

Multiple and severe disadvantage among lone mothers receiving income support



Efforts to improve the social and economic participation of lone mothers receiving welfare should be mindful of the obstacles experienced by many of these women, and recognise the need for appropriate support and services for those who require assistance.

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Since 1999, reform of the income support or welfare system has been a priority of the Australian Government. One of the key client groups targeted by the reforms and policy initiatives is lone parents, particularly lone mothers who comprise the vast majority of lone parents. The aim of this paper is to quantify the extent to which lone mothers experience personal circumstances – or barriers – that are likely to impede or make more difficult their transition into employment.

The paper outlines the key aspects of welfare reform in Australia, then discusses research examining barriers and obstacles to employment and workforce participation, and the prevalence and consequences of these factors for lone mothers. Drawing on data from the National Survey of Mental Health and Wellbeing, conducted by the Australian Bureau of Statistics, it sets these issues in an Australian context.

The Australian experience of welfare reform

Although welfare reform is an international phenomenon, the Australian experience is unique in terms of the drivers of reform and the responses

being implemented (FaCS 2002). An obvious impetus of welfare reform is concern about the growing number and percentage of people of working age receiving income support payments.

Some policy analysts question the sustainability of current welfare expenditure. Maximising workforce participation and productivity among people of working age will also be increasingly important in an environment in which, over the next 50 years, structural ageing will reduce the proportion of the Australian population of working age.

Analysts are also concerned that passive welfare promotes a culture of dependency and the development of attitudes and values inconsistent with work (Mead 2000). There is also concern about the number of children growing up in jobless families and the related issue of trans-generational welfare dependency (McCoull and Pech 2000).

Other drivers of welfare reform include: addressing the complexity of the current system; modernising the system to reflect current community views and family structures, and to match current labour market conditions; and addressing financial disincentives to work.



The central element of welfare reform is an emphasis on participation (involvement in work or work-like activities) as a prerequisite for receipt of payments rather than a passive income support system. Promoting involvement in economic and/or social activities is a strategy to promote or maintain welfare recipients' self-sufficiency and independence. In Australia, mutual obligations and activity requirements are strategies used to promote active participation.

However, welfare reform in Australia has a broader focus. Participation requirements are designed to match each individual's abilities and capacity (FaCS 2000). Welfare reform also involves targeted and individualised assistance. A range of services and programs (for example, Personal Support Program, Personal Advisers) have been implemented to support individuals to achieve these aims and provide assistance to those with substantial barriers to participation in the workforce.

Why lone mothers?

In Australia, 22 per cent of families with children aged under 15 are lone-parent families, and most of these (around 90 per cent) are headed by women. Around

20 per cent of Australian children live in lone-parent families (ABS 2002). Lone mothers are more likely to be income support recipients than partnered mothers, and they are also less likely to be working. There are particular concerns about the welfare of children in jobless families. The majority of jobless families are headed by unpartnered women (FaCS 2002).

Lone parents are one of the client groups targeted by the range of welfare reforms which are either being implemented or planned for the future. For example, those people receiving Parenting Payment (including lone mothers) with young children (aged 6–12 years) will be required to have annual participation interviews with a Personal Adviser, and those with older children will be required to undertake six hours of activity per week (FaCS 2000).

In United States welfare research, concerns have been expressed that a substantial minority of lone mothers have not benefited from the introduction of a more active welfare system and have had difficulty moving off welfare and into employment (Danziger, Corcoran et al. 2000; Jayakody, Danziger and Pollack 2000). As a result, there have been efforts to identify and understand the types of personal characteristics

that may be an obstacle to employment. Recent Australian research examining longitudinal income support data has shown that many lone mothers spend a considerable period of time on welfare, both on Parenting Payment Single and other income support payments (Gregory and Klug 2001).

Thus, for a variety of reasons it is important to examine the types of barriers and obstacles that may limit these women's opportunities to move into employment and cause them to spend longer periods of time on welfare.

Examining different types of barriers

Most research on the employment of welfare recipients examines the role of structural barriers such as access to child care, transport issues, job availability

characteristics. Evidence shows that many lone parents on welfare have poor levels of education, do not have job-relevant skills, and lack workforce experience, and that these characteristics are associated with continued receipt of welfare and unemployment (Danziger, Corcoran et al. 2000; Kalil, Schweingruber, and Seefeldt 2001; Olson and Pavetti 1996).

Using Australian data, Gray, Qu, de Vaus and Millward (2002) demonstrated that human capital and other socio-demographic characteristics, such as level of educational attainment, number of children, regional location, and home ownership, are associated with employment for both partnered and lone mothers. Many social policy responses emphasise these human-capital aspects (for example, transition-to-work; Jobs, Education and Training program).



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and financial disincentives (Jayakody and Stauffer 2000). This approach is inappropriate when the objective is to explain the variability in the outcomes achieved by lone mothers in similar circumstances. The research that has examined personal barriers to employment has concentrated on human-capital

There is also growing recognition in international research and policy that psychological and personal characteristics such as poor mental health, substance use disorders, physical health problems, and domestic violence are more prevalent among welfare recipients and that these characteristics represent a substantial barrier to increased workforce participation, self-reliance and movement off welfare (Danziger, Corcoran et al. 2000; Danziger, Kalil and Anderson 2000; Horwitz and Kerker 2001; Jayakody et al. 2000; Jayakody and Stauffer 2000; Kalil et al. 2001; Salomon, Basuk and Brooks 1996; Tolman and Raphael 2000).

The available literature comes mainly from the United States. While there is limited local research

ABOUT THE MEASURES

This section provides detail of the measures used to construct each of the five categories of barriers. Further information about the scales and scoring methods is available in Butterworth (2002).

- **Human capital barriers:** The survey collected socio-demographic information including labour force history (no labour force experience) and educational attainment (not completed secondary education). Individuals were considered to have a human capital barrier if they met either one of these criteria.
- **Mental health barrier:** The primary diagnostic component of the survey was based on a computerised version of the Composite International Diagnostic Interview (CIDI) Version 2.1. The CIDI is a fully structured standardised interview used to assess mental disorders in research settings and provide diagnoses according to standard and accepted definitions and criteria. This analysis used the International Classification of Diseases, 10th revision (ICD-10) classification to identify the presence of any anxiety disorder or any depressive disorder in the previous 12 months. The Kessler 10

scale of psychological distress identified respondents with a substantial level of psychological distress during the previous month (those with a score of 20 or greater). Psychosis screening questions identified respondents likely to have schizophrenia or schizoaffective disorder. Individuals were considered to have a mental health barrier if they met criteria for any one of these disorders.

- **Substance use disorders:** The CIDI was also used to identify survey respondents meeting the ICD-10 criteria for harmful alcohol use or dependence, or harmful drug use or dependence in the previous 12 months.
- **Physical conditions and disability:** A 12-item scale was used to identify self-reported common chronic physical conditions. These included asthma, chronic bronchitis, anemia, high blood pressure, heart problems, arthritis, kidney disease, diabetes, cancer, stomach or duodenal ulcer, chronic gallbladder or liver problems and hernia or rupture. Respondents with a standardised scale score of below 40 on the physical-health summary scale of the SF-12 were cate-

examining these issues, the direction of welfare reform in Australia shows that the importance of these types of personal barriers has been recognised and that the issue is on the policy agenda. What is not known, however, is the extent and prevalence of these types of barriers among welfare recipients in Australia.

Mental disorders are the leading cause of non-fatal disease burden in Australia (Mathers, Vos and Stevenson 1999). That is, mental health problems are the cause of the greatest level of impairment, functional limitation and role restriction. Mental disorders significantly reduce workforce participation, hours able to be worked, and productivity at work (Kessler and Frank 1997).

Mental health problems are also an important predictor of welfare recipients' continued reliance on welfare or movement into employment. The study of low-prevalence disorders conducted as part of the Australian National Survey of Mental Health and Wellbeing (Jablensky et al. 1999) found that 85 per cent of people with psychotic disorders rely on government payments. Common mental disorders, such as anxiety and depression, are much more prevalent than psychotic disorders, and are also associated with difficulty finding and maintaining employment, receipt of welfare, and low income (Danziger, Kalil et al. 2000; Jayakody and Stauffer 2000; Olson and Pavetti 1996). Given the well-documented relationship between mental health and socio-demographic factors such as unemployment, poverty and sole-parent status, it is not surprising that the prevalence of mental health problems is greater among lone mothers on welfare than in the general population (Butterworth 2002; Danziger, Kalil et al. 2000; Olson and Pavetti 1996).

Research on the association between alcohol and drug use and welfare receipt is less consistent, partly reflecting the use of many different types of measures in the research. International evidence shows that illegal drug use and drug dependence is

more prevalent among welfare recipients, while alcohol use/dependence is not consistently shown to be more prevalent among welfare recipients (Danziger, Kalil et al. 2000; Jayakody et al. 2000; Olson and Pavetti 1996). Nonetheless, alcohol and drug use is commonly cited as a major impediment to employment (Jayakody et al. 2000).

Lone mothers on welfare also report greater levels of physical disability and poorer physical health than those not receiving welfare (Danziger, Kalil et al. 2000; Olson and Pavetti 1996). It was shown by Kalil et al. (2001) that lone mothers on welfare with chronic physical health problems were much less likely to be working than those without health problems. In a recent review, Baker and Tippin (2002) concluded that poor physical health was a barrier to employment for lone mothers on welfare.

Finally, this analysis also considers lone mothers' experience of physical and sexual violence. There are several reasons for considering this issue. Experience of domestic violence has been identified as a barrier to employment, both indirectly through an association with poorer mental and physical health, and directly through an abusive (former) partner's interference in the workplace, or with efforts to improve skills or education (Danziger, Corcoran et al. 2000; Tolman and Raphael 2000).

In research relevant to current concerns about long-term welfare receipt in Australia, Salomon et al. (1996) found that women who cycled on and off welfare reported much higher levels of violence and abuse than those with only a single episode on welfare. There was a strong association between long-term welfare receipt and experience of domestic violence. These measures of violence are also relevant as experience of significant trauma may be a barrier to help-seeking behaviours (Miranda and Green 1999). Childhood abuse is associated with increased risk of later relationship difficulties, divorce/separation, and lone-parent status (Bifulco, Brown and Adler 1991).

gorised with a moderate or severe disability. Respondents were classified with a physical health barrier if they reported any of the physical conditions or met the physical disability criterion.

- *Experience of traumatic events (physical and sexual violence):* Personal experience of physical and sexual violence was indexed by items from the post-traumatic stress disorder component of the CIDI. The four items analysed reflect reported lifetime experience of rape, sexual molestation, serious physical assault or attack, and attack with a weapon or torture. Respondents reporting any of these were considered to have a trauma barrier.

ABOUT THE ANALYSES

The percentage of women in each group with each of the individual conditions, traumatic experiences or characteristics, was calculated, as was the percentage identified with each type of barrier (Table 1). Logistic regression models confirmed that lone-mother recipients were more likely to experience each type of barrier than other mothers.

These analyses focus on odds – a common approach in medical and clinical research. Odds provide a measure of the risk that

members of a group have a particular condition or experience. For example, the odds or the risk of lone-mother recipients having a mental health problem is the number of women with a mental health problem divided by the number who do not have a mental health problem. *Odds ratios* can be calculated by dividing the odds for one group (lone-mother recipients) by those for another group (all other mothers). The result provides a direct indication of the greater or lesser risk of having a particular condition for those in one group compared to another. For example, the odds (or risk) of a lone-mother recipient having a mental health problem are almost three times (2.97) that of other mothers. Odds ratios for each type of barrier are presented in the final column of Table 1.

Formal statistical analysis were also conducted to confirm the significance of the greater prevalence of multiple barriers among lone-mother recipients. One-way analysis of variance and poisson regression confirmed that lone-mother recipients experienced more barriers than other mothers.

Data were analysed using SPSS and STATA. Data were weighted to reflect the probability of selection within the population.

Finally, many researchers hypothesise that mental disorders and substance-use disorders are often a consequence of earlier traumatic experiences. It could be that welfare recipients have greater exposure to trauma across their lives (Turner, Wheaton and Lloyd 1995) or, alternatively, have fewer resources (financial, social support, resilience, coping skills) to adequately manage life's stressors (McLeod and Kessler 1990).

Multiple barriers

There is evidence that the co-occurrence of barriers is associated with more negative consequences than the presence of a single barrier. For example, Kessler and Frank (1997) found the level of work impairment experienced by workers with multiple common mental disorders was much greater than that of workers with only a single mental disorder. American research on welfare recipients indicates that the presence of multiple barriers, particularly where these barriers are from different domains (for example, a mental health problem together with physical disability) is much more limiting than a single barrier (Danziger, Corcoran et al. 2000; Danziger, Kalil et al. 2000; Olson and Pavetti 1996). Lone mothers on welfare who experience multiple obstacles have more difficulty finding and maintaining employment and are less likely to move off welfare.

The research discussed has been primarily conducted with welfare populations in the United States. It is important to examine these issues in an Australian context. The aim of this paper, therefore, is to estimate the prevalence of the individual types of barriers amongst Australian lone mothers receiving income support, as well as exploring the extent to which these barriers co-occur.

The Australian context

This paper reports analysis of data from the National Survey of Mental Health and Wellbeing, conducted by the Australian Bureau of Statistics in 1997. The survey was designed to provide data on the prevalence of common mental disorders, the associated levels of disability, and the use of health services in Australia. The survey was based on a representative sample of people aged 18 or over in Australian households. There were 10,641 respondents, with a response rate of 78 per cent.

The analysis is restricted to female respondents of workforce age (those aged under 60) and who were parents (defined as having a child aged 16 or under in home and previously given birth to a child).

Within this category, three groups were identified.

- The group of primary interest in the analysis comprised women who reported that they did not have a partner (separated, divorced, widowed or never married), *and* that government allowances or payments were their main source of income: 398 lone-mother recipients.
- A control (comparison) group comprised women who reported that they were married or living in a de facto relationship, *and* that government allowances or payments were their main source of income: 425 partnered-mother recipients.
- In the third group were women who reported that government allowances or pensions were not their main source of income regardless of relationship status: 1409 non-recipient mothers (unweighted).

There were a number of different measures examined for each of the five categories of barrier (see Box 1).

Table 1 Per cent of mothers in each group with each type of barrier. Odds ratios compare lone-mother recipients' risk with that of other mothers combined

Types of barriers	Lone-mother recipients a (%)	Partnered-mother recipients b (%)	Non-recipient mothers c (%)	Odds ratios Comparison of risk for lone-mother recipients and all other mothers a vs (b & c)
Individual conditions, traumas, characteristics				
<i>Human capital barrier</i>	75	64	52	2.48
Not completed secondary education	75	63	52	
Never worked	4	6	1	
<i>Mental health barrier</i>	47	27	22	2.97
Depressive disorder	20	10	9	
Anxiety disorder	30	15	11	
Substantial psychological distress	29	18	11	
Positive to psychosis screeners	5	1	1	
<i>Substance use barrier</i>	12	4	3	3.86
Alcohol use disorder/dependence	10	3	3	
Other sub use disorder/dependence	5	2	1	
<i>Physical condition or disability</i>	47	33	32	1.90
Moderate /severe physical disability	18	15	11	
Common physical conditions	40	28	25	
<i>Physical/sexual violence</i>	47	23	21	3.31
Rape	19	7	6	
Sexually molestation	24	9	10	
Serious physical attack/assault	26	9	7	
Threatened with weapon or tortured	21	7	7	



Striking differences were observed in the prevalence of mental health problems, substance use disorders and lifetime experience of physical and sexual violence.

Those without any work experience or who had not completed high-school were classified with a *human-capital barrier*. Women were considered to have a *mental health barrier* if they reported symptoms of an anxiety or depressive disorder, had a clinical level of psychological distress, or were identified by psychosis screening questions. *Substance use barriers* were based on the presence of alcohol or substance-use or dependence disorders. Women identified with a chronic physical condition or who reported substantial physical limitations were considered to have a *physical health barrier*. Women were classified as having experienced *physical or sexual violence* if they reported lifetime experience of rape, sexual molestation, serious physical attack or assault, being attacked with a weapon or being tortured.

Results

Table 1 shows the percentage of women in each group with each of the individual conditions, traumatic experiences or characteristics, and the percentage identified with each type of barrier. The table also presents odds ratios, which compare the risk of lone mother recipients having each type of barrier with the risk for all other mothers (see Box 1).

The data show that lone mothers receiving welfare were more likely than mothers in the other two groups to experience each type of barrier. Striking differences were observed in the prevalence of mental health problems, substance use disorders and lifetime experience of physical and sexual violence. In most instances, the partnered recipients were more similar to non-recipient mothers than to lone mothers receiving income support.

Most of the mothers had not completed secondary education, although the overwhelming majority had some form of labour force experience. Those who were receiving income support, and particularly lone mothers, were more likely than other mothers to have poor education. Those on welfare were less likely than the others to have previous work experience, with no marked difference between lone and partnered mothers. The odds ratios show that lone-mother recipients' risk of having a human capital barrier was around two-and-a-half times that of other mothers (see Box 1).

Almost one-third of lone-mother recipients had experienced an anxiety disorder, and around 20 per

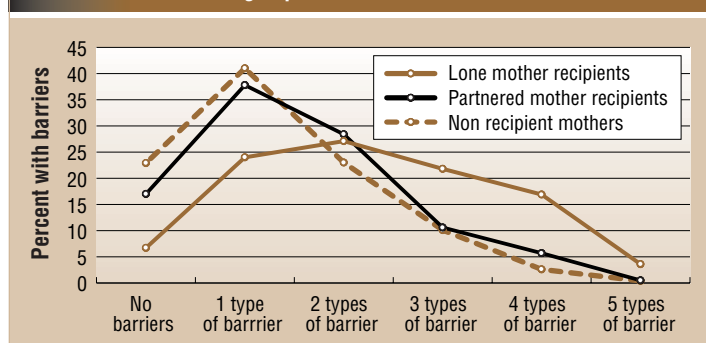
cent reported symptoms indicative of a depressive disorder in the previous 12 months. These rates are considerably higher than the rates for both the partnered recipients and the non-recipient groups. A similar pattern is observed for the less prevalent psychotic disorders. Around 5 per cent of lone-mother recipients were identified by the psychosis screening questions compared to less than 1 per cent in each of the other two groups. Overall, the risk of lone-mother recipients having a mental health barrier was almost three times the risk of other mothers.

Substance-use disorders were much less common than most of the other types of barriers examined in this analysis, but lone-mother recipients were shown to be more likely to experience both alcohol and other drug use disorders than mothers in the other two groups. The risk of lone-mother recipients having a substance-use barrier was almost four times that of other mothers.

Lone mothers also reported higher rates of common physical conditions than mothers in both of the other groups. The results were similar for the measure of physical disability. The odds ratio shows lone mothers had almost twice the risk of having a physical health barrier than other mothers.

The data also confirm the increased prevalence of physical and sexual violence in the lives of Australian lone mothers receiving welfare. Around 20–25 per cent reported each of the traumas: rape, sexual molestation, being the victim of serious physical attack or assault, and being threatened with a weapon, tortured or terrorised. The prevalence rates for each of these individual traumas in the other two groups were consistently under 10 per cent. Overall, the risk of lone mothers having a trauma barrier were more than three times the risk of the other mothers.

Figure 1 Number of types of barriers experienced by mothers in each of the three groups



It is important to recognise that the prevalence and odds ratios for the overall barriers underestimate the extent of the disadvantage experienced by lone-mother recipients. This group has greater co-occurrence of barriers within categories. For example, around 3 per cent of lone mothers on welfare had both an alcohol disorder and another drug-use or dependence disorder compared to only 1 per cent of mothers in the other groups. Similarly, 13 per cent of lone-mother recipients experienced both anxiety and depressive disorders compared to 4 per cent of other mothers. This greater overlap seems to reflect both the greater prevalence of the individual barriers and a more significant association between some of the measures.



Although the co-occurrence *within* barriers may be important (Kessler and Frank 1997), the current analysis of multiple barriers examines the prevalence of different *types* of barriers (for example, both mental and physical barriers). Figure 1 presents data on the number of types of barriers experienced by mothers in each of the three groups. The data shows that the majority of non-recipients have none or only a single type of barrier (around 65 per cent). This is similar to the results for partnered women on welfare, where about 55 per cent have one or none of the barriers examined in this study. For this group, around 5 per cent have four or more types of barriers.

The data for lone mothers receiving income support are very different. The majority (around 70 per cent) have two or more types of barrier. Further, almost 20 per cent have four or more types of barriers. It is clear that lone mothers on welfare have more barriers than other mothers.

Discussion

Research from the United States has shown that the majority of lone mothers in receipt of welfare have multiple personal barriers. This finding is critical as there is a strong association between the number of barriers a person experiences and their likelihood of employment (Danziger, Corcoran et al. 2000). The analysis here has confirmed these findings with Australian welfare recipients. Lone mothers receiving income support payments were more likely to experience each of the types of barriers and conditions examined in this analysis than partnered recipients and non-recipient mothers.

Lone mothers were more likely to: lack human capital skills (education and work experience);

experience mental disorders and severe mental health problems; have physical health conditions and physical limitations; have an alcohol or other substance-use disorder; and have previously experienced physical and sexual violence.

Lone mothers receiving income support were also much more likely to experience multiple barriers than those in the other two groups. The data showed that there was a high co-occurrence or interconnection between the various measures of personal, psychological and social disadvantage among lone mothers. It is likely that this co-occurrence reflects the systemic and entrenched nature of their disadvantage. A substantial minority of women have multiple barriers including early childhood adversity,

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domestic violence or other forms of physical and sexual violence, relationship difficulties, physical and mental health problems, limited labour market skills or attachment, and poor educational achievement.

These factors, along with other characteristics such as poverty, hardship, and poor personal resources and coping abilities, can be considered indicators of the structural context of the lives of these women.

Limitations

There are many other variables that could have been considered in this analysis, but in many cases appropriate data items were not available in the National Survey of Mental Health and Wellbeing dataset. There was no detailed information on financial circumstances, which is an important predictor of mental health. The analysis could have considered other socio-economic measures. For example, lone-mother recipients were much more likely to be in rental housing in comparison to those in the other groups. This may be an indication of their poorer financial circumstances or the current instability in their lives. Similarly, lone mothers on welfare were much more likely to reside in the most disadvantaged socio-economic areas and in non-metropolitan areas. These residential circumstances are likely to make finding and maintaining employment more difficult. It is possible that some of the variability in measures such as mental health reflect the consequences (perhaps transitory) of relationship breakdown. Examining duration since separation/divorce would enable assessment of the contribution of this effect.

The fact that the survey is cross-sectional also limits interpretation. It is, for example, not possible to resolve whether receipt of welfare, poverty and unemployment are the cause of personal barriers such as poorer mental health, or whether the presence of a mental health problem is a factor leading to selection into unemployment, poverty and welfare dependence (see Turner et al. 1995).

However, for the purposes of this discussion these issues are not relevant. There is compelling evidence that the types of barriers examined in this paper do represent an obstacle to employment and self-sufficiency. Therefore, regardless of whether the cause of the barrier was unemployment itself, it behoves policy makers to consider ways to better address these issues to promote the achievement of positive outcomes.

Policy implications

In the context of welfare reform, evidence that lone mothers are very likely to experience substantial and multiple barriers to employment is not necessarily counter to the introduction of participation requirements. Rather, better understanding of the extent of the disadvantage experienced by many women within this group provides an incentive for action.

Efforts to improve engagement and participation will provide the opportunity to assist lone mothers to overcome their barriers and improve their social functioning and economic circumstances, and those of their children. However, it is also critical that appropriate support and services are available for those who require assistance.

These data support the types of policy directions adopted internationally, emphasising: the identification of those with barriers to workforce participation (through screening and assessment processes); promoting knowledge and awareness of these barriers among service delivery staff; and policy consideration of how programs and services can better assist clients or link them with other services.

It is important to consider the rationale for examining the prevalence of these factors among welfare recipients. It is not an attempt to justify or explain away welfare dependence – for example, many women currently in employment also experience these barriers. Neither is the analysis of personal barriers seeking to condemn or lay blame on individuals for their current circumstances. Rather, the analysis is an attempt to increase understanding of important characteristics that are related to employment and self-reliance. This knowledge is crucial because, without it, the policy response could focus on options that may be ineffective for many of these women.

Finally, this analysis has identified a number of directions for future research. One early step is to explore the association between these different barriers and employment. Research is also needed to explore the causal pathways and mediators between these factors (for example, the effect of trauma and abuse mediated through mental health) and others not examined in this analysis (such as the moderating effect of coping skills and social support).

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