred while pregnant in prior 12 months in Round I.

Table 3: Percentage with Any of the Measures of Abuse and Mean Number if Any[6]

	KERN			STANISLAUS		
	Lifetime N=287 Percent	**98-99** N=287 Percent	**99-2000** N=273 Percent	**Lifetime** N=356 Percent	**98-99** N=356 Percent	**99-2000** N=311 Percent
ANY ABUSE	79%	38%	31%	83%	52%	39%
Mean number kinds of abuse if any	9.6	5.4	4.6	9.8	5.9	5.6

B. POST-TRAUMATIC STRESS DISORDER

Severe psychological problems that occur in the aftermath of traumatic incidents are termed post-traumatic stress disorder (PTSD). PTSD may occur at the same time as domestic violence or subsequent to it—sometimes not appearing for many years.[7]The criteria that must be met in order to qualify for this disorder are:

- The person has been exposed to a traumatic event.
- The traumatic event is persistently re-experienced.
- There is a persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness.
- There are persistent symptoms of increased arousal (such as difficulty falling or staying asleep).
- Duration of the disturbance is more than one month.

[6] The effect of attrition on prevalence: Although interview completion was high in the second round (95% in Kern and 87% in Stanislaus), differential attrition of respondents who reported domestic violence could cause the apparent drop in prevalence rates, particularly in Stanislaus where attrition was higher. We tested for this possibility by comparing the Round I rates of DV for persons who were not interviewed in Round II with those of persons who were interviewed. The percent in Kern of those with any abuse in Round I who *were* interviewed in Round II was 38 while it was only 21 percent among the 14 persons who were not re-interviewed (thus attrition would have little effect but the effect it had would be to *increase* rates in Round II). In Stanislaus, the rate was a little higher among those who were not re-interviewed (58 percent) than among those who were (51 percent), but this was not close to being a significant difference. The same pattern was found for physical abuse. Thus the effect of attrition was to make it *less* likely in Kern that rates appear to go down while making it *more* likely in Stanislaus. Neither effect was large, however.

[7] Woods, S. J. (2000). Prevalence and patterns of posttraumatic stress disorder in abused and postabused women. *Issues Mental Health Nursing, 21*(3), 309-324.

- The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

We did not ask about all sources of trauma—only about child or adult sexual or physical abuse. Table 4 shows the percentage of persons reporting childhood sexual or physical and adult sexual or physical abuse. The percentages total to more than 100 because some women experienced multiple types of abuse.

Table 4: Percentage of Total Group Experiencing Lifetime Sexual or Physical Trauma

TRAUMA EXPERIENCED	Kern Recipients	Stan Applicants
	N=287 Percent	N=356 Percent
Childhood sexual abuse	23%	25%
Childhood physical abuse	26	25
Adult sexual abuse	20	13
Adult physical abuse	65	56

Table 5 shows the trauma reported to be "worst" by those who met all six criteria for PTSD. In Round II we also gave respondents a chance to list emotional or psychological abuse as the most traumatic, and large numbers of women chose it. Recent research documents the likelihood of PTSD arising from psychological abuse even more than physical abuse.[8] A very large percentage of women, given the option, chose emotional/psychological as the most traumatic they had experienced. In Stanislaus it approached two thirds of those with a PTSD diagnosis.

Table 5: Which Family/Partner Trauma was Worst (Percentages of those who have PTSD Diagnosis)

	ROUND I		ROUND II	
WORST TRAUMA IF PTSD DX	Kern Recipients	Stan Applicants	Kern Recipients	Stan Applicants
	N=41 Percent	N=44 Percent	N=28 Percent	N=50 Percent
Childhood sexual abuse	23.7%	17.4%	35.7%	14.0%
Childhood physical abuse	13.2	21.7	3.6	4.0
Adult sexual abuse	5.3	0	0	6.0
Adult physical abuse	47.4	56.5	25.0	12.0
Multiple (can't separate them)	4.3	10.5	NA	NA
Adult emotional/psychological	NA	NA	35.7	64.0

[8]Street, A. E., & Arias, I. (2001). Psychological abuse and posttraumatic stress disorder in battered women: examining the roles of shame and guilt. *Violence and Victims, 16*(1), 65-78; Arias, I., & Pape, K. T. (1999). Psychological abuse: implications for adjustment and commitment to leave violent partners. *Violence and Victims, 14*(1), 55-67.

Sub-clinical symptoms. Very high percentages of women meet at least one of the criteria for PTSD—about two thirds of all respondents. In Kern a fifth meet at least four of the six criteria and in Stanislaus a third of the women meet four of the six criteria.

Some indication of the seriousness of the PTSD symptoms for women who do not meet all six criteria is provided by the percentage of women who consulted a doctor or other professional for the symptoms. In both counties, the percentage who saw a professional increases steadily with the number of symptoms, with nearly half of the women having four symptoms having consulted a professional in Round II. (See Table 7.)

These high manifestations of clinical discomfort (but at a sub-diagnostic level) show something of the psychological burden women must cope with that is related to sexual, physical, or emotional intimate partner violence.

Table 6: Percentage with PTSD (or significant symptoms of PTSD)

	ROUND I		ROUND II	
	Kern Recipients	Stan Applicants	Kern Recipients	Stan Applicants
	N=287 Percent	N=356 Percent	N=273 Percent	N=311 Percent
PTSD (All six criteria met, adult or child trauma)	13%	13%	10%	16%
At least one criterion met, adult or child trauma	NA[9]	NA	64	68
At least four criteria met, adult or child trauma	NA	NA	20	33
PTSD: ALL SIX CRITERIA, ADULT TRAUMA	7	8	6.	13

Table 7: Number and Percentage of Who Reported in Round II Seeing a Doctor or Other Professional About PTSD Symptoms, by Number of PTSD Criteria Met

PTSD CITERIA MET	Kern		Stanislaus	
	SAW A PROFESSIONAL			
	Number*	Percent	Number*	Percent
One criterion met	0	0%	0	0%
Two criteria met	4	20	3	21
Three criteria met	9	41	3	11
Four criteria met	6	46	15	48
Five criteria met	6	40	11	48
PTSD (All six criteria met, adult or child trauma)	14	50	34	68
PTSD: ALL SIX CRITERIA, ADULT TRAUMA	9	53	28	68

*This is the actual number of those who saw a professional, not the denominator of the percentage.

[9] In Round I we used a "scoring program" that did not show the percentages of each of the six criteria.

As shown in Table 6, the percentage of respondents meeting all six criteria—regardless of whether the trauma was experienced in childhood or adulthood—comprised between 10 and 16 percent of the samples, depending on site and year. In the rest of this report, however, we will limit the PTSD cases to those with an adult-experienced trauma. In general, adult-related PTSD was about half as prevalent (6-8 percent) as PTSD from both child hood and adult traumas. However, in Round II in Stanislaus 13 percent reported adult-related PTSD. Fully 78 percent of these were emotional abuse with only 15 percent being physical and 7 percent sexual abuse.

C. "SERIOUSNESS" OF ABUSE

Our approach to domestic violence has been to cast a very wide net. We have asked questions that cover all types of potential domestic abuse including emotional and verbal abuse, controlling behavior, and threats. The result has been the documentation of the very high rates of women who are or have been subjected to some type of domestic violence.

The domestic violence field has commonly distinguished physical violence from other types of domestic violence. The research community is increasingly attempting to develop other typologies that will distinguish types of domestic violence in terms of etiology, correlates, and consequences. An approach that goes beyond artificially restricting abuse to physical abuse but which is not as broad as our category of "any abuse" is particularly important in the context of welfare reform.

The Family Violence Option (FVO) was instituted in order to provide appropriate protection for women whose compliance with the requirements of TANF might jeopardize their safety. In fact, very few women have used the FVO. Does this mean that our estimates of the number of women at potential risk is lower than anticipated or alternatively that the structure of the FVO is not conducive to its being used? It will be helpful for DV advocates to be able to point to data that reflects not just "any" abuse but also what might be considered "serious" abuse, particularly within the structure of TANF requirements. We attempt to validate our construct of "serious abuse" by correlating it with other indications of seriousness, for example help-seeking behavior.

It should be understood, however, that the use of this terminology does not in any way minimize the potential impact of what we term "apparently less severe abuse" on its survivors. Note that the level of severity applies only in the aggregate, as a statistical generalization. As an example of the limitations involved, there were four respondents who reported only excessive jealousy or verbal humiliation who nonetheless sought professional help.

"Serious Abuse"

"Serious Abuse" is defined here as abuse that either has resulted in serious physical injury, is considered severe in many other studies, or appears to impact directly on the ability of the person to engage in required TANF welfare to work activity. We have included the following elements, any one of which would serve to classify the abuse as "serious":

- Physical injury (see table above)

- Response on the physical abuse questions that respondent was "choked" or "beat-up."
- Stalking
- Forced or coerced sex
- Threatened to kill woman or kill self
- Threatened or actually hurt children
- Threatened to kidnap children or call CPS
- Actual preventing a woman from working or harassing while on the job

"Apparently Less Severe Abuse"

For the purpose of the analysis, "apparently less severe" is used for the types of abuse which do not fit into the "serious" abuse category.

Table 8 shows the overall prevalence by site and year of the constructs described here.

Table 8: Prevalence By Type Of Abuse (Any Abuse Is Made Up Of "Very Serious" And "Apparently Less Serious" Abuse)

	KERN			STANISLAUS		
	Lifetime N=287 Percent	**98-99 N=287 Percent**	**99-2000 N=273 Percent**	**Lifetime N=356 Percent**	**98-99 N=356 Percent**	**99-2000 N=311 Percent**
No Abuse	21%	62%	69%	17%	48%	61%
Any Abuse	79	38	31	83	52	39
Serious Abuse	57	19	15	65	29	21
Apparently less severe	23	19	16	18	24	18

The relative frequency of different types of abuse

Table 9 below shows the relative frequency of the different types of abuse in Round I, with both sites combined. The types of abuse we have termed "very serious" are in italics. In general, the more serious types of abuse are not among the most frequent—as one would expect.

In Table 10, we show the correspondence between the number of types of abuse women reported and the percentage who were classified in the "serious abuse" category. Of those reporting one type of abuse, 21 percent were classed as "very serious;" the percentage increased linearly, reaching close to 100 percent for those respondents reporting 9 or more types of abuse. Once again, it is expectable that multiple types of abuse would tend to be associated with serious abuse.

Table 9: Relative Frequency Of Each Measure Of Abuse (Round I Both Counties)

Came to job site and harassed	*1.4%*
Threatened or hurt child	*2.0*
Harassed on job with phone calls	*2.6*
Forced or coerced sex	*3.4*
Made difficult to attend classes or training	3.7
Beat up	*6.1*
Made feel guilty about working	6.4
Prevented from working	*6.5*
Made it difficult to work	6.7
Choked	*7.0*
Discouraged from working	7.2
Limited access to income	7.3
Physically hurt	7.7
Hit with something that could hurt	8.2
Threatened to call CPS	*9.2*
Kicked, bit or hit with fist	9.6
Threatened to kill or kill self	*10.9*
Slapped	11.0
Followed	*11.4*
Threw something that could hurt	11.4
Threatened with a fist	14.8
Limited contact with family or friends	16.5
Pushed	19.6
Verbally humiliated	22.7
Had to know where and who with	25.8
Excessively jealous	29.5

Table 10: Percent Respondents Classified As "Serious Abuse" By Number Of Types Of Abuse Reported (Round I Both Counties)

# OF TYPES OF ABUSE	Serious Abuse
	N Percent
One Type of Abuse	17 21%
2-4 Types of Abuse	23 27%
5-8 Types of Abuse	39 75%
9-16 Types of Abuse	64 97%
17-23 Types of Abuse	13 100.00

Summary of evidence of validity of the construct "serious abuse"

In general, the analysis which follows supports the use of the "serious abuse" construct as defined here, as it is associated with other important attributes of domestic violence itself and with attributes of MH and AOD or the CalWORKs process. Below we summarize evidence for the validity of the construct that is presented throughout the report.

- Rates of lifetime "apparently less severe abuse" are far lower than rate of "serious abuse" indicating at a minimum that they are different constructs and perhaps suggesting that "apparently less severe" is not perceived or remembered as "abuse" in the same way as is "serious abuse."

- In Stanislaus, "apparently less severe" is less persistent across two years than is "serious abuse."

- Women experiencing apparently less severe abuse were considerably more likely than those experiencing serious abuse to still be with the abusive partner.

- Those reporting serious abuse also report substantially more depression than those reporting apparently less severe abuse.

- The rate of AOD abuse/dependence for those with serious abuse is about twice the rate reported for those with apparently less severe abuse.

- In Stanislaus, where women were just going on to cash aid, the rate of those using the current episode of welfare to escape abuse was five times higher among those with serious abuse than among those with apparently less severe abuse.

- The percentage of women with "apparently less severe abuse" who volunteered they did not seek help because the abuse was very minor, it was not really abuse, or they could deal with it themselves, was two to ten times (depending on site and year) higher than among women with serious abuse.

- The percentage of women classed as having "serious abuse" who sought DV-specific help was between four and nine times as great as the percentage classed as having "apparently less severe abuse," depending on site and year.

II. INCIDENCE OF NEW AND SUSTAINED CASES

While "prevalence" reflects the total number of cases present during a given time period, "incidence" reflects the number of *new* cases in a time period—in this case in a 12 month period. Although there is no commonly used term for it, we are also interested in the opposite—the number of cases that change to non-cases in a given time period. Finally, it is critical to know how many cases of domestic abuse persist over time. The tables below present these kinds of data organized by county. The time period in question is the two 12 month periods during which prevalence was measured (in Round I and Round II).

Table 11: Kern County New, Sustained and Not Sustained Abuse

	Either One or Both Years Percent	Recent Not Sustained Percent	New Incidence Percent	Sustained Abuse Percent
Any Abuse	50	19	11	20
Work-Related	14	8	4	1
PTSD	20	9	6	4
Physical	26	13	9	4
Serious Abuse	28	12	8	7
Apparently less severe	29	12	9	7

Table 12: Stanislaus County New, Sustained and Not Sustained Abuse

	Either One or Both Years Percent	Recent Not Sustained Percent	New Incidence Percent	Sustained Abuse Percent
Any Abuse	63	24	13	27
Work-Related	25	12	8	5
PTSD	23	7	11	5
Physical	33	14	9	10
Serious Abuse	36	15	8	12
Apparently less severe	36	18	12	6

There are four important patterns here:

- The most sustained of the subtypes of abuse is "very serious" abuse (in Stanislaus).
- A higher percentage of each category "drops out" across years than there is incidence of new abuse.
- In Stanislaus about two thirds as many serious cases developed during the second year as persisted over both years; in Kern there were more new cases than persisting cases. In both counties there was a substantial development of serious domestic violence within a year—*efforts at identifying women with DV issues should clearly not be restricted to the initial screening and processing period.*

- Finally, all of these respondents are the head-of-household—that is, no partner is on the CalWORKs case. The very high amount of abuse occurring in a two year period should make policy-makers consider carefully any policies aimed at encouraging marriages among this group. The government should not be in the position of providing incentives or coercing women into permanent relationships with abusive partners.

The table below includes only those persons who had "any abuse" in both years, i.e. the persistent category for "any abuse." It indicates the stability and change in patterns of "serious" and "apparently less severe" abuse across the two years.[10]

Table 13: Percent who Report Abuse in Both Years, by "Serious" and "Apparently Less Severe" Abuse

	Less Severe Both Years Percent	Serious Rnd I Less Severe Rnd II Percent	Serious Rnd II Less Severe Rnd I Percent	Serious Both Rnds Percent
Kern	34.5	14.5	16.4	34.5
Stanislaus	21.7	15.7	16.9	45.8

The table indicates that *between a third and one half of those with abuse in both years experience persistent serious abuse and another 15 percent move from "apparently less severe" to serious, that is the abuse escalates.*[11]

The effects of attrition on incidence

Although interview completion was high in the second round (95% in Kern and 87% in Stanislaus), differential attrition of respondents who reported domestic violence in Round I is still possible. That is, if a higher proportion of women who had reported abuse had not been interviewed in Round II than the overall proportion not interviewed, then the percentage of women with sustained abuse could appear low.

In large part this does not turn out to be a problem because there was very minor differential attrition—women reporting abuse were interviewed at the same rate as those not reporting abuse. In Kern, 98 percent of those with serious abuse were re-interviewed; in Stanislaus 83 percent. Since these figures are very close to the overall attrition rate, it is unlikely that differential attrition had a major effect on the incidence rates and rates of sustained abuse reported here. It is conceivable, however, that the 17 persons in Stanislaus with abuse in Round I whom we did not find would have reported incidence patterns somewhat different from the overall pattern.

[10] This is essentially the same table as above, but with any abuse in both years as the denominator rather than study participation in both years being the denominator.

[11] Note that the fact a woman experience less severe abuse in the first year and serious abuse in the second year does not necessarily mean a particular abuser was escalating his pattern of abuse (as is often reported in the literature). The abuse could have been committed by different partners.

III. CHARACTERISTICS, CORRELATES AND CONSEQUENCES OF DOMESTIC VIOLENCE

Over and above understanding the extent to which different types of domestic violence occur and persist or not over time, planning for services and estimating the impact on need for special consideration under TANF requires understanding four relationships:

- How are the prevalence and incidence of domestic violence related to whether or not women currently have partners? For example, there is no longitudinal national survey that asks about domestic violence and samples women who are not at that moment in a relationship.[12] Likewise, a common screening instrument for domestic violence assumes the woman is currently in a relationship. Are such assumptions justified or useful?

- The recency of abuse and its duration may be important factors in judging severity. Recency includes respondent judgements regarding whether the violence has stopped or is likely to continue.

- A key goal of the CalWORKs project is to show the interrelationships of domestic violence, mental health, and AOD issues. Other "silent barriers" that may be associated with domestic violence are low self-esteem and learning disabilities, both of which may compound the difficulties faced by victims of intimate partner violence.

- Finally, there are explicit ways in which domestic violence is thought to relate to welfare policies and procedures. Do assumptions made about welfare reform and domestic violence hold up in reality? Is the current form of the Family Violence Option useful?

A. RELATIONSHIP STATUS

Did women having a partner at the time of the interview report more abuse?

In the analysis below we first look at partner status in general, without asking if the current partner is the abuser. In the next section we look at whether the woman is still with the abuser.

At the time of the second interview, 43 percent of the Kern respondents and 35 percent of the Stanislaus respondents were living with their husband or had a "steady" partner they were romantically involved with. In the first interview it was slightly higher, at 46 and 40 percent.

[12] Presentation of Samuel L. Myers, Jr. (Roy Wilkins Professor of Human Relations and Social Justice, Humphrey Institute, University of Minnesota) at the National Institute of Justice meeting of welfare and domestic violence grantees, May 2001.

In both rounds, having a current partner made it somewhat more likely that abuse would have been experienced in the last 12 months (see Table 14). For example, in Kern in Round II, 37 percent of those who had a partner reported abuse in the last 12 months vs. 26 percent among those who did not.[13] However, in Stanislaus in Round II 39 percent reported some abuse in the last 12 months regardless of whether they had a partner at the time of the interview.

Table 14: Percentage *Any* Abuse in Year Before Interview, by Whether Have Partner at Time of Interview

	ROUND I		ROUND II	
	Kern Recipients	Stan Applicants	Kern Recipients	Stan Applicants
TOTAL NUMBER IN GROUP	**N=287 Percent**	**N=356 Percent**	**N=273 Percent**	**N=311 Percent**
Women Who *Do* Have Partner at Interview	49%	59%	37%	39%
Women With *No* Partner At Interview	27	48	26	39

Table 15: Percentage Serious Abuse in Year Before Interview, by Whether Have Partner at Time of Interview

	ROUND I		ROUND II	
	Kern Recipients	Stan Applicants	Kern Recipients	Stan Applicants
TOTAL NUMBER IN GROUP	**N=287 Percent**	**N=356 Percent**	**N=273 Percent**	**N=311 Percent**
Women Who *Do* Have Partner at Interview	21%	35%	18%	17%
Women With *No* Partner At Interview	16	25	12	23

Similarly, women with a partner at the time of interview had somewhat higher rates of serious abuse during the last 12 months than women without partners in both counties and both interview rounds. The exception was Stanislaus in Round II, where a *lower* percentage (17 percent) of serious abuse was reported among those with a partner than those without (23 percent).

There are two plausible causes for the considerably lower percentage of serious abuse among those with a partner in Stanislaus in Round II (than in Round I). The first is that many of the women in Round I reporting serious abuse could not be found to be interviewed in Round II. This seems at best a partial explanation because of the 102 women reporting serious abuse in Stanislaus in Round I only 17 were not interviewed in Round II.

A second hypothesis is that many of the Stanislaus women with serious abuse in Round I ended the relationship. This hypothesis accounts for much of the difference: in Round I there were 44 women with a partner at the time of the interview who reported serious abuse during the previous 12 months. In Round II, only 15 of the same 44 women reported having a partner while 29 had no partner.

[13] Statistically significant at $p \leq 0.08$.

Although rates are generally somewhat higher among women with a partner, the differences are not large. *These tables point to the need for CalWORKs staff to be alert to the possibility of recent domestic violence regardless of the woman's current marital status and regardless of the aid code (all of the women in our study are single heads of household).*

Were women still with their abusive partner?

To what extent were women who reported any abuse or serious abuse still with the partner who had committed the abuse?

Table 16: Percentage of Women Reporting Abuse Who Were Still With the Abuser At Interview

	ROUND I		ROUND II	
	Kern Recipients N Percent	Stan Applicants N Percent	Kern Recipients N Percent	Stan Applicants N Percent
Percentage of those with Any Abuse Still With Abusive Partner	109 24%	186 18%	86 48%	119 39%
Percentage of those with Serious Abuse Still With Abusive Partner	102 15%	54 14%	41 41%	64 36%

Overall, fewer than half the women were still with the partner whom they reported had abused them. In Round I only about 15 percent of women with serious abuse were still with the partner who perpetrated it. Surprisingly, though, women were much more likely to be still partnered with their abuser in Round II than in Round I.[14]

Did women temporarily leave an abusive partner

In both rounds we asked women who were in abusive relationships at the time of the interview if they had left or stayed apart from their current partner *because* he was abusive or threatening during the previous 12 months. To have done so is an indication of the severity of the abuse.

Of the women who were still with their abusive partner, at least a quarter reporting "any abuse" had left their partner temporarily during the 12 months previous. The percentages were higher for women reporting serious abuse—39 to 65 percent. Overall, then it appears that high proportions of women who experience abuse, especially serious abuse, either are separated from their partner permanently or have left temporarily.

[14] The analysis is for each interview round separately. We did not ask about a 24 month period.

Table 17: Percentage of Women Currently with Abusive Partner Who Had Temporarily Left During Previous 12 Months

	ROUND I		ROUND II	
	Kern Recipients N Overall Percent	Stan Applicants N Overall Percent	Kern Recipients N Overall Percent	Stan Applicants N Overall Percent
Percentage of those with Any Abuse who had left abuser temporarily	26 27%	33 39%	41 32%	46 26%
Percentage of those with serious abuse who had left abuser temporarily	8 63%	17 65%	17 65%	23 39%

Did women still see abuser who was not current partner?

Women whose abuser was *not* their current partner were asked how often they see the abuser and whether this contact is unwanted, voluntary or required by circumstances (such as shared custody of children).

Table 18: Frequency of Contact with Abuser among Women Not Living with Abuser

	ROUND I		ROUND II	
	Kern Recipients N=69 Percent	Stan Applicants N=62 Percent	Kern Recipients N=46 Percent	Stan Applicants N=83 Percent
Never see or talk to him	48	39	24	27
Occasionally see or talk to him	36	32	48	41
Frequently see or talk to him	16	29	28	32

From 61 to 76 percent of the women who do not live with their abuser see him sometimes. The percentage *not* seeing the abuser is considerably higher in Round I than in Round II. (We do not have information on whether women reporting abuse in Round I but not in Round II see the abuser.) Also, about a third of the women see the abuser frequently.

Table 19: Reason for Contact with Abuser among Women Not Living with Abuser (Percentages of those who have contact)

	ROUND I		ROUND II	
ANY ABUSE	**Kern Recipients N=37 Percent**	**Stan Applicants N=38 Percent**	**Kern Recipients N=39 Percent**	**Stan Applicants N=61 Percent**
Voluntary	46%	42%	36%	61%
Rather not see or talk to him at all but circumstances require it (work, children, neighborhood)	32	42	54	26
Other	22	16	10	13

A high percentage (26 to 54) see their abuser due to circumstances; but an equally high percentage do so voluntarily (36-61percent). Among those who experienced serious abuse the percentages of voluntary contact are only somewhat smaller.

Table 20: Reason for Contact with Abuser among Women Not Living with Abuser (Percentages of those who have contact)

	ROUND I		ROUND II	
SERIOUS ABUSE ONLY	**Kern Recipients N=30 Percent**	**Stan Applicants N=32 Percent**	**Kern Recipients N=35 Percent**	**Stan Applicants N=44 Percent**
Voluntary	37%	31%	37%	52%
Rather not see or talk to him at all but circumstances require it (work, children, neighborhood)	40	50	51	32
Other	23	19	11	16

B. RECENCY AND DURATION

Women were interviewed at a point in time. In Stanislaus it was within a few days after they had applied for cash aid; in Kern it was roughly at the same time women were applying for continuation of their aid. The prevalence and incidence information presented above cover the entire 12 months prior to the interview. Here we share information about how recent the abuse had been—with implications for whether the abuse might appropriately have been reported to CalWORKs case workers or to a DV program connected with CalWORKs.

Respondents in Round I were asked when the first incident of sexual or physical abuse by a partner had occurred—but only *if they had reported abuse in the previous 12 months.*

Table 21: Time Since First Incident of Physical or Sexual Abuse, if Any Abuse in Previous 12 Months (Percentages)

	ROUND I	
	Kern Recipients N=77 Percent	**Stan Applicants N=128 Percent**
Less than a year	10%	11%
One to three years	29	23
Three to ten years	40	40
Over ten years	21	27

Very few of the women (ten percent) reported abuse that had started within the past year. In fact in over 60 percent of the cases the abuse had started more than three years before. (Note, however, that this does not imply that the same abuser was involved over time—only that the first incident, with whatever abuser, occurred that long ago.)

Table 22: Most Recent Episode Of Sexual Or Physical Abuse If Occurred in Past 12 Months (Percentages)

	ROUND I		ROUND II	
SEXUAL OR PHYSICAL	**Kern Recipients N=35 Percent**	**Stan Applicants N=72 Percent**	**Kern Recipients N=34 Percent**	**Stan Applicants N=61 Percent**
Less than one month	11%	11%	12%	11%
One to six months	43	51	41	51
Six months to one year	46	37	47	38

About 50 percent of the episodes of physical or sexual abuse occurred in the prior six months. In Round I and II only about 10 percent occurred in the month immediately prior to the interview—in both counties. These results are consistent with what one might expect if acts of violence are distributed evenly around the calendar rather than if recent physical or sexual violence leads to

applying for welfare. However, research has shown that substantial periods of time may elapse until help is sought.[15]

Table 23: Respondent Reports Violent Behavior Has Not Stopped (Percentages)[16]

	ROUND I		ROUND II	
	Kern Recipients N Percent	Stan Applicants N Percent	Kern Recipients N Percent	Stan Applicants N Percent
Percent of entire sample in which abuser still violent	287 7.7%	356 8.7%	273 11.7%	311 14.8%
Percent of those reporting any abuse in which abuser still violent	109 37%	186 39%	86 37%	119 39%
Percent of those reporting serious abuse in which abuser still violent	54 44%	102 47%	41 44%	64 47%

About ten percent of both the Stanislaus applicants and the Kern recipients report that at the time of the research interview their abuser had not stopped his violence.[17] *Nearly half of those with serious abuse reported that the abuser had not stopped his violence at the time of the interview.*

Another aspect of recency is how recently episodes of Post-Traumatic Stress Disorder were manifested.

Table 24: Recency of PTSD Symptoms (Percentages of those with PTSD Diagnosis)

	ROUND I		ROUND II	
	Kern Recipients N=33 Percent	Stan Applicants N=44 Percent	Kern Recipients N=28 Percent	Stan Applicants N=45 Percent
Within past two weeks	79%	66%	68%	60%
Two weeks to one month	6	2	7	16
One to six months	6	14	7	18
Six months to a year	9	18	18	6

[15] Reidy, R., & Von Korff, M. (1991). Is battered women's help seeking connected to the level of their abuse? *Public Health Rep, 106*(4), 360-364. Over 70 percent of the women waited more than a year from the worst episode before seeking help.

[16] N varies by measure.

[17] Specifically, respondents were asked: Do you think [your abuser's] violent behavior toward you has stopped?

At least two thirds, and up to 85 percent, of the women reporting PTSD had had symptoms within the previous month, indicating a likely need for services.

C. DOMESTIC VIOLENCE AND OTHER "SILENT BARRIERS"

What is the Relationship of Domestic Violence to Depression?

Table 25: Percentage of Respondents with Depression Diagnosis,[18] by Type of Abuse

	ROUND I		ROUND II	
TYPE OF ABUSE	**Kern Recipients**	**Stan Applicants**	**Kern Recipients**	**Stan Applicants**
	N Percent	**N Percent**	**N Percent**	**N Percent**
No Abuse	178 13%*	170 26%*	187 14%*	192 18%*
Any Abuse	109 27%*	186 42%*	86 29%*	119 31%*
Serious Abuse	54 41%*	102 50%*	41 29%	64 39%*
Apparently less severe	55 14.5%	84 32.1%	45 23.9%	55 21.8%
Work-Related	26 38%*	64 55%*	14 21%	34 35%**
Adult Trauma PTSD	20 55%*	27 81%*	17 65%*	41 49%*
Physical Abuse	48 35%*	89 51%*	37 24%	59 35%*

* Indicates that the greater percentage of women with depression among each abused group vs. those not abused was statistically significant (using chi-square). For "Any Abuse vs. No Abuse" the contrast is shown in the first two rows In Round I 13 percent of the Kern respondents were depressed if they had no DV while 27 percent were depressed if they did; in Stanislaus this was 26 percent vs. 42 percent. For the other categories, the reference group was the converse, i.e. for "physical abuse" it was those with no physical abuse. The N in each case was the total group with that type of abuse. In the first row, first column, there were 178 persons with no abuse and 13% were depressed. [*=.05 or better **=.10]

[18] The percentages for depression are generated through the probabilities of depression diagnosis assigned by the CIDI. These percentages are somewhat higher than those generated by a cut-off of .90 on the probabilities; it is these latter, however, that are used in the "any diagnosis" measure. See the *Prevalence Report* for an explanation of why two different measures must be used.

There are several patterns apparent here:

- In general, those reporting abuse also report significantly more depression, often twice as much or more.
- The highest co-occurrence of depression and abuse in both rounds is with women having a PTSD diagnosis. The rates of depression among women with work-related abuse are also quite high.
- In both counties, the amount of co-occurring depression is somewhat lower in Round II—but it is enough so that in Kern far fewer of the comparisons are statistically significant than in Round I.
- Overall Stanislaus reports higher rates than in Kern, though the rate of depression among women reporting serious abuse in both rounds is equally high in the second round.

Patterns are similar for "any of four diagnoses" to those for depression except that all of the percentages are significantly higher. Some are extremely high: for example, another mental health diagnosis among those with a PTSD diagnosis occurs in 73 to 86 percent of the cases (depending on site and year). Among those with serious abuse 48 to 58 percent (depending on site and year) had at least one diagnosis.

Finally, we present for different types of domestic violence our best estimate of the percentage of respondents who "need" mental health services.[19] This estimate (described later in the report), combines an objective measure from the BASIS-32 symptom scale with an indication of whether women sought treatment or felt they had needed treatment. That is, this is a comprehensive measure of need that includes both those who got services and those who did not.

In Table 26 the ratio of those needing mental health services if they had a DV issue to those needing mental health services if they had no DV issue is generally at least two to one. Seventy-five percent or more of those with an adult trauma PTSD diagnosis for the previous 12 months had mental health service needs.

[19] This includes people meeting an objective standard (based on BASIS-32 scores) and also those who said they needed treatment and did not get it *as well as* those who actually got treatment (whether they met the objective criteria or not).

Table 26: Percentage of Respondents Who "Need Mental Health Services" Diagnosis,[20] by Type of Abuse

	ROUND I		ROUND II	
TYPE OF ABUSE	**Kern Recipients**	**Stan Applicants**	**Kern Recipients**	**Stan Applicants**
	N **Percent**	**N** **Percent**	**N** **Percent**	**N** **Percent**
No Abuse	178 24%*	170 22%*	187 27%*	192 27%*
Any Abuse	109 42%*	186 38%*	86 48%*	119 44%*
Work-Related	26 50%*	64 42%*	14 50%	34 44%
Adult Trauma PTSD	20 65%*	27 63%*	17 88%*	41 76%*
Physical	48 37%	89 45%*	37 57%*	59 76%*
Serious Abuse	54 46%*	102 41%*	41 63%*	64 50%*

[*=.05 or better **=.10]

What is the Relationship of Domestic Violence to Self-Esteem?

Self-esteem is a separate aspect of "mental health" status from diagnosis. Many CalWORKs programs have established programs to help participants improve low self-esteem in order to be more successful in the job market. We used the Rosenberg Self-Esteem scale, a ten item scale with good psychometric properties, to determine how self-esteem varies with the type (and therefore the severity) of domestic violence. In each county we determine the self-esteem score mean and standard deviation. The figures below show the percentage of respondents with scores lower than one standard deviation from the mean (low self-esteem). That is, we classify respondents as having "low self-esteem" if they are in the bottom 16 percent of the sample.

[20] The percentages for depression are generated through the probabilities of depression diagnosis assigned by the CIDI. These percentages are somewhat higher than those generated by a cut-off of .90 on the probabilities; it is these latter, however, that are used in the "any diagnosis" measure. See the *Prevalence Report* for an explanation of why two different measures must be used.

Table 27: Percentage of Respondents Who Have Self-Esteem Scores More than One Standard Deviation Below the Site Mean,[21] by Type of Abuse

	ROUND I		ROUND II	
TYPE OF ABUSE	**Kern Recipients**	**Stan Applicants**	**Kern Recipients**	**Stan Applicants**
	N **Percent**	**N** **Percent**	**N** **Percent**	**N** **Percent**
No Abuse	178 10%**	170 13%*	187 11%	192 12%*
Any Abuse	109 25%**	186 20%*	86 16%	119 25%*
Work-Related	26 46%*	64 20%	14 7%	34 35%*
Adult Trauma PTSD	20 20%	27 56%*	17 35%*	41 49%*
Physical	48 25%*	89 25%*	37 22%**	59 30*
Serious Abuse	54 33%*	102 25%*	41 29%*	64 31%*

[*=.05 or better **=.10][22]

In both counties, the percent of women with low self-esteem scores is significantly greater among those reporting abuse of different types—in general, on the order of two to three times.

What is the Relationship Between Domestic Violence and Alcohol and Drug Use?

The relationships between domestic violence and AOD use and dependence are still not well-understood. Women who have experienced intimate partner violence may have concurrent AOD problems, sometimes turning to alcohol or other substances in order to cope with their situation—although domestic violence is also frequent in the absence of AOD involvement by either partner.[23] Abuse of, or dependence on, alcohol or other drugs introduces a whole other set of considerations into the provision of domestic violence services. In the CalWORKs context, the critical issue is the extent to which women who seek or might seek DV services also have AOD problems that require specialized services—that is, abuse of or dependence on alcohol or other drugs.

[21] The percentages for depression are generated through the probabilities of depression diagnosis assigned by the CIDI. These percentages are somewhat higher than those generated by a cut-off of .90 on the probabilities; it is these latter, however, that are used in the "any diagnosis" measure. See the *Prevalence Report* for an explanation of why two different measures must be used.

[22] Any abuse is contrasted to no abuse. Other types are contrasted to those not having that type, e.g., PTSD to those not reporting PTSD.

[23] Wingood, G. M., DiClemente, R. J., & Raj, A. (2000). Adverse consequences of intimate partner abuse among women in non-urban domestic violence shelters. *Am J Preventive Medicine*, *19*(4), 270-275.

Table 28: Percentage of women with drug or alcohol abuse or dependence, by type of domestic violence

	ROUND I		ROUND II	
TYPE OF ABUSE	**Kern Recipients**	**Stan Applicants**	**Kern Recipients**	**Stan Applicants**
	N **Percent**	**N** **Percent**	**N** **Percent**	**N** **Percent**
No Abuse	178 9.0%	170 10.0%	187 4.8%**	192 4.2%*
Any Abuse	109 12.8%	186 15.0%	86 10.5%**	119 17.6%*
Work-Related	26 11.5%	64 17.2%	14 14.3%	34 20.5%*
PTSD	33 21.2%*	44 25.0%*	28 7.1%	50 26.0%*
Physical Abuse	48 16.7%	89 24.7%*	37 16.2%*	59 18.6%*
Apparently Less Severe	55 9.1%	84 8.3%	45 8.9%	55 12.7%
Serious Abuse	54 16.7%**	102 20.6%*	41 12.2%	64 21.9%*

[*=.05 or better **=.10][24]

Overall, AOD abuse/dependence is up to five times higher among women experiencing some types of domestic violence than women with no domestic violence. These differences are generally quite statistically significant. Based on these data, one might expect that 15 to 20 percent of those with serious abuse would have a problem with alcohol or other drugs that might involve AOD specialist treatment.[25]

What is the Relationship of Domestic Violence to Learning Disabilities?

Another "silent barrier" to economic independence is the presence of learning disabilities. There is no reason on the face of it to think that women who experience domestic violence would be more likely than others to have learning disabilities, but to the extent they do share these problems, it makes coping with an already difficult situation harder. As we see below, there was no general pattern: like other women in the sample, about 20 percent of those experiencing DV also have learning disabilities.

[24] Any abuse is contrasted to no abuse and serious abuse to apparently less severe abuse. Other types are contrasted to those not having that type, e.g., PTSD to those not reporting PTSD.

[25] Although in an earlier table we used total mental health "need," here we refer only to the level of AOD involvement which could be presumed to be beyond what a DV agency (without integrated staff) might be able to address.

Table 29: Percentage of women with learning disabilities[26], by type of domestic violence

	ROUND I		ROUND II	
TYPE OF ABUSE	**Kern Recipients**	**Stan Applicants**	**Kern Recipients**	**Stan Applicants**
	N Percent	**N Percent**	**N Percent**	**N Percent**
No Abuse	178 16%*	170 24%	187 17%	192 23%
Any Abuse	109 26%*	186 20%	86 19%	119 20%
Work-Related	26 15%	64 17%	14 14%	34 21%
Adult Trauma PTSD	20 30%	27 37%*	17 23%	41 24%
Physical	48 23%	89 22%	37 13%	59 20%
Serious Abuse	54 28%	102 22%	41 22%	64 20%

[*=.05 or better **=.10]

D. USE OF WELFARE DUE TO DOMESTIC VIOLENCE

In the Round I, women were asked if they had ever gone on welfare specifically to get away from an abusive situation and, if so, whether that was the reason for the current spell on welfare.

Consistent with the literature, almost a fifth of the women receiving welfare had at one time or another used welfare to escape an abusive situation. Somewhat less than ten percent of those receiving welfare in each county had gone on welfare to escape domestic violence during the current episode.

[26] Self-reported learning disabilities or participation in special education when in school.

Table 30: Percentages Using Welfare to Escape Abuse, Ever and for Current Spell

	ROUND I	
WELFARE TO ESCAPE ABUSE	**Kern Recipients**	**Stan Applicants**
	N=287 Percent	**N=356 Percent**
Ever use welfare to get away	18%	17%
This time use welfare to get away	8	9

Table 31: Percentages Using Welfare to Escape Abuse in *Current* Spell by Amount of Abuse in Previous 12 Months

	ROUND I	
USED WELFARE TO ESCAPE ABUSE	**Kern[27] Recipient**	**Stan Applicants**
	N=287 Percent	**N=356 Percent**
No abuse reported in past 12 months	7.9%	3.5%[28]
Serious Abuse	3.7	20.6
Apparently less severe	10.9	4.8

Although the numbers are very small, the pattern seems clear. In Kern, where women had been recipients of cash aid for at least a year, the percentage of the overall group saying they had gone onto welfare in the current spell due to DV was not associated with severity of abuse. In Stanislaus, where women were just going on to cash aid, those who were using welfare to escape an abusive situation primarily reported serious abuse.

We also asked, in Round I, if the respondent felt "unsafe" at the time she enrolled in CalWORKs. Responses are shown below. Since many Kern respondents had not at that time been recertified as CalWORKs rather than AFDC participants, the question may have been difficult for them to interpret. Stanislaus respondents, however, since they were just enrolling should have had no difficulty: 11 percent felt unsafe (Table 32).

[27] For women in Kern, we are unable to determine whether the abuse they reported for the previous 12 months is with a new or different partner from the one they used welfare to escape from.

[28] We believe the reason some of the Stanislaus applicants reporting no abuse answered this question positively is that the question instructed them to answer yes if "you were only off welfare for short periods since the time you went on to get away from an abusive situation."

Table 32: Percentage Reporting Feeling "Unsafe" at Time Enrolled in CalWORKs

	ROUND I	
UNSAFE AT CALWORKS ENROLLMENT	**Kern Recipients**	**Stan Applicants**
	N=287	**N=356**
Overall percentage feeling unsafe	9.8%	10.7%

IV. WOMEN WHO MIGHT BENEFIT FROM DOMESTIC VIOLENCE ORIENTED SERVICES

The concept of a "needs assessment" to determine the match between available services and inferred needs is common in mental health and alcohol and drug service planning but is less developed in domestic violence service planning. It is important to be clear that measures of "need" "or "who might benefit" from service are at an aggregate level. For example, one domestic violence needs assessment used police records to locate and target a geographic region in a city with extremely high rates of domestic violence. Nor is there any assumption that persons who fit the construct we develop from survey data would agree that they "need" services or would accept them if offered. The relationship between "objective measures of severity," "perceived severity," and "wanting" services is complex—probably much more so with domestic violence even than with mental health and AOD (which each have their own tangled web regarding individual choice).[29]

In the context of CalWORKs "potentially benefiting from services" could be inferred if the domestic violence is likely to interfere with the activities necessary for the woman to achieve economic independence within the prescribed time limits.

[29] Haggerty, L. A., Kelly, U., Hawkins, J., Pearce, C., & Kearney, M. H. (2001). Pregnant women's perceptions of abuse. *J Obstetrical and Gynecological Neonatal Nursing, 30*(3), 283-290. A recent article outlines the factors courts use when abused women appear before them—a particular kind of "need for services." These include: whether the abuse is continuing and the likely impact of its continuance, as well as the woman's survival strategies, her coping mechanisms, her support systems, and the severity of the physical and/or psychological abuse. Kaiser, A., Strike, C., & Ferris, L. E. (2000). What the courts need to know about mental health diagnoses of abused women. *Med Law, 19*(4), 737-751.

Thus, we have said there was potential need, in the CalWORKs context, if a woman met any of the following criteria during the previous 12 months:

- Experienced "serious abuse." Each of the criteria for serious abuse indicates an intimate partner violence situation that presented substantial risk to the woman.
- Work-related abuse. Actual preventing a woman from working, or on the job harassment are included in "serious abuse." Here we add any of four other types of work interference.
- PTSD in last 12 months that stems from adult abuse.[30] A PTSD diagnosis involve meeting six criteria which together indicate considerable interference with daily life while they are being experienced.[31]
- Finally, we believe it necessary to include self-defined need, that is, having seen a health professional, a counselor, a shelter/DV center, or sought help from police or courts. A substantial number of women reported having sought help in these ways who did not report what we classified as serious abuse. In a number of cases, for example, only extreme jealousy and verbal humiliation were reported. But obviously they occurred in such a way as to cause the woman to feel unsafe and seek help. Please see the next section for a detailed breakdown of the type of services sought.

A very direct measure of potential need for service is whether women reported having felt unsafe at the time of enrolling in CalWORKs. However, this measure is only available for the first round and only for Stanislaus, so we do not include it in cross-year comparisons. In Stanislaus, 10.7 percent of the women (all of whom were applying for welfare) reported feeling unsafe at the time of their initial interview.

Table 33 summarizes each of these measures and then combines them into one indicator of needing services—any respondent reporting one or more of the above would be considered potentially to benefit from services in the CalWORKs context.

[30] The appropriate intervention depends very much on contextual factors. Ideally a domestic violence specialist who is a trained clinician would be available. PTSD as a result of childhood abuse would also indicate need for services, but not specifically domestic violence services.

[31] Although we did not ask about work interference due to PTSD symptoms, in Round II, in Kern 13 out of 17 respondents with a PTSD diagnosis reported that symptoms had kept them from "going to a party, social event or meeting." In Stanislaus it was 29 of 44.

Table 33: Indicators of Potential Benefit from Domestic Violence Services

	ROUND I		ROUND II	
	Kern Recipients	Stan Applicants	Kern Recipients	Stan Applicants
	N=287 Percent	N=356 Percent	N=273 Percent	N=311 Percent
Serious Abuse	19%	29%	15%	21%
Work-related abuse not included in serious abuse	4	8	4	6
PTSD if caused by adult abuse	7	8	6	13
ANY OF ABOVE 3 OBJECTIVE SERVICE INDICATORS	24	35	20	31
Sought professional help for domestic violence or adult PTSD	26	27	8	16
ANY OF 4 SERVICE INDICATORS INCLUDING SEEKING SERVICE	26	37	22	32

Between a fifth and a third of the respondents, depending on site and interview, reported any of the three objective indicators of potential need for service: serious abuse, adult PTSD, or work-related abuse. Approximately another one to nine percent are added if we include those who actually sought services (and did not meet the three objective criteria). In sum, between 22 and 37 percent of the respondents had domestic violence issues for which DV-related services might *potentially* be of help.[32] Table 33a shows the two-year prevalence, incidence and persistence of need for services.

Table 33a: New, Sustained and Not Sustained Need

	Either One or Both Years	Recent Not Sustained	New Incidence	Sustained Abuse
Kern	37%	15%	10%	11%
Stanislaus	52%	20%	15%	17%

In order to understand what it might mean for CalWORKs managers trying to determine what level of DV service referrals is appropriate, we must contrast the persons who might potentially benefit with those actually receiving services—the remainder will provide some idea as to unmet need. The next section undertakes this comparison.

[32] DV-related services includes counseling for PTSD, which might occur in a DV agency or be provided by a mental health professional in a different kind of organization.

V. HELP SEEKING AND RATES RECEIVING SERVICES

Help-seeking for domestic violence is very complex behavior. Relatively little is known about why and when women decide to seek help and why they choose one avenue (police) over others (physician, counseling)[33] There is some evidence that help-seeking is related to severity of abuse.[34] Services available through CalWORKs are only one of many possible sources of assistance.

Medical care if injured. Women who reported physical injuries were asked if they saw a doctor. In Round I, 22 Kern respondents reported an injury and 9 (41 percent) saw a doctor. In Stanislaus, 32 women were injured and only 6 (19 percent) saw a doctor. In Round II, 4 out of the 18 (22 percent) Kern respondents reporting being injured saw a doctor; in Stanislaus, 10 out of 34 (29 percent) saw a doctor.

Medical care or self-medication for abuse-related PTSD. Women responding to the PTSD questions were asked both whether they saw a doctor or other professional for the symptoms and whether they took medications or used drugs or alcohol (more than once) for the symptoms. Note that anyone who reported adult or childhood abuse and responded to the PTSD module is included here, not just those who met all six criteria for PTSD. This seems justified because, as shown in Table 8, a substantial proportion of women who met less than six of the criteria still consulted a professional about the symptoms they were experiencing.

Table 34: Percentage of All Respondents Who Told Physician or Other Professional About PTSD Symptoms or Who Took Medications or Alcohol/Drugs for PTSD Symptoms *(Not Limited to Those Who Met All Six PTSD Criteria or Adult-Related Abuse)*

	ROUND I		ROUND II	
	Kern Recipients	Stan Applicants	Kern Recipients	Stan Applicants
	N=287 Percent	N=356 Percent	N=273 Percent	N=311 Percent
Told Doctor	12%	10%	9%	14%
Told Other Professional	9	5	7	7
Took medications or used alcohol/drugs for symptoms of PTSD	15	18	14	21

Out of the entire sample in each county, a total of 17 percent in Kern and 14 percent in Stanislaus had talked to a doctor or other professional in Round I and in Round II 14 percent in Kern and 21 percent in Stanislaus did.

[33] McFarlane, J., Wiist, W., & Soeken, K. (1999). Use of counseling by abused pregnant Hispanic women. *J Women's Health and Gender Based Medicine, 8*(4), 541-546.
[34] McFarlane, J., Soeken, K., Reel, S., Parker, B., & Silva, C. (1997). Resource use by abused women following an intervention program: associated severity of abuse and reports of abuse ending. *Public Health Nursing, 14*(4), 244-250.

Table 35 shows the percent seeking help *of those with a PTSD diagnosis*, (regardless of whether its origin was in adult or child abuse). Of those with a PTSD diagnosis, sixty percent or more had self-medicated to deal with the symptoms and between one fifth and three fifths had sought medical help. Table 36 shows the same figures for those with adult-trauma PTSD—with very similar percentages.

Table 35: Percentage of Respondents With PTSD Diagnosis Who Told Physician or Other Professional About PTSD Symptoms or Who Took Medications or Alcohol/Drugs for PTSD Symptoms, Not Limited to Adult Trauma PTSD

	ROUND I		ROUND II	
	Kern Recipients	Stan Applicants	Kern Recipients	Stan Applicants
	N=33 Percent	N=44 Percent	N=28 Percent	N=50 Percent
Told Doctor	36%	23%	32%	56%
Told Other Professional	27	7	21	12
Took medications or used alcohol/drugs for symptoms of PTSD	61	57	68	64

Table 36: Percentage of Respondents *With Adult-Trauma PTSD Diagnosis* Who Told Physician or Other Professional About PTSD Symptoms or Who Took Medications or Alcohol/Drugs for PTSD Symptoms

	ROUND I		ROUND II	
	Kern Recipients	Stan Applicants	Kern Recipients	Stan Applicants
	N=20 Percent	N=27 Percent	N=17 Percent	N=41 Percent
Told Doctor	35%	22%	35%	54%
Told Other Professional	20	7	18	15
Took medications or used alcohol/drugs for symptoms of PTSD	50	56	71	63

Who respondents talked with about intimate partner violence (not including PTSD). Respondents who reported any abuse in the prior 12 months (not including work abuse alone or PTSD alone) were asked if they had talked to *anyone* about it. They were then specifically asked if they had sought help from any of the persons or agencies listed in the table above and below (a medical person, a counselor, a shelter or domestic violence agency, police or courts).

Table 37: Percentage of Women with Any Abuse Who Sought Help for Domestic Violence in Previous 12 Months

	ROUND I		ROUND II	
SOUGHT HELP FROM:	**Kern Recipients**	**Stan Applicants**	**Kern Recipients**	**Stan Applicants**
	N=106	**N=175**	**N=83**	**N=117**
Talk to *anyone* about abuse	47%	59%	31%	33%
Talked to medical person after physical injury	9	7	5	9
Counselor or social worker (not a DV professional)	6	10	7	11
Domestic violence center or shelter	9	11	6	11
Police	23	27	8	8
Courts/district attorney (e.g., restraining order)	17	15	10	9
Sought help from others	7	7	24	26

In general, as seen in Table 37, between one third and three fifths of the respondents who reported abuse had talked to *some*one about it. There is a considerable difference in the pattern of "help-seeking" in Round II than in Round I. Overall, a higher percentage of respondents reported talking to someone in Round I than in Round II, in both counties. Perhaps more interesting is the decrease in the percentage who sought help from the police or courts, again in both counties. These sources of help seem to have been replaced in Round II by informal supports like family and friends. (In Round II, the "other" was broken down into categories: half sought help from family, a third from friends, with the remainder being widely spread between schools, clergy, AA or woman's group and new boyfriend.)

Help from domestic violence professionals. In the table above there is duplication in that the same person may have used police and courts and a counselor. In Table 38 we look specifically at help sought from the domestic violence specific agencies—police, courts, and a DV shelter or agency—as well as counselors who provided help with DV issues. Here the percentages represent women who sought help from police OR courts OR a DV shelter or agency OR a counselor, that is any DV–specific professional help.

Overall, about one sixth to a fourth of those reporting any kind of abuse (including work abuse but not including PTSD if it was the only type of abuse) also sought DV specific help. "Serious" abuse victims were the most likely to seek such help, with nearly one half seeking DV specific help. The percentage seeking help was generally higher in Round I. *This reduction in DV–specific help-seeking is greater than the drop in serious abuse from Round I to Round II. Even if informal supports were used instead (see table 37 above), it is of concern that those most equipped to provide help were asked for it so much less frequently.*

Table 38: Percentage of Women Reporting Abuse Who Sought Help from Police, Courts, a Domestic Violence Agency or a Counselor for DV Issues, by Type of Abuse

	ROUND I		ROUND II	
	Kern Recipients	**Stan Applicants**	**Kern Recipients**	**Stan Applicants**
	N **Percent**	**N** **Percent**	**N** **Percent**	**N** **Percent**
Any Abuse/not PTSD	109 30%	186 31%	86 19%	119 25%
Serious Abuse	*54* *46%*	*102* *48%*	*41* *29%*	*64* *37%*
Apparently less severe abuse	*55* *14%*	*84* *11%*	*45* *9%*	*55* *11%*

Why help was not requested. Women were not specifically asked how serious they thought the abuse was, but if they did not seek help they were asked why. A substantial number (especially in Round II) said they had not sought help because the behaviors were minor, they felt they could handle it themselves, or it was not really "abuse" in the mind of the respondent. In Round two almost half of those reporting apparently less severe said the abuse was minor.

Table 39: Percentage of Women Reporting Not Seeking Help Because Abusive Behavior was Minor

	ROUND I		ROUND II	
	Kern Recipients	**Stan Applicants**	**Kern Recipients**	**Stan Applicants**
	N **Percent**	**N** **Percent**	**N** **Percent**	**N** **Percent**
Serious Abuse	54 1.8%	102 2.0%	41 17.1%	64 25.0%
Apparently less severe	55 18.2%	84 10.7%	45 55.6%	55 41.8%

In Round I, the second largest category (9 out of 46 in both counties combined) was women who were embarrassed or ashamed to talk about it or said it was too hard to talk about. Other responses include: fear and "left immediately". No differences were apparent by site.

In Round II, the other major reasons for not seeking help were embarrassment/hard to talk about (15/117 of both counties combined) and left or kicked him out (13/117). No other reasons accounted for as much as 5 percent of the total.

Unidentified unmet need. Previously we defined persons who could potentially benefit from DV services as those with serious abuse or adult-PTSD or work-related abuse—or those who had self-defined a need by seeking services. To what extent did those judged to potentially benefit from services actually receive them?

Table 40: Percentage of Women Judged Potentially to Benefit from DV Services[35] Who Received Help for Domestic Violence in Previous 12 Months, by Type of Help Received

	ROUND I		ROUND II	
SOUGHT HELP FROM:	**Kern Recipients**	**Stan Applicants**	**Kern Recipients**	**Stan Applicants**
	N=75	**N=133**	**N=59**	**N=101**
Talk to *anyone* about abuse (but not PTSD)	59%	65%	47%	49%
Medical provider for injuries	13	10	7	11
MD or other provider for PTSD	12	5	15	28
Counselor or social worker	8	14	10	13
Domestic violence center or shelter	12	15	9	13
Police	32	36	12	9
Courts/district attorney (e.g., restraining order)	25	20	14	10
Sought help from "others"	11	9	22	26
GOT ANY DV OR PTSD RELATED HELP FROM PROFESSIONALS	53	51	37	50

Overall, 37 to 53 percent of those we classified as potentially benefiting from DV services received some kind of help from professionals. A somewhat higher 48 to 65 percent talked to "someone," which included friends and family.

In Table 41 below we show the percentage of the total sample in each county that potentially could have benefited from services and did or did not receive any. Approximately 10 to 18 percent of the samples, depending on interview round and site, were judged to potentially benefit from DV services but not to have received any.

The final row in Table 41 adjusts the unmet need by removing from the estimate women who made it clear when asked why they had not sought help that they did not feel help was needed or that the abuse was too minor to require assistance. In Round I this made little difference, but in Round II removing the "minor abuse" reduced the percentage needing services and not receiving them to 10-11 percent.

[35]Potential benefit: serious abuse, work-related abuse or adult PTSD or actually sought help.

Table 41: Percentage of All Respondents Judged to Potentially Benefit from DV-Related Services Who Did and Did Not Receive Services

	ROUND I		ROUND II	
	Kern Recipients	Stan Applicants	Kern Recipients	Stan Applicants
	N=287 Percent	N=356 Percent	N=273 Percent	N=311 Percent
Could benefit: Did receive	14%	19%	8%	16%
Could benefit: Did Not receive	12	18	13	16
Could benefit (minor abuse removed): Did Not receive	12	17	10	11

Please note that—as shown below by the satisfaction with services ratings and the fact that many women who have sought services still continue to experience abuse—that unidentified unmet need is not intended to profile unmet need in itself. The women who "potentially could benefit from services" is a better measure of that. Unidentified unmet need is, however, an important concept for CalWORKs service planners as it indicates the size of the group not having contact with domestic violence specialists at all.

VI. SATISFACTION WITH DV SERVICES

Helpfulness of DV services

For those reporting that they sought help from a counselor or social worker, a woman's center or shelter, the police or courts, or from "others" (primarily family and friends), we present their ratings of how helpful these agencies were.

Table 42: Percentage of Women Who Sought Help for Domestic Violence in Previous 12 Months Who Reported Assistance Rendered was "Very" or "Somewhat" helpful

	ROUND I		ROUND II	
VERY OR SOMEWHAT HELPFUL	Kern Recipients	Stan Applicants	Kern Recipients	Stan Applicants
Counselor or social worker	5/6 (83%)	14/18 (78%)	6/6 (100%)	8/13 (62%)
Domestic violence center or shelter	7/9 (78%)	16/20 (80%)	4/5 (80%)	9/13 (69%)
Police	11/24 (46%)	18/26 (69%)	7/7 (100%)	9/9 (100%)
Courts/district attorney (e.g., restraining order)	10/19 (53%)	18.26 (69%)	5/8 (62%)	6/10 (60%)
Sought help from others	7/8 (87%)	10/12 (83%)	19/20 (95%)	26/30 (87%)

In general, women who sought help found it at least somewhat helpful. (The ratings were "very helpful," "somewhat," "a little," "not helpful." Because of the small numbers, we collapsed the first two categories.) Help from friends and relatives (others) appears to have been most likely to have been thought helpful, followed by a domestic violence agency or shelter. Respondents in Round II appear particularly to have looked for, and been more helped by, assistance from informal rather than formal sources. Fewer persons in Round II sought help from the police, but they found it more valuable.

Use of the DV option

Federal and California welfare law provide for special consideration to victims of domestic violence. Round I took place between May and September of 1999. In theory, all of the Stanislaus applicants should have received information about the DV option. Kern respondents may well not have heard about it as many had not yet had an interview explaining to them the welfare-to-work requirements. By the time Round II took place one year later, however, all respondents should have received this information. (This was approximately 18 months or more past the time the counties were required to officially notify CalWORKs recipients of new welfare to work rules, which they did primarily through letters.) In the table below we show only those who responded with a definite yes. Respondents were given an option to choose "not sure," and overall about six percent of the respondents did so in each county.

Table 43: Percentages Reporting They *Had* Been Told of DV Option

	ROUND I		ROUND II	
	Kern Recipients	Stan Applicants	Kern Recipients	Stan Applicants
	N Percent	N Percent	N Percent	N Percent
Respondents with no DV	178 19.7%	170 26.4%	187 27.8%	192 38.5%
Respondents with "Any Abuse"	109 27.5%	186 32.3%	86 22.1%	119 39.5%
Respondents with work-related abuse	26 19.2%	64 35.9%	14 0%	34 47.1%
Respondents with "serious abuse"	54 24.1%	102 37.2%	41 17.1%	64 43.7%

Overall, having been told about the DV option was reported for less than half of the participants, whether they reported abuse or not. Stanislaus respondents were somewhat more likely to say they had been told of the DV option in Round I and quite a bit more likely to have been told in Round II. In Kern, the percentage responding yes actually went down from Round I to Round II whereas we would have expected it to increase. Women in need of services or with serious abuse were no more likely to remember having been told than were women with less need.

The women who reported in Round I that at the time of enrolling in CalWORKs they felt unsafe due to a current or past partner were asked if they had "talked to your current caseworker[36]" about their feelings. Only 18 percent of the Kern women (5/28) and 16 percent of the Stanislaus women (6/38) who felt unsafe had talked to their worker. Only one of the Kern women had considered applying for a DV option but 11/28 said they might have but were not informed about it. In Stanislaus, two women said they had considered applying for the DV option and 14/36 might have but did not know about it. One person in each group did actually apply for the DV option and each received a waiver from child support/paternity requirements. These findings are disturbing, but need to be considered in the context of the very slow implementation of CalWORKs activities and programs, including the DV option.

In Round II these questions were asked in a different way. *All* those answering the question regarding whether they had been told about the DV option were then asked whether they had considered using it.[37] In Kern, only two percent said yes while 20 percent (50/287) said they did not consider it because they did not know about it; the remainder did not consider using the DV Option. In Stanislaus, comparable figures were 3 percent and 16 percent (49/308). Thus even in the summer of 2000, roughly two years after the initial implementation of CalWORKs

[36] Those who had left welfare were not asked this question.
[37] Women no longer on welfare were still asked to respond for the period they were on welfare.

requirements only a minuscule percentage of the women with severe abuse considered the DV option while many more were not aware of it. Four additional women in Stanislaus, but none in Kern, had applied for the DV option since Round I.

Services and freedom from abuse

In Kern, of those who reported some DV (not PTSD) in the first year but not the second, 57 percent had talked to someone about their problem; of those who reported DV in both years, 46 percent had talked with someone about their problem. The comparable figures in Stanislaus were 64 and 60. In other words, there was little difference in whether the abuse was sustained if the victim had talked with "someone" or not.

In Kern, of those who reported serious abuse in the first year but not the second, 65 percent had talked to someone about their problem; of those who reported serious abuse in both years, 63 percent had talked with someone about their problem. The comparable figures in Stanislaus were 77 and 66. Again, there was relatively little difference in whether the abuse was sustained if the victim had talked with "someone" or not.

We repeated these analyses using the more DV specific measure of whether respondents had sought help from police, courts or a domestic violence agency or shelter. The findings were essentially the same: there were only minor difference, if any, between those with sustained abuse (serious or any) and those with non-sustained abuse in terms of whether a DV-specific source of help had been accessed.[38]

We found a similar phenomenon both with respect to mental health and AOD: persons reporting not having problems the next interview round were no more likely to be those who had received services than those who had not. In both those situations we discovered that the reason lay in the considerably higher degree of severity among those seeking services. In the DV context a comparable hypothesis would be that those who reported seeking services had a much higher number of types of abuse.

We constructed an index of severity by adding up each type of abuse (see Table 3). As shown in Table 44 below, among those reporting some abuse, the number of types of abuse was far higher for those who either "talked with someone" about the abuse or who sought a DV-specific service (courts, police, DV shelter/center). These differences are all highly statistically significant. As noted in section I, the frequency of types of abuse is associated with the severity of abuse. McFarland *et al*. found, similarly, that: "Resource use was significantly ($p < .001$) related to severity of abuse…. Women using resources at 6 months were also users at 12 months. These findings indicate a "survivorship model" whereby abused women assertively and persistently seek a variety of community resources to end the abuse."[39]

[38] We tried this analysis using just court, shelter or police and also adding any kind of counselor.

[39] McFarlane, J., Soeken, K., Reel, S., Parker, B., & Silva, C. (1997). Resource use by abused women following an intervention program: associated severity of abuse and reports of abuse ending. *Public Health Nursing, 14*(4), 244-250.

Table 44: Mean Number of Types of Abuse Reported In Round I (If Any), by Help-Seeking

TYPE OF ABUSE	Kern		Stanislaus	
	Number	Mean	Number	Mean
Talked to Someone	59	7.8***	106	7.7***
Talked to No-One	65	2.7***	80	3.4***
Got help from Police, Shelter, Courts	33	10.0***	53	10.5***
Did not get help from Police, Shelter, Courts	91	3.4***	133	4.0***

*** Significant at p≤0.00.

Through statistical modeling we can "hold constant" the number of types of abuse when looking at the relationship between sustained and non-sustained abuse for those who do and do not seek help. In Kern, the probability of sustained abuse is significantly lower for those receiving DV-specific services in Round I compared to those who do not (.26 vs. .63).[40] However, the relationship was not significant in Stanislaus. Nor is the relationship significant in either site if sustained serious abuse (rather than any abuse) is used as the dependent variable.

In summary:

- Persons seeking help (DV-specific or not) with abuse are much more likely to have suffered more types of abuse than those who do not seek help.
- In Kern, receipt of help from courts, police or DV shelters/centers in the year before the first interview was significantly more likely to result in less sustained abuse (abuse over both years). This result did not hold for Stanislaus.

[40] The number of types of abuse is held constant. P≤0.01.

Chapter Two:

Mental Health Issues

I. MENTAL HEALTH PREVALENCE[41] OVER TWO YEARS

In general rates changed relatively little from the year before the first interview to the year before the second interview. The two diagnoses that changed to a statistically significant degree were a) depression among Stanislaus respondents which dropped from 36 percent to 25 percent, and b) panic disorder in Kern, which *increased* significantly from 11 to 17 percent.[42]

Table 45: 12 Month Prevalence of Five Mental Health Diagnoses[43], by Site and Interview Round

	ROUND I		ROUND II	
	Kern Recipients	**Stan Applicants**	**Kern Recipients**	**Stan Applicants**
	N=287 Percent	**N=356 Percent**	**N=273 Percent**	**N=311 Percent**
Major Depression	22%	36%***	22%	25%***
Post-Traumatic Stress Disorder[44]	13	13	10	16
Generalized Anxiety	8	10	11	14
Social Phobias	13	6	12	7
Panic Disorder	11**	14	17**	14

**= Change from Round I to Round II statistically significant at .05
***= Change from Round I to Round II statistically significant at .01

Table 46 on the next page summarizes the changes in mental health diagnoses. The percentage of respondents having at least one of five diagnoses was the same in both years for Kern, but dropped from 44 percent to 36 percent in Stanislaus, a significant change.

41 Only clients eligible for welfare to work activities are included in these tables. In contrast to the *Prevalence Report*, this means that in Kern 42 disabled clients and 26 child-only undocumented persons were excluded.
42 We tested whether the rates changed significantly using the McNemar test. Statistical significance or its lack reflects to some unknown extent attrition from Round I to Round II.
43 All diagnoses except that of PTSD are derived from the short form of the World Health Organization's Composite International Diagnostic Interview. Scoring was developed by Ron Kessler, Ph.D., a Harvard epidemiologist, based on correlations with the US co-morbidity study—which used the long form of the CIDI. The short form pattern of responses is correlated with the long form diagnoses and a specific probability of "caseness" assigned each respondent based on that pattern. The sum of the probabilities creates the number believed to have that diagnosis in the study population. This instrument has been used by Danziger and the National Household Survey of Drug Abuse among others. The PTSD diagnosis derived from the "full" CIDI.
44 Only trauma associated with childhood or adult sexual or physical abuse was recorded.

Table 46: Prevalence of One and Multiple Mental Health Diagnoses

	ROUND I		ROUND II	
	Kern Recipients	Stan Applicants	Kern Recipients	Stan Applicants
	N=287 Percent	N=356 Percent	N=273 Percent	N=311 Percent
Any of 5 mental health diagnoses	32%	44%**	32%	36%**
Two or more diagnoses	15	21	18	18
Three or more diagnoses	9	7	10	10
Mean number of diagnoses, if any	1.9 (SD=1.0)	1.7 (SD=1.2)	2.1 (SD=2.1)	1.9 (SD=1.1)

**p<=0.05

II. INCIDENCE, REMISSION AND SUSTAINED CASES

Welfare is a "longitudinal" phenomenon. That is, many persons who become CalWORKs participants are likely to take a year or more to move off welfare, even if they are working. Once off, they may need continued support. And many participants live so close to the financial edge that they have to use welfare from time to time as a safety net. Since welfare participation occurs "over time" we also need to know how mental disorders occur over time.

Information about the incidence of different types of mental disorder (contrasting those treated and those not treated) is difficult to obtain because most studies that include non-treated persons are cross-sectional rather than longitudinal. This is true of both the major epidemiological studies in the United States in the last 20 years (Epidemiologic Catchment Area study and the National Co-Morbidity study.) Depression is one of the more extensively studied disorders. Approximately 16 per 1000 persons in the United States experience a first episode of Major Depression in a year, but rates are almost twice as high for women as for men.[45] A summary of the untreated "course" of depression states:

> Untreated depressive episodes can last from six to 18 months, but average is about eight. Treated episodes typically last from six weeks to three months. In treated depression, episodes tend to return prematurely when antidepressants are not taken for the full indication. Depression is a chronic disease that relents periodically; depressed people may experience one to two years of mental health, without symptoms, between episodes. Approximately 60%

[45] Howath, E., & Weissman, M. M. (1995). Epidemiology of Depression and Anxiety Disorders. In M. T. Tsuang & M. Cohen & G. E. P. Zahner (Eds.), *Textbook in Psychiatric Epidemiology*. New York: Wiley-Liss.

> of depressed people stand the chance of experiencing a second episode, while there is a 20% chance for chronic depression.[46]

Information on incidence of other disorders is even more limited. Incidence (new cases) of panic disorder occur in roughly 6 per 1000 persons.[47] Incidence and remission of PTSD is complicated because symptoms may occur very much later, especially with sexual trauma, or may be reactivated by later trauma. Incidence would be expected to be higher in populations with higher incidence of sexual/relationship trauma—which is true for women receiving welfare.[48]

This summary indicates that there is wide variability in the manifestation of depressive episodes but also that remission without treatment is usual (after six to 18 months). So it is reasonable to think that there would be a significant reduction in persons with a Major Depression diagnosis a year later and also that a significant percentage of new cases would have surfaced. However, not only may the "course" of a disorder vary from disorder to disorder; but when we are measuring "two of five diagnoses" or "three of five" diagnoses existing sources of information about incidence and remission are of limited usefulness.

In attempting to measure incidence we also have to consider the reliability of the instruments used to assign diagnoses. Poor reliability (agreement across interviewers and in a test-retest situation) makes determination of incidence untrustworthy. Unfortunately the instruments we use do not have well-defined test-retest and inter-rater reliability. So it is possible that some of what we call "new" cases and "not sustained" cases reflect misclassification due to instrument unreliability. It is less likely that those with consistent results over time (either no diagnosis or a diagnosis both years) reflect reliability difficulties. Finally, it is possible (but unlikely) that attrition between Round I and Round II affected the incidence and remission figures.[49]

The other factor that is not taken into account in looking at cases which are "not sustained" is that this may be due to treatment rather than spontaneous remission. We examine the likely effects of treatment on "remitted" cases later in this report.

We collected information on 12 month diagnosis twice, at the interval of a year, which allows us to determine a) the number of persons who had no diagnosis in either year, b) those who had a diagnosis the first 12 months but not the second, c) those who had no diagnosis in Round I but did in Round II, and d) those who had a diagnosis in both years.

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[46] http://www.mentalhealthchannel.net/depression/course.shtml

[47] Anthony, J. C., & Helzer, J. E. (1995). Epidemiology of Drug Dependence. In M. T. Tsuang & M. Tohen & G. E. P. Zahner (Eds.), *Textbook in Psychiatric Epidemiology*. New York: Wiley-Liss.

[48] Allard, M. A., Albelda, R., Colten, M. E., & Cosenza, C. (1997). *In Harm's Way? Domestic Violence, AFDC Receipt, and Welfare Reform in Massachusetts*. Boston: University of Massachusetts.

[49] There does not appear to be major effects on incidence/sustained disorders due to differential attrition. If more persons with a diagnosis were not found and re-interviewed than those without a diagnosis, it could make the percent "not sustained" higher and the percent "sustained" lower. However, in fact the attrition was just the same for those with diagnoses as for the group as a whole. In Kern, for example, 91 persons in Round I had a diagnosis and 88 of them (97 percent) were re-interviewed; in Stanislaus the comparable figures were 156 and 139 (89 percent). Since these figures are either the same or better than for attrition overall there does not appear to be evidence for differential attrition based on presence of mental health diagnoses. Therefore, it is likely that the figures for the second round of interviews are not biased by differential attrition.

Table 47: Incidence of New Cases and Sustained Cases Over Time: Kern County

N Interviewed Both Years=273	None In Two Years	Recent Not Sustained	New Incidence	Sustained
	Percent	Percent	Percent	Percent
Major Depression	71%	10%	10%	9%
Post-Traumatic Stress Disorder	81	9	6	4
Generalized Anxiety	85	3	6	5
Social Phobias	79	8	7	6
Panic Disorder	82	4	8	6
Any of 5 mental health diagnoses	56	12	12	20
Two or more diagnoses	77	5	8	10
Three or more diagnoses	86	4	4	6

Looking at the Kern County pattern over time, we see that 56 percent of the respondents had none of the five diagnoses during the two years being measured (the year before the first interview and the year between the first and second interviews). Of those with a diagnosis, in general the pattern was that something over a quarter had a diagnosis the first year but not the second and the same percentage had a diagnosis the second year but not the first. Almost half of those with a diagnosis in either year had a diagnosis in both years.

Table 48: Incidence of New Cases and Sustained Cases Over Time: Stanislaus County

N Interviewed Both Years=311	None In Two Years	Recent Not Sustained	New Incidence	Sustained
	Percent	Percent	Percent	Percent
Major Depression	55%	22%	10%	13%
Post-Traumatic Stress Disorder	77	7	11	5
Generalized Anxiety	80	6	10	4
Social Phobias	87	6	6	1
Panic Disorder	83	6	6	5
Any of 5 mental health diagnoses	43	20	12	29
Two or more diagnoses	69	12	10	8
Three or more diagnoses	86	4	7	3

In Stanislaus only 43 percent did not have a mental health diagnosis in at least one of the two years. The percentage having a diagnosis only in the first year, however, was statistically significantly higher than the percentage having a diagnosis only in the second year (as it was for depression).[50]

In the two counties taken together, the least likely diagnosis to be persistent was PTSD. In Stanislaus, however, social phobias were much less likely to be persistent than were other diagnoses.

Implications for service providers

In general, then, the conclusion is that there should be concern about both persistent cases (20 to 30 percent of the caseload having one or more diagnosis sustained over two years) *and* about the occurrence of new symptom patterns. *In this sample, about 12 percent reported at least one diagnosis in the second year who had none in the first. This indicates a "heads up" is needed for CalWORKs staff working with clients over time. Mental health problems may occur at any time, so screening or other attempts at identification must be on-going—not just focused at intake.*

[50] Only change in "any diagnosis" was tested. The change was significant at $p \leq 0.001$ in Kern and $p \leq 0.03$ in Stanislaus.

III. NEED FOR TREATMENT

Concept of "need for treatment." This study has documented that a sizable portion of the CalWORKs population has at least one MH diagnosis. Treatment services would conceivably be useful to all these individuals. But we know that in the general population most people with diagnosable conditions do NOT seek nor receive treatment services either because they are not sufficiently disabling and/or services are not available (because of cost or convenience) and/or persons do not want or seek treatment services. Particularly within the context of CalWORKs it is useful to try to estimate the percentage of the CalWORKs population with MH problems *that are sufficiently severe or disabling* as to make it likely that services could be needed as part of the CalWORKs focus on achieving employment and economic independence.

There is no unequivocal way to determine whether respondents "need treatment"—particularly within the CalWORKs context of whether a MH issue constitutes a hurdle to finding and retaining employment. What we attempt here (and in the AOD section that follows) is to utilize a variety of methods to estimate the number of "cases" that are sufficiently serious to need treatment services to overcome the barriers. The use of multiple methods allows us to create a *range* of estimates.

There are several potential ways of determining need with the data from this study: a) we can infer that persons meeting criteria for two or more diagnoses (including AOD) are likely to need treatment, as multiple diagnoses create a very substantial clinical burden; b) we can infer a need for treatment if psychiatric symptoms significantly impair functioning in daily life; c) we can infer that persons with scores on either of the symptom scales we administered that match those of outpatients at intake into treatment also "need treatment;" d) we can use the woman's own judgment if she indicated that she had not received treatment but needed it; and finally e) if a woman sought and received treatment we assume she had a need.

Multiple diagnoses. Table 46 above shows the percentages of persons with multiple diagnoses, which epidemiological studies show is more likely to result in functional impairment not just distress.

Functional Impairment. Respondents indicating any significant symptomatology on the BASIS-32[51]—a widely used symptom scale—were asked: "During the past 30 days, how many days out of 30 were you *totally unable* to work or carry out your normal activities because of these difficulties? They were then asked, "Aside from those days, how many days of the last 30 were you able to work or carry out your normal activities, but had to cut down on what you did because of these difficulties?"

[51] Eisen, S. V., Wilcox, M., Schaefer, E., Culhande, M., & Leff, H. S. (1997). *Use of BASIS-32 for Outcome Assessment of Recipients of Outpatient Mental Health Services*. Boston: The Evaluation Center@HSRI.

Table 49: Functional Impairment Due to Psychiatric Symptoms*

	ROUND I		ROUND II	
	Kern Recipients	Stan Applicants	Kern Recipients	Stan Applicants
	N=287 Percent	N=356 Percent	N=273 Percent	N=311 Percent
Totally unable to work/carry on activities at least 5 days in last 30	20%	15%	20%	15%
Had to cut-down on work or other activities at least 5 days in last 30	20	13	20	13
Unable to work/carry out activities and/or had to cut down at least 5 of last 30 days	24	18	24	18

*The identical percentages for both years is not a mistake. For example, the number in Kern unable to work 5 days in Round I is 58/287 and 55/273 in Round II.

Symptom scales. We can also estimate need for treatment using normed symptom scales. In addition to asking respondents to reply to questions which permit assignment of psychiatric diagnoses, we asked them to answer a 32 item widely used symptom scale—the BASIS-32. This scale asks questions which cluster into the domains of self-other, depression-anxiety, daily living, impulsive/addictive, and psychosis. The time frame for these questions is the *previous week* as opposed to the diagnostic information—which applied to anytime within the previous 12 months. We compared the scores of our respondents at the time of the interviews with the scores of 399 persons entering 11 outpatient programs. We used a procedure developed originally in the testing of pharmaceuticals to determine a cut-point at which members of our study groups had scores on the scale which were "equivalent" to the scores of the norming group at intake.[52] "Equivalence" here means that the 95 percent confidence interval for the mean of our study groups falls entirely within an "equivalence interval" that is created by adding 10% of the norming group's mean to both sides of the mean.[53] This 10% margin is slightly less than Cohen's "small" effect size.[54] So to assert equivalence is to say a) the groups are not statistically different, and b) that the difference that exists constitutes a small effect size or less.

Self-defined need. Finally, those women who were asked if they had received any mental health treatment in the past 12 months and said "no," were then asked if they had needed treatment. All of the standards are summarized below. In Round I in Kern and Stanislaus,

[52] Rogers, J., Howard, K., & Vessey, J. (1993). Using significance tests to evaluate equivalence between two experimental groups. *Psychological Bulletin, 113*, 553-565.
[53] Goldstein, R. (1994). Equivalency Testing, *Stata Technical Bulletin Reprints* (pp. 107-112). College Station: Stata Corporation.
[54] Cohen, J. (1988). *Statistical Power Analysis for the Behavioral Sciences* (2nd ed.). Hillsdale, New Jersey: Lawrence Erlbaum Associates.

73 and 77 percent, respectively, of the women reporting they needed treatment were defined by any one (or more) of the objective standards; in Round II these figures were 55 and 70 percent. Since at least 25 percent of those saying they needed treatment are not defined by the objective measures, it seems important to include self-perception as an independent measure.

Best estimate. The best estimate of those needing treatment at a point in time—the interview—is shown in italics in Table 50. It includes those who received treatment and those who said they needed treatment but did not get it. Finally, it includes at least one objective standard, the BASIS-32 score which is equivalent to those entering outpatient mental health treatment in a norming group. Note that from the standpoint of predicting success in finding employment the number of days impaired in the past 30 days may be better while for the full 12 month time period persons with at least two diagnoses may be better.

Table 50: Need for Treatment as Indicated by Self-Perception and Four Objective Standards

	ROUND I		ROUND II	
	Kern Recipients	**Stan Applicants**	**Kern Recipients**	**Stan Applicants**
	N=287 Percent	**N=356 Percent**	**N=273 Percent**	**N=311 Percent**
Respondents says she needed treatment sometime in past 12 months (but did not get it)	13%	11%	8%	6%
Have at least two mental health diagnoses in previous year	15	21	18	18
Totally unable to work/carry on activities at least 5 days in last 30	20	15	20	15
BASIS-32 scores equivalent to those of persons entering outpatient care (in previous week)	21	17	20	15
BASIS-32 equivalent to outpatient OR self-defined need & no treatment OR received treatment from a health or mental health professional	*31*	*30*	*33*	*33*

Incidence. It is striking how similar the two counties are in terms of incidence, remission and sustained disorders—particularly using the "best" measure of need (last row) for which the counties are essentially identical.

Table 51: Need for Treatment—New and Sustained Cases: Kern County

N Interviewed Both Years=273	None In Two Years	Recent Not Sustained	New Incidence	Persistent
	Percent	Percent	Percent	Percent
Respondent said she needed treatment (but did not get it)	82%	10%	5%	3%
Two or more diagnoses	77	5	8	10
Totally unable to work 5 out of last 30 days	72	13	8	7
BASIS-32 scores equivalent to those of persons entering outpatient care (in previous week)	72	8	8	12
BASIS-32 equivalent to outpatient OR self-defined need & no treatment OR received treatment from a health or mental health professional	*56*	*11*	*13*	*20*

Range of estimates. In Table 53 below we show three estimates of need. The first references only those respondents who said they had an unmet need for mental health treatment. They comprise the group that might accept a referral for services if offered with few preliminaries. The second estimate is the percentage of respondents who meet one or more of the objective standards: they have a BASIS-32 score equivalent to an outpatient norming group, they have two or more diagnoses, or they were not able to work or carry out daily activities for at least 5 of the previous 30 days due to mental health symptoms. This group comprises those who are coping with a significant burden of symptoms, measured objectively. The third group is made up of those who have a self-defined need, are equivalent in BASIS-32 scores to an outpatient norming group, or who actually received mental health services. This is the subpopulation that is most relevant when we try, as we do in the next section, to compare those "in need" with those actually getting services.

Table 52: Need for Treatment—New and Sustained Cases: Stanislaus County

N Interviewed Both Years=311	None In Two Years	Recent Not Sustained	New Incidence	Persistent
	Percent	Percent	Percent	Percent
Respondent said she needed treatment (but did not get it)	86%	8%	5%	2%
Two or more diagnoses	69	12	10	8
Totally unable to work 5 out of last 30 days	75	11	10	4
BASIS-32 scores equivalent to those of persons entering outpatient care (in previous week)	75	10	7	8
BASIS-32 equivalent to outpatient OR self-defined need & no treatment OR received treatment from a health or mental health professional	*57*	*10*	*13*	*20*

Table 53: Range of Estimates Regarding Need for Treatment

	ROUND I		ROUND II	
	Kern Recipients	Stan Applicants	Kern Recipients	Stan Applicants
	N=287 Percent	N=356 Percent	N=273 Percent	N=311 Percent
Only those who said they needed treatment but did not get it	13%	11%	8%	6%
Any of the three objective needs: BASIS-32, 2 or more dx, impaired 5 of last 30 days.	31	29	26	26
Best estimate: BASIS-32 equivalent to outpatient OR self-defined need & no treatment OR received treatment from a health or mental health professional	*31*	*30*	*33*	*33*

IV. MENTAL HEALTH DIAGNOSIS AND OTHER "SILENT BARRIERS"

It can be helpful in case finding and service planning in CalWORKs to know more about the likely clinical correlates and consequences of mental health diagnoses. To what extent are mental health diagnoses and need for treatment in the CalWORKs population associated with other personal problems that might affect individuals or their families as they move through the CalWORKs process? Personal problems of particular interest are domestic violence, alcohol and other drugs, learning disabilities, and self-esteem. All of these issues share the property of being "silent barriers" to the high level of functioning needed by CalWORKs mothers in order to achieve economic independence while protecting and nurturing the well-being of children in the family.

A. Domestic Violence

In the section of the report dealing with domestic violence we found that women who had experienced domestic violence had much higher rates of depression than those who did not experience domestic violence. Here we look at the relationship from the other direction, asking the extent to which women with mental health disabilities also are victimized by domestic violence. In the former case, the information would be useful in telling a DV service provider the likelihood that mental health issues should also be a focus of service. Here, the information would be useful to mental health providers, letting them know the percentage of women likely also to need coordinated domestic violence services.

Table 54 shows that rates of domestic violence are generally at least twice as high when there are indicators of mental health problems as when there is no diagnosis. Most of the indicators show the same pattern: 30 to 40 percent of the women with mental health needs reported serious domestic violence having occurred in the prior 12 months.

B. Alcohol and Drug Use

Using the definition of "need for AOD services" developed later in this report, we tabulated the percentage of women in each of the mental disability categories who also needed AOD services. (See Table 55.) The percentage in Round I needing AOD treatment was roughly twice as high in each county for those with a mental health diagnosis as for those with none. However, in a number of instances the rate was three times as high—almost a third of the women in the mental disability category. In particular, women with two or more mental health diagnoses were the most likely to also have a need for AOD services. In Round II, there was in general the same pattern of considerably higher need for AOD services among those with mental disabilities, although there were (unpatterned) changes within this overall pattern.

There were also important specific county differences. In Kern, those reporting inability to work or carry out normal functions at least five days a week had no greater percentage with AOD need than those with no mental health impairment. In Stanislaus, however, those

reporting an inability to function had a very high (30 percent in Round I) rate of AOD service needs.

Table 54: Percent Having Mental Health Indicators Who Also Reported "Serious Abuse" in the Previous 12 Months*

	ROUND I		ROUND II	
	Kern Recipients	Stan Applicants	Kern Recipients	Stan Applicants
	N=287 Percent	N=356 Percent	N=273 Percent	N=311 Percent
No diagnosis	14%	21%	8%	14%
Any of five MH diagnoses	32	40	30	33
Diagnosis of depression	41	41	23	35
Have at least two mental health diagnoses in previous year	31	52	37	42
Respondents says she needed treatment sometime in past 12 months (but did not get it)	32	49	27	40
Totally unable to work/carry on activities at least 5 days in last 30	36	34	27	31
BASIS-32 scores equivalent to those of persons entering outpatient care (in previous week)	34	38	33	38
Best estimate: BASIS-32 equivalent to outpatient OR self-defined need & no treatment OR received treatment from a health or mental health professional	28	39	29	31

*The N's shown are for the groups overall. Each of the types of mental health indicators has a different N (shown in the tables above). The exact correspondence of some of the figures in Kern and Stanislaus is not a mistake.

C. Self-Esteem

Low-self-esteem has frequently been cited as a problem that many CalWORKs participants must overcome in order to compete successfully in the market place. Table 56 below shows the percentage of women in our sample with very low self-esteem (more than one standard deviation below the mean) in terms of their mental disabilities.

The disparity in scores between those with mental disabilities and those without is striking. Across the two counties and in both rounds the group with no mental health diagnosis or need for service have only 5-7 percent with very low self-esteem scores. The group with any

mental health diagnosis has five to six times as many persons with very low self-esteem scores (26 to 37 percent). However, even more striking differences occur when those with no mental health diagnosis are compared with those having multiple diagnoses, functional impairment in the past 30 days, or being comparable to those in a norming group who just entered outpatient treatment. In these categories, up to 64 percent have very low self-esteem.

Table 55: Percent Having Mental Health Indicators Who "Need Treatment" for Alcohol or Other Drug Problems*

	ROUND I		ROUND II	
	Kern Recipients	Stan Applicants	Kern Recipients	Stan Applicants
	N=287 Percent	N=356 Percent	N=273 Percent	N=311 Percent
No diagnosis	11%	9%	7%	85
Any of five MH diagnoses	19	21	16	20
Diagnosis of depression	23	23	19	15
Have at least two mental health diagnoses in previous year	26	31	21	23
Respondents says she needed treatment sometime in past 12 months (but did not get it)	13	20	18	25
Totally unable to work/carry on activities at least 5 days in last 30	10	30	19	31
BASIS-32 scores equivalent to those of persons entering outpatient care (in previous week)	24	30	17	28
Best estimate: BASIS-32 equivalent to outpatient OR self-defined need & no treatment OR received treatment from a health or mental health professional	21	27	20	21

*See below for definition of "need treatment." Used here is the combination of objective and self-report measures. The N's shown are for the groups overall. Each of the types of mental health indicators has a different N (shown in the tables above).

Table 56: Percent of Those Having Mental Health Indicators Who Have Self-Esteem Scores One Standard Deviation Below the County Mean*

	ROUND I		ROUND II	
	Kern Recipients	Stan Applicants	Kern Recipients	Stan Applicants
	N=287 Percent	N=356 Percent	N=273 Percent	N=311 Percent
No diagnosis	6%	5%	6%	7%
Any of five MH diagnoses	37	31	26	36
Diagnosis of depression	47	33	36	44
Have at least two mental health diagnoses in previous year	48	44	40	54
Respondents says she needed treatment sometime in past 12 months (but did not get it)	37	33	27	50
Totally unable to work/carry on activities at least 5 days in last 30	34	43	41	56
BASIS-32 scores equivalent to those of persons entering outpatient care (in previous week)	47	60	33	64
Best estimate: BASIS-32 equivalent to outpatient OR self-defined need & no treatment OR received treatment from a health or mental health professional	36	41	23	38

*The N's shown are for the groups overall. Each of the types of mental health indicators has a different N (shown in the tables above). The properties of the mean and standard deviation are such that about 16 percent of each group *overall* has a score that is more than one standard deviation from the mean. Thus the percentages above show how unevenly that 16 percent is distributed, with those with mental disabilities having far more than their "share."

D. Learning Disabilities

We classify learning disabilities as a "clinical" because they comprise a highly complex set of psychological, genetic and cultural behaviors that—like mental health problems—are generally invisible. Like mental health problems, too, they can only be diagnosed by skilled professionals, and once diagnosed need highly skilled interventions. Unfortunately, our measures of learning disability are likely to be an understatement of the true figure, since we did not have the capacity to do extensive testing. Instead we relied on the respondents' own judgment and recall of their history in school.

The table below shows that in general there is somewhat more learning disability among respondents having mental health disabilities, though less of a differential in Stanislaus than in Kern. Except in Stanislaus in Round II, those with clear mental health needs are about twice as likely as those with no mental health diagnosis to have learning disabilities. *About 30 percent of the respondents in each county with BASIS 32 scores equivalent to a norming group of outpatient clients also have self-reported learning disabilities. This is a very serious "heads up" for mental health providers.*

Table 57: Percent Having Mental Health Indicators Who Also Have Learning Disabilities*

	ROUND I		ROUND II	
	Kern Recipients	**Stan Applicants**	**Kern Recipients**	**Stan Applicants**
	N=287 Percent	**N=356 Percent**	**N=273 Percent**	**N=311 Percent**
No diagnosis	15%	16%	14%	21%
Any of five MH diagnoses	31	30	24	25
Diagnosis of depression	28	28	31	21
Have at least two mental health diagnoses in previous year	33	26	33	25
Respondents says she needed treatment sometime in past 12 months (but did not get it)	32	26	23	35
Totally unable to work/carry on activities at least 5 days in last 30	28	32	32	27
BASIS-32 scores equivalent to those of persons entering outpatient care (in previous week)	32	30	31	32
Best estimate: BASIS-32 equivalent to outpatient OR self-defined need & no treatment OR received treatment from a health or mental health professional	33	29	26	30

*The N's shown are for the groups overall. Each of the types of mental health indicators has a different N (shown in the tables above).

V. RATES UNDER TREATMENT

A. Rates of Mental Health Treatment

In the second *Six County Report* we reported that, of the five counties we had data for, between 5 and 13 percent of those eligible (receiving cash aid through CalWORKs) received mental health or AOD services in 1999-2000. These figures include all MH/AOD services to CalWORKs recipients, not just those entered in clients' work activity plans—a much lower number.

The survey data below include only mental health services, not AOD, and they show a somewhat higher percentage receiving services overall than was reported by the county MIS—no doubt due to respondents seeing providers outside the county system. Given the more than 30 percent prevalence figures we reported in the *Prevalence Report* and here, it is encouraging that in the 12 months prior to the second round interview approximately 20 percent of the eligible population saw a mental health provider.

Table 58: Percent Of Whole Sample Seeing a Mental Health Provider in Previous Year

	ROUND I		ROUND II	
	Kern Recipients	Stan Applicants	Kern Recipients	Stan Applicants
	N=287 Percent	N=356 Percent	N=273 Percent	N=311 Percent
Saw a mental health provider for emotional problems or mental health in past year	13%	15%	15%	19%
Saw a mental health provider *or* had a prescription for psychiatric drugs in past year	NA	NA	19%	24%

Receipt of needed treatment. In the National Co-Morbidity study[55], 25 percent of all those having any mental health diagnosis received some kind of services for it in the prior 12 months—as did 8 percent of those who were not classified as having a diagnosis, the "worried well." However, this figure included not only mental health providers but human service providers and self help groups, a very broad range. Among those with at least one diagnosis, 17 percent saw a *medical* provider or other *mental health specialist provider.*[56]

[55] Kessler, R. C., Shao, S., Katz, S. J., Kouzis, A. C., Frank, R. G., Edlund, M., & Leaf, P. (1999). Past-Year Use of Outpatient Services for Psychiatric Problems in the National Comorbidity Survey. *American Journal of Psychiatry, 156*(1), 115-123.

[56] Specialist: psychiatrist, psychologist or social worker or psychiatric nurse.

The rates receiving treatment in our study respondents are substantially higher than the figures for the national sample, especially in Round II, when we take into account being prescribed psychiatric medications. Depending on the county and the interview round between 25 percent and 45 percent of those with at least one of five diagnoses reported having seen a mental health provider for mental health issues in the previous 12 months. See Table 59. About the same percentage of our samples assigned no diagnosis in Round I saw a provider as in the national sample—5-8 percent.

We have comparisons for two other measures. The national percentage of those with a major depression diagnosis who saw a health care provider was 28 percent. In our study samples, the percentage was at least that high and in Round II (when psychiatric medications were included) much higher.

When national respondents had two or more 12 month diagnoses 24 percent saw a medical or specialty provider. In our sample the figures are higher than the national figures even in Round I and double the national sample in Round II.

In the second round, between 43 and 53 percent of the study samples clearly needing services (unable to work or having scores equivalent to the outpatient norming group) received at least some treatment.

Finally, we have created here a "comprehensive" definition of "need for treatment" that includes the objective measure we think is the most valid[57], OR self-defined need for services that were not received, OR actual receipt of services. Thus, this measure (bottom row in Table 59 below) includes those we think most likely to need treatment based on objective standards and those who believe they need treatment (whether they got it or not). Using this measure, 56 percent of Round II participants needing treatment in Kern and 74 percent of those in Stanislaus received at least some "help, services, or treatment." (We focus on Round II because in that interview we asked specifically about psychiatric medications—which considerably increased the percentage of persons reporting receiving services.) This is a *very* high percentage compared with national figures.

Because we included questions about psychiatric medications in Round II, the categories in Round I and Round II are not directly comparable. In order to measure change from Round I to Round II we need the percent of those in the group defined as having a comprehensive need for treatment who saw a mental health provider—exclusive of medications. In Round I, 43 percent in Kern and 46 percent in Stanislaus of those with a MH need saw a provider. In Round II these percentages were 45 and 58.[58]

In summary, although the percentages of CalWORKs participants with mental health indicators is very high (see prevalence figures, above), the percentage receiving help is also far higher than penetration rates for public mental health services would lead us to believe. And, as we explain below, those who *do* seek help appear to be those most in need.

[57] We believe it is the best representation of need for treatment. The number of days of incapacity to carry out daily functions may well be the best measure of mental disorders as a barrier to work.
[58] The change is non-significant in Kern; in Stanislaus it approaches significance, $p<0.08$.

Table 59: Percent Of Those Having Mental Health Indicators Who Received Help for Emotional Problems[+]

	ROUND I		ROUND II	
	Kern Recipients	Stan Applicants	Kern Recipients	Stan Applicants
	N Percent	N Percent	N Percent	N Percent
No diagnosis[#]	193 7%	200 5%	186 10%	198 11%
Any of five MH diagnoses	90 27%	153 25%	87 32%	113 45%
Diagnosis of depression	52 29%	121 28%	52 38%	71 45%
Have at least two mental health diagnoses in previous year	41 34%	72 28%	48 52%	57 58%
Totally unable to work/carry on activities at least 5 days in last 30	57 33%	52 40%	41 44%	45 53%
BASIS-32 scores equivalent to those of persons entering outpatient care (in previous week)	58 38%	60 35%	54 43%	47 51%
BASIS-32 equivalent to outpatient OR self-defined need & no treatment OR received treatment from a health or mental health professional	88 43%	106 46%	108 56%	91 74%

[+]In Round II the receiving a prescription for a psychiatric medication is counted as having received a mental health service. That information is not available for Round I.
#Since we attempted to determine only the five most likely diagnoses, it is quite possible that those in the group we describe as "no diagnosis" had diagnoses that we did not inquire about.

B. Type of Service

Table 60 shows the types of mental health services received.

It should be remembered that, in Round I, Stanislaus respondents were reporting on the year *before* they received CalWORKs or Medi-Cal (although in a few instances they may have been referred to CalWORKs-related counseling during their intake process). Kern respondents received Medi-Cal but had in most case not yet been processed through CalWORKs work activities. Given these differences, the similarity in Round I service patterns is striking, with essentially equal percentages in each county having used most types of service—the two most common of which were a public mental health agency (6 percent) and a private medical provider (6 percent). A not inconsequential 1.7 percent of each study group had also gotten emergency room intervention for mental health issues (with about 1 percent having actually been hospitalized).

Table 60: Percent of Each Study Sample Receiving Services, by Type of provider*

	ROUND I		ROUND II	
	Kern Recipients	Stan Applicants	Kern Recipients	Stan Applicants
	N=287 Percent	N=356 Percent	N=273 Percent	N=311 Percent
Self Help Group (not AA)	0.3%	2.8%	2.6%	5.1%
Agency like county mental health	5.6	5.9	6.2	5.1
Private MD or psychiatrist	6.3	6.2	7.7	9.6
Private counselor	2.4	4.8	5.1	10.0
CalWORKs-related counseling	1.0	0.8	1.8	4.5
Employee Assistance Program	0.0	0.8	0.7	0.0
Religious counselor	1.4	2.2	2.9	1.9
Emergency Room	1.7	1.7	0.7	1.6
Inpatient ward	1.0	1.4	1.4	3.2
Residential program	0.0	0.8	0.7	0.6
Day treatment program	0.0	0.8	0.4	0.6
Other	0.7	2.0	2.2	2.9

*Respondents could select more than one type.

In Round II, all respondents had had access to Medi-Cal[59] and should have been informed by the welfare department about the CalWORKs-related services available through the county public mental health system. While CalWORKs-related counseling did increase in both counties, the major increase came in the private counselor category (psychologist, social worker, marriage and family counselor) who would have been accessible through the county mental health "network" providers of Phase II Medi-Cal consolidation. In Stanislaus 10 percent saw such a counselor while 9 percent saw a private physician or psychiatrist. Other categories that increased were self-help and inpatient in Stanislaus (the latter to a seemingly high 3 percent) and "other" in both counties.

[59] Except for 16 Stanislaus applicants who were participating in the CalWORKs program when interviewed but their application was later denied.

C. Psychiatric Medications

Psychiatric medications are a primary form of treatment for most mental disorders—in some cases they are the only effective therapy and in others they are prescribed in conjunction with other types of therapeutic service such as counseling or psychosocial rehabilitation.

In the CalWORKs context, staff have reported that a common way they find out about potential mental health issues is by reviewing the list of medications that clients list on a general set of questions they answer about medications and health.

Extent to which psychiatric medications are prescribed. Questions about psychiatric medications were asked only in Round II.

Table 61: Percent Prescribed and Using Psychiatric Medications

	ROUND II	
	Kern Recipients	**Stan Applicants**
	N=273 Percent	**N=311 Percent**
Had prescription for medications for mental health or AOD in past 12 months	13%	15%
Currently taking the medications	10	9

Those who stopped had a wide range of reasons for doing so. The most frequent (though only 4 persons in each county) was due to side effects, other answers given by more than one person included feeling they no longer needed it, stopped due to pregnancy, and difficulties getting the medicine (due to moving, not being able to afford it, or not seeing the same doctor any more).

Source of prescription. In the general public, only a minority of persons with mental health diagnoses receive treatment, and even fewer receive care from specialists (psychiatrists or other licensed professionals, whether from a county program or a private provider). For example, in the National Co-Morbidity study 36 percent of those with Major Depression received some services. However, only 28 percent saw a health provider and only 21 percent had seen a specialist.

As shown in Table 62, approximately 85 percent of respondents in our samples receive their prescription from a regular doctor or nurse practitioner, not from a specialty provider. In Stanislaus the percentage using a public provider is lower than in Kern.

Table 62: Percent Receiving Psychiatric Medication Prescription: by Source

	Stanislaus N=48 Percent	Kern N=36 Percent
Own provider (Not a psychiatric specialist)	60%	39%
Public provider (Not a psychiatric specialist)	25	47
Private Psychiatrist	4	6
Public psychiatrist	10	8
Total	*100%*	*1005*

By far the most frequently prescribed medications were antidepressants. Virtually all of these were the newer SSRI's or other new antidepressants (Effexor); only a couple of respondents had been prescribed the older tricyclic antidepressants. Several of the anti-anxiety drugs were indicated as being prescribed specifically for panic attack.

Table 63: Psychiatric medications prescribed (Number of each type of medication)

	ROUND II	
	Kern Recipients	Stan Applicants
	N	N
Methadone (Drug Maintenance)	5	2
Lithium (for Bipolar disorder)	1	1
Antipsychotic	2	1
Antidepressant	21	32
Anti-anxiety	4	7
Antidepressant and anti-anxiety	4	2
Other	1	1

D. Unidentified unmet need

As with domestic violence, it is important for CalWORKs planners to have a realistic idea of the extent to which CalWORKs participants have needs for mental health services but do not ever talk to a mental health professional about their needs. Again, this is not an indication of overall "unmet need" in itself because—as we see below—many persons who did have some contact with the treatment system either did not feel they were helped or appeared to be still highly symptomatic after such contact. The unidentified unmet need reflects the percentage

of women in our sample overall who appear to need to be identified, through screening or any of the other mechanisms available through CalWORKs.[60]

Table 64: Percentage of All Respondents Who Were Both Judged to Need Mental Health Services At Time of Interview And Who Did or Did Not Have Contact With A Treatment Professional During the Prior 12 Months[61]

	ROUND I		ROUND II	
	Kern Recipients	Stan Applicants	Kern Recipients	Stan Applicants
	N=287 Percent	N=356 Percent	N=273 Percent	N=311 Percent
Did have service contact	13%	15%	19%	24%
Did Not have service contact	18%	16%	15%	9%

The apparent reduction in unidentified need in Round II is in part the reflection of including psychiatric medications (which we did not ask about in Round I), but also appears to reflect increased service utilization, particularly in Stanislaus. In the table below we look at unidentified unmet need using the presence of at least two mental health diagnoses (including PTSD) during the prior year as the measure of need. This measure has the advantage of referring to the entire 12 month period (which is also the period of time during which providers were seen). However, since the level of need is so much lower over 12 months than at a point in time (the measure above) it is clearly an underestimate of unidentified unmet need.

Table 65: Percentage of All Respondents Who Had At Least Two Mental Health Diagnoses During the Prior 12 Months And Who Did or Did Not Have Contact With A Treatment Professional During That Time

	ROUND I		ROUND II	
	Kern Recipients	Stan Applicants	Kern Recipients	Stan Applicants
	N=287 Percent	N=356 Percent	N=273 Percent	N=311 Percent
Did have service contact	5%	6%	10%	11%
Did Not have service contact	10	15	8 .1	7

[60] See: Chandler, D., & Meisel, J. (2001). *Screening for Substance Abuse, Mental Health and Domestic Violence Issues in Welfare Reform Programs Guide*. Sacramento: California Institute for Mental Health; and Meisel, J., & Chandler, D. (2000). *The CalWORKs Project Six County Case Study Project Report*. Sacramento: California Institute for Mental Health, 2030 J. Street, Sacramento, CA 95814.

[61] The measure of need used here is the BASIS-32 plus self-defined need or actually receiving services.

E. Reasons for not getting treatment if respondent reported she needed it

It is also important to try to understand the reasons why women who are in need of mental health treatment did not get it. Women who reported that they had "needed treatment or counseling for a mental health or emotional problem" in the past 12 months but did not get it were asked the reasons.

Table 66: Reason For Not Getting Needed Mental Health Treatment

	ROUND I		ROUND II	
	Kern Recipients	Stan Applicants	Kern Recipients	Stan Applicants
	N=38+ Percent	N=39+ Percent	N=22+ Percent	N=20+ Percent
Just did not get around to it	86%	50%	32%	45%
Transportation	27	16	0	9
Lack child care other special services	20	16	0	0
Hours not convenient	23	11	5	5
Health coverage did not pay enough	0	9	0	5
Could not find counselor of right ethnic/language background	3	3	0	0
People important to me disapproved	10	22	5	5

+N varies slightly for the different items.

In Round I the most frequent reason by far was "just did not get around to it" (31 of 38 in Kern and 19 of 39 in Stanislaus). Kern respondents tended to report practical issues as well, such as transportation while Stanislaus women (which is to be expected of women applying for aid) cited lack of health care insurance and inability to pay. However, there are far fewer reporting practical barriers to tx in round two—and very few saying services not available.

Only about half as many women as in Round I reported in Round II that they needed treatment they did not get. Aside from "did not get around to it," percentages for all categories (except "could not pay" in Stanislaus) were small. However, 18 percent of the Kern respondents added that they did not know where to go—disconcerting in the face of the many efforts to make services known and accessible.

Other comments include:

KERN

Afraid to go.

Busy

Have to schedule way in advance and then Ihave to work on that day.

Iam waiting-I'm on a list. They were supposed to callme but they never did.

Ican't even talk to myself, how can Italk to anyone else?

Idon't have any time.

Ijust didn't. Needed for myself, but Iwillget it now.

Ijust don't like telling people my problems. Idon't like talking about it much

I'm going through so much right now, Ihave to dealwith one thing at a time.

No time to go

STANISLAUS

Because of lack of knowledge of resources and finances.

Everyone is dependent on me for everything. Idon't have time for myself. They look at me as the strong one and everyone is counting on me.

Ididn't feelIneeded it. IfeelI'm as same as anyone else.

Idon't have any way

Ijust took care of it myself. Dealwith boys' behavioralissues.

Iwouldn't go.

My child. I'm allshe has. She's allIgot. Failure to make the right decision

Myself. Laziness. Depression. Don't want to do anything.

VI. SATISFACTION WITH AND COMPLETION OF SERVICES

Ultimately the success of mental health services should be—and will be in subsequent reports—measured in the extent to which recipients of service are able to achieve the outcomes important for CalWORKs: reduced dependence on welfare, economic independence or at least employment, and enhanced family well-being. Here our concern is with what might be thought of as intervening or enabling variables. For women who initiated treatment, what percentage completed the treatment? If they did not, why? In either case what is their perception of the value of the treatment they received?

A. Course of Treatment

Although both welfare and treatment professionals working with CalWORKs participants have reported high rates of drop outs between referral and entering treatment[62] most counties have not kept accurate statistics and those that do do not necessarily define terms in the same way. There is also little known about the outcomes of CalWORKs related MH and AOD treatment once it is initiated. The sole exception to these generalizations in California is Yolo County, where evaluator Robert Landry, has established a comprehensive outcome system. In Yolo an unusually high 26 percent of CalWORKs cash aid clients have been referred for county MH or AOD services, although only 80 percent of these actually attend an assessment visit. About 8 percent of all those referred were lost in the referral process; close to 40 percent refused services and another 20 percent did not show up for their first treatment visit. About 16 percent actually have completed treatment, 10 percent terminated prematurely; and 10 percent were still in treatment. However, it is likely—as shown above for the Kern and Stanislaus samples—that some of those not accepting a referral to county services nonetheless received some mental health services.

Respondents in our survey who indicated they had received some mental health services in the past 12 months[63] were asked, "What was the outcome of the *primary* treatment or counseling you received?"

In Round I, in Kern 59 percent were still in treatment and 31 percent had successfully completed treatment; in Stanislaus, 48 percent were still in treatment and 39 percent had successfully completed treatment. The Round II results, shown below in Table 67, are somewhat more highly differentiated. Note that clinicians might have a different point of view about the outcome of treatment and that some respondents did not answer this question even though elsewhere they indicated they had received some services.

[62] Meisel, J., & Chandler, D. (2000). *The CalWORKs Project Six County Case Study Project Report.* Sacramento: Calilfornia Institute for Mental Health, 2030 J. Street, Sacramento, CA 95814.

[63] In Round I there were 38 such persons and 36 were asked this question. In Stanislaus there were 49 but for unknown reasons only 23 were asked the question. This was not a problem in Round II.

Kern respondents leaving for other reasons commented:

> The program ended, I think I should have needed more.
>
> Because I don't need meds any more.
>
> It didn't seem to be doing anything for me.

Table 67: Completion Of Mental Health Treatment

	ROUND II	
	Kern Recipients	**Stan Applicants**
	N=39 Percent	**N=59 Percent**
Still in treatment	69%	59%
Successfully completed treatment	23	22
Left due to problem with counselor or program	5	0
Left because could not afford to continue treatment	0	2
Left due to transportation or child care problems	0	2
Left due to other reasons	3	15

Stanislaus respondents said:

> Because I moved.
>
> Counselor said I didn't need to be in counseling any more.
>
> I didn't think I needed it. It made the problem worse.
>
> I moved out of situation per the advice I received. They helped me with finding a place.
>
> I was in college. I couldn't afford this on my record.
>
> I was pregnant but didn't know it.
>
> Interviewer: It wasn't working for the abusive partner.
>
> The person I was with wouldn't let me go.
>
> I couldn't wait to get out there again. I was so sick. I lied to them told them I wanted to kill myself so they would 5151 me. They kept me on a 72 hr. hold, then they had to let me go.

B. How much did clients perceive they were helped by mental health services?

Medications. The question "how much does/did the medication help" was asked of both those currently taking the medication and those who had stopped. Not surprisingly, those

currently taking medications consistently rated their helpfulness higher; three fourths of those saying "little or not at all" had stopped using the medications.

Table 68: How Much Psychiatric Medication Helped (Asked of all those prescribed medications)

	ROUND II	
	Kern Recipients	Stan Applicants
How much does medication help?	N=38 Percent	N=48 Percent
A LOT	47%	50%
SOMEWHAT	26	25
LITTLE OR NOT AT ALL	26	25

Treatment overall. Respondents who had received mental health treatment in the previous year (including psychiatric medications in the second round) were asked how much overall their services had helped them. They were also asked specifically whether they had helped them become more capable of working.

Table 69: How Much Did Services Help Overall?*

	ROUND I		ROUND II	
	Kern Recipients	Stan Applicants	Kern Recipients	Stan Applicants
	N=16 Percent	N=24 Percent	N=36 Percent	N=43 Percent
Helped me deal more effectively with problems	69%	50%	44%	53%
Helped a little	12	25	31	35
No effect	6	17	14	7
Made things worse	0	0	6	0
I'm not sure	12	8	6	5

*Only half or fewer of the persons who received MH services actually answered this question in Round I.

In Round I 11/16 Kern respondents thought they had been helped by their mental health services in dealing more effectively with problems; in Stanislaus it was 12 out of 24. In Round II, the proportions were perhaps lower in Kern (16 of 36 but a higher percentage saying they were helped a little) and the same in Stanislaus (23 of 43). If we count "helped a

little" as a positive outcome, then the percentage saying they were helped across the two Rounds ranges from 75 to 88.

Effects on work. Roughly a fourth to a third of the respondents in both sites and both rounds felt that their services had helped them become much more capable of working. Positive value was attributed (at least "a little bit") by between 57 and 77 percent of the respondents. See Table 70.

Table 70: How much did services help with working?

	ROUND I		ROUND II	
	Kern Recipients	Stan Applicants	Kern Recipients	Stan Applicants
	N=16 Percent	N=26 Percent	N=39 Percent	N=47 Percent
Helped me become much more capable of working	37%	23%	38%	30%
Helped me become somewhat more capable of working	31	23	20	30
Helped my work capability a little bit	6	11	8	17
Did not help my work capability at all	19	42	31	18
Had a negative effect on my work capability	6	0	3	4

C. Did receiving mental health services affect later diagnoses or symptom scores?

A possible measure of the effect of receiving treatment is obtained by comparing need for treatment in Round I and Round II for those who received treatment after Round I and those who did not. We would expect to find, for example, a higher proportion of persons who had a Major Depression diagnosis in Round I *not* to be depressed in Round II if during the intervening year they had received mental health treatment rather than getting no treatment.

There are three methodological considerations: a) The group receiving treatment was not chosen randomly. That is, there is *something* about persons who get treatment that differentiates them from those who do not. So a comparison between these groups does *not* account for this selection factor. b) The number of cases becomes quite small in this analysis, limiting the use of multivariate methods. c) Although we would increase statistical power by modeling the two sites together (using an interaction between time and site), we have chosen to model them separately due to the quite different populations and service systems in the two counties.

Table 71: Change In Diagnosis Or Symptom Scores For Those Receiving Treatment And Those Not Receiving Treatment In Round II: KERN

	ROUND II	
All respondents were positive for the measure in Round I. Percentages are those who were positive in Round II as well	**No Tx**	**Received Tx**
	N* (Percent)	**N* (Percent)**
Any of 5 mental health diagnoses	59 52%**	29 79%**
Major Depression diagnosis	29 45%	22 50%
Functionally impaired 5 of last 30 days	37 35%	18 33%
Severity scores on BASIS-32 = outpatient norm	31 55%	44 67%

*N is the total in the group; the percentage uses that N as the denominator.
**=p<=0.00

Table 72: Change In Diagnosis Or Symptom Scores For Those Receiving Treatment And Those Not Receiving Treatment In Round II: STANISLAUS

	ROUND II	
All respondents were positive for the measure in Round I. Percentages are those who were positive in Round II as well	**No Tx**	**Received Tx**
	N* (Percent)	**N* (Percent)**
Any of 5 mental health diagnoses	85 40%**	54 78%**
Major Depression diagnosis	63 25%**	45 53%**
Functionally impaired 5 of last 30 days	21 9%**	25 44%**
Severity scores on BASIS-32 = outpatient norm	26 27%**	28 61%**

*N is the total in the group; the percentage uses that N as the denominator.
**=p<=0.00

The measure of having received treatment was constructed by combining all those who in the Round I interview reported they were currently in treatment with all those in Round II who said they had received mental health services during the prior 12 months.[64] We would like to

[64] Adding those in treatment at the time of the Round I interview resulted in adding a fairly small number of persons to those who reported having received treatment in the past 12 months. We see the addition as correcting for memory distortion. However, all the analyses were run with just the reported round II treatment and there were only inconsequential changes.

have tested whether results are better for persons who actually completed treatment, but the numbers are too small (a maximum in any analysis of 9 in Kern and 13 in Stanislaus).

Unexpectedly, for all four measure of need (from least serious to most) in Stanislaus and for one of four in Kern, those receiving treatment in the year between Round I and Round II are significantly *more* likely to have a diagnosis or be functionally impaired when measured in the Round II interview. Since it is not plausible that treatment *causes* such a difference, it seems likely that there is in fact a strong selection effect going on.

One possible way selection might work is that even though we are "holding constant" the threshold, within that threshold those who received treatment may have had more symptomatology at the baseline. We test for this possibility by comparing the actual number of days respondents reported being totally unable to work due to mental health symptoms and by comparing the actual BASIS 32 scores at the Round I measurement.

Table 73: Pretest Impairment Mean Scores For Those Receiving Treatment And Those Not Receiving Treatment In Round II

All respondents were positive for the measure listed below in Round I. Mean days of inability to function are presented for each group. If there is selection into treatment based on severity, scores should be higher for those who received treatment in the year subsequent to the Round I interview.

	KERN		STANISLAUS	
	NO TX	TX	NO TX	TX
	Mean Days	Mean Days	Mean Days	Mean Days
Any of 5 mental health diagnoses	6	10	6	10
Major Depression diagnosis	8	9	8	9
Functionally impaired 5 of last 30 days	18*	23 *	18 *	23*
Severity scores on BASIS-32 = outpatient norm	11	13	11	13

*= statistically significant at $p \leq 0.10$; **= statistically significant at $p \leq 0.05$; ***= statistically significant at $p \leq 0.01$.

Table 74: Pretest BASIS-32 Mean Scores For Those Receiving Treatment And Those Not Receiving Treatment In Round II

All respondents were positive for the measure listed below in Round I. Mean BASIS-32 SCORES are presented for each group. If there is selection into treatment based on severity, scores should be higher for those who received treatment in the year subsequent to the Round I interview.

	KERN		STANISLAUS	
	NO TX	TX	NO TX	TX
	Mean BASIS	Mean BASIS	Mean BASIS	Mean BASIS
Any of 5 mental health diagnoses	3.8***	6.5***	2.8***	4.6***
Major Depression diagnosis	4.7**	6.8**	2.9***	5.1***
Functionally impaired 5 of last 30 days	4.7	5.8	5.2*	6.7*
Severity scores on BASIS-32 = outpatient norm	6.2***	7.8***	5.9***	7.6***

*= statistically significant at $p \leq 0.10$; **= statistically significant at $p \leq 0.05$; ***= statistically significant at $p \leq 0.01$.

As we suspected, in both counties it turns out that those who received treatment in the year before the Round II interview were in general significantly more impaired (when measured using the continuous variables of days unable to function and the BASIS-32 scores) than those who did not get treated in the year between Round I and Round II. That is, even though those treated and those not treated appeared the same (they had at least one diagnosis, or were depressed, or functionally impaired 5 out of the last 30 days, or met the same BASIS-32 threshold), when we look at impairment or symptomatology within these categories we find those who sought treatment were significantly more symptomatic and functionally impaired than those who did not. Thus, those who are "sicker" are more likely to enter treatment.[65]

[65] We ran the same analyses using logistic regression and holding the days of impairment and BASIS-32 scores at their mean. None of the results that were previously significant (i.e. showing less reduction of mental health measures among those who received treatment) were significant when so modeled, although the odds ratio remained higher for those receiving treatment.

Chapter Three:

Alcohol And Other Drug Issues

I. PREVALENCE OVER TWO YEARS

Dependence and abuse. As explained in the *Prevalence Report* the DSMIV diagnoses of alcohol abuse, alcohol dependence, drug abuse and drug dependence[66] provide a more appropriate measure of the extent to which substance abuse is a problem for CalWORKs participants than do measures of use.

We are interested in both differences between counties and differences over time within counties. Because the Stanislaus respondents were applying for aid while those in Kern had (by design) been receiving cash aid at least one year the counties are not directly comparable. For example, in the *Prevalence Report* we cite the finding that in Kern County persons who received cash aid (CalWORKs or AFDC) for two years or less were much more likely to have drug dependence or abuse than those who had received aid longer. Thus we know that time receiving aid is directly related to the measures of abuse and dependence and that the county samples differ on this dimension. However, as an indication of these differences we did perform tests of statistical significance across counties in both years for the measures in italics above. In both interview rounds, the percentage with *drug* (but not alcohol or either) dependence or abuse is significantly higher in Stanislaus. Table 75 shows the 12 month prevalence of abuse/dependence by interview round and by site.

[66] Dependence is a diagnosis involving "a maladaptive pattern of substance use, leading to clinically significant impairment or distress." It is characterized by having at least three of the following symptoms: tolerance, withdrawal, taking a substance in larger amounts or over a longer period than was intended, persistent desire or unsuccessful efforts to cut down or control substance use, spending a great deal of time on substance-related activities, reduction or loss of important social, occupational or recreational activities, and continuation despite knowledge of a severe substance caused physical or psychological problem. Thus dependence may or may not involve physiological addiction. In virtually all cases it is a long-term condition, though one that is responsive to treatment. A related diagnosis is substance "abuse." It also involves "a maladaptive pattern of substance use, leading to clinically significant impairment or distress." However, it is characterized by the presence of one or more of the following: recurrent substance use resulting in a failure to fulfill major role obligations at work, school, or home; recurrent use in situations in which it is physically hazardous; recurrent substance-related legal problems; and continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance. If dependence can be diagnosed, an abuse diagnosis is not applicable.

Table 75: 12 Month Prevalence[67] of AOD Diagnoses, by Site and Interview Round

	ROUND I		ROUND II	
	Kern Recipients	**Stan Applicants**	**Kern Recipients**	**Stan Applicants**
	N=287 Percent	**N=356 Percent**	**N=273 Percent**	**N=311 Percent**
Alcohol Dependence	4.9%	5.6%	5.1%	4.0%
Alcohol Abuse[68]	3.1	2.3	1.1	2.6
Alcohol Abuse or Dependence	*8.0*	*7.9*	*6.2*	*6.2*
Drug Dependence	2.8	7.3	3.0	5.2
Drug Abuse	0.7	1.7	0.4	2.3
Drug Dependence or Abuse	*3.5***	*8.4****	*3.4***	*7.5***
Alcohol *or* Drug Dependence	7.3	10.1	5.5	5.5
Alcohol *or* Drug Abuse	3.5	3.9	1.5	4.5
Alcohol or Drug Abuse or Dependence[69]	*10.5*	*12.6*	*6.6*	*9.3*

*= Difference between counties is statistically significant at p≤0.10; **= statistically significant at p≤0.05 ; ***= statistically significant at p≤0.01.

Illicit drug use. In Round I, the high percentage of women misusing prescription painkillers (like codeine) in Stanislaus County consisted primarily of women over 40. In Round II virtually all of the women misusing painkillers are in their 20s and 30s—that is, not the same persons.

We tested whether the difference in use of "any drug" between the Kern and Stanislaus samples was statistically significant in both years. In the first year the difference was quite significant (9 percent vs. 30 percent), but in the second year the rate in Kern went up and that in Stanislaus went down so that the differences were no longer significant.[70] See Table 76.

[67] In Round II we used the CIDI-SF which produces a probability of a diagnosis. For alcohol dependence we used the proability of .84 in order to set a threshhold; for drug dependence we used a proability of 1.0. Persons meeting these criteria were classed as alcohol or drug dependent when we conducted cross-tabulations. The prevalence figures themselves, however, are arrived at by adding all of the probabilities. The specific prevalence figures for alcohol dependence and drug dependence are thus somewhat higher and more accurate than the figures used in cross-tabulations later in the paper or for measures of dependence *or* abuse.

[68] In Round II we used the CIDI-SF which does not code specifically for alcohol or drug *abuse*. We used answers to two questions regarding use despite physical and social risks to generate abuse. Abuse is diagnosed only if dependence criteria are not met.

[69] This combined figure is slightly lower than it would be if we had used the long form of the CIDI. See footnote 18.

[70] In the second interview round we did not ask about "other drugs," which resulted in about 4 percent fewer in Stanislaus reporting use of "any drug."

The largest increases in Kern were in use of marijuana and the illegitimate use of prescription painkillers. There were increases in Stanislaus as well, particularly in stimulants (amphetamine, methamphetamine).

Table 76: Use of Drugs[71], by Site and Interview Round

	ROUND I		ROUND II	
	Kern Recipients	**Stan Applicants**	**Kern Recipients**	**Stan Applicants**
	N=287 Percent	**N=356 Percent**	**N=273 Percent**	**N=311 Percent**
Sedatives	1.4%	6.2%	1.5%	4.5%
Amphetamines/stimulants	2.4	3.7	4.0	8.0
Analgesics (prescription opiates or painkillers used on own)	1.1	12.6	5.9	6.8
Inhalants	0.0	0.0	0.0	0.3
Marijuana (Cannabis)	3.8	11.8	7.8	11.9
Cocaine/crack	1.0	1.1	0.7	1.9
LSD/PCP (hallucinogens)	1.1	0.6	0.4	0.6
Heroin	0.7	2.5	0.4	2.6
Other drugs	0.4	4.2	NA	NA
ANY DRUG	9.1***	28.9***	16.1	20.9

= statistically significant at p≤0.05 ; *= statistically significant at p≤0.01.

[71] In Round One, using the full CIDI module for drug abuse and dependence, only drugs were recorded which the person had used five or more times in the past year. The short form of the CIDI asks for "any" use.

III. NEED FOR TREATMENT

As we noted in discussing "need for treatment" with respect to mental health, there is not an objective and agreed upon standard for when services are appropriate. We consider several possible approaches here.

Abuse and/or dependence diagnosis. By definition both dependence and abuse diagnoses involve a need for treatment because they indicate either substantial personal distress or very negative effects on family or community, or both.

CalWORKs-related difficulties. We assumed that if someone attended the research interview clearly under the influence of drugs or alcohol they were not "in control" of their use patterns. Likewise, if they reported having lost a job, had job troubles, or failed a drug test due to the effects of alcohol or drugs we assumed that in the context of CalWORKs this constituted a need for treatment.

Self-perceived need. Finally, we asked respondents if at any time in the previous 12 months they had needed AOD treatment. A positive response counted as "needing treatment." In Round I, respondent perception of unmet need for treatment was small (3 persons in Kern and 8 in Stanislaus) and overlapped with the objective indicators. In Round II the percentage of women in Kern who recognized a need for treatment (but did not get it) was somewhat larger (12 persons in Kern and 15 in Stanislaus) and this then increased the overall need (Row F of Table 77).

Need defined by having received treatment. Finally, a number of persons did not report having used/abused particular drugs but later in the interview they did say they had received treatment for those drugs during the previous 12 months. (They might, for example, have been in recovery and going to Narcotics Anonymous.) They also need to be incorporated into the overall picture of those having needed treatment during the 12 month period. Row G. combines all the different indices of need.

Table 77: Standards of Need for Treatment, by Site and Interview Round

	ROUND I		ROUND II	
	Kern Recipients	Stan Applicants	Kern Recipients	Stan Applicants
	N=287 Percent	N=356 Percent	N=273 Percent	N=311 Percent
A. Alcohol or Drug Dependence/Abuse	10.5%	12.6%	6.6%	9.3%
B. Attended research interview under the influence	3.1	2.5	0.7	4.2
C. In previous 3 months, lost job or had job troubles or failed drug test due to AOD[72]	0.7	1.1	1.8	1.3
D. Abuse/Dependence *or* under influence at interview *or* employment problems	13.2	14.6	8.4	12.2
E. Stated needed treatment but did not get	0.7	1.4	1.8	0.6
F. Objective *or* subjective need (D or E)	13.2	14.6	9.9	12.2
G. Objective/subjective need OR actually received treatment	16.0	18.3	12.4	14.1

Need for recovery services. Persons who have gone through treatment and are in recovery may still need services and support. In both rounds we asked respondents if they were "a drug addict or a recovering drug addict" or "a problem drug user or recovering problem drug user." In Round II we have separated those in recovery from active abuse. However, we can closely estimate the number in recovery by subtracting out those who are currently dependent (or have an abuse diagnosis in the case of the problem alcohol or other drug users).

[72] In Round One we did not ask about failing a drug test.

Table 78: Persons in Recovery,* by Site and Interview Round

	ROUND I		ROUND II	
	Kern Recipients	Stan Applicants	Kern Recipients	Stan Applicants
	N=275 Percent	N=336 Percent	N=262 Percent	N=302 Percent
Recovering alcoholic	0.7%	3.1%	0.8%	2.3%
Recovering problem drinker	1.4	0.6	1.8	1.3
Recovering drug addict	5.1	6.9	4.5	6.0
Recovering problem drug user	0.7	0.9	5.9	6.9

*Persons with alcohol or drug dependence or abuse excluded from these analyses. N varies slightly by cross-tabulation.

Partner has a problem with alcohol or other drugs. Having a partner who has current or past problems with alcohol or other drugs may constitute a risk for being drawn into an alcoholic or drug life-style. It also is likely to make it much harder to achieve economic independence. In the table below we show the percentages of women having partners with alcohol or other drug problems or addiction. The percentages in Table 79 are of the entire study group not just those having partners. The figures are higher across the board in Round II than in Round I.

Table 79: Partner AOD Dependence/Abuse or in Recovery, by Site and Interview Round*

	ROUND I		ROUND II	
	Kern Recipients	Stan Applicants	Kern Recipients	Stan Applicants
	N=287 Percent	N=356 Percent	N=273 Percent	N=311 Percent
Partner alcoholic or recovering alcoholic	2.1%	4.5%	3.7%	5.8%
Partner problem drinker or recovering problem drinker	1.4	1.7	2.2	1.9
Partner addict or recovering drug addict	3.5	4.8	4.7	7.1
Partner problem drug user or recovering problem drug user	1.4	1.4	2.2	1.9

* Alcohol responses and drug responses are not independent.

II. INCIDENCE, REMISSION AND SUSTAINED CASES

Background. The prevalence of alcohol and other drug abuse and dependence among CalWORKs participants is likely to vary considerably over time. Both spontaneous remission and treatment might cause there to be some respondents who are not dependent in Round II who were in Round I. Likewise, it would be expected that some respondents would have diagnosable substance use disorders in Round II who had not in Round I. After a brief look at some of the literature on the course of substance use disorders, we present the number of remitted, new and sustained cases in the Kern and Stanislaus samples.

Incidence of newly initiated substance use varies greatly with both the substance and over time and even geography. For example, there were twice as many new users of cocaine each year in the early eighties as in the early nineties. Increases in the percentage of new users have been recorded recently for prescription drugs, including pain killers, for hallucinogens, and for alcohol.[73] The only prospective study of incidence of drug *dependence* using standardized instruments is now twenty years old: it found overall, a new incidence of roughly 6 per thousand in a year.[74]Because incidence varies with time and is closely associated with age and sex, it is very difficult to generalize about what one might expect in a California welfare reform population in 2000.

Much of our information about the course of alcoholism (remission) with and without treatment comes from the 1992 National Longitudinal Alcohol Epidemiologic Survey. At the time of the survey, 21 percent of the women in the national random sample were classed as "former drinkers[75]" while only 3.4 percent were "heavy drinkers." Thus there is a large percentage of women who have abused alcohol but who no longer do so. Information specifically on alcohol dependency shows that of persons dependent five years earlier and who did *not* receive treatment, only 53 percent were still dependent—5 percent of the rest were abstinent and the others still used alcohol but were no longer dependent. Persons who had undergone treatment were more likely to be abstinent (11 percent) but also more likely to be still dependent on alcohol (70 percent).[76]

Similar findings are found for heroin addiction. Because it used drug tests as well as self-report, the Robins study of returned Vietnam veterans is particularly important. Eight to

[73] National Household Survey of Drug Abuse, 2000. Available on the web: http://www.samhsa.gov/oas/NHSDA/2kNHSDA/chapter5.htm

[74] This is the Ecological Catchment Area study. Cited in: Anthony, J. C., & Helzer, J. E. (1995). Epidemiology of Drug Dependence. In M. T. Tsuang & M. Tohen & G. E. P. Zahner (Eds.), *Textbook in Psychiatric Epidemiology*. New York: Wiley-Liss.

[75] Of women who had ever received treatment for alcoholism, 48 percent classed themselves as a "former drinker."

[76] Drinking in the United States: Main Findings from the 1992 National Longitudinal Alcohol Epidemiologic Survey (NLAES). U.S. Alcohol Epidemiologic Data Reference Manual, Volume 6, First Edition, November 1998, NIH Publication No. 99-3519. Available on the web at: http://www.niaaa.nih.gov/publications/manual-text.htm There are, however, a number of other studies of the natural course of alcoholism with and without treatment that generally confirm high remission rates—usually higher for those without treatment than those with treatment. As we showed with respect to mental health issues, however, it seems highly likely that those seeking treatment have more severe problems than those not.

twelve months after their return, 898 male veterans were interviewed. Fully 20 percent had been addicted to heroin in Vietnam but only one percent (8 percent of those addicted in Vietnam) were re-addicted when interviewed. Persons who had not received treatment were no more likely to be re-addicted than those who had.[77]

These studies indicate that it is reasonable to expect substantial "turnover" among the women in our CalWORKs sample and that this should be true for those who did not seek treatment as well as those who did. But they are too general to suggest much about the actual percentages of "remission" and "incidence" that might be expected—hence the value of our two years of survey data.

Potential effects of attrition. Attrition between Round I and Round II does not affect the tests of the statistical significance of change because they are performed on only those clients who were present in both years. Likewise the percentages shown in Tables 80 and 81 are for those persons present in both years.

One might ask, however, whether differential attrition—more drop outs of substance abusers than of non-substance abusers—didn't reduce the Round II *prevalence* figures shown above in Table 75 and thus indirectly the incidence figures as well.

In fact, however, the percentage of those with AOD abuse/dependence in Round I who were re-interviewed was very high. In Kern, there were 30 persons with either alcohol or drug dependence/abuse in Round I and all except two of them were re-interviewed (93 percent). In Stanislaus, there were 45 with dependence or abuse and all but two were re-interviewed (96 percent). So it is unlikely that any of the prevalence or incidence percentages are affected significantly by attrition.[78] We will explore later whether the low percentage of sustained abuse/dependence may be due to the effects of treatment or inaccurate reporting.[79]

New and sustained cases. We have collected information on 12 month diagnosis over two years, so combining these years lets us see the number of persons who had no diagnosis in either year, those who had a diagnosis the first 12 months but not the second, those who had no diagnosis in Round I but did in Round II, and those who had a diagnosis in both years. It is possible that a relatively small part of the difference between the two rounds is due to our

[77] This and other studies of spontaneous remission are reviewed by Waldorf and Biernacki, Natural Recovery From Heroin Addiction: A Review Of The Incidence Literature, available on the web at: http://www.drugtext.org/articles/narehead.htm

[78] Since we are presenting percentages here the issue is really whether there was *differential* attrition, i.e. more attrition among persons with AOD dependent/abuse diagnoses than overall. For example, if there were 100 persons in Round I and 10 had a diagnosis, then the rate was 10 percent. If in Round II 5 of those persons could not be found (and that was the only attrition), then the attrition rate for those with an AOD diagnosis is 50% but only 5% overall. In the fact, however, the attrition rate was the same overall and for those with a diagnosis in Kern and in Stanislaus the attrition rate among those with a diagnosis was lower than overall.

[79] Another hypothesis is that the short form of the CIDI did not "pick up" as much abuse/dependence as the long form did which was used in Round I. This kind of comparative reliability testing has not been done for AOD diagnoses.

having used two different forms of the CIDI diagnostic instrument (long form in Round I, short form in Round II).[80]

We have also included here a measure of "need for treatment" that combines the DSMIV diagnoses with other objective and subjective indicators. How this measure was derived is described in Section II on determining need for services (measure F).

Overall 15 to 20 percent of the respondents in Kern and Stanislaus were judged to have dependence/abuse diagnoses or to need treatment during the two years.

Table 80: Incidence of New Cases and Sustained Cases Over Time: Kern County

N Interviewed Both Years=273	None In Two Years	Recent Not Sustained	New Incidence	Sustained
	Percent	Percent	Percent	Percent
Any illicit drug use[81]	80.2%	3.4%***	11.7%***	4.4%
Alcohol abuse/dependence	88.6	6.2*	2.9*	2.2
Drug abuse/dependence	94.5	2.9	2.6	0.0[82]
Any abuse/dependence	85.3	8.1*	4.4*	2.2
Needed treatment	80.1	9.2	6.2	3.4

*= statistically significant at p≤0.10; **= statistically significant at p≤0.05 ; ***= statistically significant at p≤0.01.

Table 81: Incidence of New Cases and Sustained Cases Over Time: Stanislaus County

N Interviewed Both Years=311	None In Two Years	Recent Not Sustained	New Incidence	Sustained
	Percent	Percent	Percent	Percent
Any illicit drug use	63.0%	16.1%***	9.0%***	11.9%
Alcohol abuse/dependence	87.8	6.8*	3.5*	1.9
Drug abuse/dependence	87.1	6.8*	3.5*	2.6
Any abuse/dependence	81.0	9.7**	5.1**	4.2
Needed treatment	76.5	11.3	7.7	4.5

*= statistically significant at p≤0.10; **= statistically significant at p≤0.05 ; ***= statistically significant at p≤0.01.

[80] The long form asks a variety of questions about each drug. Thus the long the form was very time consuming and generated a level of detail that was not necessary since our interest is in abuse/dependence regardless of the specific drug. However, the magnitude of any such changes is likely to be slight. Changing the probability threshold for drug dependence from the 100% used here to 75% added only one person (in Kern)—primarily because the few added by using the lower probability score were already classed as "abuse." The additional person would have increased the new incidence to 2.9 but would not have changed the "sustained" category.

[81] Again, in Round II we asked about "any" use of these drugs; in Round I only drugs used illicitly 5 or more times were recorded.

[82] If both the persons with dependence/abuse who were not reinterviewed had sustained abuse/dependence (which we cannot know), then this percentage would be 2/287 or less than one percent.

The statistical tests measure the difference between those who are new cases and those who are not sustained (that is, they ignore those who do not change over time). Kern respondents increased their *use* of drugs significantly but decreased significantly the total abuse or dependence (alcohol or other drugs). Stanislaus respondents showed significant decreases in all measures except total need for services.

Service implications

The occurrence of drug and alcohol problems is not static. In Round II, a substantial percentage of respondents in both counties indicated that they had drug or alcohol problems or needed treatment who had not so indicated in Round I. *In other words, efforts at identification of CalWORKs participants with AOD issues needs to be on-going , not just occurring at intake.*

IV. SUBSTANCE ABUSE DISORDERS AND OTHER "SILENT BARRIERS"

To what extent are AOD diagnoses and need for treatment in the CalWORKs population associated with other personal problems that might affect individuals or their families as they move through the CalWORKs process? As in Part I on mental health, personal problems of particular interest are domestic violence, mental health, learning disabilities, and low self-esteem. All of these issues share the property of being "invisible barriers" to the high level of functioning needed by CalWORKs mothers in order to achieve economic independence while protecting and nurturing the well-being of children in the family.

A. Domestic Violence

The role of alcohol and other drug use in domestic violence is complex, and many issues remain unresolved. It is clear, however, that a high proportion of women entering AOD treatment also have domestic violence issues—which adds an entirely different set of considerations to treatment and recovery.[83] In the CalWORKs context it means that treatment programs need to include screening for domestic violence and include provisions for ensuring the woman's safety. A treatment program that takes seriously the need to help its clients with domestic violence will be quite different from one in which domestic violence is not a priority.[84]

In both interview rounds of this study and in both counties rates of *serious* DV were far higher among those with AOD problems than among those with no drug use and no abuse or

[83] Gorney, B. (1989). Domestic violence and chemical dependency: dual problems, dual interventions. *J Psychoactive Drugs, 21*(2), 229-238.
[84] Fazzone, P. A., Holton, J. K., & Reed, B. G. (1997). *Substance Abuse Treatment and Domestic Violence* (TIP 25). Rockville: Center for Substance Abuse Treatment.

dependence. The highest rates, which approached 50 percent and were well over twice as high as those with no AOD issues, were among those with drug abuse/dependence. But in general, rates of serious DV for all AOD indicators were found in more than a quarter of the cases and were about twice the rates for those with no AOD issues.

Table 82: Respondents With AOD Indicators Who Reported Serious Domestic Violence in Previous 12 Months

	ROUND I		ROUND II	
	Kern Recipients	Stan Applicants	Kern Recipients	Stan Applicants
	N Percent	N Percent	N Percent	N Percent
No abuse, dependence or drug use	17%	24%	14%	16%
Any illicit drug use	31	39	16	37
Alcohol abuse/dependence	26	43	29	47
Drug abuse/dependence	40	48	43	53
Any abuse/dependence	30	47	28	48
Needed treatment	28	40	29	39

B. Mental Health

In Table 83 we show the percentage of respondents with alcohol or drug issues who are judged to need mental health treatment (using the standard of having BASIS-32 scores at least as severe as those of a norming group entering mental health outpatient treatment). In both rounds, percentages of women with drug use or alcohol or drug dependence or abuse were from two times to three times as high as those without. In Kern, 50 percent of women with drug abuse or dependence diagnoses had mental health symptom scores sufficient to qualify them for outpatient mental health treatment.

Implications: Since a third to a half of those with AOD issues also need outpatient treatment for mental health issues, CalWORKs services need to explicitly recognize and provide for mental health care as part of AOD services.

Table 83: Respondents With AOD Indicators Who Also Have MH Need (BASIS-32 Scores Equivalent to MH Outpatient Admits), Site and Interview Round

	ROUND I		ROUND II	
	Kern Recipients	Stan Applicants	Kern Recipients	Stan Applicants
	N Percent	N Percent	N Percent	N Percent
No abuse, dependence or drug use	245 18%	247 11%	221 17%	243 11%
Any illicit drug use	26 42%	103 28%	44 32%	65 28%
Alcohol abuse/dependence	23 30%	28 36%	14 29%	17 47%
Drug abuse/dependence	10 50%	30 37%	7 43%	19 53%
Any abuse/dependence	30 33%	45 36%	18 28%	29 45%
Needed treatment	46 37%	65 29%	34 38%	44 29%

C. Self-Esteem

Patterns of self-esteem among women with AOD issues follow those of need for mental health treatment quite closely, with those having AOD problems reporting very low self-esteem twice as often as those with no AOD indicators. See Table 84.

D. Learning disabilities

In general, learning disabilities are not significantly more likely to occur among those with AOD indicators than those without—though there was a tendency for alcohol and drug dependent or abusing respondents to report higher rates of learning disability in Kern in Round II. (See Table 85.) Nonetheless, approximately 25 percent of substance abusers will probably also need help with learning disabilities in order to achieve economic independence. It would make sense to include evaluation for learning disabilities as part of AOD, MH and DV programs.

Table 84: Respondents With Very Low Self-Esteem (below one standard deviation from the county mean), by Type Need, Site and Interview Round

	ROUND I		ROUND II	
	Kern Recipients	Stan Applicants	Kern Recipients	Stan Applicants
	N Percent	N Percent	N Percent	N Percent
No abuse, dependence or drug use	245 14%	247 14%	221 9%	243 14%
Any illicit drug use	26 31%	103 19%	44 25%	65 28%
Alcohol abuse/dependence	23 22%	28 43%	14 21%	17 35%
Drug abuse/dependence	10 50%	30 30%	7 43%	19 53%
Any abuse/dependence	30 30%	45 36%	18 22%	29 41%
Needed treatment	46 33%	65 29%	34 23%	44 29%

Table 85: Percent Having AOD Indicators Who Also Have Learning Disabilities*

	ROUND I		ROUND II	
	Kern Recipients	Stan Applicants	Kern Recipients	Stan Applicants
	N Percent	N Percent	N Percent	N Percent
No abuse, dependence or drug use	245 21%	247 22%	221 17%	243 21%
Any illicit drug use	26 11%	103 22%	44 24%	65 26%
Alcohol abuse/dependence	23 17%	28 21%	14 29%*	17 23%
Drug abuse/dependence	10 10%	6 20%	7 43%*	19 16%
Any abuse/dependence	30 17%	45 27%	18 33%**	29 24%
Needed treatment	46 24%	65 25%	34 29%	44 27%

*Statistically significant at $p \leq 0.10$ in comparison with those with no abuse or dependence.
**Statistically significant at $p \leq 0.05$ in comparison with those with no abuse or dependence.

V. RATES UNDER TREATMENT

Receipt of some treatment. Receipt of treatment for alcoholism is uncommon in the general public—probably only 9 percent for women alcoholics.[85] So it would not be surprising to find relatively few of the CalWORKs respondents seeking treatment. Nonetheless, as noted in the section on incidence and remission, a very substantial proportion of those with alcohol dependence do stop (in one study, 51 percent of those with a lifetime diagnosis of alcohol dependence were not drinking when surveyed)[86] as do at least some populations of the general population who are dependent on drugs. Additionally there is evidence that drug use is more short-lived for women than men.[87]

Respondents were asked if they had "gone anywhere or seen anyone or received treatment or counseling designed to help you reduce or stop your alcohol or drug use—or to treat medical problems associated with your alcohol or drug use, like a doctor or an emergency room?" Later in the interview they were asked, "Now just to be sure I have it straight, at any time during the past year did you receive *any* help, treatment or services related to drinking or use of medications or drugs?" Persons who answered affirmatively to either question were counted as having received services—a range of 5 to 8 percent over both interviews.

Table 86: Received any AOD Services, by Site and Interview Round

	ROUND I		ROUND II	
	Kern Recipients	Stan Applicants	Kern Recipients	Stan Applicants
	N=287 Percent	N=356 Percent	N=273 Percent	N=311 Percent
Received any AOD services	5.2%	8.1%	5.1%	6.1%

Overall, Table 86, 5 to 8 percent had received AOD services in the prior 12 months. Table 87 below shows the results tabulated by the type of use/abuse/need. Between 15 and 20 percent of respondents, depending on site and interview round, who had used an illicit drug in the prior 12 months had also received at least *some* treatment. Women with drug abuse or dependence diagnoses were most likely to have received treatment—in Kern about one third did and in Stanislaus almost 60 percent did. In Kern there is an apparent trend toward somewhat higher rates of persons receiving treatment in the year prior to Round II. However, in Stanislaus the rates receiving treatment went down for some measures and up for others. Overall for both counties between 32 and 45 percent of those needing treatment (as defined above) actually received some treatment. Below we show substance-specific treatment.

[85] Day, N. L. (1995). Epidemiology of Alcohol Use, Abuse and Dependence. In M. T. Tsuang & M. Tohen & G. E. P. Zahner (Eds.), *Textbook in Psychiatric Epidemiology*. New York: Wiley-Liss.
[86] Ibid.
[87] Anthony, J. C., & Helzer, J. E. (1995). Epidemiology of Drug Dependence. In M. T. Tsuang & M. Tohen & G. E. P. Zahner (Eds.), *Textbook in Psychiatric Epidemiology*. New York: Wiley-Liss.

Table 87: Respondents Receiving Alcohol/Drug Treatment in Previous 12 Months, by Type Need, Site and Interview Round

	ROUND I		ROUND II	
	Kern Recipients	Stan Applicants	Kern Recipients	Stan Applicants
	N* Percent of N	N* Percent of N	N* Percent of N	N* Percent of N
Any illicit drug use	26 19%	103 18%	44 20%	65 21%
Alcohol abuse/dependence	23 17%	28 32%	14 29%	17 29%
Drug abuse/dependence	10 40%	30 43%	7 57%	19 58%
Any abuse/dependence	30 20%	45 36%	18 33%	29 45%
Needed treatment	46 33%	65 45%	34 41%	44 43%

*N is the total number in the category on the left, e.g., the total number of illicit drug users. The percentage is the number receiving treatment with the N as a denominator. **This is the measure of need that combines objective and subjective measures and adds those who actually received treatment. It is higher than the other measures because some people reported receiving treatment for drugs that they did not report abusing or being dependent on.

Substances for which treatment was received. Women abusing stimulants (amphetamine/methamphetamine) were the most commonly receiving treatment (range 1.5 to 2.4 percent of the overall study groups) with alcohol showing very similar rates (1.4 to 2.5 percent), and heroin third (1.0 to 1.7 percent).[88] See Table 88.

Respondents were also asked to provide the name of the *primary* drug for which they received treatment during the most recent treatment episode. Although numbers were small, methamphetamine and heroin were the drugs more likely to bring people into treatment—half or more of those who received treatment listed these as the primary drug. See Table 89. Relatively small numbers of respondents reported receiving treatment for alcohol (given the high prevalence rates for alcohol abuse/dependence).

[88] We did not compute the percentages using all those reporting using alcohol or a particular drug because some people reported receiving treatment for drugs they did not report using during the time period. This makes sense assuming the treatment started prior to the 12 month period.

Table 88: Substances for which Treatment was Received, by Site and Interview Round*

	ROUND I		ROUND II	
	Kern Recipients	Stan Applicants	Kern Recipients	Stan Applicants
	N=287 Percent	N=356 Percent	N=273 Percent	N=311 Percent
Alcohol	1.4%	2.5%	1.8%	1.6%
Prescription sedatives/tranquilizers	0.3	0.3	0.0	0.6
Prescription pain killers	0.7	0.8	0.4	1.0
Stimulants (methamphetamine, amphetamine)	2.4	2.0	1.5	1.9
Marijuana/hashish	1.0	0.3	0.4	0.6
Cocaine	1.4	0.8	0.4	0.6
PCP, LSD, Hallucinogens	0.7	0.0	0.4	0.0
Inhalants/solvents	0.3	0.0	0.0	0.0
Heroin	1.4	1.7	1.5	1.0

*Percentages use the entire group as the denominator. Categories are not unduplicated.

Table 89: Primary Substance for which Treatment was Received, Number by Site and Interview Round

	ROUND I		ROUND II	
	Kern Recipients	Stan Applicants	Kern Recipients	Stan Applicants
	N	N	N	N
Alcohol	1	4	2	2
Prescription stimulants	1	2	0	1
Prescription pain killers	0	2	1	1
Methamphetamine	4	6	4	5
Marijuana	2	0	0	1
Cocaine/crack	2	2	0	1
PCP	0	0	1	0
Heroin	2	6	3	3
TOTAL	12	22	11	14

How recent is AOD treatment? Most of those saying they had received treatment had done so quite recently (most within 2 weeks)—the exception was Stanislaus in Round I. See Table 90.

Table 90: Recency of Treatment, by Site and Interview Round

	ROUND I		ROUND II	
	Kern Recipients	Stan Applicants	Kern Recipients	Stan Applicants
	N=15 Percent	N=22 Percent	N=13 Percent	N=14 Percent
Within last 30 days	60%	36%	61%	71%
31 days to 6 months	13	32	23	0
More than 6 months ago	27	32	15	29

Primary type of treatment received. Respondents reporting having received AOD treatment were asked about the type of treatment received at the most recent episode. There is little consistency from site to site or across years other than some tendency toward using alcohol/drug outpatient and self help. In the first round, half of the clients getting treatment got it in a mental health program. The self-help groups were both Alcoholics Anonymous and Narcotics Anonymous. The actual names of the programs used make it clear that some persons sought treatment (especially residential) outside of the county they lived in.

Table 91: Type Program Where Treatment was Received, by Site and Interview Round

	ROUND I		ROUND II	
	Kern Recipients	Stan Applicants	Kern Recipients	Stan Applicants
	N=15 Percent	N=12 Percent	N=13 Percent	N=13 Percent
Residential facility	7%	17%	8%	0%
Outpatient alcohol/drug program	13	25	61	46
Outpatient mental health program	47	0	31	8
Prison or jail	0	8	0	0
Self-help group	20	33	0	38
Other	13	17	0	8

Mandated treatment. We were interested in whether treatment was chosen voluntarily or was mandated or otherwise coerced, particularly by CalWORKs. Overall around 60 percent of those answering the question said that they were required by someone to enter treatment. The "someone else" include the DMV (1 person), SSI (1 person) and "a friend" and a suggestion (not requirement) by CPS worker. Results are in Table 92.

Table 92: Treatment was Mandated*, by Site and Interview Round

	ROUND I		ROUND II	
	Kern Recipients	Stan Applicants	Kern Recipients	Stan Applicants
	N=14 Percent	N=23 Percent	N=10 Percent	N=14 Percent
Child welfare mandate	8%	19%	20%	23%
Court, probation, parole mandate	50	52	33	35
CalWORKs required	7	0	0	8
Landlord, housing agency, shelter mandated	0	0	0	0
Someone else required it	21	9	10	23
TOTAL PERCENT MANDATED	*79%*	*56%*	*60%*	*64%*

*More than one answer could be chosen. N's vary by no more than one.

Unidentified unmet need for AOD services. As with domestic violence and mental health, it is important for CalWORKs service planners to have an estimate of the extent to which persons in need of AOD services do not have contact with any AOD resources. Again, having contact may not address the service needs fully (as shown in the next section), but an initial goal is to identify and offer services to everyone with a need for AOD services.

Table 93: Percentage of All Respondents Who Were Both Judged to Need AOD Services and Who Did or Did Not Have Contact With AOD Services During the Prior 12 Months[89]

	ROUND I		ROUND II	
	Kern Recipients	Stan Applicants	Kern Recipients	Stan Applicants
	N=287 Percent	N=356 Percent	N=273 Percent	N=311 Percent
Did have service contact	5.2%	8.1%	5.1%	6.1%
Did Not have service contact	10.8%	10.1%	7.3%	8.0%

Based on self-report survey information, approximately ten percent of the women had unidentified unmet need at the onset of the welfare reform requirements (Round I). This percentage went down somewhat in Round II, but in Stanislaus, so did the percentage of persons who did have service contact.

[89] The measure of need used here is the BASIS-32 plus self-defined need or actually receiving services.

VI. SATISFACTION WITH SERVICES

A. Course of Treatment

In Round I, 9 respondents in Kern and 22 in Stanislaus answered the question regarding the outcome of their AOD treatment. In Kern 78 percent were still in treatment while only 36 percent of those in Stanislaus were. In Kern the 22 percent not in treatment said they had completed it successfully while in Stanislaus there was a 45 percent completion rate—one client did not complete treatment because of being arrested, and 3 others for unspecified reasons.

In Round II there were 13 persons in each county who answered a question about the outcome of their treatment. In Kern, 77 percent were still in treatment and the remainder said they had completed treatment successfully. In Stanislaus the comparable figures were 69 percent ongoing and 31 percent completion.

Thus overall, in both sites and both rounds, few persons had completed treatment at the time of the interview (5 in both rounds in Kern and 14 in both rounds in Stanislaus).

B. Client-perceived Helpfulness of Services

The small number of clients answering the questions about effectiveness of service (range of 11-20) and the fact that clients answering were predominantly still receiving services makes any conclusions quite tentative. Given that caveat, the vast majority of respondents said their AOD services had helped them deal more effectively with problems.

Table 94: How much did AOD services help overall?

	ROUND I		ROUND II	
	Kern Recipients	Stan Applicants	Kern Recipients	Stan Applicants
	N=11 Percent	N=18 Percent	N=13 Percent	N=17 Percent
Helped me deal more effectively with problems	73%	72%	75%	71%
Helped a little	18	11	17	29
No effect	0	17	0	0
Made things worse	0	0	0	0
I'm not sure	9	0	8	0

A question regarding how much services helped with employment also drew favorable responses. Between 60 percent and 90 percent, depending on site and year, were at least somewhat favorable with roughly 40 percent in the first round highly favorable and over 50 percent in the second round highly favorable.

Table 95: How much did AOD services help with working?

	ROUND I		ROUND II	
	Kern Recipients	Stan Applicants	Kern Recipients	Stan Applicants
	N=11 Percent	N=20 Percent	N=13 Percent	N=17 Percent
Helped me become much more capable of working	45%	40%	54%	59%
Helped me become somewhat more capable of working	36	5	15	18
Helped my work capability a little bit	0	15	8	18
Did not help my work capability at all	9	40	23	6
Had a negative effect on my work capability	9	0	0	0

C. Objective correlates of treatment

Below we have tabulated the outcome status at the end of Round I (in treatment, completed treatment successfully, needed treatment) by the same outcomes in Round II. Note that the defining characteristic here was that persons had an abuse or dependence diagnosis. The "needed treatment category" included a few persons who reported entering treatment but left before the treatment was completed successfully.

Those saying they had successfully completed treatment in Round I (Column 3) had positive outcomes in Round II as well (with one exception). Those who were receiving treatment at the time of the Round I interview (Column 2) also had successful outcomes. Thus, in general, outcomes for those who reported receiving treatment in Round I were good as of the Round II interview.

Those (Column 1) who were categorized as abusing or dependent on alcohol or drugs in Round I (with no treatment) showed anomalous results, however. While about a quarter continued to need treatment in Round II, about 70 percent reported that they were no longer abusing or dependent on alcohol or drugs in the 12 months prior to the Round II interview—even though they never reported having received treatment.

Table 96: Outcome in Round I by Outcome in Round II: Abuse or Dependence

	COLUMN 1		COLUMN 2		COLUMN 3	
	If Needed TX in I		If Receiving TX in I		If Successful Tx in I	
	Kern	Stan	Kern	Stan	Kern	Stan
Outcome in Round II	**N**	**N**	**N**	**N**	**N**	**N**
No Abuse or Dependence in Round II	16	23	3	5	4	8
In Treatment	0	2	2	2	1	1
Completed Treatment Successfully	1	0	1	1	0	1
Abuse or Dependence in Round II: Needed treatment	6	9	0	0	0	1

What accounts for the large percentage of persons with abuse/dependence diagnoses in Round I who did not have them in Round II, even though they reported receiving no treatment? In Round I the 16 Kern and 23 Stanislaus respondents meeting this description reported the following types of dependence/abuse.

- *Prescription drugs:* One of the Kern respondents was dependent on prescription sedatives in Round I as was one Stanislaus respondent. Six other Stanislaus respondents were dependent on prescription painkillers like codeine or Demerol. It is possible that their abuse of these drugs in Round I was linked to a medical condition and was discontinued when the medical condition remitted.

- *Alcohol:* Six of the Kern respondents and five of the Stanislaus respondents were abusing alcohol in Round I but did not report abusing it in Round II. Eight Kern and ten Stanislaus respondents reported alcohol dependence.

- *Marijuana:* Two Kern respondents reported marijuana dependence as did one Stanislaus respondent. Two other Stanislaus respondents reported marijuana abuse.

- *Cocaine/amphetamine:* In Kern 1 person was dependent on cocaine; in Stanislaus two were. In each county three were dependent on amphetamines.

- *Other drugs:* Five persons in Stanislaus were dependent on "other" drugs. They were the only people in either sample with this diagnosis. Unfortunately we did not record what they were, but they must be quite unusual since the list of drugs we asked about was very extensive. However, it did not include designer drugs (such as Ecstasy, Fentanyl and GHB). In the Round II interview no "other" category was provided, so respondents using the less common drugs may have been skipped.

The Round II results show that these persons might have been experiencing AOD problems even if they did not meet the standard for dependence or abuse.

- *Drug use:* Six of 16 in Kern and 8 of 23 in Stanislaus reported using some drug. These included in Stanislaus: heroin (one person), cocaine (one person), LSD (one person), marijuana (4 persons), prescription painkiller (one person), a tranquilizer (one person), prescription or street stimulants (four persons). In Kern it included marijuana (four persons), stimulants (one persons), painkillers (one person),

- *Bingeing on alcohol:* One person in each county said they drank more than 10 drinks at a time, and four in Kern and seven in Stanislaus reported drinking 4-10 drinks at a time.

Respondents may also have under-reported their substance use/dependence, which is common.[90] However, we would expect more under-reporting in Round I than in Round II—when serious problems had already been reported before.

All in all, 9 of 16 in Kern and 11 of 23 in Stanislaus reported using an illegal (or non-prescribed) drug or bingeing on alcohol. One Stanislaus respondent did not report use but the interviewer reported she was under the influence of alcohol or drugs at the interview. The National Longitudinal Alcohol Epidemiologic Survey showed that in the course of five years almost half of persons dependent on alcohol stopped being so without treatment.[91] So it is not beyond the realm of possibility that some of the eight Kern and ten Stanislaus respondents dependent on alcohol in Round I reduced their dependence—perhaps in response to the new demands placed upon them for finding employment.

In summary, about half of those who did not report abuse or dependence in Round II did report alcohol or drug use that might still be serious. Six of the persons with Round I dependence may have stopped misusing their prescription painkillers and five who reported using unusual drugs in Round I may not have been asked the diagnostic questions in Round II. In the end, however, there are a number of persons in each county who either stopped being dependent on alcohol or drugs without the benefit of treatment or who did not report dependence/abuse even though it existed—both are plausible but with the information available we are unable to determine which is true.

[90] For example, see: Morral, A. R., McCaffrey, D., & Iguchi, M. Y. (2000). Hardcore drug users claim to be occasional users: drug use frequency underreporting. *Drug Alcohol Depend, 57*(3), 193-202.
[91] Drinking in the United States: Main Findings from the 1992 National Longitudinal Alcohol Epidemiologic Survey (NLAES). U.S. Alcohol Epidemiologic Data Reference Manual, Volume 6, First Edition, November 1998, NIH Publication No. 99-3519. Available on the web at: http://www.niaaa.nih.gov/publications/manual-text.htm

Chapter Four:

CalWORKs Related Treatment Services for Mental Health or AOD

CalWORKs Related Services for Mental Health or Alcohol or Drug Problems

California is a leader among states in providing funding for mental health and AOD services targeted to CalWORKs participants. Our two study counties were "early adopters," having very early established co-located MH/AOD services at welfare sites. Our survey contained a number of questions about whether clients were informed of MH/AOD services available through CalWORKs, whether they used them, and how helpful they were.[92]

The first question was: "Were you told or given information by a CalWORKs worker that you can get free mental health or alcohol and drug treatment services if any of those conditions interfere with you fulfilling your welfare-to-work plan?"

As shown in Table 97, below, about 40 to 60 percent of respondents reported having been told about CalWORKs related treatment. Although one might think part of the low responses is poor memory due to lack of salience, there was essentially no difference between the group overall and those with either mental health or AOD needs (as defined elsewhere in this report).

Contrary to expectation, the reports of having been told were no higher in the second round, although for reasons that are unclear, the relationship between the counties was reversed.

Table 97: Percent Told AOD/MH/DV services available through CalWORKs

	ROUND I		ROUND II	
	Kern Recipients	Stan Applicants	Kern Recipients	Stan Applicants
	N Percent	N Percent	N Percent	N Percent
All respondents	279 40.1%	349 58.2%	270 59.6%	305 36.1%
Respondents with objective or subjective need for mental health tx	107 39.2%	125 50.4%	85 60.0%	96 43.7%
Respondents with objective or subjective AOD need for tx	36 37.8%	51 60.8%	27 55.6%	36 36.1%

If respondents reported receiving *or* needing mental health or AOD services in the previous year they were asked if they had been offered help for problems with drinking, medications or other drugs, or mental health.

[92] The indicators of receipt of service cited in the mental health and AOD chapters included services received through CalWORKs; this chapter focuses on them. Receipt of DV services related to CalWORKs was considered in Chapter I.

Table 98: Percent* *offered* mental health services through CalWORKs if actually received MH/AOD services or said they had needed MH/AOD services

	ROUND I		ROUND II	
	Kern Recipients	Stan Applicants	Kern Recipients	Stan Applicants
	N Percent	N Percent	N Percent	N Percent
Offered help with mental health problems if had objective or subjective need for services	33 21.2%	47 29.8%	55 20.0%	49 26.5%
Offered help with drinking if abuse or dependent on alcohol	7 0.0%	12 16.7%	7 0.0%	11 18.2%
Offered help with medications/drugs if abuse or dependent on drugs	5 20.0%	16 6.2%	6 16.7%	16 31.2%

*As usual, N refers to all qualified respondents; percent is percentage of the N. So, for example, in row one of column one, 33 persons in Kern had answered this question who had objective or subjective need for mental health services. Of these 33, 21 percent were offered help.

Only small numbers of persons who needed services answered the question regarding whether CalWORKs-related services were offered. A very small percentage of those in either county who needed services reported that they had been offered through CalWORKs (0 to 31 percent).

A further question was whether respondents (regardless of our judgment of need) had actually gone to any CalWORKs arranged AOD/MH services.

Table 99: Percent of Each Study Sample Receiving CalWORKs Arranged Services,

	ROUND I		ROUND II	
	Kern Recipients	Stan Applicants	Kern Recipients	Stan Applicants
	N=287 Percent	N=356 Percent	N=273 Percent	N=311 Percent
Actually went to AOD/MH services arranged through CalWORKs	0.8%	1.0%	1.8%	4.8%

Since many clients around the state, especially AOD clients, enter CalWORKs services through the "back door," by entering treatment first and then getting CalWORKs authorization, we asked clients who said they had CalWORKs arranged services how they got them. In this sample almost all the respondents had been referred by CalWORKs first rather than entering treatment first—although this result may be an artifact of our asking the question in terms of "CalWORKs arranged services."

Those who did not actually go to services were asked why. Most respondents in Round I replied they just had not gotten an appointment yet while two were already in treatment elsewhere; one said, “I'm scared finding out all the things that are wrong with me.”

In Round II, 2 of the 8 Kern and 2 of the 11 Stanislaus respondents said they were already receiving treatment elsewhere. Here are the responses of the others:

KERN

She wanted to come to my house, I thought it was unnecessary. It's not that bad.

I didn't go to the appointment. But they will set it up again.

They required 3-hour orientation and I never had time to do that.

Cause it's too far. I was going to go to mental health closer to my house.

I didn't or can't explain to myself how I feel.

I didn't want to believe it. One minute I'm stable and strong, the next I'm collapsing.

STANISLAUS

I didn't want people to know my business.

I wanted to work.

I just got through it on my own.

Because it is CalWORKs not Mental Health. They are social workers not doctors.

Went to AA

I asked for help and didn't get my calls returned.

They wanted me to try my medications first. It worked.

I don’t know. Not getting help through CalWorks.

I'm still waiting.

Those who went to CalWORKs arranged services were asked: “In general how much have the mental health or alcohol or drug services you have received through CalWORKs helped you?” In Round I, only 3 people in each county answered the question. Results from Round II are shown below.

Table 100: Helpfulness of CalWORKs Arranged MH/AOD Services

	ROUND II	
	Kern Recipients N	**Stan Applicants N**
“Helped me deal more effectively with my problems”	2	5
“Helped a little”	2	6
No effect, made worse, could not judge	3	4
TOTAL	**7**	**15**

Those who went to CalWORKs arranged services were also asked to “rate your overall experiences with the mental health, or alcohol or drug services that CalWORKs arranged.”

As before there were only 3 in each county in Round I. Round II results are shown below. The person who rated her experiences as "very bad" explained that she was told she did not need the service and was not treated with respect.

Table 101: Overall Rating of CalWORKs Arranged MH/AOD Services

	ROUND II	
	Kern Recipients	**Stan Applicants**
	N	**N**
Excellent	2	3
Good	2	8
Some good, some bad	2	3
Bad	0	0
Very bad	0	1
TOTAL	**6**	**15**

The numbers above are too small to draw broad conclusions from. However, when we consider as a whole the percentage who say they were told of CalWORKs-related services, the percentage who were referred to services, the percentage who went, and the percentage indicating effectiveness or satisfaction, we would have to say that the CalWORKs-related services had a limited impact on the approximately 20 percent of respondents in Round II who needed mental health services or the approximately 15 percent of respondents who needed alcohol or other drug services.

Chapter Five:

Overlap Among Domestic Violence, Mental Health and AOD Needs and Services

THE OVERLAP OF DV, AOD AND MH

In the chapters above we have presented the percentages of persons reporting AOD/MH/DV who have an overlap with on each of the other issues. Here we present the overlap of all three conditions. For each condition we present either what we have called "need for treatment" or, in the case of DV, "could potentially benefit from services." All three of these measures include in them self-defined need for services as indicated by having sought out some level of professional services. Table 102 shows the percentages having service needs for one, two or three issues within the same year. Approximately one fifth have needs for more than one type of service. Roughly half have a need for *at least* one type of service.

Table 102: Percentage of Respondents with Need for Services for Multiple Conditions, by County and Year

	ROUND I		ROUND II	
SERVICE NEEDED	**Kern Recipients**	**Stan Applicants**	**Kern Recipients**	**Stan Applicants**
	N=287 Percent	**N=356 Percent**	**N=273 Percent**	**N=311 Percent**
One only	29%	32%	24%	28%
Two	16	18	16	17
Three	4	6	3	6
ONE OR MORE	*49*	*56*	*44*	*51*

Figures 1 and 2 are Venn diagrams that show the specific overlap between the three conditions in Round I and Round II. The largest overlap in Round I—which is most indicative of the need for integrated or multidisciplinary services—is between mental health and domestic violence. In Kern 10 percent of the whole population has a need for both types of services (with an additional 13 percent for domestic violence alone and 10 percent for mental health alone). In Stanislaus, there is likewise 10 percent of the sample with both conditions (with an additional 17 percent with domestic violence alone and 10 percent mental health alone). However, in both counties 4 percent of the sample has both AOD and mental health needs. In Kern 3 percent overlap between domestic violence and AOD while in Stanislaus 2 percent do.

In Round II the greatest overlap in both counties is again between DV and MH needs: in Kern 10 percent of the sample have this need and in Stanislaus 12 percent do. In Stanislaus in both rounds, 6 percent of the entire sample needed *all three* types of service (in Kern it was 4 and 3 percent, respectively).

A second set of Venn diagrams, Figure 3 and 4, presents the overlap between those persons with *unidentified* unmet needs. That is, these are persons who did not see a service provider but who were judged by us to need mental health or AOD services or to potentially benefit from domestic violence services. *Note that for the DV unidentified unmet need we have taken out the women who volunteered that abuse was minor or services not needed, as shown in Table 41.*

In Round I in Kern county, the largest *single* source of unidentified unmet need is for mental health services alone (18 percent) while in Stanislaus it is domestic violence (17 percent with mental health at 16 percent). In Kern the largest overlap is for domestic violence and mental health (4 percent); in Stanislaus, there is an overlap for 3 percent of the population both for mental health/AOD and mental health/domestic violence.

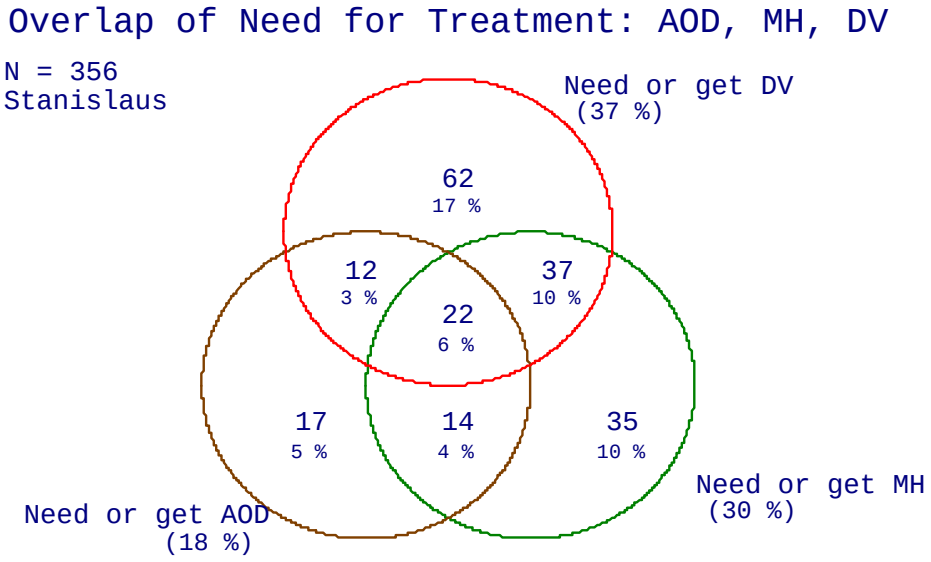
In part because we added a measure of use of psychiatric medications in Round II, the unidentified unmet need for MH declines. In fact, in Stanislaus in Round II the unidentified unmet need for MH, for AOD and for DV are all very close to 10 percent. In Kern, it is 7 percent for AOD, 10 percent for DV and 15 percent for MH. The largest overlap in Kern is 4 percent (DV and MH) while in Stanislaus it is not more than 1 percent for any combination.

Table 103: Percentage of Respondents with Unidentified Unmet Need for Services for Multiple Conditions, by County and Year

	ROUND I		ROUND II	
SERVICE NEEDED	**Kern Recipients**	**Stan Applicants**	**Kern Recipients**	**Stan Applicants**
	N=287 Percent	**N=356 Percent**	**N=273 Percent**	**N=311 Percent**
One only	22	29	18	19
Two	7	6	6	4
Three	1	>1	1	<1
ONE OR MORE	*31*	*36*	*25*	*23*

Finally, Table 103, shows the overlap of unidentified unmet need for each of the three issues we have been considering. In Round I about a third and in Round II about one quarter of the population have at least one unidentified unmet need for AOD/MH/DV services. Five to 8 percent have, at any time or site, unidentified unmet needs for more than one type of service.

Figure 1: Needed or received services in Round I



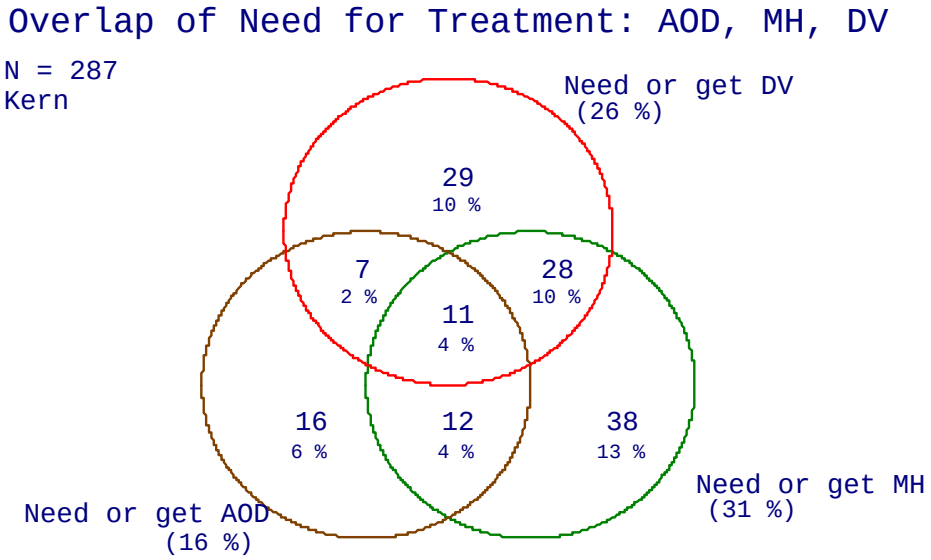
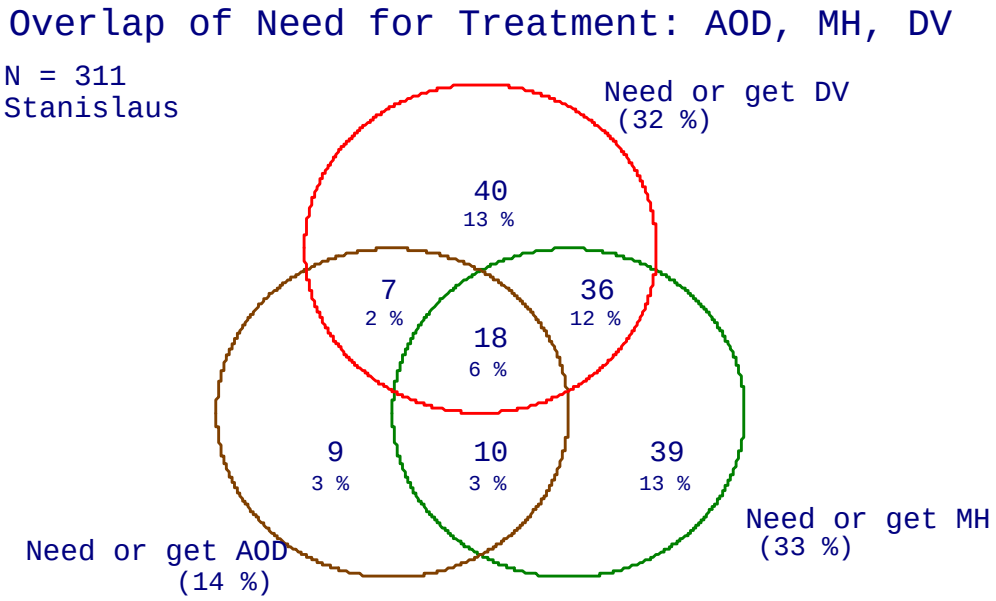


Figure 2: Needed or received treatment in Round II



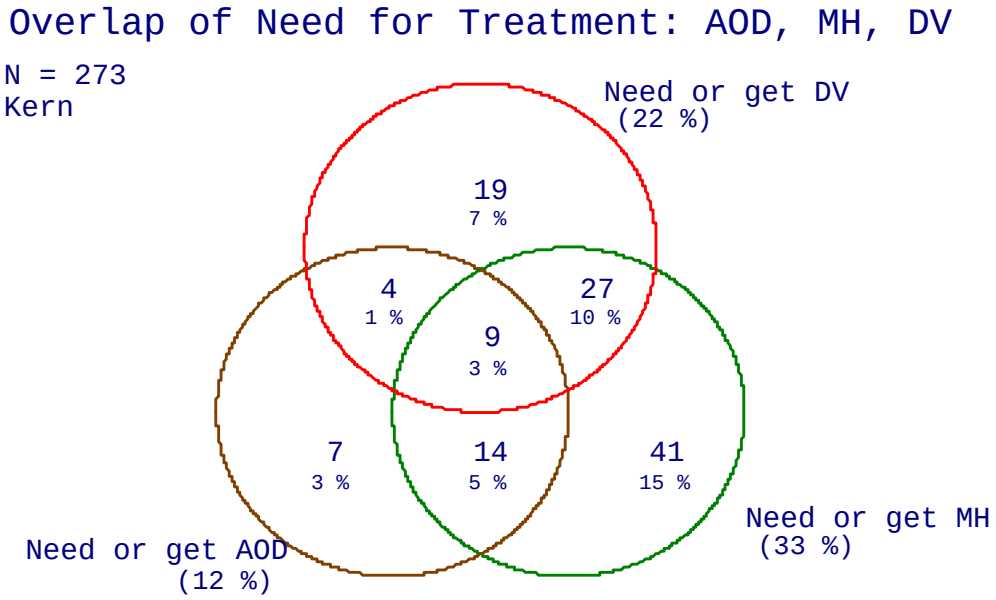
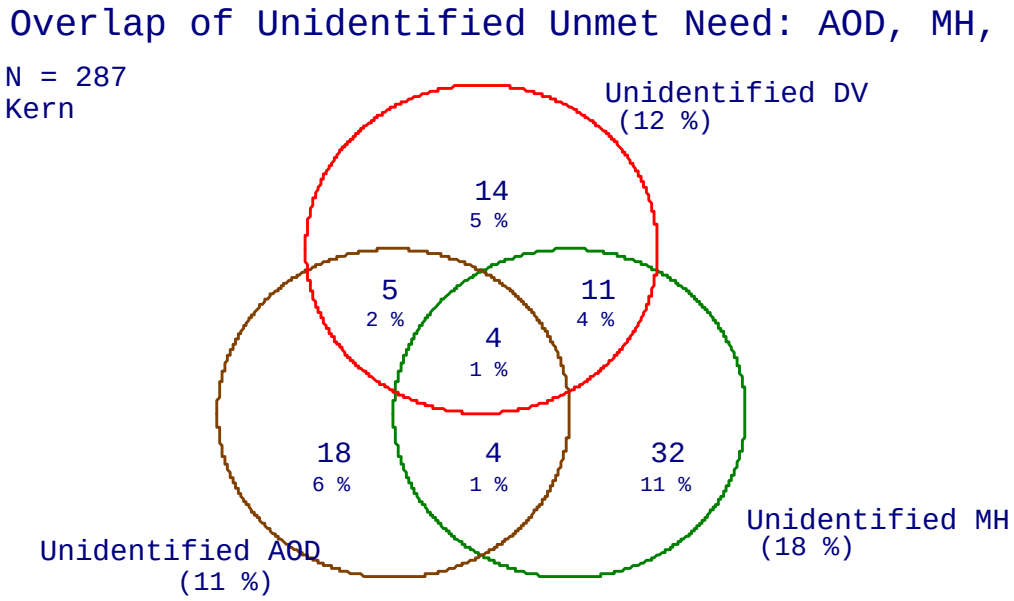


Figure 3: Unidentified unmet service needs in Round I



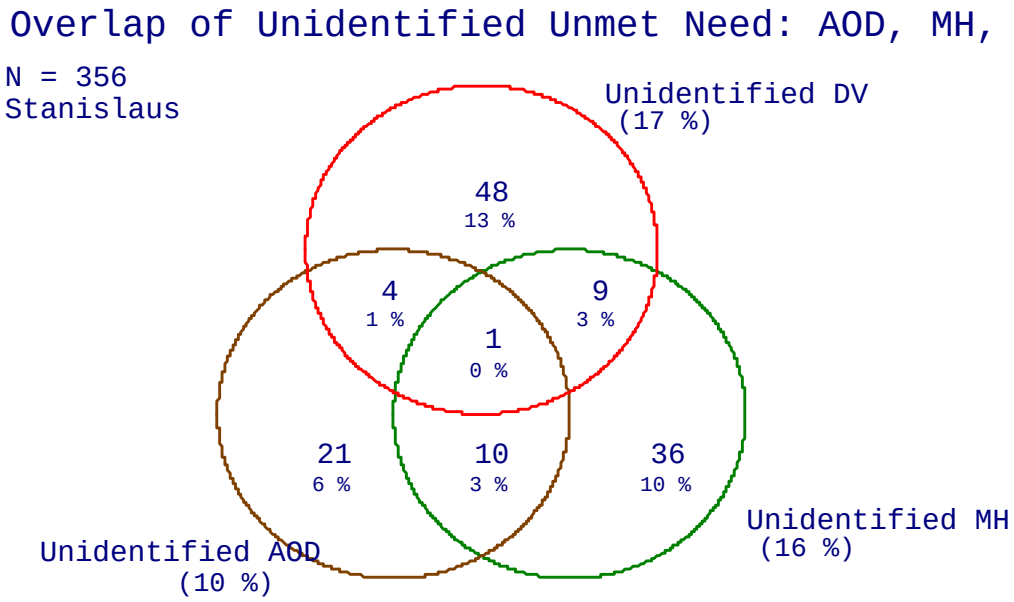
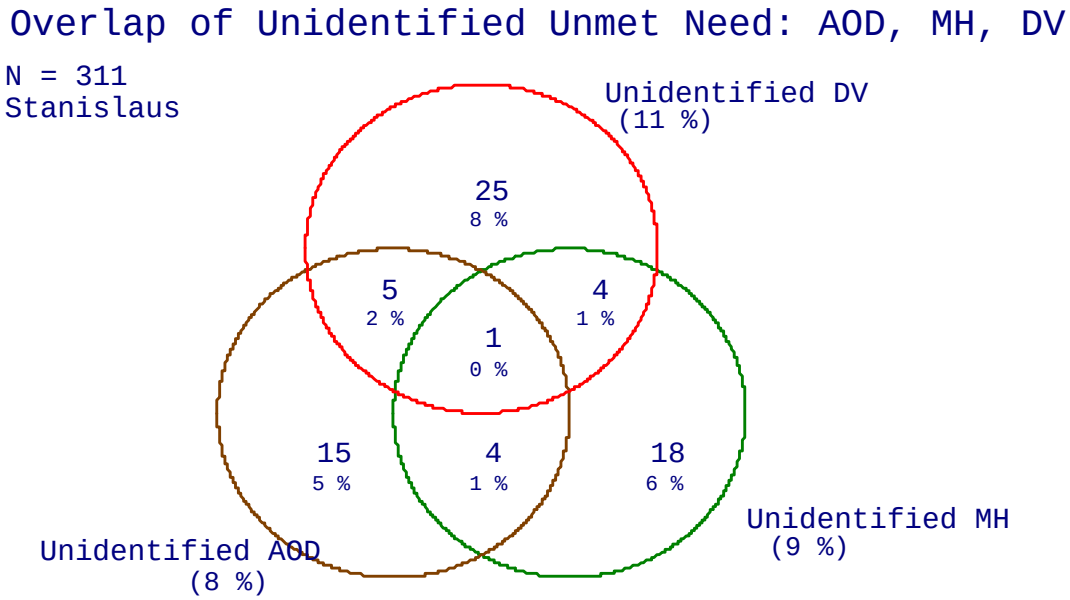
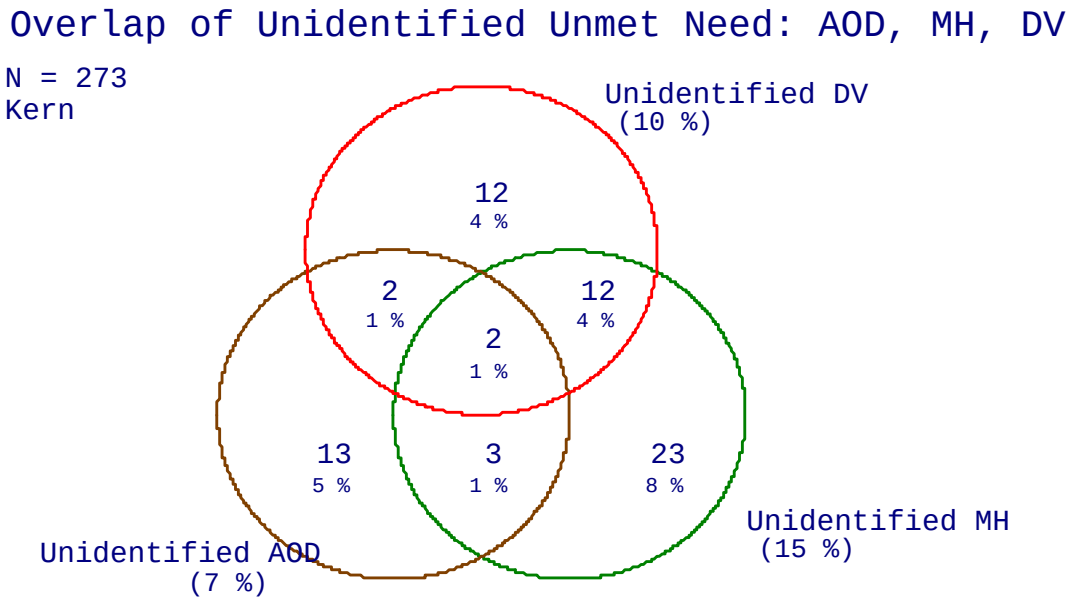


Figure 4: Unidentified unmet service needs in Round II





Appendix:

Study Design and Methodology

Study design and methodology

Sampling. In the summer of 1999 we conducted one and a half hour-long research interviews with 703 randomly sampled CalWORKs participants in Kern County and in Stanislaus County.[93] (We also sampled women who had been identified by CalWORKs as needing AOD/MH/DV services and had received such services; they are not reported on here.) The basic conditions for study participation were the same in both counties:

- Age: 18-59
- Language: Fluency in English or Spanish
- Female Head of the Household (relative-caretakers and two-parent families were not eligible)
- CalWORKs applicant or recipient: applying for CalWORKs and eligible for Welfare to Work (in Stanislaus) or CalWORKs recipient for at least one year (Kern).

However, the samples in the two counties differ in one important way. In Stanislaus County the sample was comprised of *new applicants* for CalWORKs while in Kern County subjects had to *have received AFDC/TANF at least one year*.

- Stanislaus Applicants: All new applicants in Stanislaus are assigned to a week-long job club. For a three month period we attempted to recruit into the study from the job club *all* those fulfilling the study criteria. The final sample comprised 356 women. Study participants came from throughout the county since all new applicants apply for aid and go through the job club process at a central site.
- Kern Recipients: a random sample was drawn from 4,732 CalWORKs recipients in the Bakersfield area who had received at least one year of cash assistance and were recertified between mid-April through July. A total of 347 women were interviewed.[94]
- However, this difference is less than it appears since 79 percent of the Stanislaus sample had received cash aid in the years 1996–1998.

Because of a misunderstanding with the Kern social services department staff, who drew the sample, the initial Kern sample included 49 persons not required to participate in Welfare to Work activities and therefore less likely to be identified and assessed for AOD/MH/DV services. Of these, 31 were women receiving SSI and the remainder were women in the country illegally whose children receive cash aid but who do not themselves. While both these subpopulations are

[93] An additional 83 participants in Stanislaus and 96 participants in Kern were selected from persons who had formally been identified by the county through its regular CalWORKs process as having an AOD/MH/DV issue and who had received at least one unit of service. These groups will be described on in a subsequent report on treatment-related issues.

[94] A total of 49 of these women were undocumented or classed as disabled and thus not required to participate in Welfare to Work activities.

of interest in themselves they do not shed light on problems faced by women who are required to have work activities and who face time limits. This error in sampling was discovered just as the *Prevalence Report* was going to press. Although the inclusion of these respondents made little difference in the Round I prevalence rate[95], we have excluded them from the analysis in this report.

Attrition in Round I. As an incentive, study participants were offered a $30 gift card for Wal-Mart in Round I (and a $50 card in Round II). Interviews occurred at the welfare department in both counties in Round I and were intended to occur on a day in which the participant had other already-scheduled activities. Thus, for the initial interview for both groups we depended on a complex set of logistics and information transfer between the welfare department and the research interviewer staff. There turned out to be many difficulties with this methodology. The major consequence was that participants were often not at the site at the time at which they were scheduled.[96] This meant interviewers had to try to contact them by letter and phone and arrange for them to come in for the interview. Home visits were not part of the study design, primarily to protect the safety of women who might be in abusive relationships.

Of the Stanislaus study-eligible applicants 71 percent were interviewed (5 percent refusal rate). In Kern, 55 percent of the recertification sample were interviewed (7 percent refusal rate). In both counties most of the attrition was due to the inability of interviewers to reach CalWORKs participants by phone in order to try to schedule an interview. The completion rate for Stanislaus is comparable to that in the two post-welfare reform surveys that have focused on AOD/MH/DV issues of 63 percent and 70 percent.[97] We compared characteristics of the Stanislaus and Kern interviewees with those who were eligible but did not participate in order to detect possible bias created by attrition. In Stanislaus the groups did not differ to a statistically significant degree on any measure. In Kern there are no differences on most measures but there are statistically significant but substantively unimportant differences on percent speaking Spanish as first language (more in the interviewed sample), age (interviewed sample slightly older), and time on welfare (slightly smaller percent of interviewed sample on welfare longer than a year). We believe the Stanislaus sample is representative of the population applying for CalWORKs during the sample period, and the Kern sample is substantially representative of the population that was recertified during the sample period. Sampling and the effects of attrition are described in more detail in Appendix I.

[95] For example, of the Kern CalWORKs group 35 percent experience domestic violence in the past year while of the group required to participate in Welfare to Work activities it was 36 percent. Likewise the figures for any mental health diagnosis were 31 percent vs. 30 percent and for any alcohol or drug dependent/abuse 9.5 percent vs. 10.7 percent. That is, the prevalence rates were virtually identical.

[96] A recent New Jersey study also attempted to interview a defined sample at recertification interviews but was forced to give up and take any client present on a given day. Kline, A., Bruzios, C., Rodriguez, G., & Mammo, A. (2000). *1998 New Jersey Substance Abuse Needs Assessment Survey of Recipients of TANF* . Trenton: Department of Health and Senior Services, Division of Alcoholism, Drug Abuse and Addiction Services.

[97] Barusch, A. S., & Taylor, M. J. (1999). *Understanding Families with Multiple Barriers to self-sufficiency* . Salt Lake City: Social Research Institute, University of Utah; Speiglman, R., Fujiwara, L., Norris, J., & Green, R. S. (1999). *Alameda County CalWORKs Needs Assessment: A Look at Potential Health-Related Barriers to self-sufficiency* . Berkeley, CA: Public Health Institute.

Round II Attrition. Round II interviews occurred in Bakersfield at welfare offices; in Modesto, the project rented an office. Interviewers made every effort to complete all interviews, including making some home visits if they were determined to be safe for staff and respondents, interviewing in jail and residential facilities, going to other nearby cities if a respondent had moved, and in a few cases interviewing by phone if the respondent had moved more than two hours traveling distance.

In Kern County, a total of 287 respondents were eligible for inclusion in the Round II interview of Welfare-to-Work participants. Of these 273, or a total of 95 percent were re-interviewed. In Stanislaus County, the original 356 were eligible for Round II interviews.[98] Of these, 311 (87 percent) were re-interviewed.

CalWORKs AOD/MH/DV Services in Kern and Stanislaus Counties

The two counties—Kern and Stanislaus—were selected because of their leadership in developing ideas for working with the study population and their emphasis on cooperative planning among their local domestic violence centers and their mental health/substance abuse and welfare departments. Thus these counties offer a very good chance to develop "best practices" models.

Both counties have steadily improved their CalWORKs AOD/MH/DV services and have increased the percentage of persons identified as needing such services. In Kern County in 1999-2000 774 CalWORKs cash aid participants received AOD services and 1,718 received mental health services. In Stanislaus during the same year 477 received AOD services and 809 received mental health services. Although accurate figures for domestic violence are not available, we have calculated[99] that the persons receiving county-based AOD and mental health services comprised 12.3 and 12.9 percent of the CalWORKs eligibles in Kern and Stanislaus, respectively.

These services are described in detail in the Six County Case Study reports available on the CIMH website: www.cimh.org/calworks.

Measuring prevalence

A prevalence rate is defined as the number of "cases" divided by the total number of persons at risk at a given point in time or during a given time period. In defining prevalence of AOD/MH/DV issues we have most often used the previous 12 months as the relevant time period.

In defining a "case," we have, to the extent possible, used the widely accepted and rigorously defined algorithms in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM IV). A survey instrument embodying these definitions is available for many (but not all) of the mental disorders most likely to occur in the

[98] Sixteen of the Stanislaus respondents had been eligible when interviewed but were subsequently denied cash aid.
[99] Meisel, J. (2001). *The Second CalWORKs Project Six County Case Study Project Report*. Sacramento: Calilfornia Institute for Mental Health, 2030 J. Street, Sacramento, CA 95814.

CalWORKs population, for alcohol and other drug dependence and abuse and for post-traumatic stress disorder. We have assigned these diagnoses to study participants through the use of the Composite International Diagnostic Interview (CIDI).[100] The CIDI is a standardized interview developed, adopted and promoted by the World Health Organization for epidemiological studies around the world. It has been used in hundreds of studies, and its reliability and validity are well documented.[101] For the mental health diagnoses (except for PTSD) the CIDI-Short Form was used.[102] In Round II, the CIDI-Short Form was also used for alcohol and for drugs. The CIDI and how each mental health and AOD diagnosis is defined and scored are described in detail in Appendix II of the *Prevalence Report* available on the CIMH website at http://www.cimh.org/calworks. The CIDI is supplemented by the BASIS 32, a widely used measure of mental health/AOD outcomes that focuses on symptoms during the previous *week* and the SF-12, a widely used measure of health and mental health functioning during the previous *month*.[103]

With regard to domestic violence, or intimate partner abuse, there is no such widely accepted epidemiological definition of a "case." The instrument most often used, the Conflict Tactics Scale (CTS), is quite limited in the range of behaviors it measures.[104] We have, however, used many of the items in the CTS as they permit comparability. We have adopted measures of emotional abuse and controlling behaviors from a 1993 national survey in Canada and the 1995 National Institute of Justice survey in the United States.[105] We restricted our definition, as well, to acts committed by "a current or past partner." Incidents were recorded separately for the previous year and any time in the past. A few items also permit evaluation of the respondent's judgement of current danger at the time of the interview.

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[100] Alcohol and other drug program staff are more likely to be familiar with the Addiction Severity Index. While extremely widespread as an intake and outcome assessment tool for substance abusers applying for treatment, it is not validated as an epidemiological instrument. The only direct comparison of clinician-assigned DSMIII diagnoses and a prediction of diagnosis generated by the ASI showed the ASI to miss approximately 20 percent of the substance use disorders in a psychiatric inpatient population: Lehman, A. F., Meyers, C. P., Dixon, L. B., & Johnson, J. L. (1996). Detection of Substance Use Disorder among Psychiatric Inpatients. *Journal of Nervous and Mental Disease, 184*, 228-233.

[101] Wittchen, H. (1994). Reliability and validity studies of the WHO--Composite International Diagnostic Interview (CIDI): a critical review. *Journal of Psychiatric Research, 28*(1), 57-84.

[102] Kessler, R. C., Andrews, G., Mroczek, D., Bedirhan, U., & Wittchen, H.-U. (In press). The World Health Organization Composite International Diagnostic Interview Short-Form (CIDI-SF). *International Journal of Methods in Psychiatric Research.*

[103] Ware, J. E., Kosinski, M., & Keller, S. (1996). A 12-Item Short-Form Health Survey (SF-12): construction of scales and preliminary tests of reliability and validity. *Medical Care, 32*(4), 220-233; Eisen, S. V., Wilcox, M., Schaefer, E., Culhane, M., & Leff, H. S. (1997). *Use of BASIS-32 for Outcome Assessment of Recipients of Outpatient Mental Health Services*: the Evaluation Center@HSRI.

[104] Straus, M. A., & Gelles, R. J. (1990). *Physical Violence in American Families*. New Brunswick: Transaction Publishers. Also see: Morse, B. J. (1995). Beyond the Conflict Tactics Scale: assessing gender differences in partner violence. *Violence And Victims, 10*(4), 251-272.

[105] Johnson, H., & Sacco, V.-F. (1995). Researching violence against women: Statistics Canada's national survey. *Canadian-Journal-of-Criminology, 37*(3), 281-304; Tjaden, P., & Thoennes, P. (1998). *Prevalence, Incidence, and Consequences of Violence Against Women: Findings From the National Violence Against Women Survey* (http://www.ncjrs.org/txtfiles/172837.txt): National Institute of Justice, Violence Against Women Office.