

Low-Income Women's Use of Substance Abuse and Mental Health Services

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Abstract: This paper examines the utilization of mental health, alcohol, and drug treatment in a sample of low-income women. We analyze data from the Women's Employment Study, a study examining the barriers to employment for welfare recipients, and compare prevalence rates of mental health disorders and service utilization with the National Comorbidity Survey. Fewer than one in five of the respondents with a current mental health and/or substance dependence problem in the Women's Employment Study (WES) received treatment in the past 12 months. A logistic regression model of the association among demographic variables, risk factors, and service utilization in the WES found that having a co-occurring substance dependence and mental health disorder was significantly associated with receiving treatment. Those respondents with an increased number of barriers were significantly less likely to receive treatment. The authors argue that the success of welfare reform may hinge on low-income women's access to and utilization of appropriate services.

Key words: mental health services, substance abuse, low-income women, welfare.

In the past decade there has been a steady increase in the use of outpatient mental health and substance abuse treatment in the general population.¹ There is a concern, however, that low-income women are not receiving as much treatment as others, although mental health and substance abuse disorders may be a barrier to transitions from welfare to work for some.^{2,3} Changes in welfare laws, which mandate rapid involvement in the workforce and set lifetime time limits for welfare benefits, mean that lack of access to mental health and substance abuse treatment may affect employment opportunities. This paper addresses the identified need for and subsequent utilization of mental health, alcohol, and drug treatment services in a sample of women randomly selected from a list of women receiving cash assistance.

The importance of engaging Temporary Assistance for Needy Families (TANF) recipients with substance abuse/mental health problems in appropriate treatment, has prompted some states to permit time exemptions to clients who are actively receiving treatment.⁴⁻⁶ The federal government has recognized that women have historically faced many barriers in accessing mental health and substance abuse

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services and have set aside a portion of the substance abuse and mental health block grants specifically to increase the availability of these services for women. Few studies, to date, have evaluated empirically low-income women's access to mental health and substance abuse services. A number of factors bear on whether welfare recipients are able to enter and participate in substance abuse and mental health treatment programs.

Several demographic variables are associated with utilizing mental health and substance abuse services. Although people with the highest levels of education are the least likely to have a psychiatric disorder, they are the most likely to seek mental health services when they do have a disorder.⁷ In a comparison of public and private mental health services, African Americans were found to be less likely than whites to receive mental health services even after controlling for income and education. An analysis of African American mental health service utilization during the 1990s found that although African American service use did increase over time, this was generally a matter of discussing mental health problems in a general medical setting rather than receiving specialized mental health services.⁸⁻¹⁰

Derr, Douglas, and Pavetti¹¹ found that living in a rural area increased the difficulty of receiving services because of the general lack of services available and the stigma associated with treatment in a small community. Other studies of rural populations have found barriers to services similar to those identified by urban respondents, including cost of care, lack of health insurance, and inadequate transportation.¹²

Poor women seeking substance abuse and mental health treatment often lack adequate financial resources.^{13,14} Research suggests that the costs associated with treatment, including the lack of insurance coverage, are the most common reasons identified by people with mental health and substance abuse problems for not getting treatment.^{5,11,15,16} In a comparison of the United States, Ontario, and the Netherlands, income in the United States was positively related to obtaining specialized treatment for a mental health disorder.¹⁷ In addition, low-income women may face several distinctive barriers to substance abuse and mental health services such as inadequate transportation and lower levels of education.¹⁸⁻²⁰

Research has shown that women on welfare face gender-specific barriers as they attempt to access mental health and substance abuse treatment, including child care responsibilities.²¹⁻²⁶ For women with low incomes, outside child care is often unavailable or unaffordable. There is evidence that pregnancy and/or the responsibility of caring for children affect a woman's propensity to receive substance and mental health services.²⁵⁻²⁸ For many women who were abusing substances, the fear of losing custody of their children was a major motivation for seeking treatment. However, many women found that having children complicated their efforts at getting treatment.²⁹

Beyond obstacles to mental health and substance abuse service utilization, researchers have also examined the factors associated with service use. For example, in a study of respondents from a general population survey of Ontario adults with an alcohol or drug use disorder, researchers found that having a concurrent mental health disorder, being older, and living in an urban setting were some of the key factors associated with service use.³⁰ Treatment components that have enhanced a

woman's ability to enter substance abuse treatment include nonconfrontational approaches, gender-specific groups, addressing other issues beyond substance abuse, involving other family members, and providing supportive services to allow women to remain in treatment.⁵

Utilization of services is more difficult for those women who are experiencing co-occurring substance and mental health disorders.^{31,32} The Legal Action Center, in a review of 20 model substance abuse treatment programs for welfare recipients in seven states, identified several common components among successful programs. These included the screening of welfare recipients by trained professionals for alcohol and drug problems, creating gender-specific treatment, coordinating treatment across social service systems, and evaluating the effectiveness of treatment programs.³³ Substance abuse services and mental health services are traditionally organized independently of each other and few are designed to meet the needs of pregnant and parenting women.^{34,35}

In this paper, we examine the extent of service utilization by low-income women in the Women's Employment Study (WES) who meet the diagnostic screening criteria for one of six mental health and substance disorders. We consider whether the rate of service utilization differs by disorder and comorbidity of disorders. We then compare the prevalence of mental health disorders, substance dependence, and subsequent service utilization of low-income women in the WES and a sample of women in the National Comorbidity Survey (NCS) that uses a comparable instrument to measure mental health and substance dependence disorders. We then turn our attention to whether sociodemographic variables and a number of other personal factors affect service utilization. These factors include child care, transportation, insurance, and education.

Method

Study Overview. We report data from the first two waves of the WES, a longitudinal survey of welfare recipients in an urban Michigan county. Michigan's Family Independence Agency, which administers the state's TANF program, provided names and addresses of all single-parent cases in the selected county. The sample included single mothers who received welfare in February of 1997, had a racial identity of either white or black, and were United States citizens. Because non-citizens and other ethnic/racial groups made up only a small proportion of the overall caseload, there was insufficient sample size to examine these groups in detail. With these exceptions, the WES sample can be characterized as a simple random sample, systematically selected with equal probability from an ordered list of eligible women.

In the first two waves, we collected data on physical health, mental health, demographic characteristics, income, health insurance, current/most recent job, current welfare status, and work and welfare histories. In the fall of 1997, trained interviewers conducted face-to-face interviews with a random sample of 753 women; the second wave of the study was conducted in the fall of 1998. The response rate for wave one was 86.2% (753/874), and for wave two was 92% (693/753 women interviewed at wave one, 79% of the original sample).

The WES sample is representative of the population and has been verified on the basis of race, age, months on welfare, welfare caseload size, employment codes, and monthly reported income. There was no attrition within the sample between waves one and two on any of the key demographic, mental health, or substance dependence variables. The comparison of sample distributions to population distributions produced no differences that warranted corrective weights in analysis.²

Data from the WES will be presented from each wave (wave 1, $N = 753$; wave 2, $N = 693$) to establish overall prevalence rates of mental health and substance dependence disorders in the sample. We also present data on persistent mental health and substance dependence disorders (both waves, $n = 693$). We then turn our attention to those respondents who wanted mental health and/or substance abuse treatment, but did not receive treatment ($n = 53$) and present information on why these respondents were unable to access treatment. Finally, we examine service utilization rates and barriers to care for those respondents with mental health and substance dependence disorders ($n = 197$).

We also present comparable data from a sample of women based on race (black or white) and age (18–54) in the NCS ($n = 2,379$), which relied on a comparable instrument to measure mental health and substance dependence disorders. The NCS was the first survey to administer face-to-face structured psychiatric interviews (Composite International Diagnostic Interview [CIDI]) to a nationally representative sample in the United States. The NCS survey was conducted in the early 1990s and assessed the prevalence and correlates of DSM-III-R disorders.^{36,37} Part two of the NCS included questions on service use questions.¹ The WES data relied on a short form version of the CIDI to compare prevalence rates of mental health and substance dependence disorders among low-income women with similar women by race and age in the general population. Although the WES and NCS asked similar service utilization questions, the availability of services has expanded from when the NCS was conducted to the time of the WES survey.

Participants. Fifty-five percent of respondents were African American and 45% were non-Hispanic white. The sample was limited to recipients between the ages of 18 and 54 with 27% under 25, 45% between the ages of 25 and 34, and 27% who were 35 or over. Eighty-six percent of the participants lived in urban census tracts. Although respondents were identified as single-parent cases in administrative data, a little more than one quarter (32.9%) of the respondents were currently living with a spouse or partner. This discrepancy in living arrangements is primarily due to the time gap between when the sample was drawn and when the interview was conducted. Nearly half (43%) were the primary caregiver for at least one child between the ages of 0 and 2. For a further discussion of the sample, see Danziger and associates.²

Measures. This paper explores the identified need for and subsequent utilization of mental health, alcohol, and drug treatment and the barriers to accessing these services for low-income women. The criteria that we use for variables in this study are described below.

Mental health and substance abuse services. After having been interviewed in the Fall of 1997 (in wave one) to establish baseline data, women were asked at wave

two, in the Fall of 1998, whether they ever had a concern about having a mental health, alcohol, or drug problem. If respondents reported ever having a concern about a mental health, alcohol, or drug problem, they were asked whether or not they had ever received mental health services and substance abuse services and if they had received services since wave one. Respondents who had received services since wave one were asked where they received care (a stay in the hospital, treatment center, support group, or halfway house) and whether or not they had seen a counselor or were taking psychotropic medication. A dummy variable was created that included all services received since wave one (approximately 12 months).

Reasons for not receiving mental health, alcohol, or drug treatment. Respondents who said that they had ever had a concern about a mental health, alcohol, or drug problem, but had not received treatment since wave one were asked why they did not get help. These answers were coded and covered different domains including cost, structural barriers, and perceptions of treatment.

Mental health disorders and substance dependence. Mental health disorders and substance dependence were measured using diagnostic screening batteries developed from the University of Michigan Composite International Diagnostic Interview (UM-CIDI).³⁸ The screening scales assess DSM-III-R disorders; they were developed from data from the NCS, the first nationally representative survey to administer a structured psychiatric interview.³⁶ We used short-form scales to assess major depression, generalized anxiety disorder (GAD), social phobia, and alcohol and drug dependence in the past 12 months. GAD was measured at wave one and not at wave two; social phobia was measured at wave two and not at wave one. We measured lifetime and 12-month posttraumatic stress disorder (PTSD) prevalence using the long form of the UM-CIDI.

We utilize the more restrictive *dependence* criteria for alcohol and drug problems in the past 12 months, rather than *use* or *abuse*. The short-form measures utilized in this study do not provide adequate measures for use and abuse criteria. A combined variable of either having drug dependence and/or alcohol dependence in the past 12 months was created that is referred to as substance dependence.

We created dichotomous variables for those respondents who met the screening criteria for any of the mental health or substance dependence disorders at either wave. We also created dummy variables for the following diagnostic categories at wave one, wave two, and for those meeting the criteria at both waves: any substance dependence, (either alcohol and/or drug dependence), any mental health disorder (any of the five disorders measured at each wave), and co-occurring disorders (both a substance dependence and a mental health disorder during the same wave).

Barrier to treatment index. We created an index of four barriers to not receiving mental health or substance abuse services by adding the total number of obstacles women reported. The index ranged from 0 to 4. The four items in the index were transportation problems, child care problems, not having a high school degree, and not having medical insurance. A respondent was identified as having a transportation problem if she lacked access to a car and/or did not have a driver's license. Limited public transportation in the urban county where the study took place made having access to a car vital. Respondents were also asked if they had a

child care problem that interfered with their obtaining and keeping a job, and if they currently lacked health insurance and/or Medicaid coverage. Respondents were identified as having less than a high school education if they had not received a high school diploma or general education diploma.

Results

Prevalence of Disorders. Table 1 lists the prevalence of each mental health disorder for waves one and two of the study and compares them with national rates found in the NCS.³⁶ Rates of depression in WES decreased over the two waves from 25.4%–16.5%. Respondents in the WES at wave two were significantly more likely to be depressed than their counterparts in the NCS. PTSD remained nearly the same at a rate of about 14.5% across both waves of the WES, but was nearly 3 times higher than the prevalence in the NCS. The prevalence of GAD and social phobia in WES was significantly higher than the rates found in the NCS.

Women in the NCS had significantly higher rates of alcohol dependence than respondents in the WES at wave two (4.1% versus 1.4%). When combining alcohol and drug dependence to examine substance dependence, 5.0% of the respondents in WES were substance dependent at wave one and 3.6% were substance dependent at wave two. Overall, rates of substance dependence remained low at both waves and were significantly lower than the prevalence of substance dependence in the NCS. Having any mental health or substance dependence disorder declined from 35.1% to 28.7% from wave one to wave two. Respondents in the WES at wave two had significantly higher rates of having any of the three mental health and substance dependence disorders than women in the NCS (28.7% versus 24.7%).

Table 1 also reports the percentage of respondents who had one of the disorders at both waves one and two. The most prevalent persistent disorders were depression (8.5%) and PTSD (6.4%). Persistent substance dependence was 1.6%. Nearly one in six respondents (17.8%) met the criteria for at least one of the six disorders at both waves.

Mental Health, Substance Dependence, and Service Utilization. Table 2 presents service utilization rates for those respondents with current mental health and substance dependence disorders at wave two. Of those respondents who had any mental health or substance dependence disorder at wave two ($n = 198$), 19.3% ($n = 38$) received treatment in the past 12 months. Service utilization among respondents with drug dependence was higher than any another mental health disorder. Caution in interpreting these results is advised due to the small number of respondents ($n = 15$) identified with a drug dependence disorder at wave two.

Respondents in the NCS were significantly more likely to receive treatment for major depression than women in the WES. In addition, respondents with PTSD in the NCS were significantly more likely to receive treatment than WES respondents (31.8% for NCS respondents versus 20.2% for WES respondents). Although the number of respondents receiving treatment who had a diagnosis of drug or alcohol dependence was small in the WES, the overall prevalence rates were higher than those respondents in the NCS with similar disorders. Overall, respondents in the WES who had any mental health and or substance dependence disorder at wave two were significantly less likely to receive treatment than those respondents in the

Table 1.**PREVALENCE OF 12-MONTH MENTAL HEALTH AND SUBSTANCE DEPENDENCE DISORDERS IN WAVE 1, WAVE 2 AND BOTH WAVES OF THE WES AND NCS**

Disorder	WES 1 (N= 753)			WES 2 (N= 693)			Both waves (N= 693)			NCS (N= 2379)	
	%	n	SE	%	n	SE	%	n	SE	%	SE
Major depression	25.4	191	0.4	16.5	114	0.4	8.5	59	0.3	12.1*	1.0
Social phobia	—	—	—	7.5	52	0.3	—	—	—	8.8**	0.7
GAD	7.2	54	0.3	—	—	—	—	—	—	4.6*	0.5
PTSD	14.6	110	0.4	14.4	99	0.4	6.4	44	0.3	5.5*	0.6
Drug dependence	3.3	25	0.2	2.2	15	0.1	1.0	7	0.1	1.9	0.3
Alcohol dependence	2.8	21	0.2	1.4	10	0.1	0.6	4	0.1	4.1*	0.4
Substance Dependence	5.2	39	0.2	3.6	25	0.1	1.6	11	0.1	5.2*	0.5
Co-occurring substance dependence and mental health disorder	4.3	32	0.2	2.5	17	0.2	1.0	7	0.1	2.6	0.3
Any mental health or substance dependence disorder	35.1	263	0.5	28.7	198	0.5	17.8	122	0.4	24.7*	1.3

Comparisons are with female respondents ages 18–54 in the NCS. All comparisons are for 12-month diagnoses.

*p = 0.01.

**p = 0.05.

Differences are between WES 2 and NCS except for generalized anxiety disorder.

Abbreviations: GAD, generalized anxiety disorder; NCS, National Comorbidity Survey; PTSD, posttraumatic stress disorder; SE, standard error; WES 1, Women's Employment Study wave one; WES 2, Women's Employment Study wave two.

NCS who had any of the three mental health or substance dependence disorders that were measured (19.3% versus 29.2%).

Respondents with persistent disorders had rates for utilization of services similar to those of respondents who only had a disorder at wave two. Roughly one third (32.2%) of the respondents who had depression at both waves had received treatment in the past 12 months. One in five (20.5%) of respondents with PTSD across both waves received any treatment in the past 12 months. Those respondents with persistent drug dependence were more than twice as likely to have received treatment in the past 12 months as respondents with persistent alcohol dependence, but the numbers for these disorders were quite low. One in four respondents (24.8%) who had any mental health or substance dependent disorder across both waves received treatment in the past 12 months.

Table 2.**PERCENTAGE OF WOMEN WITH DISORDERS WHO RECEIVED TREATMENT IN THE PAST 12 MONTHS**

Disorder	Disorder at both waves receiving treatment in past 12 mo (%)		Disorder at wave 2 receiving treatment past 12 mo (%)			NCS treatment past 12 mo		
	%	<i>n</i>	%	SE	<i>n</i>	%	SE	<i>n</i>
Major depression	32.2	19	26.3	0.4	30	33.6*	2.9	97
Social phobia	—	—	19.2	0.4	10	21.8	2.7	46
PTSD	20.5	9	20.2	0.4	20	31.8*	5.5	41
Drug dependence	71.4	5	60.0	0.5	9	41.5**	10.8	19
Alcohol dependence	33.3		20.0	0.4	2	26.3	6.0	26
Substance dependence	60.0	6	44.0	0.5	11	29.2*	5.6	36
Co-occurring substance dependence and mental health disorder	71.4	5	52.9	0.5	9	36.9**	7.7	23
Any mental health or substance dependence disorder	24.8	30	19.3	0.4	38	29.2*	2.1	167

Comparisons between wave two of the WES and the NCS are for female respondents aged 18–54 in both samples. Prevalence estimates are percentages by rows. For example, in the first row of numbers, 26.3% is the percent of respondents who had a current diagnosis of major depression and utilized services, not the percent of people using services who carried a diagnosis of major depression.

Treatment includes a stay in the hospital, treatment center, or halfway house. It could also include seeing a counselor, participating in a support group, or receiving medication.

* $p = 0.01$.

** $p = 0.05$.

Abbreviations: NCS, National Comorbidity Survey; PTSD, posttraumatic stress disorder; SE, standard error; WES, Women's Employment Study.

Factors Affecting Treatment. Those respondents who wanted treatment but did not receive services were asked why they did not obtain treatment (Table 3). The most common reasons for not seeking treatment were cost or insurance problems (26.4%) and a fear of treatment (26.4%). Respondents also mentioned not knowing where to go for help (13.2%), not having time for treatment (11.3%), and problems such as no transportation (9.4%) and no child care (7.5%) when attempting to seek treatment. Over two thirds (69.8%) of respondents who were concerned that they had a mental health problem, and did not receive mental health services in the past year, screened positive for a current mental health disorder.

Based on our review of previous research we created an index of barriers to receiving treatment that included not having any insurance, not having a car and/or driver's license, not having any child care if it was needed to gain employment,

Table 3.**REASONS FOR NOT RECEIVING MENTAL HEALTH TREATMENT FOR THOSE RESPONDENTS WHO WANTED TREATMENT, BUT DID NOT RECEIVE TREATMENT (*n* = 53)**

Reason	%	<i>n</i>
Cost/insurance	26.4	14
Child care problems	7.5	4
Transportation	9.4	5
Fear of treatment	26.4	14
Don't believe in treatment	0.0	0
Don't need treatment	11.3	6
Wait list too long	0.0	0
Didn't know where to go	13.2	7
Didn't have time	11.3	6

and having less than a high school education. We compared these four factors between those respondents who had a mental health and/or substance dependence disorder at wave two and those who did not have a disorder. The only significant difference in barriers between those who had a mental health and/or substance dependence disorder was that those respondents with a disorder were more likely not to have a car and/or driver's license (40.9% with a disorder versus 32.4% without a disorder).

For those respondents who had a mental health and/or substance disorder, we then examined whether the number of barriers a respondent reported was associated with receiving treatment (Table 4). The results show that those with no or one barriers have higher rates of service utilization than do those with two barriers. No respondent with three or more barriers utilized any of the treatment services.

Table 5 presents a logistic regression model of the association among demographic variables, risk factors, and service utilization for those respondents with a mental health and/or substance dependence disorder. In this model, having a co-occurring substance dependence and mental health disorder at wave two was significantly associated with receiving treatment in the past 12 months. Those respondents with higher barrier index scores were less likely to receive treatment. Persistence of mental health disorders was not significantly associated with service utilization, nor were any of the demographic control variables. Specific barriers in the treatment barrier index were also tested individually; none were found to be significant (analysis not reported).

Discussion

There are several limitations to the results that we present in this paper. In each wave of the study, there are only five mental health disorders measured. Comorbidity in the sample was underestimated owing to the limited number of disorders

Table 4.

BARRIER TO TREATMENT INDEX: NUMBER OF BARRIERS FOR THOSE RESPONDENTS WITH A MENTAL HEALTH AND/OR SUBSTANCE DEPENDENCE DISORDER AND PERCENTAGE RECEIVING TREATMENT ($n = 197$)

Number of barriers	Receiving treatment	
	%	n
0 ($n = 38$)	18.4	7
1 ($n = 87$)	16.1	14
2 ($n = 54$)	9.3	5
3–4 ($n = 18$)	0.0	0

Barriers to treatment in the index include no insurance, no car and/or license, no childcare, and having less than a high school education or GED.

Table 5.

LOGISTIC REGRESSION COEFFICIENTS FOR RISK FACTORS AND SERVICE UTILIZATION AMONG WOMEN WITH A MENTAL HEALTH AND/OR SUBSTANCE DEPENDENCE DISORDER ($n = 197$)

	B	SE	Exp (B)
Race (black)	-0.68	0.55	0.50
Age 18	0.00	0.04	1.00
Age 25–34	0.01	0.54	1.01
Cohabiting	-0.67	0.63	0.51
Urban	0.28	0.73	1.32
Poverty	0.46	0.58	1.59
Persistent mental health disorder	0.56	0.57	1.75
Co-occurring substance dependence and mental health disorder at W2	1.84*	0.70	6.27
Barrier Treatment Index	-0.73**	0.34	0.48
Constant	-1.97	1.06	

* $p = 0.001$.

** $p = 0.05$.

Abbreviations: B, Beta; SE, standard error; W2, Women's Employment Study wave two.

Unless it is standard at the Journal of Health Care for the Poor and Underserved I do not think we should have B and SE defined in abbreviations, I have not seen that in journals before.

measured. However, we did include disorders with some of the highest prevalence in the NCS (depression, substance disorders, and social phobia). In addition, there may be an underestimation of service need for women experiencing a drug or alcohol problem owing to the use of *dependence* rather than *abuse* in identifying the population in need of treatment.

We may also have underestimated service utilization in this sample in that the study was designed to only ask respondents if they sought services if they self-identified a mental health or substance dependence concern. It is important to note that, of the 197 respondents who had a mental health disorder during the past 12 months, over half (60.1%, $n = 119$) stated that they had no concern about having a mental health problem. Thus, these individuals were not asked service utilization questions. Future studies of service utilization among this population should use a more inclusive measure of service utilization and the present results should be interpreted with these limitations in mind.

The identification of mental health and alcohol and drug problems is an important first step for welfare agencies attempting to move clients into the workforce. Once clients have been identified as having a mental health or substance abuse problem, it is necessary to create an environment that encourages clients to seek treatment. Intensive case management of recipients undergoing treatment may help to address many of the barriers identified in this paper. Welfare-to-work programs in Michigan at the time of this survey did not routinely assess mental health and substance dependence problems. Self-disclosure by recipients was viewed as the primary mechanism for staff and program managers of welfare-to-work programs to learn about a recipient's problems; Michigan has no time limits for welfare receipt.³⁹

Our results also indicate that having two or more disorders increased the likelihood that a respondent would receive treatment. This may indicate that making specialized services available to women with comorbid disorders would be beneficial. In addition, the number of women with persistent disorders indicates an area that warrants future research. Women with the most severe level of disorders might find that they are eligible for Social Security and Supplemental Security income and in that way acquire the resources to overcome some of the barriers addressed in this paper.

Increased barriers decreased the likelihood that a respondent would receive treatment. Barriers to service utilization identified in this paper include structural barriers to services such as cost, transportation, and child care. More than one quarter (26.4%) of the respondents who wanted treatment and did not receive it reported that they had a fear of treatment. Future research should focus on the nature of the fears that low-income women have of treatment. Fear of treatment requires a different approach from that called for to overcome structural barriers to treatment, directed more towards education and public service announcements that could help to address the concerns of low-income women who may be in need of mental health and substance abuse treatment.

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Notes

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