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ABSTRACT

This document examines screening and assessment for physical and mental health conditions that impact Temporary Assistance for Needy Families (TANF) recipients' ability to work. The document begins by defining screening and assessment and discussing their relevance for agencies serving TANF recipients. The next section answers policy questions pertaining to the following assessment-related issues: (1) objectives of screening and assessing for disabilities; (2) the best uses of exemptions or deferments; (3) TANF agencies' responsibilities to screen for disabilities; (4) kinds of disabilities that should be considered in screening and assessment; (5) appropriate times for screening; (6) appropriate screening tools for TANF settings and for use by frontline TANF staff; (7) ways TANF agencies can use outside experts to screen/assess TANF clients; (8) systematic administrative processes that can support individual screening techniques; (9) work assignments and workplace accommodations that can be considered for TANF recipients with physical or mental health issues; and (10) considerations in sharing information with employers. Pertinent research findings are presented along with profiles of innovative programs in Maine, Vermont, Maryland, Florida, Missouri, Oregon, and Tennessee. Concluding the document are the addresses (including World Wide Web sites, when available) of 9 resource contacts and sources for 24 publications. (MN)

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By Fredrica D. Kramer

Background

TANF agencies are eager for better ways to understand the extent of disabilities in their recipient caseloads in order to provide needed services or develop work accommodations. Since long term support under other programs, even for those who can qualify, may ensure only very limited income, the aim is to get as many who can work into jobs as early as possible and not squander time-limited TANF benefits. But many disabilities do not reveal themselves during routine intake procedures, and many may not be revealed to TANF staff or within the TANF agency at all, but will need the intervention of specialists or other service providers to discover their true nature. And many may reveal themselves only over time or in the context of work experiences to which recipients have previously not been exposed.

This Issue Note is concerned with mechanisms to identify physical or mental health conditions of recipients or those for whom they care, and the setting and support necessary to use them responsibly. There has been much attention to screening recipients for substance abuse (see Nakashian, *forthcoming* 2001), but less guidance on other mental or physical impediments, which are the focus here, or on multiple impairments. Many screens for mental health issues are likely to require an expert to administer; answers to even the simplest questions generally require an expert to interpret or prescribe further assessment. Screens for many physical impairments may strain the tact of front-line workers and certainly require verification by medical personnel.

The terms screening and assessment are often loosely applied, somewhat overlapping, and mean different things to different treatment communities. In welfare agencies screening may refer to oral or written questions to help recipients self-disclose. To others the terms may refer only to questions that have been tested and found reliable within specific populations, frequently populations known to be at risk. Because of the paucity of distinct tools developed specifically for TANF and the probable need for expert assistance, screening and assessment are thought of here as processes on a continuum and the distinction between the two is often somewhat blurred. Screening aims to identify the *potential* presence of a limitation as distinguished from no limitation, or individuals who are at risk of a condition, and generally necessitates further assessment or definitive diagnosis by an expert on that condition. If there is suspicion of a disability, programs are obligated to determine if there is one. Assessment is the process of establishing the extent and severity of a limitation and, potentially, what alternative services or accommodations in jobs or work assignments might permit the recipient to engage in work, either immediately or after some other intervention. Importantly, assessment should refine the initial judgment with regard to an individual's desires, objectives and capabilities; the same clinical condition may be limiting to one individual but overcome by another who devises remedial strategies on her own or with additional help.

Screening and assessment by staff within the TANF agency can provide a basis for consultation with specialists, referral for further assessment or services, or diversion to other programs. It can also provide the basis for team case management or for accommodations by workforce development programs or employers.

Policy Issues

What are the objectives of screening and assessing for disabilities? One purpose of screening and assessment in TANF is to identify individuals who might be eligible for long-term support under the Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI) programs. Better screening techniques might identify new entrants who are eligible for SSI/SSDI and others who could be better served apart from stringent work requirements.

Another purpose is to identify TANF recipients who should be exempted from work requirements, and potentially protect them from inappropriate sanctions due to an unrecognized disability, or those 20 percent who may be exempted from federal time limits to benefits. Similarly, screening may identify victims of domestic violence in order to waive program requirements but access needed help. Screening can also be used to place recipients in deferred status, stopping the time limit clock and allowing for further assessments.

A third purpose is to enable the provision of treatment or services to help individuals with disabilities engage more effectively in work or training, and to guide ongoing case management to maintain needed services—increasingly important in the face of time limits. Some limitations may be self-evident (e.g., use of assistive devices, missing limbs, obvious vision or hearing impairments, obvious behavioral problems); others are not known to TANF staff, not tested for, not self-reported—or even known to the recipient. Some may be only somewhat work limiting with appropriate help; some may need intensive or long-term support.

Toward the same end, screening can be used to identify disabilities of other family members (such as chronic health or behavioral problems of children) that affect the ability of adult recipients to get or keep jobs. Assessment can develop interventions to permit the head of the household to go to work. As TANF agencies take on more family-centered case management, they might also consider using TANF funds to address the work prospects and limitations of adults in families with child-only cases. These individuals have not historically been the concern of welfare agencies although their employment will continue to affect the well-being of TANF children over the long-term, whether the children continue to receive TANF assistance or, if disabled, are transferred to SSI.

Assessment can identify potentially helpful job accommodations, and can also protect clients from inappropriate assignments that would place them at risk of physical or psychological harm. In this context assessment aims to identify specific functional limitations in relation to tasks required in a specific job setting that a person would have difficulty or be unable to perform. Systematic questions (see Job Accommodation Network (JAN)) can help TANF and workforce development staff identify appropriate jobs, define ongoing supports from case managers or service providers to sustain employment, negotiate work site accommodations, and assure employers that such accommodations are within their reach and will help retain committed workers. Beyond the agencies' legal obligations to help, they can stimulate a recipient's own thinking about how to accommodate her disability.

What are the best uses of exemptions or deferments? While exemptions from work requirements may spare clients inappropriate work assignments, they may also deny help that could prepare them for work at the end of TANF benefits. Clinicians and physicians who participate in exemption determinations can be informed, for example in information accompanying medical verification forms, about the consequences of recommending full exemptions, and be encouraged to work with clients to identify activities that might offer assistance prior to the loss of benefits. Since individual

capabilities and desires may vary greatly, determinations should take care to reflect long-term aspirations and the means to achieve them. Sometimes limited exemptions can facilitate needed treatment or services. All states have currently met required work participation rates and hence have great latitude in defining activities to render a client more work-ready. Thus, screening, assessment, treatment, and counseling can be allowable work activities (though not countable toward the federal work participation rate). Such options might also encourage participation and compliance.

Similarly, SSI is an essential support for the severely disabled and states should be proactive in assisting those who may qualify to apply for SSI benefits. Effective sorting for SSI may also make TANF hardship exemptions available to the harder to place who do not qualify for SSI. But SSI uses a restrictive definition of disability (the inability to engage in any substantial gainful activity by reason of a medically determinable physical or mental impairment expected to result in death or that to last for more than 12 months) and, although there are now work incentives, it has not historically had great capacity to offer other employment assistance. Rather than focus only on transfer to SSI, states may also want to consider using TANF and workforce development resources to continue to help those SSI-eligible who so wish to get assistance to engage in work or training in order to improve their income prospects in the long run. States may use maintenance-of-effort (MOE) funds to stop the clock while applying for SSI and while helping clients connect with such services.

What responsibility does the TANF agency have to screen for disabilities? The responsibility to serve individuals with disabilities under TANF, the Workforce Investment Act, and the Americans with Disabilities Act of 1990 (ADA) is two-fold: to identify disabilities in order to help clients obtain needed services or accommodations without which the work requirement cannot be imposed; and to prevent discrimination in public programs and in the workplace. (See Kramer, 1999 for a fuller discussion and further references on ADA and TANF).

Under ADA, public entities cannot discriminate against individuals with disabilities in the ways in which they screen, determine eligibility, or deliver services, and they must make "reasonable modifications" to avoid discrimination, unless such modification would fundamentally alter the nature of the program or service. ADA requires public entities to self evaluate whether policies and procedures are consistent with the Act, including physical accessibility, application procedures, screening and assessment, job search and work assignments as they would be experienced by persons with disabilities. For example, job search before application and before assessing for disabilities if suspected, or inadequate assistance with application or other program procedures for those with known disabilities, would be inconsistent with the ADA (see further OCR, January 19, 2001). Executive Order 13078 (March 13, 1998) calls on programs that work with welfare clients to incorporate "reasonable accommodations" into education, job training, and employment settings. Employers may not ask about the existence, nature or severity of a disability until after a conditional job offer, thus hidden disabilities are not considered prior to assessment of non-medical qualifications.

What kinds of disabilities should be considered in screening and assessment? There is no definitive list of physical or mental impairments that could pose work limitations. Conditions may affect different individuals differently. Some impairments carry social stigma that will affect the ability to function in the workplace, the comfort levels of staff, and hence the means by which programs can discover them. Conditions that might affect work include chemical addictions, cardiovascular and pulmonary conditions (e.g., heart conditions, high blood pressure, asthma and allergies), cognitive and developmental limitations, chronic fatigue disorder, genetic disorders (e.g., cerebral palsy or epilepsy), diabetes and other endocrine disorders, muscular or skeletal disorders (arthritis, back pain, fibromyalgia and cumulative trauma disorders), and hearing and vision impairments. Problems with speech recognition or the use of assistive devices may also require work accommodations. Psychiatric disorders include depression, obsessive-compulsive, panic, and post

traumatic stress disorders, and schizophrenia and bipolar disorder (which will generally enable SSI eligibility).

Hidden disabilities may also contribute to the failure to gain steady employment. Thus, learning disabilities (LD) may cause low educational achievement, and undiagnosed depression rooted in childhood sexual abuse or domestic crises or intermingled with substance abuse may contribute to poor work histories. Many of the impairments mentioned above may also be hidden (e.g., some psychiatric disorders, cognitive or hearing impairments, chronic fatigue disorder), unrecognized by the clients themselves but an important influence on job success.

When should screening take place? TANF programs might consider a three-tiered approach in order to open up a dialogue and allow disabilities to reveal themselves over time. First, as part of eligibility determinations and recertifications, intake workers or case managers can pose generic questions (e.g., "Do you or any of your children have any physical or other condition that you feel would limit your ability to participate in work or training?" or "Would you like to talk to a specialist in confidence about any issues that are troubling you or affecting your ability to work). Staff should be trained to be alert to red flags, or use formal screening tools, themselves or with the help of experts, to provide the basis for further assessment. Second, in the context of a broader employability assessment a client should be questioned about recent work experiences (e.g., "Did you have any physical or other limitations that you think contributed to your not being able to do that job satisfactorily?") to suggest in concrete terms what the client found difficult and to point to clues about hidden disabilities. Third, after a termination of work or training, if there are unexplained failures on jobs, frequent quitting, or the case worker suspects a hidden physical or psychological issue may have interfered with performance (e.g., inappropriate response to a supervisor, unexplained fatigue, inability to read or follow directions, excessive need for breaks, obesity) the caseworker can refer the client to a specialist for a clinical evaluation. In settings such as vocational rehabilitation, where the client may have self-identified in order to get help, a trained clinician may be better able to probe the nature and extent of work limitations and uncover hidden disabilities. Throughout, staff should be trained to consider the potential for disabilities and for accommodation to avoid sanctioning for noncompliance.

Questions developed by JAN may be adapatable to conversations geared to screening for disabilities, developing work assignments or understanding failures, such as:

- what symptoms or limitations is the individual experiencing; what tasks are/were being performed?
- how do these symptoms or limitations affect overall job performance or specific tasks?
- what accommodations might reduce the problem—such as assistive devices, restructuring job duties, attention to psychological and physical aspects of the work challenge; has the employee been consulted about possible accommodations?

Are there formal screening tools that can be used effectively within the TANF program? The appropriate use of many screening protocols is narrowly bounded. First, instruments may have imperfect or unknown reliability, increasing the risk of improper diagnosis. Many are validated only for specific populations and few have been developed specifically for the TANF population (e.g., the four-question CAGE test used by many TANF agencies to screen for alcohol abuse was developed for individuals who have exhibited a potential drinking problem and may be untested outside of a clinical setting). Second, some require highly trained or legally certified professionals to administer, and most require trained professionals to interpret the results. Third, extensive probing on sensitive issues, including some physical limitations, may be very intrusive, making the basis for presumption critical so as not to burden the majority of applicants with intrusion, and in turn burdening minimally trained front-line workers to make these presumptions. Finally, many employability problems are the

result of marginal dysfunctions or the combination of challenges that afflict many individuals with very low income and these issues may not lend themselves to closed-ended identification or clinical diagnoses.

Rather than the one-time use of a simple tool, identification and assessment will often require ongoing, iterative, and informal procedures. Assessments by experts to understand limitations and identify remedial strategies can take a long time (a VR counselor, for example, may be able to assess only a few clients in a day). While it would be a violation of the ADA to impose a work assignment if a suspected impairment might destine failure, the presence of a disability in some clients may be indicated only by many failed work experiences. TANF agencies need to craft ways to be alert to such patterns, on their own or with the help of experts.

Whatever the tool, the environment within the agency and between staff and client needs to be conducive to revealing personal difficulties. Clients need to feel that help rather than punishment (e.g., loss of children to child protective services, humiliation, spousal abuse) will result. Physical space to reveal information in calm and privacy is critically important, and often at a premium in TANF offices. Agencies might look toward (perhaps extensive) training to educate and sensitize staff to physical and mental health issues, including their potential interaction with domestic violence and substance abuse, in order to create an environment that encourages self identification, and to open channels between TANF staff and experts to make referrals for further screening or assessment seamless and unintrusive. Just as important, in order for staff to be motivated to uncover disabilities they need to know that there will be adequate resources to respond to disclosures.

Are there any screening tools that can be used effectively by front-line TANF staff? Many agencies are reconfiguring their front-line staff from eligibility workers to case managers, responsible for diagnostic and referral services throughout the course of TANF assistance. It is therefore increasingly important to understand the appropriate application of screening tools, requisite staff training—and caseload size and compensation to support these new responsibilities, and when to seek expert assistance.

The first tool can be a strategic prompt or the imposition of the work requirement that results in self-identification. Staff may need expert advice on how directly to pose even seemingly simple questions and how to avoid collecting extraneous information. Staff also need to learn to flag responses to routine intake questions (such as, "...my husband or boyfriend doesn't want me to work") and to use common sense clues such as bruises, needle tracks, alcohol breath, unusual fearfulness, inappropriate fatigue or reversed letters in written submissions, as a basis for seeking further assessment. Equally important, staff need training in how and when to seek help to protect the client from mistaken identification—and the intrusion and inappropriate exposure it creates. Staff need to be sensitive to cultural diversity so as not to misinterpret some behaviors as signs of depression or other mental health issues. Many agencies have allied with vocational rehabilitation, mental health and other specialists to team up for more careful evaluations. TANF agencies are likely to have to pay for expert help from other programs in order that the help conforms to TANF program and time constraints.

There are some formal verbal or paper and pencil instruments that TANF staff are beginning to use, many that are low cost and seemingly quick to administer, some that clients can self-administer. Some tools use yes/no or scaled questions, others more open-ended questions that require an interview setting. If self-administered, especially if completed off-site, follow-up is essential to determine if failure to complete the form or return to the program was triggered by the very impairment for which the tool was intended to screen. Language barriers can also create impediments to effective screeniuns, and both multi-lingual translations of written instruments or the choice of an interpreter require sensitivity to cultural nuance and to privacy.

The most frequently used tools screen for substance abuse, which is not the focus here (see Urban Institute, 2000, Appendix A and Nakashian, 2001 for descriptions of instruments, and APHSA, 1999 for 50-state survey of current TANF practices). But the co-occurrence of substance abuse and psychiatric disorders may argue for expert help in the use of even simple substance abuse screening tools). Several states (e.g., LA, MT, OR) have developed questions to screen for domestic violence, though experts warn of the safety risk of disclosure and the importance of expert help and protection. Refined tools for mental health screening probably require professionals to administer (see Derr et al., 2000 for description of instruments), though questions about current or recent treatment for mental health issues—with adequate confidentiality protections—may not. Some states are using more experienced case workers, on-site social workers, or behavioral checklists to do up-front screening. North Carolina uses a checklist on substance abuse and mental health issues that intake workers complete and score (the instrument is proprietary) for follow-up by a trained counselor. Others (WA, KS, AL) have developed LD screening tools designed specifically for TANF clients.

How can TANF agencies make effective use of outside experts to screen or assess TANF clients? The predominant strategy among states appears to be crafting organizational linkages with providers with expertise in one or another disability (see Urban Institute, 2000). Experts can both help clients get needed services and protect clients, and in turn agencies, from the risk of misdiagnosis, labeling, and inappropriate assignment. But effective linkages depend heavily on good contractual relationships and the availability of providers in a local area, which is uneven across localities and disabilities. Given this unevenness and the fact that multiple issues often exist simultaneously, it may be productive to use local experts in one disability to gain access to experts in other areas and other disabilities. In selecting among providers it is important to consider their capacity to deliver screening or assessment services within TANF timeframes. Also, in the absence of shared missions, objectives, and cultures, TANF agencies need to become effective advocates for their clients as they work with vocational rehabilitation and mental health agencies, community colleges and other service providers, and in turn that they use those experts to encourage employers to accommodate potentially challenging clients.

Are there systemic administrative processes that can support individual screening techniques? As an overall strategy, TANF agencies might consider having caseworkers, physicians, or medical review teams reexamine all those currently exempted due to disabilities or other medical exemptions. Second, they might review the circumstances of recipients who have left the TANF rolls and returned. Third, where caseload decline has been precipitous, they might review all those remaining to try to identify issues that could explain clients' inability to leave and point to appropriate remedies. In each case, looking for issues that may be interrelated (such as diabetes, obesity, hypertension, and back pain) may help in understanding how employability is compromised and what accommodations could enable work. Fourth, states might explore modifications to their administrative data systems to help track families with disabilities, particularly those with exemptions, and others who leave the rolls.

Programs should also consider the many windows of opportunity to make information about conditions and services available and in which clients can come forward for help, either to the TANF agency or to other providers. Application, eligibility determination, orientation, work assessments, case managers' tracking efforts and waiting rooms can all be opportunities to dispense information, observe a client's progress and consider the need for intervention. The three-tiered approach described earlier assumes screening and assessment occur throughout a client's tenure in TANF, as she progresses or fails to progress in jobs, training or treatment. Staff training should address how to be alert at each point to the need for help and how to dispense information or make referrals. Some problems, such as depression, perhaps rooted in domestic violence, may not be revealed in response

to direct inquiries, but only as a result of dissemination of neutral information, or as a bi-product of receiving services for another problem.

The TANF agency will need to put in place detailed protocols to protect privacy and confidentiality of assessments, and to govern interagency or service provider collaborations. It may be necessary to consult experts and advocates in the disability community on laws governing confidentiality to develop safeguards to govern staff procedures and interagency agreements. (See Nakashian, 2000 and Thompson and Mikelson, 2000 for additional references).

What kinds of work assignments and workplace accommodations can be considered for recipients with physical or mental health issues? For those with physical impairments, accommodations (see JAN website) might include wheelchair or other worksite accessibility (e.g., to parking, entrance, restrooms, supplies, desk/computer/workstation), ergonomic workstations to aid fine motor functions, or the use of personal assistance or employee support services. For individuals with psychological or physiological conditions that create fatigue or weakness, flexible work and leave schedules, periodic breaks, stress-reducing ergonomic workstations or working from home may be appropriate. For allergies and respiratory difficulties, photosensitivity, headaches, or exposure to chemicals and allergens, ventilation, a variety of lighting solutions (some low cost) and attention to noise can be considered. For persons with cognitive impairments suggested remedies include using written instructions, schedulers or organizers to aid memory, self-paced workloads, flexible work hours and rest periods, prioritized work assignments, minimal distractions and maximal structure. Sensitivity training for coworkers, stress reduction strategies and allowing access to medical professionals, counselors or employee assistance programs may all help persons with stress-related difficulties.

Many accommodations, along with job sharing and job coaching, apply to a multitude of impairments, and all should be considered in working with individuals with disabilities. TANF case managers can work with workforce development staff and employers to craft accommodations, and staff can consult advocacy organizations and JAN for information on specific disabilities to help particular clients. As individuals with disabilities become an increasing portion of the workforce, employers might consider these as part of their overall approach to human resources management.

How much information should be shared with employers? Often the ideal is to arm the client with sufficient information to negotiate her own workplace accommodations without the employer ever needing to know of a disability. Some disabilities, however, need to be divulged to employers in order for supervisors to make needed accommodations and for ADA protections to apply. Given the potential for harm both in disclosure and in failure to receive adequate accommodations, TANF staff should probably seek the assistance of experts from VR or other agencies in determining the appropriate approach for each client. Sometimes the client knows best, and in all cases the client needs to be a partner in deciding about appropriate disclosure.

Research Findings

High rates of chronic medical conditions are found among the poor, although their effects on working are less certain. There is also some evidence families sanctioned in TANF have higher incidence of mental health and related difficulties (see Callahan, 1999).

The National Survey of American Families finds 35 percent of low income families have poor mental health in at least one of four areas (anxiety, depression, loss of emotional control and psychological well-being (Zedlewski, 1999 in Derr et. Al, 2000). Estimates for welfare recipients vary in part depending on definitions and survey techniques. National survey estimates range from 6 to 23 percent using narrowly defined measures of affective disorders and up to 39 percent using indicators

symptomatic of depression (Johnson and Meckstroth, 1998). The same review finds 42 to 54 percent of domestic violence victims receiving welfare suffer from depression. Jayakody et al., 1999 find about 19 percent of welfare recipients, compared to 15 percent of nonrecipients, in the 1994-5 National Household Surveys of Drug Abuse qualify for a diagnosis of psychiatric disorder; a psychiatric disorder and crack/cocaine use raised the odds of welfare use significantly. A survey of TANF recipients in one large urban area in Michigan (Danziger, et. al, 2001) found 27 percent met the criteria for major depression, 15 percent for post-traumatic stress disorder (PTSD), and 7 percent for generalized anxiety disorder. Estimates of clinical depression in long-term recipients show even higher levels (see Derr, et al., 2000). Another review (Kalil, et. al, 1998) reports 42 percent of AFDC recipients (compared to 20 percent of nonrecipients) in the 1992 National Longitudinal Survey of Youth (NLSY) were at risk for clinical depression. Traumas form rape, domestic violence and sexual molestation may put many at risk of PTSD, which is three times higher among low income women that the general population.

Health and mental health conditions often combine with other barriers creating serious obstacles to work. The 1997 National Survey of American Families found about a third of current TANF recipients had health limits to work or very poor mental health (Loprest and Zedlewski, 1999). The Washington State Learning Disabilities Initiative found in addition to the 35 percent learning disabled, 14 percent of JOBS participants were slow learners (IQ of 70-80) and 5 percent showed mild mental retardation (IQ below 70). In one NLLSY analysis (Pavetti, 1997) 63 percent of those with severe barriers worked less than 25 percent of the time or not at all.

Children in low income families are likely to have more health problems, which may result in more chronic or handicapping conditions in adulthood, and families with major health issues are likely to have a harder time maintaing employment. Loprest and Acs (1996) found between 11.1 and 15.9 percent of AFDC children had some activity limitation, almost 4 percent had one or more chronic conditions, and over 14 percent of school-age children had some special need (special classes, or limitations or inability to attend school). Earlier data from 1194 Disability Supplement to the National Health Interview Survey found 40 percent of AFDC families had an adult and child with a long-term functional limitation, with a child or an adult and child in over half (in Callahan, 1999).

Many with disabilities want to work (National Organization on Disability poll in Kramer, 1999). Recent changes in SSI facilitate some work or continued Medicaid, and in 14 states 10 to 20 percent of SSI disabled recipients do some work (SSA, 2000). At least 30 states (Holcomb and Thompson, 2000) have changed TANF work participation policies to involve more recipients with disabilities. But screening for disabilities in TANF is still early in implementation and there have been few, if any, evaluations of the use and effects of different instruments or techniques in the context of TANF.

Innovative Practices

TANF agencies have collaborated with others to develop screening questions, train or cross-train staff, help clients apply for SSI, and refer clients for assessment and treatment. In **Vermont** the VR agency developed questions to screen and refer clients with physical or other limitations, **Maine** contracts with three non-profit agencies to screen and provide services across the state, and in **Maryland** a contractor (with an attorney) helps clients apply for SSI, while the TANF clock stops (see Kramer, 1999 for details and contacts). Other examples include:

Anne Arundel County (MD) contracted with Goodwill and a local career center to review all medical exemption cases, aiming to develop an employability plan even for those who might still receive SSI and to surmount the 60-month time limit until another source of income was identified. Home visits allowed the contractor to discover multiple conditions and family or caretaker issues that

had eluded physicians using clients' own assessments. A fifth were found to have ill family members, over a third needed further assessment or treatment, and 20 percent were able to be employed. The contractor, who now assesses all those who say they cannot work, can provide quick turnaround assessment, serve those caring for disabled children, and provide on-the-job coaching and long-term follow-up. Contact Vesta Kimble, 410/269-4500.

The **Florida** Department of Mental Health and Substance Abuse developed a 32-question screening tool (not proprietary and available from the state), which is now administered to all TANF applicants at intake or orientation. Screeners, hired through local service providers, are licensed or certified professionals or bachelor's level workers, and although they may be specifically trained in one area are now, in the third year of the program, generally comfortable with questions addressing other issues. The 15 to 20 minute interview was tested for a year and refined with input from the providers. The instrument can be self-administered though that is less than ideal in part because it has a scoring system that includes verbal and non-verbal cues. About 40 percent of recent cases have been referred for further assessments. Contact Celia Wilson, 850/410-1187.

Jackson County, MO is pilot-testing a three-tiered strategy. Clients answer a series of self-administered yes/no questions (with explanation) about physical or emotional problems of the client or other family member, special work needs, current medication, treatment or problems with drug abuse, and application for Worker's Compensation, SSI or other disability benefits. Answers allow the intake worker to determine health limitations and make referrals to a more experienced case manager to administer an 11-question "Feelings and Behavior Inventory" developed and validated by the State Department of Mental Health to screen for depression. Clients are referred to the managed care, mental health or substance abuse provider for further diagnosis and employability assessment. Case managers received two days of training on interview and observational techniques. Contact Connie Ward, 573/751-9488.

Portland, OR, experienced in screening for mental health issues since the JOBS program, now uses the 45 days between application and receipt of TANF benefits to require attendance at addiction and mental health awareness classes conducted by a mental health professional. Classes introduce the issues and services available, and use a self-administered questionnaire for systematic screening. Scores indicating need for further assessment are sent to case managers. The neutral format and use of the same clinician for counseling and follow-up services increases the potential for self-disclosure. The mental health professionals are co-located with TANF, conduct assessments and help case managers screen and refer clients with signs of anxiety, depression, attention or behavior problems. The long-standing interagency collaboration ease assessment for the client and help coordinate case management and treatment. Informed consent is sought early, but case records note client capabilities rather than clinical diagnoses to protect confidentiality. Contact Christa Sprinkle, 503/256-0432.

In **Tennessee** the state used the University of Tennessee to develop a comprehensive screening tool aimed at short-term treatment. The University now provides regional coordinators and oversees clinical "family service counselors" who are provided under contract to the state by local mental health organizations. The counselors are co-located in TANF offices, housing, and employment and training sites and can offer brief (longer as needed), solution-focussed therapy in-house (an allowable work activity), or refer out for further services. TANF applicants are informed about the program and available services at intake and re-certification. Caseworkers have also gained experience in recognizing red flags that suggest the need for further screening or services. Contact Holly Cook, 615/313-5465.

RESOURCE CONTACTS

Center for the Study and Advancement of Disability Policy. Contact Bobby Silverstein, 202/223-5340.

Disability and Business Technical Assistance Centers, 800-949-4232 or http://www.adata.org

Goodwill International. Contact James Van Erden, 301/530-6500.

Job Accommodation Network (JAN), 800-ADA-WORK or http://janweb.icdi.wvu.edu

Judge David L. Bazelon Center for Mental Health Law. http://www.bazelon.org/pubs.html

National Technical Assistance Center for State Mental Health Planning. Contact Paul Musclow, 703/739-9333 or http://www.nasmhpd.org/ntac

National Technical Assistance Center on Welfare Reform and Disability. Contact Martin Gerry, 785/312-5346.

Presidential Task Force on Employment of Adults with Disabilities. Contact Richard Horne, 202/693-4939.

US DOL/Office of Disability Employment Policy. http://www50.pcepd.gov/pcepd/about/about.htm

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