

**PROVIDING MENTAL HEALTH SERVICES TO TANF RECIPIENTS:  
PROGRAM DESIGN CHOICES AND IMPLEMENTATION  
CHALLENGES IN FOUR STATES**

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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 paper, 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 paper 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.

## **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.)

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.

## **REVIEW OF THE LITERATURE**

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.

### **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).

### **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 1). 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).

There is wide variation in the reported rates of mental health conditions among welfare recipients. 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). 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 1). 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).

### **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.<sup>1</sup> 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.

## **METHODOLOGY**

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,

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

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 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.<sup>2</sup>

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.

### **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 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.

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<sup>2</sup> Ten of the programs were operating statewide. Programs varied in the extensiveness of the services they provide.

- **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.<sup>3</sup>

Based on these criteria, we selected eight study sites—a rural and an urban site in each of four states (see Table 2).

## 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.

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.

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<sup>3</sup> 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.

## RESULTS

In this section of the paper we summarize the results of this study. First, we discuss the key choices the study state have made in designing and providing mental health services to welfare recipients. Then, we identify key implementation issues involved in providing mental health 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. The choices each of the study sites have made in these areas is summarized in Table 3.

**1. 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 (see Table 4). 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. Each of the services are described in greater detail below:

- **Screening and assessment.** All of the programs use some variation of screening and assessment to identify clients and link them to 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.<sup>4</sup> 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. 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.

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<sup>4</sup> How broadly clients are screened varies by local office.

- **Linking clients to existing mental health treatment.** 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.
- **Short-term, solution-focused mental health counseling.** 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. 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.

- **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. 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 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.
- **Training/consultation 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: (1) in-service training, (2) case staffings, (3) recommendations for employment plans, and (4) individual consultation with employment case managers.
- **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.).
- **Assistance in applying for SSI.** 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.

**2. Eligibility for mental health 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.

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.

**3. 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.

**4. 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. For example, 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. 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. Using multiple approaches in combination appears to be the most effective strategy and the one used by most local offices.

**5. 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.

**6. 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.

**7. 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

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 section, we examine some of these key implementation challenges and present the innovative strategies used by the study sites to meet these challenges. 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.

### **1. Encouraging 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.

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. For example, 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.

**2. Encouraging client participation.** Even the most well-designed mental health services are successful only insofar as clients participate in them—initially 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.

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 stigma associated with mental health treatment 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. In addition, according to mental health staff, protecting the confidentiality of clients creates a trusting relationship, which encourages client to participate in mental health services.

An ongoing challenge for program managers and mental health staff is to provide mental health services that are sensitive to cultural and language differences. Some study sites focus on addressing the cultural and language differences between clients and case managers to encourage participation in mental health services. 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.

**3. 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. Another strategy for integrating mental health and employment services is to educate mental health treatment providers about work and participation requirements. 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. 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. Similarly, mental health counselors in Utah work closely with contracted mental health treatment providers to ensure that treatment is short-term and employment-focused.

**4. Creating a professional support network.** 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.

**5. Maintaining client confidentiality.** Another key implementation issue is 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.

**6. Monitoring and tracking client participation.** 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. 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.

## SUMMARY OF KEY FINDINGS

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. 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.

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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TABLE 1

PREVALENCE OF SPECIFIC MENTAL DISORDERS AMONG WELFARE  
RECIPIENTS

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

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

TABLE 2

## SUMMARY OF KEY PROGRAM DIMENSIONS

<b>Program Dimensions</b>	<b>Florida</b>	<b>Oregon</b>	<b>Tennessee</b>	<b>Utah</b>
<b>Types of mental health services provided</b>	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
<b>Target population</b>	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
<b>Range of service needs addressed</b>	Mental health Substance abuse	Mental health Substance abuse	Mental health Substance abuse Domestic violence Learning disabilities Child behavioral problems	Mental health
<b>Strategies for identifying clients with mental health conditions</b>	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)
<b>Integration of mental health services into employment plans</b>	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)
<b>Agencies administering and providing mental health services</b>	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)
<b>Funding Approach</b>	\$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

TABLE 3

STUDY STATES AND SELECTED URBAN AND RURAL SITES

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

TABLE 4

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.