Case Study of an Approach for Preparing Individuals with Low Income for Work

Kentucky Targeted Assessment Program

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Lead entity:
University of Kentucky

Service area:
35 of Kentucky's 120 counties

Setting:
Rural and urban

Number of participants in 2019:
2,085

Focus population:
TANF and child welfare clients

Initial year of operation:
2000

Introduction

Kentucky's Targeted Assessment Program (TAP), which operates in 35 of the state's 120 counties, provides comprehensive assessment and intensive case management services to parents who are involved in the state's child welfare and Temporary Assistance for Needy Families (TANF) systems. The goal of the program is to help participants overcome barriers to self-sufficiency and family safety by focusing on (1) mental health, (2) substance use, (3) intimate partner violence, and (4) learning disabilities or deficits. Through motivational interviewing and strengths-based intensive case management, TAP staff prepare participants for treatment, refer them to community-based services and treatment programs, and facilitate their follow-through with referrals and services. In addition, TAP staff help participants remove structural barriers to engagement, which may include lack of child care, transportation, food, clothing, housing, utilities, and medical care.

This report includes the following sections: Where TAP Operates; Who TAP Serves; What Services TAP Provides; How TAP Manages Staffing, Communication, and Funding; How TAP Measures Program Participation and Outcomes; and Promising Approach, Challenges, and Future Plans.

About this report

This case study (OPRE Report # 2021-66) is part of a series of nine comprehensive case studies that showcase innovative approaches for supporting the employment of low-income individuals and families, including Temporary Assistance for Needy Families recipients. Each case study highlights key components of implementation, including their linkages to wraparound supports, to expand the knowledge base of these programs. The programs featured in the series represent a diverse range of service strategies, geographies and community contexts, focus populations, and service environments. The case studies are sponsored by the Office of Planning, Research, and Evaluation in collaboration with the Office of Family Assistance, both within the Administration for Children and Families in the U.S. Department of Health and Human Services.

Where TAP operates

TAP operates throughout Kentucky in a mix of urban and rural areas. The program is centrally administered, though implementation varies based on a community's needs and resources. To better understand how TAP was implemented in different settings, the case study team focused on its implementation in Louisville, the state's largest city with over 600,000 residents, and in Hazard, a rural town in eastern Kentucky with fewer than 5,000 residents.

Economic snapshot of Kentucky

	Perry County	Jefferson County	Kentucky
Total population (2018)[a]	26,917	767,154	4,440,204
Median household income (2018)[b]	$31,046	$54,357	$48,392
Percentage of people below poverty level (2018)[b]	27.1%	14.8%	17.9%
Unemployment rate (2019)[c]	6.1%	4.0%	4.3%

Notes: Perry County includes Hazard, KY and Jefferson County consists wholly of Louisville, KY, the locations visited by the site visit team. Unemployment data presented here do not reflect shifts in the economy that have occurred since the onset of the COVID-19 pandemic. See box on page 17 for more information about changes to the economy and how TAP responded to the pandemic.

Source: [a] U.S. Census Bureau (2019); [b] U.S. Census Bureau (2019b); [c] U.S. Bureau of Labor Statistics (2020a,b).

Kentucky has been severely affected by the opioid epidemic. According to the Kentucky Chamber Workforce Center, Kentucky ranked fourth among U.S. states in drug overdose deaths in 2017, with the majority of these deaths resulting from opioid overdoses (Kentucky Chamber Workforce Center 2019). Parents' abuse of opioids and other drugs can result in formal involvement by the state child welfare agency. Parental substance use has a direct impact on TAP referrals; about half of all individuals referred to TAP report substance use problems. Staff noted that in recent years they have seen an increase in methamphetamine and cocaine use. One staff person mentioned that the state has experienced an increase in the abuse of suboxone, a prescription medicine used to treat adults who are addicted to opioids.

Medicaid is a major source of funding for treatment of substance use disorder for low-income individuals. Prior to Kentucky's Medicaid expansion in 2014, substance abuse treatment was only covered for pregnant and postpartum women, so treatment access increased greatly with the expansion. The expansion also included those without dependents, enabling TAP participants who had temporarily lost custody of their children to access treatment.

Who TAP serves

TAP provides services to parents who are involved in Kentucky's TANF program or child welfare system who have at least one of the following barriers to self-sufficiency and stability: (1) mental health issues,

Eligibility requirements for TAP

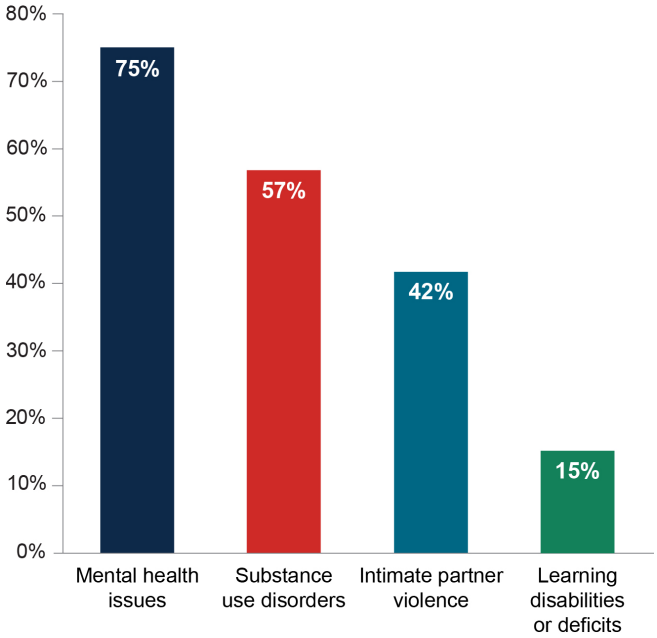
- Receive TANF or be involved in the child welfare system
- Have income below 200 percent of the federal poverty level
- Have children younger than 18 years old
- Have at least one barrier to self-sufficiency, which could include:
  - Mental health issues
  - Substance use disorders
  - Intimate partner violence
  - Learning disability or deficit

(2) substance use disorders, (3) intimate partner violence, and (4) learning disabilities or deficits. To be eligible for services, parents must also have income below 200 percent of the federal poverty level and children younger than age 18. Although parents who are not living with their children are not eligible for TANF, they are eligible for TAP if reunification is a possibility.

The vast majority of TAP participants are referred to the program from the child welfare system. Although both parents and children are involved in child welfare cases, TAP specialists focus on addressing parents' barriers to well-being and the child welfare system focuses on addressing the safety and well-being of children. In state fiscal year (FY) 2019, about 83 percent of referrals to TAP came from the child welfare system, 15 percent came from TANF, and the remaining 2 percent came from community service providers and self-referrals. About half of the child welfare referrals were parents whose children had been removed from their home with the possibility of reunification, while the other half were parents whose children were at risk of being removed from their home. In most instances, TANF and child welfare caseworkers assess cases to determine their likely eligibility for TAP before making a referral. Typically, these caseworkers notify TAP staff of a new referral via email. However, they sometimes involve TAP staff in a case planning meeting to learn about a case that will be referred.

Many TAP participants report multiple barriers to employment, as well as basic needs. The most prevalent barrier among them is mental health, followed by substance use, intimate partner violence, and learning disabilities or deficits (Figure 1). Participants' most commonly reported unmet needs include housing (35 percent), transportation (30 percent), support with social or family relationships (29 percent), and support with parenting (20 percent). TAP staff also said that a lack of health insurance limits participants' ability to access services and that participants needed help with enrollment. The vast majority of TAP enrollees are white, unmarried females who hold a high school diploma (Table 1).

Figure 1. TAP participants' assessed barriers



Source: TAP 2019 Annual Report
N = 2,085 assessed participants

Table 1. FY 2019 demographics of TAP participants

Demographics	TAP participants
Age (mean)	32
Gender (female)	88%
Race (white)	83%
Marital status (married)	16%
Number of children (mean)	2.3
Education (less than a high school diploma)	27%

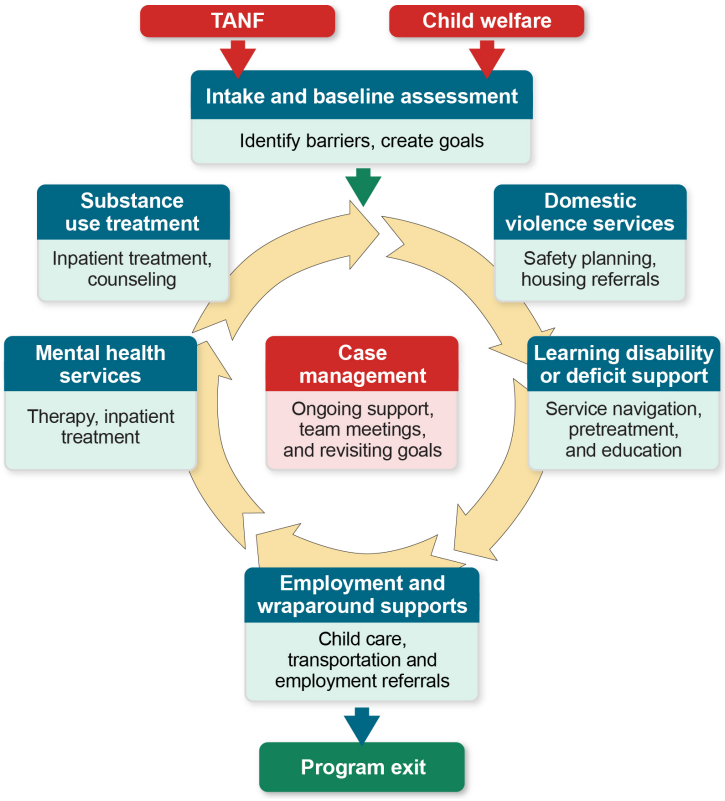
Source: University of Kentucky Center on Drug and Alcohol Research (2019).
N = 2,085 assessed participants.

What services TAP provides

A team of researchers at the University of Kentucky (UK) Center on Drug and Alcohol Research, which is a center in the College of Medicine, developed and operates TAP in close partnership with the TANF and child welfare programs. The state's Department for Community Based Services (DCBS), which administers the state's TANF and child welfare programs, contracts with UK to operate TAP.

Through frontline staff called TAP specialists, TAP offers flexible services and supports based on participants' needs and evolving circumstances. The program begins with an intake meeting and participant assessment, which is followed by case management and referrals to an array of services (Figure 2).

Figure 2. Participant flow and services



Intake, assessment, and service planning

Key program practices

- Comprehensive assessment
- Advocacy for participants
- Intensive staff hiring and training
- Co-location and flexible collaboration with referral sources and community partners

Before receiving services, prospective participants attend intake meetings, complete assessment interviews, and engage in service planning.

At intake meetings, prospective participants learn about the program and provide written consent to participate. TAP specialists attempt to contact participants to schedule an intake meeting within 30 days of referral. Given the nature of the population served by the program, many participants do not maintain consistent cell phone numbers or addresses. In their attempts to make a first contact, TAP specialists may make phone calls, send letters, or visit homes (sometimes with a referring DCBS child welfare caseworker). TAP specialists will attempt contact for up to 90 days before informing TANF or the child welfare system of their actions and the reason TAP was unable to provide services.

In their first contact with participants, TAP specialists explain the program and schedule an intake appointment. Based on the resources and ability of the participant, the meeting could be scheduled at the DCBS office, a community agency, or the participant's home. During the intake meeting, TAP specialists describe the potential benefits of participating in the program and the services that TAP is and is not able to provide. They are careful to highlight the difference between TAP services and services provided by the child welfare or TANF systems. TAP is not part of the TANF or child welfare system and has no authority to make determinations regarding TANF or child welfare cases. If participants agree to engage, TAP staff obtain written consent to participate and authorizations to release information that are HIPAA and federal substance abuse confidentiality guidelines (42CFR) compliant, review the participant's rights, and perform a baseline assessment or schedule a follow-up appointment to do so.

Participation in TAP and TAP-recommended services is not mandatory, but there are consequences if referred participants do not engage in services. Compliance with TAP-recommended services may become part of a parent's child welfare case plan, though parents may engage in these services without TAP's help. TANF recipients referred to TAP who do not participate are required to participate in work activities or seek an exemption from the work requirement.

A comprehensive baseline assessment identifies participants' barriers. Within 30 days of first contact, TAP specialists complete a baseline assessment survey. The baseline assessment collects in-depth information about the services that can benefit participants. TAP specialists receive information about participants from their referring child welfare or TANF caseworker, such as why the participants are in the child welfare system and what their goals are. However, the baseline assessment collects more comprehensive information about the participant, including the following:

- Characteristics, including gender, marital status, race, education, employment status, housing situation, number of children, receipt of TANF, and involvement with child welfare system

- Problems with daily activities in the past three months, such as accessing transportation, housing, child care, or medical treatment; covering expenses; working or completing schoolwork; meeting DCBS requirements; getting along with family and friends; and parenting
- Physical health, mental health, and substance use issues
- Trauma history (childhood and adulthood)
- Intimate partner abuse and violence experiences
- Learning disabilities or deficits
- Other basic needs and barriers, such as legal problems
- Treatment history; prior involvement in services
- Strengths and goals

Jessie's* story

Jessie is working on regaining custody of her three children, who are all younger than age 4. Child Protective Services removed the children from her custody after an alcohol-related incident.

Jessie had attended a private college and studied science until her athletic scholarship was cut due to an injury. After briefly transferring to a community college, she stopped going to school and worked at an insurance company. She took time off when her youngest child was born, but she eventually stopped working entirely due to the high cost of child care.

Previously, Jessie had received outpatient services for substance use disorder from a local program, but she said that these services did not sufficiently address all of her barriers. Since her child welfare caseworker referred her to TAP, Jessie has worked with her TAP specialist to return to her sobriety supports, apply for health insurance, attend parenting classes through a local provider, work on reinstating her driver's license, discuss intimate partner violence, and address mental health needs.

Once she is approved for health insurance, Jessie hopes to begin therapy with a private psychiatrist. She plans to re-enroll in community college in a few months to finish a degree in computer science. She hopes to reunify with her children soon.

**Participant's name has been changed.*

TAP specialists collect this information using a structured form. All specialists are trained in three evidence-based approaches for working with participants and use these approaches beginning at the intake appointment: (1) motivational interviewing, (2) strengths-based case management, and (3) cognitive behavioral therapy.

The assessment informs participants' service plans to address their needs. Within three days of completing the baseline survey, the TAP specialist logs on to a web-based system and completes a rating scale and service needs instrument. The TAP specialist provides an assessment of the participant's barriers and needs based on the responses on the baseline survey and the specialist's professional judgement. The TAP specialist rates the participant's need for medical care, mental health treatment, substance abuse treatment, services for intimate partner violence, testing for or help with learning disabilities or deficits, and need for further education on a five-point scale that ranges from "no need" to "extreme need."

After conducting the assessment, the TAP specialist develops a narrative report that (1) summarizes the participant's barriers and strengths; (2) recommends the services to address any identified mental health, substance use, intimate partner victimization, or learning issues; and (3) outlines the plan to address the barriers. The TAP specialist reviews the report with the participant to ensure agreement with the recommendations. The TAP specialist also shares information from the assessment with the DCBS caseworkers to keep them informed and provide information that may be helpful as they develop their plans.[1]

Case management

TAP specialists act as advocates and sources of support to help participants move toward self-sufficiency. They said they work to develop close relationships with participants and often act as liaisons between participants, child welfare and TANF caseworkers, and other service providers. The releases that a participant signs during the intake meeting allow TAP workers to discuss case information with TANF workers, child welfare staff, and other service providers. However, TAP specialists are not compelled to share all information they discuss with participants, unless a participant's or another person's life or safety is at risk. One TAP specialist described this intermediary role as a "selling point" of the program. According to TAP staff, participants often tell specialists things that they have not disclosed to their TANF or child welfare caseworker, either because they feel more comfortable with their TAP specialist or because the TAP specialists are more often available for formal and informal meetings. TAP staff said that some participants may be hesitant to discuss certain barriers with child welfare caseworkers for fear of disclosing something that could affect their reunification plan, but they may be more open to sharing with their TAP specialist, who they know is not bound to disclose that information to other parties.

Participant advocacy

TAP specialists advocate on behalf of participants to other service providers, including TANF and child welfare staff. TAP specialists create safety for participants to disclose personal information they may not share with other service providers. Specialists are not required to disclose this information, unless a person's life or safety is at risk, but may draw from it as they liaise with other service providers.

The overarching goal of TAP is to help participants move toward self-sufficiency. Each participant's path toward self-sufficiency, however, is different. Some come to TAP ready to engage in services provided by community partners; others do not. Thus, TAP staff may provide pretreatment services to prepare and motivate participants to follow through with referrals and immediate referrals for those who are ready.

Pretreatment services prepare participants for treatment and other services. Commitment to pretreatment is key to the TAP model. Through pretreatment services, TAP specialists help participants minimize internal and external barriers and prepare to engage with treatment and other services. For example, if a parent is nervous or ambivalent about enrolling in a substance use treatment program, a

[1] TAP specialists access the TANF system to enter the findings from the assessment and recommended services. For participants referred from child welfare who sign a release, TAP specialists will provide the report to the child welfare worker.

TAP specialist will use motivational interviewing to help a participant see the need and benefits of seeking treatment. Similarly, if a parent has no child care, the specialist will help resolve this barrier. The TAP training manual describes specialists' core pretreatment responsibilities, which include "doing things no one else will do" (Carleton, 2012). This written expectation reflects an attitude that was threaded throughout the TAP program: TAP specialists were willing to provide both social-emotional support and practical assistance, such as transportation, that participants may not be receiving from their social networks or other programs.

Referrals to services follow the case plan. Referrals to services and subsequent case plans depend upon the needs and goals of each participant. For example, for participants who identify intimate partner violence as a barrier, TAP specialists may make referrals to local shelters, help find alternative housing, or work with the participant on safety planning. For those who are employed and trying to maintain employment, TAP specialists may help participants with pre-planning for challenges, such as what they should do if a child gets sick. Although the case management model used by TAP staff is structured and consistent, TAP specialists reported having room for creativity and flexibility in determining a participant's course of action.

Martha's* story

A TAP specialist identified mental health as a key barrier for Martha, a young mother with three children who struggles with anxiety and bipolar disorder. Martha's mental health issues have prevented her from obtaining a driver's license and maintaining employment.

Martha dropped out of college when she gave birth to her youngest child. Although she worked at various fast-food restaurants in the past, Martha felt this employment worsened the symptoms of her bipolar disorder.

Managing her mental health and regaining custody of her children are Martha's top priorities. A TAP specialist supports her in working toward these goals by checking that she attends doctors' appointments and other commitments, stays sober, and remains "in a good place mentally."

Martha's TAP specialist drives her to therapy. The specialist also helped her apply for Supplemental Security Income (SSI). "I rely on [my TAP specialist] for moral support," Martha said. "She hypes me up [and] makes me feel like I'm doing the best I can."

**Participant's name has been changed.*

TAP specialists facilitate participants' follow-through with referrals through a process they call "warm handoffs." Often, TAP specialists will accompany participants to their first appointment with a new provider or, if they cannot, will touch base with the participants soon afterward. They closely monitor engagement by following up with participants and service providers and helping when problems with participation arise. One TAP specialist said that participants are often intimidated by "the system." She sees it as her job to familiarize participants with available services, in part so that they feel comfortable accessing them on their own after leaving the TAP program. A high percentage of participants follow through on the TAP specialists' recommendations and at least begin participating in services. According to the 2019 TAP Annual Report, 83 percent of participants who were referred to mental health services followed through compared to 82 percent who were referred to substance use services, 74 percent who were referred to intimate partner violence services, and 52 percent who were referred to services for learning disabilities or deficits (University of Kentucky Center on Drug and Alcohol Research 2019). TAP staff attributed the high percentages to their warm handoffs; the relationships they had with co-

located DCBS staff and with community service providers; and the administrative support they provided to participants, such as helping them fill out paperwork and transporting them to required appointments.

Employment services

The TAP model operates under the premise that multiple barriers affect employment and that identifying and addressing the barriers improves participants' ability to obtain and maintain employment. TAP specialists said that it is common for participants to prioritize treatment for mental health and substance use issues or to secure safe and stable housing before turning to employment. Many TAP participants are either not employed or not considered to be ready for employment. In 2019, about two-thirds (64 percent) of participants were unemployed at the time of the baseline assessment, while 15 percent identified work readiness as a barrier (University of Kentucky Center on Drug and Alcohol Research 2019).

TAP specialists refer participants who are ready to pursue employment to TANF employment specialists or other community-based organizations. For example, they make referrals to local employment offices and community action agencies that provide resume assistance and job coaching. For participants with learning disabilities or deficits or other disabilities, TAP staff may rely on vocational rehabilitation to help connect participants with jobs that cater to participants' strengths. TANF requires that 25 percent of all participants it refers to TAP participate in work activities within six months of their TAP assessment. TAP leaders noted that they did not have any problems meeting this performance metric. In 2019, more than two-thirds (70 percent) participated in a countable work activity within six months of baseline assessment; the average amount of time to participation was 7 weeks.

Other community services

TAP specialists may refer participants to other services provided by community partners for substance use and mental health treatment, education, transportation assistance, or child care. In some cases, TAP specialists offer direct transportation services so that participants can engage with community partners. TAP specialists stressed the importance of having a network of local service providers, given TAP's inability to fund services directly. One TAP specialist described herself as adept in "scavenging" for services and resources—that is, for getting creative in finding available supports in the community. For example, when in search of furniture for a participant who was moving out of an intimate partner violence shelter, one TAP specialist learned that a local school administrator collected donated furniture and asked other local providers to help her haul a used couch to the participant's new home.

TAP's connection to TANF

DCBS funds TAP to provide supports for those engaged in the child welfare or TANF systems and who have identified barriers to self-sufficiency. The TANF program referred 15 percent of TAP participants.

Participants receive substance use and mental health treatment from community partners. TAP relies on a large network of community partners that provide a spectrum of mental health and substance use services. These services can include intensive residential substance use disorder treatment programs, outpatient treatment programs, and group therapy. The network of partners in

each community depends upon the number of providers available and their capacity.

In 2018, TAP conducted a survey of its specialists, asking them to rate the availability of high quality substance use disorder and mental health treatment in their area by using a four-item scale, with 1 being "poor," 2 being "fair," 3 being "good," and 4 being "very good" (University of Kentucky Center on Drug and Alcohol Research 2019). Respondents rated substance use and mental health treatment at an average of 3.2, with more than two-thirds of the specialists reporting that the availability was either good or very good. However, there were differences by region across the state, with Louisville (Jefferson County) receiving the highest scores of 3.8 for mental health and 3.5 for substance use. By contrast, the Eastern Mountain region (containing Perry County) received a score of 2.9 for both mental health and substance use. Even where scores were relatively low, however, TAP specialists mentioned being able to make referrals to a nonprofit community mental health center that provides services for mental health, developmental disabilities, substance abuse, and trauma in addition to outpatient and residential treatment.

Interested participants are referred to education or training services. Participants who are ready and interested in pursuing education or training may be referred to programs that can help them with this goal. For example, TANF recipients can enroll in the Kentucky Community and Technical College System (KCTCS) and participate in the state's Ready to Work program. In this program, participants receive paid work-study opportunities in their field of study; the work-study income does not affect their TANF eligibility or reduce their benefits. An adult education program called Kentucky Skills U also exists for TANF recipients who are working toward their GED.

Participants can receive transportation supports from TAP or community partners. The TAP survey also asked specialists to rate the availability of transportation services. The average score across the state was a 2.0, or "fair." Not surprisingly, this score varied substantially across the regions. For example, the rural Eastern Mountain region (containing Perry County) received a score of 1.6, while Louisville, an area with more available public transportation options, scored highest at 3.5 (University of Kentucky Center on Drug and Alcohol Research 2019).

TAP specialists often provide transportation in their own personal vehicles for participants, many of whom do not have a driver's license or vehicle. They also look to community organizations and service providers for transportation assistance, such as bus cards and van rides, for participating clients. For example, participants in Louisville can use a ride-share program to pay discounted fares to take a van to their jobs in areas where the public bus does not run during their shifts. Some substance use treatment programs also provide discounted public transportation tickets to participants.

Kentucky's TANF program offers multiple transportation assistance programs, but only 15 percent of TAP participants receive TANF assistance and qualify for these benefits (University of Kentucky Center on Drug and Alcohol Research 2019). For example, TAP specialists reported that participants referred through TANF in Louisville can receive $200 in flexible transportation assistance if they meet activity guidelines. TAP specialists encourage them to spend part of this money on a monthly bus pass but said that it can be difficult to convince participants to take on a high up-front cost. TAP specialists also reported that TANF can also provide up to $1,500 each year for vehicle repairs, but only if the vehicle is in the participant's name and the participant has an active driver's license.

The availability of child care referrals vary by location. TAP refers participants to local resource and referral organizations to identify child care providers or apply for child care subsidies. TAP may also work with the TANF or child welfare system to secure child care slots and subsidies for participants who qualify. Similar to the availability of transportation services, the availability of child care services varies across the state. Overall, TAP specialists rated the availability as "fair," with an average score of 2.0, though this score ranged from a low of 1.8 in the Eastern Mountain region to a high of 3.5 in Louisville (University of Kentucky Center on Drug and Alcohol Research 2019). Specialists in the rural area said that there is an extreme shortage of child care providers, with only three centers in the county and waiting lists as long as eight months. Although child care providers may be scarce in some areas, child care was not described as an immediate need for many participants. About half of the TAP participants who were referred to the program from child welfare were parents working toward family reunification. In addition, most participants were unemployed. Staff said that participants frequently expressed concerns about putting their children in low-quality child care centers, so TAP specialists try to educate participants about how to identify quality child care, prepare them with questions to ask providers, and teach them how to advocate for their children's needs.

Service length and exit

There is no time limit on TAP services. On average, participants stay in TAP for 30 weeks, but that timing varies based on participant needs and circumstances. There is no definitive point at which a participant must exit services; TAP specialists reported having participants on their caseload for as long as two and a half years and as briefly as one in-person meeting. TAP specialists said that even if participants complete services or begin meeting a work requirement, they might not close the case immediately. After a TAP case has been closed, TAP specialists may make additional referrals without reopening the case, or the participant may be referred for a new service episode depending on their need.

In general, reasons for closing a case include the participant completing a case plan, refusing or not engaging with TAP services, not keeping appointments, relocating, or becoming otherwise ineligible. TAP specialists complete a case closure instrument after participants leave the program. It records the reason for the case closure as well as information about the services that the participants received from TAP, including the amount of time the specialist spent with the participant and the number of phone calls and in-person meetings that occurred. It also includes questions about the four major barriers, including a participant's acceptance of referrals, level of engagement with services, and the TAP specialist's rating of overall "stage of change." For participants referred from child welfare, the instrument includes questions about the status of the child welfare case and the assistance provided in helping participants meet their case plan. For participants referred from TANF, the instrument includes questions pertaining to their readiness to work and participation in work activities.

Jennifer's* story

Jennifer is a mother in her late 30s with two children younger than age six. She has experienced intimate partner violence, which limited her ability to leave her home and seek employment. She also has experienced a substance use disorder. When a case study team member met Jennifer, she did not have a driver's license and had recently experienced the death of multiple family members. Her most recent employment was over a decade ago in a customer service role. Jennifer described the TAP program as "lifesaving."

Jennifer was referred to TAP by Kentucky's TANF program in early 2019, after surviving a violent conflict with her partner and arriving at a domestic violence shelter with her children. After the comprehensive assessment, her TAP specialist used warm handoffs to services for transitional housing, intensive outpatient substance use treatment, Medicaid, the Supplemental Nutrition Assistance Program (SNAP), dental care, parenting support, and community service placement to fulfill her work-readiness requirement while in treatment. Her case was closed after five months with TAP.

TANF again referred Jennifer to TAP in late 2019 because she was experiencing continued barriers to work. Some of these persistent barriers were mental health issues, lack of child care, and lack of transportation. Despite these factors, her TAP specialist said that she was like a new person from when she first entered the program: her self-confidence had improved dramatically, and she no longer faced intimate partner violence or substance use. Jennifer's TAP specialist helped her find subsidized housing and moved donated furniture into her new home. Jennifer and her older child received mental health counseling, and Jennifer completed intensive outpatient treatment.

Jennifer planned to enroll in college in 2020 to pursue a career as a substance use counselor, inspired by her TAP specialist, who also had earned a degree later in life. Jennifer said, "The way I look at it is somebody that I look up to very, very much went back to college about the same age as I am and look at her now." In working toward this goal, Jennifer took her driver's license test with a car borrowed from TAP's community partner and tested for placement in college courses. Her TAP specialist helped her apply for Ready to Work, a statewide work-study program, and for financial aid. TAP continues to engage with and support Jennifer at monthly treatment team meetings with her substance use counselors and therapists.

Jennifer said that she felt financially stable for the first time in her life and was proud of being able to buy her children Christmas presents for the first time in 2019—partly due to her engagement with the TAP program. Jennifer said TAP specialists are "the most amazing people I've ever met. They go above and beyond to help you and do whatever you need them to do—make you feel better about everything and help you find resources.... They're my angels. I wouldn't be here today [if it weren't for them]."

**Participant's name has been changed.*

How TAP manages staffing, communication, and funding

TAP specialists, who work closely with their local DCBS offices and community partners, are hired after an intensive process. In addition, they receive up-front and on-the-job training. The program is funded through TANF funds.

Staffing

Since TAP began providing services in 2000, all staff have been supported under the TANF-funded contract between DCBS and UK and hired by UK. TAP staff primarily consist of the specialists, who focus on programmatic activities. The TAP specialists (57 across the counties) and the five field supervisors who manage them work in their assigned regions, while the administrative staff work at UK in Lexington. Administrative staff include the TAP program director, who is responsible for providing administrative support and program management, and the program coordinator, who coordinates TAP services across the counties. The UK team also includes a small staff of researchers, who focus on evaluating program outcomes and implementation. Table 2 summarizes the TAP staff and their responsibilities.

Training topics for TAP specialists

- Six-week orientation on TAP assessments and policies, the four target barriers, and trauma-informed and evidence-based practices, such as motivational interviewing
- Mentorship, including shadowing opportunities, with experienced TAP specialists, and DCBS child welfare and TANF staff.
- Ongoing feedback once they begin to serve participants

TAP specialists are co-located with DCBS staff. In Louisville, TAP staff are co-located at Neighborhood Places, city government–funded hubs of community services that include DCBS, the city government, the county public school system, a heating assistance program, and mental health services. In Hazard, TAP staff are co-located at the DCBS office.

Table 2. TAP staff

Staff position	Responsibilities
Program director	Manage program implementation and supervise TAP staff
Principal investigator (PI), co-PI, program evaluator	Oversee and conduct TAP research
Program coordinator	Supervise and coordinate TAP services across counties
Field supervisor	Supervise TAP specialists and manage a small caseload
TAP specialist	Receive referrals, conduct comprehensive assessments, and provide case management

Source: Information provided to the site visit team by TAP staff.

TAP specialists are hired through an extensive selection process. The qualifications for TAP specialists are a master's degree in a field related to human services and a minimum of three years of experience working with populations dealing with at least one of the four TAP focal barriers. When a position opens, TAP uses a collaborative community hiring process by convening a local selection committee of TAP staff, local DCBS TANF and child welfare staff, and community partners. This group reviews applications and interviews candidates for TAP specialist positions. Feedback from community partners is important in the hiring process. As noted in the training manual for TAP specialists: "This process is crucial to fostering positive communication and functional community relationships because these community partners are the main referral sources for TAP participants." TAP staff shared that in

practice it may take up to three rounds of posting a position to find a qualified candidate who gains the approval of the selection committee.

TAP specialists receive training, mentorship, and ongoing feedback. New TAP specialists undergo a six-week orientation before they are assigned participants. TAP leaders said that their orientation, comprehensive program manual, and online training modules developed by TAP provide specialists with an introduction, or "indoctrination," to TAP's practices and philosophy. Specialists are trained on the TAP assessments, policies, and four target barriers. This training includes education about trauma-informed practices and TAP's evidence-based practices, including motivational interviewing, strengths-based case management, and cognitive behavioral therapy.

The orientation also includes a mentorship model for new staff to shadow experienced TAP specialists as well as DCBS child welfare and TANF staff. Specialists reported that shadowing multiple experienced specialists allows them to observe different approaches to working with participants. Shadowing DCBS staff gives new specialists opportunities to learn TANF and child welfare policies and procedures and build relationships with staff in other DCBS agencies. TAP specialists may also tour community partner offices and shadow their staff.

TAP specialists receive ongoing feedback once they begin to work with their own caseload. For example, supervisors will review the TAP specialists' narrative assessment summary reports and other participant updates during their first year and provide feedback. Specialists are also encouraged to attend trainings hosted by local partners, such as trainings or presentations on sexual assault, intimate partner violence, and child welfare. One specialist said they appreciated regular training refreshers on "the basics."

TAP staff reported that because it can take a full year to understand the TAP specialist role, the program expects staff to stay in their positions for at least two years. The average tenure is between five and six years.

Collaboration and communication

The TAP model calls for specialists to communicate regularly with other TAP staff, DCBS, and partners, though these opportunities look different in each program setting. Across offices, interviews with TAP specialists revealed an emphasis on fostering a learning community in the TAP program. Co-location of TAP with DCBS is a key feature of the TAP model because it facilitates referrals from DCBS to TAP and allows for informal collaboration between TAP specialists and DCBS caseworkers. TAP staff also participate in various meetings with DCBS and community partners, including the following:

Co-location and collaboration with partners

TAP specialists collaborate with key partners through co-location with DCBS and regular meetings with DCBS and other community partners

- **Quarterly community advisory council meetings**. TAP convenes quarterly meetings with community partners and DCBS in each region. These meetings allow TAP staff to learn about available services and changes in services, inform partners about the support they provide to participants, and network with the other service providers. These meetings also provide opportunities

for TANF and child welfare staff to alert local providers about policy changes that may impact them or their clients.

- **Meetings with DCBS and partners.** TAP specialists and DCBS periodically facilitate meetings that include the participant, TAP specialist, DCBS caseworker, and service providers to discuss a participant's progress. TAP staff highlighted these meetings as one of TAP's most productive practices. The meetings provide recurring opportunities to get all stakeholders on the same page, while also allowing participants to ask questions, disclose new barriers, and discuss their goals. Other meetings between TAP, DCBS, and their partners may be scheduled without the participant. These meetings may address problems identified by TAP or DCBS, changes in policies and procedures, and ways to improve the program. For example, in Louisville, the Neighborhood Place has monthly integrated service meetings in which TAP staff can collaborate with community partner staff, discuss any concerns or questions they have, and discuss particular participants they are serving.

Funding

The state funds the TAP program with TANF dollars. According to UK staff, the total amount expended on TAP in state FY 2019 (July 1, 2018–June 30, 2019) was about $4.7 million.

In 2019, UK received a Kentucky Opioid Response Effort grant for $2 million from the Substance Abuse and Mental Health Services Administration (SAMHSA) to expand TAP in 5 of the 35 counties where it currently exists and to initiate services in 11 additional counties. The grant focuses on high-risk counties impacted by the opioid epidemic, by helping participants access medication-assisted treatment and increase their treatment retention. As of December 2019, UK was starting the process of hiring new TAP specialists for the expansion.

How TAP measures program participation and outcomes

UK research staff conduct analyses of data from TAP's web-based system as well as periodic research on the program's outcomes. Quarterly and annual reports to DCBS based on TAP's data present information on the baseline assessments; case closures; and the work readiness of participants, as demonstrated by the number of job applications that were submitted, employment obtained, and participation in job training and education. For participants receiving TANF, the report includes information on the number of weeks it took before they began participating in work activities that meet the TANF requirements. For those who are unable to participate in work activities because of a disability, the report presents information on the extent to which they applied for disability benefits and whether their application was approved.

When participants' cases are closed, the TAP specialists rate the progress that was made since the baseline assessment. In measuring progress toward overcoming major barriers for participants who terminated TAP services in FY 2019, TAP specialists rated 82 percent of participants as making any progress with their mental health issues, 83 percent making any progress on their substance use disorder issues, 83 percent making any progress on intimate partner violence, and 56 percent making any progress on their learning disabilities or deficits.[2] Among participants identified with work readiness as a barrier, TAP specialists rated 77 percent as making any progress in their work readiness and 71 percent as

[2] TAP specialists rate participants' progress using a 5-point Likert scale ranging from "no progress" to "a lot of progress," with "any progress" defined as "a little," "some," "moderate," or "a lot" of progress.

showing an increase in submitting applications for employment (University of Kentucky Center on Drug and Alcohol Research 2019).

The annual report also shows the extent to which TAP is meeting the program objectives established by DCBS, which focus on making sure clients referred to TAP are assessed for barriers to employment or family reunification, referred to services designed to address those barriers, and receive the services (Table 3).

Table 3. Selected performance outcome measures

Measure	Objective	Performance in FY 2019
Percentage of referred clients who were assessed	50	68
Percentage of assessed participants who were referred appropriately to address barriers	100	100
Percentage of participants recommended for pretreatment services who received these services	75	89
Percentage of participants recommended for service coordination services who were provided these services	75	91
Percentage of Kentucky Works Program (TANF) participants who participated in countable activities within six months of assessment	25	70

Source: University of Kentucky Center on Drug and Alcohol Research (2019).

UK also tracks and compares outcomes of participants at enrollment to outcomes of the same participants six months later (Leukefeld et al. 2012; Stanton-Tindall et al. 2008). The first pre-post study was conducted when UK followed up with a random sample of TAP participants, who had enrolled between June 2006 and July 2007, and six months later, between January 2007 and December 2007. Relative to the baseline assessment, participants experienced decreases in mental health symptoms, substance use, and intimate partner violence. UK replicated this study one year later. The second study also found statistically significant decreases in substance use, intimate partner violence, and learning disabilities or deficits. In addition, the study found statistically significant reductions in the percentage of participants experiencing work difficulties, having an open child welfare case, and receiving public assistance. It also found a statistically significant increase in employment. However, this pre-post analysis does not allow one to infer that the reduction in barriers was caused by participation in TAP. It is possible that even without the program participants would have improved over the same time period.

How TAP adapted during the COVID-19 pandemic

At the end of June 2020, Kentucky had recorded 349 COVID-19 cases per 100,000 residents, lower than the national average of 821 cases per 100,000 residents. [a, b] Despite being less severely affected than other states, Kentucky suffered economic harm at the outset of the pandemic, as the state unemployment rate spiked to 16.2 percent in April 2020. However, Kentucky's economy appeared to recover quickly, as the unemployment rate dropped to 5.0 percent in June 2020. [c] TAP received fewer referrals from TANF and child welfare in some counties due to changes in those agencies' needs during the pandemic. Specifically, TANF granted all participants good-cause work waivers at the beginning of the pandemic, which excused TANF recipients from having to participate in work activities due to the pandemic. Child welfare caseloads declined when schools closed, and these changes in referral partner caseloads may have contributed to lower TAP referrals in some counties. To respond to evolving local needs, the needs of its participants, and to the operational challenges presented by the pandemic, TAP did the following:

- **Transitioned to virtual service delivery.** TAP workers began to conduct initial comprehensive assessments on the phone. TAP staff said that the new procedure has reduced participants' transportation barriers, but it prevents staff from observing nonverbal cues. After the initial assessment, TAP workers conducted case management using each participant's preferred virtual meeting method (for example, FaceTime or phone). If a virtual connection was not possible (for example, if a participant lacked cell phone reception at home), TAP workers met with participants at a distance in a park or on a porch. The majority of service providers that work with TAP participants, including substance use treatment and mental health service providers, also provided services virtually. TAP staff stopped providing transportation to in-person services in personal vehicles during the public health crisis.
- **Transitioned to virtual collaboration with TANF and child welfare partners.** Due to reduced office staffing capacity and remote work, previously co-located TANF, child welfare, and TAP staff were not able to collaborate in person in DCBS offices. TAP staff offered a variety of options for virtual communication with TANF and child welfare partners, but the transition eliminated TAP staff's ability to receive warm handoffs and hold informal check-ins with other case managers.
- **Connected virtually with community partners.** Local TAP programs facilitated quarterly videoconference community advisory meetings. TAP staff reported an increase in attendance and suggested this was due to increased community partner collaboration in response to the pandemic, especially in rural communities, and the elimination of transportation barriers.
- **Adapted staff hiring, training, and other work policies.** TAP used the Zoom videoconference platform to conduct job opening interviews, hold hiring committee meetings with community partners, and train staff, including job shadowing for new staff. UK's flexible work policies allowed TAP staff to shift work hours to accommodate child care and other family obligations. TAP workers were also permitted to communicate with participants outside of traditional work hours, if that also worked for the participant.

Sources: [a] USAFacts (2020); [b] Johns Hopkins Coronavirus Resource Center (2020); [c] U.S. Bureau of Labor Statistics (2020).

Promising approach, challenges, and future plans

Overall, the TAP program demonstrates a promising approach to reducing barriers for child welfare and TANF program participants. Several key elements of the program can not only create opportunities for participants to work toward their goals but also for systemic change to happen within the community and the human services system in Kentucky. Further, UK is looking to enhance TAP services and expand into additional counties.

Promising approach

TAP staff discussed four key program elements of their approach:

1. **Comprehensive assessment.** The assessment that TAP specialists administer at program enrollment identifies barriers that negatively affect self-sufficiency and family stability, including the four target barriers of mental health issues, substance abuse, intimate partner violence, and learning disabilities or deficits. It also identifies participants' unmet basic needs, legal problems, and physical health problems. TAP staff noted that participants will often discuss issues with them that they are afraid to tell their DCBS worker and treatment providers.
2. **Co-location and collaboration with referral sources and partners.** TAP specialists develop strong relationships with DCBS and local community partners. Housing TAP specialists in DCBS offices enables TAP workers to communicate effectively with DCBS workers about their shared clients and helped participants access services across the programs. TAP staff facilitate quarterly meetings with TANF and child welfare staff as well as service provider staff. They also participate in other collaborative community partner meetings to share updates and learn about new services. They may consult on cases with DCBS, and sometimes participate in DCBS team meetings.
3. **Participant advocacy.** TAP specialists act as advocates for their participants. Although they have no authority to make determinations regarding any DCBS case, their close relationship with DCBS can ensure that the agency has a good understanding of the participant's situation and service needs. The TAP specialists have more time to spend with participants and can be considered less threatening than TANF workers, who control participants' monetary benefits, and child welfare workers, who might be responsible for removing their children. One TAP staff member noted that, although TAP is part of the system, participants understand that TAP staff are working on their behalf.
4. **Staff hiring and training.** Because the model provides TAP specialists with latitude to determine how to work with their clients, UK has an intensive selection process to ensure that TAP specialists are experienced and, in the words of a UK administrator, have a "passion for helping low-income people." Because it is important that specialists develop good working relationships with local partner agencies, TAP convenes a local committee of staff from DCBS and other partner agencies to assist with the selection of new staff. Staff training is intensive and includes a six-week orientation followed by shadowing other specialists before taking on any cases.

Challenges

TAP specialists and UK leaders discussed two challenges they faced in implementing the program:

1. **Lack of public transportation.** Because the program relies on the resources in each community, staff noted that the lack of transportation negatively impacted many of their participants. The lack of public transportation options, particularly in areas outside of the cities, can be a key barrier to participants accessing services and complying with DCBS requirements. As a result, TAP specialists often meet participants in their home to deliver TAP services and transport them to appointments for

treatment, job interviews, and DCBS meetings. Although this can take a significant amount of the TAP specialists' time, this appears to help staff develop closer relationships with participants, who are grateful for the time the workers spend with them. Staff can also use the time in their car to have meaningful conversations about any issues the participants are facing.

2. **DCBS staff turnover.** High staff turnover among DCBS staff was another challenge that several TAP staff mentioned in interviews. Staff turnover creates confusion for participants and requires them to "start over" with a new staff person, who may not recognize the progress that has been made. It can also affect communication between TAP and DCBS caseworkers. Child welfare clients first work with intake workers, then are assigned to ongoing caseworkers, which causes additional confusion. TAP staff provide some stability to participants during these transitions.

Future plans

DCBS has valued its partnership with TAP, which has resulted in several rounds of expansions into new counties since it began as a pilot project in 8 counties in 2000. In 2019, TAP, in partnership with DCBS, received a grant from SAMHSA to operate the TAP Opioid Use Disorder (OUD) Project in 11 new counties and expand TAP in 5 existing counties. The focus population will be low-income parents who have or who are at risk for opioid use disorder and co-occurring disorders. The program will use the same TAP model to increase participant engagement, reduce barriers to treatment, increase access to medication-assisted treatment and other community treatment services, and increase treatment retention. In addition to serving participants, the TAP OUD staff will serve as a resource to community partners to provide consultation and training and help identify new service strategies.

Other efforts are underway for TAP to become involved with cases earlier. One county is piloting a program through which TAP is co-located at family court hearings and parents can be referred to TAP services by the court. In several counties, UK is working with the local child welfare office to make referrals to TAP at families' initial intake rather than wait until cases are transferred from the investigation team to the ongoing team.

FOR MORE INFORMATION

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Methodology

The State TANF Case Studies project seeks to expand the knowledge base of programs that help low-income individuals, including TANF recipients, prepare for and engage in work. The study is showcasing nine programs selected because of their different approaches to working with these individuals. Mathematica and its partner, MEF Associates, designed and conducted the study.

To select programs for case studies, the study team, in collaboration with the Administration for Children and Families (ACF), first identified approaches that showed promise in providing low-income individuals with employment-related services and linking them to wraparound supports, such as child care and transportation. These approaches might increase self-sufficiency directly by helping participants find employment or indirectly by providing supports and alleviating barriers to employment. The study team identified four approaches, or domains:

1. Wraparound supports
2. Full-family transitional housing and supports
3. Employment-based interventions
4. Collective impact and collaborative community initiatives

Within each domain, the study team then identified potential programs by searching key websites, holding discussions with stakeholders, and reviewing findings and lessons from ACF and other studies. The next step was to narrow the list of programs based on initial discussions with program leaders to learn more about their programs and gauge their interest in participating. The final set of case study programs was selected for diversity, in terms of geography and focus population. Case studies of these programs illustrate the diverse practices operating around the country to assist TANF recipients and low-income individuals in finding and maintaining employment. Their selection does not connote ACF's endorsement of the practices or strategies described.

For each program selected, two or three members of the project team conducted a site visit to document its implementation. For eight programs, team members conducted two- to three-day visits to an average of two locations per program. The visit to the ninth program was conducted virtually via video conferencing due to COVID-19 pandemic travel restrictions. Each site visit consisted of semistructured interviews with administrators of the program, leaders of their partner agencies, and the staff providing direct services. The site visit teams interviewed, on average, 15 staff per program. During in-person visits, the teams also conducted in-depth interviews with an average of three participants per program and reviewed anonymized cases of an average of two participants per program. In addition, teams observed program activities, as appropriate.

For this case study, three members of the research team conducted a three-day site visit in December 2019 to two program locations in Hazard and Louisville, Kentucky. The team conducted semi-structured interviews with 10 staff, including TAP specialists in both Hazard and Louisville as well as TAP leaders at the University of Kentucky in Lexington. Eight staff from partner organizations were interviewed across the two program locations. The team conducted in-depth interviews with two participants from Hazard and two participants from Louisville. The team also reviewed anonymized case files for two participants in Hazard and two in Louisville with TAP specialists. The team conducted a follow-up telephone call in August 2020 with a program leader to learn how TAP responded to the COVID-19 public health emergency.

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This report was prepared under HHSP233201500035I-HHSP23337037T. views expressed in this publication do not necessarily reflect the views or policies of the Office of Planning, Research, and Evaluation, the Administration for Children and Families, or the U.S. Department of Health and Human Services.