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Providing Mental Health Services to TANF Recipients: Program Design Choices and Implementation Challenges in Four States

Final Report

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ACRONYMS

The acronyms listed below are used throughout this report.

AFDC: Aid to Families with Dependent Children

AFS: Adult and Family Services

AWI: Agency for Workforce Innovation

CAGE: CAGE comes from the four-question substance abuse screening questionnaire used in Utah: Have you ever felt the need to **Cut** down on your using/doing? Have you ever felt **Annoyed** by people complaining about your drinking? Have you ever felt **Guilty** about your drinking? Do you ever drink an **Eye-opener** in the morning to relieve the shakes?

CalWORKs: California Work Opportunity and Responsibility to Kids Program

DCF: Department of Children and Families

DHS: Department of Human Services

DWS: Department of Workforce Services

FCS: Family and Children's Services of Greater Chattanooga

FSC: Family Services Counseling

LCSW: Licensed Clinical Social Worker

MOE: Maintenance-of-Effort

MPR: Mathematica Policy Research

MSW: Master's in Social Work

OFS: Office of Family Support

OPS: Other Personnel Services

PRWORA: Personal Responsibility and Work Opportunity Reconciliation Act of 1996

PTSD: Post-traumatic Stress Disorder

SAMH: Substance Abuse/Mental Health

SPED: Single-Parent Employment Demonstration

SSDI: Social Security Disability Insurance

SSI: Supplemental Security Income

TANF: Temporary Assistance for Needy Families

UT: University of Tennessee

EXECUTIVE SUMMARY

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) shifted the emphasis of the welfare system from providing ongoing cash assistance to needy individuals to moving them into jobs. This shift created new expectations and opportunities for nearly all poor families seeking government assistance, including those facing multiple and significant barriers to employment. In the past, these hard-to-employ individuals were rarely required to meet work requirements, either by working or participating in an approved work activity. As a result, few states had specialized services to address barriers to employment. With the new emphasis on work, however, programs targeted to hard-to-employ welfare recipients have recently emerged in an effort to help these individuals find and keep a job.

In this report, we profile the efforts of four states (Florida, Oregon, Tennessee, and Utah) to address the mental health conditions of welfare recipients, one of the many barriers that they may face. This report is based on the findings from a study that Mathematica Policy Research (MPR) conducted for the U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation. This study was designed with three purposes in mind: (1) to identify and provide detailed information about the design and structure of mental health services developed by state and local welfare offices to address the mental health needs of welfare recipients, (2) to highlight options for delivering these services, and (3) to discuss the key implementation challenges involved in and the lessons learned from providing mental health services to welfare recipients.

POLICY CONTEXT

The flexibility built into the federal welfare reform legislation allows states to use TANF funds to provide nonmedical mental health treatment services for welfare recipients and other low-income families at-risk for TANF involvement. Although most welfare recipients qualify for Medicaid, which allows them access to mental health treatment through a Medicaid-funded treatment provider, TANF recipients may not be aware they have a mental health condition that may be affecting their employability, or they may not know how to

access Medicaid-funded mental health services. To address the mental health needs of these individuals, states have used TANF funds primarily in three ways: (1) to identify clients with mental health conditions and refer them to Medicaid-funded providers, (2) to provide specialized short-term counseling services, and (3) to augment existing Medicaid-funded mental health treatment.

RATIONALE FOR PROVIDING MENTAL HEALTH SERVICES TO WELFARE RECIPIENTS

The rationale for providing mental health services to welfare recipients is based on research showing that welfare recipients and other low-income populations are at-risk for mental health conditions that may affect their ability to obtain and/or maintain employment. Although the reported rates of mental health conditions among welfare recipients vary widely, they are always substantially higher than rates in the general population. Estimates differ depending on how mental health conditions are defined and measured and by the population studied. In the National Survey of America's Families, 35 percent of low-income families reported having poor mental health using scales measuring anxiety, depression, loss of emotional control, and psychological well-being (Zedlewski 1999). Danziger et al. (1999) found similar rates of mental health conditions among welfare recipients (36 percent). In a look at the prevalence of mental health, substance abuse, and domestic violence issues among California's CalWORKs participants, Chandler and Meisel (2000) found that more than one-third of these individuals had at least one diagnosable mental disorder in the previous 12 months, and about 20 percent had two or more. Of those with a mental health disorder, more than one-fourth indicated that their disorder created "a lot" of interference with life or daily activities. The high incidence of spouse/partner violence, childhood abuse, crime, and rape among poor women, in particular, puts them at greater risk for mental disorders such as depression, post-traumatic stress disorder, and generalized anxiety disorder.

Overall, there is a strong relationship between mental health and employment. For instance, mental health conditions often result in fatigue, an inability to concentrate, and poor interpersonal skills, all of which can adversely affect employment. Furthermore, those with mental health conditions are more likely to have poor and sporadic work histories, to be unemployed, and to be receiving cash assistance.

METHODOLOGY

The exploratory study documented in this report is based on in-depth site visits to eight communities, a rural and an urban location in each of four study states—Florida, Oregon, Tennessee, and Utah. In each visit, we conducted semi-structured interviews with a variety of program administrators and staff and with mental health treatment providers to gather information on services that address the mental health needs of welfare recipients. We also reviewed psychological assessment tools, reporting forms, service delivery pathways,

confidentiality forms, and other information related to mental health services programs. When selecting programs for this analysis, we sought to represent the diversity of approaches to addressing the mental health needs of welfare recipients. We also looked for programs that had enough implementation experience to provide lessons to other administrators interested in implementing similar programs. The criteria used to select programs included the following:

- Provision of mental health services statewide or countywide
- Mix of programs developed pre- and post-PRWORA
- Experience serving a substantial number of clients
- Variation in administrative and service delivery structures
- Mix of rural and urban sites

OVERVIEW OF THE STUDY SITES

The study sites represent a range of programs designed to address the mental health needs of welfare recipients. Two of the states, Oregon and Utah, have been providing mental health services to welfare recipients for many years before welfare reform. Utah is the only state in which state employees, rather than contracted mental health agencies, provide mental health services, and Florida is the only state to administer the program through an agency outside of the TANF system.

Florida. In Florida, TANF funds have been used to purchase mental health treatment for welfare recipients and those at risk for TANF involvement. These funds also pay for outreach staff, who link individuals to mental health services. The services themselves are administered and coordinated by the Mental Health and Substance Abuse Program Offices, which operate outside the welfare office and workforce development system. The development of an administrative structure outside of the TANF eligibility and TANF employment services system has made integration difficult.

Oregon. In Oregon, the focus is on assessing clients and linking them to Medicaid-funded mental health treatment providers. Oregon has integrated mental health services into the welfare agency by co-locating mental health staff in most local welfare offices and by allowing each district office to develop an administrative structure that takes into account the resources available in the local community.

Tennessee. The Family Services Counseling (FSC) program in Tennessee provides assessment and short-term, solution-focused mental health treatment for welfare recipients. Using a program model that is uniform statewide, Tennessee strives for maximum integration of mental health services into the welfare office by co-locating program administrators in the state welfare office, and family services counselors and district

coordinators in local welfare offices. Individuals with more intensive mental health needs are linked to a Medicaid-funded mental health treatment provider.

Utah. Social workers in Utah conduct clinical assessments and some short-term therapy. They also link clients to Medicaid-funded mental health treatment and to some contracted mental health treatment providers. Hiring mental health staff members as employees of the welfare agency has created a high level of integration of mental health services into employment services.

KEY CHOICES IN DESIGNING AND PROVIDING MENTAL HEALTH SERVICES

Although each study state has developed a different approach to addressing the mental health needs of TANF recipients, they have all had to make decisions regarding seven key program design elements: (1) the types of services provided, (2) the population targeted for services, (3) the range of personal and family challenges addressed, (4) strategies for identifying clients in need of assistance, (5) integration of mental health and employment services, (6) administrative and service delivery structure, and (7) funding.

Types of mental health services provided. The TANF-funded mental health services provided in the study states include (1) screening and assessment, (2) linking clients to existing mental health treatment, (3) short-term, solution-focused mental health counseling, (4) expansion of existing mental health services, (5) resource/consultation for employment case managers, (6) intensive case management, and (7) assistance in applying for SSI. The states vary substantially in the emphasis given to each service. For example, mental health specialists in Oregon primarily screen and assess clients for mental health conditions and link them to a mental health treatment provider in the community. In Tennessee, family services counselors conduct in-depth assessments, and provide crisis intervention and short-term mental health treatment. Individuals with more severe mental health conditions are linked with Medicaid-funded treatment providers. In Florida, outreach workers identify and screen clients for whom services may be appropriate and link them to Medicaid-funded providers or to contracted mental health treatment providers who are paid through TANF funds. Clinical social workers in Utah, who are stationed in the local welfare offices, conduct clinical assessments and make diagnoses and recommendations for mental health treatment. They also provide some crisis intervention services and short-term, employment-focused mental health treatment.

Eligibility for mental health services. Eligibility is defined in a variety of ways and may or may not be contingent upon TANF participation. All of the states offer mental health services to all adults on TANF; Tennessee and Florida extend services to children and other family members within the TANF household. Tennessee and Utah made mental health services available to individuals transitioning from welfare to work. Florida has extended eligibility to non-custodial parents and other low-income families with an income up to 200 percent of the poverty line.

Range of service needs addressed. According to several researchers, a substantial proportion of welfare recipients have multiple barriers to employment, and the presence of multiple barriers decreases the probability that these families will find and retain a job (Danziger et al. 1999, Zedlewski 1999, Olson and Pavetti 1996). Thus, when designing a system to address the mental health needs of welfare recipients, program administrators must decide whether mental health needs should be addressed separately or in combination with other personal and family challenges. Addressing needs in combination means designing services not only for mental health conditions, but also for a host of other issues that may be preventing clients from finding employment. However, it is likely to be difficult to find staff who are expert in assessing and treating multiple types of conditions or issues. Utah is the only study state to focus its program only on mental health needs. Florida and Oregon focus on mental health and substance abuse issues, and Tennessee focuses on mental health, substance abuse, domestic violence, learning disabilities, and children's behavioral issues.

Strategies for identifying clients with mental health conditions. A variety of strategies are used to identify clients with a mental health condition. In all of the study sites, clients may self-refer after listening to a formal presentation describing mental health services, or they may be identified during a broad group screening conducted by an outreach worker or a licensed mental health professional. In three of the study sites—Oregon, Tennessee, and Utah—the primary way clients are linked to mental health services is by referrals from employment case managers. In Utah, licensed social workers participate in review hearings for clients in sanction status or for those reaching the end of their time limit. Florida and Tennessee have developed extensive community outreach campaigns to inform partnering agencies and clients who receive services outside of the welfare office about mental health services.

Integration of mental health and employment services. Most of the study states allow flexibility in the number and types of work activities that can be included in a client's employment plan. For example, a mental health counselor may request that mental health services be included in the plan or may recommend that the number of required hours in work activities be modified to accommodate a client's mental health issues and needs. Florida is the only state that restricts the number of hours, to five per week, that a client can participate in mental health services as part of an employment plan.

Agencies administering and providing mental health services. Deciding how to administer and deliver services is an important step in designing mental health program for welfare recipients. The key challenge for program administrators is to create a service system that builds on the strengths of the mental health resources in the local community *and* successfully integrates mental health services into welfare employment efforts. TANF program administrators are not experts in the design and delivery of mental health services, usually making it necessary for them to rely on other agencies or specialized staff for the design and delivery of mental health services. Interagency coordination is therefore critical to program success.

The study states developed very different administrative structures for delivering mental health services to TANF recipients. In three states—Oregon, Tennessee and Utah—the TANF agency maintains primary oversight of the program, although the extent to which the TANF agency is actively involved in the delivery of services varies considerably. Utah is the only state to hire staff directly to provide mental health services to TANF clients. In Oregon, each local district decides how to provide services, with most relying on contracted service providers. Tennessee has contracted with the University of Tennessee to administer the program and with local providers to deliver services. In Florida, program responsibility has been transferred to the agencies responsible for delivering and/or monitoring mental health and substance abuse services. These differences in administrative structure reflect differences in the structures for providing employment services to TANF recipients as well as differences in the scope of mental health services provided.

Paying for mental health services. The study states have primarily used their TANF block grant and state Maintenance of Effort (MOE) funds to pay for mental health services. These funds are distributed in two ways. Under the first model, the state welfare agency or state legislative body allocates TANF or MOE funds specifically to provide mental health services. In Florida, the state legislature allocated $45 million in TANF/MOE funds to provide mental health and substance abuse treatment to welfare recipients and to low-income families at-risk for TANF involvement. The state welfare agency in Tennessee designated $8 million to provide mental health and other services (e.g., for substance abuse problems, domestic violence issues, and learning disabilities) to welfare recipients. Programs like these, which operate under a designated funding source, appear to have a distinct identity and a centralized program administrator and some uniformity in terms of how they operate. Under the second model, which Oregon uses, funding for mental health service is included in a pool of funds designated for all services designed to help TANF recipients find employment. In Oregon, the decision about how much of this funding is allocated to mental health services is made primarily at the local level. Under this model, mental health services compete with other services for funding.

KEY IMPLEMENTATION ISSUES

Our analysis of the study states indicates that there are six key implementation issues involved in providing mental health services. We also discovered interesting approaches and innovative strategies developed by local offices to improve service delivery.

Encouraging employment case managers to refer clients to mental health services. A social worker in Salt Lake City, Utah, trains newly hired employment staff to identify mental health conditions. In Tennessee and most of Oregon, contracted mental health counselors co-located in the welfare office build relationships with employment staff to encourage referrals. The mental health program director in Florida developed a referral pathway chart for employment and mental health staff that outlines the process for referring clients to mental health services.

Encouraging client participation. To increase client participation in mental health services, staff have been flexible about where they provide services. In Tennessee, family services counselors meet with clients in their homes or at a location convenient to the client. To address the cultural and language differences in one site in Florida, paraprofessionals from the community were paired with licensed mental health counselors to translate counseling sessions, build relationships with TANF clients in the community, and link clients to mental health services.

Integrating mental health services into work activities. All of the study states count mental health treatment as a work-related activity in client's employment plans. Mental health and employment staff gradually increase conventional work activities until the client becomes employed. States have developed other strategies for integrating mental health into work activities. In Tennessee, mental health staff use a short-term, solution-focused treatment model. In Multnomah County, Oregon, mental health staff educate treatment providers about work and work-participation requirements.

Creating a professional support network. Mental health staff must be able to handle the wide variety of personal and family challenges facing individuals who participate in mental health services. Mental health staff in most sites have developed a professional support network to help them handle difficult cases and to exchange information about different community resources. In Oregon, mental health staff meet weekly to staff cases. Contracted mental health staff in Tennessee participate in routine case staffings in their agencies.

Maintaining client confidentiality. In general, the confidentiality of information shared by the client is well-maintained. All the study states have developed confidentiality forms to allow the exchange of information between mental health and employment staff, mental health treatment providers, and other community agencies. Social workers in Utah ensure that client case files are secured in a locked filing cabinet. In some sites, mental health counselors co-located in the welfare office have had difficulty finding private office space, an issue that is critical to maintaining client confidentiality.

Monitoring and tracking client participation. Employment case managers and mental health staff typically work together to monitor and track client participation and progress in mental health services. Monitoring and tracking appears to be a difficult task in most of the study states. Tennessee has the most comprehensive process for tracking client participation. In each client's file, mental health staff keep a record of the client's service plan, participation and progress in treatment, and contacts with mental health staff.

GENERAL CONCLUSIONS

The mental health needs of welfare recipients may be addressed in any number of ways, and there is no evidence to suggest that one model for providing mental health services is better than any other. More research is needed to examine the effectiveness of the mental

health services that are now provided in improving the employability and general well-being of welfare recipients. But regardless of the questions that may remain, it is clear that mental health services can be a valuable resource for employment case managers in their effort to move hard-to-employ individuals from welfare to work.

CHAPTER I

INTRODUCTION AND OVERVIEW OF THE STUDY

Recent changes in federal and state policy reflect a dramatic shift in the nation's approach to supporting the income of poor Americans and improving their labor force participation. Before the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) was passed, poor families were entitled to cash grants through the Aid to Families with Dependent Children (AFDC) program as long as their income and assets remained below a specified level and they met procedural requirements. In 1996, AFDC was replaced by the newly created Temporary Assistance for Needy Families (TANF) program, which sets a lifetime limit on benefit receipt and emphasizes employment over public assistance as the primary means of support for poor families. In response to time limits and steadily increasing work participation requirements, most state TANF programs encourage participants to find employment as quickly as possible.

Unlike the legislation governing previous welfare employment programs, which were designed to serve a small share of families receiving cash assistance, PRWORA created new expectations and opportunities for nearly all poor families seeking government assistance, including individuals with behavioral or emotional disorders that can create formidable barriers to employment. In the past, such families were rarely required to participate in employment programs. As a result, few states had strategies in place to assist clients with significant barriers to employment. While efforts to address the needs of these individuals are still in their infancy, far more programs are in place today than before the advent of welfare reform.

It is estimated that between one-fourth and one-third of welfare recipients have a serious mental health condition that could affect their ability to find and/or maintain

employment (Sweeney 2000). While mental health conditions represent only one of the many personal and family challenges faced by TANF recipients in search of work, the number of recipients affected by mental health conditions is large enough and the identification and treatment of such conditions is specialized enough to have attracted the attention of researchers and policymakers as well as practitioners and program administrators.

In this report, we profile the efforts of four states—Florida, Oregon, Tennessee, Utah—to address the mental health needs of welfare recipients. The report is based on findings from a study conducted by Mathematica Policy Research (MPR) for the U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation. The study was designed with three purposes in mind: (1) to describe in detail the design and structure of mental health services developed by state and local welfare offices[1] to address the mental health needs of welfare recipients, (2) to highlight different service delivery options in designing and implementing these services, and (3) to discuss the key challenges and lessons learned in providing mental health services to welfare recipients.

By highlighting the key choices involved in integrating mental health services into a work-oriented welfare system, this report offers practical guidance to program administrators who are interested in addressing the mental health needs of TANF recipients or other low-income families. It is not intended to prescribe a model for providing mental health services to welfare recipients. As shown in Table I.1, we identified seven key dimensions that define the study states' approaches to the mental health needs of welfare recipients: (1) the types of mental health services provided, (2) the target population, (3) the range of needs addressed, (4) strategies for identifying clients in need of mental health services, (5) the integration of mental health services into TANF employment plans, (6) the administrative structure for delivering services, and (7) the approach to funding mental health services.

Designing programs to address the mental health needs of welfare recipients is a complex endeavor. Program design decisions made in one area may influence the design of other program dimensions. For example, programs that address a variety of barriers such as mental health, substance abuse, learning disabilities, and domestic violence require an administrative structure and staff skills that differ from programs that address mental health conditions exclusively. In weighing potential approaches to address the mental health needs of welfare recipients, careful consideration needs to be given to each key program dimension and how it might influence the overall approach to providing services.

In this introductory chapter, we discuss the context for this study, the prevalence and types of mental health conditions among welfare recipients, and how mental health

[1] For the purpose of this report, *welfare office* is used as a generic term to describe a place that serves welfare recipients, which, in some areas, may be a combined welfare/workforce development system.

TABLE I.1

SUMMARY OF KEY PROGRAM DIMENSIONS

Program Dimensions	Florida	Oregon	Tennessee	Utah
Types of mental health services provided	Screening and assessment Linking clients to existing treatment Expansion of existing mental health services Intensive case management	Screening and assessment Linking clients to existing treatment Short-term mental health counseling (crisis intervention only) Training/consultation for employment case managers Intensive case management Assistance in applying for SSI	Screening and assessment Linking clients to existing treatment Short-term mental health counseling Training/consultation for employment case managers Intensive case management Assistance in applying for SSI	Screening and assessment Linking clients to existing treatment Short-term mental health counseling Expansion of existing mental health services Training/consultation for employment case managers Intensive case management Assistance in applying for SSI
Target population	Low-income families with incomes below 200 percent of poverty	Adults on TANF	Adults and children on and transitioning off TANF	Adults on and transitioning off TANF
Range of service needs addressed	Mental health Substance abuse	Mental health Substance abuse	Mental health Substance abuse Domestic violence Learning disabilities Child behavioral problems	Mental health
Strategies for identifying clients with mental health conditions	Formal presentations Broad screenings Referrals by employment case managers Community outreach	Formal presentations Broad screenings Referrals by employment case managers	Formal presentations Broad screenings Referrals by employment case managers Automatic referrals to mental health services (sanctions) Community outreach	Referrals by employment case managers Automatic referrals to mental health services (sanctions and time limits)
Integration of mental health services into employment plans	Up to 5 hours of mental health services per week in work plan	Modified work plans (Flexibility in types of activities and hours for clients participating in mental health services)	Modified work plans (Flexibility in types of activities and hours for clients participating in mental health services)	Modified work plans (Flexibility in types of activities and hours for clients participating in mental health services)
Agencies administering and providing mental health services	Mental health & substance abuse program offices Contracted service providers	Local employment service providers and welfare offices Contracted service providers	University of TN Contracted service providers	State welfare agency Contracted mental health service providers (minimal)
Funding Approach	$45 million statewide Designated funding	Varies by district No designated funding, included in funding for employment services	$8 million statewide Designated funding	$1.7 million statewide Designated funding

conditions affect employment. We also describe the study, including our general approach to the work, the selection of the study sites, and the data collection procedures. Chapter II covers key program design issues, including how to define the types of services to be addressed and how to identify clients with mental health conditions. Chapter III discusses the key decisions involved in building an infrastructure to provide services, that is, deciding who will provide and administer services and how the services will be funded. Chapter IV highlights the issues involved in implementing mental health services for welfare recipients, and Chapter V summarizes the lessons learned from this early look at programs designed to address the mental health needs of TANF recipients. Appendix A includes a detailed description of each study site, and Appendix B provides contact information for obtaining copies of the program forms, including the screening and assessment tools used in the study states.[2]

A. CONTEXT FOR THE STUDY

PRWORA gave states considerable flexibility in deciding how to spend their TANF block grant funds. States may use TANF funds to provide nonmedical mental health treatment services for welfare recipients and other low-income families at risk for TANF involvement. Such services might include specialized short- or long-term counseling services, or outreach, assessment, and case management intended to link clients to existing mental health services. In addition, TANF funds can be used to expand the capacity of treatment providers as long as the expansion covers only nonmedical services and is targeted to families who are eligible for TANF-funded services. States can also use funds from the Welfare-to-Work grants program to provide mental health services, although there are more constraints on who can be served with these funds.

Most welfare recipients qualify for Medicaid, so they can access mental health treatment through Medicaid-funded providers. While some TANF recipients may be receiving services through these providers, others may not know how to access such services, while still others may not be aware that they have a mental health condition. The flexibility of TANF allows states to fund efforts designed to identify clients in need of services and link them to existing Medicaid-funded mental health services. It is also possible that TANF recipients need services not easily accessed or offered by a Medicaid provider. Program administrators could address these needs by using TANF funds to expand existing services or to provide services not currently offered by Medicaid providers. The drawback is that TANF funds now available for mental health services may shrink as a result of either the outcome of the reauthorization debate or a downturn in the economy. (The latter would force states to use the funds to provide cash assistance and employment services to the families moving onto welfare because of the downturn.)

[2] Appendix B is available at www.aspe.hhs.gov\hsp\TANF-MH01\forms\.

The states profiled in this report are leading the development of innovative approaches to providing mental health services to TANF recipients. In all of the approaches, existing services have been augmented, not replaced. In addition, all of the states have used TANF funds to identify recipients in need of mental health services and to link them with these services. Two of the states have created specialized mental health services that are delivered within the welfare system, and two have expanded the capacity of existing providers to serve TANF recipients or TANF-eligible families.

Medicaid-Funded Mental Health Treatment Providers

In most states, Medicaid covers a basic range of services for treating mental health conditions, such as individual or group therapy, crisis intervention, psychiatric evaluations, medications, day treatment, and inpatient care. States decide not only the type of Medicaid-funded mental health benefits, but also the amount, scope, and duration of benefits. In general, the type and amount of treatment for those accessing Medicaid often are more restricted than for those with private health insurance.

Within each community are Medicaid-funded mental health treatment providers, which are any mental health agency where welfare recipients can access mental health treatment using Medicaid assistance. Access to treatment through Medicaid-funded service providers tends to vary within and between states. For example, in some areas, frequent staff turnover and a limited number of staff have created difficulties in accessing treatment at the Medicaid service provider.

For TANF recipients referred to the Medicaid treatment providers, the treatment typically has a short-term orientation and tends to be provided in groups rather than individual therapy. Clients who are seen individually may be scheduled for treatment every other week. In addition, therapy may be geared toward those with diagnosable mental disorders, which may not include all TANF recipients referred to mental health services.

The advantage to using the Medicaid managed care providers for treatment is that state Medicaid funds can be used to draw down federal matching funds to help share the cost of treatment. This allows TANF funds to be used for other purposes. The drawback to using Medicaid treatment providers is that the types and amount of treatment are often restricted and, in some areas, clients have difficulty accessing treatment.

B. RATIONALE FOR INTEGRATING MENTAL HEALTH SERVICES INTO TANF PROGRAMS

Although most states have made significant progress in moving families off welfare and into the labor force, many families continue to receive cash assistance. While some of these

families are new to the TANF system, many have been receiving assistance for some time and may therefore be at risk of losing cash assistance due to approaching time limits. As legislators and TANF administrators assess the progress that has been made since the passage of welfare reform, it is becoming apparent that some individuals, especially those with mental health conditions, may need more job-related assistance than most welfare employment programs are designed to provide. Because mental health conditions are more common among low-income families in general and welfare recipients in particular than they are among the general population, addressing the mental health needs of welfare recipients is a priority for many program administrators. The goal of providing services to these individuals is to increase the likelihood that they will be able to make the transition from welfare to work and remain employed.

1. Higher-Than-Average Incidence of Mental Health Conditions among Low-Income Families and Certain Minority Groups

According to a report by the U.S. Surgeon General (1999), low-income families and certain minority groups have higher-than-average rates of mental disorders. Those in the lowest socioeconomic group are about two-and-a-half times more likely to have a mental disorder than those in the highest socioeconomic group (Holzer et al. 1986, Regier et al. 1993). In a study of mental health conditions among single mothers, Jayakody and Stauffer (2001) found that single mothers have significantly higher rates of psychiatric disorders than do married mothers, and that low-income single mothers and those receiving cash assistance have even higher rates of psychiatric disorders than do single mothers who earn more than $20,000 a year. In a review of depression and low-income women, Lennon et al. (2001) reported that the rates of depression among low-income families are approximately twice those in higher-income families. Poor women—particularly those who have been exposed to traumatic experiences such as childhood abuse, domestic violence, rape, and other criminal behaviors—are at even greater risk for mental health problems (Bassuk, Browne, and Buckner 1996; Bassuk et al. 1996; Brooks and Buckner 1996; Miranda and Green 1999).

African Americans and Native Americans also have higher rates of mental health conditions compared to whites. However, some researchers argue that most of these differences can be attributed to disparities in socioeconomic status (U.S. Department of Health and Human Services 1999). There are fewer differences in the rates of mental disorders between whites and other ethnic groups.

Though there are few differences in the overall rates of mental illness between men and women, women are more prone to certain mental health conditions such as depression, post-traumatic stress disorder (PTSD), and anxiety disorders (Ulbrich et al. 1989, McLeod and Kessler 1990, Turner et al. 1995, Miranda and Green 1999). It is estimated that the rate of depression among women is 1.5 to 3 times the rate among men (Lennon et al. 2001).

2. Higher-Than-Average Incidence of Mental Health Conditions among Welfare Recipients

Compared to the general population, welfare recipients have higher-than-average rates of mental health conditions (see Table I.2). Approximately 6.5 percent of the general population is diagnosed with major depression in a given year. Fewer individuals are diagnosed with PTSD (3.6 percent) or generalized anxiety disorder (3.4 percent) (U.S. Department of Health and Human Services 1999).

TABLE I.2

PREVALENCE OF SPECIFIC MENTAL DISORDERS AMONG WELFARE RECIPIENTS

Disorder	U.S. General Adult Population	Female Welfare Recipients in Michigan	Long-Term Welfare Recipients in Utah
Major Depression	6.5%	26.7%	42.3%
Post-Traumatic Stress Disorder	3.6%	14.6%	15.1%
Generalized Anxiety	3.4%	7.3%	6.7%

Sources: U.S. Department of Health and Human Services (1999), Danziger et al. (1999), Barusch et al. (1999).

There is wide variation in the reported rates of mental health conditions among welfare recipients. Estimates differ depending on how mental health conditions are defined and measured, and by the population studied. In the National Survey of America's Families, 35 percent of low-income families reported having poor mental health using scales measuring anxiety, depression, loss of emotional control, and psychological well-being (Zedlewski 1999). Researchers in Michigan found similar rates of mental health conditions (36 percent) among welfare recipients (Danziger et al. 1999). In a look at the prevalence of mental health, substance abuse, and domestic violence issues among California's CalWORKs participants, Chandler and Meisel (2000) found that more than one-third of these individuals had at least one diagnosable mental disorder in the previous 12 months, and about 20 percent had two or more. Of those with a mental disorder, more than one-fourth indicated their disorder interfered "a lot" with life or daily activities.

Major depression is the most common mental disorder among welfare recipients, followed by PTSD and generalized anxiety disorder. The prevalence of depression is startlingly high. In a Michigan study of barriers to employment faced by female welfare

recipients, 27 percent of the study sample screened positive for clinical depression (Danziger et al. 1999). Researchers in Utah, using the measure for depression used in the Michigan study, found that 42 percent of long-term welfare recipients in Utah had clinical depression in the year before the interview (Barusch et al. 1999). This rate is nearly seven times that of the general adult population. Barusch et al. also found that 57 percent of these long-term welfare recipients were currently at risk for depression. Other researchers have found sizable differences in the rates of depression between welfare recipients and nonrecipients (Olson and Pavetti 1996, Leon and Weissman 1993).

While it is clear that depression is the most widespread mental health condition among the welfare population, what is not clear is the extent to which the depression precedes unemployment and receipt of cash assistance or vice versa, the depression being a product of the stress and frustration associated with those experiences. Regardless of which comes first, the symptoms of depression—sleeplessness, loss of self-esteem, social withdrawal, apathy, and fatigue—often interfere with the ability to find and keep a job and to support a family.

In addition to depression, generalized anxiety disorder and PTSD are prevalent among the welfare population and are often a result of childhood maltreatment, domestic violence, and other traumatic experiences. Welfare recipients experience generalized anxiety disorder and PTSD at rates substantially higher than the general population (see Table I.2). In-person interviews of women on welfare in Michigan revealed that the incidence of PTSD is four times that of the general population (Danziger et al. 1999). And the rate of generalized anxiety disorder among these women is twice as high as in the general population. Using the same measures as the researchers in Michigan, researchers in Utah found similar results among long-term welfare recipients (Barusch et al. 1999).

3. Strong Relationship between Mental Health and Employment

Overall, there is a strong relationship between mental health and employment. Those with mental health conditions are more likely to have poor and sporadic work histories, to be unemployed, and to be receiving cash assistance. Nationally, between 70 and 90 percent of working-age adults with serious mental illnesses are unemployed (Baron et al. 1996, National Institute on Disability and Rehabilitation Research 1993). Other studies focusing more broadly on mental disorders have also found that the presence of a mental disorder is associated with a decreased likelihood of working. Mintz et al. (1992), who looked at the relationship between depression and the general capacity to work, found that about half (52 percent) of depressed patients said that they had some level of functional work impairment. Lennon et al. (2001) concluded that depression may interfere with an individual's capacity to retain employment. In a review of research, Johnson and Meckstroth (1998) reported that mental health conditions not only result in lower rates of labor force participation but also in reduced work hours and lower earnings among those who are working.

Examining the link between mental health conditions and employment in welfare recipients, Danziger et al. (1999) found that major depression significantly decreased the likelihood that a woman on welfare would work, although other conditions such as generalized anxiety disorder and PTSD had no noticeable effect on employment. Focusing on the relationship between mental health conditions and welfare receipt, Jayakody et al. (1999) found that the presence of one or more of four psychiatric disorders increased the likelihood of receiving cash assistance by 32 percent.[3] In a related study, researchers reported that those who were diagnosed with major depression were 40 percent more likely to receive cash assistance than those not so diagnosed (Leon and Weissman 1993). Finally, Olson and Pavetti (1996) found that welfare recipients without a mental health condition were almost twice as likely to be employed throughout the year compared to those with a mental health condition.

Mental health conditions may affect employment in various ways, creating, for example, an inability to concentrate, fatigue, poor interpersonal skills, and difficulty sustaining a job. The stigma associated with mental health conditions may prevent a person from requesting workplace accommodations such as a flexible work schedule to manage a mental disorder.

C. DESCRIPTION OF THE STUDY

This study was designed to be exploratory in nature. Our primary goal was to gather as much information as possible on mental health services for welfare recipients in selected states and to identify the key decisions involved in providing these services and the options for delivering them. We were also interested in documenting the challenges faced, and lessons learned, by state and local welfare administrators and program staff in implementing and providing these services. This study is based on in-depth site visits to eight communities, including a rural and an urban location in each of four study states—Florida, Oregon, Tennessee, and Utah. Here we explain how we identified candidate programs for the study, our approach to site selection, and our data collection methods.

1. Initial Identification of Programs Designed to Address the Mental Health Needs of Welfare Recipients

To begin this study, we gathered information on a broad range of programs and agencies that provide mental health services to welfare recipients or other low-income populations. To identify these programs, we reviewed several recently published reports on programs for the hard-to-employ, searched the Internet for such programs, and consulted with other researchers and program administrators who we knew were knowledgeable about and/or were providing mental health services to welfare recipients. In addition, the National Governor's Association sent an announcement to key state contacts notifying them that we

[3] Psychiatric disorders included in the study: (1) major depression, (2) generalized anxiety disorder, (3) agoraphobia, and (4) panic attack.

were looking for programs designed to address the mental health needs of welfare recipients. From these sources combined, we identified 23 programs that were providing mental health services to welfare recipients and other low-income families; 16 of these programs were operating state- or countywide.[4]

After we developed a list of programs, we held brief telephone conversations with each of the program administrators providing mental health services at the state or local level. Calls typically lasted 30 minutes and covered a range of topics, including client characteristics, program staffing, number of clients served, types of services provided, ways clients are informed about services, length of time the state or community had been offering services, and general experience in delivering these types of services.

2. Selection of the Sites

Our goal in selecting the sites was to include a range of programs that were operating at the state or county level, had sufficient experience in serving welfare recipients, and that varied in how they structured and provided services. We also wanted to include a mix of rural and urban sites. Specific site-selection criteria included the following:

- **Provision of Mental Health Services to Welfare Recipients Statewide or Countywide.** Programs designed to address the mental health needs of welfare recipients vary in scale. Some operate at the state or county level and are integrated into the full range of services provided to welfare recipients. Others are individual programs run through one agency that serve a narrowly defined group of clients. We selected only programs operating on a state or county level, but they could be run out of the welfare, workforce development, or mental health systems.

- **Operating Before or Since the Implementation of PRWORA in 1996.** Most of the programs we identified were implemented in response to state and federal welfare reform efforts. However, several programs were designed before the passage of federal welfare reform. Our goal was to include programs that, together, would represent a range of experience. For instance, from the programs that have been in operation for a longer period of time, we hoped to gather more information about how they have evolved. From the more recently established programs, we hoped to gather information on program design in the context of a work-based assistance system and a block grant funding arrangement.

- **Service Provision to a Relatively Large Number of Clients.** We wanted to include programs that have substantial experience in providing mental health

[4] Ten of the programs were operating statewide. Programs varied in the extensiveness of the services they provide.

services to welfare recipients, as defined by the number of clients served. We selected statewide programs that had served at least 500 clients and countywide programs that had served at least 200 clients since inception.

- **Variation in the Structure and Delivery of Services.** States and localities can structure and deliver mental health services to welfare recipients in a variety of ways. For example, some programs provide all of the services in-house, others use contracted service providers, and still others use a combination of the two. We attempted to include programs that would represent this variation in service type, structure, and delivery. In addition to the administrative framework for providing mental health services, we also considered the administrative structure for providing employment services, staffing for mental health services, the approach to identifying clients with mental health conditions, and the location at which mental health services are provided.

- **Rural/Urban Mix of Study Sites in Each State.** We wanted to include an urban and a rural site for each state to learn how location, community demographics and infrastructure may influence the way mental health services are structured and delivered. In choosing the urban sites, we wanted to include at least one site with a very large and demographically diverse TANF population. In general, we let program administrators recommend sites. We were also looking for urban and rural sites in close proximity to one another or sites that may have implemented an innovative approach to providing services.[5]

Based on these criteria, we selected eight study sites—a rural and an urban site in each of four states (Table I.3). A detailed description of each state's approach to providing mental health services to welfare recipients appears in Appendix A.

3. Data Collection

We collected data for this study primarily through two- to three-day site visits. In addition to collecting information on service delivery, types of services provided, and implementation challenges and lessons, we gathered information about the environment in which these services are provided, including the state welfare system (e.g., policies and administrative structure) and the mental health service delivery system for low-income families.

[5] For example, in Utah, St. George (Washington County) was selected because the program uses a Welfare-to-Work competitive grant to expand the capacity of existing mental health services.

TABLE I.3

STUDY STATES AND SELECTED URBAN AND RURAL SITES

State	Urban Sites		Rural Sites	
	Site	**TANF Cases**	**Site**	**TANF Cases**
Florida	Miami (Dade County)	16,615	Belle Glade (Palm Beach County)	222
Oregon	Portland (Multnomah County)	3,500	Astoria (Clatsop County)	125
Tennessee	Chattanooga (Hamilton County)	2,450	Clarksville (Montgomery County)	571
Utah	Salt Lake City (Salt Lake County)	2,165	St. George (Washington County)	800

During each site visit, a two-person team conducted 60- to 90-minute semi-structured interviews with a wide range of welfare and mental health program staff, including staff from the welfare office, mental health treatment providers, and other key players involved in identifying and treating mental health conditions. In addition, we collected organizational materials (e.g., program descriptions, organization charts, service delivery pathways, etc.), screening and assessment tools, reporting and tracking forms, outcome and evaluation reports, and other types of materials at each site. We synthesized all of this information in in-depth descriptive program summaries for each state.

CHAPTER II

DESIGNING A MENTAL HEALTH SERVICE SYSTEM FOR TANF RECIPIENTS

Each of the study states has a distinctive approach to addressing the mental health needs of welfare recipients. In Oregon and Utah, mental health services were implemented in the early 1990s, before welfare reform, as a part of a range of services to address barriers to employment faced by welfare recipients. Since the passage of welfare reform, Florida and Tennessee have developed statewide systems for addressing the mental health needs of TANF recipients. More specifically, all four states vary with respect to the decisions they have made regarding four key program elements: (1) the types of services provided, (2) the population targeted for services, (3) the range of personal and family challenges addressed, and (4) strategies for identifying clients in need of assistance. In this chapter, we explore these decisions states have made in each of these areas.

A. TYPES OF SERVICES

There is great variation in the types of mental health services provided by the study states to TANF recipients (see Table II.1). In Oregon, mental health specialists primarily screen and assess TANF clients for mental health conditions and link them to a mental health treatment provider in the community. In Tennessee, family services counselors conduct in-depth assessments and provide crisis intervention and short-term mental health treatment. Individuals with more severe mental health treatment needs are linked with Medicaid-funded treatment providers. In Florida, outreach workers identify and screen clients who appear to need mental health services and link them to Medicaid-funded providers or to contracted mental health treatment providers that are paid through TANF funds. In Utah, clinical social workers stationed in the local welfare offices conduct clinical assessments and make diagnoses and recommendations for mental health treatment. They

TABLE II.1

TANF-FUNDED MENTAL HEALTH SERVICES PROVIDED IN THE STUDY STATES

Services	Florida	Oregon	Tennessee	Utah
Screening and assessment	X	X	X	X
Linking clients to existing treatment	X	X	X	X
Targeted short-term mental health counseling		**	X	X
Expansion of existing mental health services	X			X
Resource/consultation for employment case managers		X	X	X
Intensive case management*	X	X	X	X
Assistance in applying for SSI		X	X	X

*In all of the study states, intensive case management is provided in some of the local welfare offices (or contracted mental health service providers).

**Mental health counselors in Oregon provide crisis intervention only.

also provide some crisis intervention and short-term, employment-focused mental health treatment.

The choice of which mental health services to offer is often based on the needs of clients and the resources available in the local communities. This section explores the types of mental health services provided through the local welfare office and describes some of the ways that these types of services are delivered. Most programs include one or more of the following services: (1) screening and assessment, (2) linking clients to existing treatment, (3) targeted short-term mental health counseling, (4) expansion of existing mental health services, (5) resource or consultation for employment case managers, (6) intensive case management, and (7) assistance in applying for Supplemental Security Income (SSI).

1. Screening and Assessment

All of the programs use some variation of screening and assessment to identify clients and link them to mental health services. In general, this process occurs in two stages. In the

first stage, TANF clients are screened to detect individuals more likely to face mental health conditions. This may be a broad screening during TANF orientation or an individual screening by employment or mental health staff. In the second stage, clients are assessed through a more in-depth examination of the nature and extent of the mental health condition. Assessments may also include a recommendation about the number of hours and types of activities to include in the client's employment plan. The box on the next page more fully describes the screening and assessment tools and the techniques used to identify TANF recipients in need of mental health services.

The study states approach screening and assessment in several ways. Florida is the only state that has hired outreach staff to identify and screen welfare recipients and other low-income families to determine those who may need mental health services.[6] These outreach staff are not licensed mental health professionals; they use a standardized screening instrument and are expected to make referrals to treatment providers in the community based on the results of the screen. Further assessment and treatment planning is provided by licensed mental health professionals after the referral is made. Oregon, Tennessee, and Utah have hired primarily licensed mental health staff, who are highly skilled in conducting mental health assessments, to carry out a screening and assessment before a treatment referral is made. The screening and assessment process in these three states is designed to identify persons in need of mental health treatment, determine the most appropriate treatment provider, assess the client's ability to participate in work activities, and develop a plan for addressing the client's mental health and employment needs. In Utah, staff also use standardized assessment inventories to diagnose specific mental health disorders.

2. Linking Clients to Existing Community Mental Health Treatment Services

In Florida and Oregon, the primary purpose of mental health services is to identify clients with mental health conditions through an assessment and link them to mental health treatment providers within the community. In Utah and Tennessee, mental health counselors provide short-term therapy to some clients and link others to mental health treatment agencies. However, mental health counselors who have high caseloads or are working with clients with extensive mental health needs typically link clients to other treatment providers. The complexity of the process for linking clients to mental health services depends on the availability and structure of mental health services in the local community; the process is often streamlined when the mental health counselor is an employee of the agency to which the client is referred.

One of the primary challenges faced by mental health counselors in linking clients to services is obtaining access to treatment in a timely manner. The wait time for treatment is particularly problematic under managed care arrangements. In some sites, clients are required to wait up to a month before they see a mental health counselor, and sometimes

[6] How broadly clients are screened varies by local office.

Screening and Assessment Tools or Techniques Used to Identify TANF Recipients in Need of Mental Health Services

Mental health staff use a variety of tools and techniques to screen and/or assess clients. The study sites use three such tools to screen and assess welfare recipients for mental health conditions:

Standardized instrument. Standardized screening and assessment tools are used statewide in Florida and Tennessee. Although these tools vary in length, they cover a wide variety of mental health and other conditions. Florida outreach workers use a 32-item screening tool that focuses exclusively on substance abuse and mental health. Tennessee is the only study state that has created a standardized, general assessment tool for use by licensed mental health professionals. It covers a range of topics such as source of stress, current functioning, health, and history of counseling. Mental health counselors in Tennessee also use the following, more specific tools to assess mental health needs and related needs: a Learning Needs Screening, Drug and Alcohol Referral Screening, Family Violence Screening, and a Functional Assessment screening tool. The advantage of using a standardized assessment tool is that it creates uniformity in the program and levels out the variation among workers in screening and assessment skills. The drawback is that it is difficult to adjust or tailor the instrument to client needs; as a result, some key information may be overlooked.

Clinical inventories. Many mental health counselors who do not use a standardized assessment tool use some type of clinical inventory in combination with their own clinical skills to conduct client assessments. Clinical inventories detect clinical depression, generalized anxiety, personality disorders, and suicide risk, among other disorders. Clinical inventories can be administered differently depending on the mental health counselor. Some mental health counselors use specific inventories depending on what mental health conditions they sense may be an issue for clients. For example, if a social worker suspects that a client may be depressed, he/she would use a depression scale to explore this possibility in greater depth, but the depression scale would not be administered to every client. Other mental health professionals use the same inventories for all clients. The advantage of clinical inventories is that they are a valid, reliable way to identify specific mental health conditions. The drawback is that they tend to be long, and staff may need additional training to score and interpret results.

Clinical expertise. Many of the mental health professionals we interviewed rely on their experience to guide the types of questions they ask a client during an assessment. They may or may not include clinical inventories to augment this expertise. The advantage of clinical expertise is that it allows the mental health counselor to individualize the assessment. The challenge is that it may be costly or difficult to hire licensed mental health staff with this expertise.

even longer to see a psychiatrist. The ability to access treatment in a timely manner appears to be worse in the urban than in the rural areas. According to mental health professionals, as the wait for treatment increases, so does the likelihood that the client will no longer participate in treatment. Mental health counselors often provide short-term mental health treatment until a mental health treatment provider can see the client.

Overall, there are two primary advantages to having mental health counselors link clients to services: clients have someone to guide them through the process of accessing mental health treatment, and according to some workers, counselors can actually help clients access treatment more quickly, especially when it is provided through Medicaid providers. One of the challenges for mental health counselors is that their role requires them to be aware of different treatment options in the community.

3. Targeted Short-Term Mental Health Counseling Services

The study states provide two types of short-term mental health counseling services to TANF recipients through the welfare system—crisis intervention and short-term employment-focused counseling. Crisis intervention services are typically and more easily provided when a mental health clinician is co-located, and therefore readily available, in local welfare and employment service offices. Crisis intervention services are offered in the welfare office in all of the study states except Florida. These services are provided when a client is extremely emotional (e.g., crying, angry, etc.) or when a client has told mental health or employment staff of a plan to harm themselves or others. The goal of crisis intervention is to stabilize a client and link him or her to appropriate services (such as hospitalization or a crisis unit at a local mental health agency).

Utah and Tennessee hire or contract with licensed mental health professionals to provide short-term mental health therapy to welfare recipients. On average, short-term therapy consists of 6 to 10 sessions and may be provided individually or in groups. In general, the therapy is employment-focused and is designed around addressing barriers to employment. Those with long-term mental health needs are referred to a Medicaid provider.

4. Expansion of Existing Mental Health Services

Two of the study states, Florida and Utah, have used TANF funds to expand community mental services. Florida contracts with a wide variety of community providers to provide the full range of mental health services to TANF recipients, including individual and group counseling, marital therapy, intensive case management, substance abuse treatment, and numerous other nonmedical treatment options. These services are also available to those at risk for TANF involvement. Florida is the only state that provides funding to existing providers to provide long-term therapy for TANF clients. Utah uses a more targeted approach to expanding the services available to TANF recipients. Generally, clients who need extensive mental health treatment are referred to Medicaid-funded

Tennessee's Solution-Focused Brief Therapy

In Tennessee, in-house mental health counselors are trained extensively in solution-focused brief therapy and are expected to use it in providing treatment to TANF clients referred to their program. The objectives of solution-focused, brief therapy are to identify the problems that keep a client from becoming employed and to explore options for resolving those problems. Solution-focused therapy is based on four major concepts:

1. **The overall goal is change.** The counselor's role is to guide clients through the process of identifying what needs to change to improve their circumstances, and to motivate and encourage clients to make these changes.

2. **There are practical solutions to problems.** The counselor helps clients to focus on what is possible and changeable, and to outline a plan for working through barriers.

3. **Clients define their goals and determine how they will reach them.** The counselor raises client's consciousness about problems by pointing out discrepancies in their handling of issues, rather than by telling clients what they need to change and how they should do it.

4. **It is important to identify and tap into clients' strengths and resources.** The mental health counselor helps clients recognize and tap into their own strengths and resources to solve problems.

providers. However, if the wait for services at a Medicaid provider is longer than two weeks, or if the services needed are not available, the client can be referred to a mental health professional who is not funded through Medicaid. Contracting out mental health treatment also allows the program administrator to determine the treatment model or approach used by the contractor, which they cannot do with a Medicaid-funded service provider.

5. Training/Consulting for Employment Case Managers

Except in Florida, mental health counselors in the study states provide consultation and training for employment case managers in how to identify and manage clients with mental health conditions. The types of consultation vary by local office, but mainly include the following:

- **In-Service Training.** Mental health counselors in some offices provide in-service training to new and experienced workers in how to identify clients with mental health conditions and in how to handle difficult behaviors.

- **Case Staffings.** Mental health counselors are often included in case staffings for clients who are about to be sanctioned or who are nearing the end of their time limit. Employment case managers with whom we talked indicated that they often rely on the expertise of the mental health counselors to make recommendations for how to handle cases and to identify resources in the community to which a client may be referred.

- **Recommendations for Employment Plans.** Mental health counselors frequently provide initial and ongoing recommendations to employment case managers about the types and volume of activities to include in clients' employment plans. Recommendations are based on client assessments completed by mental health counselors.

- **Individual Consultation with Employment Case Managers on Difficult Cases.** Employment case managers often consult with a mental health counselor when faced with a difficult case, such as a client with a personality disorder. Mental health counselors tell case managers about certain behaviors they can expect to see with certain conditions and about ways to handle these behaviors.

6. Intensive Case Management

Mental health counselors or other mental health staff may also provide more intensive case management that includes working with clients to develop basic life skills such as managing their time, setting goals, and budgeting their money. It may also include linking clients to other types of services in the community (e.g., substance abuse treatment, domestic violence service, homeless shelters, food pantries, etc.). In Clarksville, Tennessee, and St. George, Utah, master's level mental health clinicians are paired with bachelor's level workers to provide intensive case management and mental health services. In these arrangements, the bachelor's level workers primarily provide the intensive case management, leaving the clinicians more time to conduct assessments and provide short-term treatment. Western Palm Beach County Mental Health Clinic, a contracted mental health service provider in Belle Glade, Florida, hired one intensive case manager exclusively for welfare recipients.

7. Assistance in Applying for SSI (Supplemental Security Income)

Mental health staff may also provide assistance in applying for SSI (Supplemental Security Income) to clients with a diagnosed mental health condition that prevents them from working. In Utah, social workers coordinate psychological evaluations and walk clients

through the often long and difficult application process. Assistance in applying for SSI is also extended to TANF recipients in Tennessee and parts of Oregon. Providing this kind of service requires mental health staff to act as advocates for clients and to be informed about the policies and procedures for accessing SSI. In general, mental health counselors estimate that 5 to 10 percent of the clients who are referred to mental health services may be eligible for SSI.

Types of Mental Health Conditions and Other Challenges Among Welfare Recipients

According to mental health providers, welfare recipients who participate in mental health services exhibit a wide range of mental health conditions that act as barriers to work. The most prevalent of these conditions are depression, PTSD, generalized anxiety, and adjustment disorders. A small percentage were reported as having more challenging mental health conditions such as personality disorders or psychotic disorders (e.g., schizophrenia).

In addition to these conditions, welfare clients participating in mental health services face a host of other barriers to work. For instance, mental health counselors indicated that many clients have been emotionally, physically, and/or sexually abused during childhood, or have experienced other types of major trauma. Still others face such challenges as domestic violence, low self-esteem, limited parenting skills, homelessness, lack of supportive networks (such as family or friends), and poor coping and problem-solving skills. It is unclear whether the mental health conditions are results of the families' poverty and dysfunction, or whether the poverty and dysfunction are products of the mental health conditions.

B. THE POPULATION TARGETED FOR SERVICES

The population targeted for TANF-funded mental health services differs by state, reflecting, for the most part, whether program administrators chose to provide services only to TANF recipients, to those considered "at risk" for TANF involvement, and/or to those who once received TANF services. Program administrators also considered whether to serve only adults on TANF or to extend mental health services to children. These decisions about the target population influence not only who might be eligible for mental health services, but also how many individuals might be eligible.

1. Adults on TANF

All of the study states provide mental health services to adult TANF recipients. However, Oregon was the only state to provide mental health services *only* to adults receiving TANF. The other states expanded eligibility by continuing mental health services for some period after the TANF case closed by providing services to children in the household or by defining eligibility using income criteria rather than TANF receipt. The decision to restrict eligibility to adults on TANF reflects primarily resource constraints, but it also reflects the goals of the program. In Oregon, the primary goal is to identify clients in need of services and link them with resources in the community. The hope is that by the time clients leave assistance, they will be solidly connected with mental health providers who can provide ongoing services that are not tied to their TANF eligibility. In addition, providing mental health services to the head-of-household on TANF reflects Oregon's belief in the importance of helping the primary breadwinner become employed. In Multnomah County (which includes Portland), mental health staff already carried high caseloads. Families outside of TANF could only have been served at the expense of TANF recipients or by allocating additional funds to the program.

2. Adults Transitioning off TANF

The transition from welfare to work creates a new set of challenges for nearly all families. For adults with a mental health condition, the transition can be even more challenging. To provide parents with extra support if they need it, Tennessee and Utah extend eligibility for mental health services to TANF recipients for a year after their TANF case closes. Because Tennessee and Utah also provide short-term mental health counseling services directly to TANF recipients, it is possible that many of these individuals would not be receiving services from other mental heath providers, making it especially important to continue to deliver services through the TANF program to clients leaving TANF. Providing support to families during the transition to work could help to improve job retention.

3. Children in TANF Households

According to the U.S. Department of Health and Human Services (2000a), at least one in five children and adolescents age 9 through 17 has a diagnosable mental health disorder in a given year. Mental disorders among children can lead to failure in school, alcohol or drug use, violence, and suicide. Furthermore, the responsibilities and emotional stress associated with managing a child with a mental health condition can limit a parent's employability.

Two of the study states, Tennessee and Florida, extend eligibility for mental health services to children living in a TANF household regardless of whether the household head is receiving mental health services. The decision to provide mental health services more broadly to children of TANF families requires program administrators to think differently about the types of services offered. For instance, the mental health needs of children differ

from those of adults, so an entirely different set of treatment options must be offered. This approach may be more costly than restricting services to adults on TANF, but it addresses the needs of the entire family.

Another advantage of extending mental health services to children is that it may actually encourage parents who need treatment to participate in treatment. Mental health counselors indicated that parents may feel more comfortable accessing treatment for their children than for themselves and that being exposed to and involved in treatment through their children frequently decreases parents' anxiety about their own participation in mental health treatment.

4. Low-Income Families

Florida has taken full advantage of the flexibility to use TANF funds to serve families who may not be receiving cash assistance. For instance, TANF recipients and their children, former TANF recipients, households with a child-only TANF case, and non-TANF families that meet income and eligibility guidelines are eligible to receive TANF-funded mental health services. Non-TANF families include (1) a parent, caretaker, relative, or child in a family with an income less than 200 percent of the federal poverty level, (2) families receiving services in the Family Safety system (Florida's child welfare agency), (3) noncustodial parents where there is a court-ordered child support requirement and both custodial and non-custodial parents earn less than 200 percent of the federal poverty level and live in Florida, and (4) individuals receiving SSI or Social Security Disability Insurance (SSDI). Because many families move on and off of TANF, this "preventive" approach may reduce the number of families who receive cash assistance by helping parents stay employed. In addition, providing mental health services more broadly improves access to mental health services for sanctioned families, those who have reached their time limit, and families at-risk for TANF involvement.

C. DEFINING THE RANGE OF NEEDS TO BE ADDRESSED

Several researchers have found that a substantial proportion of welfare recipients have multiple barriers to employment and that the presence of multiple barriers decreases the probability of finding and keeping a job (Danziger et al. 1999, Zedlewski 1999, Olson and Pavetti 1996). Thus, an important decision in designing a system to address the mental health needs of welfare recipients is whether to address mental health issues separately or in combination with other personal and family challenges. The advantage of the latter approach is that it could address other issues that may be preventing clients from finding employment. However, it is likely to be difficult to find staff who are expert in assessment and treatment in multiple areas.

Decisions about how broadly to address service needs influence the kind of staff hired, how clients are identified for services, and the types of services provided. Among the study

states, there are three different models, or approaches, to defining the range of needs to be addressed: (1) primary focus on mental health conditions, (2) primary focus on mental health and substance abuse issues, and (3) broad focus on a variety of personal and family challenges. This section describes each model and its associated strengths and weaknesses.

1. Primary Focus on Mental Health

Programs designed to address mental health needs exclusively tend to provide intensive, comprehensive mental health services through experienced clinical staff. Utah's program focuses primarily on identifying mental health conditions and providing the services to address those conditions. Mental health staff may address other conditions (e.g., substance abuse, domestic violence, and child behavioral problems) as they arise, but staff mostly refer clients to agencies in the community to deal with other types of service needs. The advantage of this approach is that employment and mental health staff can focus exclusively on identifying and treating mental health conditions. In addition, staff in these programs typically have extensive experience in providing mental health treatment. They have a solid understanding of the mental health system and ways to access mental health treatment. The downside of this approach is that mental health staff may be so specialized that other conditions that may affect work go undetected and untreated.

2. Primary Focus on Mental Health and Substance Abuse

In general, there are high rates of co-occurrence between substance abuse and mental health conditions. A study conducted by Reis (1995) estimates that more than half of those with a mental health disorder also have problems with substance abuse. Individuals with co-occurring conditions often have treatment needs that addresses both substance abuse and mental health issues. Unfortunately, there is a shortage in most communities of treatment that addresses both conditions (U.S. Department of Health and Human Services 1999).

Oregon and Florida focus on both mental health and substance abuse needs. In Oregon, the staffing is structured in one of two ways. In some areas, one worker handles both substance abuse and mental health conditions. For example, in Astoria, the specialist has a Ph.D. in clinical psychology and is a certified substance abuse treatment provider. In other areas of the state, specialists in either function work as a team. In Multnomah County, for instance, individuals hired as either mental health or substance abuse specialists meet weekly to staff cases and coordinate the mental health and substance abuse treatment of clients.[7]

Given the prevalence of co-occurring substance abuse and mental health conditions, the service model addressing both may be especially effective. The primary challenge in implementing this model is to find staff who are clinically proficient in both areas. Typically,

[7] One specialist has combined mental health and substance abuse responsibilities.

it is easier to find individuals with training in one area or the other. In most communities, hiring staff who perform separate functions is easier than hiring staff with combined expertise. However, in some areas, particularly in rural locations, there are not enough clients to justify the need for two specialists. For instance, the Florida state Mental Health and Substance Abuse Program Offices contract with mental health and substance abuse agencies to provide services, relying on outreach workers to link clients to these services.

3. Broad Focus on a Variety of Personal and Family Challenges

Tennessee is the only state in this study that provides mental health services as one of several services targeted to hard-to-employ welfare recipients. Family services counselors in Tennessee address mental health, substance abuse, domestic violence, learning disabilities, and child behavioral conditions in welfare recipients. According to program administrators, identifying learning disabilities and providing services to address them has been the most difficult challenge for family services counselors.

Program administrators in Tennessee attempt to hire staff with expertise in at least two of the five service areas. In addition, the program director coordinates extensive training in how to identify the various mental health needs and in the types of services available in the community for addressing them. The advantage to this "holistic" approach to service provision may be an increase in the employability of TANF clients to the extent that none of the conditions interfering with employment goes unaddressed. The primary challenge in using this approach is finding staff with expertise in most of the service areas.

D. IDENTIFYING CLIENTS IN NEED OF ASSISTANCE

One of the first steps in providing mental health services is identifying clients who would benefit from the services and who are willing to participate in mental health treatment. Not only do programs vary in how clients are identified for mental health services, local offices within the same program frequently vary in their approach to identifying clients. Overall, there is no evidence to suggest that one approach is better than another for identifying clients in need of mental health services. Using multiple approaches in combination appears to be the most effective strategy and the one used by most local offices. Some of the primary ways that clients are identified for or informed about mental health services are discussed below.

1. Broad Screenings for Mental Health Needs and Informing Clients about Services

Broad screenings during client orientation to employment services and job club workshops are one way in which clients are informed about and identified for mental health services. In some local offices, mental health staff administer screening tools to all welfare

recipients during orientation to identify those at risk for mental health conditions. Welfare recipients in Miami, Florida, who receive employment services from the AWI (Agency for Workforce Innovation) Hialeah One-Stop Center, are screened by a bachelor's level outreach worker. A licensed clinical social worker in the St. John's welfare office in Portland, Oregon, talks with new welfare recipients during orientation and administers a depression scale and a general mental health screening.

A local welfare office in Astoria, Oregon, which has a unique approach to screening, identifies clients as candidates for mental health services during the initial intake. For instance, when clients first apply for cash assistance, they meet with the lead staff person, who has more than 20 years of experience as a welfare case manager. This lead staff person screens for TANF eligibility, informs clients about mental health services, and conducts a brief assessment to identify clients who may have a mental health condition. This type of approach may be more realistic in rural areas, where the caseloads are relatively small and staff are familiar with the families who receive cash assistance.

The advantage of broadly screening welfare recipients in the welfare office ensures that clients are identified and linked to services. The drawback of broad screening is that clients who may not need mental health services or who are not willing to participate in treatment are referred to mental health staff, which may overload mental health staff.

Clients also are informed about mental health services during formal presentations given during individual or group orientations, or during other meetings in the welfare office. Clients may then self-refer to mental health services. In Tennessee and Utah, mental health services are described to new and returning clients as part of their standard orientation. Clients receiving employment services in the Caleb One-Stop Center in Miami, Florida, learn about mental health services during the job club workshop. Clients may refer themselves to the program based on the information they obtain during the presentations.

Formal presentations ensure not only that clients are informed about mental health services, but also that they receive the same information about the services. Furthermore, it brings clients and mental health staff together, creating a direct link to services, rather than relying on a referral from employment staff. One challenge is obtaining permission from local welfare administrators to participate in client TANF orientation or during job search workshops to talk about mental health services.

2. Referrals by Employment Case Managers

Most programs rely heavily on employment case managers to identify clients in need of assistance and to refer them to mental health services. Employment case managers may be trained to identify mental health conditions as part of their own orientation when they are hired, during in-service meetings or case staffings, or individually by mental health counselors.

According to employment case managers, clients vary in how and when they disclose a mental health condition, but whether they even do so depends on the level of trust between the case manager and the client. This principle of trust is also critical to getting a client into treatment insofar as it also operates in the relationship between the employment case manager and the mental health counselor. Case managers report that they are more likely to make a referral if they trust the mental health counselors and believe the services they provide will benefit the client. In some local offices, a few case managers referred a large proportion of clients to mental health services. In other offices, the number of referrals was more evenly represented across case managers.

To find out more about how clients needing assistance are identified, we asked employment case managers about which behaviors or characteristics acted as a red flag for a mental health condition. Employment case managers cited extreme displays of emotion (such as anger or crying), no emotion at all (flat demeanor), lack of concentration or focus, unkempt appearance, children with behavioral problems, lack of participation or reluctance to participate in program activities, recent eviction from public housing, and making decisions not based on current conditions or with an eye toward the future. In general, most of the employment case managers we interviewed were able to describe some client behaviors and characteristics that signaled a mental health condition.

The advantage of relying on employment case managers to make the referral is that they have the most contact with clients and can therefore more accurately identify those who may have mental health needs. The drawback is that some employment case managers may be uncomfortable talking about mental health issues with clients and so may not refer clients to mental health services. For this reason, it is important to use a variety of approaches to link clients to mental health services.

3. Automatic Referrals to Mental Health Services

In some states, certain subgroups of the TANF population are automatically referred to mental health services. These subgroups include families who have been sanctioned for noncompliance in work activities, families nearing the end of their time limit on cash assistance, and clients with a potential drug or alcohol addiction. In Tennessee, sanctioned families are referred to the Family Services Counseling program. In Utah, licensed clinical social workers participate in extension hearings for families nearing their time limit. In addition, welfare recipients in Utah who respond "yes" to two or more questions on the four-question CAGE[8] substance abuse screening questionnaire are automatically referred to mental health services by the employment case manager.

[8] The name of the CAGE test comes from an acronym of first letters from questions used in the instrument. For example, the first letter "C" comes from the question, "have you ever felt the need to **C**ut down on your using/doing?"

The advantage of automatic referrals to mental health services is that clients most in need of these services are likely to get them. That is, the automatic referrals apply to people who are sanctioned or who are reaching their time limit but have not found employment, and we would assume that these clients are in this position because they face more severe barriers to employment, one of which could be a mental health condition. The challenge for the system is getting these clients to participate in mental health services. Some of the same barriers that prevented them from working or from participating in their employment plan may also be obstacles to participating in mental health treatment.

4. Community Outreach

The welfare/employment services local offices are not the only avenue through which clients are informed about mental health services. Some programs use extensive community outreach campaigns as well. Fliers, pamphlets, and formal and informal presentations are part of this "social marketing" effort. Florida and Tennessee's outreach efforts are noteworthy.

In Florida, outreach workers are the link between welfare clients and the mental health service delivery system. These individuals, who have at least a bachelor's degree, are employed by the contracted mental health and substance abuse treatment providers who screen clients and link them to services within their agency or with another contracted service provider. Outreach workers regularly visit community service providers (such as health clinics, day-care centers, food stamp offices, homeless shelters, and other agencies), leaving brochures about the program and talking with staff at these organizations. Outreach workers may be co-located in the welfare office or in other agencies, such as the local Head Start program and the health clinic.

In Tennessee, the program director, district coordinators, and welfare administrators have developed an intense and widespread social marketing effort. Tennessee's social marketing effort mostly consists of presentations and training sessions for welfare staff and other community partners, such as vocational rehabilitation, and education and training providers. The purpose of these efforts is to educate employment case managers and other agency workers who serve TANF recipients about the mission, goals, and successes of the Family Services Counseling program. According to the program director, the intense social marketing campaign not only informs people about the services, but also creates a sense of pride and enthusiasm among program staff members about providing these services.

The advantages of community outreach are that it informs service providers outside of the welfare office about mental health services and helps to cultivate collaborative relationships between agencies. For states that base eligibility for mental health services on income as well as TANF receipt, community outreach helps to identify low-income families who are at risk for TANF involvement. The drawback to this approach is that it is time-consuming and resource-intensive.

CHAPTER III

CREATING AN INFRASTRUCTURE TO PROVIDE MENTAL HEALTH SERVICES

A key challenge faced by program administrators is to create an administrative infrastructure through which appropriate mental health services are cost-effectively delivered to those in need. Such an infrastructure must draw on the strengths of the mental health resources in the local community *and* successfully integrate mental health services with employment services for welfare recipients. However, because TANF program administrators are not experts in the design and delivery of mental health services, it is usually necessary for them to rely on other agencies, organizations, or specialized staff for these functions. Cross-agency coordination is therefore critical to program success. In this section, we examine the key decisions made by the study states in their efforts to create a service delivery structure to address the mental health needs of TANF recipients. These decisions fall into four areas: (1) developing an administrative structure for the program, (2) defining staffing needs, (3) determining where services will be provided, and (4) allocating program funds.

A. DEVELOPING AN ADMINISTRATIVE STRUCTURE FOR THE PROGRAM

Each study state developed a very different administrative structure for delivering mental health services to TANF recipients. In three of the study states—Oregon, Tennessee, and Utah—the TANF agency maintains primary oversight for the program, although the extent to which the TANF agency is actively involved in the delivery of services varies considerably. In Florida, the responsibility for program oversight was transferred to the agencies that deliver and/or monitor mental health and substance abuse services. These differences in administrative structure reflect differences in the structure through which

employment services are provided to TANF recipients as well as differences in the scope of mental health services provided.

1. Utah: TANF Agency Provides Mental Health Services

Utah is the only study state in which mental health services for TANF recipients are provided primarily in-house through the TANF administrative agency. For over 10 years, licensed clinical social workers hired as welfare staff have been providing mental health treatment to welfare recipients in the welfare office. In 1996, Utah consolidated the six agencies that handled employment, job training, and welfare functions into the Department of Workforce Services (DWS). In 1998, a social work unit was formed within DWS to provide mental health services, and a uniform statewide set of policies, procedures, and reporting forms was developed. All mental health staff that serve welfare clients are DWS state employees. A state program manager administers and monitors the mental health services and acts as a liaison with welfare administrators to coordinate mental health services. Although most mental health services are provided by DWS staff, the state contracts with other mental health professionals to provide more extensive services when a Medicaid provider is not available to provide them in a timely manner.

The benefit of an in-house service delivery system is that program staff can be easily integrated into the agency's employment program, which may improve the communication between employment case managers and mental health staff and increase the number of referrals to mental health services. One of the drawbacks is that social workers can become professionally isolated within the local offices, making it difficult for them to obtain professional consultation from other mental health counselors. In Utah, the mental health program administrator in Salt Lake City provides supervision for all of the mental health workers. Social workers in rural areas communicate by E-mail and telephone when they need clinical consultation and support.

2. Oregon: Contracted Provider or Employment Services Agency Provides Mental Heath Services

Oregon has a state-administered TANF system, but local (district) offices have considerable flexibility to decide how to structure and provide employment-related services to TANF recipients. A program analyst in the state TANF agency acts as the statewide coordinator for mental health services. The program analyst oversees the policy guidelines and training for mental health and substance abuse services. The program analyst also coordinates with the mental health contracted treatment providers and addresses contractual questions. In the local offices, there is wide variation in the organization of mental health services. In two counties we visited, local program coordinators administer, monitor, and supervise the mental health and substance abuse services in their counties. Most counties have specialists in mental health and substance abuse treatment who have extensive experience and strong clinical training. Some offices have separate specialists for mental

health and substance abuse treatment, while other offices have a specialist with expertise in both areas.

Most mental health services are staffed by contractors, and, in general, contracting arrangements are handled either by the Adult and Family Services (AFS)[9] district office or through the prime employment and training service contractor. For example, in Astoria, the AFS district office contracts directly with Clatsop Behavioral Healthcare for a part-time (20 hours a week) licensed counselor to provide mental health and substance abuse services to welfare recipients. This licensed counselor is co-located in the Astoria welfare office and Clatsop Behavioral Healthcare. In Multnomah County, the employment and training service providers, Mount Hood and Portland Community colleges, hire mental health specialists directly. Through a subcontract with local mental health treatment providers, these specialists work within the local welfare offices. Mental health treatment is provided by Medicaid providers. In general, the Medicaid-funded mental health agencies provide a range of outpatient mental health services, including assessment, case management, and individual and group therapy. In-patient treatment is limited to the urban areas, and treatment for co-occurring mental health and substance abuse conditions is limited throughout the state.

The advantage of this model is that local communities can develop an administrative structure that works best for them. In addition, it provides district offices with an opportunity to fully integrate their mental health services into their welfare employment services program.

3. Tennessee: Contracted Agencies Administer and Deliver Mental Health Services

Tennessee's Family Services Counseling (FSC) program is under the purview of the TANF agency. However, the TANF agency has a contract with the College of Social Work at the University of Tennessee (UT) to administer the FSC program. In January 2000, UT hired a director to design and implement the FSC program. Family services counselors began receiving referrals in February 2000. FSC program staff are hired through both UT and local contracted service providers. The FSC program director and district coordinators are university employees. Within each district, the TANF agency contracts with local not-for-profit agencies to provide family services counselors and clinical supervision. In some of the communities, the local agencies had formed collaborative relationships prior to the FSC program. These relationships were instrumental in implementing the program in these areas. For example, DHS contracted with Family and Children's Services of Greater Chattanooga (FCS) to provide family services counselors for Hamilton County because FCS has been administering programs such as life skills training, parenting classes, employee assistance programs, and outpatient mental health treatment for over 120 years.

[9] AFS operates Oregon's welfare programs, which have a strong emphasis on employment and work supports.

When clients need services, they are referred to the TennCare mental health providers in addition to FSC counselors. The types of providers vary across the state. For example, urban Hamilton County has a variety of treatment providers, including a residential and an outpatient substance abuse treatment center, while rural Montgomery County has only one mental health center and several not-for-profit agencies that provide primarily group treatment to low-income families.

The advantage of this model is that it allows the welfare office to delegate responsibility for administering and providing mental health services to mental health professionals while maintaining some oversight over the program. Contracting with UT and local providers has made it possible for Tennessee to develop a statewide program model while drawing on community resources to deliver services at the local level. In addition, since the program was developed under the auspices of the TANF agency, it has been well integrated with welfare employment services from the start. The co-location of the mental health program director in the state welfare office and the co-location of district coordinators and mental health counselors in local welfare offices have also helped to integrate services.

4. Florida: Mental Health Agency Administers the Program and Contracts with Providers to Deliver Services

Florida is the only study state to transfer full responsibility for the operation of its mental health services program to an agency that has no direct ties to the welfare or the employment services system. The program is housed within the Department of Children and Families (DCF)[10] and operates under both the Mental Health and the Substance Abuse Program offices but collaborates on policy issues with the Office of Economic Self-Sufficiency.[11] A program director and three staff members in the state office administer the program. In each DCF district or region, at least one specialist oversees program activities in the local office. All program employees are hired as "other personnel services" (OPS) employees, which are temporary positions renewed every six months, without employment benefits (such as health insurance, sick leave, and retirement).

The DCF district or region administrator selects and contracts with mental health and substance abuse treatment providers in each local community. The terms of these contracts are negotiated with the TANF specialists and local district administrators. In some communities, there is one primary contractor, and in others there are many contractors. Contracted service providers include a range of organizations such as substance abuse and community mental health centers, residential treatment providers, faith-based organizations, and hospitals. The contracted service providers hire outreach workers, conduct clinical assessments, and provide mental health and substance abuse treatment.

[10] DCF is responsible for the state's economic and self-sufficiency services, family safety system services, mental health and substance abuse services, and adult and developmental services.

[11] The Office of Economic Self-Sufficiency is responsible for determining eligibility for TANF and other public assistance programs for low-income families.

The advantage of transferring administrative responsibility to a mental health agency is that the state can bring into play the agency's in-depth understanding of the local mental health system that the TANF agency does not have. The drawback is that it can be much harder to integrate mental health services into existing welfare employment services, and, indeed, Florida's system is the least integrated of the four study states. The integration of services is further complicated by the fact that the employment services system that serves TANF recipients is locally administered, making the employment expectations and service delivery structure different in every local office.

Communication and Collaboration between Agencies and Workers

A recurring theme in each study site is the importance of communication and collaboration among agency administrators and mental health and employment staff. Three strategies or factors appear to foster or improve communication and collaboration.

1. Co-location of Workers. Co-location of mental health staff in the welfare office or at locations where welfare recipients are served improves the communication and collaboration between employment and mental health staff. In Tennessee, the program director of mental health services (an employee of a contracted service provider) also is co-located in the state welfare administrative office.

2. Program Coordinators at the Local Level. Some sites have coordinators at the local level whose primary responsibility is to foster collaborative relationships among agencies. In Tennessee, eight district coordinators and, in Florida, 22 TANF substance abuse/mental health specialists facilitate communication and collaboration among workers and agencies and oversee program implementation at the local level. In Multnomah County, Oregon, the employment service provider hired a local program coordinator to oversee and administer mental health and substance abuse services in the eight welfare offices in the county.

3. Build on Established Collaborative Relationships. Sites in which community agencies have a long history of collaboration are more likely to work effectively together to develop and deliver mental health services to welfare recipients. At the state and local level, relationships established before program implementation can be valuable in designing and implementing mental health services for welfare recipients.

B. PROGRAM STAFF

The types of staff who provide mental health services are directly related to the types of mental health services provided to welfare recipients. The study states differ not only in the

types of staff who provide mental health services but also in the roles and responsibilities of staff with similar job titles. For example, mental health counselors in Oregon primarily assess clients and link them to mental health treatment, whereas mental health counselors in Tennessee assess clients and provide short-term mental health treatment. Staff roles and responsibilities may also vary by local office within the same program. In addition, state regulations sometimes dictate the type of staff who can be hired. For example, only licensed clinical social workers can deliver certain mental health services, such as clinical assessments and mental health treatment. Based on the programs in this study, we have identified four types of staff who provide mental health services: outreach workers, mental health counselors/specialists, interns in a master's of social work (M.S.W.) program, and intensive case managers. Some of their responsibilities and the services they provide are described below.

1. Outreach Workers

In Florida, more than 100 outreach workers have been stationed throughout the state to screen TANF recipients and other low-income families and to link them with mental health and substance abuse treatment. Typically, outreach workers are bachelor's level staff with training in psychology, social work, or other social service-related fields. Outreach workers inform clients about the social services available to them and community agencies about social services offered.

The drawback to using outreach workers to screen TANF clients is that this creates an additional step in linking clients to services. In addition, the workers may not be professionally trained to handle intense traumatic experiences that may be disclosed to them by clients (such as having been raped, witnessing a murder, or physical or sexual abuse during adulthood or childhood). Outreach workers indicated that when they heard of these kinds of experiences, they quickly referred the clients to licensed mental health professionals.

2. Mental Health Counselors/Specialists

Mental health counselors are mostly licensed clinical social workers (LCSWs), certified social workers[12] supervised by an LCSW, or other licensed mental health professionals (such as psychologists and marriage and family therapists). The credentials required by the state depend on the types of mental health services provided. For example, in Tennessee, which provides a wide range of services, mental health staff are required to have expertise in at least two of five areas (mental health, substance abuse, domestic violence, child behavior, or learning disabilities). In some areas of Oregon, staff are required to have expertise in both mental health and substance abuse.

[12] Certified social workers have completed a master's degree in social work but do not have clinical licensure.

In addition to their clinical training, mental health counselors in the study states have extensive experience in providing mental health treatment and a deep understanding of the mental health service delivery system. Both professional credentials and experience are a key consideration in the hiring decisions of program administrators. In most states, licensure is required to conduct in-depth psychosocial assessments and mental health therapy. Certified social workers may provide these services only under the supervision of an LCSW or other licensed mental health professional.

Social workers have a range of responsibilities associated with providing mental health services to welfare recipients. These responsibilities may include performing client assessments, providing or linking clients to mental health treatment, making recommendations for the volume and types of activities to include in an employment plan, consulting with employment case managers, and monitoring and tracking client participation in mental health treatment. Caseload sizes, which vary by site, are influenced by the types of services provided, number of TANF clients served in the local welfare office, and the length of time case managers hold on to a case.

The benefit of hiring licensed mental health professionals is that they are trained to deal with the challenging behaviors and mental health conditions often exhibited by TANF clients. Accessible to employment staff, they can also serve as resources for the client and employment case managers. The drawback is that qualified mental health professionals may be difficult to find and expensive to retain compared with bachelor's level staff.[13]

3. M.S.W. Interns

Utah is the only study state that uses M.S.W. student interns to provide mental health services to TANF recipients under the supervision of an LCSW. Interns are trained by the program manager and perform many of the same functions as the full-time social workers, such as performing clinical assessments, consulting with employment case managers, attending staffings, referring and monitoring treatment, and conducting short-term therapy. The advantage of using interns is that they are a less costly way to expand staff capacity. The challenge, at times, is providing the supervision and mentoring support that interns require.

4. Intensive Case Managers

Intensive case managers, also known as specialized case managers, may be employment case managers with a reduced TANF caseload of hard-to-employ clients or bachelor's level mental health staff who work with LCSWs to link clients to services. Intensive case

[13] Salaries range from $30,000 to $35,000 per year for a licensed mental health counselor compared to between $18,000 and $23,000 for bachelor's level staff.

managers in Utah's welfare-to-work-funded GROW[14] program teach clients basic living and problem-solving skills, link clients to mental health and other services, and monitor and track client participation in mental health services. In Clarksville, Tennessee, a bachelor's-level intensive case manager assists the LCSW by coordinating services, and by monitoring and tracking client participation in mental health and other activities. Western Palm Beach County Mental Health in Belle Glade, Florida, hired an intensive case manager to assist clients receiving mental health services with housing referrals, immigration paperwork, and SSI applications and to teach clients about job search activities and resume-writing skills.

The advantage of intensive case managers is that they can provide some of the linking and monitoring responsibilities performed by the mental health counselor, allowing the mental health counselor to focus on client assessments and mental health treatment. The drawback is that, at times, limited funding restricts the amount of social work staff that can be hired to provide mental health services. Typically, intensive case managers are used to augment, rather than to replace, clinical workers.

C. SERVICE LOCATION

Where mental health services are provided influences how and the extent to which clients are connected with mental health services. We observed several variations among sites with regard to where mental health services are provided. Except for Tennessee, which co-locates all mental health counselors in the welfare office or with contracted employment service providers (e.g., a local housing project), most states vary by local office as to where services are provided. In some of the study sites, mental health workers co-located in the local office that serves welfare recipients provide services in that office. In other study sites, mental health workers are co-located and provide services in other agencies that serve low-income families (e.g., public health centers, Head Start offices, etc.). Contracted mental health counselors often work out of the agency where they are employed.

1. Welfare Office/Employment Center (Co-located Workers)

Most mental health workers, regardless of where they work, indicated that being co-located in the welfare office is the ideal arrangement for providing mental health services. Tennessee and some offices in Utah, Oregon, and Florida co-locate mental health staff in the local welfare office. Providing mental health services in the welfare office by co-locating mental health staff has several advantages:

- **Mental health staff are more integrated into the employment service delivery system.** According to mental health workers, co-location helps them

[14] GROW stands for Gain immediate employment, Reach needed training, Opportunities for improved wages, and Work toward career goals.

build a relationship with employment staff, which tends to increase the number of referrals to mental health services.

- **Client access to mental health services is improved, and a direct link is created for referring clients to the program.** Providing mental health services in the welfare office gives clients direct access to mental health staff because they do not have to rely exclusively on employment case managers to refer them to mental health services (especially in offices where the mental health counselor participates in orientation).

- **Fewer clients may drop out of mental health treatment.** Providing mental health services at the local welfare office may increase the likelihood that clients continue in treatment, especially when clients regularly attend job search workshops or other activities at the welfare office.

- **Mental health counselors become an immediate resource for employment staff.** The closer proximity of the two types of staff gives mental health counselors an opportunity to educate employment staff about how to handle clients with mental health conditions, to participate in agency meetings and case staffings, and to deal readily with client crises.

The primary challenge in providing mental health services in the welfare office is finding enough office space in which mental health counselors can meet privately with clients.

2. Contracted Service Providers

In some local offices, mental health services are provided in the contracting agency's office by a mental health counselor. The screening and assessment services provided by the mental health counselor are paid for with TANF funds, but the treatment may be paid for either by TANF or Medicaid funds. In this arrangement, the employment case manager refers clients with mental health conditions to the contracted mental health service provider. Outreach workers in Florida and some mental health counselors in Oregon provide services out of the agency where they are employed.

One advantage of providing mental health services out of the contracted service provider's offices is that clients "look like" other nonwelfare individuals receiving mental health services, removing the stigma of being identified as welfare recipients and thereby making it more likely that they will stay in treatment. The drawback is that, unless clients are directly and quickly linked to mental health staff, they may not participate in mental health services, or they may miss appointments because of the inconvenience of traveling to a location apart from the welfare office, especially if they are ambivalent about participating in mental health services to begin with.

3. Other Locations

Mental health services are also provided at locations other than the welfare office or contracted service provider agency. In Florida, outreach workers co-located in community health clinics and local Head Start offices identify families that may benefit from mental health services. In St. George, Utah, where private office space is limited in the local employment center, mental health counselors provide services in a DWS administrative office three blocks from the local employment center welfare office. Services are typically provided at these other locations when it is not possible to co-locate mental health counselors in the welfare office.

One advantage to this approach is that it allows mental health staff to network with staff at other agencies. It also helps to identify clients who are at risk for welfare involvement who may otherwise be overlooked. For the social worker in the St. George welfare office, the advantage to being co-located at the administrative office is that she has access to private office space. The drawback to providing mental health services in other locations is that it may make it more difficult to link the employment case manager's clients to mental health services staff.

D. FUNDING ARRANGEMENTS

The study states primarily used their TANF block grant and state MOE (Maintenance-of-Effort) funds to pay for mental health services. These funds are distributed in two ways. Under the first model, the state welfare agency or state legislative body allocates TANF or MOE funds specifically for the purpose of providing mental health services. In Florida, the state legislature allocated $45 million in TANF/MOE funds to provide mental health and substance abuse treatment to welfare recipients and low-income families at risk for TANF involvement. The state welfare office in Tennessee designated $8 million for mental health and other services for welfare recipients. Programs for which funds have been earmarked in this way appear to have a distinct program identity with a centralized program administrator and some uniformity in how the program operates.

Under the second model for funding mental health services, which is used in Oregon, the money is part of a pool of funds designated for services designed to help TANF recipients find employment. In Oregon, the decision about the amount of funds to allocate to mental health services is made primarily at the local level.

Both approaches to funding have strengths and limitations. The first model guarantees that a certain amount of resources will be used to provide mental health services. It also requires strong centralized leadership at the state level to develop a service delivery structure and process. This model can be limited insofar as it makes it more difficult to integrate mental health and employment services. So while a program with an independent funding arrangement has more autonomy, it also requires more effort to integrate mental health and welfare policies and service delivery. Under the second funding model, integration of mental

health and employment services becomes easier, as mental health services exist as one of a range of options to help welfare recipients become employed. The drawback is that mental health services compete with other services for funding, making the availability of funds more tenuous.

In addition to TANF and MOE funds, states may use funds from the Welfare-to-Work grants program to provide mental health services.[15] Washington County (St. George), Utah, is 1 of 11 counties participating in a competitive Welfare-to-Work grant. Part of the funding for this grant has been used to hire additional social workers and intensive case managers to expand social work services in the southern area of the state. The advantage of Welfare-to-Work funds is that they offer program administrators another way to pay for mental health services. These funds can be used to pay for client assessments and mental health treatment, and for supportive services while clients receive treatment. The drawback is that the narrow eligibility criteria for welfare-to-work programs restrict the types of clients who may participate in mental health services paid for with these funds.

[15] Welfare-to-Work funds were authorized by the Department of Labor in 1998. Competitive and state formula Welfare-to-Work grants are no longer available.

CHAPTER IV

KEY IMPLEMENTATION ISSUES

Even with a strong program design and a well-developed administrative structure, implementing programs to address the mental health needs of welfare recipients presents ongoing challenges. In this chapter, we examine some of these key implementation challenges and present the innovative strategies used by the study sites to meet these challenges. The chapter covers (1) strategies to encourage employment case managers to refer clients to mental health services, (2) strategies to encourage clients to participate in mental health services, (3) ways to integrate mental health services into work activities, (4) options for creating a support network for mental health staff, and (5) approaches to monitoring and tracking client participation in mental health services. We conclude with a discussion of implementation issues that are specific to rural areas.

A. STRATEGIES TO ENCOURAGE EMPLOYMENT CASE MANAGERS TO REFER CLIENTS TO MENTAL HEALTH SERVICES

Addressing the mental health needs of welfare recipients represents a dramatic shift in the focus of welfare programs. Before welfare reform, there was little emphasis on encouraging welfare recipients to find employment and even less on helping individuals resolve personal and family challenges that may form obstacles to work. While some welfare staff have adapted easily to the new emphasis on work and mental health, using all of the resources at their disposal, others not yet comfortable delving into recipients' personal lives may not see the value of programs designed to address the mental health needs of their clients. In addition, some staff may be overwhelmed by their broad range of responsibilities unrelated to client mental health needs, while still others with high caseloads may be able to accomplish only tasks that require immediate attention.

Given that the system is still in flux, the study sites, acknowledging that referrals from welfare staff are critical to the success of their programs, make a concerted effort to educate welfare staff about the availability and usefulness of mental health services. The most common strategies for encouraging referrals include the following:

Training workers to identify a mental health condition. For employment case managers to refer clients to mental health services, they must be able to identify clients who may have mental health conditions that prevent or restrict employability. Mental health staff frequently work with employment case managers individually and in groups to teach them how to recognize some of the behaviors or characteristics that may signal the need for mental health services.

Developing a simple referral process or a "clear pathway" for linking clients to mental health services. Most of the study sites have developed a simple and quick process for referring clients to mental health services. Typically, employment case managers submit a short form to the mental health counselor to refer clients to treatment. Some mental health staff have used flow charts to illustrate for employment case managers the process for referring clients to mental health services.

Keeping caseloads manageable. The size of an employment case manager's caseload often influences the relationship between the case manager and client, which may affect the number of referrals to mental health services. According to some case managers, clients are more likely to disclose mental health conditions once they have developed trust in the case manager, which is more likely to happen when a caseload is small and the manager has more time for each client. A manageable caseload also allows the employment case manager to follow up with clients who are referred to mental health services.

Stationing mental health and welfare staff closer together. In general, the more accessible mental health staff and service providers are to welfare staff, the greater the likelihood of referrals. According to program staff at all levels, co-locating mental health staff in welfare offices and employment centers (one-stop centers) is the most efficient way to make mental health workers accessible to welfare staff. The physical proximity encourages more contact, more communication, and, hence, more trust on the part of welfare staff in mental health staff. Because of this trust, welfare staff feel more comfortable about, and are therefore more inclined to, refer their clients to mental health services. Mental health staff members who are not co-located in the welfare office may find other ways to develop relationships with the employment case managers. In St. George, Utah, where the social worker is not co-located in the employment center that serves welfare recipients, the social worker regularly attends staff meetings, participates in agency functions, and finds ways to interact with agency staff on an individual and ongoing basis.

B. STRATEGIES TO ENCOURAGE CLIENTS TO PARTICIPATE IN MENTAL HEALTH SERVICES

Even the most well-designed mental health services are successful only insofar as clients participate in them—initally and on an ongoing basis. For program staff, the challenge is therefore to encourage participation. In most of the study sites, participation in mental health services is voluntary, but it becomes mandatory if the client includes it as an activity in his/her employment plan. Family services counselors in Tennessee estimate that the initial no-show rate for clients referred to their agency is about 50 percent but that more clients participate over time. Statewide, two-thirds of clients who have been referred to the program have completed the initial assessment. Other states reported similar participation rates. Client participation rates in mental health services vary by local office and often are influenced by such factors as how quickly clients are linked to services, the accessibility of services, stigma associated with participation in mental health treatment, and the relationships between clients and employment and mental health staff. The following are some of the strategies that successfully increased client participation in mental health services in the study sites:

Addressing the stigma associated with mental health treatment. The stigma associated with mental illness and treatment may deter some employment case managers from talking with clients about mental health services and referring them to the program. The stigma may also make clients less willing to participate in mental health services. To address the stigma and thus encourage greater participation in mental health services, the study sites sought ways to educate clients and case managers about mental health conditions and services.

Mental health staff in some sites talk candidly with clients and employment case managers about mental health conditions. For instance, mental health counselors in the St. John's and Albina welfare offices in Portland, Oregon, talk with clients for typically 90 minutes during orientation about the signs of a mental health condition, how mental health problems may affect their behavior, and ways to treat mental health conditions (such as exercise, medication, mental health therapy, etc.). Social workers in Utah provide in-service training to case managers and discuss mental health treatment with individual managers to make them more knowledgeable about and comfortable with mental health services. Partly to "de-mystify" the treatment process, mental health staff in Florida replaced words such as "treatment" with "life-management help."

Offering flexibility in service location. Tennessee and some welfare offices in Utah are flexible in where they conduct client assessments and provide short-term mental health treatment. Services are provided at the welfare office, in the client's home, at a community-based agency, or at any other location convenient to the client. According to mental health staff in these states, providing services in the welfare office or at locations other than the local mental health agency makes clients less apprehensive about participating and improves access to treatment, especially in rural areas.

Providing supportive services such as transportation and child care while delivering mental health treatment. All of the study states provide child care and transportation assistance for clients participating in mental health services when those services are included as an activity in employment plans. Without supportive services, some clients may not be able to take advantage of the mental health services available to them.

Modifying existing policies or creating new ones to ensure that they support clients participating in mental health services. Flexibility in TANF work requirements (volume and types of activities) appears to encourage both employment counselors to include mental health treatment in an employment plan and clients to participate in mental health services. In Florida, where no more than five hours of mental health services per week can count toward the work requirement, few employment case managers include mental health services in employment plans. The other study states (Oregon, Tennessee, and Utah) do not restrict the number of hours or types of mental health services that count toward the work requirement. Instead, this decision is left to the employment case manager or mental health counselor. These mental health counselors suggested that the modified employment plan encourages clients to participate in mental health services.

Another policy that may influence participation in mental health treatment is extending or temporarily suspending time limits for families in treatment. Utah extends the time limit for families facing severe personal and family challenges who are participating in mental health treatment. In Tennessee, the month of assessment does not count toward the time limit, and families with severe mental health conditions may request an "interruption," or a temporary stop in the "clock" ticking toward the time limit. Currently, about half of the clients participating in mental health treatment have been granted such interruptions.

In most states, clients who include mental health services in their employment plan are subject to grant sanctions if they do not participate in mental health program activities. However, sanctions are not used to force clients to participate in mental health treatment against their will. In general, participation in mental health services is voluntary, and clients may also choose to include treatment in their employment plan.

Providing services that consider and address cultural differences. An ongoing challenge for program managers and mental health staff is to provide mental health services that are sensitive to cultural and language differences. Mental health staff in the study states identified three primary ways in which cultural and language differences may influence mental health service delivery. First, if ethnic and racial differences are not considered by counselors, they may act as a wedge in the relationship between the client and mental health counselor, eroding the trust that is central to this relationship. In the absence of this trust, the effectiveness of mental health services may be reduced. Second, bilingual children are sometimes expected to serve as translators between the mental health counselor and a parent or parents. Children cast in this role are exposed to life stressors and personal details of the parents' lives otherwise "reserved for" adults. The result, according to mental health staff, may be an emotionally unhealthy environment for the children. Third, cultural differences in how mental illness and mental health treatment are perceived can influence the level of

comfort in participating in mental health services and therefore the decision to participate at all.

Some of the study sites have attempted to address these cultural and language differences. For example, in Belle Glade, Florida, paraprofessionals from the community are paired with licensed mental health counselors to facilitate the relationship between the client and mental health counselor. For instance, bilingual paraprofessionals may translate in counseling sessions, build relationships with clients in the community, and link clients to mental health services. In Miami, program administrators at contracting agencies have hired mental health outreach workers and counselors who are racially and ethnically similar to communities in which they work.

Protecting client confidentiality. According to mental health staff, protecting the confidentiality of clients creates a trusting relationship, which encourages client to participate in mental health services. Mental health counselors take several precautions to protect the confidentiality of clients. In general, mental health counselors begin the process of working with clients by clearly explaining the steps they take to protect the confidentiality of clients' information. Counselors then ask clients to sign release-of-information forms allowing the exchange of information between mental health counselors and other agencies. In some areas, mental health counselors store all client records in a locked filing cabinet.

C. INTEGRATING MENTAL HEALTH SERVICES INTO WORK ACTIVITIES

One of the distinguishing features about programs designed to address the mental health needs of welfare recipients is the strong emphasis on employment. In all of the study sites, mental health program workers reiterated that the goal of mental health services is to help the client move from welfare to work. Some of the ways states integrate work into mental health services include the following.

Counting participation in mental health services toward the TANF work requirement. All of the study states allow mental health services to be counted as a work activity in the client's employment plan. This policy not only creates an incentive for clients to participate in treatment but also encourages employment and mental health staff to work together in helping the client progress toward self-sufficiency.

States vary in who can modify employment plans. In Tennessee, the mental health counselor is the only person who can modify the client's employment plan, whereas in Utah and Oregon, mental health counselors make recommendations about the types and amount of activities, but the employment case manager makes the final decision. In most cases, the employment case manager accepts the recommendations of the mental health staff. When mental health is written into the employment plan, the employment case manager is also responsible for ensuring that the client participates in treatment.

Educating treatment providers about work and participation requirements. At many of the study sites, mental health staff help mental health treatment providers understand the TANF requirements for receiving cash assistance, such as work requirements, time limits, sanctions, etc. In Multnomah County, Oregon, mental health counselors specifically said that educating treatment providers about TANF requirements is one of their job responsibilities. This educational experience not only strengthens the relationship between mental health and employment staff but also brings dual-system support to the effort to move welfare recipients into jobs by building the treatment providers' understanding of the circumstances of welfare recipients and the demands placed on them to become employed.

Allowing Mental Health Activities in Client Employment Plans

PRWORA requires states to meet increasingly higher work participation rates and specifies which work-related and mental health activities can count toward that requirement. However, because of substantial caseload declines, states actually have considerable flexibility in defining the types of mental health activities that can count toward the work requirement. In fiscal year 1999, states were required to have 35 percent of all families participating in work activities, less any caseload reduction credit. On the basis of caseload declines, 23 states were not required to have families participating in work activities, and only 2 states were required to have 20 percent or more of their TANF caseload participating in work activities (U.S. Department of Health and Human Services 2000). This loosening of the work requirement has allowed states to approve participation in activities such as mental health counseling or to temporarily defer clients from participation in work activities while they address issues that may be interfering with their ability to find or maintain employment. The biggest challenge states are likely to face in permitting mental health activities to be included in employment plans is overcoming the belief by policymakers that participation in mental health counseling or other similar activities may weaken the emphasis on work. This need not be the case if these activities are provided with an eye toward helping clients find and maintain employment. Oregon and Utah are two states that have broadly defined the activities that can be included in a client's self-sufficiency plan, and neither their participation rates nor their program emphasis has been negatively affected.

Using a short-term, employment-focused and/or solution-focused mental health treatment model. Some states, such as Tennessee and Utah, have encouraged mental health counselors and treatment providers to use a short-term, employment-focused mental health treatment model for working with TANF clients. In fact, family services counselors in Tennessee have been trained to use a short-term, solution-focused mental health treatment approach. District coordinators in the state review case files at random to ensure that mental health counselors use this approach. Similarly, mental health counselors in Utah work closely with contracted mental health treatment providers to ensure that treatment is

short-term and employment-focused. Mental health counselors in Tennessee and Utah indicated, however, that some clients require a different approach However, in general, mental health staff believe that the short-term, solution-focused method is effective for welfare recipients with less severe mental health conditions.

Providing employment services in mental health treatment facilities. In Florida, where mental health treatment is provided by using TANF funds, some of the mental health treatment facilities have developed employment-focused activities exclusively for welfare recipients referred to them. For example, Western Palm Beach County Mental Health, a contracted treatment provider in Belle Glade, developed a job-seekers club, in which TANF recipients receiving mental health services meet to talk about life skills such as prioritizing, balancing work and family responsibilities, and child rearing.

Developing a plan to transition clients from mental health treatment to work. Mental health staff at most of the sites work closely with employment case managers to monitor client progress in treatment and to recommend ways for gradually increasing work activities. Recommendations may be given during case staffings or during informal conversations between employment case managers and mental health staff.

D. CREATING A PROFESSIONAL SUPPORT NETWORK FOR MENTAL HEALTH STAFF

In general, mental health counselors working with welfare recipients have a difficult job. The people they see have experienced severe trauma such as childhood abuse, domestic violence, rape, homelessness, and other personal tragedies. The ability to deal with these complex life circumstances requires not only intense clinical and/or problem-solving skills but also a knowledge about the other mental health resources available in the community. Many mental health counselors working with welfare recipients may not have an obvious link to a professional support network, especially in rural locations, where professional support networks may be limited.

Mental health staff in some of the study sites have developed professional support networks to help solve difficult cases and to establish a source of ongoing training and consultation. For example, in Multnomah County, the program coordinator convenes weekly meetings with mental health and substance abuse specialists to discuss agency business and to staff difficult cases. In addition, specialists consult each other or their supervisor when they need professional guidance or support. In Tennessee, the program director holds regular training sessions for mental health counselors and district coordinators. In addition, local contracted mental health agencies provide clinical support to counselors on their staff who are co-located in the welfare office. In Utah, social workers meet every month, alternating each month with statewide and half-state meetings, to staff difficult cases and to talk about ways to improve mental health services. The program director at the state level provides clinical support to the social workers.

E. MONITORING AND TRACKING CLIENT PARTICIPATION IN MENTAL HEALTH SERVICES

In most of the study sites, the goal of mental health services is to help clients manage mental health conditions that may be limiting their ability to find and retain a job. Typically, mental health services are included in the client's employment plan and count toward the TANF work activity requirement. The purpose of monitoring and tracking client participation in mental health services is to ensure both that clients are participating in mental health services when they are included in the employment plan and that they are progressing toward employment. Contracted mental health treatment providers tend to be more responsive than Medicaid providers in reporting client participation and progress to employment case managers in the welfare office. This may be the case because the contract reporting requirements stipulate that treatment providers provide employment and mental health staff with feedback about clients' involvement in mental health treatment.

Employment case managers and mental health staff typically work together to monitor and track client participation and progress in mental health services. However, in most of the study sites, the employment case manager is ultimately responsible for ensuring that the client is participating in mental health services. In Tennessee, family services counselors submit weekly participation reports to the employment case manager. The employment case manager sanctions clients who do not participate in mental health services if the services are included in an employment plan. In Salt Lake City, social workers provide a monthly report to employment counselors summarizing each client's level of employability, participation in mental health treatment, and recommendations for modifying the employment plan. In the Florida sites, contracted service providers reported directly to the state and to regional TANF substance abuse and mental health program administrators, since few clients included mental health services in their employment plans. In Oregon, responsibility for tracking and monitoring client participation often is left to the employment case manager, with some help from mental health staff.

According to agency staff in most of the study states, monitoring and tracking client participation and progress in mental health treatment has been a difficult challenge for the three reasons explained below.

To protect client confidentiality, mental health treatment providers are cautious about the kinds of information they share with employment case managers. For the most part, mental health treatment providers share information about clients with employment case managers whether or not the client is participating in mental health services. Some employment case managers said they would like more information about the employability of clients than many of the treatment providers give them. According to mental health staff in the welfare office, mental health treatment providers are more comfortable talking with them than with employment case managers about clients.

Finding Private Office Space to Protect Client Confidentiality

Most mental health staff have years of experience as counselors. They have been oriented to confidentiality issues as part of their professional training and their experience in providing mental health services. Overall, maintaining client confidentiality is handled professionally in all study sites. However, one confidentiality issue that did emerge was the availability of private office space to conduct assessments and therapy, particularly when mental health counselors are co-located in the welfare office. In some sites, mental health counselors have been able to negotiate for their own private office. In other sites, mental health counselors use private conference rooms to meet with clients. Given the sensitive nature of their interactions with clients, mental health counselors indicated that access to private office space is essential to successful, confidential service provision.

Many of the mental health treatment providers, especially those funded through Medicaid, do not fully understand the work participation requirements associated with welfare receipt. In Utah, for example, mental health staff had difficulty obtaining feedback about clients from the Medicaid mental health treatment provider. After meeting with the Medicaid agency staff to explain TANF work requirements and to discuss ways to improve communication between the agencies, the process and frequency of feedback from the treatment providers improved.

In some areas, mental health treatment providers, especially Medicaid-funded providers, have high staff turnover and a limited number of staff, which makes it more difficult to provide feedback in a timely way. In some parts of Utah and Oregon, the staff turnover at the Medicaid-funded service agency made the monitoring and tracking of client participation more difficult. In recent years, for example, the number of Medicaid-funded mental health clients served by Valley Mental Health in Salt Lake County, Utah, has increased sharply, straining already limited resources. This has increased staff workload, which has contributed to high staff turnover.[16]

F. CONSIDERATIONS IN PROVIDING MENTAL HEALTH SERVICES IN RURAL AREAS

Although urban and rural areas face many of the same challenges in addressing the mental health needs of welfare recipients, some aspects of service provision are easier in rural areas, while others are more difficult. In general, we observed four primary considerations when providing mental health services in rural areas.

[16] Valley Mental Health is the county's sole Medicaid-funded mental health treatment provider and is paid under a capitated managed care funding arrangement.

Clients in rural areas compared with those in urban areas have less difficulty accessing mental health treatment in a timely manner, but they have more difficulty accessing certain types of treatment. In two of the study states, Oregon and Utah, clients in rural sites find it easier to access mental health treatment in a timely way than do clients in the urban sites. Clients seeking Medicaid-funded mental health treatment in urban areas have had to wait up to a month to see mental health therapists, which is substantially longer than the wait experienced by clients in the rural sites. However, in most of the rural sites, clients had more difficulty accessing certain types of treatment, such as psychiatric evaluations, residential treatment, and treatment for co-occurring mental health and substance abuse conditions.

In Tennessee, the proportion of referrals to mental health services is substantially higher in rural than in urban areas. According to researchers at UT, two-thirds of the referrals to the FSC program come from rural areas even though the number of inndividuals referred account for one-third of the state's welfare population. It is unclear why there is a difference in referrals between rural and urban areas. However, employment case managers in the rural areas suggested that they get to know the clients well and tend to have strong collaborative relationships in their own offices and with other agencies. The other study sites had less data than Tennessee on this issue.

Some mental health staff and clients are required to travel long distances to provide or to access services. Mental health staff in rural areas typically provide services in multiple welfare offices and over a large geographical area compared to staff in urban sites. For example, one social worker in Utah provides services to welfare recipients in five counties, which limits the accessibility of the social worker in each of the offices and reduces the time the social worker can meet with clients. Mental health staff in other rural communities have similar arrangements and face similar challenges. Furthermore, some clients living in remote areas have difficulty accessing mental health services and participating in mental health treatment because of the distances they are required to travel.

According to mental health staff, the stigma associated with mental illness and mental health treatment is particularly strong in rural areas. The stigma of participating in mental health services is frequently discussed among mental health counselors and clients in rural areas, where there is concern that neighbors and friends might "find out" that clients are receiving mental health services. Mental health counselors in rural areas also suggested that, in general, employment case managers and clients themselves are more biased about mental illness and more uncomfortable about participating in mental health treatment.

CHAPTER V

CONCLUSIONS

This review of programs designed to address the mental health needs of welfare recipients was intended to be exploratory in nature. We identified the types of mental health services provided to welfare recipients and how these services are administered and delivered by state and local welfare offices. We outlined the key decisions involved in designing and providing mental health services as well as the types of service delivery options associated with each decision. We also documented many of the primary implementation issues. Our overall goal was to create a guide for program administrators in other states and communities interested in delivering mental health services to welfare clients. This guide is also intended to assist researchers who are interested in evaluating mental health service programs for welfare recipients. Through our investigation, we have arrived at several conclusions about what is involved in providing mental health services to welfare recipients and about the relationship between these services and the work-related thrust of welfare reform.

- ✓ **Mental health services can be a valuable resource for employment case managers seeking to move hard-to-employ individuals from welfare to work.**

Employment case managers said that mental health services help them to address the personal and family challenges faced by hard-to-employ welfare recipients. Mental health staff offer specialized services that employment case managers are not trained to provide. Mental health staff also help employment staff understand mental health conditions and how these conditions may affect the clients' ability to find and keep a job.

- ✓ **There are a variety of ways to address mental health needs of welfare recipients; there is no evidence to suggest that one model for providing services is better than any other.**

In each local community, Medicaid-funded mental health services are available to welfare recipients. However, some recipients may not be aware that they have a mental health condition that affects their employability. And even those aware of their condition may not know how to access treatment. In the study states, TANF and Welfare-to-Work funds have been used to link clients to existing mental health treatment or to expand treatment options or create new ones. The experience of the four states suggests that the mental health needs of welfare recipients may be addressed in a variety of ways.

Florida. In Florida, TANF funds have been used to purchase mental health treatment for welfare recipients and those at risk for TANF involvement. These funds have also been used to hire outreach staff who link individuals to these services. Mental health services are administered and coordinated by mental health and substance abuse agencies, which operate outside the welfare office and workforce development system. Operating mental health services out of an agency outside of the TANF eligibility and TANF employment services system has made integration difficult.

Oregon. In Oregon, the focus is on assessing clients and linking them to Medicaid-funded mental health treatment providers. Oregon has integrated mental health services into the welfare system by co-locating mental health staff in most local welfare offices and allowing each district office to develop an administrative structure that reflects the mental health resources available in the community.

Tennessee. The Family Services Counseling program in Tennessee provides assessment and short-term, solution-focused mental health treatment for welfare recipients using an approach that is uniform statewide. Through this statewide model, Tennessee is striving for maximum integration of mental health services into the welfare office by co-locating program administrators in the state welfare office. Family services counselors and district coordinators are co-located in the local welfare offices. Individuals with more intensive mental health needs are linked to a Medicaid-funded mental health treatment provider.

Utah. Social workers in Utah conduct clinical assessments and some short-term therapy. They also link clients to Medicaid-funded mental health treatment and to some contracted mental health treatment providers. Hiring mental health staff members as employees of the welfare agency has more solidly integrated mental health services into the workforce system that serves TANF recipients.

- ✓ **Regardless of program design and administrative structure, it is a challenge to integrate mental health and employment services.**

Mental health services are delivered most effectively when they are integrated into employment services. Connecting the two influences not only the process for identifying and linking clients to services but also the monitoring and tracking of client participation in mental health services. In addition, integrating services fosters strong collaborative relationships between mental health and employment staff, improving the exchange of information between agencies about mental health services and welfare requirements and ultimately benefiting clients by serving a broader range of their needs.

Regardless of the administrative structure through which mental health services are provided, however, it is a challenge to fully integrate these services into a welfare employment program. Some employment service staff are skeptical of any service that appears to detract from the immediate goal of getting clients employed. Others are simply too busy to identify and refer clients who might benefit from mental health services. The single most effective strategy for fostering integration appears to be co-locating employment services and mental health services staff. When it is not possible to do this, extra efforts are necessary to build trusting relationships between mental health and employment services staff.

Integrating mental health and employment services is especially difficult when the mental health service delivery structure is completely separate from the TANF employment structure. In Florida, for instance, mental health treatment providers rely on outreach workers to link clients to services, and they rely on district coordinators at the local level to coordinate mental health and employment services. The state has developed an expansive set of mental health services for TANF recipients and those at risk for TANF involvement. However, except in a few communities, integration of mental health and employment services is limited. Program administrators attribute the lack of integration to the fact that the workforce development system, the agency that provides employment services to welfare recipients, was not included in the initial planning stages for the mental health services. Efforts at the local level (such as co-locating mental health workers in the one-stop centers) have improved the coordination of services in some communities.

- ✓ **Identifying clients in need of mental health services is more art than science.**

Florida is the only study state that has developed a standardized screening tool used by outreach staff to identify clients who may need mental health services. Most of the study states rely on employment case managers to identify clients in need. Once clients are referred for services, highly skilled licensed mental health professional conduct in-depth psychosocial or clinical assessments with clients. The purpose of the assessment is to identify those for whom mental health treatment may be appropriate and to recommend the types and volume of services to include in the client's employment plan. Tennessee is the only study state that uses a standardized tool to conduct the in-depth assessment. The

assessment format and process in the other study states varies by mental health counselor. When hiring mental health counselors, many program coordinators or managers place a very high value on experienced mental health workers with very strong assessment skills.

- ✓ **As in many welfare-related programs, it is a challenge to get clients to participate in mental health services, although this challenge varies by site.**

The initial no-show rate is estimated to be around half in most of the study states, although this varies some by site. There is no evidence to suggest that certain groups of clients are more likely than others to miss appointments. However, mental health staff suggest that no-show rates tend to be lower when the mental health counselor is co-located in the welfare office. In addition, clients who are identified through broad screenings may be less inclined to show up for the initial assessment because broad screenings may incorrectly identify clients as needing services. Mental health staff indicate that even though the initial no-show rate is high, many clients referred to mental health services over time complete the in-depth assessment with the mental health counselor.

- ✓ **Use of TANF funds to pay for mental health treatment increases the flexibility in the types of nonmedical mental health services provided and allows program administrators to purchase or provide mental health treatment that focuses on employment.**

In most areas and with the help of mental health staff, clients are able to access mental health treatment through the local Medicaid-funded mental health service provider. However, in some areas, there is a delay in accessing treatment and/or some limitations on the types of services provided (e.g., therapy is provided in groups rather than in individual sessions). Using TANF funds to pay for mental health therapy increases the flexibility in the types of nonmedical mental health services that can be provided. It also allows program administrators either to purchase therapy that is structured around the goal of moving welfare recipients into work and/or to create new services that work toward this goal.

- ✓ **More research is needed on the effectiveness of mental health services in improving the employability and general well-being of welfare recipients.**

In general, most of the study sites have not heavily emphasized evaluating the overall success of mental health services. Program administrators typically track the number of referrals and types of services used. However, few have examined how mental health services affect clients' employability or general level of well-being. Some sites have shared success stories about how clients who participated in mental health services have found and kept a job, but this evidence is anecdotal. Only Tennessee has an extensive evaluation study underway.

Evaluation of Tennessee's Family Services Counseling Program

The College of Social Work at UT is evaluating the Family Services Counseling program. The evaluation has several components, including (1) an analysis of administrative data collected from the case files of mental health counselors; (2) focus groups with district coordinators; (3) mail surveys to local service providers, district coordinators, and Department of Human Services case managers; and (4) phone interviews with 400 welfare recipients who participated in mental health services.

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In the absence of evaluation research and outcome data, it is difficult to determine the success of these programs in improving the employability of welfare recipients. However, even with an evaluation, the outcomes of mental health services are not always easy to measure. Relying strictly on employment outcomes does not capture other benefits of mental health services, such as general family functioning and individual and family well-being. Still, it is important to evaluate mental health programs for welfare recipients to determine the effectiveness of these services in moving welfare recipients to work. In addition, evaluation research can reveal ways to improve the quality of mental health services in terms of addressing mental health needs that may be specific to welfare recipients.

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APPENDIX A

PROFILE OF THE STUDY SITES

Florida's TANF Substance Abuse/Mental Health Program

Program origins. In 1998, the Florida legislature allocated $20 million from the TANF block grant for mental health and substance abuse services. By the end of 1999, most of the local welfare offices around the state had fully implemented the TANF Substance Abuse/Mental Health (SAMH) Program for participants in the state welfare program, known as WAGES. Eligibility for the TANF SAMH Program was expanded in 2000 to target families at risk of becoming WAGES participants. Non-WAGES participants are distinguished from WAGES participants administratively, but there is no distinction in the amount or types of services they can receive. In 2001, funding for the TANF SAMH Program was increased to $45 million. The TANF SAMH Program served over 24,000 people in 2000 and the state estimates that 25,000 people will be served during 2001.

Scope of barriers targeted. The TANF SAMH program targets individuals with substance abuse or mental health conditions.

Eligibility for mental health services. Individuals eligible for the TANF SAMH Program are WAGES recipients and their family members and also non-WAGES families with incomes less than 200 percent the Federal Poverty Level. Services can be provided to noncustodial parents as long as both custodial and noncustodial parents are below the income requirement and are permanent residents of Florida. Also eligible for services are individuals who have left WAGES within the past 12 months, child-only cases[17], families receiving services in the Family Safety system (the child welfare agency) and individuals receiving Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI).

Strategies for identifying participants with mental health conditions. There is wide variation among the local one-stop welfare offices for informing and identifying participants of the TANF SAMH program. The primary approaches used by the outreach workers are described below.

- **Referrals by WAGES Staff.** Statewide, TANF SAMH outreach workers are co-located in most of the one-stop centers at least part time. Being co-located within the office appears to help develop relationships between the outreach workers and WAGES staff, which tends to increase the number of referrals.

- **Presentations during WAGES Orientation and Job Club Workshops.** Presentations during orientation and job club workshops are one way outreach workers inform WAGES participants about the TANF SAMH Program. The frequency of these presentations varies by local office. At the Caleb One-Stop Center in Miami, participants learn about the TANF SAMH Program during the employment services provider's job club.

[17] For the child or anyone in the household that meets the income eligibility requirements.

- **Community Outreach.** In areas where the outreach worker is not co-located within the one-stop center, there is an emphasis on developing community outreach activities to inform low-income families about the TANF SAMH Program and to encourage participation in screening and treatment. In some areas, outreach workers make home visits and work with other agencies, such as community health clinics, day-care centers, and food stamp offices, to gain access to TANF participants and low-income families. Additionally, some contracted service providers have negotiated with community agencies to co-locate outreach staff within their agencies.

Types of mental health services provided. The TANF SAMH program provides screening, assessment, and treatment for participants with mental health and substance abuse conditions.

- **Screening.** TANF SAMH outreach workers use a standard 32-item survey to conduct screenings. The screening tool includes CAGE questions to detect drug and alcohol abuse and a mental health screening tool. A scoring system for the screening tools allows outreach workers to determine whether a client should be referred to treatment. There are also two emergency referral questions and seven automatic referral questions. The state requires use of the uniform TANF SAMH Program Survey, but additional questions can be added to the screening. Discretion for how broadly to screen participants is left to the local one-stop administrator. Some centers screen all WAGES participants during orientation. Others screen only participants referred by the WAGES case managers, other community agencies, or those self-referred.

- **In-Depth Psychosocial Assessments.** The outreach workers schedule intake appointments for in-depth psychosocial assessments with licensed mental health or substance abuse counselors typically within 10 days of the initial screening. The psychosocial assessments vary by treatment provider, but counselors usually speak with participants about their health status, employment and economic circumstances, drug and alcohol use, legal status, family history, and family/social relationships. In most cases, outreach workers refer participants to their own agencies. However, when the participant requires treatment that an outreach worker's agency does not provide or if there is a wait for treatment, the participant is referred to other mental health and substance abuse treatment providers within the area. Referring participants to other agencies occurs primarily in urban areas where there is more than one treatment provider.

- **Mental Health Treatment.** In general, there are few restrictions on the types of services provided under the TANF SAMH contracts. Treatment plans are negotiated with the participant and contracted mental health/substance abuse treatment provider and approved by the TANF SAMH specialist. Some agencies offer a wide variety of mental health and substance abuse services, while other agencies contract to provide a very narrowly defined service. For

example, one Miami treatment provider offers outpatient mental health treatment for adults only. A second, larger, treatment provider in Miami offers an extensive range of mental health and substance abuse services for children and adults including outpatient, in-home/on-site, outreach, residential treatment, and case management for addressing substance abuse and mental health needs.

The relationship between mental health services and work requirements. Florida requires participation in at least 30 hours a week of work activities, which includes job search, vocational training, work experience, adult basic education and up to five hours per week of mental health and substance abuse treatment. Participants also are assigned to one of two time limit tracks. Participants who are work-ready can receive cash assistance for 24 out of 48 months; those with more serious barriers to employment are allowed cash assistance 36 out of 72 months. Additional months may be added to a participant's time limit to compensate for months that they are actively involved in mental health or substance abuse treatment. The lifetime limit for all participants is 48 months.

Participants also may obtain an exemption from the time limit. Hardship exemptions are granted when a client has been participating diligently in work activities but still has a barrier to employment or is enrolled and participating in a program that extends beyond the time limit. Participants awaiting SSI approval also are exempt from the time limits. However, most participants are granted a deferral rather than an exemption. A deferment lasts up to 90 days and allows the client to be temporarily relieved from the work requirement. Deferments are granted when there are serious barriers that limit the client's ability to work. Typically, the client must obtain a written statement from a doctor to receive a deferral. Participants who are deferred from the work requirements are still subject to the time limit.

Administrative structure. The TANF SAHM Program is housed within the Department of Children and Families[18] (DCF) and operates under both the Mental Health and the Substance Abuse Program Offices but works in collaboration on policy issues with the Office of Economic Self-Sufficiency.[19] A program director and three staff members in the state office administer the TANF SAMH Program. Within each of the DCF districts or regions, there is at least one TANF SAMH specialist to oversee program activities within the local offices. All of the TANF SAMH employees are hired as OPS (Other Personnel Services) employees. These are temporary positions, renewed every six months, without employment benefits (such as health insurance, sick leave, and retirement).

The DCF district or region administrator selects and contracts with mental health and substance abuse treatment providers within each of the local communities. These contracts

[18] DCF is responsible for the state's economic and self-sufficiency, family safety system, mental health and substance abuse services and adult and developmental services.

[19] The Office of Economic Self-Sufficiency is responsible for determining eligibility for TANF and other public assistance programs for low-income families.

are negotiated with the TANF Specialists and local district administrators. In some communities there is one primary contractor, and in others there are multiple providers. Contracted service providers include a range of agencies, including substance abuse and community mental health centers, residential treatment providers, faith-based organizations, and hospitals. The contracted service providers hire the outreach workers, conduct clinical assessments and provide mental health and substance abuse treatment.

Funding mental health services. The Florida legislature allocated $45 million to the TANF SAMH Program for 2001. TANF SAMH dollars are used to pay for the administration and most nonmedical services provided through the TANF SAMH Program. Medicaid covers the cost of medical services, such as medications and psychiatric assessments. Approximately 4 percent of the TANF funds are for administrative overhead and the rest is for direct services. Funding is distributed to each of the 13 DCF districts and 1 regional office using a formula based on the welfare population within the district or region. Funds from the DCF district or regional offices flow down to the local service providers, with whom contract amounts and types of services are negotiated. Monetary reimbursements may vary among the different service providers. Overall, local offices are given broad flexibility in how the funds are spent.

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Oregon's Mental Health Services

Program origins. Oregon began to create a welfare program with a strong emphasis on work and supportive services in the mid-1980s. Beginning in 1992, Oregon started expanding the services provided to welfare recipients to include mental health and substance abuse services. The expansion of services was the result of a statewide analysis of client needs. There was special concern for those clients who were leaving and returning to welfare. Based on clients' needs analyses, the state found many clients could benefit from mental health and substance abuse services. The state purposely implemented a broad policy that gave local and district offices the flexibility to design mental health and substance abuse services based on the needs and resources of the local communities.

Scope of barriers targeted. Local welfare offices provide services to address mental health and substance abuse issues.

Eligibility for mental health services. All clients applying for cash assistance are eligible for mental health services. There is a 45-day assessment period where clients are required to look for employment prior to certification for TANF benefits. Clients in the assessment phase and those receiving cash assistance may be screened to assess their need for mental health services.

Strategies for identifying clients with mental health conditions. Local offices vary in how they identify clients to participate in mental health services. In most offices, clients are informed about services from multiple sources. The primary ways clients are identified for services are described below.

- **Intake**. Some local offices have their most experienced case managers conducting intake and asking clients questions regarding the circumstances that brought them to the welfare office. The intake worker screens for eligibility, informs clients of services, including mental health and substance abuse services, and may refer clients to mental health services.

- **Orientation.** Mental health specialists may screen clients for mental health and substance abuse issues during the welfare orientation. The orientation screening procedures vary across local offices. For example, in the St. John and Albina welfare offices, clients receive separate group screenings for substance abuse and mental health during their initial orientations. In Astoria, there is one mental health/substance specialist who administers a brief group screening for both mental health and substance abuse during orientation

- **Welfare Case Manager.** Clients are most commonly referred to the mental health specialist through the welfare case manager. Typically, either the client will disclose mental health issues or the case manager will identify mental health needs after the client fails to participate in program activities or has trouble keeping a job.

- **Specialized Case Manager/Worker.** In some local offices there are case managers who handle a caseload of clients with severe barriers to employment. These specialized case managers conduct more thorough assessments of clients' mental health and they work closely with mental health specialists.

- **Self-Referral.** Clients may refer themselves to the mental health specialist directly after being informed about mental health services during orientation or by their case managers.

- **Clients in Sanction Status.** Clients who are in sanction status and have indicators of mental health conditions are referred to mental health services and encouraged to participate in an assessment.

Types of mental health services provided. Once clients are identified, mental health specialists provide a wide range of services to both clients and welfare case managers. They are described below.

- **Screening and Assessment.** Mental health screenings and assessments are the primary service provided by mental health specialists. Most of the mental health specialists do not use a formal assessment tool, but instead rely on their professional experience to guide the types of questions that they ask. Assessments typically consist of open-ended questions aimed at uncovering current problems. Information usually is gathered on the clients' mental health history, physical health, family history, and drug and alcohol use.

- **Connecting Clients with Mental Health Services.** Mental health specialists link clients to treatment. The mental health specialists may refer clients to their own agencies (if they are employees of a contracted service provider), or other agencies within the community.

- **Short-Term Crisis Intervention.** Mental health specialists handle crisis situations and work to stabilize clients before referring them to mental health treatment.

- **Training and Consultation for Welfare Case Managers.** Mental health specialists provide in-service training for welfare staff and consult with case managers on a case-by-case basis, giving them guidance on ways to handle difficult behaviors and attitudes among clients.

The relationship between mental health services and work requirements. Oregon operates under a federal waiver that allows for flexibility in time limits for receiving cash assistance and work requirements. Most clients involved with mental health services have an individualized case plan developed by the case manager, mental health specialist, and client. The activities included in the individualized case plans are based on the severity of the client's mental health condition and may require fewer hours than a case plan without mental health services. Often, the focus of the work plan is to start the client out slowly with

moderate activities, and gradually move into work activities. In most cases, even with mental health services, clients are required to do some work activities, such as a life-skills training workshop. Clients that are participating in an individualized work plan are not subject to the time limits.[20]

Administrative structure. The administrative structure of Oregon's mental health services is comprised of one state program analyst and local mental health and substance abuse specialists. The program analyst oversees the policy guidelines and training for mental health and substance abuse services. The program analyst also coordinates with the mental health contracted treatment providers and addresses contractual questions if they arise. In the local offices there is wide variation in the organization of mental health services. In two counties, there are local program coordinators who administer, monitor, and supervise the mental health and substance abuse services in their counties. Most counties have specialists in mental health and substance abuse who have extensive experience and strong clinical training. Some offices use separate specialists for mental health and substance abuse, while other offices have hired a specialist with expertise in both areas.

Most of the staffing for mental health services are handled by using contractors and, in general, are arranged in one of two ways. Contracting may be handled either by the AFS[21] (Adult and Family Services) district office or through the prime employment and training service contractor. For example, in Astoria, the AFS district office contracts directly with Clatsop Behavioral Healthcare for a part-time (20 hours a week) licensed counselor to provide mental health and substance abuse services to welfare recipients. This licensed counselor is co-located in the Astoria welfare office. In Multnomah County, the employment and training service providers, Mount Hood and Portland Community Colleges, hire the mental health specialists and subcontract with local mental health treatment providers for outstationed workers in the area.

Mental health treatment is provided by Medicaid providers. In general, the agencies provide a range of outpatient mental health treatment services, including assessment, case management, and individual and group therapy. In-patient treatment is limited to the urban areas, and throughout the state there is limited treatment for co-occurring mental health and substance abuse conditions.

Funding mental health services. Local offices determine how much of their TANF funds are allocated to mental health services. TANF funds cover the cost of the local mental health specialists and the district coordinators. Medicaid covers the cost of all mental health treatment.

[20] In Oregon, a client not participating in an individualized work plan can not receive cash assistance for more than 24 months out of 84 months. The time limit applies only to nonparticipating clients.

[21] AFS operates Oregon's welfare programs, which has a strong emphasis on employment and work supports.

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Tennessee's Family Services Counseling Program

Program origins. In 1999, the director of Families First Services[22] initiated an assessment of the types and prevalence of work barriers among TANF recipients. Based on local welfare administrators' reports, Tennessee's Department of Human Services (DHS) determined that a portion of families on cash assistance needed more intensive clinical case management and counseling services. This prompted the creation of a statewide program, Family Services Counseling (FSC), to assist families with barriers to move from welfare to work. DHS contracted with the College of Social Work at the University of Tennessee (UT) for the administration of the FSC program. In January 2000, UT hired a director to design and implement the FSC program. Family services counselors began receiving referrals in February 2000.

Scope of barriers targeted. The FSC program targets TANF customers and family members with mental health conditions, learning disabilities, or substance abuse, domestic violence, or child behavioral problems, but will also provide services to families with other types of challenges, such as parenting difficulties and homelessness.

Eligibility for mental health services. Services are available to all family members on the TANF case. Families may receive FSC services while on cash assistance and up to 12 months after case closure.

Strategies for identifying customers with mental health conditions. Tennessee uses a multifaceted approach to identify and connect customers to the FSC program.

- **Orientation.** TANF clients first are made aware of the FSC program at their group orientations. During orientation, a family services counselor explains the FSC program and provides an outline of the types of services offered and how to access these services.

- **Case Managers.** TANF clients are commonly referred to the FSC program by DHS case workers. During the development of a customer's personal responsibility plan, the case worker may recommend FSC services. The DHS case workers are educated about the FSC program, and they are trained to identify substance abuse problems, mental health conditions, and domestic violence.

- **Referrals by Employment Service Providers or Community Agencies.** The local contracted employment and education agencies are informed about FSC

[22]Tennessee developed the Families First program in 1995. The program emphasizes education and training for families on cash assistance to move them toward self-sufficiency. Since the implementation of Families First, there has been a 38 percent reduction in the number of families receiving cash assistance, from 91,499 in 1996 to 56,690 in 2000.

services. They may refer customers to the program through the DHS case worker or directly to a family services counselor.

- **Mandatory Referrals.** DHS case workers are mandated to offer referrals to sanctioned clients. Sanctioned clients who chose FSC as an activity to remedy a sanction are required to meet with family services counselors during the two-week compliance period before they can begin receiving cash assistance again.

- **Community Outreach**. The FSC program has a widespread social marketing effort. Presentation and training sessions for DHS staff and other community partners help educate workers statewide about the FSC program mission, goals, and success. Some areas have outlocated family services counselors to inform clients about the FSC program. In Chattanooga, for example, there is a family services counselor located at the Harriet Tubman Housing project.

Types of mental health services provided. There is a range of mental health services available to customers in the FSC program. They are described below.

- **Standardized Assessment.** All customers receive a statewide standardized assessment with a family services counselor to determine the appropriate treatment for the client.

- **Solution-Focused Therapy.** Family services counselors provide solution-focused therapy to their clients. Family services counselors receive extensive training on using a solution-focused brief therapy approach, which identifies and uses client strengths and resources to identify and solve problems.

- **Linkage with Local Mental Health Providers.** Customers that require intensive long-term treatment or medication management are referred to mental health centers accepting TennCare.[23] Family services counselors also refer customers with learning disabilities or domestic violence, substance abuse, and child behavioral problems to other agencies for assessment and treatment.

- **Intensive Case Management.** The family services counselors provide customers with individualized assistance to address barriers to self sufficiency. Family services counselors may assist customers with supportive services such as housing and transportation.

- **Consultation with DHS Case Workers.** The family services counselors make recommendations to DHS case workers for modified work plans based on their work with clients. Because family services counselors are co-located in the local welfare offices, DHS case workers frequently consult with them about difficult

[23] TennCare is Tennessee's Medicaid program.

cases and most family services counselors provide training for DHS staff to identify barriers to work among clients.

- **Assistance with Applying for SSI.** The family services counselors help to coordinate psychological evaluations and walk customers through the Supplemental Security Income application process.

The relationship between mental health services and work requirements. While the Families First program emphasizes employment, it allows customers to participate in other activities such as mental health treatment, education, or training before going to work. Customers referred to the FSC program are not required to participate in self-sufficiency activities until a family services counselor has assessed them. The month of the client's assessment does not count against their time limit for receiving cash assistance, and a family services counselor may request a time limit interruption for clients with severe mental health conditions. There is a broad range of activities that may be included in the client's self-sufficiency plan, including mental health treatment. Most customers participating in the FSC program blend work activities, such as life skills workshops, with mental health treatment. The goal is to gradually move customers into work, but work is not required as a first activity.

Administrative structure. Staff members for the FSC program are hired through UT and local contracted service providers. The FSC program director and district coordinators are university employees. Within each district, DHS contracts with local not-for-profit agencies to provide family service counselors and clinical supervision. In some of the sites, the local agencies had formed collaborative relationships prior to the FSC program. These relationships were instrumental in implementing the FSC program in these areas. For example, DHS contracted with Family and Children's Services of Greater Chattanooga (FCS) to provide family services counselors for Hamilton County because they have been administering programs such as life skills training, parenting classes, employee assistance programs, and outpatient mental health treatment for over 120 years.

When customers need services, in addition to family services counseling, they are referred to the TennCare mental health providers. The types of agencies providing treatment vary across the state. For example, the urban area of Hamilton County has a variety of treatment providers including a residential and an outpatient substance abuse treatment center, while rural Montgomery County is more limited, with one mental health center and several not-for-profit agencies that provide primarily group treatment to low-income families.

Funding mental health services. The operating budget for the FSC program is approximately $8 million. Most of the money allocated is used to contract with UT for program administration and with local not-for-profit agencies to hire family services counselors. Most TANF families can access mental health treatment through their TennCare assistance. Families who leave cash assistance generally qualify for transitional TennCare benefits, which cover mental health treatment.

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Utah's Mental Health Services

Program origins. Utah began providing mental health services in 1990 when the Office of Family Support (OFS) hired two licensed clinical social workers to help clients with mental health needs access treatment. In 1993, OFS implemented the Single Parent Employment Demonstration (SPED) program[24], which allowed a broad range of activities to count as required self-sufficiency activities and gave case managers flexibility in determining the number of hours clients had to participate in self-sufficiency activities. Under SPED, two additional social workers were hired to identify mental health and substance abuse problems, provide brief therapy and work on the conciliation process for families who were noncompliant and being recommended for sanctioning. Eventually, social workers were hired statewide and the types of services social workers provided were determined locally.

In 1996, Utah consolidated the six separate agencies that handled employment, job training and welfare functions into the Department of Workforce Services (DWS). At this time DWS administrators decided to reorganize and centralize social work services. In 1998, the social work unit was formed with a program manager at the state level and a uniform statewide set of policies, procedures, and reporting forms were developed.

Scope of barriers targeted. Social work services focus on mental health conditions. The social workers may address substance abuse and other needs of the client by linking them to service providers in the community.

Eligibility for mental health services. All TANF clients qualify for mental health services and may continue to receive services up to a year after TANF case closure. In general, social work services are geared toward the welfare recipient rather than the entire family receiving cash assistance.

Strategies for identifying clients with mental health conditions. Clients are informed and identified for social work services in a variety of ways and at different points while on cash assistance.

- **Orientation Video**. During the first meeting with an employment counselor, clients are shown a computerized slide show that gives an overview of the FEP and outlines the services available, including mental health services. This is typically the client's first introduction to mental health services.

- **Client Assessments/Case Managers.** All employment counselors complete a standardized assessment with each client to gather information about the client's background, including work, family, legal, and medical history. Case managers refer clients to mental health treatment based on the assessment results and if a client demonstrates signs of a mental health condition.

[24] In 1996, the SPED program was expanded statewide and renamed the Family Employment Program (FEP).

- **Automatic Referrals.** The CAGE questionnaire is administered during the client assessment to screen for possible substance abuse conditions. If the customer responds "yes" to two or more of the four CAGE questions then the employment counselor is required to make a referral to the social worker. The client may chose not to participate in mental health services.

- **Conciliation Process and Time Limit Extension Reviews.** If a client is not participating in program activities or is nearing their time limit, a social worker may be included in case staffings and recommend social work services.

Types of mental health services provided. Once clients are identified and referred to mental health services, they are given an appointment with a social worker. The types of services social workers provide are described below.

- **Clinical Assessments.** A primary function of the social worker is to provide clinical assessments. Most social workers use mental health inventories in their clinical assessments, but they vary in the types of inventories they chose to use. The inventories selected typically detect mental health conditions, such as clinical depression, generalized anxiety, personality disorders, and suicide risk. Assessments are performed at the DWS office, in clients' homes, or at other locations convenient to clients. Summaries of the assessments are distributed to the employment counselors to assist them in negotiating realistic and effective employment plans with their clients. The more detailed clinical assessments are shared with the Medicaid or contracted treatment provider.

- **Link Clients to Mental Health Treatment.** Social workers have two different options for linking clients with mental health treatment. First, social workers may refer clients to the local Medicaid provider. The Medicaid mental health provider is used for all clients needing long-term treatment or medication management. The social workers facilitate the process of accessing treatment through the Medicaid provider. On average, clients may wait up to one month to see a therapist from the Medicaid provider. Social workers can typically get a client into treatment with the Medicaid provider in less time. In cases where TANF recipients would be required to wait longer than 10 days for treatment or where clients would benefit from a particular treatment[25], social workers may refer clients to a contracted treatment provider in the area. The contracted service providers offer outpatient individual and group treatment as well as psychological assessments. Therapy is short-term and focused on helping the client meet employment goals.

[25] For example, clients with PTSD are frequently referred to the Trauma Awareness and Treatment Center, an agency that specializes in treatment for survivors of physical and sexual abuse.

- **Crisis Intervention**. Social workers deal with immediate crises among clients. Social workers help to stabilize clients and link them with inpatient or crisis intervention treatment.

- **Short-Term Therapy.** In some offices social workers will conduct short-term therapy with clients who have less severe mental health treatment needs. Typically, treatment lasts 6 to 10 sessions and is focused on helping clients become more employable.

- **Consultant/Resource for Employment Case Managers.** Based on the assessment, social workers makes treatment recommendations and general recommendations regarding other barriers or issues identified during the clinical evaluation process. Employment case managers report that they often rely on the clinical expertise of the social workers in making decisions about the types of activities and amount of hours they should include in clients' self-sufficiency plan. Social workers may also provide guidance to employment counselors for strategies in interacting with the customer and may provide in-house training. Social workers in all the employment centers frequently participate in case staffings.

The relationship between mental health services and work requirements. DWS administrators allow case managers flexibility in deciding the types of activities and participation hours required of clients. In the client's self-sufficiency plan, the employment counselors can include any activity, including mental health, that will help the customer become employed. The 36-month time clock does not stop for clients participating in mental health treatment, but clients may receive an extension for a mental health or physical health condition, a substance abuse problem, or other severe barriers to work. Extensions are determined at 32 months during a mandatory extension review with the client, employment counselor, supervisor, and social worker. Extensions are conditional on clients participating in program activities. Extensions are reviewed monthly.

Administrative structure. All social work services staff are DWS state employees. There is a state social work program manager who implements, administers, and monitors the social work services and acts as a liaison to coordinate social work services among employment center administrators. The program manager also negotiates and monitors the social work treatment provided by the mental health treatment contractors. The social workers are typically licensed clinical social workers (LCSWs) with extensive experience in providing clinical treatment. Social workers may also be experienced bachelor's level staff members, certified social workers with a master's of social work degree or interns[26] that are supervised by an LCSW.

[26]There are 20 social workers and 6 interns across the state for 2001. DWS has an arrangement with the Graduate School of Social Work at the University of Utah to provide clinical internships to master's of social work students in local employment centers.

Funding mental health services. Federal TANF and state maintenance of effort funds pay for mental health services administrative staff, DWS social workers and contracted mental health treatment services. Statewide, approximately, $1.2 million is allocated for social work services staff and $456,000 for contracted mental health treatment. The majority of nonmedical mental health treatment is paid for with Medicaid funds. All medical-related services are covered through Medicaid.

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