Supported Employment Demonstration

Interim Process Analysis Report (Deliverable 7.5a)

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Contracting Officer's Representative (COR):
Thomas Hale
Alternate COR: Marion McCoy

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Authors
Jocelyn Marrow, Ph.D.
Tamara Daley, Ph.D.
Jeffrey A. Taylor, Ph.D.
Mustafa Karakus, Ph.D.
Tina Marshall, Ph.D.
Megan Lewis, Ph.D.

Prepared for:
Social Security Administration
Office of Acquisition and Grants
Division of Programs Contracts
1540 Robert M. Ball Building
6401 Security Blvd
Baltimore, MD 21235

Prepared by:
Westat
An Employee-Owned Research Corporation®
1600 Research Boulevard
Rockville, Maryland 20850-3129
(301) 251-1500

Contributors

Listed below are the contributors to the Interim Report:

- William Frey, Ph.D., Westat
- Robert E. Drake, M.D., Ph.D., Westat
- Howard Goldman, M.D., Ph.D., Westat
- Jennifer Huang, Ph.D., Westat
- April Fales, M.S., Westat
- Jarnee Riley, M.S., Westat
- Deborah R. Becker, M.Ed., Westat
- Lisa Dixon, M.D., Ph.D., Columbia University

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List of Acronyms

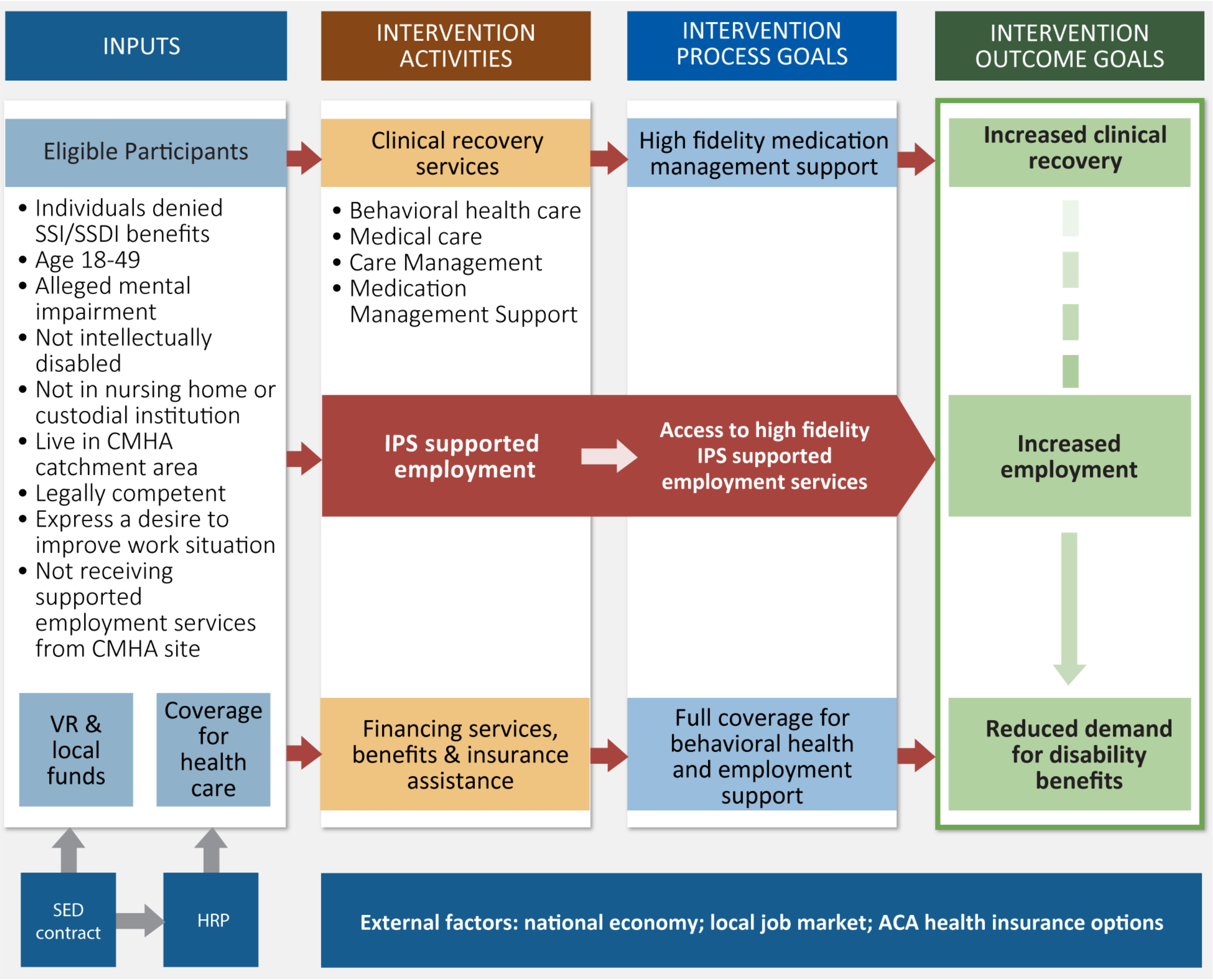
ACA	Affordable Care Act
ADHD	Attention Deficit Hyperactivity Disorder
CIDI	Composite International Diagnostic Interview
CMHC	Community Mental Health Center
FTE	Full-Time Equivalent
HRP	Healthcare Reimbursement Plan
IPS	Individual Placement and Support
IPS SE	Individual Placement and Support model of supported employment
IT	Information Technology
MHTS	Mental Health Treatment Study
MIS	Management Information System
MMS	Medication Management Support
NCC	Nurse Care Coordinator
PST	Problem Solving Therapy
PTSD	Post-Traumatic Stress Disorder
SED	Supported Employment Demonstration
SMI	Severe Mental Illness
SSA	Social Security Administration
SSDI	Social Security Disability Insurance
SSI	Supplemental Security Income
TA/QA	Technical Assistance/Quality Assurance

1. Introduction

The Supported Employment Demonstration (SED) provides an experimental test of two interventions intended to improve various outcomes for individuals who the Social Security Administration (SSA) denied disability benefits on initial determination after evaluation for a mental impairment. Employment is the primary outcome of interest for the SED interventions, with improved clinical recovery and reduced demand for disability benefits additional as secondary outcomes of interest. The interventions include evidence-based supported employment and integrated behavioral health services, as well as additional funds to cover co-pays or deductibles associated with medical treatment, work-related expenses, and short-term financial assistance intended to help resolve financial crises that create barriers to employment. The theory of the SED is that early intervention with evidence-based clinical and rehabilitative activities, before an individual with a mental impairment gets onto the SSA disability rolls, will improve clinical recovery, increase employment, and add supports so that such individuals will not require disability benefits, or will delay the need for them. Exhibit 1-1 depicts this theory in more detail in a logic model for the SED. Substantial evidence suggests that the Individual Placement and Support (IPS) model of supported employment (IPS SE) integrated with behavioral health services improve employment and clinical recovery outcomes (Bond et al., 2012; Brinchmann et al. 2019; Frederick & VanderWeele, 2019; Kinoshita et al., 2013; Marshall et al., 2014; Metcalfe et al., 2018; Modini et al., 2016; Suijkerbuijk et al., 2017). Research has demonstrated these effects with individuals who are already on disability in multiple clinical trials and in the SSA Mental Health Treatment Study (MHTS) (Drake et al., 2016). The SED tests whether the same outcomes are achievable with individuals at an earlier stage in their history of benefits from SSA.

The SED compares outcomes in each of three experimental arms with approximately 1,000 individuals per arm, all of whom received denials from SSA on their disability benefits applications. Implementation of the demonstration occurs in 30 selected sites around the United States. Participants randomly assigned to each of the two intervention arms receive IPS SE, integrated behavioral health services, and financial supports for approved services and expenses. In addition to these services, characterized as the Basic-Service array of services, individuals in the Full-Service arm also receive the services of a Nurse Care Coordinator (NCC), a role that was an element of the intervention in the MHTS. A multi-component service team that includes a team lead, at least one IPS specialist, a care manager, an NCC, and access to a medication prescriber provides the Full-Service intervention. The team providing Basic-Service treatment replicates the Full-Service team with one critical exception—the team lacks an NCC. Hence, the SED presents an opportunity to assess the effectiveness of the enhancement of the NCC in Full-Service, over-and-above the effects of Basic-Service, alone. We will compare both of these intervention arms to the counterfactual condition of the Usual Services (control) arm of the SED in which individuals randomized to this arm receive an information packet listing services available in their communities. Participants in each of the three conditions who lacked health insurance received access to needed healthcare and help finding health insurance. We referred uninsured participants to federally qualified health centers or study-approved public clinics that offer medical services free of charge or on a sliding scale. The study paid for healthcare expenses for these uninsured participants until they could enroll in an insurance plan through their state's Health Exchange (Marketplace) during the Affordable Care Act (ACA) Open Enrollment Period.

Exhibit 1-1. Supported Employment Demonstration logic model



The evaluation of the SED has four main components, the Participation Analysis, the Process Evaluation, the Impact Evaluation, and the Benefit-Cost Analysis, with an emphasis on the process and impact evaluations. The logic model presented in Exhibit 1-1 illustrates the elements of these two critical evaluation components.

This interim report presents early findings from the process evaluation based on data collected over the first two years of demonstration implementation. It focuses on intervention activities and the intervention process goals, as depicted in the logic model, concentrating on the implementation of treatment services and their fidelity to the service models. It also focuses on the experiences of the clinicians, service providers, and administrators involved in the implementation of the SED. Treatment participants provided opinions on their experiences for this report also. The process evaluation answers the basic questions: "Was the SED implemented as intended? What can be learned from the processes associated with implementation?" The process evaluation enhances the evaluators' ability to interpret the findings of the impact evaluation and to be certain that any failure to achieve intended outcomes is not due to failure to implement the SED as intended.

Among other elements of the evaluation, the Process Evaluation assesses the fidelity of the SED services to the intended model for IPS and other related services. It identifies aspects of the SED program operations that required or received new or additional technical assistance. The process evaluation also includes descriptions of the experiences of SED participants from their recruitment and enrollment, to their engagement (or disengagement) with services in the demonstration. Finally it will assess the feasibility of expanding SED-type services in other communities or implementing some of its features through changes in policy.

This interim report begins with a description of data sources, including from the in-person site visits, Monthly Service Use Check Lists, and fidelity assessments. The report next describes contextual factors and participant characteristics that affected service delivery. The next sections provide descriptions of the services delivered from the perspectives of direct services staff of the SED and participants. We strengthen our emerging picture of implementation based on qualitative analysis derived from interviews and ethnographic observations with quantitative analysis of the Monthly Service Use Checklists and reimbursements, demonstrating patterns of engagement, service use, and participants' needs. The report concludes with a discussion of implications of the findings.

2. Data Sources

This Interim Process Evaluation Report relies on three sources of data collected periodically during SED implementation. Demonstration implementation began in December 2017 upon enrollment of our first SED participants. Enrollment of the full complement of 3,000 study participants ended in March 2019. Given the three-year participation period for each study participant, demonstration implementation will end in March 2022. The basis of this report concerns only the initial 24 months of demonstration implementation, from December 2017 through December 2019. The primary source of data derives from on-site interviews (referred to as the Process Evaluation Site Visits) with demonstration site staff and study participants in all three study arms. These interviews occur annually for each demonstration year, beginning in the early summer months completing by early fall.

The process evaluation also includes an assessment of two complementary aspects of implementation that affect internal validity. One is the assurance that treatment providers deliver services as planned, often referred to as fidelity to a treatment model or service. Hence, the process evaluation includes independent assessments of fidelity conducted annually by an experienced team of consultants. The second aspect of internal validity concerns the extent to which treatment group participants engage with the services available to them. We developed a Monthly Service Use Checklist to collect data related to service engagement. Analysis of the checklist provides a sketch of the services provided to and received by participants in the treatment groups. The checklist retrospectively tracks services rendered to individual study participants in both the Full-Service and Basic-Service treatment groups during the previous month. A key element of the checklist includes distinguishing between services delivered face-to-face and services delivered remotely or via telephone. The following sections provide a brief overview of each data source, data collected, and schedule for data collection.

2.1 Site Visit Aims and Methods

The Process Evaluation Site Visits have several key aims. One aim is to assemble input from site staff explaining how they implemented the SED, their perceptions on how SED participants compared to clients generally served by their agency, and how they adjust their services to fit participants' unique characteristics and needs over their three years of study participation. A second aim is to hear from participants in the study. We want to understand more about their life and how they came to apply for disability benefits, why they decided to join the study, their expectations for the study and how they perceived the study as they began to engage with services, and what their experiences are up to the time of the interviews.

We also have an interest in understanding SED staff and participant perceptions of the environmental factors that form the context for the services they provide or that they receive, respectively. Among the topics of interest are perceptions of state and local policies (e.g., healthcare), community supports, and barriers toward assistance and work.

Each visit to the 30 demonstration sites in Years 1 and 2 required two visitors over a contiguous agreed-upon four-day period. Westat recorded all interviews with permission from staff and participants. In nearly all cases, staff and participants gave permission to audio-record the proceedings. Interviewees who received a $40 honorarium included participants, but not members of staff.

Qualitative data collected during the visits came from (1) key informant interviews with SED service providers, (2) focus groups with treatment arm participants, (3) person-centered interviews with SED participants, and (4) observations of service delivery activities (site staff engaging with study participants). In year two, we replaced the focus groups with (5) extended ethnographic observations of SED participants in natural contexts.

Key Informant Interviews. In Years 1 and 2, we interviewed between three and six SED service providers, including IPS specialists, NCCs, team leads, and care managers. Site visitors selected appropriate site staff for interviews with the assistance of the site's team lead. Site visitors recommended that Team Leads select staff who had the largest time committed to SED from among SED service providers. For example, if a site had four SED care managers, whose Full-Time Equivalent (FTE) ranged from 5 to 22 percent, site visitors suggested scheduling the care managers with 22 percent commitment to SED. Visitors interviewed staff individually, or along with other SED staff at the same site. Table 2-1 shows the number of interviewees by category for site visits in Years 1 and 2.

Table 2-1. Number of SED staff interviewed by staff role

Staff role	Year 1	Year 2
Administrator/Site director	31	0
Team lead	35	32
IPS specialist	55	31
Care manager	36	28
Nurse Care Coordinator	31	29
Other	3	5
Total	**194**	**125**

Focus Groups. During Year 1, we held two participant focus groups at each site; one for Basic-Service participants and one for Full-Service participants. The focus groups enabled site visitors to speak with up to ten participants from each treatment group about their employment history and goals for the future, physical and mental health, disability applications, and SED service usage and experiences. Across a total of 60 focus groups, attendance ranged from one to seven participants, with an average of three SED participants per group. See Table 2-2 provides the number of focus group participants by type of group.

The team purposely selected focus group participants from among those Basic- and Full-Service participants who were not participating in a person-centered interview. For more details, on the sampling, see Table 2-2. Site visitors stopped soliciting potential focus group participants once 10 participants agreed to be in each group. In practice, site visitors frequently called every treatment-arm participant at the site and left messages when possible. In more than a few cases, participants who had not agreed to attend the focus group because they had never answered the phone or returned a phone call, showed up for the focus group based on messages left by a site visitor.

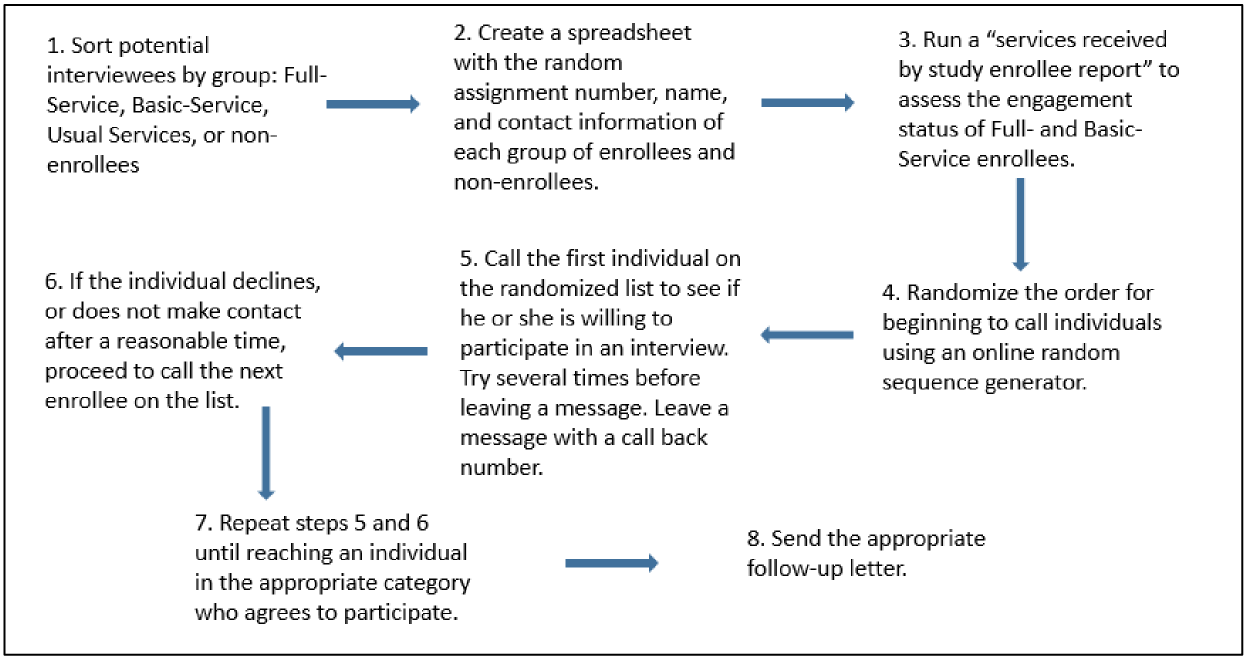
Table 2-2. Focus group participants by full-services and basic-services

Type of group	Number
Full-Services participants	89
Basic-Services participants	93
Total	182

Person-Centered Interviews. For site visits in both years, visitors scheduled six person-centered interviews, each designed to last about one hour. These interviews aimed to learn about participants' employment history, mental and physical health, applications for disability income, SED service usage and experiences (if applicable), and their goals for the future. Site visitors spoke with interviewees in natural settings that the interviewees chose. Interview locations included interviewee homes, the demonstration site, or somewhere in the community, such as a public library or coffee shop.

In Year 1, we randomly selected interviewees according to the steps shown in Exhibit 2-1. The goal was to interview one Basic-Service participant; one Full-Service participant; one Usual Services (control group) participant; two individuals who chose not to enroll in the study; and one participant in Basic-Service or Full-Service who appeared unengaged with services per their Monthly Service Use Checklist data. When a participant scheduled early in the week and subsequently did not show up for the interview, site visitors attempted to schedule another participant from the same category as a replacement. However, in some cases, it was not possible to schedule a replacement interviewee in the remaining available time.

Exhibit 2-1. Person-centered interviewee recruitment process for Year 1



1. Sort potential interviewees by group: Full-Service, Basic-Service, Usual Services, or non-enrollees

2. Create a spreadsheet with the random assignment number, name, and contact information of each group of enrollees and non-enrollees.

3. Run a "services received by study enrollee report" to assess the engagement status of Full- and Basic-Service enrollees.

4. Randomize the order for beginning to call individuals using an online random sequence generator.

5. Call the first individual on the randomized list to see if he or she is willing to participate in an interview. Try several times before leaving a message. Leave a message with a call back number.

6. If the individual declines, or does not make contact after a reasonable time, proceed to call the next enrollee on the list.

7. Repeat steps 5 and 6 until reaching an individual in the appropriate category who agrees to participate.

8. Send the appropriate follow-up letter.

One aim of the person-centered interviews in Year 2 was to interview as many of the same individuals as possible from the previous visit. Visitors were not able to reach all former interviewees, but no interviewee reached from Year 1 declined a second interview. Those who we did not reach fell into the following categories: relocated; did not answer or respond although staff believed they still live in the area; or could not be located (including by site staff). For each Year 1 interviewee we could not locate, the site team replaced the participant with an individual who participated in a focus group during Year 1, drawn from the same treatment group. Site visitors also employed this process to replace individuals who did not show or canceled their interview during Year 1. As in Year 1, we made efforts to reschedule or identify a new interviewee if a cancellation occurred during the week of the site visit. As shown in Table 2-3, in total, site visit teams interviewed 148 individuals in Year 1 and 174 individuals in Year 2. Approximately 59 percent (N=87) of the individuals from Year 1 were also interviewed in Year 2.

Table 2-3. Numbers of person-centered interviews

Person-centered interviewee type	Number of interviews Year 1	Number of interviews Year 2
Participant (Full-Services)	42	61
Participant (Basic-Services)	45	58
Participant (Usual Services)	30	35
Non-participant (ineligible or not interested in work)	31	20
Total	148	174

The site visitors conducted most person-centered interviews in the community or the home of the interviewee, guided by interviewee preference. Overall, 47 percent of the interviews occurred in the interviewee's home, 23 percent occurred in a local restaurant or coffee shop, and 15 percent took place in a local public library. The remaining interviews occurred either at the demonstration site or at another location.

Extended Ethnography. We introduced the Day-in-the-Life activity in Year 2. This activity was presented to participants as an opportunity to experience a "day in their life" or to "walk in their shoes" for an afternoon. Each pair of site visitors discussed which participant would feel the most comfortable with this activity, which involved spending an additional two to three hours together after the person-centered interview. Site visitors encouraged participants to engage in whatever activity they might usually do during that time, and invited participants for a meal or coffee. Most typically, the extended ethnography involved spending time at the participants' home or a restaurant. Examples of specific additional activities included going to a shopping mall; touring places of significance in the participant's life; watching the participant pack for a trip; watching TV; picking up the participant's grandchild from the bus; running errands; going for a hike with the participant and their dog; and accompanying a participant while she made food deliveries as an employee. This extended interaction gave site visitors a more in-depth snapshot of the lives of SED participants and the opportunity to learn more about their personal stories and the barriers to employment they face. We conducted the extended ethnography activity at 16 of the 30 sites in Year 2.

Observation of Service Delivery. Site visits included observations of staff at work with each other and with participants. We observed demonstration site's team meetings for the Full-Services and Basic-Services teams in both years. These observations gave site visitors insight on how the teams functioned and worked together to address participant needs, and their direct interactions with participants. In Year 1, when possible, Westat also observed a staff/participant meeting where they discussed employment, accompanied staff on a job development activity, or accompanied staff and a participant on a job exploration activity. In Year 2, site visitors arranged to shadow one of the SED team members (Care manager, IPS specialist or NCC) across a 3-hour period. The objective of these activities was to see staff interact with participants in a natural setting, ideally in the community, to record what staff typically do with participants. Sites selected whichever staff was most likely to be working with participants on the day of the visit. This activity also allowed site visitors to meet additional participants. Table 2-4 provides a list and count of types of ethnographic observations related to service delivery in Years 1 and 2.

Table 2-4. Number of ethnographic observations related to service delivery Years 1 and 2

Type of observation	Year 1	Year 2
Basic-Service team meeting	25	26
Full-Service team meeting	26	26
Combined team meeting	2	3
Job development	9	7
IPS specialist-participant meeting	19	31
Care manager-participant meeting	6	7
NCC-participant meeting	3	4
Multiple staff-participant meeting	5	5
Other	10	1
Total	105	110

2.2 Monthly Service Use Checklist

The Implementation Team developed the Monthly Service Use Checklist to monitor engagement in team-provided services to study participants. The primary interest was to obtain a measure of face-to-face encounters in each particular month of study participation and the nature of those encounters. Team leads complete a checklist monthly for each participant in their treatment group with input from team members. Team leads enter the data directly into the study's electronic management information system (MIS). The MIS provides automated lists of participants with upcoming checklist completion due dates to help facilitate timely completion given month-end dates are based on participant enrollment dates and, therefore, different for each participant.

The checklist (appearing in Appendix A) provides information on monthly participant engagement in seven areas: (1) circumstances that preclude face-to-face meetings with demonstration site staff, (2) number of face-to-face meetings with the IPS specialist, and types of IPS services received, (3) number of opportunities to receive Problem-Solving Therapy (PST), (4) number of face-to-face meetings with the care manager, and types of services received, (5) Medication Management Support (MMS) services received and specialty referrals, (6) employment status and job development activities, and (7) school and vocational training.

2.3 Fidelity Assessment Aims and Methods

The IPS fidelity assessment is one component of the SED process evaluation to help us determine whether the sites implement the IPS model as intended. Understanding fidelity to the IPS model is critical to communications about the extent of treatment implementation and to future replicability. Previous research informs us that implementations that adhere closely to the evidence-based model prove more effective than those that have low fidelity. To the extent that the demonstration sites meet fidelity expectations, we can be confident that sites delivered the essential elements of the intervention to participants as designed.

We developed two additional assessment protocols to assess fidelity to the model of MMS and the NCC role at each demonstration site.

At each of the 30 SED sites, two reviewers conducted onsite fidelity assessments in 2018 and 2019 using the standard 25-item IPS Fidelity Scale and the newly developed MMS and NCC scales. Fidelity reviewers scored items following the protocol, with the exception of slight modifications to four items made to accommodate differences created by the overlay of the SED study on typical IPS service delivery. The companion report, *Supported Employment Demonstration Summary of 2018 and 2019 Fidelity Assessment Ratings,* provides more information about the fidelity review team, data collection methods, IPS fidelity tools and scoring protocol.

3. SED Direct Service Staffing

Process evaluation site visitors annually collect information about each SED team during site visits. The purpose is to capture levels of experience of staff, their training, as well as staff turnover. Further, the visitors collect data on team organization and functioning. The following sections describe the staff characteristics at the 30 demonstration sites, team structure and organization, time allocation, turnover, and team collaboration and communication.

3.1 Staff Characteristics

Table 3-1 presents an overview of the credentials of staff at the 30 demonstration sites at year 2. Among team leads, IPS specialists and care managers, 98 percent had at least an Associate or Bachelor degree with 37 percent possessing Masters-level credentials. Most IPS specialists (63%) had a BA, with an additional 25 percent having a MA or MSW. Westat recommended that sites hire care managers with either Bachelor's or a Master's degrees. Among care managers in Year 2, approximately 55 percent had a BA or BS with the remainder having a MA or MSW.

Table 3-1. Highest degree of team staff in place at Year 2

	HS		AA		BA/BS		MA/MSW		RN	
Degree type	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Team lead	1	3	1	3	15	42	19	53	0	0
IPS specialist	5	6	5	6	51	63	20	25	0	0
Care manager	0	0	0	0	29	55	24	45	0	0

Many SED staff have a background in an academic discipline relevant to mental health service delivery. Table 3-2 presents the percent of staff across the study having a psychology, counseling, or social work background. For staff with an AA, BA, MA, or MSW, 69 percent have a background in psychology, counseling, or social work. Care managers were especially likely to have this background; among the 53 care managers working at sites in Year 2, 87 percent reported a degree in one of these areas. Other team members highlighted the value of this background. For example, an IPS specialist at one site described having a care manager with clinical experience as a "major resource" for both the participants and the team. This staff member felt that care managers with a clinical background bring their knowledge in a general way, such as understanding mental health diagnoses, as well as knowing the best approach to handle safety issues, such as what to do if a participant says they are suicidal. In at least one site, the care manager also serves as the therapist, a configuration that team members felt was advantageous, although the care manager said it could be challenging at times.

Table 3-2. Staff with a psychology, counseling, or social work background, Year 2

Staff type	N	%
Team lead	24	69
IPS specialist	43	57
Care manager	46	87

Site administrators and team leads reported that they sought to hire staff with the right "fit" for the SED study. Managers across sites concurred that they needed staff who were comfortable working in doing outreach and delivering services in community settings. Further, staff needed to be persistent and patient with participants. A degree in a mental health-related discipline was only one of many salient characteristics. For example, a team lead explained they preferred to hire

> Someone that can engage people whether they're wanting to be or not, but finding those creative ways to get them engaged. Someone that is patient, someone that could persevere—sometimes it takes calling and calling. Someone that can get cussed out and you're still OK…. Just having that person that could really work as a team. Because it's a team effort and it's going to take the effort of the whole team bringing those ideas in.

Sites hired about half of their SED team members specifically for the SED. Some sites preferred experienced staff over less-experienced staff to fill SED roles; other sites found that some less-experienced staff were more open and flexible in how performed their duties.

Many sites filled positions on the SED team with staff who were already working within the site. These sites selected the most experienced staff available, particularly IPS specialists. As one team lead said, "We decided that we were going to take our best employment specialists and move them to this grant, the ones that have more experience, more training, and had really good outcomes as far as placements and getting people to work." Some sites found this to be a successful strategy because internal hires were already familiar with how IPS teams worked. Another site which transferred IPS specialists to SED, highlighted not only their experience with the job tasks prior to SED, but that the professional relationships among team members pulled them through the initial growing pains of SED implementation. The team lead explained, "I knew [them] prior to starting this; there was a little bit more trust around, 'We're figuring this all out together. It'll be okay.'"

Choosing staff already working at the site occasionally backfired as a strategy because some staff found SED participants more frustrating than the clients usually referred to IPS by their site. At one site, for example, one IPS specialist found SED participants' ambivalence toward work frustrating, compared to his prior clients. While some IPS staff recognized the need to change their strategies and were able to adjust, this was not always the case. In the aforementioned example, the team replaced this member with someone experienced in doing more active outreach with clients. She focused on re-engaging participants. Within a few months, engagement with the SED increased at the site, according to the team lead. A team lead at a different site, with many years of experience of working in mental health, noted, "Sometimes with those eyes that are fresh, that don't work with [clients at our organization], they're not going to pigeonhole people." Another team lead felt that it was helpful that her team did not consist of "a ton of people who were entrenched in this old way of thinking…newer folks were more open to considering new philosophies."

Among the IPS specialists in place during year 2, two-thirds had worked at the site less than a year before joining the SED team; most were hired for SED. Fewer care managers were hired specifically for the SED position, but as shown in Table 3-3, over half of those employed in Year 2 (57 percent) were new to the site. Most team leads, in contrast, were at the site between 1-5 years before starting SED, and approximately 40 percent had a tenure of five years or longer.

Table 3-3. Length of SED staff tenure at organization prior to joining SED, Year 2

	Number of years at organization								
	1 year or less		1-5 years		5-10 years		10+ years		Average
SED position	N	%	N	%	N	%	N	%	MEAN years
Team lead	5	14	17	47	7	19	7	19	8.0
IPS specialist	52	64	20	25	5	6	4	5	2.8
Care manager	3-330	57	13	25	7	13	3	6	3.5
NCC	22	67	9	27	2	6	0	0	2.7

3.2 Team Structure and Organization

Treatment teams include a team lead, at least one IPS specialist, and at least one care manager for the Basic-Service teams, and the addition of at least one NCC for the Full-Service team. A description of the intended role of each staff member follows below.

- The **team lead** coordinates and leads team meetings, and documents service delivery. The team lead is familiar with IPS service delivery.

- The **IPS specialist** provides employment services, including job development, coaching, follow-along supports, and other vocational services.
- The **care manager** provides wrap-around services, including coordination and support for housing, legal assistance, and benefits counseling. The care manager also provides clinical care management, shared decision-making, and problem-solving therapy as needed.

- The **NCC** is a registered nurse. The NCC works with Full-Service participants and their prescribers to facilitate evidence-based medication management.

A key difference across sites is whether sites assign each staff member participants from both Basic-Service and Full-Service, or whether each staff member's assignment is exclusive to one treatment group or the other. Westat allowed sites to structure staff caseloads as either exclusively comprised of participants in one treatment arm, or as comprised of both Basic- and Full-Service participants. According to team leads, 16 sites have IPS specialists with mixed caseloads of Basic- and Full-Service participants. Two-thirds of sites have care managers who serve participants from both treatment arms. All but three sites assign team leads both Full-Service and Basic-Service teams. Table 3-4 presents a summary of the team structure across the 30 sites at Year 2. The Nurse Care Coordinator works only with the Full-Service participants.

Table 3-4. Team structure (N=30 sites)

Staff type	Work with only one treatment condition	Work with both FS and BS conditions	Other configuration
Team lead	3	27	0
IPS specialist	12	16	2[a]
Care manager	8	20	2[a,b]
Nurse Care Coordinator	30	0	0

[a] At two sites, some staff work with only one treatment condition and some work with both.

[b] One site did not have a care manager at the time of the site visit.

How the sites divide Full- and Basic-Service caseloads among staff members has implications for treatment. IPS specialists bring varied backgrounds, styles and skill sets to their caseloads. They vary in their level of education, whether they have worked in mental health previously, and how long they have worked at the site. At one site, visitors noted that a Full-Service IPS specialist was younger and had less experience with handling complex cases than the Basic-Service IPS specialist. At another site, both IPS specialists moved from other positions within the organization; one having worked as a therapeutic behavioral specialist with children; the other who had handled scheduling appointments for the therapists at the site. Participants in one group or the other may not get better services, but groups may consistently receive services that differ according to the team members' skills and strengths. SED teams with homogenous caseloads (all Full-Service participants or all Basic-Service participants) may have IPS specialists attend only "their" (Basic- or Full-Services) meeting. As a result, IPS specialists at these sites may not hear about strategies and opportunities that would benefit participants on their own caseload. Additionally, teams with separate treatment arm assignments do not have much flexibility to transfer a participant to a different staff member if they discover that someone is not a good match, or there is need for coverage. On the other hand, teams that have Basic- and Full-Service participants integrated on each staff member's caseload get exposure to the NCC's work with Full-Service participants. What they learn from the NCC in regards to treating Full-Service participants may influence the services they seek to provide for their Basic-Service participants, which may result in outcomes across Basic- and Full-Service treatment arm participants that are more similar than participant outcomes at sites where staff do not carry mixed treatment-arm caseloads. .

3.3 Staff Time Allocation

SED team members vary across sites in how much time they dedicate to SED services versus other services or activities at the site. Prior to the site visit, team leads completed a roster listing each team member and various characteristics of the staff, including the amount of time they allocate to the SED. In examining the percent FTE that sites assign to SED staff, and SED staff members' caseload size at the time of the site visit, we note that the percent time dedicated to the SED has, on average, increased from Year 1 to Year 2 for three of the four positions, largely due to the rolling enrollment as sites achieved their targets. In addition, we note the following:

- **Team leads** averaged an assignment of 62 percent FTE on the SED during Year 2, compared to 55 percent in Year 1. There are thirteen team leads who are 100 percent committed to the SED. Twelve team leads carry a caseload. In some sites, team leads do not carry an official caseload, but step in to address difficult cases or help with engagement.

- **IPS specialists** averaged 80 percent FTE on SED during Year 2; during the first site visit, this was 81 percent. Sixty-four percent (52/81) are full-time on the SED. Caseloads for IPS specialists range from 1 to 81 (M=21) participants.

- **Care managers** averaged 71 percent assignment of their time to the SED during Year 2, as compared to 60 percent during Year 1. Thirty of the 53 care managers (57%) are

100 percent focused on the SED. Sites report that caseloads vary from three to 83 participants (M=31).

- **NCCs** averaged 72 percent assignment of their time to the SED during Year 2, up from 64 percent at the first site visit. Twenty-five (25) of the 33 NCCs spend at least half their time committed to SED participants. Seventeen NCCs were full-time in Year 2, compared to only five in Year 1. Caseloads range from five to 45 enrollees (M=27).

During site visit interviews, team members often described their caseloads first giving the official total of participants assigned to them, and then the actual number they see, due to challenges with engagement. For example, an IPS specialist noted a caseload of "seventeen that are active, and then probably three or four that don't communicate for different reasons," and an NCC broke down her caseload as "fifteen people that I see once a week, in some cases, every other week. I have about fifteen people that I see maybe once a month or so. Then I have about fifteen or so people that I can hardly ever find."

3.4 Turnover

Staff turnover is a problem in community mental health and vocational service settings across the U.S., and SED staffing is not immune to it. During the first six months of SED implementation, there was staff turnover at almost every site. Between May-September 2018 and May-October 2019, turnover lessened; seven sites experienced no turnover at all, and 12 sites experienced relatively little, with 75 percent of staff remaining from Year 1 through Year 2. Turnover of 50 percent or greater occurred in 11 sites. (See Table 3-5.)

Table 3-5. Staff turnover and other changes between Year 1 and Year 2

Percentage of team	Number of sites
No turnover	7
1%-25% turnover	12
26%-50% turnover	9
Greater than 50% turnover	2
Total	30

Among sites experiencing turnover, about half the sites (N=12) lost up to 1 and 25 percent of their staff, and for 11 of these 12 sites, this meant losing just one person. Most often, staff remaining at the site reported to site visitors that the reason for turnover was higher pay available in other positions, whether within the same organization or elsewhere. Low unemployment rates in the communities around many sites were helpful to participants seeking jobs, but, as one team lead noted, it affected their ability to retain team members "because they're looking at other opportunities too." Another reason for turnover, especially in IPS specialist positions, is due to employees discovering that they are not suited for the work and switching to another type of work altogether. This was most common among IPS specialists hired with no experience. The requirement to visit participants in their homes, places of work, and in the community may have contributed to turnover. With participants located throughout the catchment area, staff must think carefully about organizing their time. It was common for team members to describe, for example, visiting people who lived in the same area on the same day in order to be more efficient with their commute. As one team lead summarized, “It’s a different way of looking at your schedule and doing things.”

Even among sites with little or no turnover, staffing changes still occurred when new staff were hired or moved from other parts of the organization to provide additional coverage. All but one site had at least one new staff member who joined the team between Year 1 and Year 2 as described in Table 3-6. More information on turnover related to the NCC position is in the companion report, *Supported Employment Demonstration Summary of 2018 and 2019 Fidelity Review Ratings for Nurse Care Coordination and Medication Management Support.*

Table 3-6. Number of new staff between Year 1 and Year 2

Number of new staff	Number of sites
None	1
1	7
2	11
3	5
4	4
5	2
Total	30

Turnover is invariably disruptive, even when teams knew about an impending staff change and eased the transition with a “warm handoff” between outgoing and incoming staff. Staff said turnover on the SED team is especially difficult because it’s “such a short study” and hiring repeatedly means lost time—a feeling of racing against the clock. Turnover can result in gaps in participant engagement, and even when new staff are in place, there can be challenges re-engaging participants. An IPS specialist characterized changes in participant engagement as “significant…most of them are just like, ‘I don’t even want to talk to a new person, I’ve already told my story and obviously that person didn’t care because they left, don’t want to do this again.’” At this particular site, the staff member estimated that at least 25 participants have had three different care managers since the start of the project.

Although a challenge, SED teams have found ways to manage the turnover. Several sites described staff who took on dual roles, for example, team leads provided employment support, care managers who helped the nurse with appointments; and teams that drew support from the broader organization to provide coverage until someone new was hired. Fidelity Assessment Scores from 2018 and 2019 were 4.4 and 4.5, demonstrating that turnover did not strongly impact IPS specialists ability to fulfill their role.

3.5 Team Collaboration and Communication

The factors described above—staff background and experience, team structure, caseload size, turnover within teams—all contributed to how teams function, and potentially, to how well teams facilitate positive outcomes for participants. Some of these, such as caseload size, team structure, and integration to facilitate collaboration—also appear in IPS fidelity measure. Other aspects of SED teams not assessed through the fidelity measure may ultimately prove important to participant outcomes. A well-functioning team requires more than just having a set of individuals in place who are doing their jobs: in site after site, team members talked about their work as rooted in the relationships among team members and their ability to collaborate with one another. When asked about the best ways to help participants get a job, we heard the phrase "it's a team effort" multiple times. At one site, the care manager provided the additional explanation that a team effort meant that "it's not, 'I'm gonna get all my stuff done and I don't care about you,'" but rather, a deliberate effort to consider how other team members might be able to help meet the needs of any given participant.

Team meetings facilitate this sense of a team effort. Every SED site has a weekly team meeting. Based on our observations and interviews, these meetings differ in key ways. Some meetings had written agendas that identified the order of topics and the specific participants discussed. Other meetings were more open-ended. For example one site's team lead began the meeting by asking the team what they would like to cover. Some teams use the meeting as a time to run through as many participants as possible (as many as 20 or more), having staff report on their contact with participants in order to complete the Monthly Service Use Checklist required for the study. At the other extreme, some team meetings involved discussion of only a few participants. Driving these differences may be the intensity of communication among staff during the week. For example, in a site with just a few participants discussed during the meeting, the team lead has a conversation every day with every team member about their cases, and team members reported texting or talking throughout the day. The meetings addressed only the highest-need participants.

Site visitors who observed team meetings noted a number of productive types of discussions. Based on observations of the team meetings, site visitors highlighted multiple positive practices including the following: demonstrating deep knowledge about participants; sharing ownership and responsibility toward participants leading to collaboration; demonstrating of positive regard for participants; and evincing positive regard for other team members. Examples of these include the following:

- **Staff demonstrated their knowledge about participants**
  - The team lead was familiar with all participants and their circumstances.
  - Team members knew about participants even if not on their caseload.
  - Staff reported on participants without looking at notes.
- **Staff shared responsibility and collaborated**
  - There was a sense that a participant (and his/her success) was shared, rather than just "my client" "your client"- no contentiousness or protectiveness about not wanting other staff to see participants.
  - Worked together to figure out best way to reach hard-to-reach participants, e.g., tag-teaming.
  - Team members worked together to strategize options for a participant.
  - Everyone had a chance to speak about the participant.

- **Positive regard towards participants and towards work as a goal**
    - The complexity of participants' lives did not intimidate team members; they don't give up on the possibility of employment.
    - Members did not dwell on the challenging aspects of participants' behavior or don't view participants as 'challenging' at all.
    - Staff discussed participants with affection and empathy, even those who have caused frustration.
- **Positive regard for other team members**
    - Camaraderie was evident among team through laughter and sharing.
    - Team members paid attention when one another speaks, and are not on their computers or phones.

Team members also emphasized the value of open and frequent communication outside the team meetings. If something pressing arises, rather than wait for a weekly meeting, one IPS specialist said, "We just call each other and talk about it…I have a distinct relationship with each person, they all have different relationships with each other, and it's cohesive. And I think it's really productive and works that way." Staff of several sites talked about calling and texting one another several times during the workday. Site visitors observed this during our time spent with staff. For example, during a visit to a participant's home, an IPS specialist received several updates from the care manager about another participant they were hoping to visit the following morning. One team lead talked about a group text in which team members would connect and provide support for each other. Team members talked about even how the physical structure of their workspace helped build a sense of collaboration, such as how the desks facing each other reflects the goal of having an integrated team. At another site with a similar configuration, an IPS specialist acknowledged that

> The open format took a little bit for me to get used to because everybody was in everybody's ... I don't want to say business, but it was just that everybody was just there. But I understand why it's necessary now because we all work so close together. If I have an update, it's easier to kind of go, "Hey," instead of walking down to two different offices.

A Nurse Care Coordinator described her communication with the care manager as "all day long, we're inseparable!"

4. Factors Influencing Delivery and Receipt of Interventions

In this section, we discuss the challenges SED participants faced, as described by SED staff and participants. These problems include many unmet basic needs, mental health problems, and physical health problems and limitations. We continue with a discussion of important barriers participants face when seeking employment, including lack of transportation, criminal justice involvement, and housing instability. The final section describes participants' disability appeals and reapplications while involved in SED.

4.1 Presenting Problems of SED Participants

Unmet Basic Needs

SED staff reported that many of the challenges they face delivering services—and IPS Services in particular—were due to the varied and multiple unaddressed basic needs with which participants entered the study. Many staff members made the point that while typical clients at their organization experienced similar hardships in their lives as SED participants, typical clients' referral sources usually addressed outstanding needs prior to engagement with employment services. Some SED participants entered the study with housing instability, difficulty accessing reliable transportation, and untreated physical health, mental health, and substance use problems. Staff described a sizable group of participants as prioritizing meeting their immediate needs, as opposed to searching for employment: "The SED population…there's a lot of just basic needs that are not being met right now. Although we do have folks that are very interested in working, they're also worried about, 'How do I eat today? Where am I going to sleep tonight?' and are really consumed with those challenges." The majority of staff members—64 percent—described SED participants as having fewer basic needs met (for example, for food, shelter, clothing, transportation) in comparison to the "typical" client of their organization[1].

Around five percent of participants in all treatment arms (Full-Service, Basic-Service, Usual Services) described themselves as "homeless or in a homeless shelter, hotel, motel, or correctional facility" on the baseline survey. However, SED staff observed that many more SED participants were coping with housing instability. At one site, a staff member explained that among the individuals in their caseload, "I think we only have one or two [SED participants] who are truly identifying themselves as homeless, but it seems like most of them are either on the verge of that, or really, like, couch-surfing. They really don't have a place to call home and don't have a reliable way of taking care of themselves." An administrator of a site with a large program serving homeless clients explained that

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[1] These data come from in-depth interviews of staff members who either responded to a question about differences between SED participants and their sites' typical clients, or spontaneously discussed the differences. Not all staff members addressed differences between SED participants and typical clients, and not all staff who described differences referred to the extent to which each group had their basic needs met. Other important topics staff described included differences in the types and degree of impairments, engagement, commitment to work, and access to support and benefits.

SED participants "are on the fringes of going…into the undertows of homelessness…. There's a level of acuity there that needs to be addressed, and if not, then we'll eventually see them [among the homeless clientele]."

Health Problems

In this section, we present key themes from interviews with SED staff and focus groups with participants about participants' impairments and how their impairments restrict their capacity to work. We also discuss how staff perceive the impairments of SED participants as compared to typical clients of their sites.

Medical Needs. Across sites, SED staff said that "the physical [health] issues end up taking precedence" over employment or mental health concerns for many participants. For example, one IPS specialist acknowledged that managing back, hip, and knee pain were difficult for participants. She lamented how she struggled to deliver employment services because participants, "Won't pursue work, or some of them won't even talk about work until something is done about their back or their hip or knee."

In baseline surveys, participants reported an average of three (3) physical conditions. Sixty-five (65) percent of participants reported back pain and forty-nine (49) percent indicated they were obese. One in three (33%) reported hypertension or a lung condition (asthma, emphysema, chronic bronchitis, or lung disease). Participants endorsed physical health-related quality of life on the SF-12 that was more than one standard deviation below the national norm.

Indeed, many participants viewed addressing physical problems as necessary before they could realistically hold a job. For example, a participant explained "I have to focus on my health. I can't focus on other things. I have to put my health first and then I can find a job." In focus groups and interviews, participants were more likely to highlight their physical health problems and pain than their mental health problems. Another participant asked rhetorically, "How am I going to try to do employment if I'm having a struggle just to make it to go to the bathroom?'"

Managing pain was overwhelming for many participants. Some who were in physical pain described challenges in finding jobs for which they don't have to remain in one position—standing or sitting—for long. As one participant noted, "I can't have a job where I'm standing because of my back. And I can't have a job where I'm sitting all day because of my back." In some cases, participants had pain so debilitating that they could not even leave their homes, as described by one IPS specialist:

> We have a lot of clients that were either in car accidents or had various head trauma where they deal with consistent chronic pain. I mean, I have one guy that spends 90 percent of his life either in his bed or in the recliner right next to his bed from a car accident, the pain is so severe. I think that's probably been one of the biggest challenges, the chronic pain piece.

Addressing the substantial physical impairments of participants was a new challenge for teams. For example, a team lead noted an increased emphasis on medical care coordination for participants, noting that the physical health needs were "a little bit out of our area of expertise. We're learning things. We're trying to coordinate people with specialists and physicians. So that's been a little bit different." Some staff sought and received specialized training on topics such as fibromyalgia and chronic pain because they had no experience working with these conditions prior to the SED. In contrast to mental health problems, SED staff reported that participants exhibit greater prevalence and severity of physical impairments than typical clients using services at their site. Phrases used by staff to describe this comparison included: SED participants having "more serious" medical issues of "greater severity," "more physical limitations," "significant physical disabilities," "medical problems to a higher degree," "bigger physical health barriers to stability," and "multiple health issues."

Although sites' usual clientele also present with physical limitations, staff explained that physical health issues stabilize prior to their engagement with the site and definitely before engaging in employment services. Physical health conditions were not the reasons they sought services at the site. In contrast, SED participants often displayed multiple unaddressed physical health issues at intake, especially among those participants who entered the study without having health insurance.

IPS specialists learned to tailor employment services for people with physical health impairments. They searched for jobs that did not require the participant to stand all day. They worked with participants and employers to secure accommodations for physical limitations from the employers. They sought reimbursements from Westat for items to mitigate pain while working, such as supportive shoes, cushioned mats on which to stand, back and knee braces, walkers, compression socks, canes, and hot cold pads among others. They requested assistive technology from their local Departments of Vocational Rehabilitation. For a participant with severe intestinal issues who was afraid to leave the house and the convenience of his bathroom, IPS specialists focused their search on work-from-home positions. Care managers searched for specialty doctors to address SED participants' various medical needs.

For some participants, both the participant and the SED Team agreed that employment was not an appropriate goal for the participant until the participant's health status changed. There were examples at nearly every site. For example, the need for an immediate heart transplant superseded the employment search for one participant. Another participant at a different site had not been able to eat for several years and required intravenous feeding for twelve hours each day. A third participant had a rare form of cancer with no known cure, although she expected to receive palliative surgeries to alleviate pain when it becomes too much to bear. Site visitors accompanied the IPS specialist on a visit to this participant's home. There was no talk of employment. Instead, the IPS specialist provided support, reminded the participant about upcoming doctors' appointments, and made suggestions for the participant could seek payment for some outstanding bills. These are only a few examples of many participants for whom staff and the participant themselves concluded employment was not a realistic option.

Mental Health Needs. While staff felt that they spent more efforts on helping SED participants meet basic needs and manage physical impairments, they also felt that the mental health problems of participants were different than those of their sites' usual clientele. Staff members repeatedly observed that participants exhibited symptoms of anxiety (including Post-Traumatic Stress Disorder (PTSD)), depression, and personality disorders, rather than symptoms of psychosis. At almost every site, staff echoed a team member's summary that "pretty much everybody is anxiety and depression," when asked to describe the common mental health concerns of participants. For example, a care manager explained the difference between SED participants and the typical clients of her organization in the following:

> [SED participants] don't have a level of symptoms that would traditionally meet the level of needs that we can help with. A lot of my normal case load…come in through Access or the intake process, have a higher level of acuity, higher level of needs as far as mental health treatment.

A Nurse Care Coordinator described the range of mental health concerns of the SED participants she treated in comparison to the typical clients of her organization, who were mostly individuals with psychotic disorders:

> There's some bipolar [among SED participants] but usually not with psychotic features, so that's different in that the level of acuity is lower and yet it's still causing significant issues in terms of their day-to-day life. They're able to perform ADLs; this is not true of all of our clients here. A lot of our people here are…learning how to do laundry, how to cook, how to shop, how to shower. These folks are not like that.

Eighty-one (81) percent of participants endorsed symptoms consistent with one or more mental health conditions and only ten (10) percent reported only mental health symptoms and no physical symptoms on the baseline survey, as shown in Table 4-1. Participants' self-reported mental health quality of life on the SF-12 Mental Composite Score on the baseline survey was more than 1.5 standard deviations below the mean. About 45 percent of participants endorsed symptoms on the Composite International Diagnostic Interview (CIDI) that may indicate PTSD. Forty-four (44) percent of participants endorsed symptoms suggesting Antisocial Personality Disorder, while forty (40) percent endorsed symptoms indicating Borderline Personality Disorder. In total, sixty-four (64) percent reported symptoms indicative of any personality disorder from Cluster A, B, and C. Thirty (30) percent reported symptoms of depression.

Table 4-1. Percent of participants endorsing mental and physical symptoms, baseline[a] (N=1876)

Mental health only[b, c]	Physical health only	Both mental and physical health
9.8%	7.6%	81.1%

[a] 1.5% of participants endorsed no symptoms at baseline. Data include only participants who completed both the CIDI and the baseline interview.

[b] Data do not represent diagnosed conditions but rather those who met criteria indicating the possible presence of a mental health condition.

[c] Source: Composite International Diagnostic Interview (CIDI)

Participants' mental health conditions posed substantial barriers to work. Anxiety and depression were debilitating for many SED participants, and not only caused problems on the job but also made it difficult to even search for jobs. An IPS specialist explained

> One of my clients, she's just super anxious and gets so afraid of even applying to work that she'll kind of miss meetings. She just won't apply to jobs. Just kind of psyches herself out. Just has a hard time with utilizing

> coping strategies. So it's just really working with her on managing her anxiety symptoms.

Descriptions of anxiety and how it affected participants' employment were common in focus group discussions. Some participants felt that anxiety affected their cognition to the point where they were ineffective workers. For example, one participant explained:

> My main problem is that since 2006 I've been suffering from anxiety, and the anxiety really doesn't let me do much in terms of work. Because as soon as my brain starts to feel a little tired, I start feeling it. I just feel the need to repeat things, stop doing whatever I'm doing, things like that. That's why I haven't been looking for a job because I'm not really sure I'm going to be able to keep it or do one hundred percent of the work because of the anxiety.

A participant at another site indicated that her difficulty completing work tasks was severe enough that it led to termination:

> I'll start doing something and not even five minutes later, I'm off doing something else. I cannot finish the one task that I'm supposed to do. I can get a job with no problem, but when you have depression and anxiety and stress and everything else and PTSD and stuff like that, it's hard to keep a job.

Many participants reported anxiety about leaving the house. For example, one participant who had made some progress in overcoming her dread of stepping outside explained:

> The biggest thing right now is my anxiety. For the longest time, I couldn't even leave the house. It was just stressful. We got symptoms that just were beyond control…I don't know if a job will hurt or help that, I'm willing to try and hope that everything will work out, but we'll see.

Staff thought most participants' PTSD symptoms were the result of sexual, physical, or emotional childhood trauma. A care manager at an urban site told us that participants' PTSD was a result of "cumulative life trauma, the chronic poverty, housing issues, stuff like that." Participants' descriptions accorded with these observations, for example, a female participant who linked her challenges in dealing with authority figures at work to her PTSD, which stemmed from childhood abuse:

> I been going to therapy for two and a half years. So, I'm learning about me. I have a problem dealing with higher authority. I was abused as a child. I don't wanna go there, but a lot of stuff reminds me. Like if a person yell at me, that will take me back to that ten-year-old or eight-year-old girl.

Another participant who identified as having PTSD as a result of childhood experiences described how this affected him in the work environment:

> Large crowds, being around loud noises like working in a restaurant, the banging of the pots and pans makes me jump and it makes me turn around.

> If I turn around too fast, I'll lose my footing and I could fall, I could hurt myself. A lot of it has to do ... a lot of my symptoms have to do with my childhood, the way I grew up, living in bad neighborhoods, hearing gunshots every night, living in and out of vehicles, living in and out of national parks as a child, growing up that way.

Moreover, there was a sizable group of participants whose mental health problems were undiagnosed before intake. As discussed in the section "Referrals" below, some SED participants entered the study with limited or no prior experience of mental health treatment. Others denied having mental health impairments altogether and avoided seeking treatment after enrollment.

4.2 Other Barriers to Employment

In addition to physical and mental health impairments, many participants experienced numerous other barriers to employment. Throughout this report, we mention many of these barriers in the context of discussing how staff and participants worked to overcome them. Here, we elaborate on some of the barriers, including lack of transportation, criminal justice system involvement, and housing instability.

Transportation

SED staff and participants described a lack of reliable transportation as a barrier to seeking and maintaining employment. Transportation was inevitably the first barrier when we asked staff to discuss what challenges prevented participant engagement with services and participant employment. Staff were able to overcome transportation problems by conducting appointments with participants at their homes or other community locations convenient for the participant. Some SED team members provided transportation to and from the workplace to participants on a limited basis, but all acknowledged this was not a long-term solution.

Surprisingly, just under eighty (80) percent of participants reported they had "access to reliable transportation when needed" on the baseline survey. However, since approximately the same percentage did not have a job at baseline, it is quite likely that when answering the question most participants were not thinking about how they would get to and from a place of employment, or even how they would get to the demonstration site.

Problems accessing transportation were most prominent in rural and mixed rural/urban areas. Most sites provided participants with monthly bus passes to facilitate participants' job search-related activities. Other sites provide passes or tokens for single or round-trip rides. In rural and mixed rural/urban areas, bus service was sometimes not reliable and the transit system was not extensive. For example, one mixed rural/urban site reported that the bus runs only from 8:00 AM to 4:30 PM, which eliminated accepting work on evening shifts and also 9-to-5 jobs. Sometimes the bus system in the catchment area only ran every hour, necessitating the participant arrive at their job or appointment extremely early. On the return trip they do not have the flexibility to stay a little later to assist their boss or coworkers, or else they will miss their ride home.

Transportation for participants who lived in rural areas is a serious barrier to job searches and job interviews, and, in some cases, maintaining employment. At one mixed rural/urban site, some of the lowest income enrollees without transportation literally lived "in the middle of a chicken field," and would need to drive 20 minutes just to reach small towns with only low paying jobs, such as work in retail or fast food. These participants are unlikely to earn enough at these jobs to afford to purchase a vehicle, or to pay a transportation service consistently. Some townships near rural areas where participants lived have low-cost ride-sharing services for residents with disabilities, but these services are generally in very high demand and restricted in how they may be used. (That is, they may prioritize transportation to medically necessary appointments over transportation related to employment.)

Some participants did not have a driver's license, access to a car, or the money to buy gas. Other participants did not drive or use public transportation due to PTSD or anxiety.

Criminal Justice System Involvement

Involvement with the criminal justice system is another barrier to employment. At baseline, thirteen (13) percent of participants reported that they experienced arrest and booking in the past year, whereas 53 percent experienced arrest and booking at least once in their lifetime. Crimes ranged from misdemeanors to felonies; from disorderly conduct or theft to domestic violence or murder. All sites reported at least a few participants whose criminal records made employment more challenging. Some participants with criminal records reported that they had nearly given up on looking for a job, since employers have turned them down repeatedly because of their records. Other participants mentioned pending trials or sentencing dates that made job development difficult.

Some IPS specialists with participants who had criminal records worked with them to expunge their records when it was possible. IPS specialists also look for "felony-friendly," or "background friendly," jobs that do not require a background check for employment, or that will hire someone with a record. One team discussed searching among small businesses for jobs for a participant with a criminal background, because, in their experience, they are less likely than large business or franchises to conduct a background check.

However, the problem with felony- or background friendly jobs is that they are usually entry-level jobs, which is a problem for participants with higher education and skills who are interested in intermediate and senior positions. Staff reported that these participants sometimes "aimed low" and chose to apply for jobs where they knew they would not be asked about a criminal record because they were uncertain or uncomfortable talking about their criminal record with employers. (Participants with criminal backgrounds considered warehouse jobs and jobs in the food industry as those that would not ask about a criminal background.) However, these types of jobs were problematic for participants with physical limitations.

An option for participants with criminal backgrounds who wanted jobs that would include a background check was to explain to the employer their criminal background. Staff worked with participants to develop a sincere narrative they would share with employers during interviews to explain their crime and how they have changed since then. IPS specialists then role-played interviews in which the participant would explain their background so that the participant would feel confident about broaching the subject of their criminal justice involvement with employers.

Housing Instability

A major challenge at nearly every site is that a sizeable group of participants did not have stable housing at the time of enrollment. Site teams reported that at intake, some participants lived in their cars, others "couch-surfed" among relatives and friends, and still others live in tents. Housing instability is a Catch-22 for employment. Staff reported that participants with inadequate housing usually wanted to address their housing before focusing on employment. However, it was sometimes difficult to qualify for, and maintain housing, without employment. For participants who did not want to work towards employment before they found adequate housing, this usually meant a very long delay before beginning IPS services in earnest, as finding appropriate housing was the most difficult barrier to overcome.

A major challenge was a lack of affordable housing in certain locales. In particular, a strengthening economy drove up housing prices, while waitlists for Section 8 housing closed, or waitlists were five or more years long. While some participants relocated to outlying areas where rents are cheaper (and public transportation is sparse) others became homeless, or at risk of homelessness.

Care managers and other SED staff described referring participants to external or internal providers who specialize in providing housing assistance. Sites who referred participants to specialized housing assistance felt that they benefitted from assistance navigating the cumbersome and confusing process of applying for housing. They also felt that the professional connections housing assistance staff have allowed them to advocate effectively on behalf of participants. A care manager described a participant who needed housing for a family of eight. The care manager explained that there was no way her skills were up to the challenge of finding housing for this family. However, the specialized service professionals were able to locate subsidized housing for the entire family.

4.3 Disability Benefit Appeals and Reapplications

All SED participants made at least one recent unsuccessful application to SSA for disability income, as that was the basis of eligibility for the SED. Some participants ended their efforts to obtain benefits either before or during the study, while other participants continued to pursue disability income while enrolled in SED.

It is important to note that SED staff were not always aware of participants' applications and appeals to SSA for disability income. Some SED staff deliberately avoid asking whether participants are reapplying, and because there was no external way for site staff to know, they may learn about appeals and reapplications only if the participant tells them. An IPS specialist explained that she felt that a lot of participants who were appealing "might have the feeling, like 'we shouldn't tell her.'" Staff sometimes discovered by accident, or only when a participant finally brings it up. When asked whether participants on their caseloads had received Supplemental Security Income (SSI)/Social Security Disability Insurance (SSDI) or were in the process of appealing or reapplying, most staff said they were not sure, or that they knew of one or two cases even when site visitors were aware of more.

Influence on Engagement

Staff reported that it was common for participants who were appealing or reapplying for benefits to disengage with SED services. This is often at the advice of lawyers, but even participants who did not have lawyers were sometimes cautious about participating in employment services. Many participants believed that SSI or SSDI was more valuable than any employment they would be able to secure.

Site staff reported that most participants became less motivated to engage with IPS services if and when they started receiving disability benefits. Some participants completely disengaged; they did not return phone calls. One care manager described a particularly frustrating case in which a participant quit pursuing employment after receiving his award letter from SSA, even though he had job lined up after completing an entire training program. Other participants remained engaged after receiving a disability income award only with coaxing.

Even though most participants seemed to become less motivated to pursue employment once they received benefits, staff reported that a minority of participants become more motivated, and the motivation of some participants seemed unchanged. According to staff, participants whose engagement in employment services increased after receiving benefits recognized that the amount they received in SSI benefits was "too little to live on."

Site visitors' ethnography with a participant during two annual site visits may shed some light on why participants who receive benefits may engage more with employment services after SSA approves them. The first year we met with Susan (a pseudonym), she told us working was impossible because of pain. She said she could neither stand nor sit for long periods of time. She had received disability income in another state before moving to the catchment area of the SED site. Wistfully, she told us she could not afford to visit a pain management clinic because the intake fees were three to four hundred dollars, and the shots for pain she was currently receiving were useless. She did not believe that any treatment, beside painkillers, would work for her. She told us doctors had diagnosed her with Borderline Personality Disorder and Bipolar Disorder. On the CIDI, she indicated that she experienced symptoms of psychosis. Her demeanor belied her anger and frustration: she felt that SED services were not what she needed. The subsequent year when we met with her, Susan told us SSA had approved her for disability income. She was working towards completing her GED and, with her IPS specialist, exploring employment opportunities that might accommodate her impairments. While she still experienced pain, she decided to try physical therapy to manage it, rather than seek painkillers. Site visitors noted a change in her outlook—she was hopeful about her future—talking about possible employment she might like, and how she would save to take a trip to visit her adult sons. The stability of meager, but reliable, income seemed to provide enough security that she could plan for a better future.

Staff Strategies

SED staff described providing benefits counseling as a way to keep engagement with SED services for participants who were appealing or reapplying for benefits. Some SED team members explained that participants needed education to help understand their options and dispel the fantasy that benefits were adequate. Staff members talked about participants having a false sense of security, with "some people think getting benefits is the end…I think people think it's like the jackpot and you're just living large. I don't think they really know the truth." A SED benefits counselor explained that the part she "loves most" about her work is that she can educate participants on what they can do with an extra 500 dollars per month. She said she explains to participants, "If you go to work part-time and start working and earning some money, you're still going to get your partial SSI which means you still get your Medicaid." Providing information about work options to participants who were appealing SSI ensured that even if they made a decision not to work, "they're empowered, and they have the information." Perhaps not a typical strategy, an IPS specialist at one site said she will set up an appealing or reapplying participant to talk with other SED participants or clinic clients who have been through the same challenge of wanting to appeal or reapply and also look for a job. According to her, because it's a small town, "That's where the majority of their counseling comes from: their family, friends, and individuals in the community." A care manager said she works with participants to understand that they cannot realize their goals with benefits. She described a participant who believed he had no other options other than SSDI. He had searched for a job on his own prior to enrollment, and failed. She framed the conversation around the participants' stated dreams, and then noted that each of the participants' goals – buy a house, own his own business—would not be possible if he were on SSDI. She then had an opening to say, "instead of appealing this time, why don't we just give the employment thing a shot?" She was able to help this participant find full-time employment and affordable housing.

SED staff also described how they talk with participants about the benefits of work, such as improving participants' self-esteem; giving them something to do; making them feel like they're productive; getting them out of the house and not isolating themselves; putting "some money in your pocket," and finding something "fun for you to do, something that then you're going to feel good about contributing." One IPS specialist reported a different tactic to convince people to be receptive to work: He explained that it's good evidence for an SSI/SSDI applicantto try a job and have it *not* work out.

In contrast to challenging participants, some IPS specialists and care managers talked about taking care not to threaten participants' plans to obtain SSI/SSDI, and instead to remove the fear that the study will "make" them get a job. One team member described how he might say, "Hey, that's totally fine if you don't want to talk right now, but can we still? This is a free service; let's meet and talk about it. And maybe you don't want it now, but maybe you want it down the road, or maybe there's some other things we can work on like education, or whatever." An IPS specialist described her work with participants focused on SSI/SSDI as "always trying to drop those seeds," offering other options and opportunities. Several respondents talked about phrasing work-related effort as a "Plan B," something to have ready in case SSA denied their application. Backing off from talking about work and instead focusing on other services offered through the study, such as assistance with medical appointments, housing, and accessing food and clothing, was also a strategy that team members used to maintain a connection with participants who might later changes their minds about employment.

The Role of Support Networks

Guidance provided by disability attorneys is a major hindrance to participants' engagement with services. Many sites reported that participants told them that their lawyer has advised them not to look for jobs, not to work, and to withdraw from the study. One site reported that a lawyer dropped the participant's case when he learned that the participant enrolled in the study. Moreover, staff felt that participants had a "false sense of hope" when an attorney takes their case, believing "they wouldn't take my case if I wasn't going to eventually get it." Staff at one site believed that attorneys might be manipulating the system, holding off making a credible application for the participant for years until the participant was eligible for the maximum in back payment, and then, "somehow, their appeal goes through and they get disability." Staff claimed that this attorney-created "waiting period" increased poverty and stress for the participant. Team members described explaining to participants how much money lawyers will claim of back pay, and suggesting it might not be worth it to work with a lawyer.

In some cases, families pressure participants into pursuing benefits instead of employment. A care manager described a home visit with a participant during which the participant's mother – who receives disability income—yelled out, "All she needs is Social Security! That's all she needs. She don't need to work! All she needs is Social Security!" Across sites, we heard many other stories of recalcitrant parents who tried to discourage engagement with employment services. Under these circumstances, staff reflected that it may be difficult for participants to consider what work can offer. Team members relayed that it is difficult for participants to engage in job searching when their support systems are saying "Listen! Don't let them talk with you about getting employed! Then you're going to lose the money that you do have, and this is the only thing you have coming in." In response to families initially not wanting the participant to work, at least one site tried to educate family members as well as the participant.

5. Combined Service Usage

Team leads track face-to-face contacts with study participants each month using the Monthly Service Use Checklist. Working with team members, the team lead notes any reason why an enrollee was prevented from participating in face-to-face services, whether the enrollee had a face-to-face meeting (onsite or off), the number of face-to-face meetings, and the nature of each meeting as these pertain to employment, medical, or other social support services. The checklist data presented here concern general engagement in services over the 18 months of the study by the 1,035 participants in the Full-Service (n=505) and Basic-Service (n=530) treatment groups who were enrolled long enough to accrue 18 months since study enrollment. These data do not include the 922 enrollees with fewer than 18 months of study involvement, nor does it include the 40 enrollees found to be on disability benefits or participants found to have participated in another SSA demonstration before the study began.

Over the course of participants' first 18 months of enrollment, 89.2% of enrollees met face-to-face at least once with an IPS specialist; 82.4% met at least once with a care manager. Together, 92% of enrollees met face-to-face with either an IPS specialist or a care manager at least once over the 18 months. That leaves 8% (83) new enrollees that did not meet face-to-face with either an IPS specialist or care manager since enrollment. While we have no systematically collected data to illuminate the status of these 83 enrollees, there is substantial reporting from staff interviews that give relatively clear general understanding of the situation. Interviews with demonstration site staff clearly articulate the difficulty that staff had engaging – even for the first time – new enrollees in general. The handoff to sites did not always include a definitive contact date or time, and many new enrollees simply disappeared. With aggressive follow up using all contact information available, site staff found that many of these individuals were homeless, incarcerated, ill and hospitalized, and without transportation. Others indicated they were not interested in coming in – perhaps a reflection that enrollment was only for the incentive received.

General engagement data for face-to-face contacts with the IPS specialist or care manager appears in Exhibit 5-1 below. The graph details both Full-Service and Basic-Service contacts with demonstration site staff. Overall, the patterns are similar with little variation between the two treatment groups with regard to IPS or care management services. In the initial month (first month following enrollment) 60% of study participants had a face-to-face meeting with either the IPS specialist or the care manager. That percentage jumped to about 65% in month 2, but then dropped off over the next three months to around 50%. From month 5 through month 18 the percentage of participants engaged in face-to-face meetings ranged between 40% and 50%. IPS-only, care manager-only, and IPS plus care manager face-to-face contacts followed a similar pattern but with substantially lower percentages. IPS specialist contacts were the highest between 50% and 60% in the initial three months, but trailing off to the 30% to 40% range for the remainder of the 18 months. Care manager face-to-face contacts began near 40% in months 1 and 2, but then dropped off steadily over the next three months to the 25% to 30% range through month 18.

Exhibit 5-1. **General IPS or care manager engagement in 18 study months [Note: "months" below refer to the month since enrollment. For each participant, the first month is their first month of participation following enrollment.]**

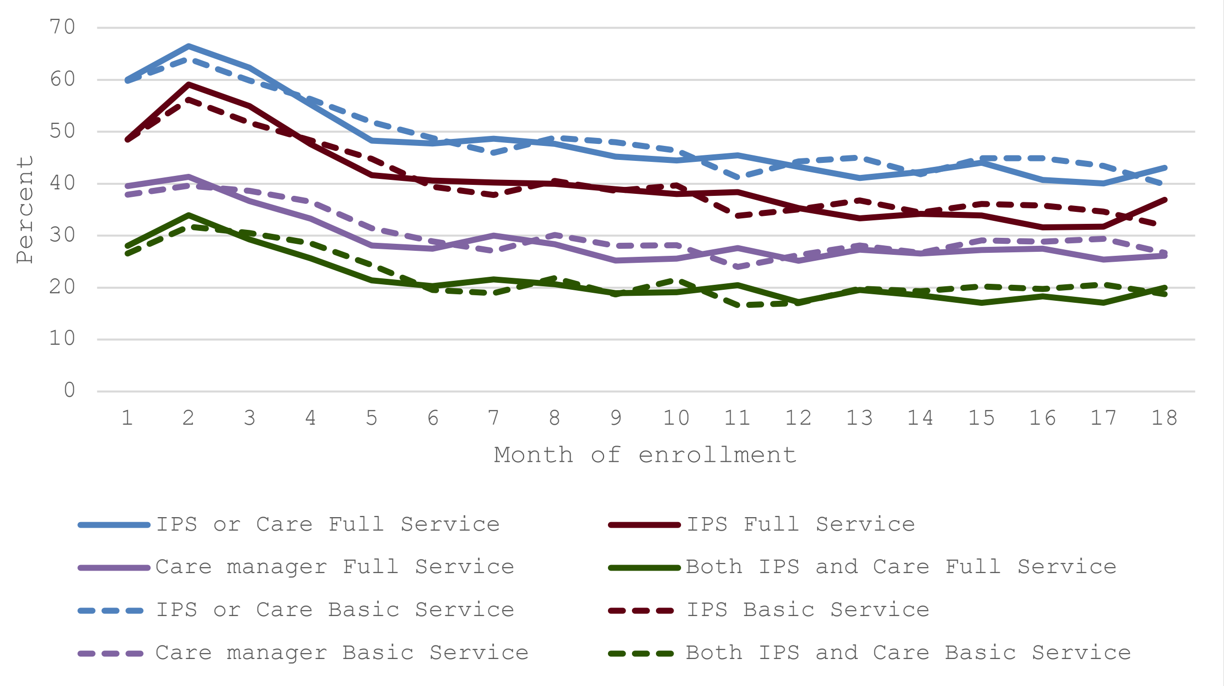
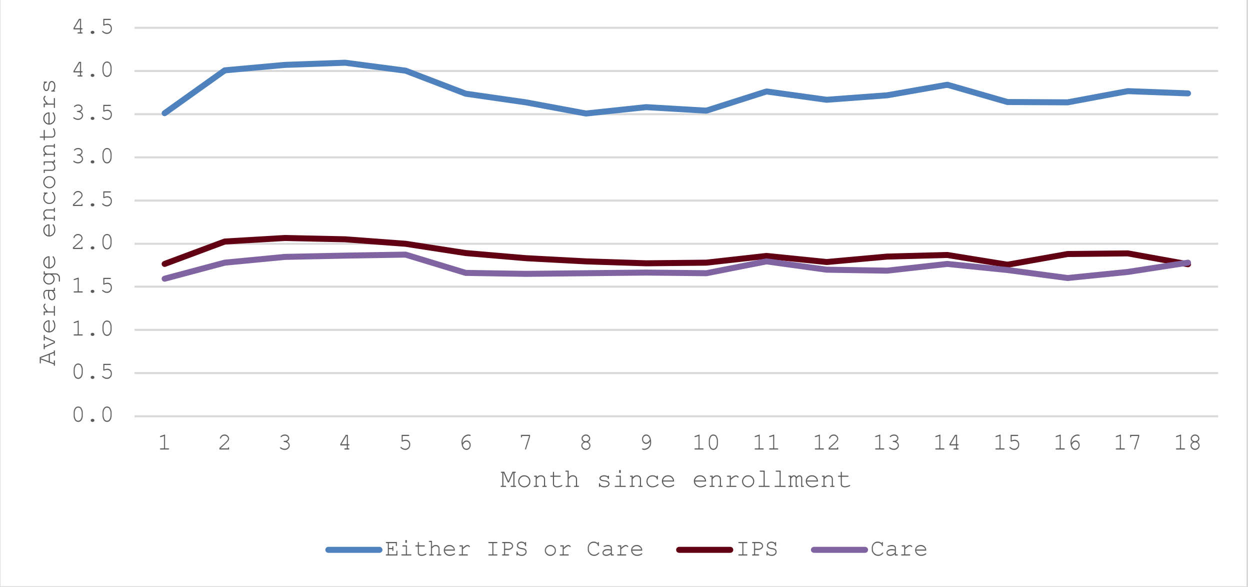


Exhibit 5-2 shows a plot of the monthly average number of face-to-face contacts with an IPS specialist or care manager over the initial 18 months of study participation. For participants with at least one contact with the demonstration site in the month, the average number of face-to-face contacts across the 18 months ranges between 3.5 and 4.1 contacts per month with either the IPS specialist or the care manager. The average number of face-to-face contacts with the IPS specialist ranges between 1.8 and 2.1 contacts per month. The number of face-to-face meetings with the care manager ranges between 1.6 an 1.9 per month.

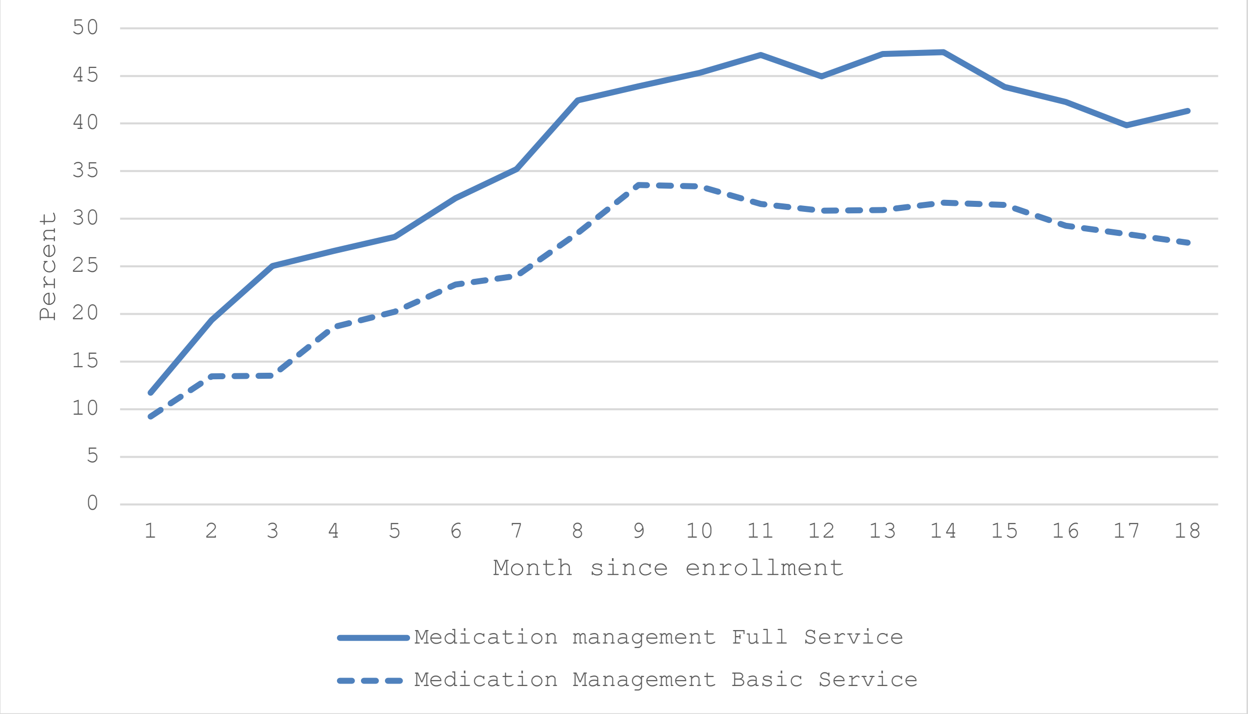
Exhibit 5-2. Average number of contacts per month for participants with at least one contact in the specific month (no-contact enrollees removed from each monthly analysis)



The Full-Service treatment group also had access to a Nurse Care Coordinator (NCC) who managed healthcare needs of participants. The Basic-Service group did not have such a person on their Treatment team. However, some had access to nursing services at their demonstration site. The NCC received training on a protocol addressing MMS as well as general healthcare support. Basic-Service support staff received no training whatsoever from the study and followed no study-approved systematic protocol.

Exhibit 5-3 shows the percent of Full-Service and Basic-Service participants with at least one MMS contact in each of the 18 months (Full-Service n=505; Basic-Service n=530). The trajectories of engagement for both treatment groups are similar; they begin around 10% and rise over the next 10 months to a high of 47% (Full-Service) and to 34% (Basic-Service), before falling off to around 40% in months 17 and 18 (Full-Service), and to the mid to upper twenties for Basic-Service participants.

Exhibit 5-3. Percent of participants with at least one monthly medication management engagement contact



6. Employment Services

Individual Placement and Support (IPS) Supported Employment (SE) services are the centerpiece of the SED intervention. Over 23 randomized controlled trials support the effectiveness of IPS, an evidence-based intervention for people with serious mental illness who desire to work (Drake et al., 2016). Over the past two decades, practitioners and researchers have refined the infrastructure, implementation, procedures, and funding requirements to sustain quality IPS services in agencies with integrated mental health care. The most recent manual used by IPS trainees, *IPS Supported Employment: A Practical Guide* (Swanson and Becker 2013) provides practical advice to service providers to implement high fidelity IPS.

IPS emerged from the field of psychiatric rehabilitation and shares with psychiatric rehabilitation a focus on shared decision making and client-centered care (Drake et al., 2012; IPSWorks.org). The core principles of IPS are:

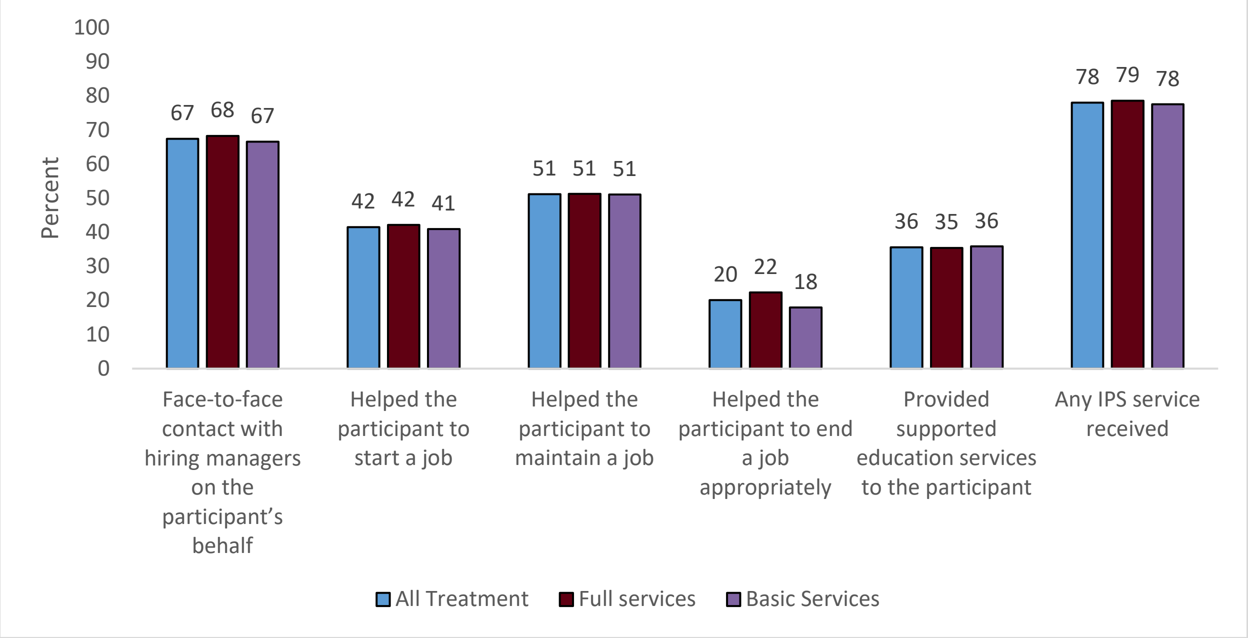
1. **Competitive Employment.** Service providers view competitive employment (as opposed to employment set aside for people with disabilities) as the goal for clients who want to work.
2. **Zero Exclusion.** Community Mental Health Centers (CMHC) exclude no clients from IPS because of symptoms, substance use, justice system involvement, job readiness, etc.
3. **Integrated Services.** IPS services integrate with mental health services.
4. **Worker Preferences.** Clients' preferences guide services provided, not clinical judgement.
5. **Benefits Planning.** Employment specialists help clients obtain information about how their earnings may impact their government benefits.
6. **Rapid Job Search.** The job search process is rapid; clients do not need lengthy assessments or training.
7. **Systematic Job Development.** Employment specialists develop relationships with potential employers on behalf of people on their caseload, and potential people on their caseload.
8. **Time-unlimited Support.** Support while employed ("follow-along supports") continue for as long as the client wants and needs.

6.1 Service Usage Rates

The Monthly Service Use Checklist identifies five key services that signify positive movement toward getting a job. Based on the perspective of the IPS specialist, these services include (1) face-to-face contact with a hiring manager on behalf of a participant, helping participants (2) start a job, (3) maintain a job, (4) end a job (appropriately), and (5) provide supported education to a participant. Exhibit 6-1 shows the percent of participants, including All (1,035), Full-Services (505), and Basic-Service (530), that received particular employment services from an IPS specialist during the initial 18 months of study.

Exhibit 6-1 shows the percentage of participants who received key IPS services from an IPS specialist at any time during their 18 months of study participation. Looking simply at the three bars for each service, it is readily apparent that there is little difference between the Full-Service and Basic-Service participants on the types of services received from their IPS specialist. The percentages receiving each service are nearly identical in all cases. Overall and across all 18 months, nearly 4 in 5 participants received at least one IPS service. Among the five key services monitored, face-to-face contacts with hiring managers on a specific participant's behalf was the service provided most frequently. Sixty-eight percent of the Full-Service participants utilized this service, while 67% of Basic-Service participants did. A little over half of all participants received help to maintain a job, while about four in ten participants had help to start a job. The IPS specialists assisted about 20% of participants to end a job appropriately. About one in three participants received some sort of supported education services.

Exhibit 6-1. Percent of participants receiving IPS services during initial 18 months of study for Full-Service and Basic-Service groups



6.2 Description of Services Delivered

Nearly all SED staff demonstrated a keen awareness of the principles of IPS, and gave examples of how they implemented them with SED participants. In the following sections, we report how these staff described their own implementation of IPS services with study participants, the challenges both they and their teams faced, and solutions to those challenges.

Identifying Participants' Preferences, Goals, and Tailoring Their Job Search

SED staff spoke at length about personalizing the job search process for each participant; that is, helping participants identify jobs they would like. A personalized job search is the central component of the fourth principle above, "Clients' preferences guide what services are provided, not clinical judgement."

Every CMHC in the study had an intake process for clients, and SED IPS specialists generally began to collect information on participants' preferences during the intake. IPS specialists reviewed participants' work history, recorded the jobs they have held, why they left, and asked them to describe what they liked and disliked about each job. They revisited participants' opinions and experiences of previous jobs again when they helped them write a resume, which served as a second opportunity to learn about participants' work experiences.

Eliciting participants' work preferences was not always easy. We observed one meeting between a young woman participant and her IPS specialist in which the IPS specialist tried a few different ways to help the participant identify what kind of work she would like. Instead of interpreting questions such as "What would your ideal job be like?" as asking what *kind* of job she prefers, the participant responded by describing interpersonal problems at previous jobs she wished to avoid. For example, she said that a job with "good communication" is necessary for her, because she does not want to be "let go without warning."

Nevertheless, it is very important for IPS specialists and participants to understand what work expectations and work environments might be suitable and unsuitable. One IPS specialist said she asks participants to describe their "triggers": "And then when they tell me what their triggers are, I automatically say, 'Okay these [employment opportunities] won't work because these are your triggers.'" Some participants prefer work environments where they interact with others; other participants want to work alone and not interface with the public. Because some participants take psychotropic medications, they might experience daytime drowsiness. Staff reported that other participants preferred to search for a job that begins in the afternoon or evening. According to staff, some participants with physical impairments began the job search process convinced that they could never work again. Rather than succumbing to the idea that no job was possible, IPS specialists worked with these participants to think about less physically demanding jobs they might like and be able to do.

SED staff and participants sometimes viewed less-desirable jobs as stepping-stones to better jobs. For example, one IPS specialist reported working with a participant who had no experience and no high school diploma or GED The participant wanted to become a receptionist. After discussing with her IPS specialist, she decided to take a job as a fast food worker to begin building work experience while she finished her GED, with the eventual goal of pursuing a career as a receptionist. Regarding building a resume with jobs participants do not intend to keep, another IPS specialist at a different site explained, "If I take this initial job right now, it's not going to be my forever job, but it could be a step to lead to the next job…. And talking about employment more as a pathway, rather than an outcome." Staff also reported that participants took jobs they did not want because they were desperate for work. Staff viewed these "survival" jobs as stop gaps until the participant could find work in the career path of interest to them.

Many IPS specialists discussed helping participants set reasonable goals for employment. Sometimes participants had goals in mind that for which they did not have sufficient education or experience to qualify. An example that more than one IPS specialist gave were participants who wanted to be doctors. One IPS specialist explained that he handles this situation this way:

> We never shoot down a dream if that's what you want to do. Let's pursue it…what does being a doctor mean? What does being a doctor look like? … Because a doctor could be having a position where you wear a coat, and so if that is what it is, we work…with the participant to better identify…what the goal job is, what would you like to do? What are you willing to do outside of the targeted job?

Not only do IPS specialists help participants assess how their skills and experience might help them achieve their goals, they also assess how other considerations might influence their ability to meet their employment goals. For example, one IPS specialist reported that they have some participants who want to work full time, but who are experiencing a number of crises that make working full time unrealistic until the crises resolve.

Frequently, staff mentioned that SED participants were dissimilar to the type of client typically served in the IPS model. The 2013 IPS training manual assumes the client is a person with serious mental illness who has seen a prescriber and caseworker for at least a brief period before expressing a desire to return to work and beginning involvement with IPS. We assume that this "typical" IPS client has established secure housing, a source of income, and stable health. In contrast, staff reported that many SED participants began receiving IPS services while in the midst of crises: housing instability, coping with untreated physical health conditions, untreated mental health conditions, and no reliable source of income. IPS specialists occasionally found themselves trying to manage the unmet needs of participants. As one IPS specialist explained, "I'm trying to deescalate her [the participant] on some situation that happened at home, versus really talking about employment." Another IPS specialist put it bluntly, "Stuff gets out of order: we're not going to work on a vocational profile if you don't know where you are going to stay."

Developing Confidence in Ability to Work

One robust reoccurring theme of the interviews with SED direct services staff members was that providing support and encouragement to participants is among the key ingredients necessary for success with employment. For example, when asked what helped participants be successful in reaching their employment goals, an NCC said, "It's the support, it's the support, it's just being human!"

IPS specialists described some strategies to help participants develop confidence. Several described breaking down the job search process for participants to help them accomplish their goals step-by-step. For example, an IPS specialist said that if she is "slowly encouraging them and offering assistance for something that doesn't take long, or is simple to fill out, then they [participants] realize, 'Oh, there is somebody out there that can help,' and they start to do a little more on their own." Most staff reported that the key to helping participants develop confidence is to maintain the attitude that participants can be successful: "The biggest thing is staying positive. Saying 'Well, you can do this. You totally can!' It's the biggest thing. [When you are] real positive with them, they are willing, and seem like, 'Oh yeah, I can do it.'"

Staff explained that a number of SED participants have never had supportive people in their lives. One care manager, reflecting on what makes her SED team successful said, "Many of these people [SED participants], all they need is somebody in their corner just saying, 'I think you can do it.' It's amazing how many people have not had that ever. It's been amazing to see how far somebody goes when they do have that." At another program, a care manager described how transformative it can be for someone who has received little support in their lives to receive care:

> I had one [participant] who wore these baggy, horrible clothes and just looked like… I was like, "gosh girl!" and then, the other day, she's got makeup on, she's ready to go out to work and she's feeling good about herself…. It's about having that team all working with her; it's about going to those appointments and feeling needed and wanted and cared for.

Staff described some participants as "beat down" and told repeatedly by the people to whom they are the closest that they cannot succeed. Some participants reported to SED staff that their parents or significant others convinced them over many years that they were not capable of working. Staff reported that these participants had a strong negative self-image that they needed to help them overcome with encouragement and focusing on their strengths and resiliency.

SED staff explained that other participants described bad experiences at work, usually bullying, which made them fearful of putting themselves in another workplace where they might be vulnerable to intimidation or harm. Some participants had become overwhelmed with the pace of work at previous workplaces and been fired, which made them anxious about trying a different job. Others reported to SED staff that they had a career at the time they became ill or impaired, and had lost their job due to poor performance. For example, an IPS specialist told us he worked with a participant who had a traumatic brain injury following a car accident. The participant previously worked as a graphic designer. After recovering from acute injuries, he took a job in his field and was fired. The IPS specialist said that a lot of the work they did together was helping him regain his confidence to try again. The participant eventually found a job on his own in the graphics design field making as much money as he had been before his injury.

Managing Interpersonal and Behavioral Issues

IPS specialists explained that part of their work involves helping participants manage their feelings and behaviors during the job search, interview process, and while on the job. Frequently, staff reported that participants had difficulty managing conflicts with supervisors and coworkers. Other participants needed assistance in advocating for themselves when conflicts arose. Still others needed instructions in how to behave appropriately in the workplace.

Reviewing participants' past job experiences is important for learning about the patterns of behavior or interpersonal difficulties that may affect participant experience in future jobs. IPS specialists reported they found that some SED participants did not have insight into the reasons why they lost a previous job. Staff reported they needed to proceed carefully with these participants; they frequently framed discussions of the circumstances that led to dismissal as "learning experiences."

For example, a team lead explained that she tells participants, "Let's sit down and figure out what didn't work, what we need to put into place to make it better in the next attempt, what it's going to take to make that next job work for you." Another IPS specialist explained that the goal of discussing jobs lost in the past with participants who are having difficulty understanding why they were let go is "address…it in a way that the client feels empowered to make a change, whether they take responsibility or not."

IPS specialists described trying to maintain good rapport while gently confronting participants' problematic behaviors. For example, one IPS specialist said that she was working with a participant in his late forties who lost every job he has ever held for making misogynist, homophobic, or racist comments. When told that his comments were offensive and inappropriate, he became agitated and defensive. She reported that her strategy with him has been to remind him that he should keep his statements about other people in the workplace positive. She explained that she hopes he will eventually internalize her advice, so that when he is at work he would say to himself, "Maybe I shouldn't make negative or derogatory comments about a coworker whose lifestyle I don't agree with...."

Because of the difficulty some participants had with identifying the reasons they had lost jobs, IPS specialists sometimes sought permission from participants to speak with their former employers. IPS specialists would talk with the employer about what happened that resulted in the participant being let go, and any suggestions they had for how the IPS specialist might help the participant keep future employment. They also asked about participants' strengths so they could focus on finding jobs for the participant that played to their strengths.

Site Visitors learned that IPS specialists worked with some participants to manage negative impulses while at their job site. A common scenario with participants was they lose a job because of an angry outburst. For example, an IPS specialist helped a participant redirect anger at customers, coworkers, or his supervisor at the Dollar Store by going into the bathroom and screaming in the mirror when he became overwhelmed. Some IPS specialists reported that they help participants who had recurrent problems managing anger to avoid work settings that might trigger an outburst. For example, one IPS specialist worked with a young woman who was working in fast food settings and consistently getting into fights with her coworkers. The participant decided, in discussion with the IPS specialist, to try to avoid working with other young people in high-pressure settings.

Many IPS specialists discussed needing to help participants develop interpersonal skills and an understanding of work culture sufficient to succeed in a job. For example, IPS specialists explained to participants that when they had to miss work due to a doctor's appointment or sickness, they needed to inform their employer. Another IPS specialist reported that she role-played with a participant who wanted more hours to practice how to ask for this and strategized how he would respond depending on the boss's response.

SED staff reported that participants sometimes struggled with the authority of their supervisors. An IPS specialist gave the example of a participant who responded to her supervisor's instructions poorly: "Like instructions—she takes them as being bossed around, being treated unfairly…. Little by little she's [starting] to understand this is how it is at a job environment." Another IPS specialist described sitting with a participant while she interviewed for a job at a restaurant who had difficulty responding to questions appropriately. The IPS specialist recounted the interview:

> The manager asked her, "Well, how did you hear about the job?
>
> And she said, "Oh, I was locked up with [employee]…. She referred me here…."
>
> She [was] giving out too much information. Then it went down, so every time she opened her mouth…. Then, he's like, "So, what do you know about the dish washing business?"
>
> She said, "Oh, I love to clean them."
>
> I'm like, "Okay, that's a good answer."
>
> And then she's like, "I have eight kids…. They're all with the state now."

Unsurprisingly, the manager did not hire the participant for the job. After this interviewed, the IPS specialist said she talked to the participant about not sharing everything about herself, just what the manager needed to know.

Supporting Participants' Employment

What the IPS community refers to as "follow-along supports" include a variety of activities to help participants succeed in their job once they find employment. Following the model, once a client has a job, the IPS specialist should continue to meet with them at least once a month, and adjust the frequency depending on participants' needs and choices (Drake et al., 2012; IPSWorks.org). Support for employment might include everything from working alongside the participant to help them learn their tasks, to mediating at workplaces on behalf of participants, to serving as a sounding board for participants venting about workplace problems (Swanson and Becker 2013).

A recurring theme of the interviews, especially during the second year of site visits was the difficulty convincing participants to continue meeting with the IPS specialists after they entered a new job. Some IPS specialists felt that "dropping-out" of contact once employed was more likely for SED participants, in comparison to other clients at their CMHCs or other social service organizations. IPS specialists described participants as less socialized to continue receiving services from the CMHC than other clients. They described needing to explain to participants the benefits of ongoing support from the IPS team. IPS specialists conveyed to participants that they could help problem-solve situations at work, and they could mediate with the employer around sticky interpersonal issues or accommodation requests if the participant desired. An IPS specialist described how she entices participants to continue to engage in the following: "It seems [in] the SED study, once they get a job, they don't want to meet with me anymore. It's like pulling teeth. Sometimes I'll say, 'Okay, how about I pick you up from work, or how about I take you to work?' IPS specialists worried that participants who did not receive consistent follow-along supports might delay seeking help until a problem at work is insurmountable and they lose the job.

IPS specialists urged participants to continue meeting with staff. They encouraged participants to allow the staff to help them manage any issues at the workplace before they become big problems with the advice: "Don't wait until it's too late and your job is gone." IPS specialists found it was helpful to participants to continue working on interpersonal skills, communication, and assertiveness after the participant found work. One IPS specialist explained that this phase of service delivery entailed "a lot of teaching and coaching and role-playing." As described above, some IPS specialists coached participants how to respond appropriately to authority in the workplace. Participants also needed help learning how to assert their needs in an appropriate way. This involved requesting time off, a schedule change or an accommodation for a health condition or an impairment. IPS specialists used a range of strategies for helping participants receive what they needed, including coaching the participant through role-play before the participant makes the request, accompanying the participant while they speak with their supervisor about the request, or even making the request of the supervisor on behalf of the participant.

A large part of providing support to employed participants was allowing them to vent about troubles at their workplaces. An IPS specialist describing the ways she provides support explained, "Sometimes it can be more of being a cheerleader. They're having a rough day [and] just answering the phone and talking them through that rough day."

Sometimes participants expressed to their IPS specialists that they felt their manager disliked them or that their treatment was unfair. In these cases, IPS specialists sometimes offered to talk with the manager to find out from their perspective what might be happening. For example, an IPS specialist explained that she "makes it very discreet, where it's not like, 'Hey she thinks you're really getting on her all the time." It's more like, "Is there anything she can do to improve their productivity at work? How can I help?" Frequently, the manager is quite pleased with the employee, but when they are not, the IPS specialist described trying to present the manager's complaints in a constructive manner. For example, one IPS specialist explained, "Sometimes hearing it straight from the employer, it doesn't always come out the best, but you have that middle person to reword things. We know our consumer's personality; we can reword in a way that they will take it better."

IPS specialists had different philosophies regarding how much they should advocate on behalf of participants, with most willing to go to lengths to ensure participants remained in good standing with the employer. IPS specialists mediated between the participant and others at the workplace to resolve interpersonal problems, requested accommodations for participants, and even worked with the employer to modify the duties of the job. In the case of one participant who was having trouble setting beds for her hotel cleaning job, the IPS specialist and the participant talked with the manager about changing her responsibilities. The IPS specialist explained

> We had a lady that was working at a hotel and she was having issues doing the bedspreads. She was like, "I cannot do this duvet cover," which neither can I. She had just decided to throw in the towel on this. Well, we're like, "Hold on, they say that you're so good with all these other things, let's see what we can do." We went and talked with her employer and…they were going to let her clean all the bathrooms, and do all the soaps and stuff like that, and the laundry part of it and bypass the duvet covers.

Advocating directly with employers on behalf of participants required the participant give their consent for the SED team to share basic information about their participation in Supported

Employment. IPS specialists discussed with participants the benefits and disadvantages of disclosing their personal situations and what they are comfortable with the IPS specialist sharing about them with an employer. IPS specialists described revisiting the possibility of disclosing to participants' employers during employment, particularly when the IPS specialist thought they could help the participant by meeting with the employer.

IPS specialists said they explained to employers during job development that they can contact the IPS specialist if they are experiencing an issue with a participant. According to the SED teams, employers really appreciated this arrangement. One staff member explained that when she took a participant to an interview at a local business, the managers were "totally fascinated with this whole project, like, 'Wait a minute—so if he has issues that we see, we can call you guys and you can help?' 'Yeah, I mean, our job is to help him keep his job.' She was like, 'That's fantastic.'" Many IPS specialists reported that it was not uncommon to receive a call from an employer who wanted the IPS specialist present at a meeting between the employer and participant to address some behaviors that were disruptive in the workplace.

Developing Jobs

When speaking of job development, IPS specialists referred to three activities. The first involves the IPS specialist visiting businesses where participants on their caseload might be interested in working. During the first visit (or, in IPS parlance, the "first cup of tea") the IPS specialist seeks information about the business and tries to set up a time to speak with the hiring manager. The purpose of visiting the hiring manager is to understand the work available and the work environment so that the IPS specialist can match participants who might be interested in the work, able to perform the required tasks, and comfortable with the business culture. IPS specialists doing this kind of job development usually have a participant in mind to match to the business, and the purpose of job development is to assess whether the business is a good fit for the participant. The second type of job development activity involves the SED participant and the IPS specialist visiting the business together. When the IPS specialist job develops with the participant, the participant has consented to disclose to employers that they are receiving job coaching from the IPS specialist's organization. Sometimes, the IPS specialist already had developed a relationship with the employer and believed that the participant would be a good match to available openings at the business. In other instances, "job development" might occur spontaneously, for example as part of a trip to scope employment opportunities in the geographical area the participant can realistically travel to and from. The third type of job development activity mentioned was visiting a work site without a participant and with no specific participant in mind. In this case, the IPS specialist may not have known enough about the business to have a good match in mind.

Job development usually takes place in person at the place of business. IPS specialists most frequently spoke of conducting job development at retail and fast food establishments, restaurants, manufacturing plants, and warehouses. Businesses offering services that IPS specialists frequently sought to include in job development efforts included home health care, hotel laundry and housekeeping, and reception and light clerical jobs. IPS specialists described asking about the type of work that they do at their business, the work environment, the type of job candidates that tend to make good employees, and the employee skills and characteristics they prefer. Once they have spent the time to learn about what the manager wants and needs, IPS specialists reported that employers tended to take seriously any referrals of job candidates they made to the business.

IPS specialists described job development on behalf of highly skilled participants as more difficult than job development for entry-level work. Gaining access to hiring managers who might make decisions about employing information technology (IT) technicians, teachers, nurses, accountants, etc., was quite difficult. IPS specialists who sought to develop higher-level jobs found that they needed to be "a little more formal about it, rather than this informal dropping in on people." IPS specialists frequently called or emailed employers to learn about employment opportunities at these levels. Some IPS specialists working in high-income, urban areas on behalf of highly-skilled participants found it very difficult to get past business' gatekeepers to meet with a hiring manager who might have an employment opportunity suitable for someone with specialized education and experience. For example, an IPS specialist described a participant who had worked as a graphic designer for five or six years. By chance, the IPS specialist learned that her spin instructor's husband worked at a business that produces art for hotels. The IPS specialist described her experiences trying to speak with a hiring manager as unsuccessful: "I went in there and chatted with someone.... They gave me an email address. I exchanged emails with someone a couple of times, but just never was able to arrange a sit-down with someone who actually informs the hiring decisions." Job development and job coaching for participants with skills in information technology (IT) were especially difficult. During a team meeting at a CMHC, site visitors observed a discussion about asking an IT person at the CMHC to review the participant's resume, as the SED Team members did not understand the specialized jargon the participant used to describe his skills.

The challenges of developing jobs in rural areas are somewhat different than in urban areas. IPS specialists who developed jobs in rural areas sometimes referred to communities as "tightknit," where "A lot of times you'll know someone in common [with the hiring manager], or you'll have something in common, and it's kind of easier to find a link that helps them build that trusting relationship with you." Unlike in urban areas, where hiring managers seemed more elusive, staff described employers in rural areas as taking time with IPS specialists and participants to explain their businesses and opportunities.

The most problematic feature of rural job development was the low density of jobs available. This made finding suitable employment opportunities for participants without transportation difficult, if not impossible. One Team located in a rural area in the northern US described the local town as a "farm town," with "fields of nothing" if a participant could not work as a farm hand. As military bases tend to be located in rural areas, sometimes they provide good options for job development. However, nearly half of participants cannot consider work on a military base because their prior involvement with the criminal justice system precludes gaining the security clearances necessary.

IPS team members made a distinction between "survival jobs" and jobs that are part of a career trajectory. Survival jobs are inevitably entry-level, poorly paid, and cannot be used as a stepping-stone to launching a career. As one IPS specialist put it, a survival job is "something to earn a paycheck in order to eat…. That's not a career you're necessarily looking to build." IPS specialists might help a participant take a survival job, such as working in a fast food restaurant, in order to build some work experience, or if the participant needs cash immediately. Another IPS specialist explained, "If they're on the verge of getting kicked out of their apartment or whatever, and they need to just find a job now…we may get you into a job just so you can get some bills paid, but we can continue working on what that dream job is, what…is going to give you a lot of satisfaction in the long term." Some IPS teams lamented to the site visitors that all the employment opportunities that seemed available in their communities seemed to be survival jobs. In one rural area of the southeast, the poorest participants were most likely to live in the most rural areas without access to transportation. This IPS team despaired of placing one participant in particular who lived "literally in the middle of chicken farms" with no transportation, and the nearest commercial area—with only fast food and other survival jobs available—a twenty minute drive by car. An IPS team located in an expensive, urban area said that they take into consideration the cost of living in the area and the amount of money people need to earn in order to manage. They try to job develop only in industries and with employers that will provide a living wage.

One of the most robust themes elicited from discussions of job development among SED teams was how to manage employer stigma towards people with mental health disorders. Most IPS specialists said that they did not identify themselves as inquiring about employment on behalf of people with mental illness. Instead, IPS specialists were more likely to identify their job as "helping people get back to work," or as "working at a nonprofit…[that] helps people find jobs." As the IPS specialist gets to know the business and the hiring manager more closely, they may provide a business card. Once the employer sees the organization the IPS specialist works for, they sometimes reacted negatively. One employer inquired of the IPS specialist who had described a participant that she thought was a good match, "What's wrong with him? Can they do this work?" Even less restrained were other employers who said, for example, "Oh, those people [at the CMHC] are crazy." In any case, IPS specialists felt that employers' expressions of prejudice against people with mental illness were an opportunity to provide some education. If the IPS specialist felt they were not receptive to the idea of hiring someone with a mental illness, they knew not to send participants to the workplace.

6.3 IPS Fidelity Results

The core principles of the IPS model appear throughout the IPS Fidelity Scale. The fidelity review team employed the standard, 25-item IPS Fidelity Scale (Becker, et al., 2015) to rate each site in 2018 and 2019. Assessors rate each item on a 5-point behaviorally anchored dimension, ranging from 1, representing lack of adherence, to 5, indicating close adherence to the model.

In 2018, the fidelity assessment ratings captured sites at the point of start up with the SED study and early in their work with SED participants. The majority of sites (17 or 57%) scored 'fair fidelity' with a mean average of 90 (out of 125) on the IPS Fidelity Scale. Eight sites lost eight or more points for not having enough clients working to assess specific fidelity items. As hypothesized, the 2019 sites were fully operational and able to be rated on all fidelity items. Overall total average fidelity ratings increased from 95.8 in 2018 to 100.3 in 2019. Fidelity assessment ratings demonstrated improvement in 12 sites (40%) with 60 percent of sites achieving good or exemplary IPS fidelity and the remaining scoring fair fidelity. Sites with improved fidelity ratings showed positive changes in staffing, supervision and executive team support as well as a deeper understanding of the IPS model.

Issues related to the initiation of the research study, including ongoing enrollment of participants resulting in changing caseload sizes, onboarding of staff and supervisors, staff turnover, and engaging and responding to the unique characteristics of SED participants impacted the 2018 IPS fidelity ratings. In 2019, full staffing along with full targeted enrollment sites demonstrated evidence-based IPS. Full results of the fidelity assessment appear in the companion report, *Supported Employment Demonstration Summary of 2018 and 2019 Fidelity Assessment Ratings.*

7. Other SED Services

While employment services are the centerpiece of the SED intervention, as assisting denied disability applicants with employment is the impetus behind the demonstration, wraparound services frequently were at least as important as employment services for participants to achieve their employment goals. As discussed above, many participants began the SED with unmet basic needs that they wanted to address before seeking employment. In this section, we discuss some of the wrap-around services provided to participants, including Care Management, Nurse Care Coordination, Technical Assistance and Quality Assurance, Psychiatric Consultation, Referrals, and Reimbursements.

7.1 Care Management Services

Care managers work with both treatment teams to provide and help coordinate behavioral health care and other practical needs of study participants. At a minimum, care managers assess participants' needs related to mental health care management, short-term supported education, social skills training, financial assistance, housing assistance, substance abuse counseling and treatment, family counseling and legal assistance. The study protocol expects care managers to build on their skills to engage participants in a therapeutic relationship, work in unison in a multi-disciplinary team, practice treatment integration, ensure individualization of needs, and provide client-centered and culturally-competent services.

When asked about the activities conducted for the SED project, care managers generally described their work as twofold: providing referrals, and providing services directly to participants through Problem Solving Therapy (PST), a standardized, evidence-based method for assisting participants to address everyday obstacles with shared decision-making and simple cognitive-behavioral strategies.[2]

Service Usage Rates

Treatment group enrollees have access to a wide variety of social services, typically through their care manager. These services include (1) housing, (2) medical care, (3) substance use reduction, (4) legal, (5) financial, (6) symptom management, (7) family education, (8) peer support, and (9) practical skills training. Exhibit 7-1 presents a display of the percentage of each treatment group engaging in key care manager services. Again, as with IPS services, both Full-Service and Basic-Service enrollees received similar services. There is not much noteworthy about expected service needs between groups, nor did we expect that the two groups would evince dissimilar service patterns. Six in ten enrollees received practical skill training, and six in ten received symptom management help. These services appeared to be the most provided/requested among enrollees. Nearly half of all treatment group participants required assistance with medical care; and four in ten required help with housing.

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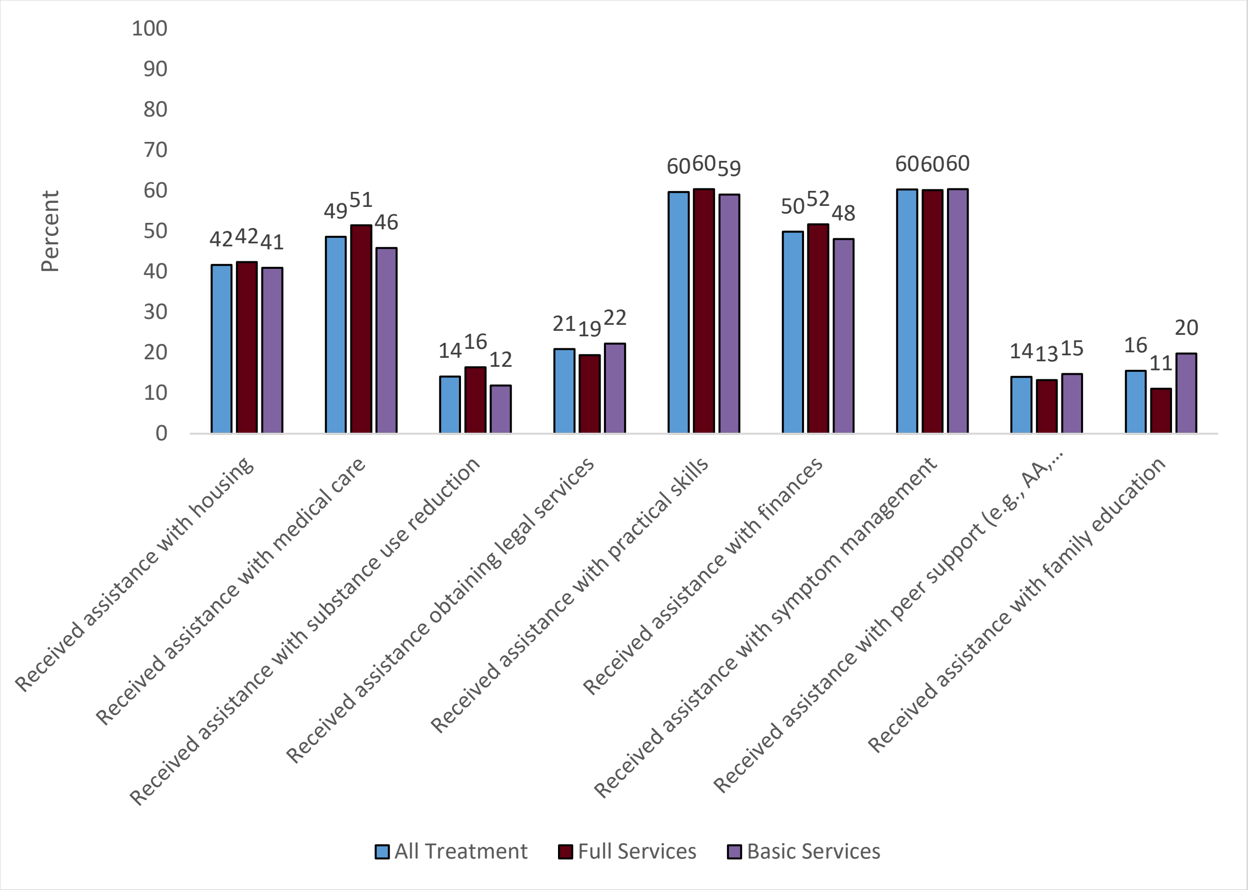
[2] Westat, with support from the U.S. Social Security Administration (2017). Care Management for the Supported Employment Demonstration project.

Less common service needs included legal services, substance use reduction services, peer support, or family education. Between 10 and 20 percent of enrollees engaged in each of these services.

Exhibit 7-1. Percent of treatment group enrollees engaging in key care manager service areas



Care Coordination

SED participants often entered the study with limited past engagement with mental health and social services, and are in need of immediate referrals for a wide range of services. A major component of the care managers' job is to provide referrals for resources in the community and help participants connect with these referrals, including by transporting them or otherwise walking them through engagement processes. In many cases, these services are to address participants' priority needs, such as housing or food security.

Several care managers experienced in providing therapy noted that addressing immediate needs often takes precedence over therapy, even when they can immediately tell that an individual could greatly benefit from individual therapy. A care manager explained

> When I meet with the participant and I get into the background, I already know this person can really benefit from individual therapy. In order for

> them to participate in individual therapy, I need to make sure that the basic needs or that hierarchy of needs are being met. If those are not met, then I can't have a person fully present to participate in individual therapy. As I meet with each participant, I'm assessing where the need for case management is. If it's something that can be readily and easily linked out, I know that's being addressed. I provided the linkage. Now let's focus on the mental health piece of it.

Care managers reported providing referrals and coordination across all the basic areas of need. Across sites, care managers often spoke of providing housing assistance or referrals to participants recently evicted, currently living in a shelter, with unscrupulous landlords, or living with family in unhealthy relationships, among other situations. In addition to referrals, care managers described developing creative solutions to housing shortages, such as exploring possibilities of participants finding roommates, and educating participants on the apartment application process and the realities of what type of housing they can afford. In addition to providing direct financial assistance to participants, such short-term support for rent or utility bills, care managers also described working with participants to increase their financial literacy and develop payment plans.

Lastly, for participants in the Basic-Service treatment condition, who do not have access to the NCC, care managers reported that coordinating physical and mental health services for participants was another large aspect of their workload. This includes connecting participants with therapists, scheduling appointments, transporting participants to appointments, providing co-pays, and addressing health-related needs, such as obtaining glasses.

7.2 Nursing Care Coordination and Medication Management Services

The NCC is an integral member of the Full-Service team who participates in weekly team meetings. The primary role of the NCC is to ensure that Full-Service participants receive evidence-based MMS. At the beginning of the study, Westat conducted a training for the NCCs that included a comprehensive review of evidence-based standards for psychiatric medication management.

As per the study design, NCCs were to meet with each Full-Service participant within 30 days of their enrollment and conduct an assessment, the results of which they record in the MMS Report. This assessment includes reviewing medications the participant is taking, adherence and side effects; conducting psychological screens for depression, anxiety, PTSD, Attention Deficit Hyperactivity Disorder (ADHD), and substance use; checking vital signs; and ordering laboratory test as needed. The NCC gathers consent from the participant to contact prescribers and send results of the screens.

Thereafter, NCCs met with the participant at least once every ninety days over the course of their SED enrollment. One week before each appointment with the prescriber providing psychiatric medications, the NCC meets with the participant to complete the MMS Report, which the NCC sends to the prescriber. The NCC asks the prescriber to fill out a report on the appointment with the participant detailing changes in medication, dosages, or other treatments at each appointment.

In practice, the NCCs took on a wide range of roles. Because participants have multiple comorbidities, and frequently lacked social support, housing, basic necessities, and access to medical care, NCCs helped participants with more than MMS. They assisted participants with making appointments with primary care, psychiatric services, and specialty medical care. They provided transportation to appointments. NCCs accompanied participants during appointments, and ensured that the doctor and other medical personnel heard participants' concerns. They sorted medications for participants, assisted with wound care, and provided psychoeducation. They instructed participants on nutrition, smoking cessation, and weight loss. One NCC even grocery shopped with a participant and then demonstrated how to cook a healthy meal. Some NCCs supported the efforts of the IPS specialists by suggesting job opportunities.

Site visitors noted variability in the way sites integrate the NCC position into the provision of SED services. Some of this appears related to the complex needs presented by participants. However, variability in the number of hours sites allocated the NCC to the SED also created differences in the intensity and types of service provided.

Sites ranged in the amount of dedicated time the NCC spent on or with SED clients. This variation may contribute to differences in the degree to which the NCC feels overwhelmed, is able to keep up with assessments and regularly contact participants, and how frequently he or she is able to attend appointments with participants and engage in other activities in the community, which require more time. In general, most NCCs working full-time on the SED were located in the "full" sites, but not exclusively, and some full sites had less than full-time NCCs. Even in Year 2, when enrollment was complete, there were four full sites that were managing with an NCC that was less than 1 FTE; there were also 3 half sites that did have a full-time NCC (see Table 7-1).

Table 7-1. Number of sites by NCC time dedicated to SED

NCC FTE	Year 1		Year 2	
	# half sites	# full sites	# half site	# full site
Less than .50 FTE	5	3	4	2
.50 FTE	3	4	3	1
.75 FTE	0	3	0	1
1 FTE	2	10	3	16

Note: One site engaged two NCCs. Data above reflect their combined FTE.

Providing Medication Management Services

NCCs need to assess whether the psychotropic medication prescribed to participants is evidence-based, and should help providers avoid unnecessary polypharmacy. Liaising with prescribers to ensure that all Full-Service participants receive only evidence-based treatment is among the most critical tasks of the NCC.

As an example of the kind of work the NCCs do to coordinate evidence-based care for participants, one NCC described a participant who was seeing a psychiatrist and a pain management specialist:

> She's on a lot of different medications and she asked the psychiatrist for Ambien…for sleep. She has difficulty sleeping and the psychiatrist did not want to prescribe that for her. [The psychiatrist] felt that with her

> medication regimen, it was not good—worrying about CNS depression…. Then in my conversation with the client, she goes, "Oh yeah, I went to the ER and I got prescribed Ambien." Then in my mind, "click." I immediately talked to the psychiatrist and said, "Listen, [she] is getting it from the ER doctor," so they can have that conversation. That initiated the psychiatrist to call her pain management specialist, and come together, and consult and figure this out with her.

In this instance, the NCC identified that the participant's medication regimen—prescribed by more than one doctor—was not in conformity with evidence-based guidelines for medication management. She alerted the prescribers who then worked with the participant to design a safer and more effective treatment.

Some prescribers are employees of the SED site, or the same organization as the site (i.e., "internal"); others prescribers are external to the host organization. NCCs and other SED staff reported that "internal" providers were nearly always responsive to NCCs' requests to share information and documentation. Multidisciplinary collaboration was usually already part of these sites' workflow, in which prescribers have regular meetings with other members of clients' treatment teams. It was not difficult for the NCCs at these sites to work with their prescribers to meet SED requirements for medication management. Further, at most sites with electronic medical records, NCCs have full access to internal prescribers' records, obviating the need for prescribers to create documentation specific for the SED.

However, some participants utilize prescribers external to the site for their psychiatric treatment. Some participants had pre-existing relationships with external prescribers that they wanted to maintain, which was their prerogative. Other participants receive SED services at sites that do not include prescribers, necessitating outside referrals for psychiatric care. Some sites with prescribers on staff had extensive wait lists for psychiatric consultations. Still other participants did not want to see prescribers at the SED site and requested referrals to external prescribers.

NCCs and team leads reported variation in how responsive external providers were to communicating and collaborating with the NCC. After receiving the participant's consent, the first communication between the NCC and a prescriber is usually a letter the NCC sends to the prescriber introducing the project and their role in it. After making the initial contact, the NCC tried to meet with the prescriber in person, phone, text or fax. Some prescribers were reportedly very enthusiastic about the value added by the NCC to their patient's treatment. For example, one prescriber requested that the NCC fax the MMS Report on the morning that the prescriber would see the participant. This report, completed by the NCC, and sent to the prescriber, lists current and past medication trials side effects, psychological screen results, vital signs, and any lab results, is no more than seven day old when sent. Another external prescriber of a participant at a different site reportedly "loved" getting the report because it "saved them time"—providing corroborating clinical data on the participant. In a few cases, external prescribers relied on the NCC to solve a problem they were having with the participant. For example, after one participant missed appointments with her external prescriber for three months, the prescriber asked the NCC to encourage the participant to make and attend a medication management appointment. In this case, the NCC did discuss with the participant and the latter resumed her regular appointments with the prescriber.

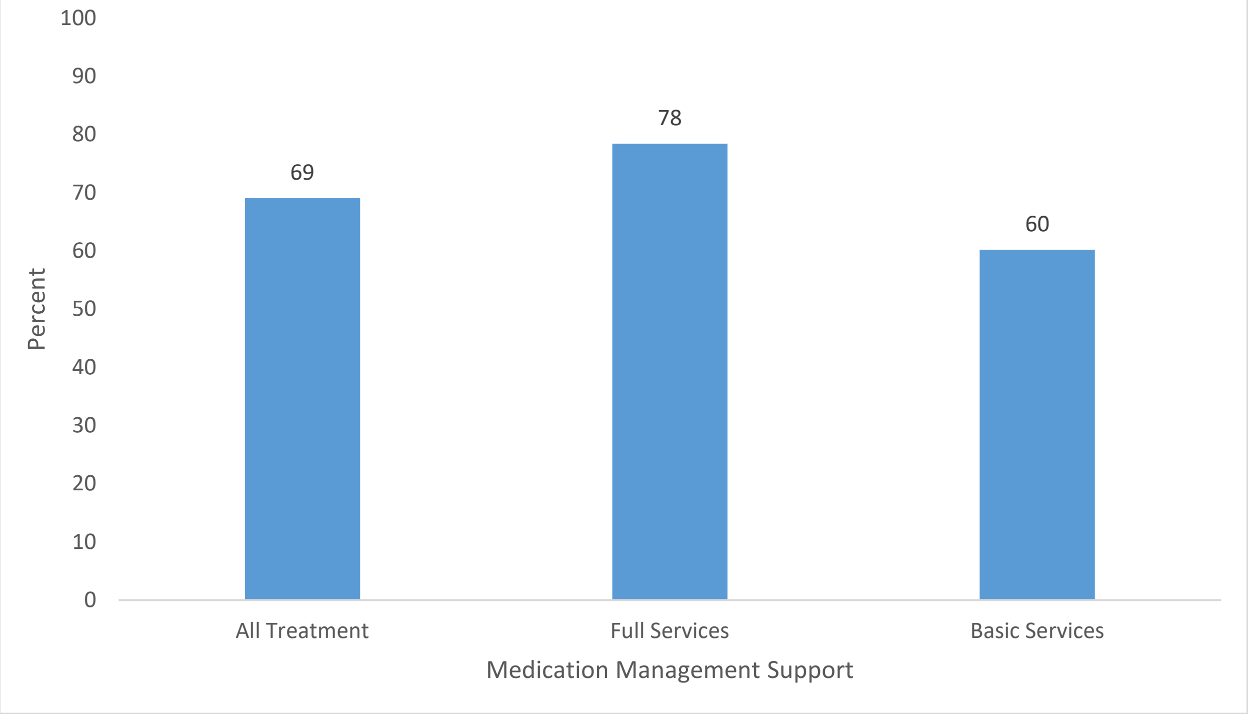
However, NCCs and team leads reported that many external prescribers were unresponsive to NCC communication. NCCs said that many external prescribers did not respond to phone calls, texts, or other communications. Few were willing to fill out the Prescriber Report form, a signed document from the prescriber listing any medication adjustments made during the consultation with the participant. NCCs and team leads believed that, in general, nonresponsive prescribers did not have objections to communicating with the NCC. Instead, they felt they did not have enough time for the NCC and SED-related tasks.

NCCs described several strategies for reaching external providers. One strategy described by an NCC was attending the first available appointment with the participant as a good opportunity to introduce the SED project and the NCC role to the prescriber. These NCCs found that that a face-to-face meeting with the prescriber made a difference to ensuring future communications: "If they [prescribers] see a face, they're like, 'They actually need this.' Versus a fax. It just gets pushed aside into another pile of stuff that they need to do in the office." Other NCCs said that nurses sometimes serve as gatekeepers to the physicians at primary care offices, and, in these offices, NCCs found it useful to get to know the nurses and persuade them of the importance of communication with the physician. However, this strategy did not apply to private psychiatrists, who usually do not have nurses on staff.

Medication Management Support Usage Rates

The NCC assigned to each Full-Service treatment team provides healthcare support, but primarily should offer support for medication management. Not surprisingly, many sites also employ nurses to serve their typical clientele. While there is no NCC assigned to the Basic-Service treatment team, Basic-Service teams often recognize the need for assistance from a nurse for some participants. Thus, the medication management data provided in Exhibit 7-2 is expected, but surprising in some ways. Nearly eight in ten Full-Service enrollees engaged with the NCC in medication management. However, six in ten Basic-Service enrollees also engaged in some form of medication management.

Exhibit 7-2. Percent of treatment group receiving services noted as medication management



Managing Care

The care management tasks of the NCC on behalf of Full-Service participants exceeded managing medical and psychiatric treatments. Sometimes, tasks of the NCC and the care manager on the SED teams overlapped. Whereas the NCC makes referrals and sets up appointments to primary care, psychiatrists, and other specialty health care for Full-Service participants, the care manager frequently assumed these duties for Basic-Service participants. Similarly, NCCs frequently assisted Full-Service participants with obtaining health insurance through the ACA marketplace, and advocated with insurance companies for reimbursement for treatments, whereas care managers did this on behalf of Basic-Service participants. All direct services staff (care managers, IPS specialists, NCCs, and sometimes, team leads) provided transportation for participants and assisted with requesting reimbursements from Westat for dental and other health care. Care managers also accompanied participants to doctors' appointments, a frequent responsibility of the NCC.

Some staff members believed that Full-Service participants benefited from the greater availability of care management services with two team members dedicated to ensuring good referrals and follow up. One care manager explained, "I have to take a bigger role [In Basic-Service] than I do in Full-Service because, again, I had the nurse attached [in Full-Service]. They help as far as the clinical aspect of helping them find therapists and stuff, and explaining to them in more depth. On the Basic [Services side] I have to do a little bit more research." Another care manager explained that he has a participant with cancer. The participant had "a lot of medical questions," he tried to answer, which made him think "I was trying to do the nursing job at the same time as the case manager job." To get the information the participant needed, he consulted with a nurse outside the organization.

Focusing Nursing on Employment

Many NCCs described their role on the SED team as unique in comparison to nursing roles they have assumed in previous clinical positions. As Full-Service nurses, their focus is to help the participant get a job and keep it. All interventions Full-Service nurses make on behalf of participants should facilitate employment. NCCs explained that this goal involved thinking about participants' work preferences and how treatment or accommodations could mitigate their symptoms and impairments while on the job. For example, an NCC made a referral to a neurologist for a participant with seizures who was interested in construction. She explained, "It could be a liability if he was having a seizure and he was on a ladder."

NCCs found that their training and knowledge in medicine lent authority to their professional opinion about participants' capacity for work. For example, an NCC discussed a participant with back problems who told her, "I'll never be able to work; I'll be a cripple." She told the participant that she would work with him to "help you feel better physically and emotionally…so you can work again." Another NCC described her first meeting in which the participant told her she is disabled and needs to have disability income. The NCC explained that her goal was to facilitate the participant's employment, and all her work will be to that end. She said that she told the participant, "I need to be honest with you as well. I will try everything before I admit to everyone and myself that 'yes, you are disabled,'…and if you say 'no,' then you did not try everything." In the end, she persuaded the participant to set employment goals.

Advocating for Participants with Providers

An activity many NCCs undertook on behalf of Full-Service participants was advocating for participants with their prescribers. This frequently involved the NCC attending psychiatrist and primary care appointments with participants. As described under "Medication Management Services" above, one advantage of the NCC's attendance at prescriber appointments was to facilitate communication between the prescriber and the NCC. NCCs found it simpler to accompany the participant to appointments to explain the SED, the NCC role, and the information needed from the external prescriber, rather than trying to contact the prescriber before or between appointments. Other benefits to the NCC's participation in prescriber appointments include helping participants gather and process information about their health conditions and treatments; redirecting physicians to consider participants' requests, and providing information about the participant that lead to better treatment.

NCCs and other SED staff explained that NCCs assisted participants with gathering information and understanding the information provided by prescribers. The presence of the NCC empowered the participant to ask the prescriber questions that he or she would not have asked without the NCC's presence. NCCs described going over with participants what they wanted to know from their prescriber before the appointment and then prompting participants to air their concerns. For example, an NCC said that during an appointment, she reminded a participant who was concerned about rectal bleeding to ask his doctor about it. Staff reported that participants valued the NCC's presence at appointments because the NCC could remind the participant what the doctor told them and explain it to them.

Several NCCs reported using their authority as medical professionals to advocate for the participant. Physicians were sometimes dismissive of participants' concerns. For example, when the participant with rectal bleeding did bring his concern to the doctor, the doctor replied, "Well that's not what we're here for today; we're here for your back." At this point, the NCC intervened to insist politely, "Well, that may be, but I have to respectfully tell you that this is happening right now and I think it needs to be looked at, whether it's on the schedule or not." The doctor listened and did a workup on the participant. This NCC said that she tries to "coach and model" how to speak with physicians and what is reasonable to ask for.

NCCs who accompanied participants to appointments were able to use their knowledge of the participant to improve treatment. One NCC described a participant with liver disease in palliative care whom she suspected has PTSD from childhood abuse. She was talking with his doctors about how PTSD may sustain and aggravate his alcohol use. Another participant at a different site had resorted to heroin to control back pain. The participant had been getting steroid shots in his back; however, until NCC met with the provider at the participant's appointment and said, "Yeah, this [steroid treatment] isn't working out," the doctor had no idea how serious the back pain was. Subsequently, the doctor referred the participant to an orthopedic surgeon.

SED staff believed Full-Service participants benefited from this additional support. As an IPS specialist explained, "Where a lot of times people maybe aren't super informed about their health and [the NCC] is able to help them be a little bit more informed or figure out some questions to ask to be a more informed consumer."

Integrating with the Team

The majority of sites reported that the NCC was well-integrated with the rest of the SED Full-Service team. Examples of this include the NCC's involvement with job development activities, or informing the team how participants' health may affect employment. NCCs that appeared to have a higher degree of integration attended weekly team meetings and also communicated with SED staff outside meetings via email and text. NCCs report meeting participants in the community, and sometimes conducted these visits with other SED staff.

SED team members, including SED administrators, care managers, IPS specialists, and NCCs spoke of how NCCs integration enhanced the team in several ways. Staff provided examples of how NCCs were able to address participants' immediate health issues, which later allowed participants to focus on employment. NCCs also alleviated the burden of communicating with providers and completing referrals for participants. Several sites also reported that NCCs were very effective communicating with providers. One SED administrator described all these advantages to having an NCC integrated in Full-Services in the following:

> Coordination of care. I feel like it's been really beneficial for having somebody on the team that's working on the releases, working on getting the information from the different hospitals, from the different outside providers, being able to communicate that information to the team and the summary as well as coordinating with the doctors. It's been really helpful. [The NCC] also provides the Full-Service team with facts about different things that are going on with the client that we otherwise wouldn't know.

> We have to WebMD with the other team. We'll ask the doctor, but we're trying to figure stuff out, we don't have that professional sitting right there with us on the Basic-Service team. It's a lot to juggle for the care manager to do on her own.

However, at a minority of sites, SED staff appeared to work separately from the NCC and seemed to interact infrequently. While the NCC provided medical information to the team, they did not collaborate beyond this. This may have been the result of frequent NCC and SED staff turnover and subsequent incomplete training and shaky understanding of roles and responsibilities. One care manager lamented the lack of integration of the NCC with the SED team in the following:

> There's not really much coordinated teamwork or collaboration between what she's doing and what I'm doing to try to kind of enhance one another. She's kind of just another source of information about client's needs, like the employment specialists are, and sometimes she'll come to me for information for what she needs to get done, but it does seem like we're just each doing our own separate thing. Probably it's not intentional, it's just kind of developed that way because we're both part-time….I'm still not entirely sure what exactly she's doing.

Nurse Care Coordination Fidelity Results

The NCC and MMS fidelity assessment are components of the SED process evaluation to assess service delivery. Understanding how the NCC delivers MMS services is critical to communications about the extent of treatment implementation and to future replicability. Additionally, understanding if other agency staff provide components of MMS to Basic-Service participants will provide context for comparing outcomes between the Basic-Service and Full-Service participants.

At each of the 30 SED sites, two reviewers conducted onsite fidelity assessments in 2018 and 2019 including chart reviews and interviews with the NCC and team leads to assess service delivery. Fidelity reviewers followed a protocol in scoring an 18-item NCC Fidelity Scale and 16-item MMS Fidelity Scale for each site. The fidelity assessment team analyzed data at the individual- and site-levels.

As hypothesized, the evidence suggests that Full-Service participants received significantly more MMS services than Basic-Service participants. Most Full-Service charts sampled to assess MMS fidelity included participants who authorized communications (63% or 128 of 204 in 2018; 57% or 85 of 150 in 2019). Of these charts, most showed evidence that the NCC was in contact with their medication prescriber(s) (84% or n=107 in 2018; 85% or n=72 in 2019) and that the NCC and prescribers exchanged clinical information (75% or n=96 in 2018; 75% or n=64 in 2019).

NCC and MMS fidelity assessment results may indicate that there is a difference between the study arms. Verifying that the study arms are distinct, allows for future analysis comparing outcomes according to the study design. Full results of the fidelity assessment appear in the companion report, *Supported Employment Demonstration Summary of 2018 and 2019 Fidelity Review Ratings for Nurse Care Coordination and Medication Management Support.*

7.3 Technical Assistance and Quality Assurance

The Implementation Team monitors sites in three ways: (a) one of the IPS technical assistance/quality assurance specialists attends a team meeting of each of the 60 teams monthly and then reviews progress separately with the team leader; (b) the SED team leads fill out the Monthly Service Use Checklists to indicate whether participants are working, looking for a job, having some contact but unemployed and not pursuing work, or having no contact; and (c) the Implementation Team meets weekly and reviews one or two sites in detail.

The Technical Assistance/Quality Assurance (TA/QA) specialists have helped teams with common participant issues. Among the most notable include:

Engagement. Some SED participants have been challenging to engage in any services and/or employment services, as discussed more extensively in Section 8 on "Engagement with Services." The site teams conduct outreach by visits, phone calls, and letters to engage participants.

Unmet Basic Needs. TA/QA specialists have helped provide site teams with strategies to help participants with urgent concerns, such as health care, drug use, domestic violence, food insecurity, housing, finances, and transportation, as a step toward motivation for employment.

It was also necessary to address issues related to participants who were involved in illegal activities, or who were dangerous. Participants who were involved in heavy drug use and other illegal activities, such as dealing drugs and prostitution, typically avoided contact with the SED team until they needed help due to a crisis. With guidance from TA/QA staff, the teams tried to engage them during crises. A small number of SED participants have histories of violent behavior and incarceration. They are often angry with staff, sometimes act violently within the agencies, and sometimes threaten staff. TA/QA staff worked with teams to set limits and try to help these participants under safe conditions.

The Implementation Team also worked to improve performance in underperforming sites. At the end of Year 1, the Implementation Team identified six sites that were consistently underperforming, based on the three monitoring processes described above, and instituted remediation plans. The issues varied somewhat in these sites: excessive turnover, new team leaders, and IPS specialists with no experience, and inability to locate participants, were the common themes. Depending on the issues, these plans included in-person site visits, more training, telephone case consultations, and regular calls from the implementation team leaders, Drake and Becker, to review progress. At least three of the six sites have shown noticeable improvements in staffing, morale, engagement of participants, and employment outcomes.

Individual Consultation

The Implementation Team has provided at least 50 case consultations (less than two per site). Sites requested consultations for guidance with particularly challenging participants, and for participant circumstances that seemed intractable. A majority of the consultations involved participants with substance use disorders and personality disorders. Many teams, especially those with less experienced clinicians, had difficulty working with these participants. Consultations provided ongoing education on substance use disorder and personality disorder as chronic illnesses and stressed the long-term process of recovery.

Some examples of participants and their circumstances discussed during consultations included the following:

- Participants who did not believe they had a behavioral health problem, rejected help, but continued to have difficulty meeting their employment goals due to their behavioral health problems. The focus of consultation for these cases was to help staff work with the participant to complete evaluations and follow up with treatment recommendations.
- Participants who had multiple medical problems, including chronic pain and metabolic conditions, related to tobacco addiction and severe obesity.
- Participants with minimal education who were caretakers for disabled family members, and had criminal justice involvement hindering their employment goals.

Some consultations focused on the morale of SED direct services staff. SED staff who did not leave the jobs sometimes lost hope and motivation for working with clients who are so challenging. They expressed feelings of stress and burnout. Many consults aim to promote hope and resilience among staff.

Staff members consistently report that consultations provide them with a better sense of service direction, more hope, compassion, and increased skills for engaging challenging clients and coping with their own stress. We do not yet have systematic data on how the consultations influence participants' outcomes, but we have anecdotal evidence that some have benefitted. For example, two participants who were stuck in a sheltered workshop obtained competitive employment as soon as staff began to set limits. Several participants who were refusing telephone contact responded to consistent letters from staff by attending meetings. Participants who were threatening violence responded to stronger limits. A few participants with complicated medical problems and polypharmacy received better care when connected with specialists.

7.4 Referrals

Referring participants to appropriate and affordable health and social services is part of SED service delivery, and a service most often performed by care managers and Nurse Care Coordinators. Teams expected to make referrals for mental health and substance use treatment; however, staff expressed surprise at the number of complex physical health challenges necessitating referrals to specialty medical services. Many participants entered the study in crisis and needed immediate referrals to help meet their basic needs for housing, food, or substance use treatment. Sites that regularly relied on states' vocational rehabilitation services to provide funding, opened cases for participants with vocational rehabilitation, if the participant qualified for those services. Other types of referrals included dental care, optometry, housing, food, clothing, legal help, childcare, transportation, and public assistance. Many SED teams described relying on community resources to help participants pay for necessary services and goods before requesting reimbursement from Westat in the interest of sustaining participants' connection with the community resource after the SED is complete.

Connecting the "unconnected"

SED providers described a large group of participants as lacking "rootedness in the mental health system" or "unconnected from services," in contrast to typical clients at their sites. That is, many SED participants began to receive IPS and other SED services without any previous engagement with mental health or social services. Because SED participants were not well-connected with services, many needed immediate referrals for mental health, primary and specialty medical care, and wraparound services. SED staff who worked at their site before beginning SED found new challenges in connecting SED participants with services. In contrast to clients at their sites, who were usually "aware of their options and services a little bit more," treatment-naïve SED enrollees needed immediate referrals and "a lot of education" about mental health and mental health services.

A first roadblock at some sites was finding resources for participants who did not have a documented psychiatric disorder, as participants were not eligible for many of the usual referrals requiring a psychiatric disorder that were leveraged most frequently by clinic staff. After a psychiatric assessment, some participants did qualify for service earmarked for those with serious mental illnesses; however, other participants failed to receive a diagnosis that would make them eligible. At some sites, this meant that the latter group of participants could not utilize psychiatric and psychotherapeutic services outside the SED umbrella. SED staff at these sites felt that these circumstances interfered with good implementation of IPS: "One of the beautiful parts about IPS and why it works is because it is integrated with behavioral health treatment. We're removing that half (for participants without serious mental illness), which is really half of the supports that the clients have in place."

Some SED staff noted that an added difficulty in helping "unconnected" participants find employment rapidly was uncertainty about how their impairments might affect their job performance. For example, a care manager reported that SED staff sometimes needed a little time to observe the participant to understand how they might need to assist the participant in managing their impairment on the job. In contrast, for "typical" clients of the site, the IPS specialist may consult with the clinician who made the referral to IPS to grasp the challenges the client may have seeking and maintaining employment.

Making Affordable Referrals

SED staff searched for appropriate and affordable referrals for participants when SED participants needed assessments or treatments they could not receive at the site because the site did not provide the service, participants did not qualify for the service, or the site had a long wait-list for the service. Participants' health insurance (or lack of insurance) made it challenging to find care that participants could afford during and after the three years of demonstration. Referrals to low-cost or sliding scale clinics were an important option for participants without any form of public or private insurance. Participants with Medicaid had more options, but in some geographical regions, staff described difficulties finding psychiatrists who would accept Medicaid payment: "There's plenty of private psychiatrists [who] will take Medicare or private insurance. But it is very challenging to find someone who will take Medicaid who doesn't have a really long wait-list." Staff described assembling referral lists of outside providers and what types of insurance they accept, and trying to match participants with providers who could provide the service needed at an affordable cost.

Sustaining Participants' Engagement with Referrals

SED staff were concerned about the sustainability of participants' treatment once the demonstration ends. While the demonstration paid for some out-of-pocket costs incurred by participants for medical treatment, these payments would not continue indefinitely. Thinking ahead to the end of the study, SED staff said they "tried to help them [participants] get connected to services in the community that they can continue to access on an ongoing basis." This meant making referrals to services that would be convenient and affordable for the participant to access. As an NCC explained, "If participants find it easy [to access], then they are going to stick with it." SED Teams tried to make referrals to services near an individual participant's home, and cluster multiple services geographically for "one-stop shopping" so the participant could schedule appointments back-to-back to save time and transportation costs.

Referrals to Specialty Behavioral Health Services

SED staff reported participants receiving referrals for specialty behavioral health services as part of the Monthly Service Use Checklist. Among participants enrolled at least 18 months as of January 1, 2020, 34.2 percent received specialty behavioral health services at least once.[3] Exhibit 7-3 shows the percentage of SED participants receiving specialty behavioral health services by the participant's month of enrollment in the study. Less than 10 percent of participants received specialty behavioral health services each month. The highest percentage receive these services in their first month of enrollment in the SED. It is possible that the number of referrals for specialty behavioral health services was highest in the first month of enrollment because staff sent participants who had just enrolled in the study for an initial psychological evaluation. Participants that did not need follow up visits would then not continue to receive behavioral health services in later months.

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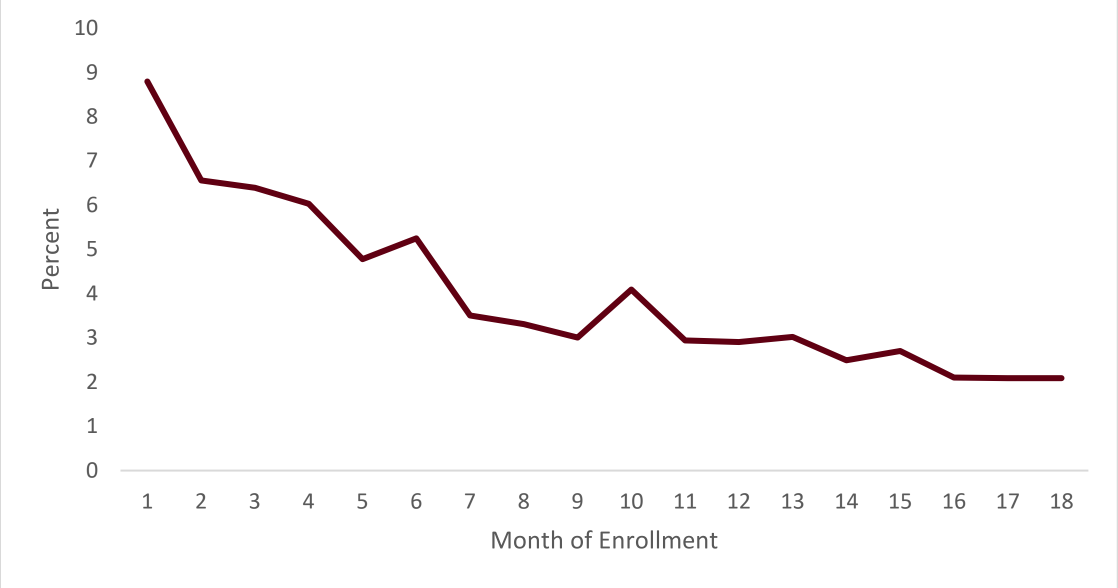
[3] The Monthly Service Use Checklist asks SED staff to write a description of the Specialty Behavioral Health service in an open-ended field. There are a variety of services listed in this field. Some descriptions are general, such as "behavioral health" or "psychiatrist." There are also more specific services listed, such as "sleep therapy" and "couples counseling." Site staff may have made a referral for the specialty behavioral health service, meaning that often the staff member completing the checklist may not know the exact services received by the participant.

Exhibit 7-3. Percent of participants receiving specialty behavioral health services by month of enrollment



Note: Includes only Full- or Basic-Service Treatment group members enrolled at least 18 months as of January 1, 2020 (n=1,035)

7.5 Reimbursements

The SED required all demonstration sites to provide study participants in the treatment groups with a wide range of services intended to meet individual work-related needs. The core of both treatment packages is the evidence-based IPS employment service model. In their effort to foster employment, demonstration sites must provide access to needed behavioral health (and medications) and care management services, including wrap-around services when needed, such as access to housing, legal aid, or financial services. The intention of these reimbursement funds is to help participants with challenges deemed by the treatment team to impose an immediate barrier to working. All resources and funds focus toward fulfilling the goal of returning to work. The first three sections below describe reimbursable services and items associated with participant needs. The final sections provide some general descriptive statistics for the reimbursements that took place between December 2017 and December 2019. We first look at the number of reimbursements processed by the Westat team, and then examine the overall distribution of reimbursements. Finally, we discuss the average monthly expenditure per reimbursement by type of service. We separated all quantitative results by Basic-Service and Full-Service groups.

Scope of Coverage

For services or items to be eligible for reimbursement, the participant's treatment plan must clearly state the need for the service item. Eligible services and items for reimbursement include:

- **Clinical and Other Behavioral Health Services.** These services include psychotherapy, individual or family counseling, physical health care, psychiatric consultation, physical therapy, and occupational therapy.

- **Behavioral Health-Related Medication Expense.** Coverage includes deductibles, co-pays, and full cost of prescription drugs for the treatment of mental health symptoms, if not covered by the participant's health insurance.

- **Individual and Work-Related Expenses.** These consist of items or services directly related to taking a specific job and are typically associated with IPS service delivery. Examples include business-appropriate attire, certifications, licensures, and transportation costs for interviews. In special situations, it would also include dentures or other dental services that may alleviate a barrier to entering a job.

- **Non-Clinical Support Services.** These consist of other items needed to help participants overcome barriers impeding their return to work. Typically associated with care management, these include services and expenses for temporary, short-term, or emergency assistance to address housing, legal, or transportation barriers. The reimbursement must enable the participant to overcome the barrier completely and not represent an ongoing need.

Health Care Access

Approximately 80 percent of study participants had health insurance at the time of enrollment into the study. The remaining 20 percent did not. Across all three study arms, Westat assisted uninsured participants in obtaining insurance through the ACA. The study provided an Uninsured Handbook to those who are not eligible for any health insurance. The handbook contains information on public health clinics (free and sliding scale) in or near the catchment area of the demonstration site. Clinics listed in the Handbook provide preventive care and general medical services to uninsured individuals. The study reimbursed the cost for services at these clinics until the participant could obtain health insurance during annual open enrollment for the ACA.

External Providers

Participants have the right to choose their own providers. Treatment teams might have encouraged participants to consider changing from an external provider to a site provider in order to facilitate better integration of care. However, the participant ultimately made the decision. Treatment services provided by external parties are eligible for reimbursement. The participant's treatment plan must clearly document the need for the service and the treatment team must approve the external provider. All participants must receive IPS supported employment and care management services directly from the study site. In rare cases, where health insurance covers a service, but the external (preferred) provider does not accept the insurance, the study would not pay for the service. An example is when an external provider does not accept Medicaid, the study would not be obligated to pay. The participant must use their health insurance to cover the service where ever it would be accepted.

Reimbursement Process

Demonstration site staff are responsible for treating and communicating with treatment participants. When the treatment team identifies a participant need that requires expenses not covered by the participant's health insurance or the normal study capitation payments, the site must submit a reimbursement request through the study Management information System (MIS) to cover the cost. Reimbursement planners at Westat receive and review all submitted reimbursement requests for the following services or items:

Westat requires preauthorization for payments to outside vendors for the following types of services/items:

- **Offsite behavioral health services** (evaluations, therapy, and medication management)
- **Medical and dental services** (e.g., co-pays, physical and occupational therapy, routine medical and dental care, vision care).
- **Medications for chronic** (e.g., diabetes, cardiovascular disease) **and acute conditions** (sinus infection or abscess).
- **Individual work-related expenses** (interview/professional attire, coursework for certification or licensure, work equipment or supplies, and transportation costs for interviews or work)
- **Non-clinical support services** (housing, utilities, legal needs, childcare, auto repairs/payments; transportation).

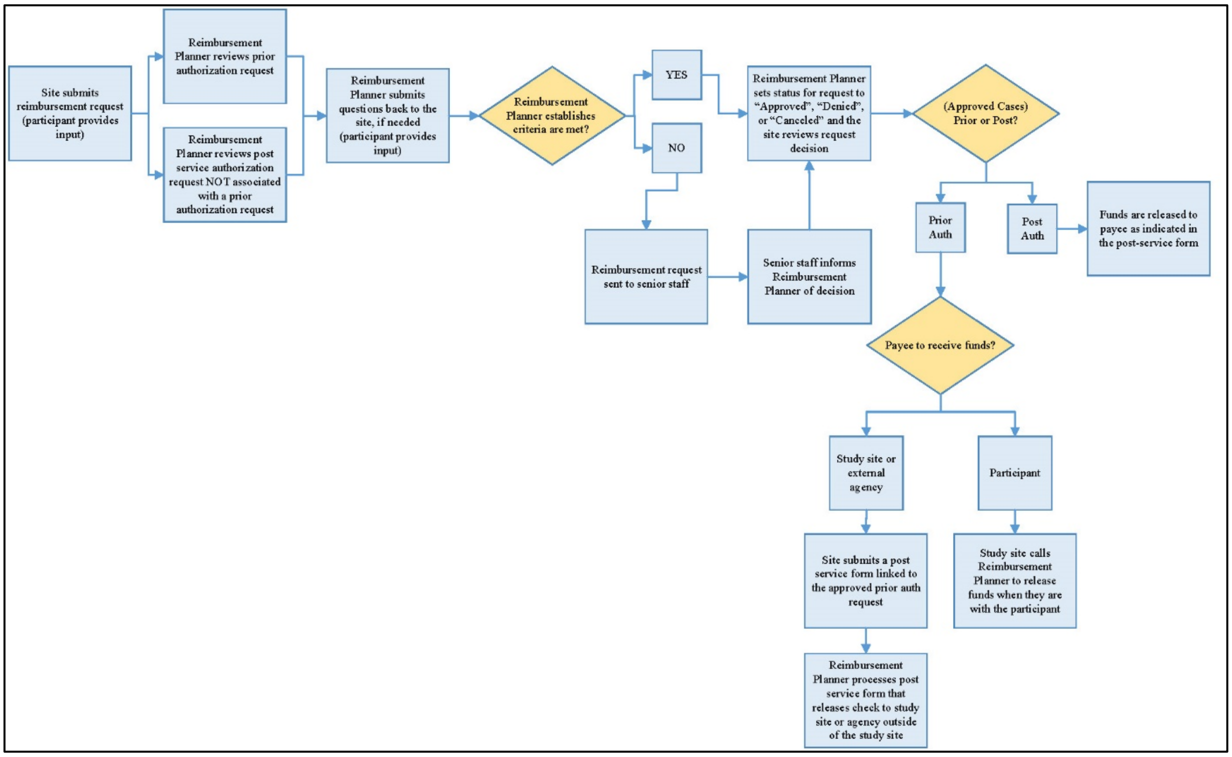
Westat reimbursement planners evaluate each request against a set of pre-established criteria associated with affirmative answers to each of the following questions:

1. The participant currently engages with the site?
2. The team lead has approved the request?
3. Cost or duration of services are reasonable?
4. The site sought funding from other local resources? If so, which ones?

If the request meets the established criteria (yes to all questions), the site receives approval to proceed. If not, the planner sends the request to a senior advisor for review. The review process takes time as senior medical or IPS/vocational advisors weigh in as to the appropriateness of the request. Sometimes the advisors along with TA/QA Implementation staff held discussions with the site team to better understand the rationale for the service or item, or discuss alternative solutions.

With input from senior advisors, the reimbursement planner sets the status of the request to "Approved", "Denied"[4], or "Canceled". Exhibit 7-4 shows the reimbursement request process relationship between Westat, site staff, and participants.

Exhibit 7-4. Reimbursement process map



During process site visit interviews, we asked site staff and participants about their experiences with the reimbursement. Site staff frequently described team meetings as convenient forums for discussion about participants' reimbursement requests. Careful deliberations about reimbursements prior to submitting requests act as a way to minimize the likelihood of denial and therefore manage participant-staff relationships. Staff also described efforts to manage expectations and educate participants on what were "appropriate requests," the length of time it takes to process reimbursement requests, and the necessity of submitting claims for prior authorization rather than post-service requests.

Many staff members understood Westat to be the funding "source of last resort," and described seeking out other community programs for assistance. For example, staff across various sites explained that they pursued funding from the local Department of Vocational Rehabilitation for work clothes and education funding prior to seeking assistance from the study for similar expenses.

In addition to learning how to select reasonable requests and frame convincing arguments to ensure a streamlined approval, staff described several improvements implemented by Westat over the course of the study that have facilitated the reimbursement process. For example, staff appreciated

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[4] Sites have the opportunity to appeal denied reimbursement requests. If they do, Westat assigns an independent medical or vocational advisor to review the request.

having direct access to the reimbursement planners who may be able to facilitate expedited review in the case of emergency situations.

Statement from a study participant

"The most important part was the jumpstart to getting my degree and you definitely helped me do that. As far as I'm concerned right now, everything else is small and an extra added benefit to what you already helped me with."

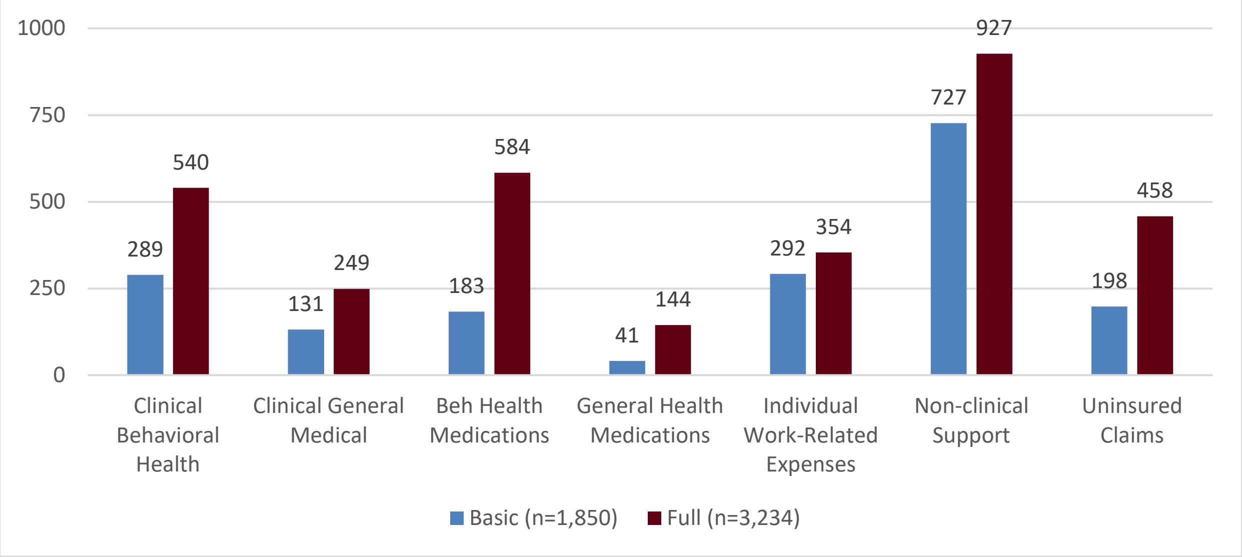
Beyond positive impressions about the reimbursement process and improvements the study has implemented over time, many staff articulated how reimbursements provide critically important services and benefits to study participants that far outweigh the amount of work involved in submitting requests. SED staff and participants frequently described receiving approval for expenses related to interview- and job-appropriate attire, transportation, housing and utilities, medical and behavioral health, past due loans and fines, training and education, and communication and technology. Participants were very appreciative of the care they received and they expressed that the support they received was very critical in improving their lives and making them ready for employment.

Number of Claims Processed

The Westat team processed a total of 5,084 reimbursement claims during the 24 months between December 2017 and December 2019. Roughly, this translates to 212 reimbursements per month. As sites enrolled more participants and as participants actively started participating in the study over time, the number of reimbursements per month increased. The number of reimbursements per month was 135 for the Full-Service arm 77 for the Basic-Service arm. This is likely due to the fact that Full-Service treatment arm provided additional services through the NCC (e.g., MMS).

Exhibit 7-5 shows the number of reimbursements by type of treatment services. Reimbursement requests for non-clinical support is highest in both groups. For the Full Services Group, second highest was reimbursement for behavioral health medications, followed by clinical behavioral health services. For the Basic-Service treatment arm, second highest was individual work-related expenses followed by clinical behavioral health services. Not unexpected, there were more reimbursement requests for general medical services and medications among Full Services participants than the participants in the Basic Services group.

Exhibit 7-5. Number of reimbursements processed by service types, December 2017 to December 2019



Total Amount Paid

Total amount of reimbursement claims paid during the 24 months between December 2017 and December 2019 was $2,432,889 (Exhibit 7-6). The majority of the disbursements went to individual work-related expenses, with 38 percent of the total. Non-clinical support was about 21 percent of total reimbursements followed by medications with 20 percent (10% for behavioral health and 10% for general health medications). Payments for behavioral health clinic visits and general medical visits were 9 percent and 6 percent of the total, respectively.

Exhibit 7-6. Distribution of total reimbursements processed by service types, December 2017 to December 2019

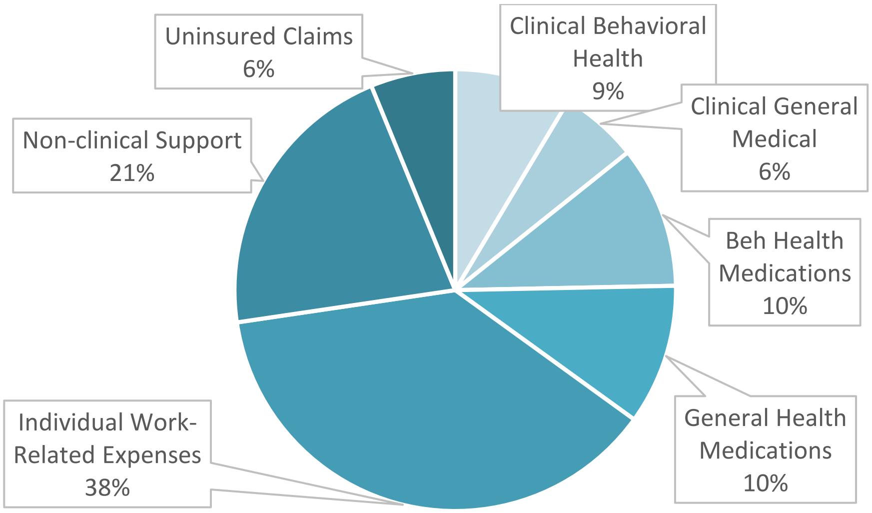


Table 7-2 shows total reimbursements by service types for each treatment group. Individual work-related expenses were the highest percentage in both groups, 34 percent in Basic-Service, and 40 percent in the Full-Service treatment arm. Following were payments for non-clinical supports, 27 percent in Basic-Service and 18 percent in Full-Service groups. It is not surprising that reimbursements for behavioral health services and medications were higher among the Full-Service than Basic-Service treatment arm.

Table 7-2. Distribution of total reimbursements processed by service types and treatment groups, December 2017 to December 2019

	Basic-service		Full-service	
	Amount ($)	Percent	Amount ($)	Percent
Clinical behavioral health	77,568	8%	130,333	9%
Clinical general medical	66,895	7%	71,343	5%
Beh. health medications	93,907	10%	158,264	11%
General health medications	83,906	9%	165,144	11%
Individual work-related expenses	313,570	34%	600,340	40%
Non-clinical support	251,035	27%	261,148	18%
Uninsured claims	47,061	5%	103,374	7%
Total	933,942	100%	1,489,946	100%

Finally, we examined average monthly reimbursements by type of service for both treatment groups. Table 7-3 presents the mean reimbursements for each service with 90 percent confidence interval. We see that general medical reimbursement requests on average had the highest monthly amount. Average payment for the uninsured claims and individual work-related expenses were second and third highest, respectively. We see that once a claim is generated, there was no statistically significant difference between the treatment groups for a given service type.

Table 7-3. Distribution of total reimbursements processed by service types and treatment groups, December 2017 to December 2019

	Basic-service		Full-service	
	Mean ($)	90% CI ($)	Mean ($)	90% CI ($)
Clinical behavioral health	198	60-370	210	77-529
Clinical general medical	451	58-911	381	85-935
Beh health medications	55	9-103	55	9-102
General health medications	84	4-365	95	6-421
Individual work-related expenses	221	57-694	253	40-745
Non-clinical support	166	27-475	148	21-429
Uninsured claims	236	22-1,060	277	22-814

Conclusions

Westat team processed a total of 5,084 reimbursement claims totaling to $2,432,889 during the 24 months between December 2017 and December 2019. These disbursements directly supported study participants working toward employment or to overcome challenges to finding and maintaining employment. Treatment sites also receive additional funding from the study to form IPS teams and provide employment services. The findings to date indicate that the participants have complex challenges and require additional wrap-around services and supports in addition to employment services they receive from the sites.

It is important to note that Westat formed a dedicated team and created a very structured process for claim reimbursements. The study would not be implemented successfully and reimburse these traditional (e.g., medications) and nontraditional supports (e.g., rent support) in a timely fashion if there was not a very effective and accountable reimbursement system in place. As in any study, as we experienced unexpected situations, we revised and improved the review and approval system, as needed. Such examples include elevating a request to higher level review when a claim is not clear in terms of its relation to employment goals. We also needed similar additional reviews for behavioral health service requests that did not have an evidence-base. Having a strong review process helped to resolve issues quickly and helped us provide a satisfactory response to the sites and participants.

It is evident from the reimbursement analyses and qualitative interviews that the study participants have significant challenges in keeping up with their financial obligations and keeping a stable housing which may both affect their ability to focus on getting or keeping a job. Non-clinical supports include temporary rent payments, support for bills related to working, and supports in emergency situations that may negatively affect participant's employment. These nonclinical supports along with individual work-related expenses constitute a significant component of the overall reimbursements in this study.

8. Engagement with Services

Staff interviews highlighted the biggest challenge working with SED participants is the difficulty engaging many of them in services, and once engaged, maintaining their involvement. Staff felt that the extent to which they needed to work to keep participants involved was unprecedented in their experience.

In our interviews with staff, participants' lack of engagement, and strategies for encouraging engagement with services, were among the most important topics. Seeking to understand why participants do not engage in services in order to try to serve them more appropriately, staff discussed a number of reasons why many participants find engaging difficult. While a few staff members said that they thought some participants signed up for the study with little intention of working, most believed the reasons for an apparent lack of interest in receiving SED services were more complex.

Some participants were simply too sick to attend appointments, let alone work towards employment. These participants were in the terminal stage of an illness, in too much physical pain, too psychotic to communicate with adequately, or too depressed to get out of bed for appointments. Other participants had substance use problems and spent most of their time either high, or sick with withdrawal, according to staff. Homeless, transient, and very impoverished participants were difficult to locate, and, at times, could not be reached by phone. Incarceration kept some participants from engaging; others entered locked detox programs. Participants also missed appointments because of difficulties accessing childcare and transportation.

In general, when staff discussed participant engagement issues, they meant that they struggled to contact participants and to meet with them. During in-depth interviews, staff gave rough estimates of the number of participants with whom they had recently lost contact, which ranged from twenty to fifty percent of their caseloads at the time of the Year 2 site visits. Data from the Monthly Service

Use Checklists recording the services each participant received during each of the first 18 months of enrollment shows that about forty to fifty percent of all enrolled participants had at least one face-to-face encounter with the IPS specialist or the care manager. That is, data from the Monthly Service Use Checklists confirm the off-the-cuff estimates of direct services staff.

Sites employed similar strategies to attempt to contact these participants: first calling and leaving messages on the participant's phone; calling the personal contacts participants provided during intake for help locating the participant; sending letters to the participant's last known address, and visiting the participants' home and leaving a note if they participant was not home or did not answer the door. Some teams temporarily transferred unengaged participants from the caseloads of IPS specialists to the team lead, who took responsibility for attempting contact at regular intervals.

Engaging participants was by no means a linear process from less engagement to more engagement. According to staff, for many participants, engagement "ebbs and flows," "waxes and wanes," or is like "a roller-coaster" of ups and downs. SED staff searched for patterns in engagement across their caseload, some staff theorizing engagement was higher in the winter, while others thought engagement was higher in the summer. They tried to make sense of variations of service usage within each individual participant's history; that is, what to make of participants who had seemed gung-ho to work with the team at the beginning of the study who then underwent a "puzzling disappearance"? Or, how to understand why participants whom they could not find for months suddenly reappeared interested in employment services? Sometimes a crisis in participants' lives seemed to bring them back to services; at other times, crises preceded participants "dropping off the face of the earth". Nevertheless, data analysis of the Monthly Service Use Checklist supports staff observations that engagement tended to be either intensive or absent. The 40-50 percent of participants who did have at least one face-to-face meeting with an IPS specialist or care manager averaged between 3 and 4 meetings during the month.

The Study Context

Arguably, the single most important reason why staff found engaging participants with services challenging is an artifact of the study. It is important to note that the context of the SED is different than the context in which IPS specialists usually receive referrals and discharge cases. CMHC and other social service organizations providing IPS services generally have a high demand for IPS services and therefore prioritize work with clients who feel ready to start the job search process. Clients who enroll in IPS services and miss appointments, avoid staff calls, or otherwise fail to use the service, are discharged after 30 to 90 days (depending on the organization's policies) to make available the opportunity for other clients to use the service. In contrast, SED participants must formally dis-enroll from the study for the site to discharge them from services. Passive withdrawal, such as failing to respond to calls and no-showing for appointments, does not lead to discharge. Instead, SED staff find themselves in the position of continuing to try to persuade "unengaged" participants (who would have been discharged if they were the organization's clients) to meet with them.

SED participants' entry into the SED and IPS services was markedly different from the entry of most sites' usual clientele into IPS services. Generally, individuals referred for IPS have behavioral health supports and they receive the referral to IPS from a behavioral health care worker. They already know what to expect when they visit a CMHC or social service agency because their referral source was one. In contrast, in the words of an administrator, "with SED…we're identifying folks who haven't sought our services." While SED participants may be interested in employment, as they indicated during recruitment, they may not have fully grasped what is involved in receiving employment services at a CMHC or other social service agency. Further, an individual may want a job, but not want to become a client in a social service organization.

Clienthood Socialization

While recruiters thoroughly described the services offered as part of SED, an eligible individual with no experiences with social service agencies is unlikely to have fully grasped the responsibilities and entitlements that are part of clienthood (cf. Alcabes and Jones 1985). Some participants did not identify as someone with a mental health problem and were unconvinced they should attend a CMHC. Staff reported that many participants entered the study "unsure of what they signed up for," unfamiliar with expectations, and uncertain whether they wanted to work with the SED team. A site administrator explained that new participants with no experience with social services have trouble understanding how to interact with the professionals who are helping them. This administrator explained that at the beginning of enrollment, participants, "are still getting accustomed, to this point, to being involved in services.... They kind of get confused about our role: 'We're not your friend, but we're a professional, so we care.'"

Treatment-naïve participants sometimes had unrealistic expectations of the SED. Staff described some participants as dis-engaging from services in frustration when they did not see results quickly. A care manager explained, "I feel like a lot of our clients want instant results. For instance, they want housing now; they want benefits now…it's hard for them to realize that it's a process. I feel like they get a little frustrated with me." A team lead at a different site said he explained to treatment-naïve participants

> We're going to help you look [for employment], and we will go and talk to employers and try to seek connections, and we'll utilize any that we already have. But it doesn't mean that tomorrow I'm going to set you up with a manager just because you want a job. It doesn't happen that fast. A fast placement usually means a fast termination.

Socializing SED participants into the client role and explaining the service delivery process were strategies to keep participants engaging in the early months of enrollment. For example, the team lead quoted in the paragraph above continued

> We've gotten really good at describing the program, letting them know what they signed up for at the outset, because what we learned is that if you don't do that really well…their expectations are different and usually they'll end up being frustrated and drop out, or be really upset that things aren't moving the way they thought they would [and] just stop returning calls. Like, "This isn't what I thought it would be."

An administrator at a different site concurred that socialization was the first stage of engaging with participants with no social service experience, "We're trying to work with them…to get them to understand: do they need to be here? We're trying to identify what their mental illness is, if they have one, [and to] also change their thought processes."

Some SED staff described participants who expected to get payments for receiving services. Other participants seemed to expect that the site would dole out cash to them. While staff sometimes interpreted these requests for payment as the participant trying to "take advantage" of the site, it also revealed the extent to which SED participants misunderstood what they could expect as a social service client.

Low Expectations

Typical clients beginning IPS have been involved in behavioral health and social services long enough that they have a realistic idea of what to expect before they meet their IPS specialist. In contrast, some SED participants began uninitiated into the client role in social services agencies. Their lack of familiarity with social services led some participants set expectations too high for their work with SED, causing disappointment and frustration. Other participants—some with no social service experience, and others with bad experiences—expected very little. Participants who had very low expectations of services did not see much advantage to engaging with them. According to SED staff, participants had low expectations for a number of reasons, including: previous negative experiences; difficulty establishing trust; and hopelessness about their health problems and employability.

It is important to remember that SED participants' previous encounters with so-called "street-level bureaucrats," such as police, teachers, and social workers (Lipsky 1980; Hopper 2006) may have been negative, humiliating, and sometimes punitive. Further, negative attitudes towards service providers are not only individual; participants generally resided in communities where it is commonsense to avoid such encounters. According to baseline survey data, more than fifty-three (53) percent of SED participants experienced arrest and booking for a crime at some point in their lives. While we do not have data on the number of participants who have had their parental rights terminated, site visitors learned that it is not a rare event among SED participants.

All SED participants recently received a denial from SSA, which many participants experienced as invalidating of their struggles with health problems and poverty. In the following, a care manager explained the perspective of some struggling participants towards services as conditioned by their past experiences seeking help from organizations:

> They've been denied disability and apparently, they thought it was a sure thing: "I've got this disability; I've got this diagnosis, I'm going to get my disability." They were counting on that. It didn't come through….They've reached out to food banks in the community; they have their lights cut off in the past; and they've had their water cut off in the past. They just couldn't get the help they needed. I think they feel that the world is against them.

Lacking trust in any service providers, these participants are wary of anyone who purports to offer them anything. Another staff member, a team lead, articulated their perspective this way: "They're used to being on their own a lot. They're not used to trusting people. 'Are you really here to help me?' They really don't understand that side of the world." Another team lead explained,

> I think, a lot of times they're waiting for us to—I guess—quit on them. And I've seen social services, and we're just…we're not very nice sometimes. And people get so frustrated [with them]. I know I get frustrated calling [for services] as a clinician, and then, I'm speaking their speak. I couldn't imagine being…just a layperson calling. You [would be] like, 'Forget it. I'll just starve."

This team lead acknowledged how difficult it is to find resources for people in need. He found himself becoming upset and frustrated when he asked for something on behalf of a client and was met with a refusal. He empathized with how much more infuriating it must be to be asking on your own behalf from a position in dire need.

A robust theme among SED staff member responses to the question of why participants did not utilize the services referred to participants as lacking self-confidence, lacking motivation, and feeling hopeless about their employment prospects. These three characteristics staff attributed to SED participants tended to co-occur. That is, staff perceived participants who lacked self-confidence as also usually unmotivated and hopeless. An IPS specialist put it succinctly, "Some [participants] lack a lot of motivation, which I see as a lack of confidence. They've already decided in their head that it's not going to work, so they don't bother to try."

Many participants who lacked the confidence to seek employment had previous experiences of failure. For example, site visitors interviewed a participant who made a suicidal gesture at her place of work in response to bullying. She worried that no one would hire her because of her behavior at her previous workplace, and had been too ashamed to pursue employment for four years. However, she attributed her IPS specialist's encouragement and matter-of-fact assumption that she would find another job to her success in eventually securing a job she likes in her field of expertise. Several IPS specialists concurred that they served as "cheerleader[s]" for participants lacking self-confidence.

9. Discussion and Implications

This interim report describes how research sites implemented the SED during the first two years of operation. It is important to emphasize that SED is a first demonstration targeting a unique population of individuals who made an unsuccessful application for disability income based on alleged mental health impairments. We did not know much about this population prior to SED because most previous research studies examined current or previous SSDI/SSI recipients, not denied applicants.

SED started as planned with three arms (Basic-Service, Full-Service, and Usual Services) and successfully recruited 3,000 participants. This demonstration provides a unique opportunity to study characteristics of the population of denied applicants and their service needs in order to achieve self-sufficiency through employment.

In this reported we focused on the following:

1. Characteristics of the population of participants who alleged a mental health condition on a failed application for disability benefits.
2. Contextual, environmental, and site-related factor that posed challenges.
3. Modifications of service delivery to respond to these challenges.

Participants reported multiple physical and mental health impairments. Prominent mental health problems included PTSD and symptoms of personality disorders. Participants described considerable physical impairment, disease, and pain. Baseline survey data reveal that the average participant reported three physical health conditions impairing their ability to work. Participants reported symptoms of mental health conditions also. On average, participants endorsed symptoms of four mental health conditions on the CIDI. However, according to treatment teams, this population differed from the population of people with Severe Mental Illness (SMI). Instead, SED participants suffered from PTSD, anxiety, depression, and traits of personality disorders. Histories of childhood and adult trauma, poverty, and ongoing struggles to meet basic needs may underlie many of these conditions.

IPS specialists responded to the health challenges of participants by looking for jobs that accommodated participants' physical limitations, and addressing the maladaptive behavioral patterns that impeded successful employment. IPS specialists reported managing anger on the job was a challenge for some participants. Some participants were very reactive to perceived criticism, which IPS specialists addressed by mediating between the dissatisfied employer and the participant. Other participants appeared to lack any source of emotional support in their lives. For these participants, the support provided along with IPS and wrap-around services could be transformative. Most teams described one or more participants at their site who blossomed with the care shown them by SED staff.

Participants were treatment-naïve and/or unconnected from services at enrollment. A sizable group of participants were unconnected from any social services, and unfamiliar with what to expect from services and service providers. This presented at least two challenges to SED staff. The first, as described above, was to provide services for participants' many unmet needs for shelter, food, clothing, and medical care. As behavioral health and employment specialists, SED staff expanded their knowledge of local resources as they sought appropriate referral sources for these participants.

Second, treatment-naïve participants needed socialization into the social service client role. Staff responded by making explicit the service delivery process and the roles of staff as professionals invested in participants' personal growth. Even so, some participants responded with frustration to what they perceived as a slow pace toward meeting their needs and employment goals. Other participants had low expectations conditioned by previous negative social service experiences, and did not see any advantage to participation. These wary participants were a challenge to engage at the outset.

While most participants utilized SED services, maintaining ongoing engagement in services was a challenge. Engagement difficulties are likely due to a number of factors. The primary reason SED Team struggled with engagement is that participants could not passively withdrawal from the SED. That is, the SED did not discharge participants who repeatedly no-showed for appointments, missed or avoided calls. This is unusual for most sites: because demand for IPS services at sites is high, sites discharge from IPS services clients who disengage in these ways. For staff previously providing direct services at the sites, maintaining engagement with participants who were ambivalent about services, or not quite ready to seek employment, were new activities.

In addition to those participants who misunderstood SED services and became frustrated, or were wary, other participants failed to engage due to hopelessness, lack of motivation, and depression. Still other participants were too sick to attend appointments. Some participants had substance use problems. Participants who were impoverished and homeless could be difficult to locate. Some participants missed appointments because they lacked adequate transportation or childcare. Other participants moved out of the catchment area, became incarcerated, or entered locked detox programs.

Monthly Service Use Checklist data indicates that more than percent (92) of participants met with an IPS specialist at least once, whereas about 8 percent of participants were lost after enrollment. On average, about 40 to 50 percent of participants met with an SED team member in a given month. These 40 to 50 percent of engaged participants met 4 to 5 times with their providers, suggesting that engagement was sufficient. SED providers described this pattern of engagement as "ebbing and flowing" in which participants utilized services relatively consistently for a period of time, then dis-engaged, and then engaged again later on, etcetera.

Some participants had difficulty meeting with providers once employed. Some employed participants failed to see the need to continue to meet with providers once they had a job they liked. Among employed participants, it is likely that some of this dis-engagement is healthy: their mental health symptoms attenuated once employed, and they saw no further need for services. Other participants were simply overwhelmed with the demands of family, work, and other obligations and had difficulty making time in the workday for SED-related appointments.

A final challenge to implementation and participant engagement was staff turnover. During the first two years of the study, all but one site experienced turnover in staff. More than one-third of sites experienced turnover of more than one-quarter of their SED staff. As expected, this high rate of turnover impacted fidelity ratings, which, while acceptable, were lower than expected. Staff turnover was disruptive to creating rapport with participants.

Preliminary analyses indicate that participants needed wrap-around support in addition to medical and mental health treatment to reach employment goals. Participants enrolled in SED with many unmet basic needs, including for shelter, food, clothing, and transportation in addition to care for un- and undertreated physical health, mental health, and substance use conditions. According to staff, many participants began to receive SED services in the midst of crises caused by these unfulfilled needs.

Because most participants in dire straits prioritized seeking shelter, food, and basic medical care over seeking employment, staff and participants delayed intensive engagement with employment services until these participants achieved some stability. Therefore, we expect that, for this subset of participants, the road to employment may be longer than for usual IPS services clients and for other SED participants.

Further, some needs, such as for housing or intractable chronic health conditions, staff and participants found difficult to resolve quickly. Finding affordable housing in many locations was a challenge, and not entirely resolvable within the scope of the SED. Managing (or even adequately identifying) participants' complex medical and behavioral health needs also required time and specialized expertise.

In order to assist these participants, the SED provided funds in the form of reimbursements to help engaged participants meet urgent, short-term need for housing, utilities, legal needs, childcare, and transportation as long as fulfilling these needs furthered employment goals. These reimbursements for non-clinical support were about 21 percent of the total of all funds dispersed, with reimbursements for all out-of-pocket medication expenses totaling approximately 20 percent, and reimbursements for all out-of-pocket health care provider office visits totaling 15 percent. The need for funding to meet basic needs was greater than the cost of out-of-pocket medication expenses, or for out-of-pocket office visits.

It is also important to note that the greatest reimbursement expense was for work-related expenses, at 38 percent of the total. These expenses included business- and interview-attire, certifications, licensures, and transportation costs, among other expenses needed to interview for, or begin, a specific job.

Challenges related to systemic poverty remain obstacles to participants' goals for employment and well-being. In sum, chronic poverty is as great an obstacle to SED participants' employment as their mental health and physical health impairments, and is arguably more intractable than their health concerns. While SED assisted with participants' needs for housing, transportation, and childcare in the short-term, the demonstration cannot effect change to overcome these barriers systemically. Staff turnover plagued the SED during the early months of implementation; however, sites reported that this turnover was consistent with turnover in entry-level positions at their sites, generally. These are all systemic problems not easily addressed within the scope of the demonstration.

It is critical to emphasize that sites, working with the Implementation Team show credible efforts toward mitigation of all other challenges to the implementation. These efforts include connecting and socializing participants into social services, treating chronic comorbid mental and physical health conditions, working with employers to provide accommodations for impairments, addressing participants' criminal records, helping participants manage their behavior during interviews and employment, and providing emotional support.

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Appendix A

Monthly Service Use Checklist

Supported
Employment
Demonstration

Participant Study ID: ____________________
Participation Study Month (1-36): ____________________
Team Member Completing Checklist: ____________________
Date Checklist Completed: ____________________

Appendix A
Monthly Service Use Checklist

Instructions: Treatment teams should complete this form to document individual participant's service use during the previous month, from {INSERT START DATE} to {INSERT END DATE}. The team should rate services during weekly team meetings.

Sometimes there are circumstances that prevent an individual from participating in the study. Please answer the following three questions to determine whether the checklist should be completed for the period {INSERT START DATE} to {INSERT END DATE}.

Pre-Checklist Questions:

P1. Did hospitalization prevent the individual from participating in the study for this entire period?
- ☐ Yes (DO NOT RESPOND TO THIS CHECKLIST)
- ☐ No (GO TO P2)

P2. Did incarceration prevent the individual from participating in the study for this entire period?
- ☐ Yes (DO NOT RESPOND TO THIS CHECKLIST)
- ☐ No (GO TO P3)

P3. Was there another reason that prevented participation in the study during this entire period? ***Note that if "the individual is employed" or "the individual is not engaged", these are not considered circumstances that prevent study participation.***
- ☐ Yes (GO TO P3a)
- ☐ No (GO TO IPS SERVICES Q1)

P3a. Please specify the reason that prevented this individual from study participation.
____________________ (DO NOT RESPOND TO THIS CHECKLIST)

Supported
Employment
Demonstration

Participant Study ID: ____________________________
Participation Study Month (1-36): ____________________
Team Member Completing Checklist: __________________
Date Checklist Completed: __________________________

IPS Services

	Yes	No
1. Did the IPS specialist have a face-to-face (in-person) contact with the participant?		
1a. If yes, what is the approximate number of face-to-face (in-person) contacts? ________________		
1b. If no, were there community outreach attempts?		
2. Did the IPS specialist have a face-to-face (in-person) contact with hiring managers on the participant’s behalf?		
2a. If yes, what is the approximate number of face-to-face (in-person) contacts? ________________		
3. Did the IPS specialist help the participant to start a job this month?		
4. Did the IPS specialist help the participant to maintain a job?		
5. Did the IPS specialist help the participant to end a job appropriately this month?		
6. Did the IPS specialist provide supported education services to the participant?		

Problem Solving Therapy

	Yes	No
7. Did the participant receive PST?		
7a. If yes, what is the approximate number of meetings? _____		

Care Manager Assistance (Formerly Called Case Manager)

	Yes	No
8. Did the care manager have a face-to-face (in-person) contact with the participant?		
8a. If yes, what is the approximate number of face-to-face (in-person) contacts? ________________		
8b. What services were provided? Check all that apply. ☐ Outreach for engagement ☐ Assistance with housing ☐ Assistance with medical care ☐ Assistance with substance use reduction ☐ Assistance obtaining legal services ☐ Assistance with practical skills ☐ Assistance with finances ☐ Assistance with symptom management ☐ Assistance with peer support (e.g., AA, NA, group therapy) ☐ Assistance with family education		

Supported
Employment
Demonstration

Participant Study ID: ______________________________
Participation Study Month (1-36): ______________________
Team Member Completing Checklist: _____________________
Date Checklist Completed: ____________________________

Medication Management Support

	Yes	No
9. a. Is the participant receiving medication management from an *onsite* prescriber?		
b. If no to 9a, is the participant receiving medication management from an *offsite* prescriber?		
10. If yes to *either* 9a or 9b:		
10a. What was the approximate number of meetings? ______		
10b. Is there a prescriber's note in the participant's chart related to their meeting(s) this month?		
10c. Did the prescriber coordinate with the treatment team?		

Specialty Referral

	Yes	No
11. Did the participant receive specialty behavioral health services?		
11a. If yes, describe: ________________________________		
11b. Was the participant referred for specialty behavioral health services this month?		

Participant Employment Status

	Yes	No
12. Has the participant been employed for at least 1 day in the past 30 days?		
13. Has the participant had any contact with the team (IPS specialist, care manager, NCC, Team Leader), including by text, phone, or in person, in the past 30 days?		
13a. If no, what is the main reason that there has been no contact with the participant? ☐ missing/inaccurate contact info ☐ no response to outreach ☐ Other________________________________		
14. In the past 30 days, has the participant participated in any of the job development activities listed below (14a)?		
14a. If yes, what job development activities? Check all that apply. ☐ Job Shadowing ☐ Applying for job(s) ☐ Job Interview(s) ☐ Informational Interview(s) ☐ Mock Interview(s) ☐ Face to face follow-up with employer re. job application status		
14b. If no, what is the main reason? ☐ Lack of interest / ambivalence ☐ Difficult to reach ☐ Employed ☐ New enrollee (past 30 days) ☐ Physical comorbidities ☐ Other: ________________________________		

Supported
Employment
Demonstration

Participant Study ID: ______________________
Participation Study Month (1-36): ______________________
Team Member Completing Checklist: ______________________
Date Checklist Completed: ______________________

School/Vocational Training Participation

	Yes	No
15. Has the participant been engaged in school or a vocational training program for at least 1 day in the past 30 days?		
15a. If Yes, what type of education or training? (check all that apply) ☐ GED ☐ Certificate Program ☐ College		
15b. If Yes, how did the participant pay for this education or training? (check all that apply) ☐ State VR ☐ the study/Westat ☐ Other______________________		
15c. If Yes, what was the status of this education or training during the past 30 days? (check all that apply) ☐ In school/training now ☐ graduated or completed ☐ dropped out		

Comments (Use the Comments section to include information about virtual meetings that took place with this participant this month.)