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Programmes to promote employment for disabled people: Lessons from the United States

Anu Rangarajan, David Wittenburg, Todd Honeycutt and Debra Brucker

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of the Department for Work and Pensions

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Contents

Acknowledgements	vii
The Authors.....	viii
Abbreviations and glossary.....	ix
Summary	1
1 Introduction	9
2 Evolution of US return-to-work initiatives for people with disabilities.....	11
2.1 Introduction.....	11
2.2 Several private and public service providers provide rehabilitation and employment supports in the US	11
2.3 Increasing interest in expanding supports in more integrated settings.....	12
2.4 Tests of integrated employment interventions have targeted subgroups of people with disabilities	13
2.5 Evaluations have led to some changes in service delivery, though providers continue to deliver untested employment service models in segregated settings.....	15
3 Influence of programme rules on return-to-work outcomes.....	17
3.1 Introduction.....	17
3.2 SSA disability programme rules discourage work.....	17
3.3 UK has more-integrated system for providing disability cash and employment supports	18
3.4 Differences in US and UK disability programmes are important considerations in applying cross-national lessons.....	20

4	Findings from large-scale return-to-work initiatives that targeted SSDI and SSI claimants	21
4.1	Introduction	21
4.2	Key project features	23
4.2.1	<i>Structured Training and Employment Transitional Services</i>	23
4.2.2	<i>Transitional Employment Training Demonstration</i>	24
4.2.3	<i>Project NetWork</i>	27
4.2.4	<i>The State Partnership Initiative</i>	28
4.2.5	<i>Ticket to Work</i>	28
4.3	Evaluation designs	29
4.4	Participation rates	30
4.5	Impact findings	32
4.5.1	<i>Employment</i>	37
4.5.2	<i>Earnings</i>	38
4.5.3	<i>Benefit receipt</i>	39
4.5.4	<i>Subgroup and regional impacts</i>	39
4.6	Cost benefit analyses of programmes	40
5	Supported employment initiatives targeting people with psychiatric conditions	43
5.1	Key project features	44
5.1.1	<i>Individual randomised control trials of supported employment model, especially the Individual Placement and Support model</i>	44
5.1.2	<i>Employment Intervention Demonstration Programme</i>	46
5.2	Evaluation design	46
5.3	Impact findings	47
5.3.1	<i>Employment and earnings</i>	47
5.3.2	<i>Income and benefits</i>	47
5.3.3	<i>Subgroup, model and regional impacts</i>	47
5.4	Benefit cost analyses of programmes	48

6	Return-to-work initiatives for low-income mothers with disabilities	49
6.1	Key features of PRIDE	49
6.2	Evaluation design.....	50
6.3	Impact findings.....	51
6.3.1	<i>Employment and earnings</i>	51
6.3.2	<i>Income and benefits</i>	51
6.4	Cost benefit analyses of programmes	51
7	Lessons for future research and programme development in the UK.....	53
7.1	Pathways evaluation indicates promising impacts, but some groups might need additional supports to achieve employment outcomes	53
7.2	Lessons for enhancing employment and tracking outcomes from Pathways to Work	54
7.2.1	<i>Pathways participants with psychiatric conditions might benefit from additional supports, especially supported employment services</i>	54
7.2.2	<i>Adding work incentives to allow people to work more than 16 hours per week might further enhance Pathways outcomes</i>	55
7.2.3	<i>Long-term claimants will be likely to need more intensive supports than those currently offered in Pathways to move into employment</i>	55
7.2.4	<i>Additional data on delivered services could be helpful in understanding the effects of Pathways on its intended population</i>	56
7.3	Lessons for evaluating future UK employment initiatives for people with disabilities.....	56
7.3.1	<i>Interventions are unlikely to reduce caseload sizes among long-term programme participants</i>	56
7.3.2	<i>Identifying outcomes that can measure the success of the programme before implementation is important to a clear articulation of key evaluation findings</i>	57
7.3.3	<i>Creating a research database from administrative files on programme participation is a valuable tool in tracking the progress of disability policies</i>	57

7.3.4	<i>Rigorous evaluation findings, especially those based on random assignment designs, can be an important factor in building consensus on evidence-based practices</i>	58
7.3.5	<i>When using non-experimental methods, use multiple approaches to conduct sensitivity tests on programme impacts</i>	58
8	Discussion	59
Appendix A	Description of US disability programmes	61
Appendix B	Detailed descriptions of US return-to-work initiatives	71
	References	83
List of tables		
Table 1	Summary of major evaluation findings from US return-to-work initiatives for people with disabilities	3
Table 4.1	Summary of key features of return-to-work initiatives that targeted SSDI and SSI claimants	25
Table 4.2	Participation rates from return-to-work initiatives that targeted SSDI and SSI claimants	31
Table 4.3	Summary of impact estimates from return-to-work initiatives that targeted SSDI and SSI claimants	34

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The Authors

Anu Rangaranjan, Mathematica Policy Research, Inc.

David Wittenburg, Mathematica Policy Research, Inc.

Todd Honeycutt, Mathematica Policy Research, Inc.

Debra Brucker, Mathematica Policy Research, Inc.

Abbreviations and glossary

Note: This report uses the preferred US terminology of ‘people with disabilities’ rather than the DWP preferred terminology ‘disabled people’.

AB	Accelerated Benefits Demonstration
ADA	Americans with Disabilities Act
ALJ	Administrative Law Judge
BOND	Benefit Offset National Demonstration
CDR	Continuing Disability Reviews
CMS	Centers for Medicare and Medicaid Services
CPI	Consumer Price Index
DDS	Disability Determination Service
DOL	Department of Labor
DWP	Department for Work and Pensions
EIDP	Employment Intervention Demonstration Programme
ESA	Employment and Support Allowance
FFI	Florida Freedom Initiative
GAO	General Accounting Office
GA	General Assistance
HOPE	Homeless Outreach Projects and Evaluation
IB	Incapacity Benefit

Intellectual disabilities	Includes people with mental retardation or developmental disabilities ¹ .
IPS	Individual Placement and Support
IS	Income Support
MHTS	Mental Health Treatment Study
MR/DD	Mental Retardation/Developmental Disability
NDDP	New Deal for Disabled People
Pathways	Pathways to Work programme
PDI	Personal disability insurance
PRIDE	Personal Roads to Individual Development and Employment
Psychiatric conditions	People with affective, anxiety, and schizophrenia disorders.
RSA	Rehabilitation Services Administration
SAMHSA	Substance Abuse and Mental Health Services Administration
SGA	Substantial Gainful Activity
SPI	State Partnership Initiative
SSA	Social Security Administration
SSDI	Social Security Disability Insurance
SSI	Supplemental Security Income
STETS	Structured Training and Employment Transitional Services
TANF	Temporary Assistance for Needy Families
TETD	Transitional Employment Training Demonstration
TRF	Ticket Research File
TTW	Ticket to Work

¹ In the United Kingdom, this group is also referred to as people with learning disabilities.

TTWIIA	Ticket to Work Incentives and Improvement Act
UK	United Kingdom
US	United States
VA	Veterans Administration
VR	Vocational Rehabilitation
WCA	Work Capability Assessment
WFI	Work Focused Interview
WIPA	Work Incentives Planning and Assistance
YTD	Youth Transition Demonstration

Summary

Introduction

Policymakers in the United States (US) and the United Kingdom (UK) have shown an increasing interest in integrating people with disabilities² into the mainstream, especially in work activities. This interest has resulted in an increased number of policies and programmes in both countries that are geared towards promoting employment outcomes for people with disabilities, especially for people who receive disability cash benefits.

The US approach to people with disabilities does not have an integrated system for combining employment supports with disability cash supports. The primary US cash disability benefit programmes – Social Security Disability Insurance (SSDI) and Supplemental Security Income (SSI) – require that a person be unable to work to qualify for benefits, which limits the return-to-work outcomes, and in part explains why few people leave the SSDI and SSI programmes. In contrast, the UK's disability support system has a more integrated set of supports that emphasises promoting employment outcomes, especially for people claiming benefits from the UK's primary disability benefit programme called Incapacity Benefit (IB). The UK's Pathways to Work (Pathways) programme illustrates this more integrated employment approach by providing a series of mandatory supports geared to promote employment for new IB claimants. The UK Government is also implementing changes to further expand employment services to people with disabilities starting in October 2008 with the phase-in of the Employment and Support Allowance (ESA), which will replace the IB programme. The differences include changes in eligibility requirements that will mean more people with disabilities will be mandated onto the Pathways programme.

Despite the system differences, the US experience in providing specialised services to specific impairment groups and long-term cash disability claimants offers potential lessons to the development of similar initiatives in the UK. These

² This report uses the preferred US terminology of 'people with disabilities' as opposed to the DWP convention of 'disabled people'.

lessons will be particularly important as UK policymakers seek to further expand employment services to people with disabilities, including long-term IB claimants who might share some similarities to the populations served by the US' SSDI and SSI programmes. This report reviews evaluation findings from the US experience in providing return-to-work supports for people with disabilities and discusses the implications for similar efforts in the UK. These findings provide lessons for expanding supports and tracking services for the UK's Pathways programme, and for developing and evaluating future UK employment initiatives, especially for people with severe psychiatric conditions and long-term disability claimants.

Summary of US disability evaluations

Our review focuses on US evaluations that have been influential in informing best practices in providing services to people with disabilities (Table 1). The target populations included in these initiatives fall into one of the following general categories: SSDI and SSI claimants, people with psychiatric conditions, and low-income mothers with disabilities. Throughout this report, the definition of the term of psychiatric conditions refers to people with affective, anxiety, and schizophrenia disorders. Additionally the term intellectual disabilities, which is an important subgroup in several interventions, refers to people generally with mental retardation or developmental disabilities. With one exception, all of the evaluations include a random assignment design in which potential participants were randomly assigned to a control or treatment group. The one non-experimental study included is an evaluation of the largest federally funded US return-to-work programme – Ticket to Work (TTW) – for people with disabilities, which was included because of its size and policy importance.

Several US interventions have increased employment and earnings, but have shown no impacts on caseload size

Several of the interventions summarised in Table 1 have increased employment and earnings outcomes of participants, including people who have received SSDI and SSI for several years, but none have led to a substantial reduction in the number of people who receive SSDI or SSI benefits. In all initiatives, the impact on long-term benefit receipt was generally minimal, regardless of whether the programme was voluntary or mandatory. In part, these findings underscore the challenges of moving people off long-term benefits and into self-sufficiency, particularly given that many people targeted for these services had been out of (full-time) work for several years. However, two evaluations – Structured Training and Employment Transitional Services (STETS) and Transitional Employment Training Demonstration (TETD) – did show that the interventions could still be cost beneficial from a social perspective if they served as less expensive alternatives to existing expensive supports.

More-intensive services are generally needed to produce impacts on employment and earnings

The initiatives that had the largest impacts on employment generally provided a more intensive set of services that were customised to meet the individual's needs. This included two initiatives (STETS and TETD) that provided transitional employment services to youth with intellectual disabilities and several supported employment initiatives that provided a combination of mental health and employment supports to people with psychiatric conditions. In contrast, the interventions that provided a less-intensive set of services to a broader population generally had limited impacts on earnings and employment. For example, the case management services provided under Project NetWork and the combination of benefit and employment supports from the State Partnership Initiative (SPI) projects were generally much less costly than the aforementioned STETS, TETD, and supported employment interventions, which might, in part, explain why the SPI and Project NetWork evaluations found limited impacts.

Table 1 Summary of major evaluation findings from US return-to-work initiatives for people with disabilities

Demonstration	Intervention description	Key findings from impact analysis
Large-scale return-to-work initiatives that targeted SSDI and SSI beneficiaries		
STETS	People 18-24 years old with intellectual disabilities received: <ul style="list-style-type: none"> • introductory work exposure period • on-the-job training • follow-up and job supports 	Increases in employment and earnings and declines in SSI amounts
TETD	SSI claimants 18-40 years old with intellectual disabilities received: <ul style="list-style-type: none"> • job placement • on-the-job training • job retention services 	Increases in employment and earnings and declines in SSI amounts
Project NetWork	SSI/SSDI claimants and applicants 15-65 years old received: <ul style="list-style-type: none"> • employment-focused case management services 	Increases in short-term earnings, but no long-term increases in earnings or decreases in benefit amounts
SPI	SSI/SSDI claimants 18-65 years old received: <ul style="list-style-type: none"> • benefits counselling • case management • limited employment supports 	Increases in employment in some sites, but no changes in earnings or benefit amounts
TTW	All SSDI/SSI claimants received: <ul style="list-style-type: none"> • vouchers that can be used to purchase services from select providers 	Changes in earnings and benefit amounts are too small to differentiate from historical trends

Continued

Table 1 Continued

Demonstration	Intervention description	Key findings from impact analysis
Supported employment initiatives targeting people with psychiatric conditions		
Independent evaluations of supported employment programmes implemented in several local areas (see Bond <i>et al.</i> 2008)	Adults with psychiatric conditions received: <ul style="list-style-type: none"> • combination of competitive employment and health service 	Increases in employment and earnings
Employment Intervention Demonstration Program (EIDP)	Adults with psychiatric conditions received: <ul style="list-style-type: none"> • combination of competitive employment and health service 	Increases in employment and earnings
Return-to-work initiatives for low-income mothers with disabilities		
Personal Roads to Individual Development and Employment (PRIDE)	Low-income mothers with disabilities received: <ul style="list-style-type: none"> • vocational supports • work-based education track 	Increases in employment and earnings and declines in benefit amounts for one subgroup (single parents)

Lessons for current UK employment initiatives for people with disabilities

The US experience provides the following lessons for service delivery and tracking intervention services for the ongoing Pathways programme.

Pathways participants with psychiatric conditions might benefit from additional supports, especially supported employment services

According to UK Pathways evidence (Bewley, Dorsett, and Haile (2007), Bewley *et al.* (2008)) Pathways had mixed results in terms of impact on the employment or self-reported health of those whose main health condition at the time they were first interviewed involved psychiatric conditions, suggesting that an alternative set of supports might be necessary to enhance the outcomes of this group. The repeated success of supported employment models, which generally offer a combination of competitive employment and health services, suggests that integrating these types of supports into Pathways could be one option to improve outcomes for people with psychiatric conditions.

Adding work incentives to allow people to work more than 16 hours per week might further enhance Pathways outcomes

The expansion of the existing permitted work rules for IB, which currently restricts work to 16 hours per week before benefits are cut, might enhance more substantial

labour market attachment by Pathways participants. Several US interventions have added work incentives to the programme intervention, often through the use of a waiver that provides special work incentive benefits to programme participants. Such changes could be made directly to the permitted work rules or by expanding other policies, such as the Return-to-Work Credit that currently offers financial support to those working more than 16 hours per week.

Long-term claimants will likely need more-intensive supports than those currently offered in Pathways to move into employment

Long-term IB claimants likely have more employment barriers and support needs than the new IB beneficiary population currently served under Pathways. It is likely that these claimants will need several different types of tailored health, employment, and other services (for example, life skills) to move successfully into employment. The US evaluation findings indicate that tailoring services to the needs of each participant generally results in stronger employment outcomes, though these types of services can be relatively expensive.

Additional data on services delivered could be helpful in understanding the effects of Pathways on its intended population

The current Pathways databases include some basic information on the general services provided, such as the number of Work Focused Interviews (WFIs) conducted (see Blythe (2007)), but has more limited information on specific types of services (for example, rehabilitation, job preparation and job coaching). Provider data have been used in several US evaluations to monitor variations in service delivery across areas, learning about programme participation and take-up of different types of services, and more broadly, in understanding the relationship between the services provided and successful outcomes. These monitoring systems can also provide incentives for providers to improve service delivery, ensure that the appropriate services are being delivered to the target population, and meet performance targets.

Lessons for evaluating future UK employment initiatives for people with disabilities

The US experience also provides some more general lessons for evaluating future UK return-to-work interventions:

Identifying outcomes that can measure the success of the programme before implementation is important to a clear articulation of key evaluation findings

A logic model that states the hypotheses being tested and provides a summary of programmatic goals can be useful to participants, providers, policymakers and the evaluation team. Clearly stated outcomes that the programme is intending to affect can be particularly useful when evaluations report findings on a large

number of outcomes, because it is possible that, in looking across a large number of outcomes, some may appear to be significant due only to chance, even when there is no real effect. A strong logic model would distinguish those outcomes that should be treated as core evaluation outcomes and treat other outcomes more as exploratory findings.

Creating a research database from administrative files on programme participation is a valuable tool in tracking the progress of disability policies

Developing a research database from administrative records on IB and ESA participation could be a useful tool in monitoring programme outcomes for key UK policy initiatives. The US's Ticket Research File (TRF), which includes information on SSDI and SSI claimant characteristics and programme outcomes over a person's entire history of participating in the programme, provides an example of how this database could be constructed and maintained in the UK. The primary advantage of such a file is that it provides a systematic way of coding and storing data on programmatic outcomes that can be reused in future research projects. Additionally, the current data security procedures for the TRF also provide a model for how UK programme administrators might go about creating and protecting these data, which is important in light of recent data security concerns in the UK.

Rigorous evaluation findings, especially those based on random assignment designs, can be an important factor in building consensus on evidence-based practices

It is important to fund projects that are of sufficient size and using methods to determine successful outcomes that can be agreed upon by researchers and practitioners. The supported employment evaluations for people with psychiatric conditions illustrate the role that rigorous evaluations can play in policy development, given that the findings led to this approach being accepted as an evidence-based practice by mental health practitioners. Conversely, the influence of other evaluations of US return-to-work interventions has been limited in many cases because they lacked a sufficient sample size and/or a credible comparison group to identify programme impacts. For example, the support for supported employment models for other people with disabilities is based more on faith because of a lack of rigorous evaluation findings, which has led to much less financial support for these programmes for broader populations.

When using non-experimental methods, use multiple approaches to conduct sensitivity tests on programme impacts

The TTW and SPI evaluations identified problems with non-experimental methods that were exposed with additional sensitivity tests. In both cases, the sensitivity tests identified biases in the estimated models, which led the evaluation to use alternative methods to examine programme impacts. In both the SPI and TTW evaluations, the ability to conduct these sensitivity tests was made possible by the

large administrative databases already noted, that the evaluators used to test their models across a number of key outcomes for a variety of comparison groups.

In the future, there is likely to be continuing lessons concerning return-to-work initiatives that both countries can share. The UK approach to delivering services, including mandatory WFIs early on in the application, represents a bold approach that has not been tested within the US. The US approach to providing services to specific impairment groups and longer-term beneficiaries in ongoing demonstration projects targeted to including those with psychiatric conditions, youth, and those who lack health insurance, should provide some insights on potential best practices that could be used in serving IB and, starting in October 2008, ESA claimants.

1 Introduction

Policymakers in the US and the UK have shown an increasing interest in integrating people with disabilities into the mainstream, especially into work activities. This interest has resulted in an increased number of policies and programs in both countries that are geared towards promoting employment outcomes for people with disabilities, especially for people receiving disability cash benefits.

In comparison to the US, the UK has a much more integrated system for combining employment supports with disability cash benefits for people with disabilities. The main US cash disability benefit programmes – SSDI and SSI – require that a person be unable to work to qualify for benefits, which limits the return-to-work outcomes, and in part explains why few people leave the SSDI and SSI programmes. In contrast, the UK's disability support system has a more integrated set of supports that emphasises promoting employment outcomes, especially for people claiming benefits from the UK's primary disability benefit programme, IB. The UK's Pathways programme illustrates this more integrated employment approach by providing a series of mandatory supports geared to promote employment for new IB claimants.

This report reviews evaluation findings from the US experience in providing return-to-work supports for people with disabilities and discusses the implications for similar efforts in the UK. In the US, several evaluations of return-to-work initiatives for people with disabilities have been influential in shaping policy perspectives. Some evaluations have compared the efficacy of traditional rehabilitation supports against alternative return-to-work approaches, while others have evaluated expanded access to traditional and alternative rehabilitation supports to populations that have traditionally been underserved, such as people with severe disabilities. These findings provide lessons for expanding supports and tracking services for the UK's Pathways, and for developing and evaluating future UK employment initiatives.

Our review focuses on US evaluations that have been influential in informing best practices in providing services to people with disabilities. With one exception, all of the evaluations selected for review include a random assignment design in which potential participants are randomly assigned to a control or treatment group. The

one non-experimental study we include is an evaluation of the largest federally funded US employment programme for people with disabilities, which we include because of its size. In addition, the evaluation findings from this study provide some insights on the challenges in identifying impacts using a non-experimental design.

Three categories of rigorous evaluations of US employment supports for people with disabilities meet our selection criteria. These include:

- 1 Evaluations of initiatives that generally have targeted volunteers who receive Social Security Administration (SSA) disability cash benefits, which include people who receive cash benefits from the SSDI and SSI programmes.
- 2 Evaluations of supported employment programmes that have been tested as an alternative to traditional vocational supports for volunteers with psychiatric conditions.
- 3 An evaluation of a return-to-work initiative for mothers with work limitations who receive cash benefits from state welfare programmes.

The rest of the report presents our findings. In Chapter 2, we summarise return-to-work initiatives that have been influential in shaping perceptions about best practices in providing return-to-work services over the past 25 years. In Chapter 3, we compare US and UK disability programmes to provide contextual information for the applicability of the evaluation findings to the UK disability programmes. We then summarise findings from the efforts that have been influential in shaping employment efforts for our three categories of evaluations (in Chapters 4, 5 and 6 respectively). We use this information to identify lessons for UK initiatives in Chapter 7 and summarise major findings in Chapter 8. The report also includes two appendices that provide more detailed information on the features of US disability programmes (Appendix A) and information on the return-to-work projects and programmes (Appendix B) summarised in this report.

2 Evolution of US return-to-work initiatives for people with disabilities

2.1 Introduction

In the US, several public and private programmes offer services and supports to adults with disabilities, including cash benefits, health coverage, rehabilitation assistance, and other specialised services (for example, assistive technologies). These programmes are administered by different agencies with separate funding structures. The result is a patchwork of programmes and policies that targets different segments of the population with disabilities (Wittenburg and Favreault (2003); Wittenburg (2004)). For example, some programmes provide benefits to offset the lost income of workers, including those injured on the job, while others provide benefits to low-income populations.

2.2 Several private and public service providers provide rehabilitation and employment supports in the US

Many US local employment support programmes are a component of larger private non-profit or private for-profit rehabilitation service organisations that offer many services, including employment services, housing, and other specialised supports (Wehman *et al.* (1998)). The Vocational Rehabilitation (VR) programme provides a major source of funding to many of these organisations. VR is a nationwide federal-state programme that provides medical, therapeutic, counselling, education, training, and work-related placement assistance, as well as other services, generally arranged through agreements with local vendors. The target population for services includes any person who has a work limitation and can benefit from VR services to achieve an employment outcome. The number of VR participants is generally limited in comparison to the size of the SSDI and SSI programmes and

services in many states are limited by VR funding availability.³ In many cases, state VR agencies collaborate with other private and public service providers to provide a range of supports to people with disabilities, especially in serving people with intellectual disabilities and psychiatric conditions.⁴ Several types of employment service providers operate employment support programmes that vary in size. Some providers, such as freestanding employment providers, focus primarily on the delivery of services, whereas other providers, such as community rehabilitation programmes, provide residential and segregated employment supports, including day programmes and sheltered employment.

2.3 Increasing interest in expanding supports in more integrated settings

Rehabilitation approaches have historically emphasised sheltered and segregated employment options. Examples of segregated and sheltered settings include sheltered workshops, psychosocial rehabilitation programmes, and hospital-based vocational programmes. The motivation behind these workshops was to provide a person with an employment experience without the competitive factor that could lead to potential failure (Bussone *et al.* (1993)).

Since the 1970s, there has been an increasing interest or testing strategies to provide employment supports to people with disabilities in more integrated settings. These approaches generally emphasise promoting competitive employment outcomes in which a person with a disability can obtain a job in a more integrated setting. In part, these views on promoting more integrated options have been heavily shaped

³ State VR agencies give priority to serving people with significant disabilities, including those who receive SSDI and SSI benefits. When an agency does not have enough funding, it uses a waiting list process called order of selection, in which cases are prioritised based on their disability status. In 2004, state VR agencies served 1.4 million people with disabilities (US Department of Education (2007)). By comparison, there were 8.9 million SSDI claimants and 6.2 million blind and disabled SSI claimants in October 2007 (SSA (2007a, 2007b)).

⁴ The two largest specialised systems are the Mental Retardation/Developmental Disability (MR/DD) system and the state mental health system. In most states, MR/DD agencies provide those with intellectual disabilities with residential and social support, as well as several other services, including after-school programmes, family support and employment (Braddock *et al.* (2002)). The state mental health system is generally less centralised and provides services to a relatively broader population with a range of psychiatric conditions. Those who qualify receive services from state mental health agencies oriented toward treatment and amelioration of symptoms. In many cases, these systems collaborate with VR agencies to provide supports, especially in segregated settings.

by civil rights legislation initiatives that promoted the full inclusion of people with disabilities into American society starting in the early 1970s and have been extended through several more recent policy initiatives.⁵

2.4 Tests of integrated employment interventions have targeted subgroups of people with disabilities

The largest tests of employment supports for people with disabilities have emphasised more integrated approaches targeting people who receive SSA disability cash benefits (SSDI and SSI). The SSA administers the SSDI programme, which is a social insurance programme designed to replace the lost wages of adult workers with disabilities, and the SSI programme, which is an income maintenance programme for low-income adults with disabilities. SSDI and SSI claimants are a natural target for services because they represent the largest federally funded cash transfer programmes for people with disabilities. In addition, while SSDI and SSI claimants are automatically eligible for VR services, their participation in these services has been low. For example, according to Thornton *et al.* (2007), 4.8 per cent of all SSA disability claimants ages 18 to 57 participated in VR during at least one month in 2001.

⁵ In 1973, policymakers instituted the first civil rights legislation for people with disabilities in Section 504 of the Rehabilitation Act of 1973, which made it illegal for federal agencies, public universities, federal contractors and any other institution or activity receiving federal funds, to discriminate in hiring on the basis of disability. Several initiatives then followed that further expanded education, independent living, employment and housing opportunities for people with disabilities over the next two decades. These changes included the Education for Handicapped Children Act of 1975 (now referred to as the Individuals with Disabilities Education Act), which guaranteed a free, appropriate education in the least restrictive environment for all children with disabilities, and the Fair Housing Amendments Act of 1988, which required accessible housing units be created in all new multifamily housing with four or more units, both public and private, not just those that received federal funds. Finally, the Americans with Disabilities Act of 1990 (ADA), which prohibited discrimination in employment, access to places of public accommodation, services, programmes, public transportation, and telecommunications for people with disabilities, is the most comprehensive initiative and emblematic of many of the broad US disability policies that promote full inclusion in daily life for people with disabilities. For more information, see Golden *et al.* (in press).

A second area of testing has been the use of supported employment programmes for people with severe disabilities, especially those with psychiatric conditions.⁶ These programmes are voluntary and generally offer a combination of competitive employment and health services to populations that are recruited through social service agencies. According to Wehman and Revell (2003), funding for supported employment services typically occurs in two phases: (1) employment services funded by VR and several other federal and state agencies on a time-limited basis that may include vocational assessment, career planning, job development, job site training, assistive technology and accommodations; and (2) the provision of extended services (for example, employment supports and case management) to support work performance. Variations of supported employment models exist, including for people who do not have psychiatric conditions, though they all emphasise the provision of individualised supports on an ongoing basis to meet a competitive employment outcome. (Chapter 5 includes a more detailed discussion of supported employment initiatives.)⁷

Finally, there has been increasing interest in promoting return-to-work initiatives for low-income mothers with disabilities who receive cash benefits and in-kind supports from state welfare programmes (Derr and Pavetti (2008)). State agencies have been under increasing pressure to reach employment targets and have begun to develop employment initiatives for 'hard to serve' welfare recipients.

⁶ Supported employment services have been delivered to several groups of people with severe disorders, including psychiatric conditions and intellectual disabilities, though rigorous evaluations of the effects of these interventions exist only for programmes that specifically target people with psychiatric conditions. Psychiatric conditions include people with serious emotional or behavior impairments, such as affective (for example, depression), schizophrenia, and anxiety disorders. Intellectual disabilities generally include individuals with mental retardation or developmental disabilities.

⁷ Lutfiyya *et al.* (1988) documented four distinct models of supported employment: (1) **enclaves**: a group of individuals with disabilities work together under the supervision of an agency in a community business or industry (for example, managing a cafeteria); (2) **job crews**: agency-sponsored groups of individuals with disabilities who travel together to work sites in the community (for example, cleaning and grounds maintenance crews); (3) **small businesses**: agency-operated work sites organised as businesses (for example, restaurants, benchwork industries, and other types of businesses that serve the community); (4) **individual placement**: locating community jobs for specific individuals based upon the worker's preference and abilities, along with the job requirements.

2.5 Evaluations have led to some changes in service delivery, though providers continue to deliver untested employment service models in segregated settings

Despite the existence of an increasing number of integrated employment options, many service providers continue to use more traditional approaches to providing employment services, especially sheltered and segregated approaches (Kregel and Dean (2002)). Many providers rely on approaches that they have been using for several years, in part, because their specific approach has not been tested against an alternative. Additionally, many service providers are adding components of alternative return-to-work practices, but continue to deliver their services in more segregated settings. Wehman *et al.* (2003) argued that policy development could be substantially enhanced by identifying quality indicators for all service providers (for example, the percentage in competitive employment) in the delivery of employment supports and rigorously evaluating whether existing programmes are meeting their objectives. Additional testing of existing service approaches is likely to be necessary to make further progress in improving the delivery of employment services, particularly given that many service providers are sceptical that alternative approaches will fare better than those currently in use.

Nonetheless, the three categories of evaluations cited above have been influential in shaping perceptions about the provision of employment supports for these particular populations. A major advantage of many of these tests is that they used an experimental design in which the findings could be used to convince a broad policy audience of the effectiveness or ineffectiveness of different approaches.

3 Influence of programme rules on return-to-work outcomes

3.1 Introduction

An important factor in setting expectations for outcomes in employment programmes is an understanding of how programmatic rules and the characteristics of the target population can influence decisions to work. Below, we provide background information on US disability programmes, focusing specifically on those administered by SSA, and make comparisons to similar programmes in the UK.

3.2 SSA disability programme rules discourage work

A major challenge in promoting return-to-work initiatives to SSDI and SSI claimants is that few leave the rolls. The observed rates of exits from the SSDI and SSI programmes is currently under 0.5 per cent and has remained largely unchanged over the past 20 years (Berkowitz (2003)). According to the Social Security Advisory Board (2006), the average programme duration for a person receiving SSDI or SSI benefits at age 20 was approximately 20 years.

Except for the one return-to-work initiative targeting low-income mothers with health limitations reviewed later in the report, the major return-to-work initiatives described in Chapters 4 and 5 have targeted SSDI and/or SSI claimants exclusively or included a disproportionate sample of participants who received SSDI and SSI benefits. Consequently, the expected overall outcomes from these initiatives must be considered within the context of these programmes.

Several programmatic rules for establishing and maintaining SSDI and SSI eligibility are likely to contribute to the low rates of programme exits. The long application process for SSDI and SSI, which both use the same disability criteria, contributes

to the lengthy programme durations (Social Security Advisory Board (2006)).⁸ During this process, applicants must provide SSA with extensive medical and, in some cases, vocational documentation about their impairment and they must not work above a certain threshold of earnings to qualify for benefits. Consequently, once claimants apply for benefits, they are likely to spend several months or years outside of the workforce proving to SSA that they have an inability to work, which likely minimises their future opportunities for returning to work. The continuing eligibility requirements are also likely to contribute to the long programme durations. There are no work requirements for receiving benefits and claimants maintain their eligibility as long as they meet SSA's disability criteria, which emphasise an inability to work because of the earnings threshold noted above. SSDI and SSI claimants interested in returning to work face complex work incentives that could lead to a loss of benefits if their earnings exceed a certain threshold. The potential loss of benefits could be especially large for those with high medical expenditures, given that SSDI and SSI eligibility are tied to access to medical coverage and other supports.⁹

3.3 UK has more-integrated system for providing disability cash and employment supports

In the UK, incapacity benefits is a generic term used to cover Incapacity Benefit (IB) and Income Support (IS) claimed on the basis of disability/health problem, these are the main cash benefits for people who have an illness or disability. The eligibility requirements for the contributory portion of the IB programme most closely resemble the SSDI cash benefit described above. To qualify for contributory

⁸ Initial disability determinations take an average of 120 days. Most initial determinations are rejected and a substantial portion of these determinations are appealed, which can further lengthen the application process for benefits. For example, appeals to denials at the hearings level, where applicants can take their denied initial and reconsidered claims outside of SSA to an outside Administrative Law Judge (ALJ), took an average of 422 days to process in 2005 (Social Security Advisory Board (2006)).

⁹ SSDI claimants are eligible for Medicare after a two-year waiting period, while SSI claimants (in most states) are categorically eligible for Medicaid. Medicare is a social insurance programme that provides health care coverage primarily for people with disabilities and those over age 65. Medicaid is a federal-state, individual entitlement programme for low-income people with limited resources that provides coverage for health care for five broad categories of people: (1) children; (2) pregnant women; (3) adults in families with dependent children; (4) people with disabilities; and (5) the elderly. SSDI and SSI claimants might also qualify for other supports, such as food assistance from food stamps, though, unlike Medicare and Medicaid, eligibility for these other programmes is not directly tied to SSDI and SSI eligibility.

IB, an applicant must be below a certain age (60 for women, 65 for men), unable to work either through disability or ill-health, unable to claim Statutory Sick Pay, and have paid or been credited with the minimum National Insurance contribution in one of the past two complete tax years.¹⁰ The IS portion of IB is most similar to the SSI programme because it is income and asset tested and does not depend on a work history.¹¹ Claimants who work more than 16 hours per week will lose their IB benefits, though they are eligible for a Return-to-Work Credit of up to £40 per week for individuals working at least 16 hours per week and earning less than £15,000 annually.

The IB programme durations are substantially shorter than the SSDI and SSI programme durations described above. Almost half (46 per cent) of IB claimants leave the programme within five years (Dorsett 2006). In comparison, most SSDI and SSI claimants remain on the rolls until they reach the retirement age (65) or die.

In recent years, there have been attempts to expand employment services to IB claimants, especially new claimants, through the provision of Pathways. The goal of Pathways, along with other reforms the Government is making to IB, is to increase the employment opportunities of people with disabilities and reduce the number of individuals receiving benefits by one million (2.7 million received benefits in 2007) (Fox (2007)). The original Pathways pilot was aimed only at new IB applicants but has gradually been expanded to include those who have made an IB claim between two and six years prior to the pilot's start-up (Nice *et al.* (2008)). National rollout commenced in late 2007, and Pathways has been nationwide since April 2008.

The key Pathways elements are a series of compulsory WFIs and a range of optional services and financial supports known as the Choices Package. Pathways services are provided either through Jobcentre Plus, a national Government agency that provides employment services, or external employment providers, depending on the geographic location. New IB claimants are required to attend a series of six WFIs beginning at eight weeks after making a claim in which participants meet with a personal adviser to discuss return-to-work issues, with sanctions imposed on the benefits of customers who do not attend the WFIs.¹² In addition, participants have access to other supports, such as the Choices package of

¹⁰ There are certain exceptions for young people who might not have had the opportunity to make sufficient contributions, as well as for those who were incapable of work before their spouse died.

¹¹ People are eligible for IS if they are registered as sick or disabled, they do not have savings of £16,000 or more, and they work on average fewer than 16 hours a week.

¹² The interviews are conducted roughly at monthly intervals beginning eight weeks after filing. Existing IB claimants must attend at least three of these interviews.

interventions, including services offered under the New Deal for Disabled People (NDDP), condition management programmes, and other work preparation and work learning services.

The UK Government is also implementing changes to further emphasise employment options for people with disabilities starting in October 2008, when new customers will receive an ESA instead of IB. The ESA programme is designed to emphasise a customer's ability to work through three programme characteristics (DWP (2008a, 2008b)). ESA claimants will go through an initial assessment process called the Work Capability Assessment (WCA) that emphasises a person's abilities, rather than limitations. All new applicants will enrol in ESA beginning in October, while existing IB claimants will be reassessed using the ESA's WCA between 2009 and 2013. ESA will provide employment counselling and supports to facilitate employment and require ESA claimants to engage in employment-focused activities. Specifically, those who are assessed as able to work will receive a lower ESA benefit and be placed in a 'Work-Related Activity Group' that will be expected to engage with a personalised programme of return-to-work supports similar to those offered under Pathways. Individuals with more severe conditions who are assessed as unable to work will be placed in a Support Group that receives a higher ESA benefit amount and can participate in the employment support programme on a voluntary basis.

3.4 Differences in US and UK disability programmes are important considerations in applying cross-national lessons

It is important to consider these programmatic differences in applying cross-national lessons for return-to-work initiatives, especially in interpreting programme impacts. For example, given the differences in programme eligibility rules and shorter programme durations for IB claimants, all else being equal, we would expect UK claimants to be more likely to participate in a return-to-work initiative relative to their US counterparts. However, as the UK Government seeks to expand services to long-term IB claimants who are transferred to ESA, it is likely that those claimants might share some similar needs for return-to-work services as those receiving SSDI and SSI benefits in the US.

4 Findings from large-scale return-to-work initiatives that targeted SSDI and SSI claimants

4.1 Introduction

This chapter summarises findings from the following five evaluations that targeted SSDI and SSI claimants:¹³

- STETS (1981–1982);
- TETD (1985–1993);
- Project NetWork (1991–1995);
- The SPI (1999–2004);
- TTW (1999–present).

The two earliest demonstrations tested the effectiveness of providing transitional supports to people with intellectual disabilities. In 1981, the US Department of Labor (DOL), a federal agency charged with preparing the American workforce and ensuring the adequacy of workplaces, funded the seminal random assignment study of return-to-work supports in the STETS demonstration. Claimants were recruited from social service agencies, though most participants were already receiving SSDI or SSI benefits. Based on the successful findings from STETS, SSA subsequently funded an evaluation of transitional employment services in 1985 that specifically targeted young adults with intellectual disabilities who were receiving SSI benefits in TETD. TETD included a much larger sample of claimants than did STETS

¹³ The STETS evaluation did not explicitly target SSA disability claimants, but it did include a large sample of SSI recipients in the target population.

(745 compared to 467) in 13 demonstration communities, which allowed for a more rigorous evaluation of programme impacts. The STETS study established the effectiveness of transitional employment supports in increasing employment among youth with disabilities (Kerachsky and Thornton (1987)), and the TETD evaluation confirmed that these services improved employment rates and earnings (Decker and Thornton (1995)).

In the 1990s, SSA sponsored the Project NetWork and SPI demonstrations to gain a better understanding of the potential for providing employment supports to a broader base of adult claimants. The Project NetWork demonstration was the first time that SSA provided services directly to its client population to test the feasibility and efficacy of the case management approach to improve employment of SSDI and SSI claimants. SSA funded the SPI demonstration projects in several states to identify innovative return-to-work models with a heavy emphasis on the effects of combining vocational approaches, work incentives, and improved information on work incentives ('benefits counselling'). In addition to the state-based approach, the SPI project was unique because it also included some projects funded from other agencies, including the Rehabilitation Services Agency (RSA), which oversees funding for state VR programmes. The evaluation findings from Project NetWork and SPI provided SSA with information on the effects of different intervention strategies for promoting employment among a broader pool of claimants (Kornfeld and Rupp (2000); Peikes *et al.* (2005)).

In 1999, policy makers implemented the TTW programme, which represents the largest return-to-work initiative ever funded for SSA disability claimants. A major programme emphasis under TTW was to expand return-to-work services to SSDI and SSI claimants, which had been provided predominately through VR agencies. The programme gives claimants more choices for obtaining services and offers employment-support service providers new financial incentives to serve claimants effectively. The TTW evaluation included an assessment of programme impacts, though the findings were based on a non-experimental design and, to date, only initial findings from the first two years of rollout are available (Thornton *et al.* (2007)).

SSA is currently implementing several ongoing demonstration projects for different segments of its claimant population, including people with psychiatric conditions, youth, and claimants without health insurance (see Appendix A for more details). These projects are being rolled out in several areas across the US and should provide valuable information on the potential in providing customised supports to subgroups of SSDI and SSI claimants.

In the rest of this chapter, we summarise the findings of these five evaluations. The summary is based primarily on findings from Kerachsky and Thornton (1987) (STETS), Decker and Thornton (1995) (TETD), Kornfeld and Rupp (2000) (Project NetWork), Peikes *et al.* (2005) (SPI), and Thornton *et al.* (2007) (TTW). To make comparisons of dollar estimates across studies, we adjust all estimates using the Consumer Price Index (CPI) to 2007 real dollars.¹⁴

4.2 Key project features

The key project features of the five major DOL and SSA initiatives are shown in Table 4.1. The study design, target population, sample size, location, and services provided in each varied substantially. Except for TTW, all the projects included at least some random assignment sites (SPI included a mixture of random assignment and quasi-experimental design). The target population varied across projects, though most used a combination of SSDI and SSI claimants. The size of the target population varied substantially, as some projects targeted specific impairments (TETD and STETS), whereas the remaining projects targeted a broader population with diverse impairments (Project NetWork, SPI, and TTW). The TTW programme, which targeted approximately ten million SSDI and SSI claimants across the nation, was by far the largest initiative and represents a programme rather than a demonstration. All the other demonstration projects included considerably smaller sample sizes, ranging from just under 500 participants in STETS to more than 8,000 in Project NetWork and SPI. The three SSA-funded demonstration projects (TETD, Project NetWork, and SPI) included waivers that provided additional incentives for demonstration participants to return to work. Finally, each project provided some type of employment service, though the costs of services per participant varied substantially, with the STETS and TETD projects representing the most costly interventions (\$10,594 per participant in TETD and \$19,568 per participant in STETS).¹⁵

4.2.1 Structured Training and Employment Transitional Services

STETS, implemented between November 1981 and December 1982 in five cities (Cincinnati, Los Angeles, New York City, St. Paul and Tucson), was the seminal random assignment study of transitional employment services for youth ages 18 to 24 who had IQ scores between 40 and 80 and who were recruited into the study by local social service organisations. Many of these youth received SSI and/or SSDI benefits. The intervention consisted of three phases of work interventions: an

¹⁴ The CPI index is available at <http://www.bls.gov/cpi/> (accessed January 15, 2008). In June 2007, \$1 was worth approximately £0.5. Source: www.finance.yahoo.com (accessed 1 March, 2008).

¹⁵ Unless otherwise noted, all cost estimates are expressed in 2007 dollars. The programme costs per participant were very large in STETS because of the intensity of the intervention and the relatively small sample of participants served.

introductory work exposure period, followed by actual employment with on-the-job training (or supported employment), and finally, post-employment follow-up and job supports (Kerachsky and Thornton (1987)). The five programmes enrolled a total of 467 participants. The evaluation tracked outcomes in a follow-up survey for treatment and control group members 6, 15 and 22 months following enrolment.

4.2.2 Transitional Employment Training Demonstration

TETD was implemented between 1985 and 1987 and provided job placement, on-the-job training, and job retention services to eligible SSI claimants who were between ages 18 and 40, were diagnosed with an intellectual disability, and were living in one of the 13 demonstration communities. The demonstration included 745 eligible claimants who volunteered to participate and were randomly assigned to a treatment or a control group.

Treatment group members could receive time-limited (one year) support job placement services or on-the-job training as part of the programme.¹⁶ Long-term impacts tracked treatment and control group members over a six-year period and examined impacts on employment, earnings, benefit receipt, and total income (Decker and Thornton (1995)).

¹⁶ Longer-term follow-up support could be arranged and paid for by the site.

Table 4.1 Summary of key features of return-to-work initiatives that targeted SSDI and SSI claimants

	STETS	TETD	Project NetWork	SPI	TTW
Study design	Random assignment; 22-month follow-up	Random assignment; voluntary participation; six-year follow-up	Random assignment; voluntary participation; six-year follow-up	Experimental design in three state projects and quasi-experimental evaluation in remaining projects; two-year follow-up	Non-experimental evaluation design using comparison groups
Target population	Youth with intellectual disabilities ages 18 to 24	SSI claimants with intellectual disabilities ages 18 to 40 (Voluntary)	SSI/SSDI claimants and applicants ages 15-65 (voluntary)	SSI/SSDI claimants ages 18 to 65	All SSI/SSDI claimants
Sample	467	745	8,428	8,667 (3,366 in the three state projects that used random assignment)	All SSI/SSDI claimants who choose to participate. As of 2004, fewer than two per cent of Tickets were in use. ^a
Location	Five cities	Thirteen demonstration communities in eight states served by eight training providers	Eight selected sites	Twelve sites (four random assignment sites in three states)	Nationwide
Services	Introductory work exposure period, followed by actual employment with on-the-job training (or supported employment), and finally post-employment follow-up and job supports	Job placement in potentially permanent positions, on-the-job training that was phased out over time, and job retention services, including postplacement follow-up	Four models of intensive employment-focused case management services	Benefits counselling, case management, better access to vocational supports	Claimants receive a voucher that can be used to purchase services from select providers

Continued

Table 4.1 Continued

	STETS	TETD	Project NetWork	SPI	TTW
Waivers	No waivers	Treatment group members to remain eligible for SSI even after attempting work	No disqualification from SSI or SSDI from employment for 12-month period	Waivers to allow claimants to retain more earned income	No waivers
Cost (adjusted in 2007 dollars)	\$19,568 per participant	\$10,594 per participant	\$5,165 per participant	\$400 to \$13,000 per participant	Not available

Sources: Sav (1989); Kerachsky and Thornton (1987); Decker and Thornton (1995); Kornfeld and Rupp (2000); Peikes *et al.* (2005); Thornton *et al.* (2007); and SSA (2008).

Notes: The STETS evaluation did not explicitly target SSA disability claimants, but it did include a large sample of SSI recipients in the target population. All dollar estimates are adjusted to the year 2007 using the Consumer Price Index, which is available at <http://www.bls.gov/cpi/> (accessed 15 January 2008). Only five of the SPI projects provided cost information. In four of the five projects, the costs were less than \$2,500 per participant.

^aSee http://www.ssa.gov/work/Ticket/ticket_info.html (accessed 24 January 2008) for updates on the number of claimants issued Tickets. As of January 2008, more than ten million eligible claimants had been issued Tickets. For information on calculating Ticket participation rates, see Thornton *et al.* (2007).

4.2.3 Project NetWork

Project NetWork started in 1991, and recruited SSI claimants and applicants and SSDI claimants between the ages 18 and 65 in eight sites around the country from 1992 to 1994. The demonstration provided intensive, employment-focused case management services to test the efficacy of case management services in moving people with severe disabilities into full-time employment and off the disability rolls (Rupp *et al.* (1994)). The demonstration tested different case management models provided by staff from four different entities (SSA, private contractor, VR counsellor, and an SSA referral to other providers).¹⁷ Using a random assignment design, 8,428 claimants were recruited over the intake period and assigned to either a treatment or a control group. Eighty-five per cent received public disability benefits, while the other 15 per cent were applicants to SSI (Kornfeld and Rupp (2000)). Only those in the treatment group could receive case management services, but those in the control group remained eligible for any employment assistance in their communities.

¹⁷ The four models had the same overall features, including identical outreach procedures and waiver provisions, but they differed somewhat in the implementation of the case management intervention. Each of the four models of case management was implemented in two of the eight demonstration sites. The first three models differed only in the nature of the organisational role and experiences of the case manager. In the SSA Case Manager Model, case management was provided by SSA staff. In the Private Contractor Model, case management was provided by private rehabilitation organisations. In the VR Outstationing Model, case managers came from state VR agencies and were outstationed in local SSA offices. The fourth model, the 'SSA Referral Manager Model', was designed to be less intensive and lower in cost: the focus was on referrals to other providers as opposed to direct services to clients.

4.2.4 The State Partnership Initiative

SPI included 12 SSA-funded projects that focused on delivering direct services to SSI and SSDI claimants using at least one of the following approaches:¹⁸ (1) improving information about the effect of work on benefit receipt (benefits counselling); (2) encouraging the use of available work incentives; (3) testing modifications to programme rules to allow SSI claimants in the three state projects to earn and save more; and (4) providing better access to vocational supports. These projects were funded from 1999 through 2004. The core evaluation was intended to compare key outcomes of participants in each project with outcomes of a comparison group that was selected to have similar demographics, prior labour market experiences and benefit receipt, and to live in similar areas (using a propensity matching approach). Four projects in three states (New Hampshire, New York, and Oklahoma) used an experimental design. The target population varied across state projects, though the largest random assignment projects (New York and Oklahoma) exclusively targeted SSDI and SSI claimants with psychiatric conditions. One of the three random assignment states (New York) tested the effects of two interventions (benefits counselling only and benefits counselling plus employment supports). The SPI projects in the three random assignment states included 3,366 participants (a total of 8,667 claimants were included in all SPI projects).

4.2.5 Ticket to Work

TTW was phased in during three stages across states from 2002 through 2004, attempting to increase the access to, and quality of, rehabilitation and employment services available to disability claimants. The ultimate goal is to increase the number of claimants who become economically self-sufficient. TTW introduces a new, goal-based financing system for employment service providers in both the public and private sectors. SSI and SSDI claimants who have been given return-to-work tickets by SSA can select from an array of SSA-approved public and private providers, referred to as employment networks, that have signed a contract with SSA. Providers can decide whether or not to accept tickets from people and can determine the types of services to be delivered. As part of the evaluation effort, the programme was rolled out in three phases so that researchers could use the

¹⁸ The original SPI projects included 18 projects in 17 states from 1999 to 2004 that delivered employment-related services to people with disabilities. SSA funded 12 of the 18 state projects, and RSA funded the remaining six. The SSA-funded projects focused on testing new services for the Social Security claimants with disabilities. The RSA-funded projects, in contrast, focused on activities aimed at changing the overall system that helps people with disabilities (some of whom receive other forms of public assistance) obtain employment and live independently. One of the 12 SSA-funded projects that targeted high school students with an emphasis on education and employment aspirations was excluded from the study because the administrative data for the project was not sufficient for measuring impacts on these outcomes.

variation in the phased rollout to evaluate impacts on service use, earnings, and benefit receipt.¹⁹

4.3 Evaluation designs

With the exception of TTW, each of the evaluations was based on an experimental design. Non-experimental methods were used to identify impacts in TTW as random assignment was not an option because it was rolled out as a programme to all eligible claimants.

While the primary findings from the SPI project were based on an experimental design in four sites, the evaluation also attempted a non-experimental analysis of outcomes in the remaining sites. To generate impacts in the non-experimental sites, Peikes *et al.* (2005) used a propensity score matching methodology, in which they matched treatment group participants on multiple administrative characteristics to a comparison group of claimants using administrative data. To test this method, they compared findings from the propensity score matching methodology to the random assignment findings in the four sites that had implemented random assignment. Presumably, if the propensity score matching method was unbiased, it would produce results similar to those based on random assignment. Thornton *et al.* (2007) used the phased rollout of the TTW to identify impacts.²⁰ To test the sensitivity of the findings, Thornton *et al.* compared their results to earlier cohorts (which did not have access to TTW) to determine whether the impacts from their

¹⁹ Phase 1, which began in February 2002, saw the programme introduced in 13 states around the country. Phase 2, which began in November 2002, extended TTW to 20 more states and the District of Columbia. Phase 3, which began in November 2003 and ended in September 2004, completed the rollout in the remaining 17 states and US territories. At present, claimants in all states are sent a Ticket as they become newly eligible for the programme.

²⁰ To identify impacts, Thornton *et al.* (2007) estimated a model that compared the outcomes of SSA disability claimants in states where the TTW had been rolled out, which they defined as the treatment group, to claimants in states where the TTW had not yet been implemented. They used data from a full population of SSA claimants who were potentially eligible in the TTW and tracked outcomes of this population in the year prior to, during, and one year after the rollout of the TTW. They estimated impacts using a longitudinal fixed effects model that included a treatment indicator identifying claimants living in states where the TTW was available. By tracking a single cohort of claimants before and after the TTW mailing, this model captured variation pre- and post-TTW rollout and the contemporaneous variation in outcomes across states where the TTW had been implemented (for example, Phase 1 states in the year of mailing the Tickets) and where it had not yet been rolled out (Phase 2 and 3 states in the year of mailing the Tickets).

TTW estimates could be distinguished from historical variation in outcomes prior to TTW.²¹

The non-experimental findings from both the TTW and SPI evaluations underscored the importance of using sensitivity tests to test the robustness of findings.²² The preliminary estimates from Thornton *et al.* (2007) indicated that several of their models produced significant impacts on earnings and benefit amounts following the rollout of TTW. However, when they applied their model to an earlier cohort when TTW was unavailable, they found similar differences in estimated 'effects' on earnings and benefit amounts. Consequently, they determined the effects on earnings and benefit amounts were too small to distinguish from trends in these outcomes that existed before the implementation of TTW. In SPI, Peikes *et al.* (2005) found that estimates derived from comparison groups identified with propensity score matching were inconsistent with those derived from an experimental design (in the four sites that also had random assignment).²³ As a result, the authors chose not to estimate impacts with propensity scoring methods in the sites that did not use random assignment, as the estimates likely would be biased. These experiences also illustrate the potential challenges of identifying comparable comparison groups to estimate impacts, which is a common challenge in any non-experimental design (Glazerman *et al.* (2003); Bloom *et al.* (2002); and Fraker and Maynard (1987)).

4.4 Participation rates

Except for STETS, for which information on participation was not available because participants were not recruited from a broad pool of social service agencies' referrals rather than from a list of participants from administrative records, participation

²¹ To test the sensitivity of their findings, Thornton *et al.* (2007) applied the model used to estimate impacts to several 'pre-TTW' cohorts (for example, a 1996 cohort) of claimants who were not exposed to the TTW. Their hypothesis was that there should be no 'effects' for the earlier cohorts given that the TTW treatment was not yet rolled out. In other words, if there were any impacts from the programme, the impacts from the TTW model should be distinguishable from the historical variations in outcomes.

²² In a separate evaluation in the United Kingdom, an evaluation team used data from the Project NetWork database to test the best approach to estimating non-experimental programme impacts for the NDDP programme. Orr, Bell, and Kornfeld (2004) tested nine different types of non-experimental models using data from Project NetWork and tested whether these methods produced similar impact findings to the experimental findings from Project NetWork. They used this experience to identify the most promising method to estimate programme impacts in NDDP.

²³ The propensity score matching estimates typically tended to overstate impacts estimates obtained from the random assignment design and moreover, the magnitude of the differences varied across the sites.

in the remaining four return-to-work initiatives had participation rates of less than six per cent (Table 4.2). These low rates reflect the challenges of recruiting volunteers for a return-to-work initiative from a sample of SSA disability cash claimants. Of the 13,800 eligible claimants invited to participate in TETD, only 745 people enrolled (5.4 per cent of all eligible people). Similarly, only 8,248 of the 150,000 people targeted for Project NetWork volunteered to take part in the demonstration (5.5 per cent of all eligible people).²⁴ Although the enrolment targets, which were created by state projects to satisfy the needs for the evaluation to detect programme effects, in SPI were achieved, the participation rates for the five states for which information was available were all below five per cent (Peikes and Bartkus (2002)).²⁵ Finally, for the TTW programme, although still in its infancy, only two per cent of the more than ten million eligible claimants had assigned Tickets.²⁶ The low participation rates in TTW reflect both a limited interest in participation by claimants and a limited supply of new and innovative employment service providers, who have been unwilling to participate because they view the programme as too risky and cumbersome relative to potential payments offered. According to Thornton *et al.* (2007), as evidence of the limited private sector involvement in the TTW programme, nearly all Tickets continue to be assigned to state VR agencies (91.7 per cent as of December 2004).

The findings across each of the evaluations showed generally consistent patterns regarding the types of disability claimants likely to participate in return-to-work initiatives.

Table 4.2 Participation rates from return-to-work initiatives that targeted SSDI and SSI claimants

	Eligible population	Percentage enrolled
STETS	Not applicable	Not applicable
TETD	13,800	5.4
Project NetWork	150,000	5.5
SPI	13,000-160,000	<5.0
TTW	10,411,738	<2.0

Sources: Decker and Thornton (1995); Kornfeld and Rupp (2000); Peikes and Bartkus (2002); Thornton *et al.* (2007); SSA (2008).

Notes: Unlike the SSA demonstration projects, STETS did not use a list of claimants to recruit volunteers. Hence, participation rates are unavailable. The number of eligible claimants varied across the four SPI random assignment projects. The TTW participation rates represent participation as of January 2008 (SSA 2008).

²⁴ However, this was 99 per cent of SSA’s goal of 8,400.

²⁵ Two of the SPI states (New Mexico and North Carolina) initially attempted to recruit a narrow subset of people with disabilities before substantially broadening their targeting criteria to compensate for a slower-than-expected rate of enrolment (Virginia Commonwealth University 2005).

²⁶ See http://www.ssa.gov/work/Ticket/ticket_info.html

Compared to non-participants, participants in TETD, Project NetWork, SPI and TTW tended to be younger, more educated, and more likely to have a recent work history (Decker and Thornton (1995); Kornfeld and Rupp (2000); Peikes and Bartkus (2002); Thornton *et al.* (2004)).²⁷ In addition, concurrent claimants (those eligible for both SSDI and SSI) were also generally more likely to participate in programmes than those who are eligible for only one of the programmes (Kornfeld and Rupp (2000); Thornton *et al.* (2004)).²⁸

An important implication of these findings is that people who volunteer for demonstration programmes are likely quite different from non-participants in characteristics that cannot be observed. As noted above, this creates some challenges in measuring impacts using matched comparisons in non-experimental designs. For example, in TETD, the control group – who had volunteered to participate but had not received services – achieved employment rates substantially higher than those of eligible people who did not volunteer (Thornton and Decker (1990)).

4.5 Impact findings

Each of the five projects included impact estimates for employment, earnings and programme participation. Each project proceeded from the assumption that the return-to-work intervention would first lead to an increase in employment and earnings of participants and then to a reduced reliance on cash benefits.

²⁷ Participants in TETD were, on average, one year younger than eligible non-participants and had better employment histories. Although all reported low wages, sample members in TETD were almost twice as likely to have reported wages before the demonstrations. However, there were no substantial differences in gender, race, or marital status (Decker and Thornton (1995)). Similarly, although the sample recruited for Project NetWork did not differ from the eligible universe in general demographic characteristics or even in the nature of impairment, it did differ in some measures of health status, work history and attitudes. Volunteers tended to be healthier than non-volunteers. Volunteers were much less likely to report poor health status (17 per cent compared to 29 per cent). In SPI, Peikes and Bartkus (2002) found that participants were more likely to be living in better labour markets, employed at intake, younger, and more highly educated than non-participants. Finally, Thornton *et al.* (2004) showed large differences in participation by age and programme group. They showed that although only 22 per cent of the eligible claimants were under age 40, 45 per cent of TTW participants were in that age group. Similar to Project NetWork, concurrent claimants were more likely to participate in TTW.

²⁸ Concurrent claimants generally include people who have some limited work history to qualify for a relatively small amount of SSDI benefits and limited incomes to qualify for SSI benefits.

Given that the progression back into the labour market and ultimately getting off benefits might not be immediate for many people with disabilities, an important consideration in reviewing impacts is the available time frame for the follow-up study. Of the five evaluations, three (STETS, TETD and Project NetWork) had follow-up periods longer than two years and two (SPI and TTW) had shorter follow-up periods of approximately one year (available at the time of this report). Therefore, the impact estimates from SPI and TTW should be viewed as short-term results.²⁹

In Table 4.3, we summarise the key findings for the impacts on employment, earnings, and benefit amounts from the major evaluations of these initiatives. In general, the STETS and TETD demonstration projects were the only ones to have large sustainable impacts on employment, earnings, and benefit receipt. The findings from Project NetWork indicate initial impacts in the two years following the intervention had disappeared after year 3. The findings from SPI indicate relatively large impacts on overall employment, but zero and, in one case, negative impacts on earnings. Finally, the findings from TTW indicate that the impacts on employment, earnings, and benefit amounts in the year following the mailing of Tickets were too small to distinguish from historical variation in these outcomes.

Interestingly, the largest impacts on overall long-term earnings occurred for the projects (STETS and TETD) that had the highest per-participant project costs (see Table 4.1), suggesting that more intensive investments might be needed to move people with disabilities into more sustained long-term employment. Despite the success of the STETS and TETD projects, neither project had impacts that resulted in a substantial reduction in the claimant caseload.

²⁹ Longer-term impacts are being planned for the TTW evaluation.

Table 4.3 Summary of impact estimates from return-to-work initiatives that targeted SSDI and SSI claimants

	STETS	TETD	Project NetWork	New York	SPI Oklahoma	New Hampshire	TTW evaluation
Sample size	467	745	8,428	1,815 for benefits counselling only and 1,846 for benefits counselling and employment services	1,696	49 for SSI concurrent and 64 for the SSDI-only sample	4.7 million
Employment outcomes	Per cent in competitive employment in month 22: Impact: 12.0 pp Control mean: 19.0 Treatment mean: 31.0	Per cent employed at end of six years: Impact: 9.0 pp Control mean: 41.8 Treatment mean: 50.8	Second-year follow-up: months worked Impact: 0.7 months Control mean: 3.5 Treatment mean: 4.2	Per cent with any employment in year after enrolment: Benefits counselling only: Impact: 8.8 pp Control mean: 33.3 Treatment mean: 42.1 Benefits counselling and employment services: Impact: 17.0 pp Control mean: 33.3 Treatment mean: 50.3	Per cent with any employment in year after enrolment: Impact: 17.0 pp Control mean: 27.1 Treatment mean: 44.1	Per cent with any employment in year after enrolment: SSI: Impact: -29.5 pp Control mean: 51.9 Treatment mean: 22.4 SSDI only: Impact: -29.6 pp Control mean: 58.6 Treatment mean: 29.0	Per cent employed annually in the year after Ticket mailing in Phase 1 states: No Impacts

Continued

Table 4.3 Continued

	SPI					TTW evaluation	
	STETS	TETD	Project NetWork	New York	Oklahoma		New Hampshire
Earnings outcomes (2007 dollars)	Earnings in month 22: Impact: \$43 per week (projected over the year: \$2,236) Control mean: \$58 per week (projected over the year: \$3,016) Treatment mean: \$101 per week (projected over the year: \$5,252)	Earnings in year 6: Impact: \$1,205 Control mean: \$2,140 Treatment mean: \$3,345 Total earnings for years 1-6: Impact: \$8,100 Control mean: \$11,301 Treatment mean: \$19,401	Average annual earnings: Year 2 annual earnings: Impact: \$321 Control mean: \$3,156 Treatment mean: \$3,477 Year 3 annual earnings: No impacts	Average annual earnings in year after enrolment: Benefits counselling only: Impact: No impacts Benefits counselling and employment services: No impacts	Average annual earnings in year after enrolment: No impact	Average annual earnings in year after enrolment: SSI: No impact SSDI-only: -\$1,840	Annual earnings in the year after Ticket mailing: Impact: Too small to differentiate from historical variation in outcomes Comparison mean: \$828

Continued

Table 4.3 Continued

	SPI					TTW evaluation
	STETS	TETD	Project NetWork	New York	Oklahoma	
Benefit receipt outcomes (2007 dollars)	Benefit Amounts for SSDI/SSI in Month 22: Impact: \$-43 per month (projected over the year: \$-516) Control mean: \$250 per month (projected over the year: \$3,000) Treatment mean: \$207 per month (projected over the year: \$2,484)	SSI Benefit Amount in Year 6: Impact: \$-316 Control mean: \$5,117 Treatment mean: \$4,801 Total SSI benefit for years 1-6: Impact: -\$1,645 Control mean: \$35,861 Treatment mean: \$34,216	SSI or SSDI receipt No impacts	Not available	Not available	Not available
						Annual SSDI and SSI benefit amount No impacts Annual SSDI and SSI benefit amount: Too small to differentiate from historical variation in outcomes Comparison mean: \$10,254

Sources: Kerachsky and Thornton (1987); Decker and Thornton (1995); Kornfeld and Rupp (2000); Peikes *et al.* (2005); Thornton *et al.* (2007).

Notes: All dollar estimates are adjusted to the year 2007 using the Consumer Price Index, which is available at <http://www.bls.gov/cpi/> (accessed 15 January 2008). The STETS demonstration included estimated impacts for average weekly earnings, which we extrapolated up to project annual earnings by multiplying weekly impacts by 52. The monthly benefit amount impacts were extrapolated up to project annual benefit impacts by multiplying the monthly impacts by 12. We only present impacts that were statistically significant from zero at the five per cent level.

pp refers to percentage points.

4.5.1 Employment

The STETS and TETD demonstration projects produced relatively large impacts in promoting employment outcomes for young adults with intellectual disabilities. The evaluation of TETD found that this increased the probability of being employed by about nine percentage points during the sixth year that the participants were followed (Decker and Thornton (1995)). At the end of six years after TETD enrolment, slightly more than half the treatment group members were employed, compared to about 42 per cent of control group members.

In Project NetWork, there was an increase in employment through the second year of follow-up, though the employment effects disappeared after year 3. Kornfeld and Rupp (2000) found that Project NetWork also had some positive impacts on the number of months worked in the second year after enrolment with treatment group members working about 0.7 months, or 20 per cent more months, than control group members. A notable finding in Project NetWork was that the impacts from the demonstration faded after the second year.

Three of the intervention models from SPI states (two projects in New York and one project in Oklahoma) produced relatively large impacts on employment, and one intervention (New Hampshire) produced negative impacts (for a much smaller sample). Peikes *et al.* (2005) found that the SPI interventions in New York and Oklahoma increased the proportion of SSI participants who worked during the year after the year of randomisation relative to the year before randomisation by 8.8 percentage points in one project and by 17.0 percentage points in two of the projects. The results for New Hampshire, which had smaller samples, suggest that employment may actually have decreased by as much as 30 percentage points. Peikes *et al.* (2005) noted that the positive impacts on employment for participants in New York and Oklahoma occurred because, although both the treatment groups and the control groups experienced declines in employment over time, the decline in the employment of the control groups was even larger than the decline for the treatment groups. These findings demonstrate that interventions may be successful if they can maintain employment for claimants who are already working.

Finally, the impact estimates from the TTW evaluation showed no significant effects on employment in the year after Ticket mailing in Phase 1 states, though this finding is not surprising given that the effects on employment might take longer to materialise (Thornton *et al.* (2007)).³⁰ They noted that the effects on earnings might be larger as TTW becomes a more fully mature programme.

4.5.2 Earnings

Except for the SPI project, the evaluation findings of impacts on earnings mirrored the findings for employment. In STETS, average weekly earnings increased by \$43 in the 22nd month following enrolment, which represents a 74 per cent increase over the control group mean earnings of \$58 per week. Similarly in TETD, there were large positive impacts on earnings; during the sixth year after enrolment this was \$1,205, representing a 56 per cent increase over the control group mean earnings of \$2,140 for that year. In Project NetWork, earnings impacts tapered off by the end of the third year. In the first two years, earnings impacts were similar (approximately \$320 over both years), which translated into a ten per cent increase over a control group mean of \$3,156. In the third year, which included data only from the early cohorts of enrollees, there were no impacts. Finally, the impact estimates from the TTW evaluation showed that the impacts on earnings in Phase 1 states were too small to differentiate from historical variation in the year after Ticket mailing, which is consistent with the employment findings noted above.³¹

In SPI, the earnings impacts were insignificant and, in some cases, negative. Peikes *et al.* (2005) found no significant impacts in the New York or Oklahoma projects despite the findings of positive impacts on employment.³² They found that the reductions in earnings in New York's benefits counselling-only group occurred

³⁰ The one area in which the TTW evaluation did find small initial impacts was in enrolment in private or public employment services provided by VR agencies and private providers in the year of TTW rollout, which is important given the programme's emphasis on creating a new market for services for claimants. Unlike the earnings and benefits impacts that will be described in more detail below, the authors do find that the service enrolment impacts were significant and differed from historical variation in service enrolment outcomes. Their estimates imply a 0.1 to 0.4 per cent increase in overall service usage.

³¹ Models used by Thornton *et al.* (2007) indicated that earnings were actually higher for the treatment group following the rollout of TTW. However, as noted above, when they applied their model to the earlier cohort when TTW was unavailable, they found similar differences in estimated 'effects' on earnings and benefit amounts.

³² New Hampshire, the one site with negative employment impacts, also showed negative impacts on earnings, though the sample size for this evaluation was very small (fewer than 35 participants in the intervention).

because, although both the treatment group and the control group experienced increases in earnings during the year after random assignment, the increase was greater for the control group. One possible explanation was that people who received benefits counselling might have been more aware of the work disincentives and hence, despite overall increases in employment, chose to work on a limited basis. However, the authors emphasised using caution in interpreting the results based on these short-term effects and suggested that longer-term follow-up data might provide more answers on the earnings outcomes.

4.5.3 Benefit receipt

Of the four studies that examined public disability benefit receipt, STETS and TETD showed small but significant reductions in benefits received, while the Project NetWork and the TTW evaluations found no significant effects.³³ The STETS demonstration project, while not targeted exclusively SSDI and SSI claimants, included a large share of these claimants as participants. After 22 months, Kerachsky and Thornton (1987) found that benefit amounts to treatment group members declined \$43 per month more relative to the control group, which represented an 18 per cent reduction in average benefits relative to the control group (which had a mean benefit amount of \$250 per month). In TETD, average SSI benefits were reduced by \$1,645 over the six-year period after enrolment. Among the subgroup that received SSDI benefits at the time of enrolment, the statistically significant impact on SSDI receipt was about 11 per cent at the end of the six-year post-enrolment period (Decker and Thornton (1995)). Project NetWork did not lead to any impacts on benefits. The TTW programme did not reduce overall benefit receipt and, like the earnings impacts, had impacts on benefit amounts that were too small to differentiate from historical trends in these outcomes (Thornton *et al.* 2007).

4.5.4 Subgroup and regional impacts

An important question in any evaluation that targets a population with diverse characteristics spread across several regions, is whether the impacts vary across subgroups or regions. In general, the target populations from the projects included a population with diverse demographic and impairment characteristics whose access to employment supports was likely to vary across state lines. Even in projects that targeted a more narrow impairment group, such as claimants with intellectual disabilities in TETD, there was a substantial difference in the severity of impairment characteristics of participants (Decker and Thornton (1995)).

The TETD, Project NetWork, and TTW evaluations all included notable findings for subgroup and regional impacts that provided more in-depth information on the effectiveness of these interventions.³⁴ In general, the findings from these studies

³³ The SPI study did not examine impacts on benefits reductions.

³⁴ The STETS evaluation had too small a sample to examine subgroups. The SPI evaluation had a summary of outcomes across sites, though it did not include a detailed analysis across subgroups of claimant characteristics.

suggested that claimants who were younger, had relatively less severe disabilities, and received services earlier generally benefited more from services.

In TETD, Decker and Thornton (1995) found the largest impacts on employment were for the group with the highest IQ scores and those who were living independently at the time of the intervention.³⁵ They also found that the sites that had the greatest impacts on employment and earnings on the broadest group of participants made special efforts to tailor services to the needs of each participant. In contrast, projects that offered a more standardised intervention either were effective for only a subset of participants or achieved few, if any, impacts.

In Project NetWork, a key finding was that the least intensive of the four interventions tested (which generally provided case management services) was least successful in producing positive net outcomes for claimants. In combination with their findings for the lack of impacts after three years, Kornfeld and Rupp (2000) suggested that people with disabilities might need more ongoing supports to remain successful in the labour market and that the use of case management in future interventions should be better targeted and likely include other supports. Finally, in the TTW evaluation, larger impacts on service enrolment were found (but not on benefits and earnings amounts) for younger claimants between ages 18 and 39. This finding was consistent with TTW participation patterns by age.

4.6 Cost benefit analyses of programmes

Three projects (STETS, TETD and Project NetWork) conducted cost-benefit analyses that examined the effects of each initiative on participants, the funding agency (SSA), federal government, and society as a whole. The participant perspective represents the effect of the projects on the participant's overall well-being, including their income, employment, and social interactions. The funding agency perspective (which was SSA, except in the STETS evaluation), represents the net savings in benefit payments relative to the costs of the projects. The federal government perspective represents the effect of the projects on overall taxes and expenditures collected by all levels of government. Finally, the social perspective weighs the relative advantages of each of these groups.

³⁵ In TETD, there were statistically significant differences in impact (at the ten per cent level) only across IQ categories (although the sample size in the evaluation did not provide much power for detecting these differences). The estimates suggest that the demonstration was particularly effective in increasing earnings for the group with the highest IQ scores but ineffective for groups with low or moderate scores. The estimated impact on earnings for people living independently at the time of enrolment was very large (189 per cent), which possibly reflects their greater independence or motivation (Decker and Thornton (1995)).

All projects showed net benefits to participants by increasing their income, though the gains in STETS and TETD were relatively larger than Project NetWork.³⁶ The evaluation findings suggested that the overall net social benefits of STETS and TETD were positive and the net social benefits for Project NetWork were negative.³⁷ In both STETS and TETD projects, the evaluations found that the earnings gains of participants along with the likely reductions in outside service use offset most of the costs of the demonstration project.

None of the projects showed a net benefit to the funding agency (SSA), which reflects the difficulty in designing a demonstration project that actively reduces caseload size. For example, in TETD, which had one of the largest effects on claimant payments, Thornton *et al.* (1988) found that the estimated reductions in average SSI payments only offset 16 per cent of the cost to provide services to each participant.

The evidence on the net benefits from the federal government perspective were mixed. Project NetWork resulted in a net cost to the federal government. In STETS and TETD, the overall benefit to the government depended on the availability of other services. It was expected that both projects would result in a net benefit to the Government when compared to areas that had expensive services like sheltered workshops, but would result in a net cost if they were compared to areas that had no services.

Finally, Project NetWork was determined to represent a net social cost given its small impacts relative to large project costs, whereas the evaluations from STETS and TETD suggested that participant benefits might have outweighed the relatively high project costs. In both STETS and TETD projects, the evaluations

³⁶ Kerachsky and Thornton (1987) estimated that the net benefit to the participant was approximately \$4,300 over the 22-month observation period. Decker and Thornton (1995) found that TETD-provided average earnings gains outweighed the reductions in average SSI payments, leading to a ten per cent increase per year in income. Finally, there was a small participant gain income from Project NetWork during the first two years of programme operations due to the modest impacts on earnings noted above (Burstein *et al.* 1999).

³⁷ In TETD, Decker and Thornton (1995) found that the earnings gains of participating SSI recipients offset approximately 75 per cent of the gross costs of providing the services and savings from the shift in service use away from sheltered employment seemed likely to offset the remaining cost. In STETS, Kerachsky *et al.* (1985) estimated that participant increases in output and reduction in use of other programmes offset approximately 85 per cent of the demonstration costs. Both evaluations also cited additional benefits, such as enhanced quality of life for claimants through increased job holding, additional social interaction and higher self-esteem, that were difficult to quantify.

found that the earnings gains of participants along with the likely reductions in outside service use offset most of the costs of the demonstration project.³⁸ Both evaluations also cited additional benefits to society that were more difficult to quantify, enhanced quality of life for claimants through increased job holding, additional social interaction and higher self-esteem.

³⁸ In TETD, Decker and Thornton (1995) found that the earnings gains of participating SSI recipients offset approximately 75 per cent of the gross costs of providing the services and savings from the shift in service use away from sheltered employment seemed likely to offset the remaining cost. In STETS, Kerachsky *et al.* (1985) estimated that participant increases in output and reduction in use of other programmes offset approximately 85 per cent of the demonstration costs.

5 Supported employment initiatives targeting people with psychiatric conditions

The initial evaluations of supported employment programmes, most of which targeted individuals with intellectual disabilities, were not very influential because of their lack of a rigorous evaluation. Many of these studies included limited samples and did not include a valid comparison group for estimating impacts (Decker and Thornton (1995)).

However, the evaluations of supported employment initiatives targeted people with psychiatric conditions have become very influential in the US as a consequence of their rigorous evaluation findings. In the 1990s, several independent evaluations were conducted on the effectiveness of different supported employment models for people with psychiatric conditions (Bond (2004); Cook *et al.* (2005)). Each of these evaluations used a rigorous random assignment evaluation design to identify impacts and provided detailed documentation of the services delivered so the findings could be replicated in other settings. As a follow-up to several of these studies, in 1995, the Substance Abuse and Mental Health Services Administration (SAMHSA), the US agency that helps states increase the quality and range of treatment, rehabilitation, and support services for people with psychiatric problems, funded the EIDP in eight cities. The EIDP was designed to determine new ways of enhancing employment opportunities for people with psychiatric conditions and included a random assignment evaluation of multiple supported employment models delivered by alternative service providers in various regions.

A major part of the influence of these evaluations was their documented success on **competitive employment**, which differentiated supported employment approaches from other vocational approaches that had been historically tested for people with psychiatric conditions. Competitive employment was a very specific

definition that defined a job as one that anyone can apply for, in regular places of community employment, and that pays at least minimum wage. This differed from other employment definitions, such as paid employment, which could include payments from sheltered and segregated job opportunities. Prior to the rigorous tests of the supported employment models for this population, there was a long history of testing alternative vocational approaches for people with severe psychiatric conditions, though none were as successful as the supported employment initiatives in promoting competitive employment outcomes. For example, Bond (1992) documented findings from over 24 randomised controlled trials of other (non-supported employment) vocational approaches for people with psychiatric conditions. While some of these approaches were effective in helping individuals achieve paid employment, none were shown to have a measurable impact on competitive employment.

Based on the rigorous evaluation findings and careful documentation of the intervention, the supported employment findings have been accepted as an 'evidence based practice' in the mental health field. Consequently, the supported employment models documented in these evaluations are increasingly expected, and in some cases required (by Medicaid, state mental health authorities, and others) in the provision of services to individuals with disabilities due to psychiatric conditions (Drake *et al.* (2001)).

In the rest of this chapter, we present the findings from three major summaries of random assignment evaluations of supported employment initiatives. The first two (Bond *et al.* (2005); Bond *et al.* (2008)) are reviews of randomised control studies that compare supported employment to a variety of traditional vocational services for people with severe psychiatric conditions.³⁹ Both studies compiled data from several independent evaluations of supported employment over the past two decades that have been funded by various state and federal agencies across several states. The third is a summary of findings from the EIDP demonstration by Cook *et al.* (2005), which was funded by SAMHSA to provide a comprehensive review of supported employment initiatives in eight sites.

5.1 Key project features

5.1.1 Individual randomised control trials of supported employment model, especially the Individual Placement and Support model

Bond *et al.* (2005) summarised the findings for 12 randomised control studies comparing supported employment to a variety of traditional vocational services for people with severe psychiatric conditions. These 12 studies have been conducted by nine different research teams in various geographic regions which represent

³⁹ Bond (2004) conducted a comprehensive summary of nine randomised control studies, and Bond *et al.* (2005) updated those finding with findings from three unpublished studies of supported employment programmes.

both rural and urban communities (New Hampshire, New York, Connecticut, Maryland, District of Columbia, South Carolina, Indiana, Illinois, California and Québec). The most common supported employment model tested was the Individual Placement and Support (IPS) model, which was implemented in eight sites (see Appendix B for a detailed description of this model). A major advantage of testing this model relative to other supported employment models was that it has been well documented in a practice manual (Becker and Drake (2003)) and it has an implementation resource kit (Becker and Bond (2002)).

In addition, a well-validated supported employment fidelity scale has been developed for evaluations of IPS (Becker *et al.* (2001)). The remaining four studies used 'pre-fidelity' versions of supported employment incorporating most, but not necessarily all, of the critical ingredients described above for IPS. The control groups usually have access to standard practices, which generally included sheltered workshops, psychosocial rehabilitation programmes, hospital-based vocational programmes and state-federal VR services.⁴⁰

Bond *et al.* (2008) built on the Bond *et al.* (2005) findings by restricting their analysis to IPS evaluations that had high adherence to the IPS model in addition to the requirements for inclusion in the earlier summary (for example, random assignment, competitive employment outcomes).⁴¹ The summary included 11 studies, some of which were included in the earlier Bond *et al.* (2005) summary,

⁴⁰ Comparison groups across the programmes were diverse. Two studies used a comparison group consisting of a brokered form of supported employment, two had a psychological rehabilitation programme as a control group, and three had sheltered workshops as their comparison group. One study used a control group consisting of a diversified placement approach, while another used a traditional hospital-based programme. Another compared prevocational training before referral, and the final three studies compared supported employment to referral to state-federal VR programmes

⁴¹ The Bond *et al.* (2008) summary also responds to several criticisms raised against the IPS model and its evaluations, which, if true, would limit the application of IPS to large, programme-based populations. The first criticism, that the IPS evaluations are biased because only individuals with employment interests are included in the studies, may be accurate, but given the principles of informed consent and consumer choice, forcing individuals into IPS unwillingly is not an option. Second, while IPS has been criticised as having high drop out rates (that is, study participants leave the programme before completing services), five of the studies reviewed in Bond *et al.* (2008) that had information on retention all found that treatment group participants left the study at lower rates than control group participants. Finally, while IPS has been shown to help individuals find employment, the duration of employment has been short. To answer this criticism, Bond *et al.* (2008) point out that the studies have short observation periods, and job tenure in the studies has been similar between treatment and control group participants.

and also incorporated findings from international studies. These findings provide further evidence of the potential effectiveness of the IPS models in other settings, including international locations.

5.1.2 Employment Intervention Demonstration Programme

The EIDP was designed as a multisite, randomised controlled trial of the effectiveness of several experimental supported employment programmes for people with psychiatric disabilities in eight locations across the US delivered by mental health and rehabilitation professionals, local and state government agencies, and self-help and peer support organisations. The demonstration started in 1995 and was concluded in 2003. The study was designed to determine new ways of enhancing employment opportunities and quality of life for consumers with psychiatric conditions. The experimental study group received services under different supported employment service models designed specifically for people with psychiatric conditions, including the IPS model described above, while other experimental sites enhanced their service model by providing unique features such as developing special connections to employers.

Although the experimental programme models varied, all shared common characteristics of supported employment programme models, including a focus on integration of clinical and employment services, availability of ongoing support, development of jobs consistent with the person's career ambitions, and a focus on rapid job placement. Researchers randomly assigned more than 1,600 participants to experimental and control groups at the eight EIDP study sites, and followed them for two years. Average total costs per client varied across sites, ranging from approximately \$2,000 to \$6,000 per client, with the average costs of direct vocational services ranging from \$500 to \$2,000 per year (Cook *et al.* (2008)).

5.2 Evaluation design

All the evaluation findings summarised below are based on random assignment. As noted above, Bond *et al.* (2005) summarised 12 randomised controlled studies that compared supported employment with established vocational services, and Bond *et al.* (2008) summarised 11 studies with similar requirements but also had high IPS fidelity. The follow-up period on these studies typically is one to three years, and sample sizes tend to be fairly small (from less than 50 to over 200). Cook *et al.* (2005) included a random assignment evaluation of several different models of supported employment delivered in eight sites where participants were followed for at least two years.

5.3 Impact findings

5.3.1 Employment and earnings

Bond *et al.* (2005), Bond *et al.* (2008), and Cook *et al.* (2005) used a variety of measures to examine effectiveness of employment services: percentage obtaining competitive employment, job tenure, total wages earned and number of weeks worked. They found positive impacts on most indicators examined, except for the job tenure measure. Bond *et al.* (2005) only examined impacts on employment. The average competitive employment rate was 59 per cent for consumers in supported employment, compared to 21 per cent for controls (weighting each study equally). Bond *et al.* (2008) found comparable employment rates of 61 per cent for treatment participants and 23 per cent for control participants. They also examined four studies that assessed hours worked, finding that 44 per cent of treatment participants were employed for 20 hours or more a week compared to 14 per cent of control participants. Similarly, Cook *et al.* (2005) showed individuals enrolled in supported employment programmes were more likely to be competitively employed than their counterparts (55 compared to 34 per cent) and work 40 or more hours per month (51 compared to 39 per cent), even when controlling for demographic characteristics and work history (Cook and O'Day (2006)). Cook *et al.* (2005) found that supported employment participants also had higher monthly earned income (\$122 compared to \$99 per month).

5.3.2 Income and benefits

Cook *et al.* (2005) found that many supported employment participants continued to receive SSI and/or SSDI at the end of the demonstration and many continued to have relatively low income levels. While the earnings impact findings in these studies were statistically significant and represented significant increases in monthly income, they were generally not enough to move people off benefits. As in the SSA evaluations above, the limited number of hours and low pay might be a reflection of several claimant characteristics and programme disincentives, including a fear of losing SSI, SSDI, and medical benefits (Cook and O'Day (2006)).

5.3.3 Subgroup, model and regional impacts

The Cook *et al.* (2005) study was structured to provide a detailed comparison across supported employment models, regions and subgroups. In comparisons across sites, Cook *et al.* (2005) found models that had a more integrated set of vocational services and clinical mental health services, such as medication management and individual therapy, were more effective than models with low levels of service integration. Participants in the more integrated models were over twice as likely to be competitively employed and almost one-and-one-half times as likely to work 40 or more hours per month (Cook and O'Day (2006)). They noted the results confirm the importance of communication between service providers, integration of mental health and rehabilitation services, and a strong emphasis on vocational services in meeting employment goals. They also showed the findings

were sensitive to economic conditions, though they found all supported models outperformed the control group regardless of economic condition. Specifically, they found that impacts were larger in strong labour markets, though they continued to find impacts in areas with high local unemployment. Bond (2004) and Bond *et al.* (2001) also examined subgroup impacts, but have not found any specific client characteristics (such as diagnosis, age, education) that consistently predict better employment outcomes.

5.4 Benefit cost analyses of programmes

A major challenge in the mental health literature is determining whether supported employment programmes are cost-effective. This is because the costs of providing supported employment services are difficult to measure: sample sizes are relatively small (in comparison to SSA studies), variations exist in implementation, a limited number of benefits are usually measured (employment, earnings and job tenure), and it is difficult to determine the long-term impact of these programmes (Schneider (2003)). Depending on programme model and service provider, a rough estimate of supported employment costs per participant is between \$2,500 to \$4,500 per year in 2007 dollars (Clark (1998)). In reviewing existing findings, Schneider (2003) found that supported employment programmes appear to cost less than alternatives such as sheltered workshops or day care, though she notes the findings are dependent on the assumption of tapering off of support over time.⁴² If only the benefits of employment are taken in consideration, it is likely that the supported employment programmes cost more than the benefits they produce. However, Schneider notes there is not a comprehensive analysis of benefits from these programmes, including their effect on long-term medical costs (for example, hospitalisations), housing, or education that could influence the view of their cost-effectiveness. Without this type of information and more detailed information on costs, policy makers are left with uncertainty over their overall cost-effectiveness. At present, the ultimate criterion that policy makers can make regarding these programmes is their effects on overall social welfare through greater inclusion of people with psychiatric conditions in the workforce.

⁴² For example, Clark (1998) notes that cost savings of supported employment programmes depends heavily on context. Specifically, these studies find that the 'costs' of supported employment are likely to be high in a setting where there are no VR services at the outset because there are no other alternatives. However, if the supported employment programmes replace existing vocational programmes, there appears to be a cost savings.

6 Return-to-work initiatives for low-income mothers with disabilities

In recent years, there has been an increasing interest in identifying return-to-work initiatives for low-income mothers with disabilities. The reforms mandated by the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 spurred the creation of employment programmes to promote the self-sufficiency of individuals receiving welfare benefits, including some that were designed to help people with disabilities.

While several programme models are beginning to emerge, the only available rigorous evaluation for this group is the PRIDE in New York City.⁴³ PRIDE was designed to assist welfare recipients who had health conditions that limited employment by providing work experiences that were tailored to an individual's health condition (Bloom *et al.* (2007)).

6.1 Key features of PRIDE

PRIDE was a joint project of New York City's Human Resources Administration and the local VR programme and provided services to eligible current or former welfare recipients who were '*employable with limitations*' (Bloom *et al.* (2007)). PRIDE served more than 30,000 people from 1999 to 2004 before it was replaced

⁴³ PRIDE is the only completed study we are aware of that used random assignment to assess the impact of a programme specifically targeting recipients with disabilities. While there are several return-to-work programmes for 'hard to serve' welfare recipients that include a large population of people with disabilities, most did not explicitly target people with disabilities. In many cases, the welfare studies have defined 'hard to serve' as participants who have been on the programme for a long period (for example, several years) or had a special need, such as a substance abuse.

by a new programme that built on PRIDE's successes. Those served were welfare recipients who were assessed as having psychiatric or other health conditions that limited or interfered with, but did not necessarily prevent, work (since these were individuals who had not qualified for federal disability benefits). This population had previously been exempt from participating in the work-related requirements of receiving cash assistance; PRIDE reversed this exemption and provided a mechanism for linking this population to the world of work.

To enter the programme, participants had to undergo a comprehensive medical exam to assess whether they met the project's health eligibility criteria. Participants were then assigned to a PRIDE vendor who delivered employment services. Participants used the vendor for vocational supports (such as job search, placement assistance, and employment retention services), following either a VR track (for individuals with more severe conditions) or a work-based education track (for individuals with less severe disabilities and who had educational or language barriers to work). Unemployed participants were expected to engage in unpaid work experiences of 20 to 25 hours per week. These experiences were designed to accommodate a person's health condition, and participants could fall under sanctions for not complying with employment activities, including losing their welfare benefits.

6.2 Evaluation design

The PRIDE evaluation examined a subset of 3,000 people who were recruited in 2001 and 2002 from two subpopulations: (1) single parents (who could have been receiving welfare benefits or other benefits); and (2) 'safety net' recipients who did not have dependent children.⁴⁴ It used random assignment to place these individuals into treatment and control groups. Members of the treatment group received the usual PRIDE services as outlined above, including sanctions for not participating. The control group was exempt from participating in employment activities, which mimicked the experiences of people with disabilities before the PRIDE programme began. However, members of the control group could choose to seek employment services, though they could not participate in PRIDE. Both treatment and control group members may have had medical re-evaluations during the evaluation, and so could have been found to be employable and therefore terminated from the programme. The evaluation used a combination of administrative records and a 12-month follow-up survey to assess programme impacts. Impacts are presented separately for the two subpopulations.

⁴⁴ Federal law limits most families to 60 months of federally-funded assistance in the US, but New York transfers most of their long-term recipients to their state and locally funded Safety Net programme.

6.3 Impact findings

6.3.1 Employment and earnings

Members of the PRIDE treatment group had significant but modest increases in their employment rates in comparison to the control group, but earnings information is inconclusive. Bloom *et al.* (2007) found 33.7 per cent of single-parent treatment group members were employed at any point over a two-year period, compared to 26.5 per cent of control group members (a 27 per cent increase). For safety net recipients, 25.4 per cent of treatment group members were ever employed, compared to 18.9 per cent of the control group (a 34 per cent increase). Despite this increase in employment, a large proportion of treatment group members did not have any earnings during the evaluation period, and many participants were sanctioned for not participating in employment activities.

Bloom *et al.* (2007) also found modest impacts on earnings. Based on a 12-month survey of participants (which only included single parents), treatment group members earned significantly more than control group members (\$73 a week compared to \$55 a week).

6.3.2 Income and benefits

PRIDE decreased cash assistance for single parents but not safety net recipients, and had no observed effects on other programmes. Single-parent treatment group members received \$10,700 in cash assistance over a two-year period, while control group members received \$11,600, a significant difference of \$818 (which represents a 7.1 per cent reduction in cash assistance).

6.4 Cost benefit analyses of programmes

The existing study on PRIDE did not include information about the benefits and costs of the programme. Future reports may include these data, as well as additional long-term impacts.

7 Lessons for future research and programme development in the UK

This chapter reviews lessons from the US experience that could be beneficial in delivering services under the UK's existing Pathways programme and in the development of future evaluations of return-to-work interventions for people with disabilities. Although substantial differences exist between the US and UK disability systems in the delivery of employment supports, the US experience in providing specialised services to specific impairment groups and to long-term cash disability claimants offers potential lessons in areas that will likely be of growing interest in the United Kingdom.

7.1 Pathways evaluation indicates promising impacts, but some groups might need additional supports to achieve employment outcomes

The evaluation findings from the Pathways programme indicate promising impacts on overall employment and programme participation for new IB claimants. In examining Pathways impacts on new IB claimants in the pilot areas over the first 18 months of operations, Bewley, *et al.* (2007) found that Pathways increased the probability of being in paid work by 7.4 percentage points (a 25 per cent increase over the comparison group) and reduced the percentage receiving IB by 1.1 percentage points (a two per cent decrease relative to the comparison group).⁴⁵ Based on the success of the Pathways intervention, UK policymakers

⁴⁵ Bewley *et al.* (2008) also conducted a follow-up study of the impact of Pathways on existing claimants who had been receiving benefits for approximately one to three years. Similar to their findings for existing claimants, they found that Pathways had positive impacts on earnings and negative impacts on benefit amounts for this population as well.

have expanded services to broader pools of IB claimants nationally and there are plans to continue providing these services with the implementation of the new ESA programme.

The evaluation findings also indicate that impacts varied across subgroups of claimants and most of the impacts on employment were for those who were working less than 16 hours a week. Specifically, Bewley *et al.* (2007) found that Pathways had little effect on the employment or self-reported health of those whose main health condition at the time of the first interview involved psychiatric conditions. Bewley *et al.* also found that the largest employment impacts were for those who were working fewer than 16 hours per week, which was likely to be influenced by the threshold incentives for permitted work rules for IB benefits, which currently restricts work to 16 hours per week before benefits are cut.

7.2 Lessons for enhancing employment and tracking outcomes from Pathways to Work

To address the variations in impacts across subgroups and the more limited impacts on full-time employment, UK policymakers might look to refine elements of Pathways service delivery for certain groups. It will be important for policymakers to continue to monitor Pathways outcomes as the programmes expand, especially for long-term claimants and subgroups such as new claimants with psychiatric conditions who do not appear to be progressing in the labour market. The US experience provides the following lessons for enhancing Pathways services in these areas.

7.2.1 **Pathways participants with psychiatric conditions might benefit from additional supports, especially supported employment services**

The repeated success of supported employment models in promoting employment for people with psychiatric conditions suggests that integrating these types of supports into Pathways could be one option to improve outcomes for people with psychiatric conditions. The systematic body of rigorous research showing effectiveness of supported employment programmes in helping psychiatric consumers achieve competitive employment across a variety of settings indicates that special attention should be given to these models when serving people with psychiatric disorders (Bond (2004); Bond *et al.* (2005); Bond *et al.* (1999); Cook *et al.* (2005); Bond *et al.* (2008)). Within the mental health field, these models have been accepted as an evidence-based practice in the US and are increasingly expected, and in some cases required in the provision of services to individuals with psychiatric disabilities (Drake *et al.* (2001)). These models have been tested in a variety of locations using different service providers in the EIDP demonstration, and presumably they can also be implemented in other locations, including internationally. Four of the 11 studies included in Bond *et al.*'s (2008) review of the IPS model were conducted outside of the US (Australia, Canada, Hong Kong and six

European cities), all of which showed positive impacts. The IPS model in particular has been described in detail in a practice manual (Becker and Drake (2003)) and an implementation resource kit (Becker and Bond (2002)). Schneider (2003) notes that similar models of supported employment exist in the UK that follow the same general principles of the IPS models described above. However, Boyce *et al.* (2008) noted that adherence to the IPS model could be improved in the UK. In interviews with five leading UK-supported employment providers, one provider received a good rating, three received a fair rating, and one received a non-adherence score. Programmatic efforts by UK policy officials could facilitate provider adherence to the IPS model, especially through NDDP, to achieve better employment outcomes for people with psychiatric conditions in the United Kingdom.

7.2.2 Adding work incentives to allow people to work more than 16 hours per week might further enhance Pathways outcomes

The expansion of the existing permitted work rules for benefits under IB, which currently restricts work to 16 hours per week before benefits are cut, might enhance more substantial labour market attachment by Pathways participants. Several US demonstrations, including TETD, Project NetWork and SPI, have added work incentives to enhance programme outcomes through the use of a waiver that provides special work incentive benefits to programme participants. When special waivers are added, it is important that participants fully understand the effects of these new provisions on their benefits. The SPI evaluation confirmed the need for disability claimants to have a good understanding of programme rules if they are to respond to SSA work incentives (Peikes *et al.* (2005)). In the UK, changes to enhance work outcomes could potentially be made to the permitted work rules or by expanding other policies, such as the Return-to-Work Credit that currently offers financial support to those working more than 16 hours per week.

7.2.3 Long-term claimants will be likely to need more intensive supports than those currently offered in Pathways to move into employment

Long-term IB claimants who will be reassessed under the ESA programme, particularly those who are older or have been out of the workforce longer, will be likely to have more employment barriers and support needs than the claimants served currently under Pathways. Long-term claimants will need several different types of tailored health, employment and other services (for example, life skills) to move successfully into employment. The US evaluation findings indicate that tailoring services to the needs of each participant generally results in stronger employment outcomes, though these types of services can be relatively expensive. For example, the US return-to-work intervention that had the largest impacts on employment and benefit amounts – STETS and TETD – also provided the most intensive set of supports. In contrast, the relatively less-intensive approaches used in the Project NetWork and SPI projects produced relatively minimal outcomes.

7.2.4 Additional data on delivered services could be helpful in understanding the effects of Pathways on its intended population

The current Pathways databases include some basic information on the general services provided, such as the number of WFIs conducted (see Blythe (2007)), but has more-limited information on the intensity or content of specific types of services (for example, rehabilitation, job preparation, and job coaching). Provider data have been used in several US evaluations to monitor variations in service delivery across areas, learning about programme participation and take-up of different types of services, and more broadly, in understanding the relationship between the services provided and successful outcomes. For example, in TETD, provider data were important in showing a link between individualised services and larger employment impacts across sites. Specifically, Decker and Thornton (1995) found that sites that made special efforts to tailor services to the needs of each participant outperformed sites with a more standardised intervention. These monitoring systems have also been used in the US to track national and site-specific performance targets, to assess fidelity in the services delivered to the target population, and to provide incentives to providers for improvement of their service delivery.

7.3 Lessons for evaluating future UK employment initiatives for people with disabilities

The US experience also provides some more-general lessons for evaluating future UK return-to-work interventions:

7.3.1 Interventions are unlikely to reduce caseload sizes among long-term programme participants

As employment services are expanded to groups with more-severe disabilities in the UK, it is important to recognise that although these services might enhance employment, it is unlikely they will reduce caseload sizes. In the US, none of the previous evaluations of return-to-work efforts of SSA initiatives, supported employment, or state welfare projects led to a substantial reduction in caseloads. Although some projects, such as STETS and TETD, produced small impacts on benefit receipt, these benefits were not large enough to offset the costs of the funding agency. Even projects that had mandatory participation requirements, such as PRIDE, failed to reduce caseload sizes substantially. Nonetheless, some of these interventions may be cost effective from a social perspective if they substantially increase claimant well-being and reduce reliance on other expensive government services, including sheltered and segregated employment.

7.3.2 Identifying outcomes that can measure the success of the programme before implementation is important to a clear articulation of key evaluation findings

A logic model that clearly states the hypotheses being tested and provides a clear summary of programmatic goals can be useful to participants, providers, policymakers and the evaluation team. Clearly stated outcomes that the programme is intending to affect can be particularly useful when evaluations report findings on a large number of outcomes, because it is possible that, in looking across a large number of outcomes, some may appear to be significant due only to chance, even when there is no real effect. Specifically, because researchers will have only estimated effects, there is some chance that an effective intervention will generate mostly insignificant impact estimates or that an ineffective programme will generate significant impacts on a small number of outcomes. A strong logic model would distinguish those outcomes that should be treated as core evaluation outcomes and treat other outcomes more as exploratory findings. For example, in the TTW evaluation, Thornton *et al.* (2007) used a simple logic model to justify their selection of a limited number of outcomes to analyse in the impact analysis and to discuss how these outcomes might progress as the programme matures in later years. In evaluating impacts, they hypothesised the programme would have an immediate impact on service use by claimants and subsequent impacts on earnings and then benefits. If they found impacts on, for example, earnings but not benefits, they would have been likely to have questioned these findings based on the anticipated flow of impacts in the logic model.

7.3.3 Creating a research database from administrative files on programme participation is a valuable tool in tracking the progress of disability policies

Administrative records on programme participation are a valuable source of information for any evaluation, though these records often have to be transformed into a more usable format before they can be used for research purposes. A US example of such a linked data set is the TRF, which includes information on SSDI and SSI claimant characteristics and programme outcomes over a person's entire history of participating in the programme. Such a file potentially could be created for IB and ESA claimants in the UK. The primary advantage of this file is that it provides a systematic way of coding and storing data on programmatic outcomes that can be reused for future research projects. Additionally, to protect the confidentiality of the data, access to the file could be restricted to those who meet data security criteria. The current data security procedures for the TRF provide one model for how UK programme administrators might go about creating and protecting these data, which is important in light of recent data security concerns in the UK.

7.3.4 Rigorous evaluation findings, especially those based on random assignment designs, can be an important factor in building consensus on evidence-based practices

It is important to fund projects that are of sufficient size and implement methods to determine successful outcomes that can be agreed upon by researchers and practitioners. The supported employment evaluations for people with psychiatric conditions illustrate the role that rigorous evaluations can play in policy development, particularly given that the findings led to this approach being accepted as an evidence-based practice by mental health practitioners. Conversely, the influence of other evaluations of US return-to-work interventions has been limited in many cases because they lacked a sufficient sample size and/or a credible comparison group to identify programme impacts. For example, the support for supported employment models for other people with disabilities is based more on faith because of a lack of rigorous evaluation findings, which has led to much less financial support for extending these programmes to broader populations. Similarly, staff members of several SPI evaluations that did not use control groups stated that, had they known before the project what they later learned, they would have pushed harder for random assignment. This was particularly true of staff members in states who were convinced of the positive impact of their project but also recognised the weaknesses in their current research design.

7.3.5 When using non-experimental methods, use multiple approaches to conduct sensitivity tests on programme impacts

The use of multiple comparison groups and sensitivity tests should be an important consideration in any non-experimental evaluation. Both the TTW and SPI evaluations identified problems with non-experimental methods that were exposed with additional sensitivity tests. In both cases, the sensitivity tests identified biases in the estimated models, which led the evaluation researchers to use alternative methods to examine programme impacts. In TTW, Thornton *et al.* (2007) found a statistically significant effect on earnings, but they found similarly sized estimates when they reapplied their model to a cohort during a period before TTW rollout. For this reason, they were skeptical that the observed earnings impact estimates reflected true TTW impacts on earnings and hence, concluded that any observed effects were too small to differentiate from historical trends. In SPI, Peikes *et al.* (2005) found that estimates derived from comparison groups identified with propensity score matching were inconsistent with those derived from an experimental design (in the four sites that also had random assignment). Hence, the authors chose not to estimate impacts with propensity scoring method in the other sites, as the estimates would likely be biased. In both the SPI and TTW evaluation, the ability to conduct these sensitivity tests was made possible by the large administrative databases noted above that the evaluators used to test their models across a number of key outcomes for a variety of comparison groups.

8 Discussion

The US experience in promoting return-to-work supports for people with disabilities has resulted in some success in promoting employment outcomes, though none of the tested initiatives led to a substantial reduction in caseload size. Several US initiatives produced positive employment and earnings impacts that resulted in increased income for participants. However, the income gained was not necessarily large enough to move participants off public benefits. The impact on long-term benefit receipt was generally minimal, regardless of whether the programme was voluntary or mandatory. In part, these findings underscore the challenges of moving people off long-term benefits and into self-sufficiency, particularly given that many people targeted for these services had been out of (full-time) work for several years. Nonetheless, strong interventions potentially can be cost beneficial from a social standpoint, particularly if these interventions serve as a less expensive alternative to existing costly supports from traditional providers.

The US evaluation findings have had some effect in the delivery of employment services, though more evidence is needed to convince policymakers about the direction for more-fundamental changes to the current system of supports. The evaluations of supported employment interventions for people with psychiatric conditions are particularly noteworthy because the evaluation findings from these interventions have led practitioners to adopt this approach as a best practice. Several other US evaluations of demonstration projects have also been influential in providing information on the potential of alternative employment supports, especially in serving people who receive disability cash benefits. In general, the findings from these evaluations indicate that more-intensive interventions with individualised supports can produce relatively large impacts on employment and earnings, relative to the less-intensive (and less-costly) interventions that have been tested.

The US experience in providing specialised services to specific impairment groups and long-term cash disability claimants offers potential lessons to the development of similar initiatives in the UK. These experiences will be particularly important for UK policymakers as programmes, such as Pathways, are extended to people with more severe disabilities. These lessons include possible expansions in work incentives to the permitted work rules and/or Return-to-Work Credit, improvements

in supported employment options for people with psychiatric conditions, enhanced supports for long-term claimants, and the increasing data service provider data collection efforts to better understand the process of service delivery.

The US experience also offers some, more general, lessons in developing future employment initiatives for people with disabilities, especially long-term disability claimants and people with psychiatric impairments. Of particular importance is funding projects at a sufficient scale that they can be rigorously evaluated and the results can be used to build a consensus on best practices among policymakers and practitioners. The ability to evaluate future interventions and programme initiatives would be enhanced if UK policy officials could develop research databases from existing administrative data sources on programme participation, similar to efforts that were used in the US to create the TRF.

In the future, there are likely to be continuing lessons concerning return-to-work initiatives that both countries can share. The UK approach to delivering services, including mandatory WFIs early at application, represents a bold approach that has not been tested within the US. The US approach to providing services to specific impairment groups and longer-term claimants in ongoing demonstration projects targeted to include those with psychiatric conditions, youth, and those who lack health insurance, should provide some insights on potential best practices that could be used in serving IB and, starting in October 2008, ESA claimants.

Appendix A

Description of US disability programmes

This appendix provides, for reference, a detailed summary of US programmes that serve people with disabilities. The first part describes the SSDI and SSI programmes administered by the SSA, including its programme eligibility rules, linkages to health care coverage, and limited rates of employment rates by claimants. To illustrate the role of other US safety net programmes, in the second part of this appendix we describe other major federal and state programmes that serve people with disabilities. We conclude by describing ongoing return-to-work initiatives funded by SSA not covered in the text (because the evaluations are not yet available) and other agencies that should provide useful information in the future on best practices in serving people with disabilities.

A.1 Social Security disability programmes

The SSI and SSDI programmes are the two largest federal cash benefit programmes for people with disabilities. The SSDI programme is a social insurance programme designed to replace the lost wages of adult workers with disabilities, and SSI is an income maintenance programme for low-income adults with disabilities. The SSDI programme provides benefits to disabled workers, their spouses, and children (whether they have a disability or not). SSDI benefits are paid from a trust fund, collected in the form of payroll taxes paid by employees and employers. The SSI programme provides monthly cash benefits to aged, disabled, and blind individuals who meet income and resource limits as well as the medical eligibility requirements. Benefits are paid to blind and disabled children under age 18 and adults age 18 or older. Unlike SSDI, the SSI payments are taken from general government revenue tax funds.

Because SSDI is a social insurance programme that calculates benefit amounts based on past wages, SSDI benefits are larger than SSI benefits. In 2007, the

average SSDI monthly payment was \$981, while the maximum monthly federal cash payment for SSI was \$623 (about 75 per cent of the poverty level for an individual).⁴⁶ Based on an exchange rate of £1 to \$2 at the end of calendar year 2007, this translates to an SSDI benefit of £490 and an SSI benefit of £311.⁴⁷

Both programmes have grown substantially since 1990 and represent the largest federally-funded programmes that provide cash benefits to people with disabilities in the US. According to the SSA (2006), since 1990 the total cost of providing SSDI benefits has risen 93 per cent in real terms (160 per cent in nominal terms) and the total cost of providing SSI benefits has increased nearly 90 per cent in real terms (150 per cent in nominal terms). As of October 2007, there were 8.9 million SSDI claimants and 6.2 million blind and disabled SSI claimants (SSA (2007a, 2007b)).

Relative to SSI claimants, SSDI claimants are older, have a work history, have more education, and are more likely to have a physical impairment (SSA (2003)). Both programmes include a large share of claimants with a 'mental disorder' (36 per cent for SSI and 22 per cent for SSDI).⁴⁸

Several factors have contributed to the growth of the Social Security disability programmes, including the ageing of the population, changes in the disability determination process (especially in assessing psychiatric conditions), changes in other US welfare programmes and economic changes (see Stapleton *et al.* 1998 for a more detailed description). Other, more recent studies have suggested that this large programme has also affected the overall employment rates of people with disabilities in the US (Stapleton and Burkhauser (2003)).

Below, we describe some salient features related to the two programmes.

A.1.1 Assessing SSDI and SSI eligibility is a lengthy process

SSA administers both programmes and uses the same administrative process in assessing disability. In making eligibility determinations, SSA assesses whether a person:

⁴⁶ For more information on SSDI benefit amounts by year, see http://www.socialsecurity.gov/policy/docs/statcomps/oasdi_monthly/2007-11/table05.html (accessed 3 January 2008). For more information on SSI benefit amounts, see <http://www.ssa.gov/OACT/COLA/SSlamts.html> (accessed 3 January 2008). Many states provided a separate supplement to the federal SSI payment.

⁴⁷ Exchange rate converters are available at <http://finance.yahoo.com/currency/convert?amt=981&from=USD&to=GBP&submit=Convert> (accessed 15 February, 2008).

⁴⁸ SSA includes both psychiatric conditions and intellectual disabilities under the category 'mental disorder'.

- has a medically determined disability expected to last at least 12 months or result in death;
- was unable to engage in ‘substantial gainful activity’ (SGA), which was defined as earnings above \$900 in 2007 for all non-blind disability applicants (\$1,500 was the limit for blind disability applicants).⁴⁹

The primary eligibility difference between the SSDI and SSI programmes is that SSDI payments vary based on the claimant's earnings history, and SSI payments are fixed at federal and state maximum levels and reduced for excess earnings and income. For the SSDI application process, SSA gathers information about an applicant's work history. For the SSI application process, SSA gathers information on the applicant's income and assets. To qualify for SSI, a person must have limited income (defined as below approximately \$600 a month) and limited assets (defined as below approximately \$2,000).⁵⁰ A person qualifies for SSDI by meeting certain work history and earnings conditions that vary based on age, in addition to the disability requirements mentioned above. The SSDI programme provides benefits to persons who are blind or disabled and who have worked and paid Social Security taxes for 20 of the 40 most recent calendar quarters. Although SSDI is not targeted directly toward low-income adults, many low-income adults with limited work histories receive SSDI benefits. SSA automatically determines whether a person is applying for SSDI, SSI, or both, based on their work history. Some claimants also concurrently receive SSDI and SSI benefits (concurrent claimants) because their relatively limited work histories translate into small SSDI benefits, which puts their household income below the SSI eligibility thresholds.

The disability benefit application process is quite long. To apply for benefits, an applicant must provide SSA with detailed information on income, assets and impairment. While SSA can quickly determine whether the applicant meets the income and asset criteria, the assessment of disability status is far more complex and time intensive. Local SSA officers forward eligible cases to state Disability Determination Service (DDS) agencies, which collect detailed documentation of the applicant's impairments, including physician records and other forms. DDS then makes a decision regarding the severity of the impairment and the applicant's ability to complete any work in the national economy based on medical information

⁴⁹ See <http://www.ssa.gov/OACT/COLA/sga.html> for updates on annual SGA amounts.

⁵⁰ The specific income and asset thresholds vary somewhat by states and also depend on the marital status of the applicant. For more details, see <http://www.socialsecurity.gov/ssi/text-eligibility-ussi.htm>

and other characteristics, such as age and education.⁵¹ Initial allowance rates often vary from state to state, in part because of challenges of making complicated assessments and the differences in the characteristics of applicants across states. For example, in 2004, allowance rates for SSDI-only applicants ranged from a high of more than 65 per cent in New Hampshire to a low of 31 per cent in Tennessee (Social Security Advisory Board (2006)). Because of the complexity of this assessment, the initial DDS determinations take an average of 120 days (Social Security Advisory Board (2006), Chart 62). Initial applications are often rejected, but most applicants reapply for benefits using SSA's appeals process. The entire application process can last from several months to several years. For example, appeals to denials at the hearings level, in which applicants can take their denied initial and reconsidered claims outside of SSA to an administrative law judge took an average of 422 days to process in 2005. After an award is made at any level, SSI benefits are paid retroactively to the date of application, and SSDI benefits are paid retrospectively to five months after the onset of disability.

A.1.2 Linkage to health insurance represents an important benefit

Despite the long application process, there is a strong incentive for many people with disabilities to apply for benefits because these programmes provide access to medical coverage through Medicare and Medicaid. This access is especially important because the US lacks a universal health coverage system and relies on employer-based health insurance to cover most working-age adults. SSI claimants (in most states) are categorically eligible for Medicaid,⁵² while SSDI claimants are

⁵¹ The disability determination process occurs in five stages. Step 1 is an initial work test that requires that an applicant not be working at a job that pays more than the SGA level set by SSA (\$830 in 2005). Step 2 is a test of the severity of a person's condition. An applicant can be denied entry into a disability programme if the condition is deemed not severe or is not expected to last more than 12 months. Step 3 is a medical-listing test. A person can be allowed benefits at this stage if the disabling condition meets or equals any of the severe medical conditions listed in the SSA medical listings. Step 4 is a test of previous work, to determine whether the applicant can do the work they had been doing. If so, the case is denied. If not, the case proceeds to the fifth step, a determination as to whether an applicant can perform any work that exists in the national economy (SSA (2003)).

⁵² Medicaid is a means-tested, federal/state, individual entitlement programme that provides coverage for health care for five broad categories of people with low income and limited resources: (1) children; (2) pregnant women; (3) adults in families with dependent children; (4) people with disabilities; and (5) the elderly. Mandatory services include inpatient and outpatient hospital services, nursing home and home health care, family planning, and rural health clinics and qualified health centers. There is a great deal of flexibility in how states can administer their Medicaid programmes. States are allowed to establish their own individual eligibility criteria and to determine the amount, type, duration and scope of services to be provided (Findley (2004)).

eligible for Medicare after a two-year waiting period.⁵³ In addition, some SSDI claimants might be eligible for Medicaid if they have low incomes and meet their state's guidelines for coverage. Medicare and Medicaid both provide an important source of health care coverage to offset potentially expensive medical costs that can be more valuable in dollar terms than the actual cash benefit from SSDI and SSI.⁵⁴ For example, for a person with average monthly medical expenditures of \$1,000 (the approximate average for Medicaid participants classified as 'disabled'), the total monthly value of the SSI and Medicaid benefit combined is more than \$1,500 per month.

A.1.3 Few SSDI or SSI claimants leave the rolls due to work

Once eligible, SSDI and SSI claimants can continue to receive benefits as long as they meet SSA's disability criteria (and for SSI, income and asset criteria) and there are no mandatory work or rehabilitation requirements. SSA periodically reassesses each claimant's impairment status during continuing disability reviews (CDRs), though the observed rates of exits from the SSDI and SSI programmes is currently less than 0.5 per cent and has remained largely unchanged over the past 20 years (Berkowitz (2003)).

SSDI and SSI claimants who return to work face the prospect of losing both their benefits and health insurance coverage if their earnings exceed a certain threshold. For the SSI programme, benefits are reduced by \$1 for every \$2 of earnings, after an initial small income disregard. SSDI claimants do not lose any benefits for work below SGA, but they lose their entire benefit amount if SSA judges them to be capable of earnings above SGA. SSI and SSDI claimants also face the prospect of losing their health insurance for excess earnings, though recent changes through the TTW Incentives and Improvement Act of 1999 have expanded coverage for claimants who leave the rolls.

⁵³ Medicare is a health insurance programme primarily for people age 65 or older. SSDI claimants are eligible for Medicare after a two-year waiting period following the start of cash payments. Medicare Part A includes hospital insurance and provides coverage for inpatient hospital care, skilled nursing facility care, home health services, and hospice care. There are no premiums for this coverage. Medicare Part B is additional, or supplemental, insurance to increase the scope of services for a Medicare-qualified person. The coverage under Part B is broad, but in order that such coverage can be ensured to all, the services must be deemed medically necessary or fall within the benefits prescribed for prevention. It does require the payment of a monthly premium. Participation in the Part B programme is voluntary for the elderly and for people who receive SSDI.

⁵⁴ The types of coverage, number of providers, and services available vary across Medicare and Medicaid. Medicaid includes more coverage options with fewer co-payments, though provider reimbursements are generally lower than Medicare.

Not surprisingly, given the emphasis of disability determinations on the inability to work, the severe impairment characteristics of claimants and the potential loss of cash benefits and health coverage, few claimants leave the rolls each year because of medically recovering from their impairment. Rupp and Scott (1998) projected that SSI claimants between the ages of 18 and 34 would have an average expected duration on the rolls of about 20 years. Similarly, they found that SSDI claimants are much more likely to age out of the programme (that is, turn 65) or die than leave the rolls because they find work.

A.2 Other US disability cash and rehabilitation programmes

A variety of other US disability-oriented programmes provide income and other assistance to people who experience the onset of a disability while working.⁵⁵ These include Veteran's benefits, workers' compensation, private disability insurance and VR. To qualify for these programmes, a person must meet the specific disability requirements, which are generally less restrictive than those of SSA's programmes.

Workers' compensation, insurance funded by employers, is the largest programme that specifically targets people who are injured on the job in the private sector. Unlike programmes mentioned above, workers' compensation payments are also available for partial disabilities (either temporary or permanent). In general, workers' compensation aims to replace lost wages and pay for other medical expenses resulting from the onset of a disability on the job. The benefit levels vary by state, but temporary or permanent total disability benefits are commonly set at two-thirds of weekly earnings up to some maximum, and payments are generally discontinued upon return to work.

The Veterans Administration (VA) programme covers, under a set of programmes generally similar to workers' compensation, people honourably discharged from the military. The VA uses a disability rating (a percentage between 0 and 100) to determine eligibility for benefits. Unlike workers' compensation, however, the VA also provides disability compensation for those injured outside the service. Some people may have private insurance coverage from an employer or a personal account (personal disability insurance, or PDI). Such coverage typically insures for both short- and long-term disability.

⁵⁵ As noted in Wittenburg and Favreault (2003), people with disabilities often participate in other non-disability-related programs, such as Temporary Assistance for Needy Families (TANF) and General Assistance (GA), which provide temporary sources of support. These participants may be unaware of the disability programmes, fail to meet SSA's strict disability criteria or be unwilling to go through the rigorous application process. Similarly, in the UK, many people with disabilities presumably also participate in non-disability-related general support programmes.

VR is a joint federal-state programme that provides employment services and supports to any person with a disability. The federal RSA provides funds to state VR agencies to provide services for people with disabilities to maximise their employability, independence and integration into the workplace and community. VR programmes provide basic and customised services that an eligible individual may need to achieve their employment outcome. These may include college or vocational training, job placement services and services to help students go from school to work. VR programmes provide support to any individual who has a physical or mental impairment that constitutes or results in a substantial impediment to employment for the individual and who can benefit from VR services to achieve an employment outcome. Individuals who receive SSDI and/or SSI are presumed to be eligible for VR services leading to employment, unless there is clear and convincing evidence that they are too severely disabled to benefit from VR services. In 2001, the VR programme served more than one million people with disabilities (RSA (2001)). According to Thornton *et al.* (2007), 4.8 per cent of all SSA disability claimants ages 18 to 57 participated in VR during at least one month in 2001.

A.3 Increasing emphasis on return-to-work programmes in past five years by SSA and Centers for Medicare and Medicaid Services

Despite the TTW programme and the work demonstration programmes that are described here, there has been continued criticism of the limited degree to which the current disability system focuses on promoting employment opportunities for its claimants. The US General Accounting Office (GAO), the watchdog organisation for federal agencies, has suggested that current employment options for SSDI and SSI participants are limited in scope and should be significantly expanded (GAO (1997); Growick (2002)). They noted that the SSA has yet to propose or assess an option that could result in savings to SSA's trust fund. US GAO identified challenges in prior demonstration projects, especially the lack of a formal process for developing a long-range demonstration agenda that fits SSA's demonstration goals around a set of major policy objectives with input from key stakeholders. US GAO also criticised the prior demonstration projects for being rushed into the field without proper testing. For example, US GAO claimed that if SSA had tested various components of the TTW programme prior to launching the programme nationwide, it might have been able to identify problems and develop solutions prior to implementation.

In response to this criticism, SSA has initiated several return-to-work demonstration projects that should provide valuable information on best practices.⁵⁶ The US GAO report acknowledged that these current SSA demonstrations have been designed to examine a wider array of policy and programme issues and have been planned

⁵⁶ SSA provides periodic updates on these projects at <http://www.socialsecurity.gov/disabilityresearch/demos.htm> (accessed 13 January, 2008).

in a more rigorous manner that will ultimately improve their usefulness to the agency and Congress. These projects include:

- The **Accelerated Benefits (AB) Demonstration project**, which will provide immediate health benefits (rather than these benefits being delayed for two years) and employment supports, when appropriate, to certain newly entitled SSDI claimants. Claimants selected for the demonstration project will be randomly assigned to one of three groups: one group will be provided health benefits, a second group will be provided health benefits and receive additional care management, behavioral, and employment supports, and a third group will be a control group that will be used as comparison to see if the intervention makes a difference in health and employment outcomes. The target population includes newly entitled SSDI claimants, under age 55, who do not have health insurance and have at least 18 months before they will be eligible for Medicare. The initial random assignment for this project started in autumn 2007.
- The **Benefit Offset National Demonstration (BOND) project**, which will attempt to determine the effect of various interventions, in combination with a benefit offset, on employment outcomes that include wages, benefits, hours worked, and job retention. SSA will conduct tests of a \$1 reduction in benefits for every \$2 in earnings in combination with a variety of employment supports, with the goal of helping claimants with disabilities return to work. The project will allow claimants to face this gradual reduction in their benefits, eliminating the abrupt loss of cash benefits in the SSDI disability programme when a claimant works and has earnings over a specific amount. Participants will maintain ongoing eligibility for health care benefits and other supports linked to SSDI eligibility. The target population will include SSDI claimants in locations to be determined. This project has not yet started in the field.
- The **Mental Health Treatment Study (MHTS)**, which will provide psychiatric treatments (pharmaceutical and psychotherapeutic) and/or employment supports that are not covered by other insurance for study participants. The target population includes SSDI claimants with a primary impairment of schizophrenia or affective disorder in a select number of service areas. Recruitment of participants began in September 2006. The study remains in the field for three years, and a final report is expected in the winter of 2010.
- The **Youth Transition Demonstration (YTD)**, which will provide intensive employment supports and benefits counselling to increase the employment among youth and young adults with disabilities. The project started in 2003 with seven projects in six states, and three of these projects were selected for a random assignment evaluation. During 2007, SSA piloted new projects in five states, and ultimately chose three new sites for random assignment evaluation. These sites, which include Florida, Maryland and West Virginia, will resume full operations in spring 2008. The target population includes SSI claimants and other at-risk youth ages 14 to 25. A random assignment evaluation began in autumn 2006.

SSA is also enhancing its infrastructure for delivering employment supports by providing more information on benefits counselling and work supports. For example, the Work Incentives Planning and Assistance (WIPA) offices currently provide supports to claimants for benefits counselling and advocacy issues.

Finally, SSA is conducting several other demonstration projects that focus on other aspects of service delivery, including potentially changing programme rules to allow for better coordination among other federal and state programmes. These projects include the Florida Freedom Initiative (FFI), which aims to deliver supports and services to people with developmental disabilities and to promote self-sufficiency for them; the Homeless Outreach Projects and Evaluation (HOPE), which focuses on helping eligible homeless people apply for SSI and SSDI benefits; and the Pediatric Medical Unit, which seeks to help disability examiners process childhood disability applications.

Outside SSA projects, Centers for Medicare and Medicaid Services (CMS), the agency responsible for administering health coverage programs (including Medicare and Medicaid), is also funding initiatives to promote employment through the provision of health insurance and early intervention services. One of the most notable of these projects is the Medicaid Buy-In programme, which allows adults with disabilities to earn more than would otherwise be possible and still have Medicaid coverage. In return, participants 'buy into' the Medicaid programme, typically by paying premiums based on income. As of December 2006, 33 states were operating a Medicaid Buy-In programme to extend Medicaid coverage to working people with disabilities. In addition, CMS is funding the Demonstration to Maintain Independence Evaluation, a multisite evaluation designed to examine the effects of behavioral health services, case management, vocational services, and other services on economic and health outcomes for working individuals with potentially disabling behavioral health disorders, including those not yet on the SSI and/or SSDI programmes.

Appendix B

Detailed descriptions of US return-to-work initiatives

This appendix provides a detailed summary of the three categories of demonstration projects and return-to-work programmes included in this review. The first category includes evaluations of initiatives that have generally targeted volunteers who receive SSA disability cash benefits, which include recipients of the SSDI and SSI programmes. These cash benefit programmes represent the largest US disability cash benefit programmes. These evaluations include one funded by the US DOL and four subsequent evaluations funded by SSA. The second category includes evaluations of supported employment programmes that have been tested as an alternative to traditional vocational supports for volunteers with psychiatric conditions (many of whom receive SSDI and SSI). These evaluations include 12 small-scale supported employment projects and a larger demonstration funded by SAMHSA. The final category includes one initiative that has provided return-to-work support for mothers with work limitations who receive cash benefits from state welfare programmes. This project was funded as part of the Employment Retention and Advancement project by the US Department of Health and Human Services.

In the rest of this appendix, we provide a detailed description of the intervention and the target populations for each of the evaluations in our review. Unless otherwise noted, all cost estimates are expressed in 2007 dollars.

B.1 Large-scale return-to-work initiatives that targeted SSDI and SSI claimants

In the 1980s, two demonstration projects that included a large sample of SSDI and SSI claimants emerged that tested the effectiveness of providing transitional supports to people with intellectual disabilities. In 1981, DOL, a federal US agency

charged with preparing the American workforce and ensuring the adequacy of workplaces, funded the seminal random assignment study of return-to-work supports in the **STETS** demonstration. Claimants were recruited from social service agencies, though most participants were already receiving SSDI or SSI benefits.

Based on the successful findings from STETS, SSA subsequently funded an evaluation of transitional employment services in 1985 that specifically targeted young adults with intellectual disabilities and who were receiving SSI benefits in the **TETD**. TETD included a much larger sample of claimants than did STETS (745 compared to 467) in 13 demonstration communities, which allowed for a more rigorous evaluation of programme impacts. The STETS study established the effectiveness of transitional employment supports in increasing employment among youth with disabilities (Kerachsky and Thornton (1987)), and the TETD evaluation confirmed that these services improve employment rates and earnings (Decker and Thornton (1995)).

To gain a better understanding of the effectiveness of supports on a broader base of adult claimants in the 1990s, SSA sponsored random assignment evaluations of interventions for larger segments of the SSDI and SSI working population in **Project NetWork** and the **SPI**. SSA funded the Project NetWork demonstration, which built on the experience from TETD in designing a random assignment study for SSA disability cash claimants (Decker and Thornton (1995)), to test alternative ways to provide rehabilitation and employment services to a broad base of SSDI and SSI claimants and applicants. The Project NetWork demonstration represented the first time that SSA provided services directly to its client population to test the feasibility and efficacy of the case management approach. SSA funded the SPI demonstration projects in several states to identify innovative return-to-work models with a heavy emphasis on the effects of combining vocational approaches, work incentives, and improved information on work incentives ('benefits counselling'). In addition to the state-based approach, the SPI project was also unique because it included projects from other agencies, including the RSA, which oversees funding for state VR programmes. The evaluation findings from Project NetWork and SPI provided SSA with information on the effects of different intervention strategies for promoting employment among a broader pool of claimants (Kornfeld and Rupp (2000); Peikes *et al.* (2005)).

In 1999, policy makers implemented the **TTW** programme, which represents the largest return-to-work initiative ever funded for SSA disability claimants. A major programme emphasis under TTW was to expand return-to-work services to SSDI and SSI claimants, which had generally been predominately provided through VR agencies. The programme gives claimants more choices for obtaining services and gives employment-support service providers new financial incentives to serve claimants effectively. The TTW evaluation included an assessment of programme impacts, though the findings were based on a non-experimental design and, to date, only initial findings from the first two years of rollout are available (Thornton *et al.* (2007)).

In the rest of this appendix, we summarise the key project features from each of these projects.

B.1.1 Structured Training and Employment Transitional Services (1981/82)

The STETS, implemented in five cities (Cincinnati, Los Angeles, New York City, St. Paul and Tucson) was the seminal random assignment study of transitional employment services to promote unsubsidised, competitive employment for people who had not traditionally been engaged in regular employment. The study included 467 youths aged 18 to 24 who had IQ scores between 40 and 80.

The intervention consisted of three phases of work interventions focused on competitive employment (Kerachsky and Thornton (1987)). The first phase was an introductory work exposure period in a low-stress environment that could include up to 500 hours of paid employment. The second phase included a transitional job that involved on-the-job training or supported employment, though the intervention emphasised positions that would lead to competitive employment. These first two phases combined could not extend past 12 months. The third phase began when participants had a competitive, unsubsidised job, providing postemployment follow-up and job supports for individuals.

The evaluation tracked outcomes in a follow-up survey for treatment and control group members 6, 15 and 22 months following enrolment, finding that the programme was successful in increasing both the competitive employment and the earnings of treatment group members.

The costs of the programme were expected to outweigh the benefits. Overall programme costs for each participant were \$19,568, including the costs of the intervention and the wages paid to those in paid employment in the first two phases (Kerachsky *et al.* (1985)). While these costs did not exceed participant's earnings and their reduced programme use during the 22-month observation period, the expected overall payoff was four and a half years after participants' beginning the intervention.

B.1.2 Transitional Employment Training Demonstration (1985/93)

The TETD provided job placement, training, and retention services to eligible SSI claimants who were between ages 18 and 40, were diagnosed with an intellectual disability, and were living in one of the 13 demonstration communities. The participants included 745 eligible recipients who volunteered and were randomly assigned to a treatment or a control group. Treatment group members could receive job placement services or on-the-job training as part of the programme. TETD focused on employment placements and the provision of time-limited employment supports. Treatment group members received three core services:

- 1 Job development and placement in potentially permanent competitive jobs.
- 2 On-the-job training, which was gradually phased out to enable the participant to gain independence on the job.
- 3 Postplacement short-term support and follow-up to assist with job retention.

Treatment group members could receive services for up to one year. The control group was eligible to receive services from other programmes and permitted to take advantage of incentives offered through SSA or other sources.

To avoid jeopardising participants' receipt of SSI benefits, TETD obtained waivers to SSI regulations, which at the time required that, to be eligible for benefits, a person have limited assets. (Countable assets included most assets but excluded a home and a vehicle.) The waiver expanded the exclusions to cover any income earned from a job obtained through the demonstration (Thornton *et al.* (1988)).

Programme operators with TETD spent an average of \$10,594 per participant on services (Thornton *et al.* (1988)). This included the costs of staff time spent with, or on behalf of, participants; time spent on general outreach, recruitment, and job development; and administration and overhead required to operate the programme.

Short-term and longer-term impacts of the programmes were estimated. The longer-term impacts tracked treatment and control group members over a six-year period and examined impacts on employment, earnings, benefit receipt, and total income (Decker and Thornton (1995)).

B.1.3 Project NetWork (1991/95)

The Project NetWork Demonstration provided services to SSI recipients and applicants, as well as SSDI claimants, who were between 15 and 65, without regard to the nature of their disability. The demonstration provided intensive, employment-focused case management services and aimed to test the efficacy of case management services in moving people with severe disabilities into full-time employment and off the disability rolls (Rupp *et al.* (1994)).

The Project NetWork Demonstration, which used a random assignment design, recruited 8,428 claimants over the intake period and assigned them to either a treatment or a control group. Eighty-five per cent received public disability benefits, while the other 15 per cent were applicants to SSI (Kornfeld and Rupp (2000)).

Only those in the treatment group could receive case management services, but those in the control group remained eligible for any employment assistance in their communities. Project NetWork tested four case management models, distinguished by institutional setting and the provision of either direct or indirect services:

- 1 **SSA Case Manager Model.** Case management provided by SSA staff.
- 2 **Private Contractor Model.** Case management provided by a private rehabilitation organisation.
- 3 **VR OutStationing Model.** Case management provided by state VR agency staff outstationed in local SSA offices.
- 4 **SSA Referral/Manager Model.** Focused on referrals to other providers as opposed to offering direct services to clients.

To reduce disincentives to work, Project NetWork obtained waivers to SSI and SSDI rules for both the treatment and the control group. These waivers began in the first month in which the claimant had earnings from employment. The waivers then lasted 12 consecutive months, regardless of employment activity, and exempted months worked by SSDI claimants from being counted under the trial work period. For SSI claimants, the waivers prevented monthly earnings over substantial gainful activity from triggering a formal continuing disability review by SSA (although such reviews were not conducted regularly at the time of the demonstration). In effect, the Project NetWork waivers prevented termination from the rolls based on work participation.

The average cost per programme participant in Project NetWork was \$5,165. In addition, treatment group members were estimated to have received \$456 worth of services (that might or might not have been a result of referrals provided by Project NetWork) from other sources during the time period. In contrast, total average cost of services per control group member (consisting entirely of non-Project NetWork costs) were estimated to be \$2,500. Thus, the net incremental cost per treatment group member was estimated to be \$3,121.

B.1.4 The State Partnership Initiative (1999–2004)

The SPI included 12 SSA-funded projects, of which three states used random assignment to evaluate outcomes (one state, New York, included two random assignment interventions), that focused on delivering direct services to SSI and SSDI claimants using at least one of the following approaches:⁵⁷ (1) improving information about the effect of work on benefit receipt; (2) encouraging the use of available work incentives; (3) testing modifications to programme rules to allow SSI claimants in four state projects to earn; and save more and (4) providing

⁵⁷ The original SPI projects included 18 projects in 17 states from 1999 to 2004 to deliver employment-related services to people with disabilities. SSA funded 12 of the 18 state projects, and the RSA funded the remaining six. The SSA-funded projects focused on testing new services for the Social Security claimants with disabilities. The RSA-funded projects, in contrast, focused on activities aimed at changing the overall system that helps people with disabilities (some of whom receive other forms of public assistance) obtain employment and live independently.

better access to vocational support. The projects also attempted to change service systems to place greater emphasis on employment outcomes for all people with disabilities. All 12 SSA projects provided benefits counselling to help participants understand the effect of employment on their cash benefits, health care coverage, and eligibility for other government support programmes. Four state projects tested waivers to SSI regulations designed to make employment more attractive to claimants. These waivers permitted claimants who worked to keep more of their benefits (\$3 instead of \$2 for every \$4 earned after the first \$80), allowed them to accumulate savings up to half their annual earnings without being subject to the current asset limits, treated unearned income related to work activity as earned income and protected them from having a continuing disability review triggered solely because of participation in the demonstration (Peikes and Paxton (2003)).⁵⁸

The populations the SPI projects targeted varied. While most projects targeted both SSI and SSDI claimants, two focused exclusively on the SSI population. Six state projects targeted their programmes more broadly to people with disabilities who received other public assistance benefits, such as TANF, General Assistance, and Social Security disability benefits.⁵⁹ In terms of types of disabilities, five of the 18 state projects solely targeted people with severe psychiatric conditions, while three targeted people with psychiatric conditions and people with other disabilities. The other ten projects targeted people with any disability. Five of the 12 SSA and two of the RSA state projects required that participants be enrolled in VR, and additional states encouraged them to enrol in VR after intake.

Each SSA project was required to use its own evaluation design and data to describe its implementation and assess its impacts. In addition, MPR conducted the core evaluation, which focused exclusively on estimating the impacts of the service interventions provided by SSA funds. The core evaluation was intended to compare key outcomes of participants in each project with outcomes of a comparison group that was selected to have similar demographics, prior labour market experiences, and benefit receipt and to live in similar areas (using a propensity matching approach). In three states, a random assignment design was also used to assess programme impacts.

⁵⁸ One site that targeted high school students with an emphasis on education and employment aspirations was excluded from the study because the administrative data for the project was not sufficient for measuring impacts on these outcomes.

⁵⁹ These were funded by the RSA and hence, were not required to serve Social Security disability claimants exclusively.

Of the state projects that provided cost estimates, the cost per participant was \$12,447 (excluding overhead costs [Delin *et al.* (2004)]) in Wisconsin,⁶⁰ \$2,302 in New Hampshire (Malloy and Priest (2004)), \$1,488 in New Mexico (Nelson *et al.* (2004)), and \$388 in Minnesota (Minnesota (2004)). Vermont's **annual** cost per claimant was about \$619 (Smith and Tremblay (2004)).

B.1.5 Ticket to Work (1999-present)

The TTW programme, which was implemented under the Ticket to Work and Work Incentives Improvement Act (TTWIIA) of 1999, aimed to increase the access to, and quality of, rehabilitation and employment services available to disability claimants, and ultimately to increase the number of such claimants who become economically self-sufficient. TTW introduces a new outcome- and/or milestone-based financing system for employment service providers and gives claimants a choice of provider. Willing SSI and SSDI claimants who have been given tickets by SSA can redeem them at one of an array of approved public and private providers, referred to as employment networks, that have signed a contract with SSA. TTW also gives claimants considerable flexibility in choosing services, allowing them to come up with a mutually agreeable individualised work plan.

Providers can decide whether or not to accept tickets from people and can determine the types of services to deliver. Once the ticket is deposited with a provider, it becomes a contract between the provider and SSA (Berkowitz (1997)).

Employment networks can receive payments on either an outcome-only basis plan or an outcome-plus-milestone plan.⁶¹ For every month the claimant is off the rolls as a result of a return to work, the outcome-only plan pays providers, for up to a total of five years, 40 per cent of the previous calendar year's average monthly SSI or SSDI benefit (Roessler (2002)). The outcome-plus-milestone plan reduces the outcome payment amounts (34 per cent instead of the 40 per cent for the outcome-only plan). However, it adds four possible milestone payments tied to increasing levels of employment but not programme exit: working one month, three months and seven months out of a 12-month period, and working 12 months out of a 15-month period.

One distinguishing feature of the TTW programme is that it does not restrict the type of services offered. By leaving the choice of services to a mutual decision by the provider and the claimant, TTW hopes to empower claimants. The initial evaluation report of the programme reveals that service providers have adopted a wide range of approaches. While some of the employment networks act primarily as job placement agencies, others have focused on postemployment support

⁶⁰ This represents the amount contracted to the service provider agencies from July 1999 through March 2003, divided by the total number of enrollees through March 2003.

⁶¹ The maximum payment is about \$19,000 for a SSDI claimant and \$11,000 for an SSI claimant (Huynh and O'Leary (2003)).

through counselling and case management. Taking advantage of the complete flexibility the programme offers, one employment network offers no services – instead, it shares 75 per cent of the ticket payment with the claimant (Thornton *et al.* (2004)).

The passage of the Ticket to Work Act also allowed SSA to implement additional services and supports for its disability claimants. To help consumers make informed choices about work, SSA supported the development of a wide network of professionals who provide benefits planning and outreach assistance. SSA also funded protection and advocacy services to help claimants obtain information about employment services.

SSA rolled out the programme in three phases: Phase 1, which began in February 2002, saw the programme introduced in 13 states around the country. Phase 2, which began in November 2002, extended TTW to 20 more states and the District of Columbia. Phase 3, which began in November 2003 and ended in September 2004, completed the rollout in the remaining 17 states and US territories. At present, claimants in all states are sent a Ticket as they become newly eligible for the programme.

B.2 Supported employment initiatives targeting people with psychiatric conditions

In the 1990s, several independent evaluations were conducted on the effectiveness of different supported employment models for people with psychiatric conditions and were summarised in two major studies (Bond (2004); Cook *et al.* (2005)). Each of these evaluations used a rigorous random assignment evaluation design to identify impacts and provided detailed documentation of the services delivered so the findings could be replicated in other settings. As a follow-up to several of these studies, in 1995, the SAMHSA, the US agency that helps states increase the quality and range of treatment, rehabilitation, and support services for people with psychiatric problems, funded the EIDP in eight cities. The EIDP was designed to find new ways of enhancing employment opportunities for consumers with psychiatric conditions and included a random assignment evaluation of multiple supported employment models delivered by alternative service providers in various regions.

B.2.1 Randomised control trials of supported employment models, especially the IPS

Bond *et al.* (2005) summarised the findings for 12 randomised control studies comparing supported employment to a variety of traditional vocational services for people with severe psychiatric conditions. These 12 studies have been conducted by nine different research teams (although Becker and Drake have been consultants on a number of these studies) in various geographic regions (New Hampshire, New York, Connecticut, Maryland, District of Columbia, South Carolina, Indiana, Illinois, California and Québec), representing both rural and urban communities.

The most common supported employment model tested was the IPS model. This model was implemented in eight sites and the remaining four studies used versions of supported employment incorporating most, but not necessarily all, of the critical ingredients described above for IPS. Among the key principles defining IPS are the following (Becker and Bond (2002); Bond (1998), (2004)):

- **Services focused on competitive employment.** The agency providing supported employment services is committed to competitive employment as an attainable goal for its consumers with psychiatric conditions, devoting its resources for rehabilitation services to this endeavour, rather than to intermediate activities, such as day treatment or sheltered work.
- **Eligibility based on consumer choice.** No one who wants to participate is excluded.
- **Rapid job search.** Supported employment programmes use a rapid job search approach to help consumers obtain jobs directly, rather than providing lengthy pre-employment assessment, training, and counselling.
- **Integration of rehabilitation and mental health.** The supported employment programme is closely integrated with the mental health treatment team.
- **Attention to consumer preferences.** Services are based on consumers' preferences and choices, rather than providers' judgments. Staff and consumers find individualised job placements, based on consumer preferences, strengths and work experiences.
- **Time-unlimited and individualised support.** Follow-up supports are individualised and continued indefinitely.
- **Benefits counselling.** Consumers are given specific and timely guidance tailored to their unique circumstances.

The comparison groups in these studies received traditional vocational services, which varied across studies. Two studies used a comparison group consisting of a brokered form of supported employment, two had a psychological rehabilitation programme as a control group, and three had sheltered workshops as their comparison group. One study used a control group consisting of a diversified placement approach, while another used a traditional hospital-based programme. Another compared prevocational training before referral, and the final three studies compared supported employment to referral to state-federal VR programmes. Information about the cost of individual programmes was not included in Bond *et al.* (2005), though other reviews suggest that supported employment costs per participant are between \$2,500 to \$4,500 per year in 2007 dollars.

Bond *et al.* (2008) built on the Bond *et al.* (2005) findings by restricting their analysis to IPS evaluations that had high adherence to the IPS model in addition to the requirements for inclusion in the earlier summary (for example, random assignment, competitive employment outcomes). The summary included 11 studies, some of which were included in the earlier Bond *et al.* (2005) summary,

and also incorporated findings from international studies. Their findings were similar to those in Bond *et al.* (2005).

B.2.2 Employment Intervention Demonstration Programme (1996 to 2000)

The EIDP was a wide-reaching random assignment evaluation of employment strategies for people with severe psychiatric illness. Most of its 1,600 enrollees had diagnoses of schizophrenia, major depression, or bipolar disorder. Its eight sites were Arizona, Connecticut, Maine, Maryland, Massachusetts, Pennsylvania, South Carolina and Texas.

Treatment group members participated in a supported employment model (Cook *et al.* (2005)). This model involved integrated services provided by a multidisciplinary treatment team, focused on competitive employment tailored to the participant's career goals, and offered immediate employment services, as well as continuing and ongoing vocational supports, even after employment. In addition to these components, sites may have provided other services to complement the supported employment model.

Rather than having no services, control group members received either usual services (such as VR services) or a simplified version of the treatment services.

EIDP resulted in several major findings. People who received coordinated vocational and clinical services had better employment outcomes (measured as competitive employment, working more than 40 hours a month, and monthly income) than people in the control group (Cook *et al.* (2008)). Moreover, the difference in employment outcomes increased over time. Participants with higher levels of integrated vocational and clinical services had better employment outcomes than participants with less integrated services.

Costs varied among the sites (Cook *et al.* (2008)), with average vocational costs ranging from \$483 to \$2,069 per client per year, while total costs ranged from \$2,000 to \$6,000 per client per year.

B.3 Return-to-work initiatives for low-income mothers with disabilities

In recent years, there has been an increasing interest in identifying return-to-work initiatives for low-income mothers with disabilities. While several programme models are beginning to emerge, the only available evaluation of an intervention targeting a population of low-income mothers with disabilities is the PRIDE in New York City.⁶²

⁶² Manpower Demonstration research Corporation (MDRC) evaluated PRIDE as one of 16 Employment Retention and Advancement models that promote employment among low-income individuals. It is the only study we are aware of that used random assignment to assess the impact of the programme.

B.3.1 Personal Roads to Individual Development and Employment (1999 to 2004)

New York City's PRIDE was one of a number of welfare-to-work projects initiated in the wake of the 1996 federal welfare reform to promote the employment of people with low incomes, though it was unique because of its focus on welfare recipients with employment limitations (Bloom *et al.* (2007)). PRIDE specifically targeted welfare recipients who were '*employable with limitations*' – those who had psychiatric or other health conditions that limited but did not prevent work (that is, they had conditions that were severe enough to interfere with work activities but not severe enough that they qualified for federal disability benefits). A joint project of NYC's Human Resources Administration and the local VR programme, PRIDE served more than 30,000 people from 1999 to 2004.

PRIDE participants were expected to participate in work experiences as a condition of receiving welfare benefits. After receiving an initial comprehensive medical and vocational assessment, participants had access to employment counselling and supports and followed either a VR track (for people who had more severe conditions) or a work-based education track (for people with less severe disabilities and who had educational or language barriers to work). Unemployed participants were expected to engage in unpaid work experiences of 20 to 25 hours per week that accommodated a person's health condition, and they could fall under sanctions, including a loss in their welfare benefits, for not complying with employment activities.

The evaluation included a subset of 3,000 people recruited in 2001 and 2002 and used random assignment to place them in treatment and control groups. The treatment group received usual PRIDE services as outlined above, including sanctions for not participating, while the control group was exempt from participating in employment activities. Members of the control group could choose to seek employment services, but they could not participate in PRIDE. Both treatment and control group members were not exempt from programme re-evaluation activities during the project; they could have been found to be employable and dropped from the medical condition exemption.

The evaluation demonstrated that a large-scale employment programme for people with work-limiting conditions could be successful, both in terms of operation and employment outcomes. Though modest, PRIDE treatment members were more likely to be employed and less likely to receive welfare payments than control group members. However, a large proportion of treatment members did not have any competitive employment during the evaluation period, and many were sanctioned for not participating in employment activities.

Information about the cost of the programme has not yet been released.

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