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PERSPECTIVES

The Need for Mental Health Services Research Focusing on Poor Young Women

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Abstract

Despite the fact that the relationship between poverty and increased risk for a broad spectrum of mental disorders has been documented for several decades, very little is known about providing mental health treatments to poor individuals. In this paper, we emphasize the importance of developing, and empirically evaluating, sensitive and appropriate interventions for poor young women who suffer from common mental disorders.

Who are the US poor?
In the US, nearly 14% of individuals live in poverty, and another 20% in near poverty. The poor are disproportionally women and children such that 63% of female-headed households are poor. Young women and ethnic minorities are over-represented among the poor also, with 55% of those living below the poverty level being minorities.

Needs and Barriers to Care among Poor, Young Women
The poor have more mental disorders than those with more resources. Further, women are twice as likely as men to have a mood or anxiety disorder, including major depression and post-traumatic stress disorder (PTSD), with younger women at higher risk than older women. Research alos indicates that poor women have high exposure to traumatic events and cumulative adversity that is directly related to their mental health. This history may serve, in part, as a barrier to seeking mental health care. Other barriers in this population include lack of insurance, lack of access to primary care where mental disorders might be detected, practical problems like lack of childcare or transportation, and the inflexibility of low-income service jobs. Religious beliefs and attitudes about mental health treatment may play a role as well. Recent policy changes in the US have contributed to the vulnerability of this group as eligibility for welfare programs has reduced, and time limits have decreasd. Services for immigrants are also severely limited, and managed care strategies for those in the public sector may be confusing.

Important, Unanswered Questions
More needs to be learned about the mental health status and needs of poor women, along with the impact of loss of public support on their physical and mental health. Access to mental health care within a managed care setting also needs to be addressed, and care taken to understand the particular needs of poor populations that will actually make these services accessible to them. Insufficient attention has thus far been paid to the cost implications of providing these services to the poor. While providing treatment is associated with significant costs, the costs of not providing care, especially the effects of depression on offspring, should not be overlooked.

Challenges to Examining Mental Health in Poor Women
A number of suggestions were made for addressing practical and methodological challenges to providing mental health services. These include placing services for these individuals within their familiar medical settings, which requires close working relationships between psychiatric and medical personnel within these settings. Outreach is a necessary part of getting poor women into treatment, and should be a routine part of helping women become engaged with caregivers. Providing culturally sensitive treatments is an important focus too, through developing knowledge about the culturally based customs and expectations of target groups. Measurement issues need to be attended to, as most research instruments have been developed on middle class populations, and have not been examined for their psychometric properties and norms in less advantaged groups. Careful translation techniques are also required. Finally, working with institutions sponsoring research to educate them about special problems and challenges with these groups will help improve the quality and efficiency of the work accomplished.

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Despite the fact that the relationship between poverty and increased risk for a broad spectrum of mental disorders has been documented for several decades,[1–3] very little is known about providing mental health treatments to poor individuals. In this paper, we emphasize the importance of developing, and empirically evaluating, sensitive and appropriate interventions for poor young women who suffer from common mental disorders, such as depression. We discuss our own intervention-oriented research work, and highlight some of the major issues and challenges in providing mental health services for this population. Throughout the paper, we focus on young women because young women and their children make up the largest segment of the population who are poor and because young women are at high risk for mental disorders, particularly because of the high rates of adverse events they encounter. We focus our discussion on the following questions. (i) Who are the poor? (ii) What are their needs for, access to, and barriers from mental health care? (iii) What recent major policy changes affect the poor? (iv) What are the important unanswered questions regarding mental health services for those who are poor? (v) Finally, what are the methodological challenges to conducting mental health services research within impoverished populations?

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Who are the US Poor?

To provide mental health services to the poor, we must first consider the demographics of this population. In 1996 the United States government defined the federal poverty level as subsisting on from $0 to $16 036 per year for a family of four. According to Bureau of Census figures,[4] the number of people living in poverty in 1996 was 36.5 million, representing 13.7% of the population. Nearly 40% of those in poverty (the 'very poor') live in families with less than one-half of the income mentioned above. In addition, 52.6 million people live 'near poverty'; that is, having an income higher than the poverty level, but below 200% of the threshold for poverty. This combined group of approximately 89.1 million poor individuals comprises 33.5% of the population.

Poverty is not distributed equally in the United States. The poor are disproportionately women (38%) and children (40%). These women and children tend to live together, such that 62.6% of female-headed households are poor. Not surprisingly, *young* women are often among the poor. Specifically, 76% of women who are poor are between the ages of 18 and 44 years. Although women's incomes frequently do not rise substantially after age 45, the number of children living with them tends to decrease and, therefore, they no longer fall within the poverty range. *Young* children are also over-represented among the poor. In 1996, the overall poverty rate for children under age six was 22.7%. Furthermore, of children under age six living in female-headed households, 58.5% fell below the poverty level. Thus, mental health services for the poor need to target young women and their small children.

Not only are women and children over-represented among the ranks of the poor, but ethnic/racial status is also associated with poverty. The Bureau of Census figures indicate that 54.9% of those living below the poverty level are ethnic minorities. Shockingly, 54% of African American women and 56% of Latinas living in the United States are poor. This compares with only 25% of White women being poor. The foreign-born population is also disproportionately poor when compared with natives of the United States: 21% live below the poverty level. Clearly then, mental health services for the poor will need to include culturally sensitive treatments (including availability in Spanish and other languages) and be available to immigrants whether or not they are citizens.

What are the Needs and Barriers to Care of Poor Young Women?

Need for Mental Health Care

Several lines of evidence suggest that many poor young women are likely to need mental health care. For over two decades, researchers have noted a clear association between poverty and worse mental health.[1–3] Recently, the first study examining mental disorders in a national probability sample in the United States affirmed this link.[5] In addition, women are more vulnerable than are men or older women for incurring common mental disorders.[5–9] Specifically, women are almost twice as likely as men to have a mood or anxiety disorder, including major depression and posttraumatic stress disorder (PTSD), and women have higher prevalence of comorbidity (three or more concurrent disorders) than men. Further, *young* women (under 45) are at higher risk than older women.[5–9] Given that young women are the most vulnerable population for incurring common mental disorders and poverty is an additional risk factor for mental disorders, rates of common disorders should be high among *poor young* women.

Prevalence of Mental Disorders

The few studies focusing on poor, young women have indeed found this group to be at exceedingly high risk for common mental disorders. Bassuk and colleagues[10] studied a sample of the poorest of poor women, homeless and housed women on welfare. Using the Structured Clinical Interview for DSM-III-R,[11] they determined that 12% of the housed women met criteria for current major depression, and 16% met criteria for current PTSD. The rates for the homeless women were similar (10 and 18%, respectively).

We have conducted two studies examining rates of mental disorders among poor young women. In the first, we used the Prime MD,[12] developed to detect mental disorders in medical settings, to study women attending a public sector gynecology clinic at San Francisco General Hospital.[13] These young women (mean age 29 years) were ethnically diverse (i.e., 44% Hispanic, 30% Black, 18% White and 8% mixed/other). All were either uninsured or receiving public medical benefits. In this sample, 22% met criteria for current major depression. This compares with a 4–6% rate among women in the community.[5] Even if instrument differences (Prime MD versus CIDI) account for some of the excess in rates for the poor women, method variance is unlikely to account for all of the difference. Poor young women have substantially higher rates of depression than do women in general.

In the second pilot study, 567 women were screened in public sector family planning clinics in Prince George's County, MD, a suburban county near Washington, DC.[14] The Prime MD was again used to assess depression. The mean age was 27 years. Approximately 63% were identified as African American, 14% Latina, 14% White and 9% of either mixed or other heritage. Sixty-four percent of these women were uninsured and 24% were receiving public medical benefits. One-quarter of the women met criteria for current major depression. We also assessed PTSD, and found that 16% of the public sector women met criteria. This compares with 5% of women in the same range in a national survey.[15] Again, method variance undoubtedly accounts for some of the difference, but with rates three to four times higher than in more general samples, it seems unlikely that instrument selection alone can explain this divergence. These studies clearly document extremely high rates of mental disorders among poor young women.

Need to Address Sequelae of Trauma

In order to understand the need for mental health treatment among the poor, lifetime exposure to traumatic and stressful events should be taken into account. Stressful life events are frequent occurrences among the poor,[16,17] and exposure to trauma has been found to be higher in samples with the lowest levels of education.[18] Both of these factors have been linked to subsequent mental disorders.[9,17,19] Yet disadvantaged populations have fewer and less adequate resources for coping with stressful and traumatic life events than do more affluent groups.[20] These factors likely converge to lead to higher rates of mental disorders and need for treatment among the poor.

Unfortunately, young women are more likely to experience life stressors that are most associated with poor mental health outcomes than are men. This difference is well documented in a recent study[19] of cumulative adversity. There were several sex differences in reports of stressful life events in that study that either made intuitive sense or had been documented previously in the literature. Specifically, men reported higher incidences of accidents and illnesses, having injuries resulting in disability, having to repeat a year of school, being sent away from home and having traumatic combat-related experiences. On the other hand, women were more likely to report an unfaithful partner, a spouse addicted to alcohol or drugs, being physically abused or sexually abused or losing a spouse, child or loved one as a result of death. These stressors were then related to gross relative risk for lifetime mental disorder. Of the six stressors more common to men, only three were associated with lifetime psychiatric disorders, and those were at relatively low levels (1.2, 1.3, 1.5). Conversely, of the six events more associated with women's lives, all were related to lifetime mental disorders, and the rates of relative risk were high (1.2, 1.4, 1.8, 1.8, 1.9, 1.9).

In our research with poor women, trauma does influence poor women's need for mental health treatment. Using an expanded version of the trauma exposure questions from the National Comorbidity Survey,[9] we found that poor women attending family planning clinics in Prince George's County, MD, reported high rates of exposure to trauma. In fact, 24% reported a history of rape, 22% reported having been sexually molested, 33% reported being victims of physical attacks and 20% reported a history of physical abuse. Using the same instrument in the general population, 9, 12, 7 and 5%, respectively, of women reported these traumas. Furthermore, number of traumas experienced was positively related to experiencing mental disorders in our poor sample.

Bassuk *et al.*[10] also assessed lifetime exposure to sexual and physical victimization, using a comprehensive interview. They found that 60% of the housed and 67% of the homeless women reported severe physical violence by childhood caretakers before the age of 18; 43% of the homeless and 42% of the housed reported prior sexual molestation; 58% of the housed and 63% of the homeless reported violence by an adult partner and 20% of the housed and 25% of the homeless reported physical or sexual assault by non-intimates in adulthood. Exposure to trauma appears to be notably higher among these poor young women than in a more general population.

Clearly, trauma contributes to need for mental health care among poor young women. Unfortunately, trauma history may also serve as a barrier to seeking mental health care. In our experience, poor young women with histories of extreme trauma are difficult to recruit for treatment. Fear of re-traumatization through discussing the trauma or fear of betraying perpetrators by talking about the trauma may serve as a barrier to care. Further study of the role of trauma history in the need for, access to and acceptability of mental health care for poor young women should be undertaken.

Need for Intervention

Left untreated, the mental disorders common among these poor women lead to significant disability.[21–23] Although these disorders should be treated simply to reduce the personal pain and suffering that they cause for the women, recent findings suggest that we should also treat the mothers to reduce risk in their children. For example, women who are depressed show deficits in parenting,[24–26] and their children show more psychiatric morbidity and poorer interpersonal and academic functioning than do children of non-impaired parents.[27–33] In fact, the long range mental health and functioning of the large group of children under the age of 6 who live in poverty may be heavily dependent on the mental health of their mothers.

Access and Barriers to Mental Health Treatment

Although there are efficacious treatments that abbreviate the suffering and disability associated with mood and anxiety disorders, poor young women are particularly unlikely to seek mental health treatment. For example, in our Maryland study of poor young women, only 1 of 145 depressed women that we evaluated was currently receiving mental health treatment. Below we will consider the many barriers that limit access to mental health care for poor young women.

A major barrier to all forms of medical care for poor young women is their lack of insurance. Low-income women are more than three times as likely to be uninsured as non-poor women.[34] Only 21% of women in poverty and 56% of those near poverty have private health insurance. Over 30% of women in poverty have no insurance, while the remainder have access to Medicaid, often only temporarily while pregnant.[34] Approximately 10% of poor women purchase their own individual private health insurance.[34] These policies are frequently expensive, and may be less comprehensive than employer-based policies. Thus, even poor women with insurance may be responsible for out-of-pocket expenses, which may create unacceptable financial burden. Furthermore, mental health benefits are frequently excluded from such policies, or are still prohibitively priced for the poor.

Among the non-poor, most individuals with a mental

disorder fail to seek treatment in mental health settings.[5] Increasingly, mental health problems are being detected and treated in primary care settings.[35] Unfortunately, this method of getting mental health treatments to those in need still misses a very large segment of poor young women because they lack access to primary care medical services. Although little data exist regarding medical utilization patterns of poor young women, three types of care are most likely. (i) A small group of poor women at an income level some percentage (set by states) below poverty level (e.g., 45% of poverty level in Maryland, or $5034 per year for a mother and two children) have previously been eligible for Aid to Dependent Families and for Medicaid that provides access to managed care clinics. However, as Aid to Dependent Families is being phased out, even fewer women are eligible for Medicaid. (ii) Pregnant women (during pregnancy only) are eligible for Medicaid if they live at 185% of the poverty level and are documented US residents. (iii) Women who have incomes above 45% of the poverty level, and who are currently not pregnant, are often uninsured, and they may have *no access* to primary care. They do, however, have access to family planning services administered by the county-operated Departments of Public Health, funded by Federal Title X. Therefore, mental health services could be linked to both Medicaid clinics and family planning clinics in order to reach this population.

There are additional structural barriers to mental health care, apart from insurance and capacity to pay for services. Many poor young women are sole caretakers for their children, and, further, do not own cars. These constraints mean that many of them may not be able to afford weekly babysitting fees to attend treatment, and may lack reliable and/or affordable transportation. In our current study of providing mental health treatment for poor young women, for example, we found it was important to provide both babysitting and transportation to enable many of the women to attend treatment. Such arrangements may be crucial in recruiting women to treatment.

Another barrier to care is the inflexibility of low-income service jobs. Women employed in these jobs are often unable to obtain time off from work to attend treatments. Therefore, treatment planning needs to be flexible in this regard. Further, women who are unemployed are often ill prepared for regular attendance at treatment. For example, one woman we treated missed an early appointment because it was raining and she did not own an umbrella. When she got drenched waiting for a bus, she decided to return home. Overcoming these multiple barriers to care is an important aspect of providing mental health services for poor young women.

In addition to more practical/structural issues, attitudes towards mental health treatments among those who are poor can serve as a barrier to care. In focus groups we have conducted as a preliminary phase for a treatment study, women have told us that they are concerned about the meaning of obtaining mental health treatment: specifically, they worry that it indicates that they are crazy or that the problems they are having are their fault. They reported worrying most about medications. Fears in this realm included concerns that they will be 'out of control' when they are on medications, that they will become addicted or like 'zombies' and/or that they will be seen as crazy if taking medications.

Religious beliefs may also play a role in decisions to enter mental health treatment. Some women are concerned that coming to treatment will not be appropriate given their religious convictions. For example, one women told us that her depression was between her and God, and she felt it would violate her beliefs to seek mental health treatment. Similarly, many Latinas we have treated indicate that their religious beliefs include an assumption that suffering on earth can lead to a better afterlife. However, we have also found that religion can be very beneficial in recovery from depression. Therefore, we try to educate women about depression, while at the same time honoring and encouraging their religious convictions.

Clearly, educational and supportive approaches should be evaluated as ways to overcome attitudinal barriers to mental health care. We find that two approaches are useful. First, providing outreach in the form of telephone calls and home visits is extremely helpful in engaging poor young women in treatment. Second, getting women together in educational groups is helpful in introducing them to mental health treatment. They often say that they have not been able to discuss important issues with others and that the support from talking with others is extremely helpful. These interactions seem to help break down some of the attitudinal barriers to care experienced by poor, young women.

What Recent Policy Changes Affect Poor Young Women, Including Changes that may have an Impact on their Mental Health and their Access to Mental Health Care?

Recent legislation has created sweeping changes in entitlement programs and singled out immigrant populations for particularly harsh limits. As a result, the design and organization of services for the poor have been radically altered. In addition, health care reform has resulted in major changes in the way medical services are financed and provided to both low and higher income individuals in the United States. These changes, reviewed below, have clear implications for access to mental health services for poor young women, and, further, may place women at greater or lesser risk for mental disorders.

Welfare Reform

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 eliminates the open-ended federal entitlement program of Aid to Families with Dependent Children (AFDC) and creates a new program called Temporary Assistance for Needy Families (TANF), which provides block grants for states to offer time-limited cash

assistance to families well below the poverty level. Under the former AFDC system, families with children who did not have parental support were eligible for benefits as long as they met income criteria for the program (generally well below the poverty line).

Previously, poor (young) women could rely on welfare to provide a minimal income for them and their children when the need arose. Under the current law, states cannot use federal funds to provide assistance to families who have received cash assistance for five cumulative years (or less, at state option), with only up to 20% of the caseload exempted from this time limit. Further, single parents are now required to work at least 20 hours per week, and two-parent families must work 30 hours per week.

Under the former laws, AFDC benefits were available to each eligible dependent child and parent, regardless of the parent's age. Under the new law, unmarried minor parents are required to live with an adult, or in an adult-supervised setting, and participate in educational and training activities in order to receive assistance. Furthermore, states have complete flexibility to set a family cap policy, not providing support for additional children. Finally, former AFDC recipients will lose Medicaid after a period of up to one year of transitional support once they have exited the welfare system.

These sweeping changes in welfare have strong implications regarding the need for and access to mental health care for poor, young women. First, the dual demands of single parenting and entering the work force are likely to be particularly problematic for poor young women who already suffer from mental disorders such as depression and posttraumatic stress. Further, these dual demands may lead *de novo* to anxiety and/or depressive disorders as women ill prepared for employment are forced into jobs. At the same time, loss of Medicaid benefits could limit access to mental health treatments. Whereas those former welfare recipients who are successful at entering the job market may learn a new sense of independence, as well as enhanced self-esteem, both of which may improve mental health, those who experience development or exacerbation of mental health problems may have difficulty getting treatment if insurance covering mental health treatment is not available.

Services for Immigrants are Severely Limited

Welfare reform has also limited government benefits for legal immigrants by barring federally funded public benefits for the first five years they are in the country and 'deeming' all federal means-tested programs for new immigrants once they are eligible. Deeming means that the sponsor's income and resources are considered, or 'deemed', available to the immigrant when determining program eligibility and amount of benefits. In addition, current and future legal immigrants are barred from receiving SSI and Food Stamps until they become citizens. States have the authority to determine eligibility for all state and local public benefits.

Undocumented immigrants, those who are in the United States 'illegally', are barred from nearly all *federal* public benefits. In addition, states may not provide *state or locally funded benefits* to undocumented immigrants unless the state enacts a law. Prior to this, undocumented women were eligible for Medicaid maternity benefits. Following this law, these are not being provided for in many states.

These restrictions on immigrants are likely to have implications for their mental health, and their access to mental health interventions. First, restricting benefits may lead to increased poverty among immigrants. Given the link between poverty and mental health, one would anticipate increased mental health problems for this impoverished group. In addition, by removing access to Medicaid, these individuals are no longer eligible for mental health treatments in the public sector. Therefore, impoverished recent immigrants will have very little access to mental health interventions, apart from volunteer efforts available in some communities.

Medicaid Managed Care

Medicaid beneficiaries are rapidly being moved into managed care settings. Medicaid managed care enrollment increased by 140% from 1993 to 1995.[36] All but six states have applied for a 1915b waiver from HCFA to introduce some form of managed care for Medicaid beneficiaries. In addition, many States are using a 'carve-out' program, which places mental health services under a separate insurance contract from other medical care.[37] These changes may make gaining access to mental health treatments more confusing, and treatment may appear less available to individuals now that public hospitals and clinics are not the providers of such services. On the other hand, managed Medicaid enables poor women to access different providers (i.e., not only those who provide care to the poor) and may generally enhance medical care.

In the United States and many other countries, health care is largely private and the role of publicly funded health care is relatively small. Developing managed care contracts for Medicaid was an explicit strategy to lower public health care costs in the United States. However, in other countries, the majority of health care is publicly funded and managed. Many countries use expenditure caps to control public sector costs.[38] A comparison of the impact of these strategies on the poor would be useful. In particular, determining whether these cost-reducing strategies lower rates of care for vulnerable young women and their children would be important in understanding the harm the strategies could cause.

What are the Important, Unanswered Questions Regarding Mental Health Services and Poverty, Given the Recent Legislation?

Several important questions regarding mental health services and the poor revolve around changes in welfare or AFDC benefits. The first has to do with the mental health of this

target group. Unfortunately, very little is known about the mental health of women on welfare. Only one study to date has looked at rates of mental disorders in welfare populations. This study,[10] reviewed earlier, found high rates of mental disorder (10–12% with current major depression, 16–18% with current PTSD). Clearly, mental disorders may impair women's abilities to gain and maintain employment. More research needs to be done to address the impact of mental disorders on welfare recipients' capabilities to be employed.

The welfare legislation raises another important question relative to poor women's mental health. Specifically, what is the impact of losing AFDC on women's mental health? AFDC was originally proposed as a method of protecting vulnerable individuals. Clearly, protection from the demands of the work force, particularly for single women with young children, could have positive implications for mental health. Young women with children who are compelled to enter the work force may experience an increase in mental health difficulties, with resultant need for more services for this population.

Data from our recent study of women seeking public sector family planning services could lead to the speculation that receiving welfare benefits is *protective* for mental health status among the poor. In that study,[14] 42 women were currently receiving welfare and 227 were uninsured. Comparing these two groups in terms of mental disorders, the uninsured sample had exceedingly high rates of current major depression and PTSD (33 and 20%, respectively), whereas the women receiving AFDC had lower, albeit still high, rates of disorder (16 and 14%, respectively). This difference in rates suggests that the women without insurance may be more vulnerable to mental disorders. These latter rates of mental disorders for the AFDC participants in our study were quite similar to those for the housed welfare sample in the Boston study[10] (12% for depression and 16% for PTSD). On the other hand, their findings could be interpreted differently. The presence of a mental disorder may inhibit women from applying for welfare. This would also explain the finding that uninsured women report more mental health problems. Obviously, these data are only suggestive, but, nonetheless, indicate the need to study the impact of welfare reform on the mental health of poor young women, as well as understanding the impact of welfare reform on their need for services.

Another important question to be answered from recent policy changes is how access to mental health treatment is affected by Medicaid moving to managed care settings. As previously noted, mental health care is now often contracted separately from primary health care, using agencies in unfamiliar settings, which may reduce use even when treatments are available. In addition, moving care for the poor from county hospitals set up to serve the poor to general managed care settings is likely to have an impact on use of services. Early research suggests that poor individuals receiving mental health care from providers who have special interests in serving the poor do much better, and drop out less often, than do those who receive care from providers who do not have such interests.[39] Overall, studies are needed to determine the impact of managed care and moving care out of public sector clinics on Medicaid recipients' abilities to obtain needed mental health care.

The current laws that prohibit services to immigrants also raise important issues for study. Clearly, poor immigrants are not going to have access to mental health services. However, in most states, they will be entitled to emergency services. By denying access to earlier, and more prevention-oriented care, these folks may not only suffer more, but also eventually cost the system more money. Understanding the impact of denying benefits to legal immigrants, in terms of need for mental health services, access to services and downstream costs, would be an important arena for study. In addition, the long-term implications of denying Medicaid coverage to pregnant, undocumented women, given that their children will be US citizens, should be addressed.

Finally, many studies have looked at the cost implications of treating major depression. These studies have generally had a fairly short-term cost picture, focusing on work productivity. However, treating depression in poor young women may have important long-term consequences as well. As previously mentioned, a large literature now documents that maternal depression has devastating consequences for offspring. Therefore, the cost effectiveness of treating maternal depression should be examined within the context of the cost of disability in offspring of depressed parents.

What are the Methodological Challenges to Examining Mental Health Services for Impoverished Young Women?

Throughout this paper we have documented the tremendous need for effective mental health interventions for poor young women. Effective interventions could influence both the functional status and quality of life of poor women. Furthermore, they could potentially influence the mental health and functioning of the children these women are raising. It is therefore important to develop methods for overcoming the challenges to mental health research in impoverished populations.

Placing Services within Medical Settings

The first major methodologic problem for mental health services research with impoverished populations is developing ways to get interventions to patients. Typical studies of mental health interventions have not included impoverished persons because they do not tend to seek mental health care. However, low-income and minority patients are often seen within medical settings and can be identified and encouraged to seek treatment within those settings. In fact, the World Health Organization examined the incidence of untreated mental disorders in 15 countries world wide and concluded that medical settings are appropriate to care for mental disorders throughout the world.[40] Great Britain was the first country to move forward on identification and treatment of psychiatric disorders in

primary care settings.[41–43] In the past decade, other countries have also pursued this area.

Medical settings have proved successful in identifying and intervening with poor patients as well as middle class patients. For example, Lieberman *et al*.[44] conducted an intervention to improve the quality of attachment in young infants of Latina mothers who had been in the United States less than 5 years. In that study, mothers were recruited from San Francisco General Hospital, a setting in which they were accustomed to receiving their obstetric care. In the first study to examine treatment of depression in poor, multi-cultural medical patients, Miranda and colleagues (in preparation) received referrals from primary care physicians treating this population at San Francisco General Hospital. The study treated the patients within the setting of their primary medical care.

Because medical settings provide access to poor patients, establishing close working relationships between psychiatric and medical personnel within such settings is essential. In our recent work with the public sector family planning clinics associated with Prince George's County Department of Public Health, we spent one year working closely with staff from that program prior to beginning the study. For example, we provided training in 'dealing with difficult patients' for nursing and clerical staff. We attended regular staff meetings with administrators of the programs. Our bilingual staff translate for monolingual nursing staff when needed, watch small children while women receive medical care, etc. to make ourselves a useful part of the team seeing patients. As a result of these efforts, we now have an excellent working relationship with staff in our research setting.

Engaging Improverished Patients in Treatment

In order to get poor young women into treatment, outreach is necessary. Although initially we were concerned that we were being too intrusive when calling prospective patients repetitively to schedule appointments, upon inquiry, we were uniformly told that our repeated efforts assured them that we cared and wanted to help them. Therefore, we provide extensive outreach efforts to engage patients and help them overcome the various barriers that may keep them from treatment.

To maintain impoverished patients in treatment, providing culturally sensitive treatment is necessary. For example, in the Lieberman *et al*. study[44] mentioned above, the overarching atmosphere of the study was of the warmth consistent with Latino culture. For example, all mothers and babies received birthday cards. Similarly, the outcome evaluation was scheduled on the week of the child's second birthday and culminated in a celebration that included cake and a small gift for the child. Attrition from this one-year intervention study was only 7%, despite the marginalization and high mobility characteristics of the sample.

Measurement in Impoverished Samples

A major issue for studies of impoverished, multi-ethnic populations is measurement. Although a few studies have examined psychometric properties of instruments that have been translated into other languages, many instruments typically used in research studies have not been translated or normed with this population. Our approach to this dilemma has been twofold. First, we carefully examine all instruments to make sure that they make sense to our population. For example, measures that assume middle-class values or use many idioms of speech are undesirable. We next carefully translate instruments into Spanish for our research, using back- and forward-translation techniques.[45] We try to use consensus translations, in which the team represents a cross-section of Latino culture. We then examine the psychometric properties of the English and Spanish language instruments within our projects. Although this method is not perfect, it allows us to move forward with important research on interventions with an underserved population, and, hopefully, bootstrap measurement improvement into our studies.

A final problem in conducting both services and research in this population can be bureaucratic obstacles to this research. For example, the requirement of keeping social security numbers when reimbursing subjects for participation in research is an obstacle to involving non-citizens in research. Similarly, Institutional Review Boards governing research are often particularly wary of approving research with vulnerable populations. Additional meetings with institutional units associated with the approval and implementation of such studies may be necessary to educate them about the special needs of such studies as well as the importance of the work. Clearly, establishing a track record of what works, and providing interventions to this population, rather than simply 'studying' them, aids in overcoming these obstacles.

Conclusion

In this paper, we have documented the tremendous need for development of interventions and effectiveness research addressing mental health needs of the poor, focusing on the plight of poor young women and their children in the United States. This is a population with tremendous need for services. In addition, due to recent legislation, a number of important issues should be addressed to insure that public policy does not further endanger the mental health and access to care of this vulnerable population.

Although this paper has focused on poor women in the United States, the findings are most likely pertinent for poor women throughout the world. Epidemiological studies of psychiatric disorders carried out in African, Asia, the Middle East and Latin America have identified higher rates of disorders in women as opposed to men.[46] Furthermore, the disability-adjusted life year study recently completed by the World Bank[47] found that depressive disorders accounted for 30% of the disability from neuropsychiatric disorders suffered

by women worldwide, whereas depression accounted for only 12.7% of disability for men. Improved detection and treatment of mental disorders among poor women is called for throughout the world.

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