Four Strategies to Overcome Barriers to Employment

An Introduction to the Enhanced Services for the Hard-to-Employ Demonstration and Evaluation Project

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Overview

In the post-welfare reform world, an important policy question has taken new prominence: how to improve employment prospects for the millions of Americans who face serious obstacles to steady work. These individuals, including long-term welfare recipients, people with disabilities, those with health or behavioral health problems, and former prisoners, often become trapped in costly public assistance and enforcement systems and find themselves living in poverty, outside the mainstream in a society that prizes work and self-sufficiency.

The Enhanced Services for the Hard-to-Employ Demonstration and Evaluation Project, sponsored by the Administration for Children and Families and the Office of the Assistant Secretary for Planning and Evaluation in the U.S. Department of Health and Human Services (HHS), with additional funding from the Department of Labor, is evaluating four diverse strategies designed to improve employment and other outcomes for low-income parents and others who face serious barriers to employment:

- A comprehensive employment program for former prisoners in New York City;
- A two-generation Early Head Start program in Kansas and Missouri that provides enhanced self-sufficiency services and skills training to parents, in addition to high-quality child care;
- Two alternative employment strategies for long-term welfare recipients in Philadelphia: one that emphasizes services to assess and treat recipients' barriers to employment, and another that places recipients in paid transitional employment; and
- An intensive telephonic care management program for Medicaid recipients in Rhode Island who are experiencing serious depression.

MDRC is leading the evaluation of these four programs, using a rigorous random assignment research design. The research team also includes the Urban Institute, the Lewin Group, Group Health Cooperative, and United Behavioral Health.

This first report in the Hard-to-Employ evaluation describes the origin of the project and the rationale for the demonstration, the research design, and the four programs and the characteristics of their participants. Because the programs are so diverse, the Hard-to-Employ project can be seen as four distinct but related studies.

Enrollment of the demonstration's participants was completed by December 2006. The research team is now tracking roughly 4,000 sample members, using surveys and administrative records. Over the next several years, the project will generate a wealth of data on the implementation, effects, and costs of these promising approaches.

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Executive Summary

In the post-welfare reform world, an important policy question has taken new prominence: how to improve employment prospects for the millions of Americans who face serious obstacles to steady work. These individuals, including long-term welfare recipients, people with disabilities, those with health or behavioral health problems, and former prisoners, often become trapped in costly public assistance and enforcement systems and find themselves living in poverty, outside the mainstream in a society that prizes work and self-sufficiency.

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- Two alternative employment strategies for long-term welfare recipients in Philadelphia: one that emphasizes services to assess and treat recipients' barriers to employment, and another that places them in paid transitional employment; and
- An intensive telephonic care management program for Medicaid recipients in Rhode Island who are experiencing serious depression.

MDRC, a nonprofit, nonpartisan social and education policy research organization, is leading the evaluation of these four programs, using a rigorous random assignment research design. The research team also includes the Urban Institute, the Lewin Group, Group Health Cooperative, and United Behavioral Health. Over the next several years, the Hard-to-Employ project will generate a wealth of data on the implementation, effects, and costs of these promising approaches.

This first report in the Hard-to-Employ evaluation describes the origin of the project and the rationale for the demonstration, the research design, and the four programs and the char-

[1]The Annie E. Casey Foundation and the W. T. Grant Foundation are providing funding for the 18-month follow-up survey to study how the model being tested in Rhode Island affects children.

acteristics of their participants. Because the programs are so diverse, the Hard-to-Employ project can be seen as four distinct but related studies.

The Center for Employment Opportunities Evaluation

Every year, more than 600,000 people are released from prisons. Former prisoners have a difficult time becoming reintegrated into society. Rates of recidivism are persistently high, and many experts agree that one of the key factors affecting ex-prisoners' ability to stay out of jail or prison is their ability to find stable employment.

The Center for Employment Opportunities (CEO) is one of the nation's largest and best-known employment programs for former prisoners, serving about 1,800 people each year. Participants start the program with a four-day job readiness class and are then placed in paid jobs at one of several dozen work sites around the city. The work sites typically are public agencies that have contracted with CEO for maintenance or other functions. Participants remain on CEO's payroll and are paid the minimum wage for four days of work per week (they are paid daily, at their work site). These transitional placements are the heart of CEO's program. Ex-prisoners often have a pressing need for cash, and the placements provide them with "daily pay for daily work." In addition, CEO uses the transitional period to identify and address issues that are likely to hinder the participants' performance in an unsubsidized job. Most participants stay at the work sites for two or three months.

Participants spend the fifth day of each week at CEO's office, meeting with job coaches to discuss work performance and with job developers who help them identify permanent jobs. CEO also offers other activities, including an extensive fatherhood program that helps participants to resolve child support issues and improve their family relationships (at least half of the study's participants are parents, and their children may be receiving welfare benefits).

For purposes of the evaluation, nearly 1,000 people who were referred by their parole officer and reported to CEO were assigned, at random, to one of two groups:[2]

- **Neighborhood Work Project (NWP) group.** Individuals in this group had access to the core CEO model described above.
- **Resource Room group (control group).** The Resource Room program was designed to provide a benchmark against which to compare CEO's core program. Individuals assigned to this group participated in a revised version of the job

[2]The study does not include several key groups served by CEO, such as graduates of New York State's Shock Incarceration (boot camp) program, who are required to participate in CEO's program if they are returning to New York City.

readiness class that lasted one and a half days. Participants were then given access to a resource room equipped with computers with job search software, phones, voice mail, a printer, a fax machine, and other job search tools. When clients came into the resource room, a staff person was available, if needed, to assist them with many aspects of job search, including use of the equipment, help writing a résumé, and assistance setting up a voice mail account so that potential employers could leave messages for them.

MDRC is tracking both groups for up to three years, using administrative data and surveys to measure the impact of CEO's core services on employment, recidivism, and an array of other outcomes. Early data show that CEO is implementing the study's design as intended: About two-thirds of those in the NWP group worked in a transitional job (most of the others left the program before placement). Surprisingly, baseline data collected at the point of study enrollment show that many study participants came to CEO long after their release from prison. Because the CEO model was designed to serve people immediately after their release, it will be important to separately examine the results for those who came to CEO just after they were released and those who came later.

Two-Generational Early Head Start Evaluation

Many studies indicate that poverty is associated with worse health, behavioral, and cognitive outcomes for children. Earlier research demonstrates the value of two-generational services in meeting the developmental needs of low-income children. Yet, such programs have generally shown small impacts on parental employment (for example, the Early Head Start Research and Evaluation Project). A two-generational approach that has a more explicit focus on parents' employment and economic self-sufficiency could have wider-ranging effects than a program that focuses exclusively on children's developmental needs. Directly addressing young children's developmental needs could help parents overcome obstacles to sustained employment and economic self-sufficiency. Likewise, directly addressing the employment and economic needs of parents could improve their ability to better their own financial circumstances, indirectly benefiting children. Because many of the barriers to parental employment also impede young children's development, HHS required that the Hard-to-Employ project study the impact of a program that aims both to improve the economic circumstances of parents and the well-being of their children living in poverty.

Reconnaissance and site selection efforts identified two strong Early Head Start (EHS) programs in Kansas and Missouri that were interested in enhancing their existing services directed at improving parental employment and self-sufficiency: Southeast Kansas Community Action Program (SEK-CAP) in Girard, Kansas, and Youth-In-Need in St. Charles, Missouri.

With special funding from the Head Start Bureau at HHS, MDRC worked closely with the two EHS programs to enhance their existing services to: (1) help parents who are unemployed move into employment; (2) assist parents with low levels of education to pursue educational goals; and (3) help parents who are employed find more stable employment, advance in their jobs, and earn higher wages. The programs developed formalized employment and self-sufficiency curricula and services: They hired on-site self-sufficiency specialists to work with EHS staff and families and to create community partnerships; increased EHS's programmatic focus on employment and self-sufficiency by assisting and regularly monitoring parents' progress toward employment- and training-related goals; and tapped external employment and educational agencies and organizations to fill the gaps in existing EHS employment and self-sufficiency services.

For purposes of the evaluation, approximately 600 families were randomly assigned to either:

- **The EHS program group.** These families were enrolled in EHS services, including the parental self-sufficiency enhancements described above.
- **The non-EHS control group.** These families were not enrolled in EHS but were able to receive other community services. EHS programs provided a list of available services to families in the control group.

MDRC is tracking both groups, using surveys, administrative records, and direct child assessment to determine the impact of the two-generational model on both economic and child development outcomes. Early data indicate that the programs have made important strides in enhancing their employment and self-sufficiency services. At the same time, the data reveal that the programs have had to contend with some obstacles to the implementation of these enhancements. Despite these difficulties, the programs' experiences indicate that services aimed at addressing parents' employment and educational needs can be enhanced within the scope of a child-focused intervention.

Test of Alternative Employment Strategies for TANF Recipients in Philadelphia

As welfare caseloads nationwide have declined, policymakers, program administrators, and researchers have increasingly turned their attention to recipients who have not made a stable transition from welfare to work. Over the past 30 years, many studies have provided insight into which program models are most effective in assisting welfare recipients to find jobs, but few have targeted the most disadvantaged recipients. The emphasis on helping hard-to-employ recipients may be even more critical in light of recent changes in the Temporary Assistance for

Needy Families (TANF) program, which require states to engage a larger share of recipients in work activities.

The Philadelphia Hard-to-Employ site tests two alternative employment strategies for TANF recipients: a transitional work model that is similar in some ways to the CEO program described above and a second model that emphasizes up-front assessment of recipients' barriers to employment and preemployment services to help recipients overcome them. The two models represent typical approaches used in many places.

For purposes of the study, nearly 2,000 long-term or potentially long-term TANF recipients were assigned, at random, to one of three groups:

- **Transitional Work Corporation (TWC) group**. Individuals in this group were referred to TWC, a nonprofit organization that has operated a large-scale transitional work program since 1998. After completing a two-week orientation, TWC places participants in a transitional job, usually with a government or nonprofit agency, for up to six months. Recipients work 25 hours per week at the minimum wage and participate in 10 hours of professional development activities at TWC. These activities may include job search and job readiness instruction, preparation for a General Educational Development (GED) certificate, and other classes. TWC staff work with participants to find permanent, unsubsidized jobs and then provide job retention services for six to nine months after placement, including financial bonuses for retaining employment.

- **Success Through Employment Preparation (STEP) group**. Individuals in this group were referred to the STEP program, run by Jewish Employment and Vocational Service. STEP was developed specifically for this study and serves only study participants. The program begins with a home visit and an extensive assessment to identify the participant's barriers to work. Specialized staff analyze the results of the assessment and meet with the participant to design a plan to address her or his particular barriers to employment. Treatment can include classes (for example, GED preparation, English as a Second Language, support groups, and professional development sessions) and counseling with behavioral health specialists, as well as ongoing case management meetings. After completing the classes, participants work with job coaches and job developers to find permanent employment.

- **Voluntary Services group**. This group will serve as the benchmark against which the others will be compared. As part of the study design, individuals in the Voluntary Services group were not referred to either TWC or STEP and were ex-

cused from the requirement to participate in employment-related services — although they could volunteer to attend such services.

MDRC is tracking all three groups using surveys and administrative records to assess both programs' impacts on employment, welfare receipt, family income, and other outcomes. The analysis is designed to learn which approach is more effective for specific subgroups of recipients.

Early data show that the study has succeeded in identifying a hard-to-employ group of TANF recipients. A very high percentage of those assigned to the STEP group had contact with the program, owing to its aggressive outreach and home visits, but many did not participate for a large number of hours (although the number of hours appeared to increase somewhat after the program took steps to address this issue). In contrast, a significant proportion of those assigned to TWC did not show up at the program — TWC does not do extensive outreach — but most of those who did attend participated in transitional work as planned.

Rhode Island Working toward Wellness Project

Despite considerable progress in the field of depression treatment, many depressed individuals fail to receive adequate treatment. This is particularly likely to be the case in poor communities, where knowledge of depression treatment and quality of care may be low. Even among those individuals who seek treatment, relapse rates are quite high, suggesting the importance of strategies that maintain continuity of care.

Research on public assistance recipients indicates that as many as one-quarter of them suffer from depression, and their depression may be one of the barriers that limit their employability. Although a considerable body of random assignment research has identified various types of efficacious treatment for depression and indicates that treatment can reduce job loss, studies specifically applicable to low-income groups are not yet available.

Working toward Wellness (WtW) is a telephone care management intervention designed to help Medicaid recipients who are experiencing major depression to enter and remain in evidence-based treatment. The program is operated by United Behavioral Health, a managed care provider that offers behavioral health services to Rhode Island's Medicaid population. The care manager-outreach model was developed by Group Health Cooperative. Many of the participants are receiving TANF cash assistance or are at risk of receiving it.

For purposes of the evaluation, about 500 working-age parents who were covered by Rhode Island's Medicaid program and were assessed as having major depression were randomly assigned to one of two groups:

- **Working toward Wellness (WtW) group:** Individuals in the WtW group receive intensive outreach from care managers, first to help them to enter treatment and then, if treatment begins, to remain in it for an appropriate time. The intervention is also designed to help WtW group members take advantage of services to help them go to work. Treatment is based on the American Psychiatric Association's Evidence-Based Practice Guidelines for Major Depression, which includes psychotherapy and antidepressant medications. Outreach and care management takes place by telephone in order to reduce expense.

- **Usual Care (UC) group**: UC group members are informed that they met the criteria for clinical depression and are encouraged to seek treatment. They are given referrals to three mental health treatment providers in the community that provide Medicaid-covered services, but they are not provided outreach or care management. If sought, the treatment would be the same as that provided to others served by United Behavioral Health.

MDRC is tracking both groups for at least three years, using surveys and administrative data. By following the two groups over time and comparing their mental health, employment, and other outcomes, the study will determine the impacts of enhanced telephone-based care management for treating depression. Some of those impacts may be indirect; for example, it may be that engaging people in effective treatment for depression can lead to better work-related outcomes. Finally, a range of child outcomes will also be measured to see whether an intervention focused on parents' mental health can have indirect effects on their children.

Although it was difficult to recruit participants into the study, early data suggest that those who are participating in the WtW intervention are experiencing an improvement in their depression and are more likely than those in the UC group to receive some form of psychotherapeutic treatment.

Next Steps

Random assignment of study participants was completed in all four sites by December 2006. Preliminary results from the impact analysis are expected to be available for CEO in late 2007; results from other sites are expected in 2008 and 2009.

Chapter 1

Introduction

In the post-welfare reform world, an important policy question has taken new prominence: how to improve employment prospects for the millions of Americans who face serious obstacles to steady work. These individuals, including long-term welfare recipients, people with disabilities, those with health or behavioral health problems, and ex-prisoners, often become trapped in costly public assistance and enforcement systems and find themselves living in poverty, outside the mainstream in a society that prizes work and self-sufficiency.

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- A comprehensive employment program for ex-prisoners in New York City;
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- An intensive telephonic care management program for Medicaid recipients in Rhode Island who are experiencing serious depression.

MDRC, a nonprofit, nonpartisan social and education policy research organization, is leading the effort to test these four programs using a random assignment research design, the "gold standard" of program evaluation. The research team also includes the Urban Institute, the Lewin Group, Group Health Cooperative, and United Behavioral Health. Over the next several years, the project will generate a wealth of data on the implementation, effects, and costs of these promising approaches.

[1]The Annie E. Casey Foundation and the W. T. Grant Foundation are providing funding for the 18-month follow-up survey to study how the model being tested in Rhode Island affects children.

This first report in the evaluation describes the origin of the project and the rationale for the demonstration, the study design, the four programs and the characteristics of their participants, and identifies some early lessons about the challenges of designing and operating programs that target the hard-to-employ.

Why Focus on the Hard-to-Employ?

For at least three decades, policymakers, researchers, and program operators have developed and studied strategies to improve employment outcomes for people who face serious obstacles to steady work. Interest in the hard-to-employ surged in the 1990s, when the strong economy, rising employment, and dramatic declines in the welfare caseload all combined to focus a spotlight on groups who had been left behind. For the first time on a large scale, welfare agencies began developing or brokering services for recipients with mental health conditions, substance abuse problems, disabilities, and other serious barriers to work. Parallel changes were occurring in other systems: Criminal justice officials began to focus on the daunting problems facing prisoners returning to their communities, and the rapid growth of disability programs led policymakers to look for ways to encourage work among beneficiaries.

By definition, the hard-to-employ need special assistance to find and keep jobs. Their characteristics — disabilities, unstable behavioral health problems, very low skills, criminal records — place them at the back of the queue in a competitive labor market. To succeed, they may need special training, assistance in accessing health services or searching for a job, or other services.

There are at least four compelling reasons to invest in improving the employment prospects of those who face serious barriers to steady work. First, from a taxpayer's perspective, it is costly to support individuals who, with assistance, could work. And, in fact, Americans have demonstrated that they are typically willing to spend more in the short run to increase self-sufficiency in the long run. Second, there may be benefits for society when hard-to-employ people are able to work steadily — for example, beneficial effects on public safety, family structure, and child well-being. Third, many believe that the retirement of the baby boom generation will produce tighter labor markets in the not-too-distant future, making it critical to take the best advantage possible of our nation's human resources. Finally, many of the hard-to-employ very much *want* to work, and most Americans strongly believe that all individuals deserve the opportunity to make the most of their skills and ambitions.

What Is Known About the Hard-to-Employ?

The challenges faced by the hard-to-employ are clear, even if the strategies for addressing them are less understood. The barriers that prevent individuals from working can be grouped into three broad — and sometimes overlapping — categories:

- **Human capital deficits**, including very low basic skills, limited English proficiency, and lack of work experience.
- **Health problems**, including disabilities, behavioral health conditions (depression, substance abuse), and chronic physical health problems (hypertension, obesity) that can affect employability.
- **"Situational barriers,"** a catch-all category that includes such problems as a lack of transportation and the need to care for a disabled dependent. One of the most important situational barriers, however, is a criminal record. Convicted felons are considered highly undesirable by employers and, in fact, are legally barred from many occupations in growing employment sectors.

Classifying barriers to employment in this way is useful, because different types of barriers require different kinds of services or supports. For example, disabilities may require workplace accommodations and special job search assistance, whereas a lack of work history may be overcome by providing work experience in a supportive setting. Individuals with health problems may need care management to ensure consistent and quality treatment.

In addition, when considering potential intervention strategies, one must take into account the public systems that interact with the hard-to-employ. For example, work-focused programs for individuals with disabilities must address the conflicting messages of a disability insurance system that makes "permanent disability" an eligibility requirement but is also trying to encourage more employment. Prisoner reentry programs must keep considerations of public safety paramount. And efforts to promote employment through public health systems may be hindered by a philosophy that favors treatment over work.

Despite the broad policy interest in serving the hard-to-employ, knowledge about effective program strategies is relatively undeveloped. Other than for welfare recipients and people with serious mental illness, there have been few rigorous experimental evaluations, and many questions remain unanswered. Here is a quick review of the best research on programs for the populations served in the Hard-to-Employ demonstration:

Long-Term Welfare Recipients

Mandatory welfare-to-work programs that include both job search assistance and short-term education or training activities appear to generate the largest impacts on employment and earnings. Strategies that combine mandatory employment services with earnings supplements have generated increases in both employment and income.[2] In general, however, outcomes are much worse for the most disadvantaged welfare recipients, suggesting that other strategies, perhaps those that are more targeted and intensive, are needed to help those individuals who are hardest to employ.[3] Newer approaches, not yet tested, range from models emphasizing work-focused strategies with special supports (transitional employment or versions of supported employment) to more treatment-focused services designed to address a particular barrier, typically a behavioral health problem.

Reentering Prisoners

Research has identified few examples of successful pre- or postrelease strategies for increasing employment or reducing recidivism among offenders.[4] Many studies have found that in-prison vocational programs lead to lower recidivism, but their research designs are almost uniformly weak. Experts seem to agree that the most promising programs include some combination of pre- and postrelease services. Alternative sentencing is another promising strategy. There is some evidence that drug courts can reduce recidivism, although, again, most studies have used weak designs.[5]

Individuals with Behavioral Health Problems

Certain behavioral health problems (for example, depression, posttraumatic stress disorder, substance abuse, and domestic violence) are relatively common among low-income populations, particularly welfare recipients.[6] Research suggests that current and former welfare recipients who have both physical and behavioral health problems are less likely to find and retain employment.

Although effective treatments for many psychiatric disorders do exist and have been documented in random assignment trials — consider the example of depression, for which both antidepressant medications and psychosocial treatments show promise[7] — much less is known

[2]Bloom and Michalopoulos (2001).
[3]Bloom and Michalopoulos (2001).
[4]Bloom (2006).
[5]Belenko (2001).
[6]Danziger, Corcoran, and Danziger (2000).
[7]American Psychiatric Association (2000).

about whether employment outcomes improve as a result of successful treatment. For example, several random assignment studies of interventions to assess, recruit, and treat adults with undiagnosed depression have found that they significantly reduced depression in low-income minority populations.[8] However, impacts on employment have been either short-lived or nonexistent.[9] Programs that combine treatment for depression (such as intensive case management, assertive outreach, integrated behavioral health treatment, and use of specialty providers) with employment services have shown some promise, but there have been no rigorous evaluations.

Hard-to-Employ Parents and Their Children

Children and youth in hard-to-employ families face considerable risks to their cognitive and social development.[10] Providing direct services to children whose parents are hard to employ may indirectly help to achieve employment outcomes for the parents. For example, preschool programs for young children have the dual benefit of taking care of the child care needs of working parents and benefiting children's cognitive and socio-emotional functioning.[11] Such intervention strategies could include both center- and home-based components, as well as a program aimed at increasing employment directly (since home- and center-based interventions for children do not always increase maternal employment).[12]

In short, past experience and research suggest that there is a lot to learn about which strategies are most effective in serving various hard-to-employ populations, how best to configure these strategies within programs, and how to ensure that programs for the hard-to-employ interact effectively with the systems that are already serving (or not serving) them. The Hard-to-Employ demonstration hopes to offer answers to these questions.

An Overview of the Hard-to-Employ Demonstration and Evaluation Project

In 2001, HHS selected MDRC as the prime contractor for the Enhanced Services for the Hard-to-Employ Demonstration and Evaluation Project, a nine-year study of selected programs designed to enhance employment, family functioning, and child well-being. The project was explicitly designed to build on previous research by rigorously testing a variety of innovative, policy-relevant interventions and creating an evidence base of best practices for programs.

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[8]Miranda et al. (2006).

[9]Wells et al. (2000).

[10]Duncan, Brooks-Gunn, and Klebanov (1994).

[11]National Institute of Child Health and Human Development Early Child Care Research Network (2000); Fantuzzo, Bulotsky-Shearer, Fusco, and McWayne (2005).

[12]Yoshikawa (1994); U.S. Department of Health and Human Services (2002); Werner and Smith (1992).

Study Design

The evaluation includes three main components:

- A study of the *implementation* of the programs, the services they deliver, and the operational challenges they encounter.
- A study of the programs' *impacts*; the key outcomes measured vary by site, but include employment, earnings, public benefits receipt, depression severity, criminal justice contacts, and others.
- A study of the financial *costs* attributable to the programs.

The impact analysis uses an experimental, random assignment design, which is generally considered to be the most reliable way to assess the impact of social programs.

In a typical random assignment evaluation, individuals who are eligible for the program are assigned, at random, to a program group, which has access to the experimental program, or to a control group that is treated as though the new program did not exist. Members of the two groups are tracked during a follow-up period and are compared on a number of relevant outcomes.[13] Because the design ensures that there are no systematic differences between the members of the two groups when they enter the study, any significant differences that emerge between the groups over time can be reliably attributed to the fact that one group was exposed to the experimental program and the other was not. Such differences are known as impacts, or effects, of the program. Although all of the Hard-to-Employ programs are being evaluated using random assignment, the design must be tailored to fit each individual project. In fact, because the projects are so diverse, the evaluation can be seen as four separate but related studies.

To measure program impacts, the MDRC team will use a combination of surveys and administrative records to track the research groups over time.

Phases of the Project and Key Components

In order to structure and prioritize site development work, MDRC and its expert consultants prepared a series of papers about the implications of different targeting strategies, models, program approaches, and best practices for the evaluation design.

After discussions with HHS, the MDRC team set out to recruit programs to participate in the study. Approximately 20 were considered, nine were selected for development, and four

[13]The comparisons include everyone assigned to the two groups, including sample members who do not actually participate in the experimental program.

were able to implement random assignment. Most of the potential sites that did not go forward were too small to generate the sample sizes needed for a random assignment study. In other cases, funding or management issues caused interested programs to remove themselves from consideration.

Three of the four participating programs target discrete hard-to-employ populations — welfare recipients, reentering prisoners, and Medicaid recipients with depression — while the fourth is a two-generation project in Early Head Start programs:

1. **Center for Employment Opportunities, New York City.** Parolees are placed in paid transitional employment at one of several dozen work sites around the city for two to three months, followed by placement in unsubsidized jobs. The program also includes a fatherhood program, postplacement retention services, job coaching, and other supports.

2. **Kansas and Missouri Early Head Start.** Aimed at poor pregnant women and parents with children up to 4 years old, this "two-generation" intervention provides enhanced self-sufficiency services and skills training to parents, in addition to high-quality child care. The children in the program group are enrolled in Early Head Start services, and the parents receive assistance to identify and work toward self-sufficiency goals.

3. **Test of alternative employment strategies for welfare recipients in Philadelphia.** Parents who have received Temporary Assistance for Needy Families for at least one year or do not have a high school degree are referred to one of two programs offering different kinds of services: (1) the Transitional Work Corporation, which places participants in temporary paid jobs and provides a range of supports and job placement assistance, or (2) the Success Through Employment Preparation program, operated by Jewish Employment and Vocational Service, which focuses on identifying and treating participants' employment barriers before they are placed in jobs.

4. **Rhode Island Working toward Wellness project.** Working-age adults who have children, are on Medicaid, and are experiencing serious depression receive intensive telephonic outreach and follow-up from managed care case managers to encourage their participation in mental health treatment. The program also provides access to employment services.

Some of the participating programs — notably, the Transitional Work Corporation and the Center for Employment Opportunities — have extensive experience operating the model that is being tested. In these sites, the MDRC team worked with program staff to tailor the re-

search design to local conditions. In sites that were starting new programs or adding significant new components to an existing model, the MDRC team also provided extensive technical assistance to develop and refine the model.

Random assignment of study participants began at a different time in each site. Approximately six months after random assignment began, MDRC visited each site to assess whether the test had been implemented as designed, to identify program challenges, and to develop recommendations to strengthen implementation.

Preliminary results from the impact analysis are expected to be available for CEO in late 2007; results from the other sites are expected in 2008 and 2009.

The Focus of This Report

The next four chapters focus on the four Hard-to-Employ programs, in each case describing the details of the program's strategy, the evaluation's design, and the characteristics of the program participants and the control group members. The results of the early assessments are used to describe particular challenges the sites encountered and how they are addressing them.

Chapter 2

New York: Center for Employment Opportunities

Introduction

This chapter describes the Hard-to-Employ evaluation of the Center for Employment Opportunities program (CEO). CEO is a prisoner reentry program that provides employment services to formerly incarcerated people returning to New York City and to people under other types of community supervision. The focus of this evaluation is on the group of clients who were referred to CEO by their parole officer.

This chapter begins by providing information about the complex problems of people who have been recently released from prison and explains why it is urgent for policymakers to understand and support programs that are designed to address their needs. Next, the chapter describes the CEO program's services, followed by the research design and the procedures used in the evaluation, including the key outcomes and the data sources that will be used to track them. Then the chapter describes the characteristics of the sample population, followed by results from an early analysis of program participation patterns, including the details of each of CEO's core services and the exposure of the treatment group to these services. The chapter concludes with a description of enhancements that were made to CEO's program during the study period.

Background and Policy Relevance

Nationally, over 600,000 people are released from state prisons each year. Former prisoners must work hard to become reintegrated into the community, find stable employment and housing, and support their families. Unfortunately, the obstacles they face are substantial. Many have very little income and extensive financial responsibilities, including child support arrears, that have continued to mount during their incarceration. The criminal records of many individuals continue to severely limit their employment options and adversely affect their social outcomes. In addition, many have substance abuse and mental health problems that require ongoing treatment. Not surprisingly, rates of recidivism are extremely high. Recidivism is costly for everyone: the individual, their families, local communities, and the larger society.

The criminal justice system has experienced many changes in recent years, including a tremendous increase in incarceration. Consequently, unprecedented numbers of prisoners are being released each month. In fact, more than four times as many prisoners were released in

2004 as in 1980.[1] Many individuals are reincarcerated for parole violations and cycle in and out of prison or jail multiple times for the same original offense. Over one-third of the prison admissions each year consist of people who were out on parole.[2] The large number of former prisoners who fail to become reintegrated into society and end up back in prison costs taxpayers billions each year. In 2004, for example, expenditures on corrections were estimated to be over $40 billion.[3] Even though spending has increased, former prisoners are no more likely to succeed than they were 30 years ago. Within three years of their release, two-thirds are arrested and more than half return to prison or jail.[4]

As increasing numbers of prisoners are released to communities each year, concern for public safety is mounting, particularly in inner-city neighborhoods. Many ex-prisoners are returning to communities that already have high rates of crime, unemployment, and poverty.[5] In some neighborhoods, more than 25 percent of all men between 18 and 64 are on probation or parole. In these same neighborhoods, more than one of three families live below the poverty line and one of six receive public assistance.[6]

Prisoner reentry also has direct effects on families and children. More than half of reentering adults have children under 18, and more than 10 million children in the United States have a parent who was in prison at some point in the child's life.[7] Not surprisingly, long periods of incarceration can be detrimental to family ties and can alienate the recently released parent from his/her children. Aside from the prolonged affects on children's well-being, diminished family bonds make it all the more unlikely that prisoners will succeed at becoming reintegrated into their communities.[8] Many families who were relying on public assistance before a parent was incarcerated suffer increased financial burdens. Research has shown that as many as 44 percent of the caregivers of children with an incarcerated parent report receiving public assistance, such as Temporary Assistance for Needy Families.[9] Furthermore, upon their release, nearly one-third of former prisoners expect their families to depend on public assistance.[10]

While former prisoners face many complex challenges, work seems to be a key ingredient in determining the success or failure of their transition back to society. Studies have shown that when ex-prisoners find and maintain formal employment, their chances of recidivism are

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[1]NGA Center for Best Practices (2005).
[2]Travis, Solomon, and Waul (2001).
[3]NGA Center for Best Practices (2005).
[4]U.S. Department of Justice (2004).
[5]Roman and Travis (2004).
[6]Re-entry Policy Council (2006).
[7]Hirsch et al. (2002).
[8]Visher, LaVigne, and Travis (2004).
[9]Travis and Waul (2004).
[10]Re-entry Policy Council (2006).

reduced and that the better the job, the less likely their chances of recidivism. This finding is particularly true for older former prisoners.[11] When ex-prisoners are employed, their housing conditions may be better and their relations with their families and their communities may improve. Many recently released people report feelings of disconnect and alienation from society. Employment can be a key factor in helping these men and women feel more connected to mainstream society and in encouraging them to move away from a criminal trajectory.

Finding a steady job is a major challenge for ex-prisoners. Many employers are reluctant to hire someone with a felony record. In fact, employers are much less likely to hire a former prisoner than a member of any other disadvantaged group.[12] In a survey of 3,000 employers, two-thirds reported that they would not knowingly hire a former prisoner.[13] Most recently released people have other attributes that make them less appealing to potential employers, such as low educational attainment and limited work history. They may also have unstable work habits or competing demands from drug treatment programs, curfews, or other restrictions on their mobility that can make it even more difficult to find and keep full-time employment.

Well-rounded employment services for former prisoners are critical to ensuring better postrelease outcomes. While there are community programs that aim to provide these needed supports, few operate on a large scale and little is known about how effective they really are.

Program Description

CEO in New York City is one of the nation's largest and most highly regarded employment programs for formerly incarcerated people. Developed by the Vera Institute of Justice in the 1970s, CEO has operated as an independent nonprofit corporation since 1996. It serves an average of 1,800 returning men and women each year. Its paid staff of around 150 work in a variety of positions, including supervising transitional work crews for its Neighborhood Work Project (NWP), providing preemployment training and job development services as part of the Vocational Development Program, and providing executive and administrative support. CEO's transitional employment program is funded largely by government institutions that hire CEO work crews to perform basic maintenance and other functions. CEO also receives funding from the New York State Division of Parole, local criminal justice agencies, federal Workforce Investment Act (WIA) funds, and private foundations to cover the cost of its vocational development programs.

[11]Harer (1994); Uggen (2000).
[12]Holzer (1996); Holzer, Raphael, and Stoll (2002).
[13]Holzer, Raphael, and Stoll (2002).

Participants start the program with a four-day life-skills class focusing on job readiness that covers workplace behavior, job search skills, and decision-making. As part of this component, CEO makes sure that each participant has all the official identification and documents necessary for employment. Participants are then placed at one of 30 to 40 work sites around the city. The work sites are public agencies, such as the City University of New York, which have secured CEO's services through the New York State Division of Parole. Participants are paid New York State's minimum wage[14] for four days of work per week (they are paid daily, at their work site). These transitional placements are the heart of CEO's program. Parolees often have a pressing need for cash, and the placements provide them with "daily pay for daily work." In addition, CEO uses the transitional period to identify issues that are likely to hinder participants' performance in an unsubsidized job and to work with participants to address these issues. Most participants stay at work sites for two or three months.

Participants spend the fifth day of each week in CEO's main office, meeting with job coaches to discuss their work performance and prepare for interviews and with job developers to discuss permanent employment opportunities. During the study period (approximately January 2004 through December 2005), there were also some opportunities for short-term, employer-driven training. Participants may spend their fifth day participating in other activities, such as an extensive fatherhood program that helps participants to resolve child support issues (such as reducing current child support orders) and to improve their family relationships.

Research Design

This evaluation rigorously tests the effects of the core components of CEO's postrelease employment program for parolees. The study provides a test of whether a well-designed postrelease program model that provides immediate, transitional work and job placement services in a supportive environment can lead to increased rates of permanent employment and reduced rates of recidivism and reincarceration.

The impacts of CEO's program will be assessed using a random assignment research design. For purposes of the evaluation, clients whose parole officer referred them to the program, who reported to CEO, and who met the study eligibility criteria (discussed further below) were randomly assigned to one of two groups:

- **Neighborhood Work Project (NWP) group (program group).** Individuals who were assigned to this group received all of CEO's program services (described in detail above), including a four-day life-skills class, placement in a

[14]When the study began in 2004, the minimum wage was $5.15 per hour. In 2005, it increased to $6.00 per hour. The current minimum wage in 2007 is $7.15 per hour.

transitional job, job coaching, additional services such as the fatherhood program, permanent employment placement services, and all postplacement services.

- **Resource Room group (control group).** The Resource Room program was designed to provide a basic level of service to individuals who were assigned to the control group and to provide a benchmark against which CEO's core program could be compared. Individuals assigned to this group participated in a revised version of the job-readiness class (life skills) that lasted one and a half days. Participants were then given access to a resource room equipped with computers (with job search software), phones, voice mail, a printer, a fax machine, and other job search tools, including publications. When clients came into the resource room, a staff person was available, if needed, to assist them with many aspects of job search, including use of the equipment, help writing a résumé, and assistance setting up a voice mail account so that potential employers could leave messages for them.[15]

One risk in the design is that some members of the Resource Room group may have sought assistance from other employment programs that offer services similar to those provided to the NWP group. This could dilute the impacts of the program comparison, although there are very few other programs offering transitional work to ex-prisoners. The 15-month follow-up survey will help determine whether control group participation in other programs is really an issue, because the survey will obtain information about program participation since random assignment for both research groups.

Random Assignment and the Sample Intake Process

The MDRC team worked with CEO and the New York State Division of Parole to design a random assignment process that ensured both that the study did not decrease the number of people who received NWP services and that CEO had enough participants to fill its contractual obligations to NWP work site sponsors.

CEO enrolls a new cohort of paroled clients each Friday. In order to accommodate the research study to this routine, each week CEO staff decided in advance how many slots were available for new NWP clients. This information was then entered into a customized database designed by MDRC. When clients arrived on Friday morning, staff used the database to conduct an attendance check, and the system compared the number of attendees to the number of

[15]Control group members who worked diligently in the Resource Room for three months but were unable to find employment on their own were offered CEO's job placement services.

available NWP slots. If there were at least four "excess" clients present, the system randomly assigned between four and 12 clients to the Resource Room group.[16] If there were fewer than four excess clients present, random assignment was not conducted that week.

Certain eligibility criteria complicated the process. First, clients from several referral sources arrived together on Friday mornings. For contractual reasons, individuals referred from certain sources (such as a special program at Queensboro Correctional Facility) and Shock Incarceration[17] participants had to be placed in NWP and were therefore ineligible for the research.[18] Similarly, for both ethical and methodological reasons, individuals who had participated in the NWP program in the past year ("recycles") were also excluded from the study and assigned to the NWP program. The MDRC database automatically identified these special cases and gave them NWP slots. As discussed above, only "regular parole" clients referred from parole offices around the city were eligible for random assignment to NWP or the Resource Room program.

Only individuals who signed an informed consent form were included in the study sample. Each Friday morning, CEO gave participants a description of the study and random assignment and asked them to sign a consent form agreeing to be part of the study. Regular parole clients were randomly assigned to one of the two program groups, even if they did not agree to be in the study. Nonetheless, the vast majority of clients signed the consent form and agreed to participate in the study. Individuals did not have to consent to the study in order to receive CEO services and meet their parole obligations. Figure 2.1 shows the flow of clients through the random assignment process.

Sample build-up moved more slowly than anticipated because of the need to balance the number of clients at CEO's work sites and restrictions on the inclusion of certain groups in the study. In addition to slow sample build-up, there were some difficulties managing the expectations of participants assigned to the control group.

Before the study began, CEO placed most eligible clients who came to its offices at a NWP work site. Although CEO, the Division of Parole, and MDRC made every effort to communicate the research design and the possibility of participants not obtaining a work site placement, some parole officers were still unaware of the change at CEO and sent participants there expecting to be placed at a work site. Moreover, CEO is well known in the community, and clients often heard about the program from friends or relatives. As a result, some clients assigned to the control group expressed disappointment and frustration when they realized that they

[16]For programmatic and logistical reasons, it was decided that new Resource Room classes should comprise four to 12 clients.

[17]Shock Incarceration is New York State's boot camp program.

[18]Toward the end of the sample intake period, some Queensboro referrals were accepted into the study.

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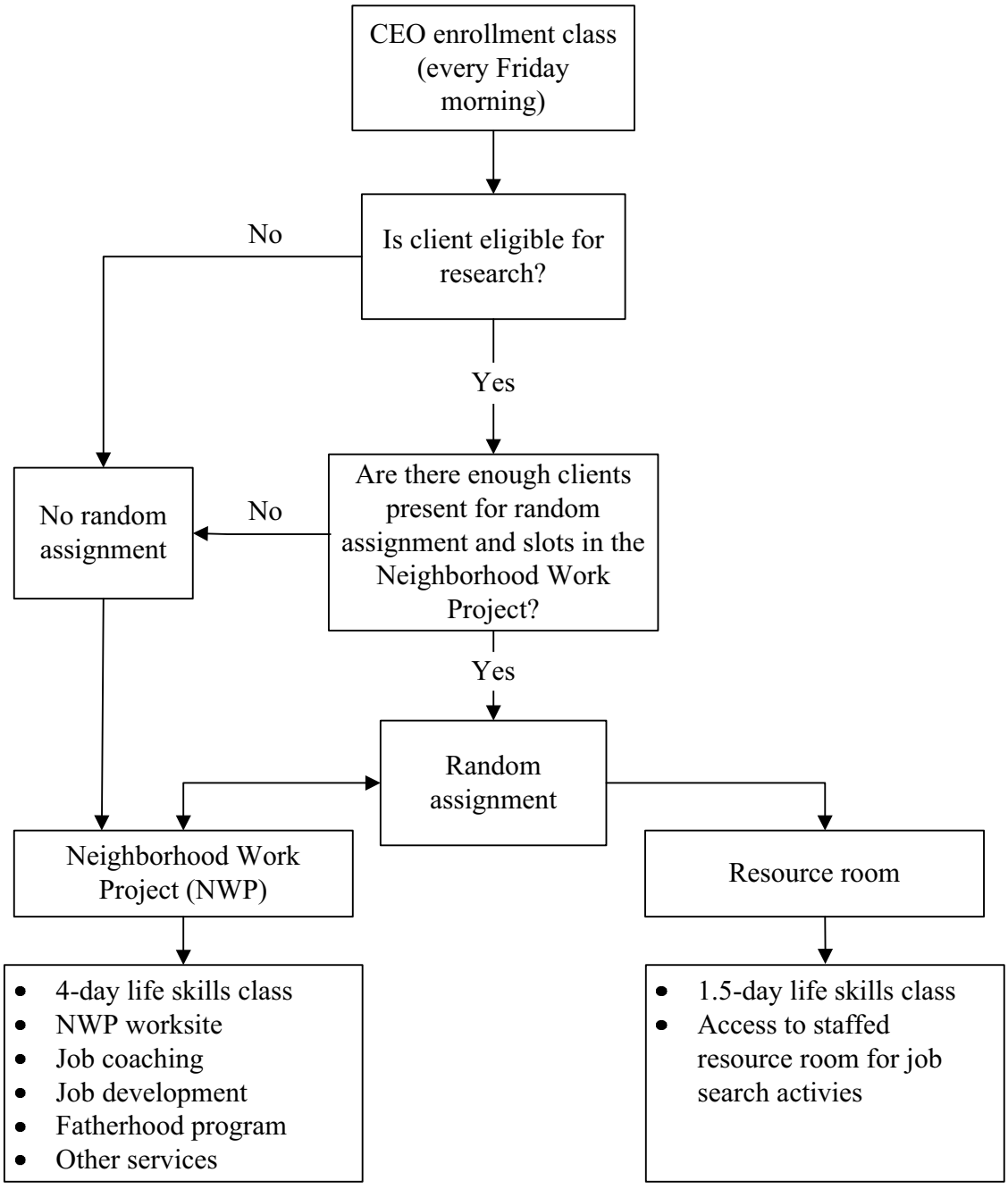
Figure 2.1

Center for Employment Opportunities
Random Assignment Flow Chart



would not be placed at a work site. Some parole officers also expressed concern that some of their clients were not obtaining NWP placements from CEO. As would be expected, these situations were uncomfortable for CEO staff. While the study did not reduce the total number of clients who obtained NWP placements, it appeared unfair to particular clients who came to CEO and were not given access to NWP. As random assignment proceeded over time, parole officers and participants became more familiar with the new process at CEO, and staff had less difficulty managing expectations.

Intake for the study ran from January 2004 through October 2005, nearly two years, and involved a total of 977 participants: 568 were assigned to the NWP group and 409 to the Resource Room group. This sample will require a 5 to 8 percentage point difference in outcomes between the two research groups to detect an impact. If the program produces an effect of less than that amount, it may not be statistically significant. It is important to note that even relatively small impacts may be quite policy-relevant. For example, if CEO can generate even a modest reduction in reincarceration, the resulting cost savings to taxpayers could be substantial.

Baseline Data and Key Outcomes

Baseline data were collected from a short baseline information sheet. Some additional baseline data were also obtained from CEO's internal database, which contained information from a referral form that parole officers are required to fill out when they refer a client to CEO. To be accepted into the program, clients must have this form when they arrive at CEO on Friday mornings.

The study will use several types of follow-up data to assess the impacts of the program:

- **Criminal justice administrative data.** These data provide information on a range of outcomes, including arrests, parole violations, convictions, and incarceration, for each member of the study sample.
- **Earnings and employment data.** MDRC is collecting data to show quarterly employment in jobs covered by the unemployment insurance (UI) system in New York State for each sample member. State employment data may be supplemented with information from the National Directory of New Hires, a database maintained by the federal Office of Child Support Enforcement. Data from the New Hires directory would provide information on earnings from employment both within and outside New York State.
- **Child support administrative data**. These data will include a history of any formal child support payments by sample members who are noncustodial parents.

- **Survey data.** A 15-month survey is currently being fielded and will be used to measure outcomes that cannot be assessed using administrative data. The survey will obtain data on jobs not covered in the UI records, participation in employment programs other than CEO, family outcomes, and receipt of public assistance and social services.

- **Program data.** These data provide information on each individual's participation in the CEO components for which he or she is eligible, including data on NWP work, job coach and job developer appointments, participation in the fatherhood program, and, for control group participants, attendance in the Resource Room.

Characteristics of the Sample

Table 2.1 presents selected baseline characteristics of the research sample. Overall, the characteristics of the CEO study sample are similar to the national population of ex-prisoners. The vast majority of sample members are male (93 percent). Almost all are black or Latino (in national samples, nearly one-third are white, likely reflecting the difference in prison populations in New York City compared with the nation). Most of the sample members are over 30,[19] similar to the average age of prisoners being released nationally, which is 34.

Almost half the research sample have at least one child under 18, although most do not live with any of their children. Of those with children under 18, fewer than one-fifth report that they have a formal child support order in place.

The process of obtaining affordable housing is complicated for a returning prisoner, because most do not have income from employment and are not eligible for many other forms of public assistance. In addition, current federally subsidized housing programs give public housing authorities the power to deny housing or terminate the leases of individuals with a history of drug use or criminal behavior. Thus, it is not surprising that only a very small proportion of the sample reside in a house or apartment that belongs to them or is rented in their name. Many live with friends or relatives or in some type of transitional housing.

Only about half the sample have completed a high school diploma or General Educational Development (GED) certificate and a very small proportion have any postsecondary education. Most do have at least some employment history. More than 80 percent report that they

[19]Note that the population in this study is considerably older than CEO's other participants, many of whom are between the ages of 18 and 25.

The Enhanced Services for the Hard-to-Employ Demonstration

Table 2.1

Selected Baseline Characteristics, by Research Group

Center for Employment Opportunities

Characteristic	Program Group	Control Group	Total	
Gender (%)				**
Female	8.3	4.5	6.7	
Male	91.7	95.5	93.3	
Age (%)				
18 to 24 years	18.4	20.5	19.3	
25 to 30 years	25.5	24.9	25.3	
31 to 40 years	30.0	30.3	30.1	
41 years or older	26.1	24.3	25.3	
Average age (years)	33.49	33.38	33.44	
Citizenship (%)				
Yes	80.2	76.0	78.5	
No	19.8	24.0	21.5	
Race/ethnicity (%)				
White, non-Hispanic	1.9	2.5	2.1	
Black, non-Hispanic	63.5	63.8	63.6	
Hispanic	31.2	30.5	30.9	
American Indian	0.7	0.5	0.6	
Other	2.7	2.7	2.7	
Any children in household (%)				
Yes	55.9	55.3	55.7	
No	44.1	44.7	44.3	
Number of children under age 18[a] (%)				*
None	54.6	52.1	53.5	
1 child	25.6	24.3	25.1	
2 children	13.0	11.9	12.5	
3 or more children	6.8	11.7	8.9	
Average number of children	0.77	0.90	0.83	*
Any children under age 18 in household (%)				
Yes	15.0	14.6	14.8	
No	85.0	85.4	85.2	
Education (%)				
High school diploma	10.1	11.3	10.6	
GED	42.8	42.9	42.8	
Technical/associate's/2-year college	3.5	2.7	3.2	
4 years or more of college	0.8	0.6	0.7	
None of the above	42.7	42.5	42.6	

(continued)

Table 2.1 (continued)

Characteristic	Program Group	Control Group	Total	
High school diploma or GED certificate (%)				
Yes	57.3	57.5	57.4	
No	42.7	42.5	42.6	
Took courses in prison (%)				
Yes	54.4	58.2	56.0	
No	45.6	41.8	44.0	
Housing status (%)				
Rent, not subsidized or public housing	7.5	9.0	8.1	
Rent, subsidized or public housing	8.3	6.7	7.6	
Lives at own home or apartment	2.2	3.4	2.7	
Lives with friends or relatives	59.7	56.4	58.3	
Transitional housing	10.8	11.6	11.1	
Emergency/temporary housing	2.8	4.5	3.5	
Homeless	1.6	0.7	1.2	
Other	7.2	7.8	7.4	
Marital status (%)				
Married, living with spouse	9.3	8.1	8.8	
Married, living away from spouse	8.0	7.3	7.7	
Unmarried, living with partner	21.6	21.5	21.6	
Single	61.2	63.1	62.0	
Ordered to provide child support to a child under age 18 (%)				
Yes	19.6	20.0	19.8	
No	80.4	80.0	80.2	
Mandated to report to CEO (%)				*
Yes	12.8	16.8	14.5	
No	87.2	83.2	85.5	
Ever employed (%)				
Yes	80.5	81.2	80.8	
No	19.5	18.8	19.2	
Ever employed for 6 consecutive months by one employer (%)				
Yes	59.8	63.9	61.5	
No	40.2	36.1	38.5	
Received paychecks for at least 6 consecutive months from one employer (%)				
Yes	57.0	60.5	58.4	
No	43.0	39.5	41.6	

(continued)

Table 2.1 (continued)

Characteristic	Program Group	Control Group	Total
Among those who were ever employed:			
Employed for 6 consecutive months by one employer (%)			
Yes	75.1	79.7	77.0
No	24.9	20.3	23.0
Sample size	568	409	977

SOURCE: CEO Baseline Information Form.

NOTES: Random assignment began on January 9, 2004, and ended on October 21, 2005.

In order to assess differences in characteristics across research groups, chi-square tests were used for categorical variables and analysis of variance (ANOVA) tests were used for continuous variables.

Levels for statistically significant differences between the program and control groups are indicated as: *** = 1 percent; ** = 5 percent; * = 10 percent.

[a]This category is missing a total of 16 sample members who stated that they have children but did not provide the children's ages.

have worked. The majority of those who have worked report that they worked for a single employer for six consecutive months.

As expected with a random assignment research design, there were few differences in background characteristics between the two research groups. Moreover, the background characteristics of the CEO sample are similar to those of the larger population of ex-prisoners, making the findings of this study all the more important to policymakers.

Many experts believe that, the sooner after release a former prisoner receives needed supports, the more likely he or she is to have a successful transition. Indeed, the CEO model is designed for people who have just been released from prison. Criminal justice data (not shown), however, suggest that many of the participants in the study were not referred to CEO directly after their release but, instead, many months later. One can imagine any number of factors that might influence the point at which a parolee is actually referred to CEO. Perhaps participants unsuccessfully explored other avenues to finding employment before their parole officer referred them to CEO.

In contrast, several other subsets of the CEO population who are not part of the study almost always come to the program immediately after their release (in one program, orientation at CEO occurs the day after prisoners are released, and they begin the program the following Monday). The results for the regular parole population are obviously quite important and pol-

icy-relevant but, at this point, it is not clear how well they will represent the results for other groups served by CEO. The MDRC team will continue to investigate how the regular parole population compares with other CEO clients.

Early Findings from the Assessment

In July and August 2004, MDRC, assisted by the Urban Institute, conducted an early assessment of the CEO evaluation. This assessment was conducted seven to eight months after the start of random assignment to ensure, early on, that random assignment and the study design model were being implemented as planned. The assessment showed a high level of participation in CEO's core program components among program group members. The data also indicated a clear difference in service receipt at CEO between the two research groups: As expected, members of the control group did not receive any of CEO's core services.[20] Such clear differences suggest that the evaluation will be a reliable test of CEO's program.

Participation and Service Receipt

As part of the early assessment, participation rates in CEO's main components were examined using NIGEL, CEO's Management Information System. These results were updated as additional sample and follow-up data were available and have not changed dramatically since the assessment. The results, presented in Table 2.2, show rates of participation in CEO's core program activities between the date of random assignment and December 31, 2005, for an early cohort of program group members who entered the program during the first year of the evaluation, between January 2004 and December 2004. By limiting the analysis to this early sample, it is possible to track participation patterns for a minimum period of one year after random assignment.

- **Life skills.** The first step in the CEO program is completion of the life-skills class. Nearly three-quarters of the NWP group completed the class, while only about 40 percent of the control group completed the shorter version that was designed for them.

- **NWP work sites.** After they complete the life-skills class, NWP participants are placed in transitional employment. As discussed above, placement at an NWP work site is the core of CEO's program. Nearly all NWP group

[20]The assessment showed that no one in the Resource Room group worked in an NWP position; however, recent data collected on NWP participation showed that there were four control group clients who worked in NWP at some point during their follow-up period. It is unlikely that four sample members will change the overall results of the study. Nonetheless, these individuals will be flagged for the impact analysis, and MDRC will examine whether their outcomes have any effect on CEO's impacts.

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Table 2.2

Program Participation and Neighborhood Work Project (NWP) Employment

Center for Employment Opportunities

Outcome (%)	NWP Group
Completed life skills	72.7
Received any job coaching services[a]	56.5
Received any job developer services	65.8
Ever worked in NWP	66.1
Weeks worked in NWP[b]	
Never worked	33.9
Less than 1 week	3.8
1-4 weeks	15.4
5-12 weeks	27.9
13-24 weeks	15.5
More than 24 weeks	3.6
Days between date of random assignment and NWP	
0-7 days	67.8
8-14 days	24.0
More than 14 days	8.2
Sample size	303

SOURCE: MDRC calculations from CEO's Network for Information Gathering Evaluation and Learning (NIGEL) system.

NOTES: This table reflects NWP employment through December 31, 2005. There were four control group members (1 percent) who worked in NWP during the follow-up period. NWP outcomes for these control group members are not shown in the table.

The sample in this table is limited to program group clients who were randomly assigned between January 2004 and December 2004, allowing at least a 12-month follow-up period for everyone. Results in this table are weighted by month of random assignment.

[a]The percentage who received any job coaching services may be underestimated due to inaccurate data entry. MDRC is working with CEO to obtain an accurate estimate of this outcome.

[b]It is important to note that weeks worked may not be consecutive but may include a total of weeks worked after an individual's date of random assignment. This variable is created by taking total days worked in NWP and dividing by 4, because participants work four days per week in NWP and attend job coaching or other CEO services on the fifth day.

members who completed the life-skills class worked in NWP during the follow-up period, and, overall, two-thirds of the program group worked in NWP. Nearly half the program group worked at least one month at an NWP work site, with most of those working between two and three months. (Of course, working longer at an NWP site is not always better; an individual may be deemed job-ready and placed in a permanent job after a relatively short period in NWP.)

- **Job coaching.** The role of the CEO job coach is to assess and promote job readiness for each NWP participant. Job coaches teach the life-skills classes, track participants' attendance and performance at NWP work sites, communicate with parole officers, and, where appropriate, issue warnings and suspensions. An important aspect of the job coach's responsibilities is to identify and address any issues needed to make an individual ready for regular employment. Job coaches do this by meeting weekly with participants and by communicating with work site supervisors. Ultimately, it is the job coach who decides when a participant is deemed "job-ready" and begins to work with a job developer to seek a permanent job. For most of the study period, job coaches were also responsible for postplacement follow-up to promote job retention. As expected, the data from NIGEL show that a large majority of the participants who worked at an NWP work site attended at least one meeting with a job coach during the one-year follow-up period (81.6 percent — not shown in table); overall, 56.5 percent of the NWP group met with a job coach.

- **Job development.** Once an NWP participant is deemed "job-ready," a CEO job developer conducts an initial assessment of the participant and begins the process of matching the participant with a permanent job. Job developers build relationships with employers in order to identify job openings and match participants with them. Job developers typically prepare participants for a particular interview and, in some cases, will accompany the participant to an interview. Job development is a particularly valuable service, because CEO has identified dozens of employers who are willing to hire individuals with a criminal record. Nearly all NWP group members who worked at an NWP site (nearly two-thirds of the program group overall) met with a job developer during the one-year period.

- **Support services.** CEO offers participants a number of other supports to assist them to find permanent employment, some directly and some through referrals to other organizations. These supports include assistance with cloth-

ing, including boots for use at NWP work sites; food allowances; assistance finding housing; transportation assistance; and other similar services.

Recent Program Enhancements

CEO implemented a few "enhancements" to the program model midway through the study period.[21] In upcoming reports, MDRC will examine whether there are any differences in the program's effects for those who came to CEO after the enhancements were in place, compared with those who started the program before the enhancements.

- **Bonuses.** As part of the job retention component, CEO began to offer bonuses to participants who hold a non-NWP job for a certain period of time. These bonuses, called "Rapid Rewards," are a series of noncash rewards (such as transportation passes) that CEO gives when participants present their pay stubs at various incremental time periods. Participants can earn over $500 in Rapid Rewards during the first 12 months of their employment.

- **Passport to success.** Work site supervisors are required to report daily about an individual's performance on the job for that day. Job coaches then use these reports as a way of keeping apprised about a client's performance and job readiness. For much of the study period, these daily reports were made on paper forms that were difficult for job coaches to keep track of for multiple participants across multiple job sites. CEO has now implemented the "passport to success" system, which requires every participant to carry a "passport" each day at the work site. The work site supervisors use the passport to report on participants' performance for that day, and job coaches review the passports at the end of each week when participants meet with them.

- **New employee work sites.** These are special NWP work sites designed for new participants. They are more intensive than the regular NWP work sites and provide more job coaching assistance and specialized individual attention. Certain supervisors and job coaches are specially trained to work with individuals at these work sites.

[21]CEO also began to operate a Young Adult Program during the study period that provided specialized services specifically designed to meet the needs of younger participants. Only a small proportion of clients in the study received these services because of timing as well as age restrictions.

Conclusions

Research has shown that stable employment can be a crucial component of successful reentry for former prisoners. Unfortunately, many ex-prisoners have attributes that make them less appealing to employers. Aside from the direct effect of being an ex-offender, many have low levels of education and previous work experience. Moreover, because prisons are overcrowded and expenses for corrections are mounting, most prisoners do not have opportunities to participate in meaningful job training programs while they are incarcerated. As a result, community-based programs have become an even more important resource for providing ex-prisoners with crucial employment-related services and job training and placement assistance. While there are community programs that provide supportive services to ex-prisoners, very few offer an immediate paid transitional job and permanent job placement services. CEO is one of the few established reentry programs operating on a large scale that offers these types of services.

Evidence from past evaluations of reentry programs showed that few, if any, strategies were effective at reducing recidivism and increasing employment among ex-prisoners. This created a widespread view that this population could not be helped. In recent years, however, experts have tried to change that view and have used research to show that some reentry strategies do show promise. To help policymakers understand better which strategies are most effective, experts and criminal justice officials agree that there is an urgent need to rigorously evaluate the most promising reentry strategies.

The Hard-to-Employ evaluation of CEO will be the first random assignment evaluation of a transitional employment program for ex-prisoners in many years. The findings of this study will provide critical answers to many questions left unanswered by previous studies. Future publications from this study will evaluate whether a strong transitional employment model can increase employment and break the cycle of reincarceration among former prisoners.

Chapter 3

Kansas and Missouri: Early Head Start

Introduction

Can the employment and economic self-sufficiency of hard-to-employ parents be improved while enhancing the development of their young children? To address this pressing question, the Hard-to-Employ project includes an evaluation of a two-generational program that addresses the needs both of low-income parents who are at risk of unemployment and their young children.

This chapter provides a brief review of the background literature that highlights the considerable developmental risks faced by very young children living in poverty and the promise of two-generational programs in addressing the unique needs of hard-to-employ parents who have young children. The Hard-to-Employ project is evaluating the effectiveness of enhanced employment and economic self-sufficiency services in traditional Early Head Start (EHS) programs, which are aimed at improving parents' employment and their educational and economic outcomes. A detailed description follows of the random assignment research design of this evaluation, the key characteristics of the study sample, and programmatic enhancements to increase the focus of EHS on parental employment and economic self-sufficiency. Findings from the early assessment are also discussed. The results highlight obstacles that can be difficult to overcome when implementing such enhancements, particularly for programs that are traditionally defined as early childhood interventions. At the same time, the results illustrate important opportunities to expand the scope of child-focused and two-generational interventions to address parents' employment and educational needs. They also call attention to the need for more evaluation research in this area.

Background and Policy Relevance

The needs of children living in poverty are a major social policy concern. Many studies indicate that poor children have worse health, behavioral, and cognitive outcomes than their more affluent counterparts.[1] The rate of child poverty in the United States remains high: About 20 percent of children under 5 lived in poverty in 2003.[2] Of the 35.9 million people living in

[1]Duncan and Brooks-Gunn (1997).
[2]Current Population Survey (2004).

poverty in the United States in 2003, about 13 million (about 36 percent) were under 18, and 4 million were under 5.[3]

Evidence from Research on Two-Generational Services

Earlier research demonstrates the value of two-generational services in meeting the developmental needs of low-income children.[4] The Early Head Start Research and Evaluation Project found that EHS improved both parenting behaviors and children's cognitive development.[5] This evaluation also identified a combination of home-based and child care-related services as one of the most effective strategies for enhancing young children's cognitive and social outcomes. Similarly, a review of early childhood programs highlights the benefits to child development of two-generational approaches. This review suggests that home-based interventions might improve family factors, such as parenting and child maltreatment, while center-based interventions might improve children's behavioral and cognitive development.[6] Taken together, these findings suggest that combining home- and center-based services might be a powerful approach to affecting the broadest range of outcomes.

Although the Early Head Start Research and Evaluation Project found positive effects for children, the findings also showed quite small impacts on parents' employment.[7] Thus, the approach's effect might be enhanced by a more proactive programmatic focus on parental employment and economic self-sufficiency.

Evidence from Welfare-to-Work Research

Experimental evaluations of welfare-to-work programs have shown mixed effects on children's development, leading to the conclusion that these programs alone, at least in the short run, neither consistently help nor harm children. The findings also indicate only small improvements in parental mental health, parenting, and home environments, suggesting that, even when their parents enter the workforce, children continue to face considerable developmental risks.[8]

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[3]Current Population Survey (2004).
[4]Shonkoff and Phillips (2000); Olds et al. (1999).
[5]U.S. Department of Health and Human Services (2002).
[6]Yoshikawa (1994).
[7]U.S. Department of Health and Human Services (2002).
[8]Morris et al. (2001).

Implications

A two-generational approach, particularly if the program focuses on parents' employment and economic self-sufficiency, can have wider-ranging effects than a program focused solely on either parents or children.[9] Directly addressing young children's developmental needs can help parents overcome obstacles to sustained employment and economic self-sufficiency. Likewise, directly addressing parents' employment and economic needs can improve their ability to better their own financial circumstances and can indirectly benefit children.

Program Description

EHS, a two-generational program that serves pregnant women and families with children under 3, emerged as an early candidate for the Hard-to-Employ evaluation for a two reasons. First, EHS focuses on promoting children's school readiness and developmental outcomes by providing a range of intensive child and family development services through home visits and center-based child care. A strong emphasis is placed on enhancing young children's physical, behavioral, language, and cognitive development, promoting positive parent-child relationships, addressing parents' social service needs, and promoting healthy prenatal outcomes for pregnant women. Second, the program targets and places a priority on high-needs and low-income families, many of whom experience multiple barriers to employment and financial self-sufficiency.

These goals of EHS are achieved through a variety of program options, including (1) center-based services, in which all services are provided to families through center-based child care services; (2) home-based services, in which all services are provided to families through weekly home visits, and the program is responsible for ensuring that families who need child care find care in the community that meets the revised Head Start Program Performance Standards; and (3) mixed-approach services, in which families receive a combination of home-based and center-based services or cycle from one service option to the other, but do not receive both types of services at the same time.

To qualify for EHS services, pregnant women and families with infants or toddlers must reside within the boundaries of an EHS program's designated service area; families must meet EHS income eligibility requirements by having a family income that is at or below the federal poverty threshold;[10] and children must be under 3 to meet EHS age guidelines, though children can remain in the program until they transition to Head Start at age 4. Families who are

[9]Werner and Smith (1992).

[10]Note that in some cases, the income requirement can be waived if the child or family has special needs (as determined by the individual Early Head Start program). However, no more than 10 percent of the program's enrolled caseload can exceed the income eligibility requirement at one time.

interested in receiving EHS services complete an application and are assigned a priority score based on their specific needs, barriers to employment, or circumstances. Priority is given to pregnant women and families who have infants or toddlers and have particular characteristics related to their employment, welfare receipt, child disability, or teenage parental status.

Reconnaissance and site selection efforts identified two very strong EHS programs in Kansas and Missouri that were interested in enhancing their existing services aimed at improving parental employment and self-sufficiency.[11] These sites were selected based on their established histories of delivering high-quality EHS services; the use of a mixed-approach services model (a combination of services that the Early Head Start Research and Evaluation Project points to as being most effective for enhancing young children's developmental outcomes);[12] their capacities to build sufficient waiting lists to sustain and justify random assignment; and support by the EHS policy councils for a random assignment study and programmatic enhancements to existing EHS services.

Southeast Kansas Community Action Program, Inc. (SEK-CAP) Early Head Start (Girard, Kansas)

SEK-CAP is a community-based agency that serves low-income families and children in 12 rural counties of southeast Kansas. It receives funding from a mix of federal and state grants to provide family outreach, transportation, housing, and early childhood educational services. The EHS program is able to serve up to 50 families located in four rural counties, including Cherokee, Crawford, Labette, and Montgomery counties.[13] All participating families receive a mix of home- and center-based services; families who do not receive EHS child care services receive weekly home visits by family educators and attend biweekly group socialization sessions, where parents and children interact with other EHS families; other families receive full-day, full-year EHS child care services and biweekly home visits from family educators.

Youth-In-Need, Inc., Early Head Start (St. Charles, Missouri)

Youth-In-Need is a multiservice agency that serves low-income families and children in eastern Missouri. In addition to operating EHS and Head Start programs, the agency provides residential treatment programs, outreach services for homeless individuals and families, after-

[11]Three programs in Kansas and Missouri were initially identified that met all of the selection criteria and agreed to participate in the Hard-to-Employ evaluation. Because of programmatic challenges, including difficulties sustaining a waiting list, one of these sites was excluded from the evaluation.

[12]U.S. Department of Health and Human Services (2002).

[13]In August 31, 2006, the EHS program received an additional grant from the Kansas Department of Social and Rehabilitation Services to serve an additional 30 families, bringing the total number of families served by the EHS program to 80.

school leadership and educational programs for youth, and individual and group mental health services. The EHS program, which is supported exclusively by federal grants, is currently funded to serve 199 families in four suburban and rural counties surrounding St. Louis, Missouri.

Youth-In-Need provides both home-based and center-based services. Families can move seamlessly from one service option to another but generally do not receive both service options at once. Families exclusively enrolled in EHS child care services receive parental support and child development services through daily interactions with EHS teachers and center-based managers at EHS child care centers. Families who do not receive EHS child care services receive weekly home visits by family educators and attend at least two group socialization sessions per month, where parents and children interact with other EHS families. However, families who receive child care through collaborative partnerships at other community-based child care centers also receive home-based services in the form of quarterly visits from a home visitor.

Programmatic Enhancements to Early Head Start Employment and Self-Sufficiency Services

MDRC has worked closely with the EHS programs at SEK-CAP and Youth-In-Need to enhance their existing services with a more explicit focus on parental employment and economic self-sufficiency, supported by additional funding from the Head Start Bureau at the U.S. Department of Health and Human Services. The focus on parental employment and financial self-sufficiency is intended to: (1) help parents who are unemployed move into employment; (2) assist parents with low levels of education to pursue educational goals as a means of improving their employment and financial circumstances; and (3) help parents who are employed to find more stable employment, advance in their jobs, and earn higher wages. Through this collaborative effort, SEK-CAP and Youth-In-Need developed formalized employment and self-sufficiency curricula and services, including:

1. Hiring an on-site self-sufficiency specialist to work with EHS staff and families on topics related to employment and self-sufficiency and to develop community partnerships with local employment-focused and educational agencies;

2. Increasing EHS's programmatic focus on employment and self-sufficiency issues by assisting parents to set employment- and training-related goals and regularly monitoring their progress; and

3. Tapping external employment and educational agencies and organizations to fill the gaps in existing EHS employment and self-sufficiency services.

Research Design, Sample Intake Process, and Random Assignment

This evaluation uses a random assignment research design to test the effects on parents and young children of the package of EHS services, including programmatic enhancements to employment and self-sufficiency services. See Figure 3.1 for an illustration of the random assignment procedure.

Families interested in receiving EHS services complete an application. For the purposes of the evaluation, the study and the random assignment process are also explained to families. Families are not required to participate in the evaluation, but the only way they can receive program services is to consent to be randomly assigned. Families who agree to be randomly assigned are then placed on the waiting list in priority order based on their needs and circumstances. When a program slot becomes available, paired random assignment is conducted with the top two eligible and interested families on the waiting list. Families are randomly assigned to either:

- **The EHS program group**. If assigned to the program group, the family will be enrolled in EHS services and will begin to receive home visits and applicable child care services.
- **The non-EHS control group**. If assigned to the control group, the family will not be enrolled in EHS services. However, the family will be able to receive whatever other community services exist and will receive a resource list of available services.

To ensure that the neediest families are not excluded from receiving services as a result of random assignment and that programs are able to meet revised Head Start Program Performance Standards,[14] each program is given a set number of exemptions from random assignment per year (determined by the number of new enrollees) to be used for the neediest families, based on specific criteria defined by the programs before the start of the study.

Enhanced Recruitment Efforts

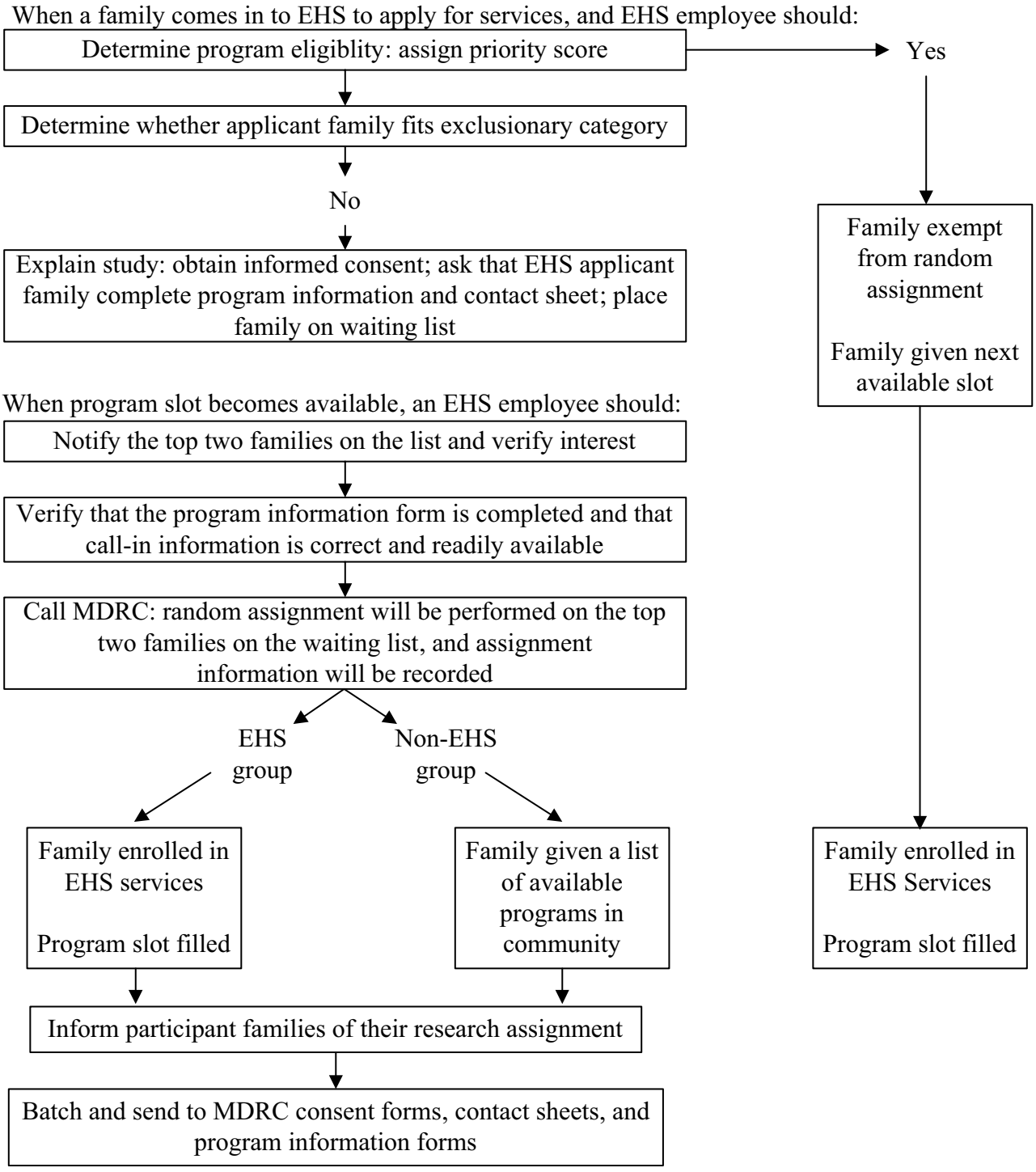
Though the programs generally had extensive waiting lists and did not have enough slots to enroll all applicant families before the evaluation began, they expressed a desire to reach a greater number of high-needs families in their surrounding communities. With the introduction of random assignment, two issues were also particularly important to address. First, there

[14]Program performance standards require that children with special needs, such as developmental disabilities, fill at least 10 percent of program slots.

The Enhanced Services for the Hard-to-Employ Demonstration

Figure 3.1

Early Head Start: Random Assignment Flow Chart



was the need to maintain a sufficient waiting list to ensure that two eligible families were available for random assignment when a program slot became available. Second, once random assignment began, the programs needed to serve at least as many, if not more, high-needs families, that is, those with a high priority score. To date, both programs have enhanced their recruitment efforts, have continued to serve at least as many, if not more, high-needs families than in the past, and have been successful in tapping new referral sources to maintain waiting lists that are sufficient to support random assignment.

Sample Build-Up

Random assignment of families to the EHS programs began in late July/early August 2004. The initial goal was to randomly assign 400 families in Youth-In-Need and 300 families in SEK-CAP over two years. However, sample build-up was slightly lower than anticipated because of difficulties estimating program intake before the study started in one site. Therefore, random assignment was extended for an additional six months in both sites to achieve the targeted sample-size goals. As of December 31, 2006, the programs had randomly assigned 610 families (305 per research group).

Baseline Data and Key Outcomes

Data for this evaluation are collected on the following key constructs.

- **Baseline demographic and descriptive data.** Baseline demographic information on the sample is drawn from common information across all of the programs' intake forms and assessments, which are completed as part of the EHS application process. The assessments generally have two components: a program eligibility determination and priority score assignment and an in-depth interview with the parent covering certain aspects of family life.

- **Parental employment.** Data on parental employment are collected from several sources. MDRC is currently obtaining unemployment insurance (UI) quarterly data from the Kansas and Missouri State Departments of Labor. These data show quarterly employment in UI-covered jobs held in Kansas or Missouri for each sample member. Administrative data records will be supplemented by survey information on parental employment experiences collected 15 months after random assignment. MDRC intends to access wage data from the National Directory of New Hires. This is a national database maintained by the Office of Child Support En-

forcement that can provide information on earnings from employment both within and outside Kansas and Missouri.

- **Income, earnings, and public assistance receipt.** Data from state administrative records track parents' income, earnings, and public assistance receipt in Kansas and Missouri for each sample member. These data are maintained by the Kansas and Missouri Departments of Human Services. This information is supplemented by survey information on parental income, earnings, and public assistance receipt collected 15 months after random assignment.

- **Parental psychological well-being, parenting, family functioning, and child care use**. Key aspects of parental psychological well-being, parenting, and family functioning, such as activities with children (play and discipline) and family routines, as well as child care use that might account for the effects of EHS on young children's development, will be assessed using survey information collected 15 months after random assignment.

- **Children's developmental outcomes.** Children's well-being will be measured by direct child assessments and survey data collected 15 months after random assignment. The survey will be administered to children's primary caregivers and includes measures of children's social/emotional, cognitive development, academic achievement, and health and safety outcomes. An interviewer also asks children (ages 2 to 4 years old) to perform several self-regulation tasks, which assess their motor control, attention skills, impulsivity, and emotional state at the time of the assessment. These tasks include walking along a line and drawing circles at varying speeds, and waiting and not peeking while the interviewer pretends to wrap a gift that will later be given to the child. For these same children, assessments of cognitive development using the broad math and reading subscales of the Woodcock-Johnson III-R will be collected. For these children, as well as those between the ages of 1 and 2, MDRC will administer a subset of the Reynell Developmental Language Scales, which assesses receptive language abilities.

- **Child welfare involvement.** MDRC is currently looking into the availability of data from the Kansas and Missouri child welfare administrative records that provide information about sample members' referrals to and

involvement with state child welfare systems, as well as substantiated and unsubstantiated cases of child abuse and neglect.

- **Program participation data.** MDRC is exploring the possibility of obtaining administrative participation records from the programs. These data provide information on each family's participation in EHS, such as the number and frequency of home visits and attendance at parent training workshops.

Characteristics of the Sample

Table 3.1 presents selected baseline characteristics of the study sample by research group as of December 31, 2006. A total of 610 families (305 in each research group) have been randomly assigned. Characteristics for parents and children are included. As expected with a random assignment research design, there were very few differences in background characteristics between the two research groups. Nevertheless, MDRC carried out a careful review of random assignment procedures. Random assignment was conducted in accordance with the prescribed protocol, and it appears that the observed differences between the research groups were due to chance and not systematic biases. All future analyses will adjust for differences in these baseline characteristics.

Overall, the characteristics of the EHS study sample fall within an expected range of characteristics that are similar to those of the national population of families served by EHS programs. For example, the Early Head Start Research and Evaluation Project indicates that 10 percent of households received Temporary Assistance for Needy Families (TANF), with this percentage ranging from 12 to 66 percent across the research programs included in the evaluation. The Early Head Start Research and Evaluation Project also shows that 40 percent of households are two-parent families and 55 percent of primary caregivers were not employed across the research programs included in the evaluation. These estimates are similar to the current study sample characteristics.[15]

As shown in Table 3.1, the majority of parents who applied for EHS services in Youth-In-Need and SEK-CAP and were randomly assigned are female (90 percent), and more than half are single and never married (54 percent). Eighty-six percent of the sample are white, about

[15]U.S. Department of Health and Human Services (2002).

The Enhanced Services for the Hard-to-Employ Demonstration

Table 3.1

Selected Baseline Characteristics, by Research Group

Early Head Start

Characteristics	EHS	Non-EHS	Total	
Characteristics of child[a]				
Gender (%)				
Female	47.5	46.5	47.0	
Male	52.5	53.5	53.0	
Average age (months)	17.9	16.5	17.2	
Characteristics of primary parent				
Gender (%)				
Female	89.8	89.4	89.6	
Male	10.2	10.6	10.4	
Average age (years)	25.74	25.92	25.83	
Marital status (%)				
Single, never married	54.8	53.5	54.2	
Married	26.2	31.4	28.8	
Separated/divorced/widowed	18.9	15.1	17.0	
Spanish/Hispanic/Latino(a)	3.3	7.0	5.1	**
Race/ethnicity[b] (%)				
White	87.7	84.3	86.0	
Black or African-American	7.3	9.4	8.3	
American Indian or Alaskan Native	1.0	0.3	0.7	
Asian or Pacific Islander	0.7	0.7	0.7	
Other	3.3	5.4	4.3	
Employment during the past 3 years (%)				
Did not work at all	15.3	15.1	15.2	
Worked 1 year or less	29.7	36.6	33.1	
Worked more than 1 year	55.0	48.3	51.7	
Characteristics of case[c]				
Average priority score	289.68	290.47	290.08	
Prenatal status (%)	10.8	10.5	10.7	
Teen parent (%)	11.5	12.5	12.0	
Two-parent family (%)	39.0	44.9	42.0	
Currently on TANF (%)	29.2	28.9	29.1	
Ever on TANF (%)	48.2	45.1	46.6	
Sample size	305	305	610	

SOURCE: MDRC calculations from Early Head Start (EHS) Program Information Forms (PIF) for families randomly assigned from July 21, 2004, through December 31, 2006.

NOTES: In order to assess differences in characteristics across research groups, chi-square tests were used for categorical variables, and analysis of variance (ANOVA) tests were used for continuous variables. Levels for statistically significant differences between program and control groups are indicated as ** = 5 percent.

[a]Prenatal cases are not included in this computation.

[b]"Other" is self-identified by the parent and may include biracial, multiracial, or a category other than white, black, American Indian, or Asian/Pacific Islander.

[c]Priority scores are assigned to families interested in receiving EHS services upon completing an EHS application and are constructed by summing points assigned to specific needs, barriers, or circumstances that a family faces (such as a family's child care needs), parental employment, single-parent status, having a child with a disability, and having a family income below the poverty threshold. Priority scores ranged from 65 to 765.

Prenatal status indicates whether the mother is currently pregnant upon random assignment.

Current TANF receipt indicates whether the family is currently receiving TANF upon random assignment.

Ever having received TANF indicates whether the family had ever received TANF prior to random assignment.

5 percent are Hispanic, and about 8 percent are black. Slightly more than half the sample (51 percent) worked more than 12 months in the past three years. About 33 percent worked 12 months or less during that period, and 15 percent had not worked in the three years before random assignment. About 29 percent of families received TANF upon random assignment and approximately 47 percent reported ever having received TANF before random assignment. A relative minority of applicants are prenatal cases (11 percent) or teen parents (12 percent). Slightly more than half the children in the sample (53 percent) are boys. Children are about 17 months old, on average, upon random assignment.

Early Findings from the Assessment

In May and September 2005, MDRC assessed the two EHS programs to: (1) ensure that the programs were implementing random assignment as planned; (2) examine levels of participation in program services, particularly engagement in EHS employment and self-sufficiency services; and (3) evaluate the sites' progress in making programmatic enhancements to their employment and self-sufficiency services.

As expected, the assessments showed that random assignment was running smoothly and that the programs had made great strides in enhancing their existing employment and self-sufficiency services. Yet there were opportunities to accelerate the implementation of these en-

hancements. The assessments also showed a less than universal level of participation in EHS. Some families did not enroll in the program after being randomly assigned to the program group. MDRC continues to provide technical assistance and to monitor sites' progress in these areas.

Participation and Service Receipt

As part of the assessments, MDRC examined participation rates in EHS to determine whether the participating families are receiving services as intended. Calculations of EHS program participation and receipt of services are drawn from an MDRC review of selected EHS case files in Youth-In-Need and SEK-CAP. The sample for this analysis is limited to the 97 families that were randomly assigned when the assessments were conducted. These results are presented in Table 3.2.

About 88 percent (85 of 97) of families randomly assigned to the EHS program group actually enrolled in EHS services. That is, approximately 12 percent of families in the program group never received any EHS services. While the level of service receipt was fairly high, this has implications for the study, since all families randomly assigned to the program group, regardless of whether they were ever enrolled, will be included in the final impact analysis. The field research suggests that some of these families opted out of receiving program services when they learned that they had been accepted into the program (that is, after random assignment), because they were not fully aware of the time commitment required for the 90-minute home visits. In other cases, families moved out of the EHS service area and, consequently, were no longer eligible for services. Despite the drop-off in EHS service receipt, differences in exposure to high-quality, intense, child-focused services between program and control groups will likely be evident, given that the control group did not receive any EHS services.

Enhancements to Employment and Self-Sufficiency Services

The programs implemented a number of enhancements to existing employment and self-sufficiency services. However, circumstances such as turnover in frontline and management staff have slowed the implementation of these programmatic enhancements, suggesting that there are still opportunities to further enhance existing services.

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Table 3.2

Participation and Service Receipt

Early Head Start

Characteristic (%)	
Enrolled in EHS program	87.6
Among those enrolled:	
Completed educational and self-sufficiency assessment tool	64.7
Completed any self-sufficiency goal	69.4
Received any referrals to a self-sufficiency activity	24.7
Has any entry related to self-sufficiency in the family's service event notes	71.8
Sample size	97

SOURCE: MDRC calculations from review of selected EHS case files from Youth-In-Need and SEK-CAP.

NOTES: The sample for MDRC calculations is limited to the families who were randomly assigned at the time the early assessments were conducted.

The sample for Youth-In-Need is limited to families randomly assigned between July 21, 2004, and April 30, 2005; the sample for SEK-CAP is limited to families randomly assigned between July 21, 2004, and March 31, 2005.

On-site self-sufficiency specialist

Both programs have hired employment staff to act as on-site self-sufficiency specialists to oversee and develop the programs' employment and self-sufficiency services, as well as to fill critical gaps in knowledge about existing employment and training resources in the community. The self-sufficiency specialists act as "resource experts" to help staff identify available employment and training-related resources and work with families on issues of employment and self-sufficiency. This has allowed the programs to become knowledgeable about resources without overwhelming the frontline staff who directly work with families. For example, home visitors can now seek out the self-sufficiency specialist when they need information to help address a specific issue or when they need to access less commonly used resources or agencies.

The employment staff are also in charge of establishing partnerships and referral mechanisms with the local agencies that provide EHS families with employment and educational services, such as job search assistance and General Educational Development (GED)

classes. This allows one staff person to establish community partnerships, increasing the likelihood of accountability and follow-up.

Increased programmatic focus on employment and self-sufficiency

The programs have placed an increased focus on helping parents to set and achieve employment and educational goals and regularly monitoring their progress. To give staff the skills and resources they needed to work with parents, the programs created resource guides and assessment tools and conducted staff training sessions on employment and self-sufficiency. The programs have also provided parent training sessions focused on employment and self-sufficiency. Notably, this heightened focus does not appear to have compromised the quality of child development and other family support services that families received.

- **Identifying parents' employment and educational goals and creating assessment tools.** To facilitate discussions of parents' employment and training-related goals, the programs created assessment tools and brief forms, so that staff could gather information about parents' employment and educational backgrounds. They also established benchmarks for completing the assessment tools and identifying parental goals; front-line staff are responsible for ensuring that all families complete an educational and employment assessment tool and set at least one employment or educational goal. These are important developments, as before these EHS programs became involved in the Hard-to-Employ evaluation, they historically had no procedures for assessing parents' employment and educational backgrounds, nor did they have a platform for discussing and monitoring parents' progress.

- **Staff training.** The programs have instituted staff training to further enhance the skills and competencies of frontline staff so that they are better able to work with families on their employment and self-sufficiency goals and needs.

- **Parent training.** Both programs have plans to conduct or have conducted in-house training sessions for families, focused on employment and self-sufficiency.

Accessing external employment and educational resources

To better serve the needs of families, the programs have begun to identify external agencies that fill the gaps in existing EHS employment and self-sufficiency services.

- **Employment and self-sufficiency resource guides.** The programs created user-friendly employment and self-sufficiency resource guides, so that staff could easily refer parents to external agencies in the community when necessary, and trained frontline staff in their use. In addition, employment staff have continued to update the resource guides with newsletters and additional information on available employment and training resources.

- **Partnerships with external employment and educational resources.** Employment staff at both programs have begun building critical partnerships with local agencies that provide employment and training services. They have met with service providers at one-stop career centers, welfare agencies, and vocational rehabilitation services. One program has successfully forged a relationship with a one-stop career center, which has agreed to dedicate a staff person to provide job search assistance to all EHS families.

Challenges in Enhancing Employment and Self-Sufficiency Services

The assessments indicate that the programs have made important strides in enhancing their existing employment and self-sufficiency services. Yet they also highlight some unexpected obstacles to the programs' implementation of these enhancements. Nevertheless, the findings identify opportunities to enhance services aimed at addressing parents' employment and educational needs, even within the scope of a child-focused intervention.

Integrating the activities of employment staff into the EHS model

It is clear that employment staff play valuable roles in developing EHS employment and self-sufficiency services. Yet the assessments also indicate that employment staff were not being used to their full potential. Several frontline staff reported that they had minimal interactions with employment staff. The field research also shows that, rather than working through the frontline staff who were assigned to particular families, employment staff often contacted families directly. This system did not function well, as many frontline staff members said that they were not informed about the employment staff's interactions with families. Moreover, this practice did not leverage the strengths of the EHS service delivery model. A more effective EHS employment and self-sufficiency service delivery model would build upon the trusting relationships between families and the staff who have the most direct contact with them.

Developing employment and training goals and using assessment tools

Even though assessment tools and targeted benchmarks were developed for employment and self-sufficiency goals, a review of EHS families' case files indicated that fewer families than expected (65 percent, 55 of 85 families enrolled in EHS, as shown in Table 3.2), actually completed the assessment tools with frontline staff. A similar proportion of families, roughly 69 percent of families enrolled in EHS, shown in Table 3.2, identified at least one self-sufficiency goal, suggesting that the programs have not met their targeted benchmarks in this area as expected.

A review of families' goals further suggests that many of them were broad, raising concerns about whether they were achievable. For example, one of the typical goals listed by families was to "get a job." The field research indicates that frontline staff spent less time than expected addressing employment and self-sufficiency. They viewed the increased programmatic focus on employment and self-sufficiency as an "add-on" specifically related to the evaluation, rather than a core component of EHS services. This difficulty was compounded because the staff felt uncomfortable about discussing employment and self-sufficiency issues with families. As shown in Table 3.2, only 72 percent of enrolled families had at least one entry in their case notes related to employment or self-sufficiency. Furthermore, discussions with frontline staff indicate that some brought up parental employment and self-sufficiency goals at every home visit, whereas others discussed them less frequently. It may be difficult to detect significant program impacts on employment-related outcomes because of the variation in the dosage of EHS employment and self-sufficiency services across families.

Delays in implementing staff and parent training

Because of programmatic challenges, such as staff turnover, the programs have delayed conducting many of the planned staff and parent training sessions focused on employment and self-sufficiency. These delays likely contribute to gaps in staff's knowledge about available community resources and their reluctance to broach the topic of employment and self-sufficiency with families.

Accessing external resources and developing community partnerships

While programs have identified new employment and training resources available in the community, the assessments indicate that, as shown in Table 3.2, few families were referred to such resources; only 25 percent of families enrolled in EHS were referred to one self-sufficiency activity at the time of the assessments. This is an area of concern, because connecting families to community-based resources is a fundamental goal of the EHS programs.

The field research indicates clear differences between urban and rural areas in frontline staff's knowledge of employment and training resources. In rural areas, where available resources are scarce, identifying resources and developing partnerships with other agencies has been particularly difficult.

Summary of findings from early assessments

The EHS programs made important strides in enhancing their existing employment and self-sufficiency services. The assessments indicate, however, that overcoming obstacles to programmatic change can be challenging. It is apparent that shifting the focus of EHS services to include a more explicit proactive focus on parents' employment, education, and self-sufficiency can be difficult, especially for programs that have traditionally defined themselves as early childhood interventions. Yet, despite these constraints, there is encouraging evidence of opportunities for programmatic change.

Recent Program Enhancements

Since the early assessments, the programs have made important strides in addressing many of the issues the assessments raised.

- **Verifying families' interest before random assignment to maintain high levels of participation in EHS services**. Before conducting random assignment, the programs have placed an increased emphasis on verifying a family's interest in receiving EHS services. They now systematically call families from the waiting list to confirm their interest in EHS services before random assignment. This may help to decrease the drop-off in EHS participation by ensuring that families will actually enroll in services if they are randomly assigned to the program group. The programs have also sought to maintain contact with families who have dropped out of the program in order to encourage them to reenroll in EHS services.

- **Targeting families who are most likely to benefit from employment and self-sufficiency services.** The programs have begun to place a priority on targeting the families who are most likely to benefit from employment and self-sufficiency services. For example, efforts have been made to target (in descending order) parents who are unemployed and/or receiving cash assistance, are not currently working full time or are underemployed, and are employed but in unstable jobs or with irregular work schedules.

- **Seamless incorporation of self-sufficiency enhancements into existing EHS services.** The programs have taken important steps to integrate the activities of employment staff into the EHS model. EHS employment and frontline staff have forged collaborative relationships to address families' self-sufficiency goals. This ensures an ongoing exchange of information regarding the employment and educational resources that families receive and the steps they have taken toward their goals. In addition, to reinforce progress toward seeing these services as integral to EHS, the programs have instituted management review and monitoring systems that hold all staff accountable for helping families set and achieve their goals. In the past, there was no accountability and monitoring system to ensure that frontline staff were delivering employment and self-sufficiency services to families as intended.

- **Accelerated plans for staff and parent training sessions.** The programs have accelerated plans for staff and parent training on employment and self-sufficiency. Several staff training sessions focused on assessing families' needs, completing assessment tools, and helping families to set achievable self-sufficiency goals. One program has provided key training for parents that includes on-site GED preparation twice a week and Money Smarts, a series of classes on budgeting. The programs also continue to identify opportunities for staff and parent training in the community.

Conclusions

The Hard-to-Employ evaluation is studying a two-generational program that addresses both the needs of low-income parents who are hard to employ and the developmental needs of young children. This evaluation constitutes an important test of a potentially powerful approach for generating benefits for parents' employment and economic self-sufficiency, as well as children's development and school readiness, and highlights the need for more evaluation research in this area.

The results of the early assessment are encouraging: They show that a child-centered program does have the capacity to significantly enhance the focus of its existing services to address families' employment, educational, and self-sufficiency needs, while retaining a strong focus on children's developmental needs. The programs successfully hired on-site self-sufficiency specialists who developed expertise about available employment and training-related resources in the community and helped staff work with parents on employment and self-

sufficiency. The programs created innovative assessment tools, conducted staff and parent training sessions, and compiled resource guides.

The early assessment findings also provide positive evidence that community organizations do have the potential to sustain a large-scale experimental evaluation; the programs have been able to support random assignment, enhance their recruitment efforts by tapping new referral sources, and continue to reach at least as many, if not more, high-needs families. They have also maintained relatively high levels of service receipt among EHS families, suggesting that there will likely be sufficient differences in exposure to high-quality, child-focused services between the program and the control groups.

The field research also uncovered some significant obstacles to implementing employment and self-sufficiency programmatic enhancements, especially during the start-up phase. The experiences of these EHS programs offer important lessons for other child-focused programs that seek to implement similar enhancements. It is critically important to involve frontline staff and gain their commitment to delivering the enhancements. It can be challenging to ensure that frontline staff view employment and self-sufficiency as a core component of EHS services, to expand their knowledge of employment and educational resources in the community, and to increase their comfort in discussing employment and self-sufficiency with families — especially in a program that has traditionally defined itself as an early childhood intervention. The obstacles the programs faced as they started up may lead to smaller program impacts for the cohorts of families that were randomly assigned during the early phases of the study. Even so, the results from the early assessments illuminate opportunities to enhance services aimed at addressing parents' employment and educational needs within the scope of child-focused interventions.

Chapter 4

Philadelphia: Two Service Models for Welfare Recipients

Introduction

The Philadelphia site in the Hard-to-Employ demonstration is testing two service models designed to increase the employment and earnings of hard-to-employ welfare recipients. This chapter provides information on the policy relevance of the study, descriptions of the programs and the research design, data on the participants' characteristics at enrollment, and early implementation findings based on program participation data and qualitative field research. The early implementation analysis indicates that intake for the study functioned as planned and that participants were correctly referred to the programs being studied. However, somewhat low enrollment and participation rates presented ongoing challenges to the study design.

Background and Policy Relevance

As welfare caseloads nationwide have declined, policymakers, program administrators, and researchers have increasingly focused attention on long-term and hard-to-employ recipients who have not made a stable transition from welfare to work. While many recipients of Temporary Assistance for Needy Families (TANF) receive welfare grants for a short period in a crisis situation or at a time of brief unemployment, a substantial proportion of the caseload is composed of hard-to-employ recipients, who often remain on TANF for longer periods. Many of these recipients face significant barriers to employment, such as physical health problems, mental health conditions, substance abuse, and limited employment and educational backgrounds.[1]

Until the 1990s, recipients with serious barriers to work were often exempt from requirements to participate in employment-related activities. During that decade, partly as a result of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, many states began to extend work requirements to a broader share of the TANF population.[2] TANF reauthorization, passed in January 2006, further strengthened the participation mandate, making it crucial that welfare agencies focus on working with hard-to-employ recipients.[3] Welfare time

[1]For example, one study synthesized results from a survey that was administered to welfare recipients in six states in 2002. It found that 40 percent of recipients lacked a high school diploma or GED, 21 percent had a physical health limitation, 30 percent met the diagnostic criteria for major depression or were experiencing severe psychological stress, and 29 percent had a child with health problems (Hauan and Douglas, 2004).

[2]Bloom and Butler (2007).

[3]TANF reauthorization strengthened the participation mandate in several ways. It adjusted the caseload reduction credit — by which states can reduce their minimum required participation rate if they reduce their caseload — so that the baseline year against which the current caseload is compared is 2005, rather than 1995.

(continued)

limits and economic fluctuations — including the economic downturn from 2001 to 2003 — also increased the need to offer these recipients effective services to assist them in the transition from welfare to work.[4]

Over the past 30 years, many studies have provided insight into which programs are most effective in assisting recipients to move from welfare to work; however, fewer have targeted more disadvantaged recipients receiving welfare. An analysis of the results from 20 welfare-to-work programs targeted at the general welfare population concluded that the programs generally increased earnings about as much for the more disadvantaged groups (defined in this case as long-term welfare recipients with no high school diploma and no recent work history) as for the less disadvantaged groups. However, the more disadvantaged groups earned considerably less than the others. This outcome suggests that it may be necessary to target resources and develop specific programs to meet the needs of the most disadvantaged TANF recipients.[5]

The National Supported Work Demonstration, implemented in the 1970s, remains one of the most comprehensive evaluations to date of programs for recipients who are harder to employ. The program offered subsidized employment to long-term welfare recipients and showed particularly large impacts for the most disadvantaged participants within the sample (very long-term recipients and those without a high school diploma).[6]

As the welfare system evolved to strengthen the participation mandate and provide only temporary cash assistance, the subsidized employment model evolved as well. Facing time-limited welfare and an emphasis on meeting participation rates through employment-related services, administrators shortened the period of subsidized employment and increased the focus on the transition to permanent work. The modified model became known as the transitional employment model. Policymakers and practitioners have recently turned to this restructured model as a promising approach to assist hard-to-employ TANF recipients to leave the welfare rolls.

The bill also required states to count toward the participation rate families receiving TANF through separate state programs — programs that receive no federal TANF funding but do receive state funding that counts toward the state's Maintenance of Effort requirement. In addition, the bill called on the U.S. Department of Health and Human Services to disseminate more explicit regulations on countable activities and required states to implement stricter internal controls to verify reporting procedures.

[4]According to the National Bureau of Economic Research, the economy went into recession beginning in March 2001. Employment declines lasted through August 2003.

[5]Michalopoulos and Schwartz (2000).

[6]The Board of Directors, MDRC (1980). The National Supported Work Demonstration showed different results for different subgroups: For example, it showed significant results for welfare recipients but not for ex-offenders.

However, further experimental research has not yet been conducted to assess the effectiveness of this model and to understand for which subgroups it is most effective.[7]

The transitional work model places participants almost immediately into subsidized work, on the assumption that barriers to employment will surface and be resolved through the working process. Another model often used with hard-to-employ TANF recipients is an intensive case management model, focusing on assessing and treating their barriers to employment "up front," or before they go to work. However, this model has also not yet been rigorously tested.[8]

The Philadelphia Hard-to-Employ site tests both the transitional employment model and the model to treat barriers to employment up front for TANF recipients who have been identified as hard to employ — those who received TANF for at least a year and/or do not have a high school diploma.[9] The evaluation compares each program group with a control group that is not required to participate in any program. It seeks to understand whether the programs improve recipients' employment, income, earnings, and welfare receipt outcomes, as compared with recipients in the control group. The study will also examine which program model works best for particular subgroups of recipients.

Program Description

Faced with the challenge of how to serve hard-to-employ recipients on the TANF rolls, administrators are seeking to understand the effectiveness of different service models. The models that this study tests grew out of programs that Philadelphia was already implementing and that administrators felt showed promise in assisting more disadvantaged recipients to make the transition from welfare to permanent work.

Both programs in the evaluation are supported primarily by TANF funds, made available from the Pennsylvania Department of Public Welfare (DPW) through the Philadelphia Workforce Development Corporation, the Workforce Investment Act's fiscal agent. These and

[7]However, the nonexperimental research into transitional work is promising. For example, a study of six transitional work programs found that rates of placement in permanent, unsubsidized employment for participants who completed the programs ranged from 81 to 94 percent (Kirby et al., 2002). See also Pavetti and Strong (2001).

[8]MDRC's Employment Retention and Advancement Project has one site — Minneapolis — that tests an intensive case management strategy to treat barriers to employment before recipients go to work, although participants in this program may also be placed into transitional employment. Early results of this test are published in LeBlanc, Miller, Martinson, and Azurdia (2007).

[9]The transitional employment model being studied in Philadelphia is similar to the model being tested in the New York site for this project; however, the New York program is targeted at ex-offenders, rather than TANF recipients.

other welfare employment and training funds are channeled through a memorandum of understanding between DPW and the Pennsylvania Department of Labor and Industry, which in turn is included in the Workforce Investment Act master agreements.

Transitional Work Corporation Program[10]

The Transitional Work Corporation (TWC) is administering the transitional employment program. TWC was formed in 1998 in a joint effort among the Commonwealth of Pennsylvania, the City of Philadelphia, the Pew Charitable Trusts, and Public/Private Ventures. It was founded to provide transitional employment to TANF recipients in Philadelphia who had received benefits for at least 24 months and were required to participate in work-related activities. It has since expanded its services to other groups and serves over 1,500 people a year. It is now one of the nation's largest and most prominent providers of transitional employment to welfare recipients.[11]

The TWC model begins with a two-week orientation, consisting of intensive job-readiness activities. After the orientation, participants are placed in a transitional job, usually with a government or nonprofit agency, for which TWC pays the minimum wage ($5.15 per hour from the start of the study through December 2006, then $6.25 from January 2007 through June 2007) for up to six months. TWC identifies on-site work partners to provide additional guidance and act as on-the-job mentors during the transitional work period. Recipients are required to work 25 hours per week and to participate in 10 hours of professional development activities at TWC. These activities may include job search and job-readiness instruction, as well as preparation for a certificate of General Educational Development (GED) and other classes. During the transitional work period, TWC staff work with participants to find permanent, unsubsidized jobs. If recipients do not find a permanent job during the six-month transitional work period, staff continue to assist them to obtain unsubsidized employment. TWC also provides job retention services to participants for six to nine months after their placement in a permanent job. In addition, the program offers bonuses of up to $800 for recipients who retain their full-time jobs during the six months following their permanent employment start date. The services offered to participants in the Hard-to-Employ demonstration are the same as those offered to TANF recipients at TWC who are not part of the study.

[10]This section describes the Transitional Work Corporation program as it operated during most of the study period; there may have been changes since then.

[11]A 2004 report examining the TWC program showed increased employment and earnings outcomes and decreased TANF receipt outcomes for TWC participants. However, the study did not use a random assignment design to compare the outcomes with those of similar individuals who did not receive TWC services (VanNoy and Perez-Johnson, 2004).

Program staff at TWC are organized into small teams of four. Each team includes three career advisers, each of whom works with participants during one of the three phases of their trajectory at TWC (orientation, transitional work, and unsubsidized work), and a "sales person" in charge of helping participants find unsubsidized work. Participants work with the four staff members on their assigned team throughout their time at TWC. On the day they arrive, they are assigned to an orientation advisor for the two-week orientation period. After completing orientation, participants transfer to the transitional career advisor, who coordinates placement in a transitional job, as well as professional development activities. When participants are placed in transitional work, they also begin to work with the sales person, who helps place them in unsubsidized employment. Once participants are in an unsubsidized job, they transfer to the retention advisor, who helps coordinate services such as transportation, child care, and bonus payments. In addition to these staff, each participant works with facilitators who lead the orientation classes and the professional development activities.

Success Through Employment Preparation Program

The program focusing on preemployment strategies to remove barriers to work, the Success Through Employment Preparation (STEP) program, is run by Jewish Employment and Vocational Service (JEVS). JEVS is a nonprofit social service agency, founded in 1941, that provides a broad range of education, training, health, and rehabilitation programs in the Philadelphia area. The STEP program was derived from Philadelphia's Maximizing Participation Project (MPP), a voluntary program for TANF recipients who are exempt from participating in work-related programs because they have a physical or mental disability or because they face multiple barriers to employment.[12] It provides intensive case management and support to assess and treat drug and alcohol, behavioral health, and vocational barriers. JEVS is one of the county's providers for the MPP program. JEVS designed the STEP program based on MPP, but targeted it for recipients who are not exempt from the participation requirement. STEP was developed specifically for this study and serves only study participants. It provides intensive services to help participants eliminate employment barriers and then helps them to find jobs.

In the STEP program, outreach staff first conduct home visits and address any barriers that might keep participants assigned to this group from coming into the office. Once the recipients are enrolled, the program begins with an extensive assessment period to identify participants' barriers to employment. Specialized staff analyze the results of the assessments and then meet with the participant and her or his primary case manager to design a plan to address these barriers. Treatment can include various life-skills classes (including, for example, GED prepara-

[12]The Maximizing Participation Project becomes mandatory for these recipients if they are receiving TANF after they have reached the 60-month time limit.

tion, English as a Second Language classes, support groups, and professional development sessions) and counseling with behavioral health specialists, as well as ongoing case management meetings. If participants' barriers are considered severe, staff may refer them to outside organizations for further assessment and treatment. After completing the life-skills courses, participants work with job coaches and job developers to find permanent employment. The timing of the employment search process depends on participants' individual motivation levels and barriers to employment, but usually does not begin before they have completed the assessments and the team has designed treatment plans. To avoid overlap with the TWC model, participants in the STEP group cannot participate in subsidized employment.

STEP's program staff are organized into small teams in charge of case management, as well as groups of clinical support specialists and employment services staff. The case management team consists of a case coordinator, who serves as the participant's primary case manager, and her or his assistants. Participants begin meeting with their case coordinator from the first day they come in to STEP and stay with the same case coordinator throughout their time in the program. The case coordinators provide general case management and coordinate recipients' interactions with the clinical support specialists and employment services staff. The clinical support specialists include behavioral health specialists, assessment counselors, and instructors. The employment services staff include job developers, who are in charge of helping participants find employment, and job coaches, who work with participants to help them retain jobs.

Research Design

This evaluation uses a random assignment design to determine whether the TWC and STEP program models are effective in assisting recipients to make the transition from welfare to work. The study is not a direct comparison of the two models; program participants' outcomes will be compared with outcomes for participants in a control group who are not required to participate in any work-related activities. In addition, the study seeks to understand whether the models are generally more effective in assisting certain subgroups of recipients and which model best serves particular subgroups.

The target population for the study is TANF recipients who have received cash assistance for at least 12 months in their lifetime or who do not have a high school diploma. The study does not include "U" cases[13] (two-parent cases, with some exceptions), recipients who are exempt from participation or have good cause not to participate, and recipients who are currently employed.

[13]A family meets the criteria for "U," or the unemployed parent category, if: it is a two-parent household with at least one common child; at least one parent is able to work; and both parents are unemployed, or at least one parent has work in which the net earned income of the TANF budget group (after allowable deductions) is

(continued)

Recipients who met the study criteria were randomly assigned at the Philadelphia County Assistance Offices, or public benefits offices, into one of the two program groups or into the Voluntary Services group, which serves as the control group. The group to which they were assigned was selected entirely at random — it was not based on any background characteristics or assessments. Approximately 37.5 percent of the sample members were assigned to the TWC group; 37.5 percent to the STEP group; and 25.0 percent to the control group. Recipients placed in one of the program groups were referred from the public benefits offices to the appropriate program — TWC or STEP — and received the services described above. Voluntary Services recipients were given a list of community resources but were not required to participate in employment activities. They could choose to participate in any work or education-related activities, with the exception of TWC and STEP, but were not penalized for failing to meet the work requirement. Participants retain their group assignments for approximately three years; during that time, individuals in one group are not allowed to receive the services offered to the other groups.[14]

Because random assignment occurred in the welfare offices rather than at the point of entry into the programs, the study includes many people who did not receive the services they were referred to because they never showed up to the programs or quickly dropped out without ever participating substantially. The samples for both program groups include some of these cases, discussed in more detail later in the chapter. This may make the differences between the outcomes for the program groups and those for the control group smaller, because the program groups will include individuals who did not receive any services, similar to many control group members. However, this design provides a structure that also offers insight into the welfare system in which these programs operate.

MDRC will continue to track the members of all three groups for at least three years after random assignment. Several data sources will inform the evaluation:

- Implementation research, including site visits and interviews with staff, will be used to understand how the services were implemented.
- DPW's and the programs' databases will be used to examine the participation of program group recipients in TWC and STEP and the participation of

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less than the family size allowance for the budget group, or at least one parent has "on the job training" in a project approved or recommended by the Job Service of the Road to Economic Self-Sufficiency through Employment and Training (Pennsylvania's TANF program).

[14]If TWC or STEP decides to permanently terminate a recipient, she or he is still mandated to participate, and it is possible that she or he would participate in a program that Voluntary Services recipients can participate in.

control group recipients in activities recorded by public benefits offices staff (such as GED or job search programs).

- Administrative records data will be used to measure participants' receipt of welfare and food stamps, as well as their earnings and employment in jobs covered by unemployment insurance. MDRC has obtained wage data from the National Directory of New Hires. This is a national database maintained by the Office of Child Support Enforcement that can provide information on earnings from employment both within and outside Pennsylvania.

- Surveys will track over time participants' employment outcomes (including informal work outcomes that do not show up in the administrative data), health insurance outcomes, receipt of services (such as employment services, mental health services, or substance abuse counseling not provided through DPW), and other outcomes.

Because of the random assignment design, any significant differences that emerge between each of the program groups and the control group (the Voluntary Services group) will be attributable to the services provided by the programs. In other words, the Voluntary Services Group will provide a counterfactual against which the programs can be compared.

Random Assignment and the Sample Intake Process

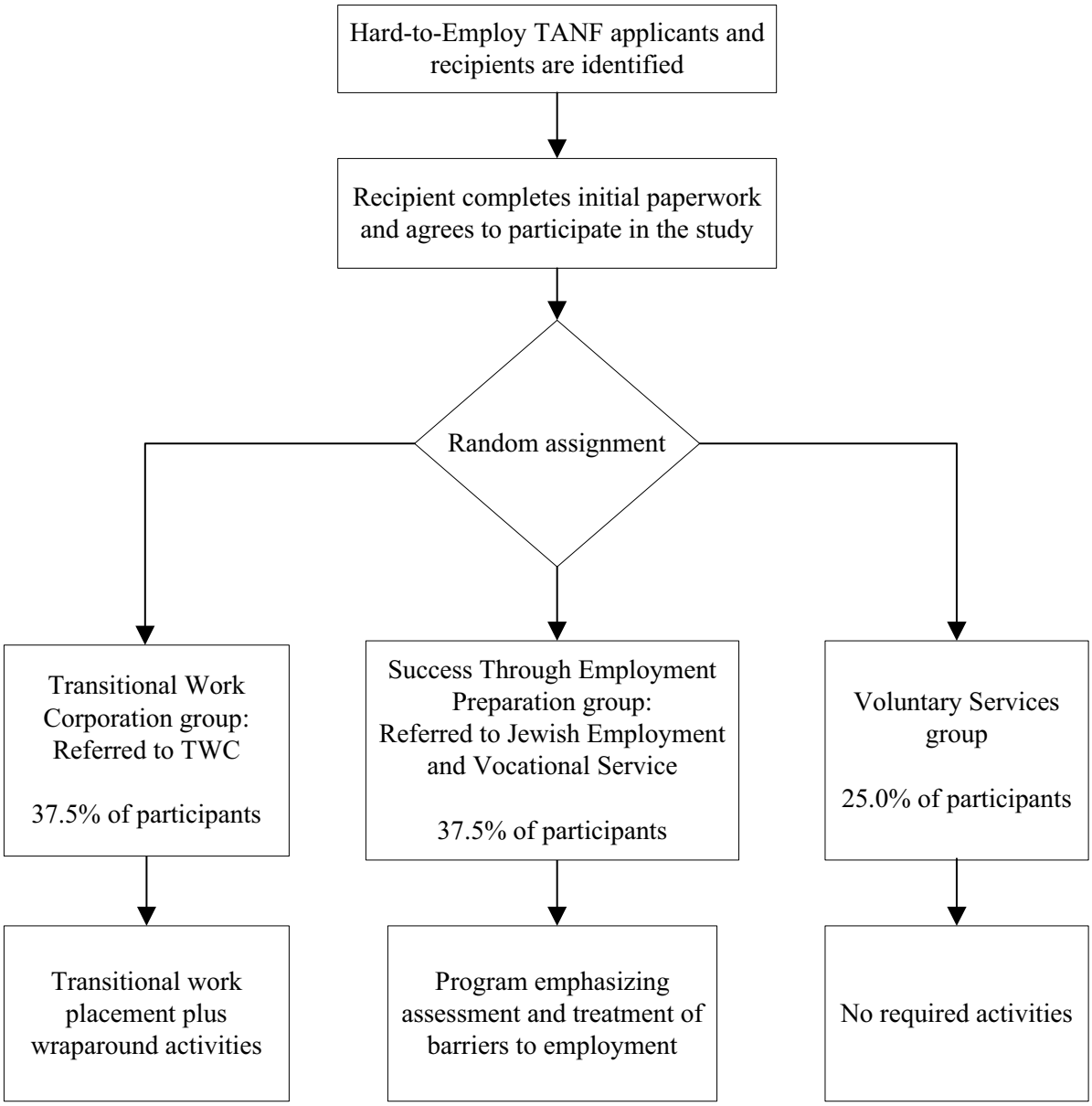
Figure 4.1 provides an illustration of the sample intake process. Intake workers screened TANF applicants to ensure that they met the study criteria and sent them to a research aide stationed in the County Assistance Office.[15] Career Development Unit workers, who are responsible for assigning recipients to employment and training activities, screened ongoing TANF recipients who were not participating in another activity. They then sent the recipients to a research aide for random assignment. Most recipients sent to the research aides entered the study, but recipients who showed that they already had specific education or employment-related plans were able to opt out of participating. Those who entered the study signed a data release form. The aide also collected their baseline information, including age, gender, race, education and employment history, family and living circumstances, and number of months of TANF receipt. Participants received a $10 gift card to compensate for the time they spent providing this information. The aide then randomly assigned recipients via a Web-based system or the telephone to one of the two program groups or to the control group.

[15]The research aides were MDRC employees. Three of the four research aides initially hired were former Pennsylvania TANF recipients.

The Enhanced Services for the Hard-to-Employ Demonstration

Figure 4.1

Two Service Models for Welfare Recipients: Random Assignment Flow Chart



Fewer recipients than expected were referred to MDRC's research aides in the first few months of sample enrollment, resulting in intake rates that were lower than predicted. To increase the flow of recipients into the study, MDRC and DPW decided early on to expand the eligibility criteria. Initially, the study included only incoming TANF applicants (both new applicants and re-applicants). However, in November 2004, DPW and MDRC agreed to include ongoing TANF recipients who were not participating in any employment-related activities. This expansion may result in reaching a somewhat harder-to-employ population, as these recipients were already not in compliance with the work requirements. In addition to expanding the eligibility criteria, MDRC and DPW also worked with the County Assistance Offices to identify procedures to ensure that all potential participants were referred to the study.[16]

MDRC completed random assignment at the end of May 2006 with 1,944 participants, which neared the goal of 2,000 participants. With a sample of this size, the study has the potential to show impacts that have important policy relevance. For example, if the programs improve outcomes by even a small amount, the resulting changes over a larger population would be substantial.

Early Findings from the Assessment

This report examines baseline data on participants' demographic characteristics, as well as participation data and qualitative field research data that allowed MDRC to provide an early implementation analysis of the programs. MDRC collected the following data:

- **Participant demographic data:** MDRC's research aides collected baseline demographic data for each participant at the time of random assignment. In this report, baseline and sample build-up data included all 1,944 sample members who entered the study from October 12, 2004 (when study enrollment began), through May 31, 2006 (when study enrollment ended).
- **Participant referral, enrollment, and participation data:** Program referrals were entered into Pennsylvania's Client Information System and transferred to the Automated Interface Management System (AIMS) database.

[16]Sample intake was also lower than expected because random assignment ended early in one office. Random assignment initially took place in three of the Philadelphia County Assistance Offices. The study design called for random assignment to continue in all three offices until the sample goal was met. However, one office ended random assignment in June 2005 to take part in a countywide initiative to provide case management services at nonprofit providers, rather than at the public benefits offices. This left only two offices. One of these offices closed down seven months later, in January 2006, although an additional office was identified to begin random assignment at that time. Intake at this added office proceeded rapidly and helped to make up for the slower flow of intake earlier in the random assignment process.

This is the process by which recipients are referred to welfare-to-work contractors, and is used to track program activity information, including actual hours of participation, program rejections, and terminations. For this report, MDRC used information on program activities from the AIMS database for all three research groups.[17] Program participation data were analyzed for 248 recipients who were randomly assigned between the start of random assignment and December 31, 2004. The analysis includes four and a half to six and a half months of follow-up with these recipients. Some data were also collected from STEP and TWC at a later date to conduct preliminary participation analyses for a larger proportion of the sample.

- **Qualitative program implementation data:** MDRC staff visited the two program sites in May 2005 and interviewed case management staff to understand the structure of the programs and the activities in which recipients were participating. In addition, MDRC staff interviewed employees at the County Assistance Offices in order to clarify the intake process and the participation-monitoring procedures.

Characteristics of the Sample

Table 4.1 shows the baseline characteristics of the sample by research group. The characteristics across the three groups are very similar, which is expected because of the random assignment design. In addition, the participants' characteristics indicate that the study is reaching a hard-to-employ population, as intended.

The average age of the participants is about 29. The large majority of the participants are female (not shown on the table). Just over 80 percent are black and about 14 percent are Hispanic.

Many of the participants have considerable barriers to employment, including low education levels, limited employment history, and responsibilities caring for children under 6. Compared with TANF recipients in other studies, the sample in this study have greater barriers to employment. Over half (56 percent) do not have a high school diploma or a GED.

[17]Although program participation data were available from the programs' MIS systems, these data were not included in the main participation analysis for this assessment in order to maximize comparability of measures across all three research groups. The data primarily used in this report reflects the information that DPW receives from the programs about recipient participation; it may not be exactly comparable with each program's internal tracking system. In addition, the 15-month survey, which began in early 2006, asked the recipients directly about their participation and may capture information about program participation that is not captured in the data presented in this report.

The Enhanced Services for the Hard-to-Employ Demonstration

Table 4.1

Selected Baseline Characteristics, by Research Group

Two Service Models for Welfare Recipients

Characteristic	TWC Group[a]	STEP Group[b]	VS Group[c]	Total	
Age (%)					
18 to 24 years	34.0	35.2	33.3	34.3	
25 to 30 years	27.5	27.6	29.0	27.9	
31 to 40 years	26.5	26.2	27.3	26.6	
41 years or older	12.0	11.0	10.5	11.3	
Average age (years)	29.5	29.3	29.2	29.3	
Race/ethnicity (%)					
Black, non-Hispanic	78.8	84.2	81.5	81.5	
Hispanic[d]	17.1	11.8	13.5	14.2	
White, non-Hispanic	2.6	2.9	3.3	2.9	
American Indian or Alaskan Native	0.1	0.1	0.0	0.1	
Asian or Pacific Islander	0.3	0.0	0.2	0.2	
Other	1.1	1.0	1.5	1.1	
Education (%)					
High school diploma	29.0	32.1	27.1	29.7	
GED certificate	8.3	6.7	6.6	7.3	
Technical/associate's/2-year college	6.4	7.3	5.5	6.5	
4 years or more of college	1.1	0.6	0.4	0.7	
None of the above	55.2	53.3	60.4	55.8	
Highest grade completed (%)					
8th grade or lower	4.6	3.5	4.6	4.2	
9th grade	10.3	9.2	10.2	9.9	
10th grade	18.2	19.3	20.8	19.2	
11th grade	29.4	28.9	31.5	29.7	
12th grade	32.0	33.8	27.5	31.6	
Beyond 12th grade	5.5	5.3	5.4	5.4	
High school diploma or GED certificate (%)					*
Yes	44.8	46.7	39.6	44.2	
No	55.2	53.3	60.4	55.8	
Marital status (%)					
Unmarried, not living with a partner	91.3	89.5	90.2	90.3	
Married, living with spouse	1.7	1.5	2.9	1.9	
Married, separated	5.8	6.0	4.4	5.5	
Unmarried, living with a partner	1.2	3.0	2.5	2.2	

(continued)

Table 4.1 (continued)

Characteristic	TWC Group[a]	STEP Group[b]	VS Group[c]	Total	
Number of children under age 18 (%)					
None	4.0	2.6	3.3	3.3	
1 child	32.9	31.3	28.5	31.2	
2 children	28.6	30.6	31.8	30.1	
3 children	18.4	18.2	20.7	18.9	
4 children or more	16.1	17.2	15.6	16.4	
Average number of children	2.2	2.3	2.3	2.2	
Children under age 6 (%)					
Yes	63.7	65.2	66.1	64.9	
No	36.3	34.8	33.9	35.1	
Limited English (%)					
Yes	5.3	4.4	5.0	4.9	
No	94.7	95.6	95.0	95.1	
Public housing (%)					
Yes	28.5	33.5	32.0	31.3	
No	71.5	66.5	68.0	68.7	
Housing status (%)					
Rents house or apartment	60.0	62.6	63.4	61.8	
Owns house or apartment	6.1	6.1	5.6	6.0	
Lives with friends or relatives	30.1	27.6	27.2	28.4	
Has transitional/emergency/temporary housing	2.6	2.6	3.5	2.8	
Is homeless, living on the street	0.1	0.0	0.0	0.1	
Other	1.1	1.1	0.2	0.9	
TANF receipt (%)					
Never received TANF	6.7	5.5	5.3	5.9	
Less than 1 year	9.0	10.3	7.8	9.2	
1-2 years	16.3	14.5	15.6	15.4	
2-5 years	43.0	44.3	44.1	43.8	
5 years or more	25.0	25.4	27.1	25.7	
Average months of TANF receipt	39.9	40.4	40.7	40.3	
Always lived in United States (%)					***
Yes	90.6	94.7	94.7	93.2	
No	9.4	5.3	5.3	6.8	
If not always, average years lived in United States	9.5	8.7	10.6	9.5	
Ever employed (%)					
Yes	91.7	92.6	90.3	91.7	
No	7.7	6.6	8.4	7.5	

(continued)

Table 4.1 (continued)

Characteristic	TWC Group[a]	STEP Group[b]	VS Group[c]	Total
Time since last employment (%)				
6 months or less	37.6	38.8	41.5	39.0
7-12 months	14.8	13.5	13.8	14.0
13-24 months	16.3	18.8	14.4	16.7
More than 24 months	21.3	20.1	18.7	20.2
Missing	10.1	8.8	11.7	10.0
Average months since last employment	18.1	18.3	16.0	17.6
Ever worked 6 or more months for one employer (%)				
Yes	69.9	70.1	66.5	69.1
No	28.8	28.3	31.4	29.3
Months employed in past 3 years				
None (Did not work)	19.7	19.3	20.1	19.7
Less than 6 months	24.2	19.3	22.0	21.8
7-12 months	24.6	24.1	21.1	23.6
13-24 months	15.7	20.1	20.7	18.6
More than 24 months	14.5	16.0	13.8	14.9
Month of random assignment				
October 2004	1.4	1.1	1.6	1.3
November 2004	4.8	4.0	4.5	4.4
December 2004	6.8	7.2	7.0	7.0
January 2005	7.0	7.3	7.2	7.2
February 2005	9.3	8.6	8.6	8.8
March 2005	7.9	9.1	8.8	8.6
April 2005	4.4	4.0	4.1	4.2
May 2005	5.3	5.9	5.5	5.6
June 2005	4.9	4.8	4.7	4.8
July 2005	1.6	1.5	1.6	1.6
August 2005	5.3	5.2	5.1	5.2
September 2005	4.0	4.1	4.1	4.1
October 2005	3.3	3.6	3.7	3.5
November 2005	2.5	2.2	2.5	2.4
December 2005	2.0	2.3	2.1	2.2
January 2006	2.6	2.1	1.8	2.2
February 2006	6.4	6.6	7.0	6.6
March 2006	8.9	9.0	8.6	8.8
Sample size	732	725	487	1,944

(continued)

Table 4.1 (continued)

SOURCE: Philadelphia Baseline Information Form.

NOTES: In order to assess differences in characteristics across research groups, chi-square tests were used for categorical variables, and analysis of variance (ANOVA) tests were used for continuous variables.

Levels for statistically significant differences between program and control groups are indicated as: *** = 1 percent; ** = 5 percent; * = 10 percent.

[a]TWC: Transitional Work Corporation.

[b]STEP: Success Through Employment Preparation.

[c]VS: Voluntary Services.

[d]Sample members are coded as Hispanic if they answered "yes" to that race/ethnicity category.

In comparison, a study of welfare recipients in three cities in Texas showed that approximately 45 to 55 percent did not have a high school diploma or a GED, and a study of recipients identified as hard to employ in Hennepin County (Minneapolis), Minnesota, showed that about 46 percent did not have a high school diploma or a GED.[18]

Approximately 92 percent of the Philadelphia sample participants have been previously employed; however, about two-thirds have worked a year or less in the past three years. This indicates a more limited work history, compared with recipients in the Texas and Minnesota studies. In Texas, 51 to 58 percent of recipients had worked a year or less in the past three years and, in Minnesota, 57 percent of hard-to-employ recipients had worked a year or less during that time.

Approximately two-thirds of the Philadelphia participants have a child under 6, and the average number of children under 18 is 2.2. A higher proportion — 35 percent — of the Philadelphia participants have three or more children, compared with participants in the Texas study (26 to 32 percent) or in the Minnesota study (32 percent).

In addition, according to data from the Philadelphia County Assistance Offices, about 70 percent of the sample members have received TANF for more than two years, and the average number of months of TANF receipt is about 40. National law stipulates that federal funding cannot be used toward recipients' TANF grants after they have received 60 months of TANF, except under certain circumstances. Many participants in the demonstration are nearing this

[18]Martinson and Hendra (2006); LeBlanc, Miller, Martinson, and Azurdia (2007). The Minnesota study includes recipients who had been assigned to TANF employment services for 12 months or longer, were unemployed at the time of random assignment, and had not worked in the preceding three months.

limit, and over a quarter are already receiving Extended TANF, Pennsylvania's state-funded assistance for recipients who have received TANF for over 60 months.

Program Enrollment and Participation

Early data indicate that the referral process functioned correctly, and that almost all recipients were referred properly. Usually the referral took place very soon after the recipient was randomly assigned, and the programs received timely notice of the referrals.[19] However, there were some early concerns regarding enrollment and participation levels at both programs. The percentage of recipients who enrolled in TWC's program was somewhat low, although this was anticipated, and discussion with TWC confirmed that the enrollment rate was not unusual. In addition, there was concern that recipients at STEP were not participating for a high number of hours and may not have received services beyond assessment. The program made some changes to address this issue, and subsequent analysis suggests that participation may have increased.

Program Enrollment

When a recipient was assigned into one of the two programs, County Assistance Office staff entered the appropriate program code into the state's database and the provider received notice of the referral the following day through the interface system. Early data indicated that this process worked correctly for most participants; as shown in Table 4.2, almost all participants were referred to the program to which they were assigned.

Once a provider received a referral from the County Assistance Office, program staff could choose whether or not to officially enroll the recipient in the program. Each program determined its own criteria for enrollment. TWC and STEP differed in their enrollment processes and in how they determined which recipients to enroll. Table 4.2 indicates the proportion of participants who enrolled in both programs.

STEP enrolled recipients after the program's outreach staff completed the initial home visit and the recipient came into the STEP office to meet with her or his case coordinator. Most (80.9 percent) of the early recipients referred to STEP completed this process and enrolled in the program. Those who did not enroll included recipients who could not be located by the outreach

[19]The referral process was designed to prevent staff from randomly assigning recipients who were ineligible to participate in the study. Nevertheless, a small proportion of recipients were randomly assigned but never referred to the programs, because Career Development Unit staff later determined that they were not required to participate in work activities for reasons such as medical exemptions or responsibilities caring for children under age 1. However, this did not happen often enough to be of major concern.

The Enhanced Services for the Hard-to-Employ Demonstration

Table 4.2

Program Referrals, Enrollment, and Participation

Two Service Models for Welfare Recipients

Outcome	TWC[a]	STEP[b]	Voluntary Services
Referred to program (%)	92.6	95.5	NA
Enrolled in program (%)	55.8	80.9	NA
Ever participated[c] (%)	55.8	80.9	28.1
Average total hours of participation[d]	172	24	168
Sample size[e]	95	89	64

SOURCE: MDRC calculations from Pennsylvania's Automated Interface Management System (AIMS) database.

NOTES: The table reflects referrals, enrollment, and participation through May 2005.

[a]TWC: Transitional Work Corporation.

[b]STEP: Success Through Employment Preparation.

[c]TWC does not enter into the AIMS database the hours that customers participated in orientation activities, because it is likely that some customers participated in these activities but were never officially enrolled in the program and do not show any hours.

[d]The sample for the average total hours of participation includes only those who ever participated (53 in the TWC group, 72 in the STEP group, and 18 in the Voluntary Services group). For TWC, if a customer completed the orientation and enrolled in the program, 30 hours were added to the hours of participation. (Ten customers enrolled in TWC but did not have any other activity hours.) This adjustment was not necessary for STEP customers. STEP's internal Management Information System showed a slightly higher number of hours than the AIMS database for some clients.

[e]The sample in this table is limited to recipients who were randomly assigned between October 12, 2004 (when study enrollment began), and December 31, 2004, to allow between four and a half months and six and a half months of follow-up.

workers and those who were located but never came in to the office. Participants' early attendance and participation, after the first visit, did not affect the enrollment process.

During most of the study period, TWC enrolled recipients only after they had completed the program's two-week orientation process discussed above. The proportion that never enrolled at TWC thus included recipients who never attended the program at all, as well as

those who showed up but did not complete the full orientation. Therefore, early data show that enrollment at TWC was somewhat low (55.8 percent). Follow-up with participants who did not show up or had poor initial attendance varied among TWC staff, but TWC's general philosophy was that participants who did not consistently attend orientation may not have been ready for the program. TWC staff confirmed that, according to TWC's program model, they traditionally did not conduct extensive outreach with recipients and that the relatively low enrollment rate was not unusual. MDRC did not encourage TWC to significantly modify its program model to attempt to enroll more recipients.

Nonetheless, the relatively low enrollment rate is of concern for the study, because if the program has impacts for the recipients who do participate, these effects may be diluted when evaluating the results of the full TWC sample. MDRC hoped the issue would be addressed through Philadelphia's presanction review process, in which third-party providers attempt to locate recipients who are not participating and bring them into compliance. However, it is unclear whether this system provided a strong mandate to participate during the research period for this report.

In summer 2005, DPW issued a directive to limit multiple referrals to the third-party sanction reviewers in order to simplify the process of implementing sanctions in cases of repeated noncompliance. In addition, Pennsylvania issued memos to staff in June, October, and December 2005, describing a universal engagement process and reiterating the new sanction procedures, in which offices would receive lists of unengaged recipients and would be required to follow up with them. However, these processes were not in place when the research for this report was conducted.

Program Participation

MDRC also measured the number of hours that recipients participated in the programs. Table 4.2 shows the percentage of early TWC, STEP, and Voluntary Services participants who ever participated and the average number of hours of group members' participation during the four and a half to six and a half months of follow-up.

Over the course of the follow-up period for this report, TWC recipients averaged a relatively high number of hours of participation — 96 hours (not shown in table). (This calculation includes group members who did not show any hours of participation. Among those who showed any hours of participation, the average number of hours was 172. There may also be some recipients who participated in some orientation activities but who do not show any participation hours, because TWC does not record those hours in the AIMS database unless the participant completes orientation.) Most of the recorded hours were probably in transitional or

unsubsidized jobs, as case management staff explained that many recipients did not participate as regularly in professional development activities as they did in employment.

Early data indicated that recipients in the STEP program participated for a relatively small number of hours — 19 hours — although program staff later took steps to increase participation. (Among those who showed any participation, the average was 24 hours.) Based on field research at STEP, MDRC was concerned that many STEP recipients were not receiving significant services beyond initial outreach and assessment and that some recipients were not even participating in assessment activities. Interviews with case management staff at STEP revealed that, despite ongoing outreach efforts, some recipients did not come in for the assessments and others took several months to complete them. Further, even for those who did complete the assessments, there was sometimes a lengthy lag time before staff analyzed the results, because few staff were allocated to this task. Because the program design required that the assessment phase be completed before recipients could participate in most other activities, many recipients remained in a waiting period, during which most of their treatment consisted of life-skills classes for a few hours per week and meetings with case management staff. As a result of the low participation hours, the differences in outcomes for the STEP group and the control group may be smaller than if more participants had received services beyond assessment. It also suggests that it will be important to try to understand the effects of receiving the full set of STEP services (as opposed to the average effects for everyone assigned to the STEP group or even everyone who showed any hours of participation) in order to draw implications about the potential effect of the program without the lag between assessment and other program services.

To address these concerns, STEP managers reported that they implemented strategies to increase participation, including streamlining the assessment process and providing immediate engagement activities that recipients could participate in concurrently with the assessments.

Although recipients in the Voluntary Services group (the control group) were not required to participate in any programs, a substantial proportion reported to the County Assistance Offices that they participated in activities during the follow-up period.[20] The majority of this participation was in vocational-type education programs, GED or high school classes, and basic education activities, although a few were engaged in structured job search activities.

[20]Voluntary Services recipients could report participation in order to receive supportive services such as child care and transportation.

Updated Program Enrollment and Participation Data

MDRC was also able to conduct preliminary analyses of enrollment and participation, using data from TWC and STEP, for a larger proportion of the research sample.[21] The percentage of the sample that was referred to each program remains high, although it is slightly lower for both programs, compared with the earlier data. The percentage that enrolled also remains similar, but increases slightly for the TWC group.

At TWC, the proportion that was ever placed in a transitional job is similar to the earlier data on the proportion of the sample that had ever participated in the program, about 60 percent. The TWC data also show that, among those who enrolled in the program, almost all were placed in a transitional job. This indicates that most enrolled participants received at least some treatment.

More recent data from STEP on the proportion of the sample that ever participated also correlates with the earlier data, about 80 percent of the sample. The new data also indicate that the number of hours of sample members' participation increased, although it is unclear whether this reflects an increase in the number of hours recipients spend in activities or improvement in recording practices.

Conclusions

The Philadelphia site of the Hard-to-Employ evaluation tests two service models designed to offer employment-related services to hard-to-employ welfare recipients. The TWC program provides up to six months of transitional employment, combined with case management services and professional development activities. The STEP model provides intensive services to assess and treat barriers to employment, followed by job search services. The evaluation is an important test of two programs that may potentially assist hard-to-employ welfare recipients to find employment. It will compare each model with a control group of recipients who are not required to participate in any activity.

The early implementation analysis shows that the random assignment process worked correctly and that sample members show some participation in both programs. However, somewhat low enrollment and participation rates presented ongoing challenges to the programs, as well as to state and local welfare administrators. The TWC group has a relatively low enrollment level, because participants were enrolled only after they completed a two-week orientation. TWC staff confirmed that this is standard for its program model and that the enrollment

[21]Data were analyzed for all participants in the STEP and TWC groups randomly assigned through December 2005. The data include at least three months of follow-up for STEP participants and at least six months of follow-up for TWC participants.

process for the evaluation functioned no differently than it did for nonsample members. The STEP group, on the other hand, shows somewhat low participation rates, even among those enrolled, because many participants remained in the assessment phase for lengthy periods without receiving other services. STEP administrators reported that they implemented changes to increase participation, including offering immediate engagement activities during the assessment period. Preliminary analysis of participation data confirms that participation did increase. Further research in subsequent reports will indicate the impacts of the programs on participants' welfare, employment, income, and earnings outcomes.

Chapter 5

Rhode Island: Working toward Wellness

Introduction

This chapter will describe the Hard-to-Employ demonstration evaluation of Working toward Wellness (WtW). WtW is a telephone care management and outreach monitoring model designed to help low-income individuals who are experiencing major depression to enter and remain in evidence-based treatment. This study is targeted specifically to Medicaid recipients in Rhode Island who are eligible for mental health services through United Behavioral Health.[1]

This chapter begins with an overview of existing research on depression treatment, particularly for low-income individuals, discusses several studies of the effectiveness of various care management models, and explains why such interventions are relevant to policymakers and researchers in this field. The chapter continues with a description of the WtW intervention and the research design and procedures used in the evaluation. It presents the baseline characteristics of the sample members, followed by an outline of the key outcomes for the study's participants and the data sources that will be used to track these outcomes. In addition, it summarizes the findings from the early assessment and analyzes the data on the sample members participating in the WtW intervention. The chapter concludes with an analysis of the preliminary results for a small number of sample members on use of behavioral health services.

Background and Policy Relevance

Research on public assistance recipients indicates that as many as one-quarter have experienced past-year depression.[2] Moreover, their depression may be one of several barriers that limit their employability.[3] Although a considerable body of random assignment research has identified various types of efficacious treatment for depression[4] and indicates that "treatment for depression can reduce job loss and work-related impairments,"[5] studies that are specifically applicable to low-income, hard-to-employ populations, in particular Temporary Assistance for Needy Families (TANF) recipients, are not yet available.

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[1]WtW is being offered through United Behavioral Health, a managed behavioral health organization that has one of the largest Medicaid behavioral health caseloads in Rhode Island.

[2]Corcoran, Danziger, and Tolman (2003).

[3]Danziger et al. (1999).

[4]Katzelnick et al. (2000).

[5]Mintz, Mintz, Arruda, and Hwang (1992).

Despite considerable progress in the field of depression care, many depressed individuals fail to receive adequate treatment — with current estimates indicating that treatment rates among depressed individuals may be as low as one-fifth.[6] In low-income communities, where knowledge of depression treatment and quality of care may be lower than in higher-income communities, even fewer people receive treatment. Moreover, even among those individuals who do seek treatment, relapse rates are quite high,[7] suggesting the importance of strategies that maintain continuity of care.

One promising way to address this problem is through care management, which is designed to support clinical treatment by actively facilitating an individual's engagement in treatment, with particular emphasis on the quality and continuity of that treatment. Six- and 12-month follow-up findings from Partners in Care, a randomized clinical trial that evaluated depression care management by nurses in primary care settings, suggest that intensive care management can decrease depression and unemployment.[8] Five-year follow-up data suggest that the impacts on depression and other health outcomes are enduring.[9] Moreover, Partners in Care appears to have been more effective among Latinos and African-Americans relative to whites. Other depression interventions[10] have been successful in targeting the disadvantaged and minority populations that are of special interest to researchers and policymakers.

More specifically, a growing number of effectiveness trials indicate that telephonic care management programs provide a cost-effective approach to improving care for depression.[11] Together, these studies have evaluated redesigned systems for the management of depression that include: (1) a telephone care management program with outreach calls; (2) an information system to monitor adherence and outcomes; (3) a system of consulting specialists or a computer support system; and (4) patient materials or self-management support (educational materials or psychoeducational interventions). Compared to usual care, these systematic interventions have led to improved clinical outcomes and patient satisfaction. Telephone approaches are also being tried in the management of other conditions, with varying degrees of success, for example, diabetes,[12] asthma,[13] and substance abuse.[14]

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[6]Kessler et al. (2003).

[7]Belsher and Costello (1988).

[8]Wells et al. (2000).

[9]Wells et al. (2004).

[10]Miranda et al. (2006); Araya et al. (2003); Smith et al. (2002a and 2002b).

[11]Hunkeler et al. (2000); Katzelnick et al. (2000); Simon, VonKorff, Rutter, and Wagner (2000); Tutty, Simon, and Ludman (2000); Simon et al. (2004).

[12]Marrero et al. (1995); Schulz, Bauman, Hayward, and Holzman (1992).

[13]Pinnock et al. (2003).

[14]McKay et al. (2004).

In addition, a study conducted by Simon and colleagues (2004)[15] evaluated the effects of two intervention programs: telephone care management and telephone care management plus telephone psychotherapy. Overall, results of this study suggest that telephone-based outreach, medication monitoring, and brief, structured psychotherapy were well accepted by patients and significantly improved their clinical outcomes, compared with usual primary care. These findings suggest the value of a public health approach to psychotherapy for depression, including active outreach and vigorous efforts to improve access to and motivation for treatment.

Program Description

Recent studies have shown that there are many factors to consider in the design of enhanced care management outreach models targeted to traditionally underserved populations (such as those who are economically disadvantaged and racial and ethnic minorities). For example, they must effectively address cultural and language differences regarding health and health care, which can also make them more resource-intensive and costly. The potentially high costs of these outreach models and the high prevalence of depression among low-income individuals, particularly women, underline the need for an inexpensive and effective type of outreach.

WtW is a telephone care management intervention designed to help Medicaid recipients who are experiencing major depression seek and remain in evidence-based treatment. Individuals are being offered WtW only as part of the Hard-to-Employ evaluation. The care manager-outreach monitoring model was developed by researchers from Group Health Cooperative in Seattle, and is currently being evaluated among a working population in a large-scale study, Outreach and Treatment for Depression in the Labor Force, funded by the National Institute of Mental Health and led by a research team from Harvard Medical School. This study is known as the Workplace Depression Study for short.[16]

The WtW intervention has two phases: (1) recruitment into in-person treatment and (2) monitoring of in-person treatment. Recruitment begins when the care manager first calls the client and continues until the client's first in-person visit with a therapist. Monitoring begins after the client's first visit with a therapist and continues until the end of the 12-month intervention. Throughout the intervention, the care management is monitored for both its quality and its

[15]Simon et al. (2004).

[16]The model has been adapted for the WtW intervention, given the considerably different target population. Outreach and Treatment for Depression in the Labor Force is focused on active employees of large corporations, whereas WtW is focused on nondisabled Medicaid recipients. Nonetheless, both are based on telephonic outreach and care management for depression offered by master's-level clinicians.

consistency. In addition, the care manager regularly administers the nine-item depression module of the Patient Health Questionnaire (PHQ-9)[17] to track the severity of the client's depression.

In general, the role of the care manager is to facilitate and support clinical treatment. More specifically, the care manager discusses possible treatments and medications with the client, continually assesses the client's depression, and, if appropriate, encourages the client to seek in-person treatment. During the recruitment phase, care managers provide initial education regarding depression and depression treatment and try to motivate the client to receive treatment.

During the ongoing monitoring phase, care managers:

- monitor clinical and functional outcomes of treatment;
- monitor treatment adherence;
- provide feedback to treating clinicians regarding adherence to treatment and clinical outcomes;
- provide education and outreach to maintain adherence to treatment and prevent unplanned discontinuation of treatment; and
- facilitate appropriate follow-up care (including referrals to specialists).

In other words, once the client has begun in-person treatment, the care manager monitors her or his progress and attendance in therapy. Since failure to show up for an appointment is common among their clients, care managers frequently remind them to keep their appointments. The care managers will often follow up with their clients one or two days after their first appointment.

While traditional in-person treatment, including medication and/or psychotherapy, is recommended to clients, a structured telephone-based psychoeducational program (referred to as the "phone program") is offered as a temporary alternative to treatment for clients who are unable or unwilling to engage in in-person treatment. The clients receive a workbook that contains didactic material, in-session exercises, and written homework exercises, which they are asked to complete before each phone session with the care manager. The workbook — which was developed by Group Health Cooperative staff and the care managers with the needs and

[17]Since WtW is a telephonic intervention, the PHQ-9 is administered by care managers over the phone. Levels of depression on the PHQ-9 range from 0 to 27, and are broken down into the following categories: 0-5 (none), 6-10 (mild), 11-15 (moderate), 16-20 (severe), and 21-27 (very severe). These levels parallel the levels assessed with the Quick Inventory of Depressive Symptomatology-Self Report measure and the Hamilton Rating Scale for Depression (HAM-D). See Kroenke, Spitzer, and Williams (2001).

experiences of the target population in mind — is a tool to encourage clients to start discussing the issues related to their depression, with the ultimate goal of getting them into in-person treatment. Therefore, while the clients are in the "phone program," the care managers continue to discuss the option of in-person treatment.

Services are provided by one full-time and two part-time care managers, who are master's-level clinicians who received training in outreach before the intervention began. Since some of their clients are Spanish-speaking, one of the part-time care managers is bilingual.

Research Design

The two main purposes of the study are to determine: (1) whether a telephone care management model focused on low-income parents can be successfully implemented and, if so, (2) whether the model is effective at alleviating depression, increasing employment and earnings, and reducing the use of public assistance. The study thus provides a unique opportunity to determine whether this relatively inexpensive type of outreach can be an effective model for state systems. In addition, this evaluation will also examine the effects of parents' depression on the development of children and adolescents in low-income families and determine whether the intervention also benefits them.

A wealth of research has documented the negative effects of maternal depression on children's development.[18] Early studies found that children of depressed parents were at similar levels of risk as children of parents experiencing other forms of psychopathology, for example, schizophrenia.[19] Children of depressed parents show decrements in social behavior and psychological functioning, as well as affective disorders, such as depression.[20]

The impacts of the WtW intervention are being assessed using a random assignment research design. Random assignment ensures that the groups are comparable when they enter the study and allows researchers to judge the likelihood that the program had an effect over time on, for example, employment rates or average earnings. For purposes of the evaluation, individuals who meet the study's eligibility criteria (discussed further below) and appear to be depressed are randomly assigned to one of two groups:

- **WtW group:** Individuals in the WtW group receive intensive outreach from care managers, first to help them to enter treatment and then, if treatment be-

[18]Weissman et al. (2006a and 2006b); Beardslee et al. (1997), Beardslee, Versage, and Gladstone (1998); Cicchetti and Toth (1998); Downey and Coyne (1990).

[19]Downey and Coyne (1990).

[20]See Cummings and Davies (1994); Downey and Coyne (1990); Goodman and Gotlib (1999, 2002) for reviews.

gins, to remain in it for an appropriate time. Treatment is based on the American Psychiatric Association's Evidence-Based Practice Guidelines for Major Depression, which includes psychotherapy and antidepressant medications. Outreach and care management takes place by telephone in order to reduce expense. In addition, WtW may have indirect effects on work-related outcomes if short-term improvements in depression subsequently lead to a greater interest and capacity to seek and retain employment.

- **Usual Care (UC) group:** UC group members are informed that they may be depressed and are given referrals to three mental health treatment providers in the community that provide Medicaid-covered services. If sought, the treatment would be the same as the standard behavioral health services generally offered by United Behavioral Health to its members. This "usual care" would not include access to intensive telephonic depression care management.

Since individuals were assigned to either the WtW or the UC group at random, any substantial differences that emerge between the groups can be attributed to the services provided by WtW. MDRC will continue to track the participants in each group for at least three and a half years. By following the two groups over time and comparing their mental health, employment, and other outcomes — such as welfare receipt — the study will determine the impacts of enhanced telephone-based care management for treating depression.

Random Assignment and the Sample Intake Process

The target population for the study includes Medicaid participants in Rhode Island who meet the following criteria: (1) They are of working age — 18 to 64 years old — and have children; (2) they appear to be experiencing major depression; and (3) they have selected the health plan option that makes them eligible to receive behavioral health care through United Behavioral Health.[21] MDRC and United Behavioral Health decided to target a working-age population, because, in addition to its central focus on improvements in depression, this study is also going to test effects on employment. In addition, the criterion of having children is important, because this research is also concerned with the potential benefits to children of improvements in their parents' well-being. Finally, eligibility to receive United Behavioral Health care is essential, given that the intervention is being offered by this company.

[21]Medicaid beneficiaries in Rhode Island who choose United Health Care (UHC) — one of the nation's largest health plans — receive their basic health care through Americhoice, another health plan that partners with UHC. Members of Americhoice are then eligible to receive behavioral health care through United Behavioral Health, which partners with both UHC and Americhoice.

Individuals are excluded from the study if they appear to be at high risk for suicide, which is important, since these individuals require immediate crisis intervention.[22] (Individuals who exhibit a high risk for suicide after they are enrolled remain in the study but are also referred for immediate assistance.) In addition, those suffering from bipolar disorder or mania, or alcohol or drug dependence, are also excluded because the presence of these conditions — even if they are occurring concurrently with major depression — could make them less responsive to this depression-specific intervention. Finally, because they are unlikely to be in need of the outreach being provided by the care managers, individuals who are actively engaged in treatment for depression are also excluded.

Figure 5.1 provides a detailed illustration of the study intake process, which involves several steps.

- Medicaid recipients eligible for services through United Behavioral Health are grouped into cohorts,[23] which are randomly chosen by United Behavioral Health approximately every two and a half months.[24] Cohorts were used so that participants would enter the study on a rolling basis, thus ensuring that the care managers maintain reasonable caseload sizes throughout the study.

- Potential study participants are mailed a letter describing the study and an initial "screener," which includes the K6 and a few additional health-related questions.[25] The K6 is a widely used, brief summary measure of nonspecific psychological distress that is comprised of six questions about mental health.[26]

[22]These individuals — as indicated in Figure 5.1 — receive a "warm" transfer, which is when the participant is transferred directly from one counselor to another, without a disruption of the telephone connection.

[23]The term "cohort" has various definitions, depending on its context. For this evaluation, a "cohort" is a group of people identified at a specific point in time for study-related purposes.

[24]The study has a total of eight cohorts.

[25]Phone cards are mailed to all individuals with the screener and cover letter. Individuals who complete the initial screener — either by themselves or by phone with a United Behavioral Health care manager — have the phone card activated. Those who complete the remainder of the baseline survey will have $15 added to their phone card. (In an effort to expedite the pace of recruitment, the amount of the incentive was gradually increased over time.)

[26]See Kessler et al. (2002). The person must have a score of 13 or higher on the K6 to screen "positive" for likely depression and further assessment for potential participation in the research. The highest possible score on the K6 is 24. In addition, people who said they were ever told by a health professional that they were experiencing depression were screened positive and received further assessment.

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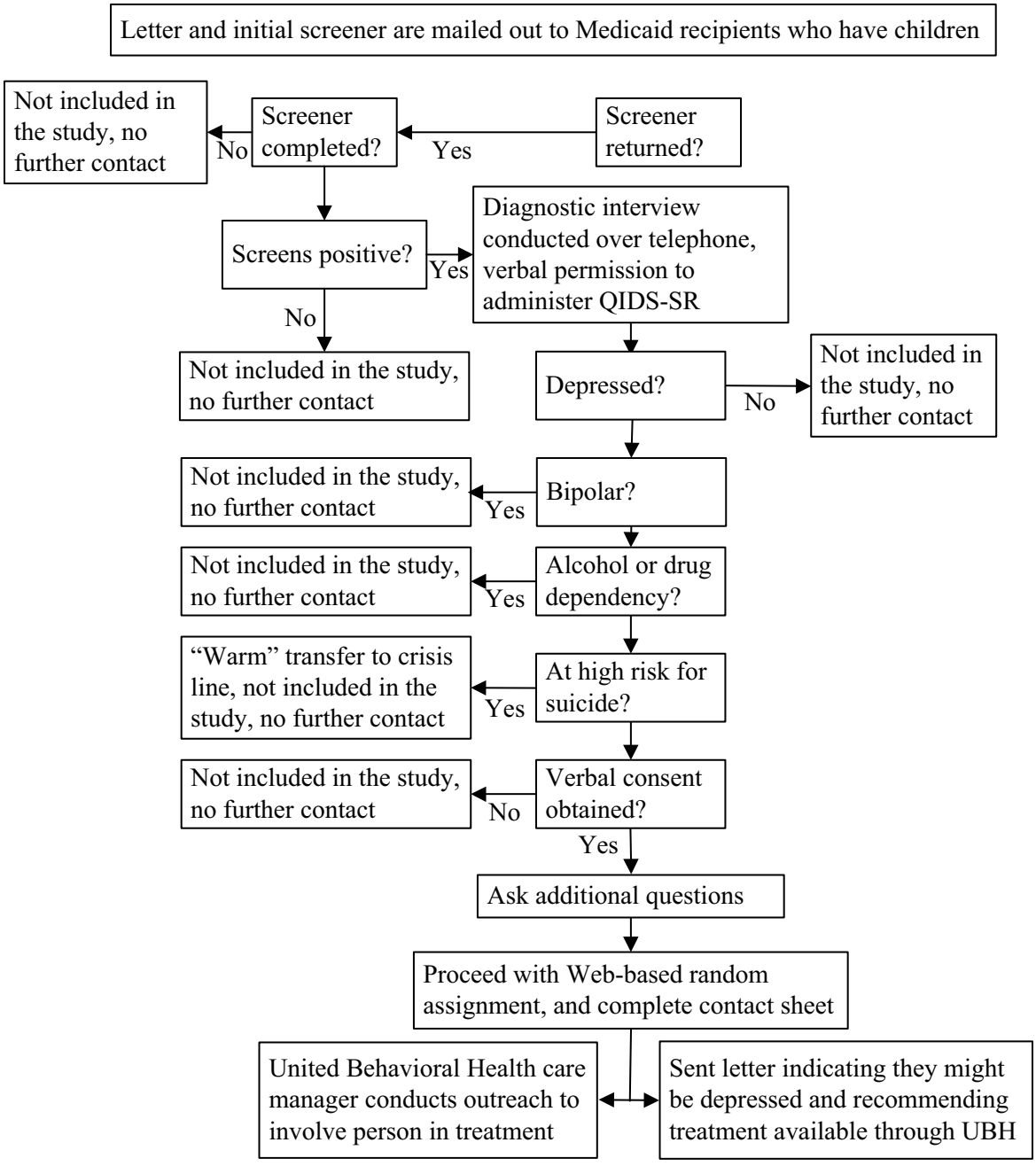
Figure 5.1

Working Toward Wellness
Random Assignment Flow Chart



- Care managers attempt to contact by telephone all individuals who return the completed screener and whose screener indicates an elevated risk for depression. If an individual is reached by telephone, the care manager will first ask permission to ask a set of questions about how the person is feeling. If the person consents, the care manager will administer the Quick Inventory of Depressive Symptomatology-Self Report (QIDS-SR).[27]

- If the person's responses indicate that she or he meets the criteria for depression,[28] the care manager will explain the random assignment study and ask the individual if she or he agrees to take part in the research. If the individual agrees to be part of the study, the care manager asks for some additional sociodemographic, health- and child-related baseline information.

- The care manager then randomly assigns the individual via an Internet-based system to one of the two research groups: WtW or UC.

Status of Random Assignment

In Rhode Island — at any given time — United Behavioral Health has a service-eligible membership of approximately 14,000 Medicaid recipients who are working-age adults with children.[29] Based on a number of assumptions, it was projected that the study would recruit between 500 and 900 individuals — equally divided between the WtW and UC groups — by December 2005. However, by December 2005, only 280 total participants were enrolled in the study. Therefore, the intake period was extended through October 2006, which resulted in a final sample size of 507.

Considering its complexity, the sample intake process worked quite smoothly. However, a number of issues adversely affected sample build-up, as described below.

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[27]The QIDS-SR is designed to determine whether the person meets the criteria for being diagnosed with major depression over the past seven days. For more information on the QIDS-SR, see Rush et al. (2003).

[28]The person must have a score of 8 or higher on the QIDS-SR to be eligible for the study. The score on the QIDS-SR ranges from 0 (not depressed) to 25 (very severely depressed). The QIDS-SR is typically coded such that the scores range from 0 to 27. Adaptation of this instrument for telephonic administration by the Workplace Depression Study research team resulted in this change in the upper boundary of possible scores.

[29]According to United Behavioral Health, 77.5 percent of the adult Medicaid recipients they serve in Rhode Island are women.

Low response rates to initial screener

Fewer people completed the initial screener than expected. The most optimistic projection assumed that 30 percent of potential participants would complete and return it, but response rates varied from 20 to 30 percent across the eight cohorts. Getting people to respond to this screener was somewhat more difficult than anticipated. Attempts to increase completion included:

- **Sending additional mailings.** United Behavioral Health started re-mailing the cover letter and screener approximately six months after the initial mailing. In general, the re-mailing most likely contributed to a higher response rate on the screener — after the re-mailing to Cohort 1, the response rate increased by 6 percent. The number of eligible study participants, however, increased only marginally. The main reason for this, discussed in more detail below, is inaccurate contact information.

- **Calling people who do not complete the initial screener.** For a brief time during the early stages of sample recruitment, the care managers attempted to contact by phone all individuals who had not returned a completed screener. Of the more than 200 "cold" calls the care managers made, only two individuals were successfully contacted and randomly assigned. Since the calls did not add much to the sample, the care managers discontinued them. Most of the calls were unsuccessful because the contact information, namely the phone numbers that came from United Behavioral Health's administrative data, was inaccurate.

Outdated and inaccurate contact information

After people had responded to the initial screener, contacting them to administer the baseline interview was the next hurdle. One unanticipated problem was, again, that contact information was out of date. The evaluation team tried to address this problem in several ways:

- **Identifying cohorts based on Medicaid eligibility date.** Originally, United Behavioral Health chose the cohorts by selecting a random sample of people who met the eligibility criteria. This process was changed slightly, starting with Cohort 3, to randomly select people closer to their Medicaid application or re-determination date. The hope was that there would be more accurate contact information for people who had recently applied to Medicaid or had recently been re-determined as eligible for Medicaid.

- **Revising the initial screener.** The letter sent with the initial screener was also revised to clarify that contact information was required to activate the phone card incentive for responding. Specifically, multiple numbers were required for the incentive, as were the respondent's preferences about when and where to call.

- **Keeping cases with temporarily disconnected phone numbers "active."** The care managers regarded people with temporarily disconnected phone numbers as "active" cases, which meant they continued trying to contact them and did not classify them as having nonworking phone numbers.

High rate of decline

A total of 687 people met the criteria for depression on the QIDS-SR. Of those, 133, or 19 percent, declined to participate in the study. As a point of reference, the rate of decline in a similar randomized trial conducted by Simon and colleagues (2004) was 5 percent.[30] This was also a test of telephonic psychotherapy and care management; however, it targeted individuals who were already engaged in some form of depression-related care. In addition, the research sample was drawn from enrollees in a large prepaid health plan in the state of Washington, whose membership is demographically similar to the Seattle-area population.

According to the care managers, people declined to participate in the Rhode Island study for one of two main reasons: (1) they did not have the time or (2) they did not think that they needed help. The care managers strongly encouraged people to participate in the study, but participation was voluntary. Therefore, although the study targeted a large number of individuals who are especially unlikely to seek depression treatment on their own, the sample might overrepresent — to some degree — people who were more likely to acknowledge that they needed help and were consequently more receptive to the possibility of engaging in care.

Characteristics of the Sample

United Behavioral Health care managers collected baseline data immediately following the administration of the QIDS-SR. The QIDS-SR is designed to determine whether the person meets the criteria for being diagnosed with major depression over the past seven days[31] and is therefore eligible for the study. Data from the QIDS-SR are analyzed for the participants who

[30] A total of 600 out of an eligible 634 (95 percent) agreed to participate in the study conducted by Simon et al.

[31] The QIDS-SR also allows for an assessment of depression severity over the past seven days. For more information on the QIDS-SR, see Rush et al. (2003).

are randomly assigned into the study. As part of the baseline survey, care managers also collect socio-demographic, employment, and prior treatment data, as well as data on participants' children.

Table 5.1 shows the baseline characteristics of the sample. Data were analyzed for the total sample of 507 study participants. As expected, the characteristics of the two research groups were similar.

The majority of the participants (74 percent) had a total score on the QIDS-SR in the moderate to severe range at baseline, with an average score of 15. The average age of the participants was about 35. Approximately one-third (33 percent) of the participants were Hispanic. More than half the participants were either single or legally separated (57 percent) and were not living with a spouse or partner (61 percent).

Prior Treatment

One of the key outcomes of the WtW intervention is to get people into treatment. As shown in Table 5.1, the baseline measure for "ever received prior treatment from a professional" is relatively high (73 percent). This could mean that these participants are amenable to receiving treatment and might be more inclined to seek treatment than those who have never received treatment. However, of this 73 percent, only 39 percent (slightly more than half) received treatment within the past year. This may indicate that the problem of being unable to seek and remain in evidence-based treatment is not the result of a failure to recognize depression.

Children[32]

In order to qualify for the study, all participants must have a child. The average number of children per participant is two, and the average age of all children in the sample is 10 (see Table 5.2). A series of questions on the baseline survey asks specifically about one or two children per participant, called the "focal" children.[33] These questions focus mainly on school and whether the children have conditions that might contribute to their parent's depression and make it difficult to work. As Table 5.2 indicates, 76 percent of the study's participants reported

[32]The data for children should be interpreted cautiously. Because of issues with baseline survey design and administration, the number of missing observations varies widely by measure.

[33]Focal children were identified at baseline, based on their age at that time. Up to two children per parent were identified as focal children. All focal children fell between the ages of 0 and 3 years old (Focal Child 1), or between the ages of 8 and 14 (Focal Child 2). Regarding the older group (8 to 14): Since there is special interest in youth between the ages of 10 and 13, children in that age range were prioritized over younger children as Focal Child 2.

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Table 5.1

Selected Baseline Characteristics, by Research Group

Working toward Wellness

Characteristic	Program Group	Control Group	Total
Total scores on QIDS-SR[a] (%)			
Mild (6-10)	11.5	15.4	13.4
Moderate (11-15)	45.5	32.7	39.1
Severe (16-20)	31.2	38.6	34.9
Very severe (21-25)	11.9	13.4	12.6
Average score on QIDS-SR	15.2	15.6	15.4
Sociodemographic characteristics			
Gender (%)			
Female	88.9	90.6	89.7
Male	11.1	9.4	10.3
Age (%)			
18-25 years	15.8	10.6	13.2
26-35 years	34.8	43.7	39.3
36-45 years	33.2	30.3	31.8
46+ years	16.2	15.4	15.8
Average age (years)	35.4	35.4	35.4
Race/ethnicity (%)			
White, non-Hispanic	44.3	47.2	45.8
Hispanic[b]	34.4	31.5	32.9
Black, African-American, non-Hispanic	12.6	11.8	12.2
American Indian or Alaskan Native	2.0	3.1	2.6
Asian or Pacific Islander	1.2	0.0	0.6
Other	3.2	2.4	2.8
Missing	2.4	3.9	3.2
Marital status (%)			
Single, never married	47.8	47.2	47.5
Married	22.9	24.4	23.7
Legally separated	9.9	8.3	9.1
Divorced	17.0	17.3	17.2
Widowed	1.6	1.2	1.4
Missing	0.8	1.6	1.2
Lives with spouse/partner (%)			
Yes	37.9	35.8	36.9
No	60.5	61.8	61.1
Missing	1.6	2.4	2.0

(continued)

Table 5.1 (continued)

Characteristic	Program Group	Control Group	Total
Average number of adults in household	1.70	1.71	1.71
Education (%)			
GED certificate	17.0	18.5	17.8
High school diploma	34.8	36.6	35.7
Technical/associate's/2-year college	17.4	12.2	14.8
4 years or more of college	6.3	8.3	7.3
None of the above	23.7	22.4	23.1
Missing	0.8	2.0	1.4
Currently employed (%)			
Yes	41.9	44.9	43.4
No	54.5	53.1	53.8
Missing	3.6	2.0	2.8
Number of months working on the current job (%)			
Did not work	58.2	54.9	56.5
1 month or less	4.2	2.5	3.3
1-6 months	6.3	8.6	7.5
6-12 months	7.2	9.0	8.1
12-24 months	6.8	6.6	6.7
More than 24 months	17.3	18.4	17.9
Average months working on the current job	18.4	16.5	17.4
Number of hours worked per week (%)			
Did not work	59.2	56.1	57.6
10 hours or less	2.1	2.9	2.5
10 to 20 hours	3.4	8.8	6.1
20 to 30 hours	8.6	7.9	8.3
30 to 40 hours	23.6	20.9	22.2
More than 40 hours	3.0	3.3	3.2
Average hours worked per week	13.8	13.5	13.6
Earnings per hour before taxes (%)			
Did not work	57.0	55.5	56.3
Less than $7	7.0	8.2	7.6
$7-$9	11.2	12.2	11.7
$9-$12	12.4	13.1	12.7
$12-$15	7.0	6.1	6.6
More than $15	5.4	4.9	5.1
Average earnings per hour before taxes	4.77	4.71	4.74
Number of children per participant (%)			
None	2.4	1.6	2.0
1 child	39.5	40.9	40.2
2 children	32.8	31.1	32.0

(continued)

Table 5.1 (continued)

Characteristic	Program Group	Control Group	Total
3 children	17.8	17.3	17.6
4 children or more	7.5	9.1	8.3
Average number of children per participant	1.9	2.0	2.0
Prior treatment (%)			
Ever received treatment from a professional			
Yes	75.1	70.1	72.6
No	24.5	29.1	26.8
Missing	0.4	0.8	0.6
Received treatment within the past year			
Yes	43.9	34.6	39.3
No	55.3	64.2	59.8
Missing	0.8	1.2	1.0
Received antidepressant medication within the past year			
Yes	39.5	35.0	37.3
No	59.7	63.4	61.5
Don't know	0.0	0.8	0.4
Missing	0.8	0.8	0.8
Alcohol/drug use (%)			
Has at least one alcoholic drink in a typical week			
Yes	29.6	29.9	29.8
No	33.6	31.9	32.7
Missing	36.8	38.2	37.5
Use any type of recreational drugs in a typical month			
Yes	3.2	4.7	3.9
No	42.7	43.7	43.2
Missing	54.2	51.6	52.9
SSI/SSDI benefits (%)			
Participant currently receiving SSI			
Yes	0.8	1.2	1.0
No	98.0	97.6	97.8
Missing	1.2	1.2	1.2
Other household member currently receiving SSI			
Yes	13.0	10.2	11.6
No	85.0	89.0	87.0
Missing	2.0	0.8	1.4
Currently receiving SSDI			
Yes	2.0	2.8	2.4
No	96.4	95.3	95.9
Missing	1.6	2.0	1.8

(continued)

Table 5.1 (continued)

Characteristic	Program Group	Control Group	Total
Other household member currently receiving SSDI			
Yes	5.5	6.7	6.1
No	92.9	91.3	92.1
Missing	1.6	2.0	1.8
Sample size	253	254	507

SOURCE: MDRC calculations from Rhode Island baseline data for families randomly assigned from November 17, 2004, to October 20, 2006.

NOTES: In order to assess differences in characteristics across research groups, chi-square tests were used for categorical variables, and analysis of variance (ANOVA) tests were used for continuous variables.

[a]QIDS-SR: Quick Inventory of Depressive Symptomatology-Self Report.

[b]Sample member is coded as Hispanic if she/he answered "Yes" to Hispanic ethnicity.

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Table 5.2

Selected Baseline Characteristic for Children, by Research Group Working toward Wellness

Characteristic	Total
All children	
Average age (years)	9.6
Gender (%)	
Male	49.6
Female	50.4
Age group (years under 19)	
0-1	9.1
2-3	8.8
4-5	9.8
6-7	11.1
8-9	12.5
10-11	12.3
12-14	16.3
15-18	20.2
Average age of children under 19 years	9.2
Sample size	987
Focal children (%)	
Has condition that presents barrier to work/school	
Yes	11.8
No	75.7
Missing	12.5
Attended school in the past year	
Yes	65.0
No	0.4
Don't know	0.4
Missing	3.2
NA	31.0
Has any physical/learning/mental health conditions	
Yes	19.2
No	69.4
Don't know	1.5
Missing	9.9
Has received professional treatment for condition	
Yes	16.9
No	71.5
Missing	11.6
Sample size	526

(continued)

Table 5.2 (continued)

SOURCE: MDRC calculations from Rhode Island baseline data for families randomly assigned from November 17, 2004, to October 20, 2006.

NOTES: In order to assess differences in characteristics across research groups, chi-square tests were used for categorical variables, and analysis of variance (ANOVA) tests were used for continuous variables.

that their child's health condition did not present a barrier to work or school. Most of the focal children did not have any physical, learning, or mental health conditions (69 percent) and had attended school in the past year (65 percent).

Follow-Up Data Sources and Key Outcomes

The study will use several types of follow-up data to assess the impacts of the program:

- **United Behavioral Health data.** These data provide information on the eligibility and use of Medicaid services, such as behavioral and physical health care, and prescriptions for pharmaceuticals, for United Behavioral Health members only.

- **TANF, food stamps, and Medicaid administrative data.** These data, collected from the Rhode Island Department of Human Services (DHS), will include information on receipt of TANF, food stamps, and Medicaid benefits. The Medicaid data from the Rhode Island DHS will provide information on service receipt for all study participants.

- **Sources of employment data.** MDRC is currently looking to access wage data from the National Directory of New Hires. This is a national database maintained by the Office of Child Support Enforcement, and therefore would provide information on earnings from employment both within and outside Rhode Island.

- **Survey data.** The current research design for the WtW study includes three follow-up surveys: one at six months after random assignment; one at 18 months after random assignment to measure outcomes that cannot be assessed using administrative data; and one at 36 months after random assignment. The survey will obtain data on jobs not covered in unemployment insurance records; participation in outreach programs other than WtW; receipt of behavioral health services not covered in Medicaid claims data; outcomes

on child well-being, depression, and other health outcomes; receipt of public assistance and social services; and material hardship.

- **Case monitoring and tracking database.** Group Health Cooperative maintains a live Web-based management information system (MIS) that provides comprehensive records on participation in WtW. The MIS is used to store information on clients' participation in the intervention, as well as to track their treatment and progress over time, if applicable. Information is collected and entered by the care managers and monitored by the consultants at Group Health Cooperative, who make weekly calls to the care managers to review cases that are flagged by the database. (The MIS automatically flags cases with PHQ-9 scores of 15 or higher.) The weekly calls are also a way of monitoring and maintaining fidelity to the intervention's design.

Early Findings from the Assessment

Sample Recruitment and Program Implementation

Generally random assignment worked properly and in accordance with its design. The complex, multistage, mail-out screening and assessment process identified the right population (working-age parents who received Medicaid and were experiencing major depression at baseline). In addition, the sample exclusion criteria were followed correctly.

Despite the complexities of the intake process, the required baseline data were collected. For the most part, the WtW and UC groups were similar at the time of random assignment.

Although the recruitment effort was quite extensive, the sample size fell short of the most optimistic projections. While the final sample of 507 will allow MDRC to detect impacts on depression that are similar in size to those found in other depression studies, the ability to analyze subgroups and detect effects on children will be constrained.

In addition, the WtW intervention is being well implemented with a high degree of fidelity to its design. The care managers are closely following the protocols for contacting and monitoring their cases and are also making intensive, ongoing efforts to encourage clients to participate in mental health treatment.

Contacts with Care Managers, Program Engagement, and Levels of Depression

Table 5.3 presents WtW group members' participation in the intervention through the end of the sample intake period. The follow-up data range from three weeks to 12 months, depending on when the person began the intervention. These data represent all 253 WtW group members.

Of the 253 WtW group members, 237 (94 percent) have been contacted by a care manager, with an average of 6.9 contacts per person.[34] In the study conducted by Simon and colleagues, of those assigned to telephone care management, 97 percent completed at least one telephone contact.[35] However, this contact rate should be used as a reference rather than as a comparison, because the target populations of these studies differ considerably.

In addition, 47 percent of the WtW group members are currently — as of January 2007 — in the monitoring phase,[36] and 25 percent are participating in the WtW phone program. The remaining 28 percent are not in treatment with a psychiatrist or a therapist. (These numbers are not shown in Table 5.3.)

Table 5.3 also shows WtW group members' initial PHQ-9 scores, their most recent PHQ-9 scores, and the percentage improvement in PHQ-9 scores for 224 of the 253 group members.[37] In general, depression severity scores for WtW group members have improved considerably since they began the intervention. Over three-quarters (76 percent) have shown some reduction in depression severity over time, and 40 percent of these had reductions in symptom severity of more than 50 percent. Only 24 percent have done worse over time; in other words, their most recent PHQ-9 score was higher than their initial PHQ-9 score when they started the intervention. It is important to remember that these depression results do not indicate whether the intervention has been effective, since follow-up data on depression for the UC group are not yet available.

Employment Status

As shown in Table 5.1, nearly half (46 percent) of the study's participants were currently employed at the time the baseline survey was administered. According to Group Health Cooperative's Case Monitoring and Tracking database, of the 237 WtW group members who

[34]The median number of contacts was six. The number of contacts ranged from one to 27.

[35]Simon et al. (2004).

[36]This means that they are in treatment either with a psychiatrist or another mental health professional, such as a therapist.

[37]As of January 2007, the care managers had not been able to administer the PHQ-9 to 29 participants.

Table 5.3
Program Participation
Working toward Wellness

Study Participants	Number	Percentage
Total eligible for baseline interview per initial screener	1,613	
Total eligible who were contacted as of Oct. 20, 2006	1,119	
Total meeting criteria per QIDS-SR[a]	687	
Total who agreed to participate and were randomly assigned	507	
Usual Care participants	254	
WtW participants	253	
Total WtW contacted by a care manager	237	93.7
Average number of contacts per participant	6.9	
Initial PHQ-9 score (lowest to highest)[b]		
0-4	NA	5.4
5-9	NA	21.9
10-14	NA	39.3
15-19	NA	26.3
20 plus	NA	7.1
Most recent PHQ-9 score (lowest to highest)[c]		
0-4	NA	28.2
5-9	NA	28.6
10-14	NA	26.7
15-19	NA	10.2
20 plus	NA	6.3
Improvement in PHQ-9 scored		
PHQ-9 score is worse than initially	NA	23.8
PHQ-9 score improved by 0-25 percent	NA	17.0
PHQ-9 score improved by 26-50 percent	NA	18.9
PHQ-9 score improved by more than 50 percent	NA	40.3

SOURCE: Group Health Cooperative's case monitoring and tracking database for families randomly assigned from November 17, 2004, to October 20, 2006.

NOTES: [a]Quick Inventory of Depressive Symptomatology-Self Report. 133 eligible people declined to participate in the study.

[b]Patient Health Questionnaire.

[c]Based on 148 WtW group members.

have been contacted, a similar proportion (45 percent) are currently employed as of January 2007, based on their most recent contact with their care manager.

Early Results on the Use of Behavioral Health Services

United Behavioral Health provided preliminary information on Medicaid use for 114 WtW and UC study participants receiving behavioral health services between November 17, 2004 (start of random assignment) and March 31, 2005. Table 5.4 presents these results by research group for two time periods: November and December 2004, and January through March 2005.[38]

The results are promising, albeit preliminary. When reviewing these data, keep in mind that the differences in service usage were not tested for statistical significance. Given the small sample sizes and the short follow-up periods, it is too early to determine whether the differences can be attributed to the WtW intervention.

The number of participants receiving outpatient care services is increasing for the WtW group (from 11 in November and December 2004 to 27 in January through March 2005), while the number remains the same for the UC group (10 in November and December 2004 and 9 in January through March 2005). Put differently, 48 percent (27 of 56) of the WtW group members received outpatient care services in January through March 2005, compared with 16 percent (9 of 58) of the UC group members. As listed in Table 5.4, outpatient services include treatment for substance (alcohol/drug) abuse, psychotherapy,[39] medication evaluation, medication management, and medical outpatient services — that is, treatment by a primary care physician.

[38]For the November and December 2004 period, these claims data are complete, given that they reflect a sufficient time for all claims to have been submitted. However, the claims data for the period January through March 2005 are less complete. The data extracted for this analysis do not include data collected after March 2005, and therefore claims made after that time are not reflected here. The follow-up period for a Medicaid claim is typically three months after the claim was made.

[39]Psychotherapy can be received in a group or in an individualized setting, in a hospital, clinic, or office.

The Enhanced Services for the Hard-to-Employ Demonstration

Table 5.4

Number of Study Participants Receiving Behavioral Services from November 2004 Through March 2005

Working toward Wellness

	Nov-Dec 2004		Jan-Mar 2005	
	WtW Group	UC Group	WtW Group	UC Group
Level of care				
Inpatient	0	0	0	0
Outpatient	11	10	27	9
Type of outpatient care				
Alcohol/drug services	3	4	3	4
Psychotherapy	2	1	5	1
Medication evaluation	4	2	7	1
Medication management	0	1	1	2
Medical outpatient care	2	2	11	1
Type of clinician				
Psychiatrist	1	1	5	1
Psychologist	2	0	1	0
Master's-level/other	7	7	6	8
Medical doctor	8	3	8	2
Sample size (total = 114)	56	58		

SOURCE: Group Health Cooperative's case monitoring and tracking database.

With regard to the type of outpatient care, the most notable differences are in psychotherapy, medication evaluation, and medical outpatient care. Looking at the period January through March 2005, one person in the UC group was in psychotherapy, compared with five in the WtW group; one person in UC was receiving medication evaluation, compared with seven in WtW; and one person in UC was receiving medical outpatient care, compared with eleven in WtW. These numbers suggest that the WtW group is more likely to receive these services, compared with the UC group. Furthermore, the WtW group is more likely to receive services from a psychiatrist (five WtW group members, compared with one UC group member) and/or a medical doctor[40] (eight WtW group members, compared with two UC group members).

[40]Participants might see more than one type of clinician. For example, someone could be seeing a MD, as well as a master's-level therapist, since some therapists cannot prescribe medication.

Conclusions

The Hard-to-Employ evaluation of the WtW intervention is the first study of a telephonic care management intervention targeted specifically to Medicaid recipients who are experiencing major depression. While there have been other studies of various types of care management models designed to help people who have various health and behavioral health needs, few have focused on getting them into in-person treatment for their depression. Working with low-income people who have significant — and sometimes multiple barriers to employment — presents additional challenges. For example, recruitment into the study and then subsequently into the intervention was complicated by the lack of accurate contact information. Despite these difficulties, the preliminary results suggest that participants in the WtW intervention may be experiencing an improvement in their depression and are more likely than those in the UC group to receive some form of psychotherapeutic treatment. These findings are promising and underscore the importance of this particular test and the need for more evaluation in this area.

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- Supporting Low-Wage Workers and Communities
- Overcoming Barriers to Employment

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