MINISTRY OF SOCIAL DEVELOPMENT
TE MANATŪ WHAKAHIATO ORA

Effectiveness of contracted case management services

Sole Parent Employment Service and Mental Health Employment Service Trials Evaluation: Final Report

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Authors

Insights MSD, Ministry of Social Development

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Disclaimer

The views and interpretations in this report are those of the Research and Evaluation team and are not the official position of the Ministry of Social Development.

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Executive summary

The Ministry of Social Development (MSD) conducted two trials designed to improve employment and social outcomes for sole parent clients (with a youngest child aged 14 years or older) and clients with depression or a stress-related mental health condition. These trials were conducted as part of the welfare reform package (introduced between July 2012 and July 2013) and the associated Investment Approach[1]. Trialling different approaches to assess whether they increase the number of people obtaining sustainable work, is a key part of the investment approach.

The Sole Parent Employment Service and Mental Health Employment Service trials were evaluated using a randomised control trial design

The evaluation of the trials aimed to assess whether clients who participated in externally contracted case management services spent a greater proportion of time off main benefit compared with clients who participated in MSD-delivered case management services.

A randomised control trial (RCT) was used to evaluate the effectiveness of the Sole Parent Employment Service (SPES) and Mental Health Employment Service (MHES) trials. For each service, the RCT compared two parallel groups (an intervention group and a control group). The intervention group received case management services delivered by a contracted provider, which were tailored to clients' individual needs, while the control group continued to receive their normal statutory entitlement and MSD-delivered case management service (eg General Case Management, Work Search Support, or Work Focused Case Management). All clients allocated to the intervention or control group were included in the outcomes analysis. Participation in the trial and the evaluation was voluntary.

The primary outcome for the evaluation was time spent off main benefit (which is used as a proxy measure for employment). Time off main benefit was measured in two ways, through: (1) an interval outcome measure which was the percentage of time off main benefit for each four-week period after assignment to intervention or control group; and (2) a cumulative outcome measure which was the cumulative number of days off main benefit. Data for the analysis was drawn from MSD benefit and contract management systems. Provider reporting data was also used to assess levels of intervention group engagement and reasons for exiting the service.

Engagement and retention of clients in the service and placement in employment was lower than anticipated for both trials

Provider contractual agreements stated that 52% of SPES clients and 50% of MHES clients were expected to be placed into employment that aligned with their work obligations. Of those who were placed in employment, 80% were expected to remain in the employment for a period of twelve months. However, process information drawn from provider reporting data showed that these expectations were not met and that, in

[1] This is ultimately about MSD directing its spend on supports and services, based on best evidence available, to where it can be most effective at improving clients' outcomes.

both trials, a high proportion of clients exited the service early or without obtaining a work placement.

Nearly half (45%) of the SPES clients and half (50%) of the MHES clients exited the intervention early because they were not fully engaged by the providers.

- SPES intervention group clients exited early because they: had a change in circumstance which meant that the service was no longer suitable for them (21%); were not able to be contacted by the provider (10%); or were not participating in the service (9%). Another 5% exited for medical reasons.
- MHES intervention group clients exited early because they: were not participating in the service (21%); were not able to be contacted by the provider (11%); or had a change in circumstance, which meant that the service was no longer suitable for them (8%). Another 10% exited for medical reasons.

After allocation to the SPES or MHES intervention group about a quarter of clients (SPES 26.5%; MHES 25%) remained in the service for six months but then exited as they had not been placed in employment by the end of the six month service period (as per the provider contract). Note: these figures exclude those described above who exited early.

Around one in seven (15.1%) SPES clients exited the service having successfully spent 12 months in continuous employment since placement. Similarly, one in eight (12.3%) MHES clients exited the service having successfully spent 12 months in continuous employment since placement.

The SPES and MHES externally contracted case management services did not increase clients' time off main benefit compared with MSD-delivered case management

Results for the SPES trial showed that for sole parent clients, with a youngest child aged 14 years or older, externally contracted case management was no more effective than MSD-delivered case management. The comparison of the intervention and control groups' interval and cumulative outcome estimates for time off main benefit were not significantly different from each other.

Initial results in the mid-trial report had indicated that the SPES might prove effective. However, the final results showed that although the estimate for the cumulative days off main benefit for the intervention group compared with the control group, tracked above zero (between 4 and 6 days above the control from 40 to 84 weeks after allocation), the confidence interval included zero. Hence, the difference between the groups is not statistically significant.

Part way through the SPES trial, the eligibility criteria were extended to include sole parents with children aged between 5 and 13 years. It is not known whether the SPES for sole parent clients with younger children is more effective than MSD-delivered case management, as this group was not included in the evaluation due to a lack of a suitable control group.

As with the SPES trial, results for the MHES trial showed that, for clients with depression or a stress-related mental health condition, externally contracted case management was no more effective than MSD-delivered case management. For both the interval and cumulative outcome measures results from the intervention and control groups were not

significantly different from each other. As the mid-trial report indicated that there were difficulties in MHES providers' engaging clients and obtaining employment outcomes, the MHES was discontinued and the service redesigned. MHES has since been replaced with the Work to Wellness service, a specialised employment service for people with a mental health condition. Insights from the evaluation and the service redesign process contributed to the development of Work to Wellness.

The redesigned Work to Wellness service has a different way of selecting and engaging with clients, as well as a different payment model and outcome measures compared with the MHES.

Conclusions

These two externally contracted case management trials did not show an increase in clients' time spent off main benefit beyond what was achieved through MSD-delivered case management approaches.

If similar trials are conducted in the future, refining the targeting, referral and engagement aspects of the services may help improve outcomes. Improvements in the monitoring information obtained from external providers may also assist with evaluation and subsequent service development.

Introduction

Purpose of the report

This report outlines the findings from evaluations of two trials of externally contracted case management services conducted by the Ministry of Social Development (MSD). The two trials were designed to improve employment and social outcomes for sole parent clients and clients with depression or a stress-related mental health condition. The evaluation of the trials aimed to assess whether clients who participated in externally contracted case management services, spent a greater proportion of time off-benefit compared with clients who participated in MSD-delivered case management services.

Background to the trials

Improving employment and social outcomes for clients

The Welfare Reform package introduced between July 2012 and July 2013 introduced a stronger work focus for a greater number of clients; adopted a long-term view and encouraged early investment where support was likely to reduce the risk of long term benefit dependence; improved incentives for people to work; and encouraged personal responsibility rather than dependence.

The reforms aimed to create a welfare system that reduced benefit dependency; was work-focused and expected and rewarded independence; was flexible and supported an investment approach[2], focused resources where the returns would be greatest; was able to work with as many people as possible to support them into work; and improved outcomes through ensuring children get health services and education.[3]

Trialling different approaches is part of the investment approach

Conducting trials using different approaches to increase the number of people obtaining sustainable work is a key part of the investment approach. Two trials, focused on improving outcomes for client groups who may face complex challenges in obtaining and retaining employment, were implemented. The trials used externally contracted employment-related case management and wrap-around employment support designed for clients (1) who were sole parents or (2) who had depression or a stress-related mental health condition recorded. The aim was to draw on expertise within non-government organisations (NGOs) and the private sector to obtain employment outcomes for more people.

[2] This is ultimately about MSD directing its spend on supports and services, based on best evidence available, to where it can be most effective at improving clients' outcomes.
[3] https://www.msd.govt.nz/about-msd-and-our-work/work-programmes/better-public-services/long-term-welfare-dependence/index.html

Summary of approaches that helped clients into employment

Enablers and barriers for 'sole parents'

There are a range of factors influencing sole parents' likelihood of employment. These include supply-side factors such as the availability of suitable employment as well as factors relating to a sole parent's circumstances. Work-ready sole parents receiving welfare assistance tend to have marketable qualifications, skills or work experience, and few of the more complex life circumstances that can limit ability to find and sustain employment. Some work-ready sole parents face few if any barriers to employment, are highly motivated to work, and have supports in place (such as ready access to informal childcare) that will enable their participation in employment (Hasluck & Green, 2007).

Other sole parents face a range of barriers to employment including: difficulties finding suitable jobs with sufficient pay, hours and employment conditions that allow them to meet parenting responsibilities; difficulties finding affordable, reliable childcare that they and their children feel comfortable using; or difficulties with transport. In addition, some who have had long periods out of work may lack confidence, motivation, up-to-date skills, or knowledge about available childcare and in-work financial assistance. Complex life circumstances, life shocks[4] and accumulated adversity may increase the need for additional support for sole parent clients (Hasluck & Green, 2007).

In the 2007 Working for Families survey, the barriers reported most frequently by sole parents who were available for, but not in, work were: finding a job that suited them (77%); getting work that paid enough (67%); getting enough hours for the job to be worthwhile (66%); having the skills employers wanted (64%); preferring to look after their children rather than use childcare (57%); cost of or access to transport (40%); suitable childcare not being available (34%); caring for someone in their family with a health problem (27%); and having a health problem or disability themselves (25%) (Inland Revenue & Ministry of Social Development, 2007).

Given the range of potential barriers facing some sole parents, evidence summarised by MSD indicates that the following measures may help them obtain and sustain employment.

- **Use of case management** that involves greater client contact with more support and assistance for targeted clients who have greater needs. There is good evidence that more intensive case management is beneficial for those disadvantaged in the labour market, such as sole parents. The quality and stability of personal relationships with case managers appears to be a key parameter for successful return to work (Cebulla, Flore, & Greenberg, 2008; Hasluck & Green, 2007).
- **More active case management** approaches may also incorporate work obligations for job seekers. Evidence suggests that increased monitoring of job search behaviour and less severe consequences for not meeting obligations are effective in generating incentives to leave unemployment benefits. However, individual circumstances need to be taken into account when implementing any consequences (Arni, Lalive, & Van Ours, 2013; Immervoll, 2010). Work obligations have been shown to increase benefit exits, and in some cases employment and earnings outcomes (Greenberg & Cebulla,

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[4] For example, recent separation/divorce, domestic violence, the occurrence of ill-health and/or disability within a family.

2008; Hamilton, 2002). But, obligations and sanctions are less effective when jobs are scarce.

- **Face-to-face assessment of each client's circumstances** enables the right assistance to be targeted to individual client's requirements. Clients who have job skills may require only job search services. However, other clients may require more advice and guidance, or "stair cased" employment or training interventions before they are ready to search for work[5] (Hasluck & Green, 2007).
- **Providing specialist, work-focused advice and guidance** to work ready and motivated sole parents can help them move into employment more quickly[6] (Cebulla, Flore, & Greenberg, 2008; Hasluck & Green, 2007).
- **Funding for participation in tertiary study** has been shown to have a positive effect in helping sole parents obtain employment in the long-term[7] (Adamson, 2004).
- **Formal education or training** programmes have a smaller impact on sole parents' employment than employment programmes in the short-term. However, they may have larger long-term employment impacts (Hansen, 2005).
- **Short-term work-focused training** has been shown to be effective in increasing employment when it provides job-specific training linked to employment opportunities (Speckesser & Bewly, 2006).
- **Mental health treatment services integrated with supported employment**[8] is effective at improving employment outcomes for sole parents with mental health difficulties (Modini et al., 2016; OECD, 2015).
- **Financial incentives**[9] can be effective at 'making work pay' by creating an appreciable income gap between benefit and paid employment, taking into account the costs of working (eg, childcare, transport to work). In-work benefits (eg, in-work tax credits) are most effective when targeted at groups with labour market challenges (Brewer, Browne, Chowdry, & Crawford, 2011; Martinson & Hamilton, 2011; OECD, 2008).

Enablers and barriers for clients with 'depression or a stress-related mental health condition'

The causes of health and disability conditions, including common mental health conditions, are often individual and complex and involve biological, psychological, social and environmental factors (Gordon Waddell & Burton, 2006). These conditions can present significant barriers to gaining and retaining employment (Baker & Tippin, 2008; Jayakody & Stauffer, 2000;OECD, 2015). Evidence suggests that intervening early with

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[5] This also applies to young parents, sole parents with children aged 0-4 years with work preparation obligations, and sole parents with children aged 5-13 years with part-time work obligations.
[6] For example, the COMPASS programme in New Zealand increased participants' probability of cancelling benefit for employment, and the New Deal for Lone Parents (NDLP) in the UK has had a substantial significant positive impact in moving clients off benefit. The NDLP is a voluntary programme (Cebulla et al., 2008).
[7] This also applies to young parents and sole parents with children aged 0–13 yrs.
[8] Supported employment includes integrated personal and vocational assistance.
[9] Financial incentives are mechanisms such as in-work benefits, minimum wages and wage subsidies.

integrated approaches across health, education and employment sectors is more likely to lead to successful outcomes (OECD, 2015).

Interventions that provide intensive support and integrated personal and vocational assistance can improve employment outcomes for people experiencing mental health problems. A number of psychological and primary health care treatments have also shown improved employment outcomes (Butterworth & Berry, 2004). Delivering mental health services integrated with supported employment services improves their effectiveness (Derr, Douglas, & Pavetti, 2001; Drake, Bond, & Becker, 2013).

Collaborative pathways to recovery tailored to the individual's needs, encompassing all factors of their environment, effectively support incapacity benefit recipients into paid work but the evidence is mixed. Such programmes may use a combination of one-on-one support, formal training, practical support (including health condition management and case management) and strong links to the labour market (Gordon Waddell, Burton, & Kendall, 2008; Hoedeman, 2012; OECD, 2010; OECD, 2015). A stepped care approach is recommended by some which starts with simple, low-intensity, low-cost interventions that will be adequate for most sick or injured workers, and provides progressively more intensive and structured interventions for those who need additional help to return to work (Waddell & Aylward, 2010).

Overall, evidence suggests the following measures are potentially useful to incorporate in programmes aiming to improve employment outcomes for clients with health and disability conditions.

- **Active case management** with an individualised approach is extremely important for this diverse population. Interventions are more likely to be effective if they tackle the multiple barriers to employment that individual clients face (OECD, 2010; OECD, 2015).
- **Intensive case management approaches** that provide intensive services such as employability assessments, individual employment plans, job placements and on-going monitoring after placements have been shown to be effective in increasing short-term earnings and employment for some clients. Specialised services (such as individual therapy, individual needs based counselling) need to be readily available alongside these services (OECD, 2010; OECD, 2015). However, even the most effective strategies may not result in employment for some hard to place participants (Bloom, Loprest, & Zedlewski, 2011)
- **Case managers with a range of skills and resources** are needed to be effective in working with clients with health problems or disabilities (Donaldson, 2012).
- **Financial incentives**[10] can be effective at 'making work pay' by creating an appreciable income gap between benefit and paid employment, taking into account the costs of working, for example, transport to work (OECD, 2010). Research suggests financial incentives are more effective for younger disability benefit recipients (Kostøl & Mogstad, 2014).

[10] Financial incentives are mechanisms such as in-work benefits, minimum wages and wage subsidies.

- **Tackling stigma, prejudice and discrimination** is central to enabling people with mental ill-health conditions to find and stay in work[11] (OECD, 2010; OECD, 2015).

Enablers and barriers for 'long-term unemployed' work-ready clients

Long-term unemployed clients' prospects of returning to work are contingent on job availability and the clients' levels of accumulated disadvantage due to such factors as skills atrophy, failure to acquire new job skills, lower earnings potential, poorer health, and unfavourable employers' attitudes towards the long-term unemployed.

For these clients, evidence suggests that 'activation measures' (compulsory activities that are designed to increase job seekers' search efforts and reduce the incentives for job seekers to remain on benefit including the use of sanctions, such as suspension of benefit, for non-compliance) are one group of measures that are effective in promoting employment. However, caveats include that an overemphasis on getting work can lead to poor initial job matches and rapid returns to benefit. Compliance effects (people leaving benefit to avoid participation) can be maximised if the requirement to participate is signalled early (Card, Kluve, & Weber, 2010; OECD, 2010).

'Wage subsidies'[12] [13] are most effective when targeted at those with labour market disadvantages, such as long-term unemployed[14] (OECD, 2008). However, they are one of the most expensive forms of employment assistance and, if not run well, can result in unintended effects. For this reason, wage subsidies should be tightly targeted to disadvantaged job seekers and closely monitored to reduce abuse by employers (Boone & Ours, 2004).

The SPES and MHES contracted services used measures shown to improve employment outcomes

Services contracted to be delivered for sole parent clients with children aged 14 years and over[15]

Aims of the Sole Parent Employment Service (SPES)

The aim of SPES was to provide employment support to those clients on Jobseeker Support who had sole parent responsibilities, and where returning to full time work was possible due to their youngest dependant being 14 years or older. Contracted case

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[11] Most countries have anti-discrimination legislation and/or quotas. There is no evidence that they have addressed labour market disadvantage associated with disability. While protecting those in employment, they may act as a barrier to employers taking on people with disabilities (Mavromaras & Polidano, 2011; OECD, 2010).
[12] Wage subsidies are payments made to employers to top up the wages of low-productivity workers. They do not increase the income gap between benefit and work, but increase the likelihood of a low-skilled worker gaining employment.
[13] Wage subsidies involve paying employers to take on a person they would otherwise not hire. Wage subsidies differ from job creation subsidies in that they are temporary and aim to encourage an employer to take on a more disadvantaged job seeker over a less disadvantaged job seeker. In general job creation subsidies aim to create additional jobs in an economy by subsidising a firm's labour costs. Job creation subsidies are more likely to result in deadweight loss because a certain proportion of firms using the subsidy would have created the position anyway, in other words they did not need the subsidy.
[14] This also applies to 'work-ready' current Job seeker clients and 'Youth (<18)' clients.
[15] This information was drawn from the Sole Parent Employment Service Agreement.

management providers were to achieve this aim through employment-related case management and assistance in overcoming barriers to full time work, including employment placement and post-placement support.

The core functions of the contracted case management providers for sole parent clients are detailed in Appendix 1. Providers were to tailor their case management activities to the individual needs of clients. Therefore, services provided by providers would have varied across clients. As these were externally contracted services, information on the type and level of services provided for each client was not available for analysis in the trial evaluation.

Enrolment in the SPES service and exiting the service

Clients were referred to the service provider after clients had been contacted by MSD and had agreed to be part of the trial. Participation in the trial was voluntary. Each referred client was assigned a service intensity rating of medium, high or very high at the time of referral relating to their barriers to employment. This rating influenced the level of payment to the provider.

The client's enrolment and acceptance by the provider was subject to an initial meeting between the client and the provider to confirm their suitability for the service and conduct a needs assessment and develop an initial employment plan with the client. This was to be conducted within one month of client referral.

Services to the client were limited to twelve months after the client's initial placement into employment. However, if the client was not in employment within six months of enrolment, or a client was placed into employment but exited that employment and did not achieve another employment outcome within six months of their original employment commencing, then the service ceased at that time.

In addition, if the client withdrew their consent to participate in the service, the provider chose to withdraw offering services to the client, or MSD withdrew the client from the service, then the service ceased.

Provider payment for services

Providers were paid for activities and the following specified outcomes. Initial enrolment and assessment activities were paid at a rate relating to the client's intensity rating. When a client was placed in employment, providers were paid a fee based on a variable scale according to number of hours per week (minimum of 20 hours per week) and the client's intensity rating (up to a maximum of one placement). If a client retained employment for 6 continuous months and for 12 continuous months, a fee was paid for each based on a variable scale according to number of hours per week and the client's intensity rating.

Outcomes expected from participation in the service

It was expected that, as a result of their participation in the service, 52% of clients would be placed into employment that aligned with their work obligations. Of the 52% who were placed in employment, 80% were expected to remain in the employment for a period of twelve months.

The evaluation focuses on off-benefit outcomes as these are able to be derived from MSD administrative data. Off-benefit outcomes are a proxy for employment outcomes, although they are not an exact match as people also exit from benefits for reasons other than employment. Information on employment outcomes will be available in the report *Effectiveness of MSD employment assistance: 2015/16*, available in 2018.

Location of the services

The contracted case management services were delivered by providers within: Auckland, Bay of Plenty, Canterbury, East Coast, Nelson, Taranaki, and Wellington regions.

Eligibility for SPES was extended but the evaluation retained the original eligibility criteria

In June 2014, the SPES trial was extended to include clients on a Sole Parent Support benefit with a youngest child aged from 5 to 13 years. These clients were not included in the evaluation analysis as the control group clients were restricted to the original trial group of sole parents clients with a youngest child aged 14 or more years of age.

Services contracted to be delivered for clients with depression or a stress-related mental health condition[16]

Aims of the Mental Health Employment Service (MHES)

The aim of the MHES was to support clients with common mental health conditions to gain work and achieve sustainable employment. Contracted case management providers were to achieve these aims through the provision of employment-related case management, placement and post-placement support, integrated with the client’s clinical support. The target group for the service was job seekers registered with Work and Income who were willing to undertake full-time employment but were limited in their capacity to look for or be available to work because of common mental health issues such as anxiety, stress or depression.

The core functions of the contracted case management providers for clients in the MHES are detailed in Appendix 1. Providers were to tailor their case management activities to the individual needs of clients. Therefore, services provided by providers would have varied across clients. As these were externally contracted services, information on the type and level of services provided for each client was not available for analysis in the trial evaluation.

Enrolment in the MHES service and exiting the service

Clients were referred to the service provider after clients had been contacted by MSD and had agreed to be part of the trial. Each referred client was assigned a service intensity rating of medium, high or very high at the time of referral relating to their barriers to employment. This rating influenced the level of payment to the provider.

The client’s enrolment and acceptance by the provider was subject to an initial meeting between the client and the provider to confirm their suitability for the service; request

[16] The information in this section was drawn from the Mental Health Employment Service agreement.

the clients consent to share information; and conduct a needs assessment and develop an initial employment plan with the client.

Services to the client were limited to 12 months after the client's initial placement into employment. However, if the client was not in employment within 6 months of enrolment or a client was placed into employment, but exited that employment and did not achieve another employment outcome within 6 months of their original employment commencing then the service ceased at that time.

In addition, if the client withdrew their consent to participate in the service, the provider chose to withdraw offering services to the client, or the MSD withdrew the client from the service, then the service would have ceased.

Provider payment for services

Providers were paid for activities and the following specified outcomes. Initial enrolment and assessment activities were paid at a rate relating to the client's intensity rating. When a client was placed in employment, providers were paid a fee based on a variable scale according to number of hours per week (a minimum of 5 hours per week) and the client's intensity rating (up to a maximum of one placement). If a client retained employment for 6 continuous months and for 12 continuous months, a fee was paid for each based on a variable scale according to number of hours per week and the client's intensity rating.

Outcomes expected from participation in the service

It was expected that, as a result of their participation in the service, 50% of clients would be placed into employment that aligned with their work obligations. Of the 50% who were placed in employment 80% were expected to remain in the employment for a period of 12 months.

The evaluation focuses on off-benefit outcomes as these are able to be derived from MSD administrative data. Off-benefit outcomes are a proxy for employment outcomes. As noted above, off-benefit outcomes are not an exact match for employment outcomes as people also exit benefits for reasons other than employment. Information on employment outcomes will be available in the report *Effectiveness of MSD employment assistance: 2015/16*, available in 2018.

Location of the services

The MHES contracted case management services were delivered by providers within: Auckland, Canterbury, Southern, and Waikato regions.

Discontinuing MHES services and ceasing the trial

From June 2014, although clients were referred to providers, no new clients were added to the MHES evaluation control group. Therefore, the evaluation of the MHES contracted case management includes clients enrolled in the service from inception in September 2013 to 9 June 2014.

The service in the form contracted in 2013 ceased in June 2016 and was replaced with a new service called Work to Wellness. Modifications to the service were made based on findings from the mid-term evaluation report and a service redesign process. The mid-

trial report had indicated that the service was not achieving outcomes and had a high drop-out rate during the referral process and after enrolment in the service. The MHES mid-trial report results are consistent with results in this report.

Evaluation approach and methods

Evaluation purpose and scope

The evaluation of the MHES and SPES contracted case management trials aimed to assess whether clients who participated in these services spent a greater proportion of time off-benefit in the months after assignment to the service compared with clients that participated in MSD-delivered case management services.

Other outcomes (such as employment and income) will be available in *The Effectiveness of MSD employment assistance: 2015/16* report, available in 2018.

A randomised control trial (RCT) was used to evaluate the effectiveness of the SPES and MHES trials

For each of the services (SPES and MHES), the evaluation design comprised a randomised control trial (RCT) that compared two parallel groups (an intervention group and a control group). The intervention group participated in case management services delivered through a contracted provider while the control group continued to receive their normal statutory entitlement and MSD-delivered case management service (eg general case management, work-search support, or work-focused case management). The control group were able to be selected for all internal case management services for which they were eligible.

The randomisation process aims to ensure that the intervention and control groups are largely equivalent. The allocation ratio for the intervention to control group was 2:1. That is, for every two clients assigned to the intervention group, one client was assigned to the control group.

All participants allocated to the intervention group or control group were included in the analysis of service effectiveness. This approach is called an intention-to-treat design. Therefore, any selection processes operating after the allocation process, that might have affected who participated in the service, did not affect the clients included in the analysis and the equivalence of the groups.

This means that the evaluation considers the ‘effectiveness’ but not the ‘efficacy’ of the services. That is, it tests the effectiveness of the service and processes that operated as a whole from the time of allocation to intervention and control groups to the assessment of outcomes. It does not provide information on the sub-group of clients who participated fully in the service and does not test the specific case management practices used.

SPES participants – eligibility criteria and data sources

The eligibility criteria for inclusion in the trial evaluation were that the client was: a Work and Income client aged between 18 and 59 years; on a Jobseeker Support benefit with full-time work obligations; and with a youngest child aged 14 years. Only clients who indicated a willingness to participate in the service were included in the trial and evaluation. That is, participation in the trial and the evaluation was voluntary.

Clients were excluded from the service for a number of reasons including that they were: outside the support area of a contracted service; considered unsafe for a variety of reasons; part of a residential support service; deaf; without a recorded telephone number; previously phoned as part of the MHES trial; or covered by a Power of Attorney.

Clients could also decline to participate in the service after their referral to the provider. The provider could refuse to accept/enrol a client if the provider was unable to contact the referred client after 15 working days or if the provider declined to accept the individual onto the service, for example, if they considered they had a conflict of interest.

The data used in the evaluation is sourced from MSD benefit-related data and the Service Outcome Reporting Tool (SORT) which includes provider reporting data. Provider reporting data was used to assess intervention group engagement and reasons for exiting the service.

MHES participants – eligibility criteria and data sources

The eligibility criteria for inclusion in the trial evaluation were that the client was: a Work and Income client aged between 18 and 59 years; on a Jobseeker Support benefit with deferred work obligations; and with any incapacity code of depression or stress. Only clients who indicated a willingness to participate in the service were included in the trial and the evaluation.

Clients were excluded from the service for a number of reasons including that they were: outside the support area of a contracted service; had one of a range of incapacity types (such as cancer, multiple sclerosis, Parkinson’s disease, muscular dystrophy, stroke, bipolar disorder, schizophrenia); pregnant; considered unsafe for a variety of reasons; part of a residential support service; deaf; terminally ill; without a recorded telephone number; or previously part of selected trials.

Clients could also decline to participate in the service after their referral to the provider. The provider could refuse to accept/enrol a client if the provider was unable to contact the referred client after 15 working days or if the provider declined to accept the individual onto the service, for example, if they considered they had a conflict of interest.

The data used in the evaluation is sourced from MSD benefit-related data and the Service Outcome Reporting Tool (SORT), which includes provider reporting data. Provider reporting data was used to assess intervention group engagement and reasons for exiting the service.

Outcome measures for the SPES and MHES evaluations focus on time off main benefit

The primary outcome for the evaluation is the time spent off main benefit. Two measures of time spent off main benefit have been used to assess whether the intervention group’s time off main benefit differed from the control group’s time off main benefit.

1. Interval outcomes: Time spent off main benefit during each four-week period after allocation. For this measure, the level of effectiveness (impact) of the intervention is

determined by calculating the difference between the intervention and control groups' average time spent off main benefit during each four-week period since allocation.

2. Cumulative outcomes: Cumulative number of days spent off main benefit since allocation. For this measure, the level of effectiveness (impact) of the intervention is determined by calculating the difference between intervention and control groups' average number of days off benefit in a time period from allocation up to a specific number of weeks after allocation. It provides a summative assessment of the interventions effectiveness.

Clients allocated to each of the services had varying follow-up times (length of time since allocation) as:

- the MHES group were recruited and allocated from September 2013 until 30 June 2014
- the SPES group were recruited and allocated from September 2013 and continue to be recruited.

This means that the total number of clients included in the analysis varies for each four-week period after allocation. Tables 3 and 4 (Appendix 2) show that the number of clients in the intervention and control groups reduces as the time from allocation increases. With reduced sample sizes available for calculation of outcome estimates, confidence intervals around the estimates of the difference between intervention and control groups increase. Therefore, the length of follow-up after allocation has been restricted to 124 weeks for the MHES evaluation and 84 weeks for the SPES evaluation.

Results

The SPES and MHES trials used similar recruitment, randomisation and analysis procedures

The recruitment, randomisation and analysis procedures were similar for the MHES and SPES evaluations. Figure 1 outlines the recruitment, randomisation and analysis sequence for the MHES evaluation, whereas Figure 2 outlines the same information for the SPES evaluation.

After clients had agreed to participate in the trial, they were randomly allocated to either intervention or control groups (refer to Figures 1 and 2).

Recruitment numbers for four week intervals are presented in Tables 3 and 4 (Appendix 2) for the MHES and SPES trials. These represent the number of clients assigned to either intervention or control groups after clients agreed that they would participate in the trial for each four-week period.

Figure 1: Participant flow diagram MHES

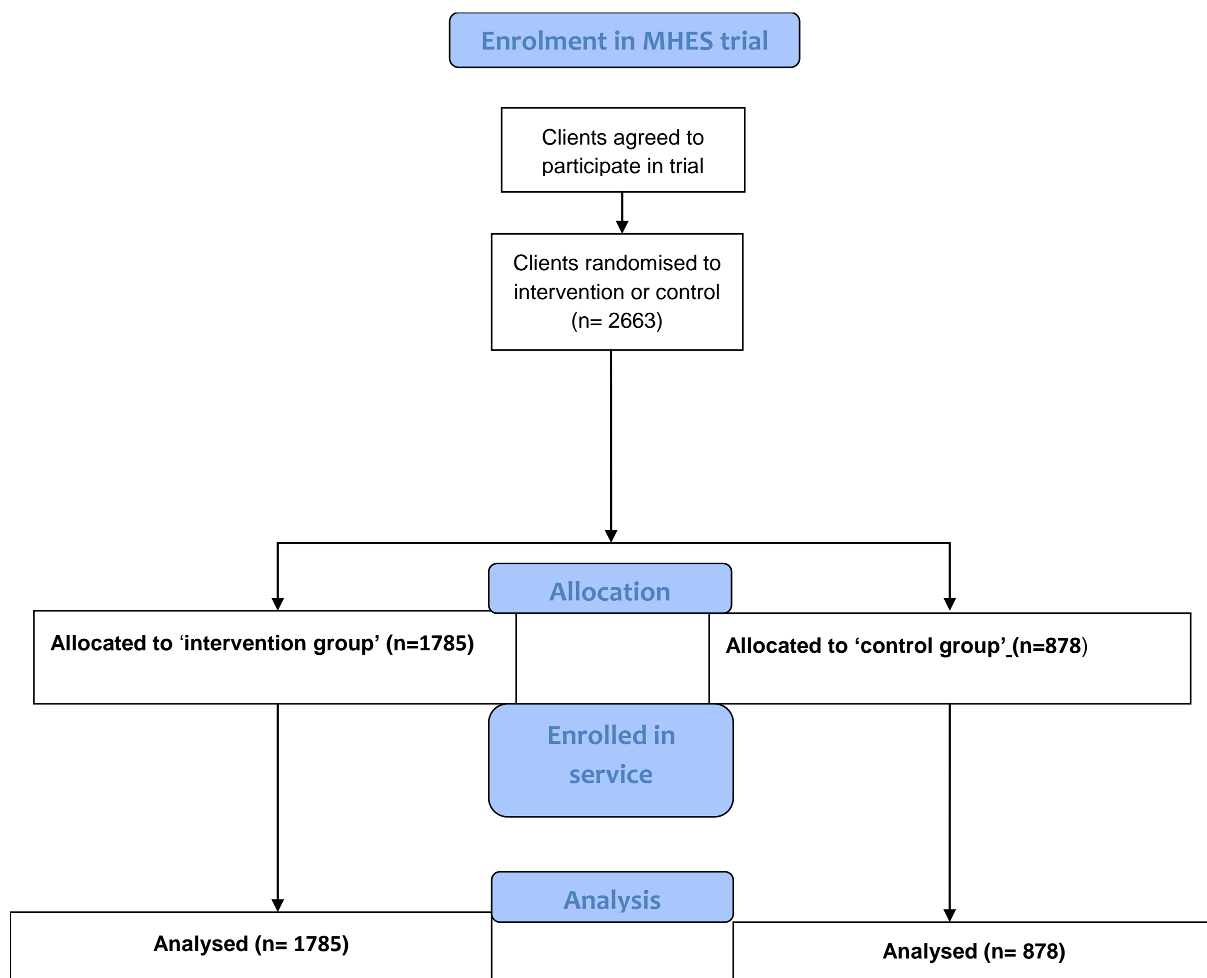
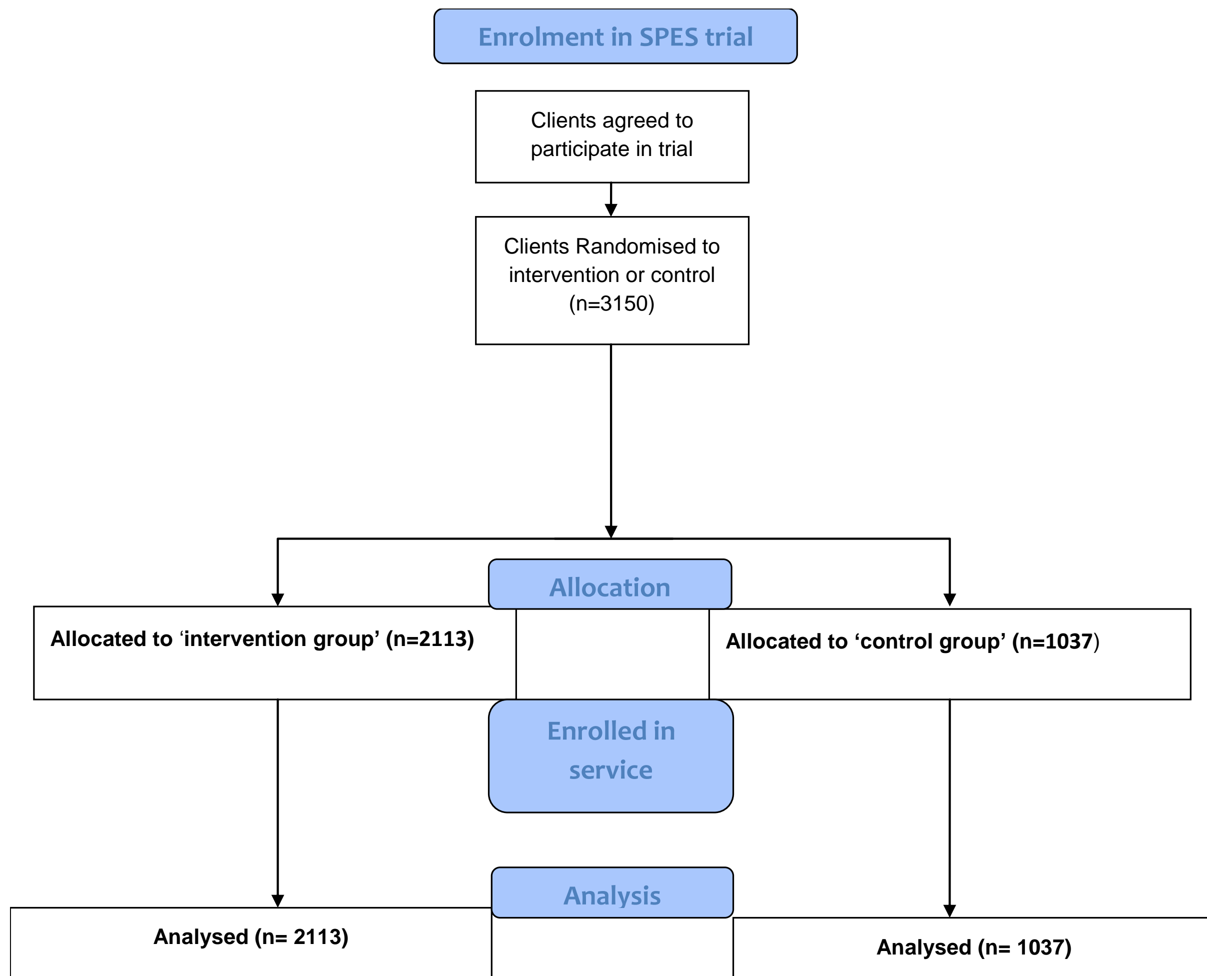


Figure 2: Participant flow diagram SPES



Recruitment, randomisation and analysis procedures for the MHES evaluation

Recruitment for the MHES evaluation started in September 2013 and ceased in June 2014. Overall, 1,785 intervention and 878 control participants were assigned during the first year of the evaluation. As recruitment stopped in June 2014, this was the maximum number of participants available for analysis.

For the MHES trial evaluation, a maximum of 1,785 intervention group participants and 878 control group participants were analysed. As noted above, the numbers available for analysis are dependent on recruitment levels across the timeframe of the trial. The number of intervention group participants available for analysis at 124 weeks after allocation was approximately 1,400 participants and the control group approximately 700 participants. It was decided to limit reporting of the results to 124 weeks because after this point estimates became imprecise, due to relatively low numbers of participants.

Recruitment, randomisation and analysis procedures for the SPES evaluation

Recruitment for the SPES evaluation started in September 2013 and results are analysed for those assigned up to October 2016. For the SPES evaluation, approximately 1,400 intervention and 700 control group participants were assigned during the first 12 to 14 months of the trial (refer to Appendix 2). However, the number of participants assigned was approximately 400 for the next 48 weeks and approximately 300 for the following 48 weeks. In total, 2,113 intervention participants and 1,037 control participants were assigned over the three years.

For the SPES trial evaluation, a maximum of 2,113 intervention group participants and 1,037 control group participants were analysed.

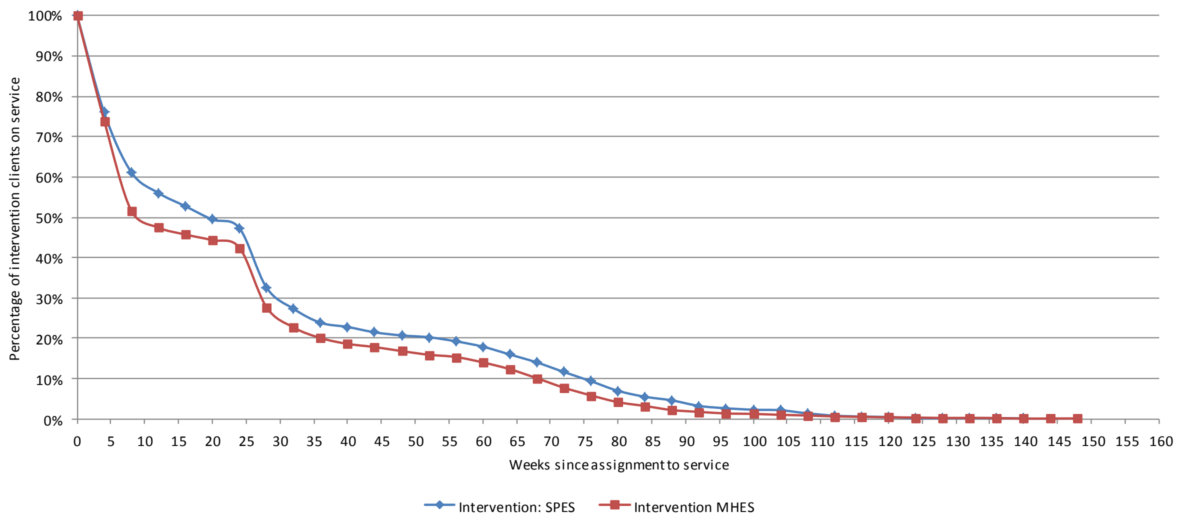
As noted above, recruitment for the trial was relatively high in the first 56 weeks, but much lower in the following two years. Therefore, at 84 weeks after allocation, about 1,500 intervention participants and 700 control participants were available for analysis. It was decided to limit reporting of results to 84 weeks because after this estimates of difference between groups became imprecise, due to relatively low numbers of participants.

MSD and provider reporting data indicated that many clients exited the MHES and SPES services early

MSD data indicated that the length of time clients participated in the services (MHES or SPES) after assignment varied considerably, with most (90−95%) having exited the service by 76 weeks.

Figure 3 shows that approximately half the evaluations' participants (56% of SPES and 47% of MHES) were still enrolled in the service at 12 weeks. That is, 44% of SPES and 53% of MHES clients had exited the service by 12 weeks. The percentage of participants remaining in the service at 24 weeks had dropped to 47% for SPES clients and 42% for MHES clients. At 28 weeks after allocation, only a third (33%) of SPES clients and just over a quarter (28%) of MHES clients were still enrolled in the service.

Figure 3: Percentage of clients participating in service for the weeks following allocation to the MHES or SPES



Provider reporting data was used to assess levels of engagement and reasons for exiting he service

Provider reporting data was used to assess levels of client engagement in the service and reasons for exiting the service. The reasons reported were limited to the predetermined categories in the provider reporting template.

The main reasons for exiting MHES included low levels of engagement with providers and not being placed in employment after six months service

Table 1 details the reasons that clients who were allocated to the MHES intervention group and referred to the service exited the service. During the course of the trial, well over a third of those allocated to the intervention group were not fully engaged by the providers as they exited because they: were not able to be contacted by the provider (11%); were not participating in the service (21%); or had a change in circumstance which meant that the service was no longer suitable for them (8%). Another 10% exited for medical reasons.

A quarter (25%) of the allocated intervention clients remained in the service for six months but then exited as they had not been placed in employment by the end of the six-month service period (as per the provider contract). One in eight (12.3%) exited the service having successfully spent 12 months in continuous employment since placement.

Table 1: Reasons for exiting the MHES as reported by providers

	Reasons for exiting MHES as reported by providers	Percentage
Targeting, engagement and retention reasons	Change in circumstances making client no longer suitable for the service	8.4%
	Client was not participating	20.6%
	Client was not contactable	10.6%
	Conflict of interest for provider or Unsafe or client is trespassed from provider premises	0.4%
	Client has moved elsewhere in New Zealand or has left New Zealand	3.6%
	Medical	10.0%
	Circumstances make employment unlikely in the next six months	6.2%
Obtaining or sustaining employment reasons	End of six-month service	24.9%
	Client unable to achieve continuous or subsequent employment post placement	3.0%
Service completed successfully	12 months in-work support has ended	12.3%
	Total	**100%**

The main reasons for exiting SPES included low levels of engagement with providers and not being placed in employment after six months service

During the course of the trial, well over a third of those allocated to the SPES intervention group were not fully engaged by the providers and exited early. Reasons for early exits included that they: had a change in circumstance which meant that the service was no longer suitable for them (21%); were not able to be contacted by the provider (10%); or were not participating in the service (9%). Another 5% exited for medical reasons (refer to Table 2).

Just over a quarter (26.5%) of the allocated intervention clients remained in the service for six months but then exited as they had not been placed in employment by the end of the six month service period (as per the provider contract). About one in seven (15.1%) clients exited the service having successfully spent 12 months in continuous employment since placement (refer to Table 2).

Table 2: Reasons for exiting the SPES as reported by providers

	Reasons for exiting SPES as reported by providers	Percentage
Targeting, engagement and retention	Change in circumstances making client no longer suitable for the service	21.0%
	Client was not participating	8.5%
	Client was not contactable	10.3%
	Conflict of interest for provider or Unsafe or client is trespassed from provider premises	0.9%
	Client has moved elsewhere in New Zealand or has left New Zealand	3.4%
	Medical	5.1%
	Circumstances make employment unlikely in the next six months	7.3%
Obtaining or sustaining employment	End of six-month service	26.5%
	Client unable to achieve continuous or subsequent employment post placement	1.9%
Service completed successfully	12 months in-work support has ended	15.1%
	Total	100.0%

There were no statistically significant differences between intervention and control groups for either trial

Outcome estimates of time off main benefit did not show statistically significant differences between intervention and control groups for either trial.

MHES did not increase time off main benefit for clients with depression and stress related mental health conditions

The evaluation found both the interval and cumulative outcome effectiveness measures used in the analysis indicated that there was no difference between the intervention and control groups' time off main benefit.

The interval outcome evaluation measure is the percentage of time off main benefit in each four-week period since allocation. Figure 4 shows the average percentage of days spent off main benefit in each four-week period following allocation for the intervention and control groups. The groups track closely to each other suggesting there is little difference between the groups.

Figure 5 confirms this suggestion. It details the difference between intervention and control groups average percentage time off main benefit in each four-week period after assignment. The result tracks closely to the 0.0% level for all time periods after allocation to a group.

Figure 4: Percentage time off main benefit in each four-week period by group (MHES evaluation)

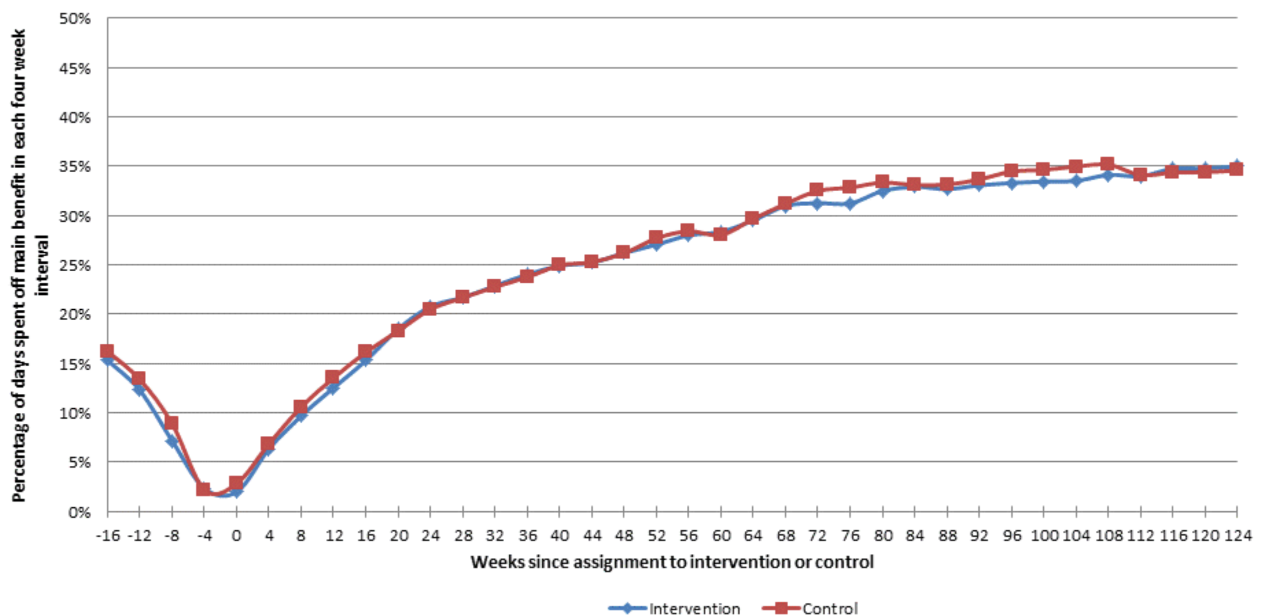
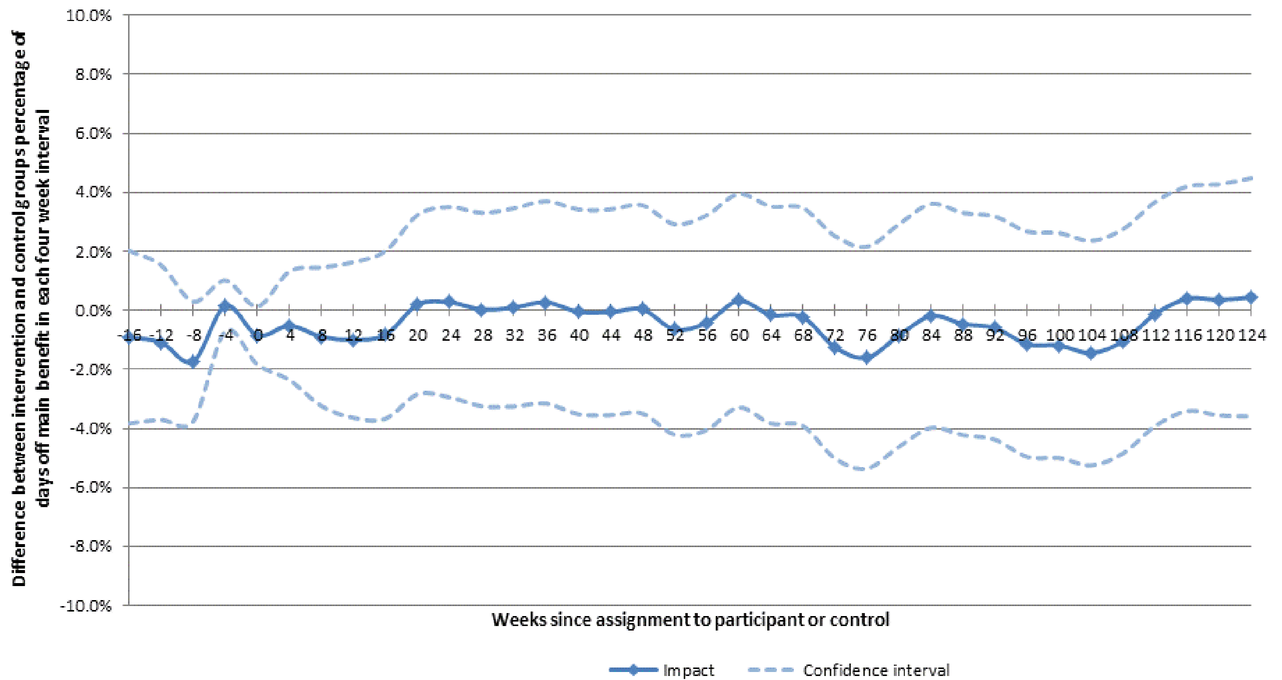


Figure 5: Difference between intervention and control groups' percentage of time off main benefit in each four-week period (MHES evaluation)



The cumulative outcome measure used to evaluate the effectiveness of the MHES trial is the cumulative amount of time off main benefit from allocation to the end of each four-week period. As with the interval outcome measure, results show the intervention and control groups' results track closely together (Figure 6). Figure 7 shows the difference between intervention and control groups' cumulative number of days off main benefit up to the end of each four-week period after allocation. These MHES evaluation results indicate that there was no statistically significant difference between the groups as the results track relatively close to the zero line.

Figure 6: Cumulative number of days off main benefit up to the end of each four-week period by group (MHES evaluation)

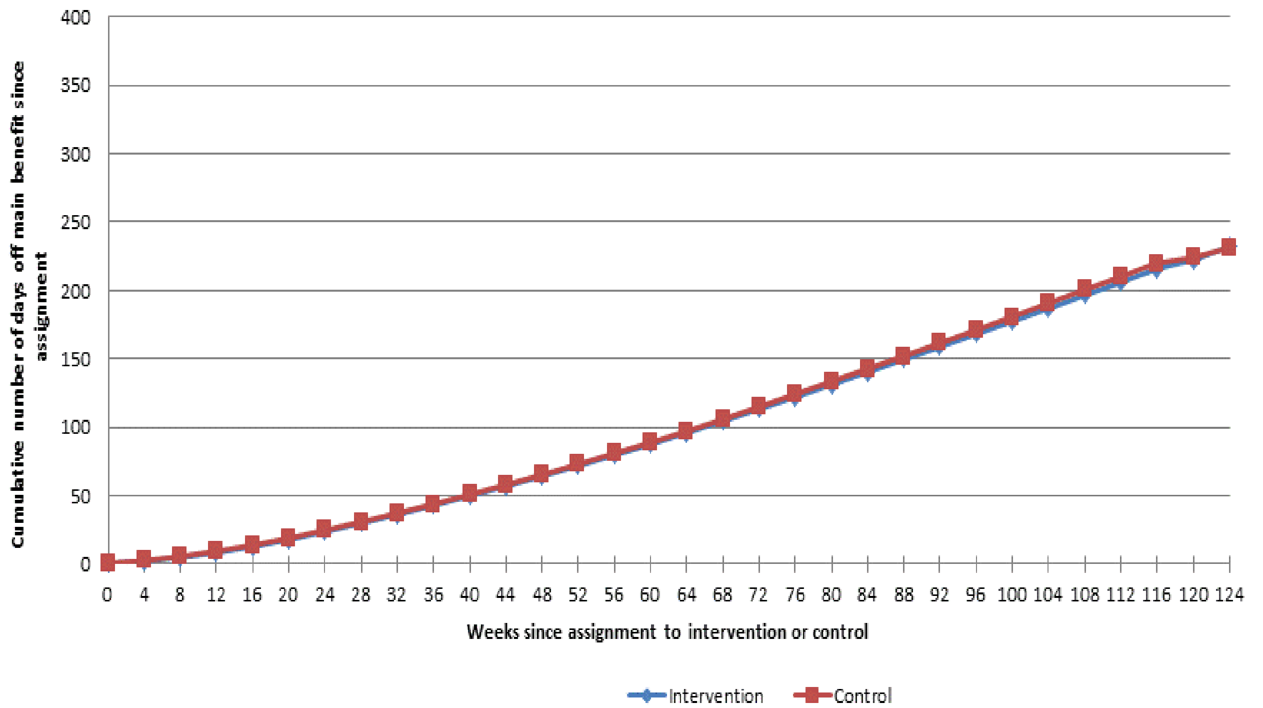
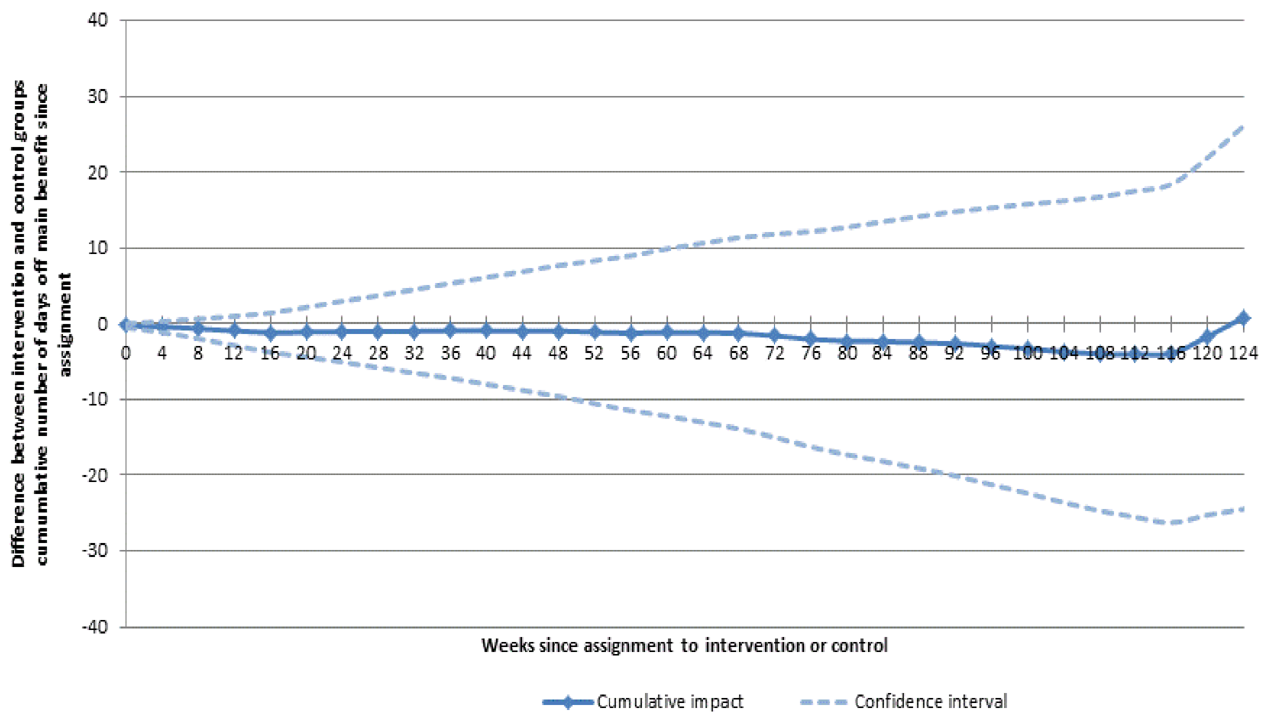


Figure 7: Difference between intervention and control group cumulative number of days off main benefit up to the end of each four-week period (MHES evaluation)



The SPES did not increase time off main benefit for sole parent clients

The evaluation found, similar to the MHES trial evaluation, both the interval and cumulative outcome effectiveness measures used in the analysis suggest that participation in the SPES trial did not increase clients' time off main benefit.

The interval outcome measure is the percentage of time off main benefit within each four-week period since allocation. Figure 8 shows the average percentage of days spent off main benefit in each four-week period for the intervention and control groups. The groups track reasonably closely to each other, although the intervention group line is above the control at certain points. Figure 9 shows the difference between the groups. It indicates that there is no statistically significant difference between the intervention and control groups. Although the estimate tracks above the zero line for the first 44 weeks, the confidence intervals include zero, indicating a non-significant result.

Figure 8: Percentage time off main benefit for each four-week period by group (SPES evaluation)

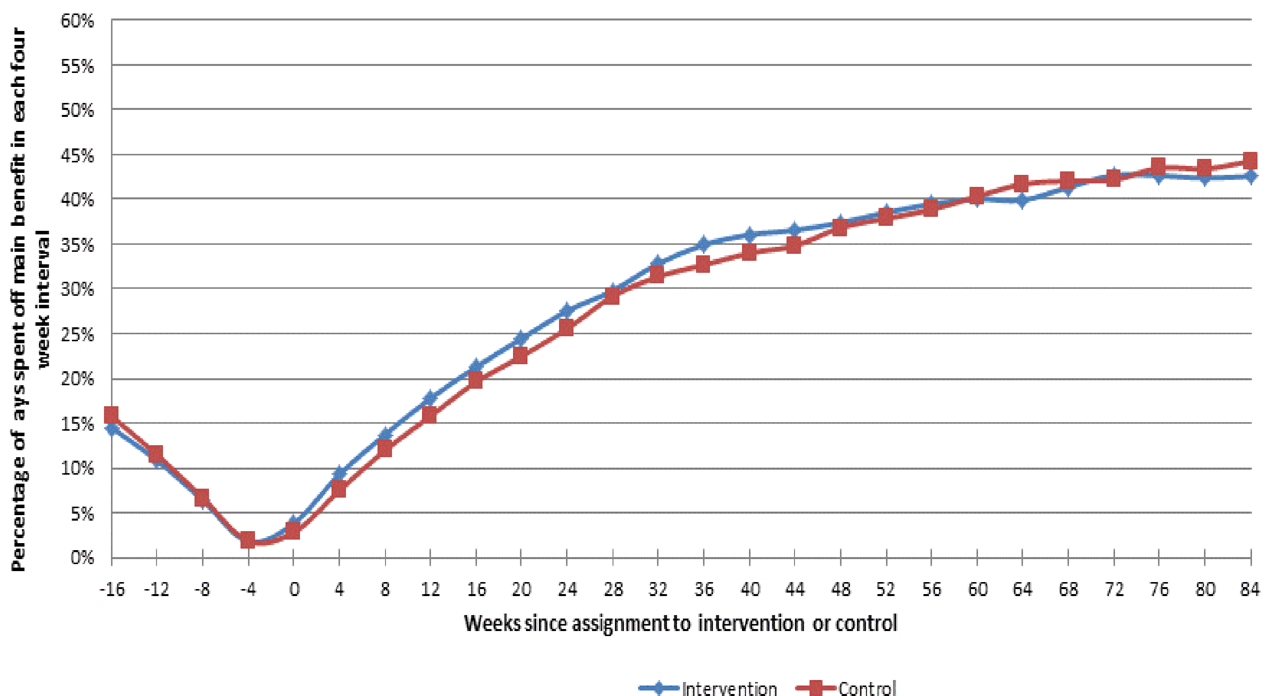
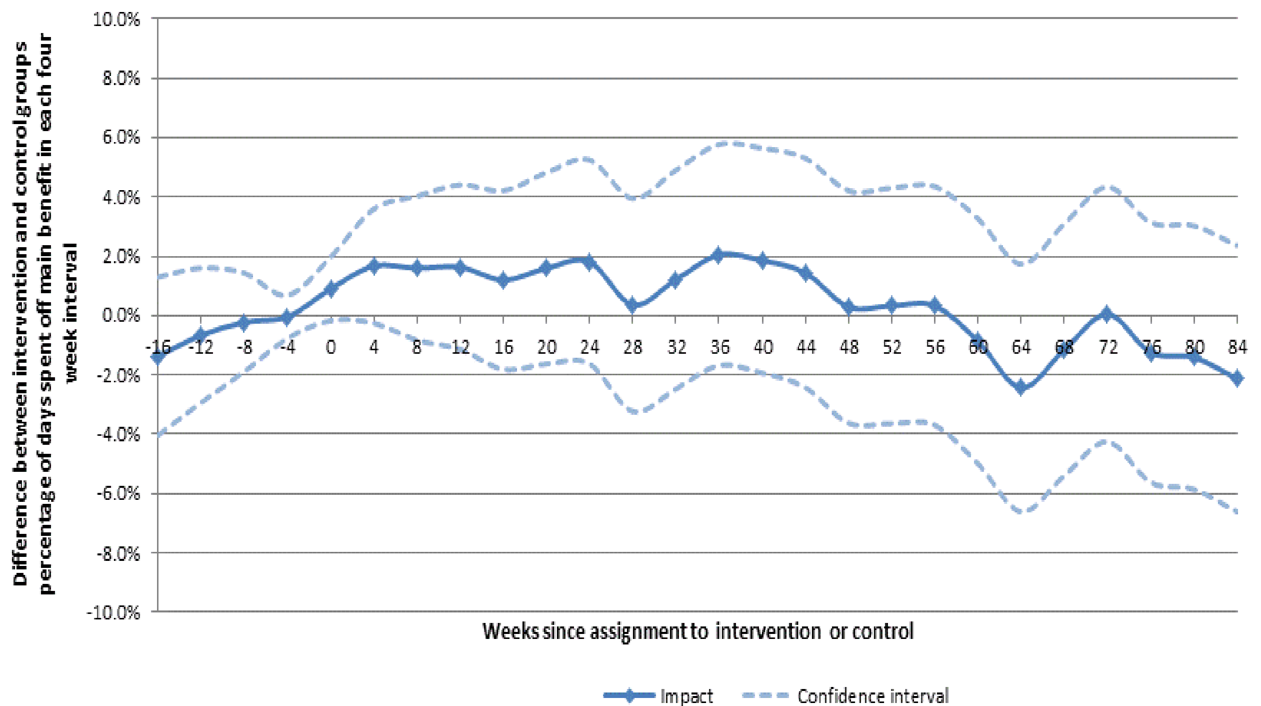


Figure 9: Difference between intervention and control groups' percentage time off main benefit for each four-week period (SPES evaluation)



The cumulative outcome measure used to evaluate the effectiveness of the trial is the cumulative number of days off main benefit up to the end of each four-week period. Results indicate the same story as the interval outcome measure, that is, the results do not show a statistically significant difference between the groups.

Figure 10 shows the cumulative number of days off main benefit for the intervention and control Groups. As with the interval outcome measure, the groups track closely to each other. Figure 11 shows the difference between the groups. Although the estimate tracks slightly above the zero line (between 4 and 6 days from 40 to 84 weeks after allocation), the confidence intervals are wide and include zero. Hence, the difference between the groups is not statistically significant.

Figure 10: Cumulative number of days off main benefit up the end of each four-week period by group (SPES evaluation)

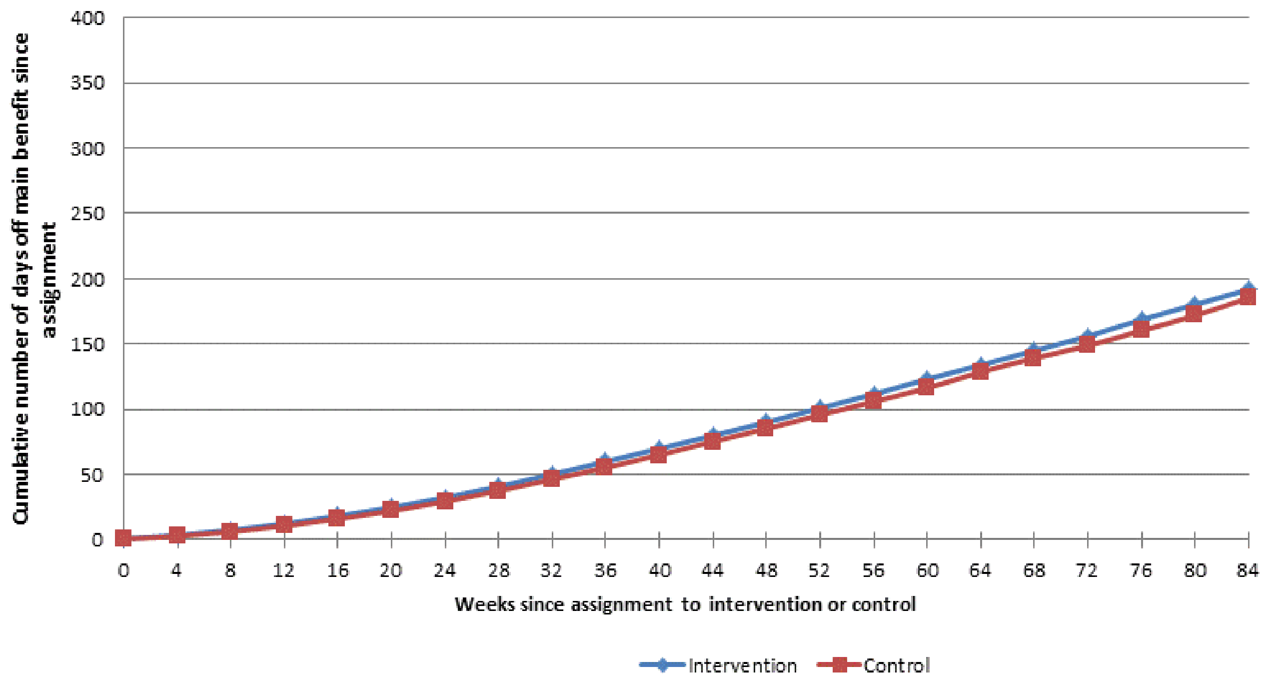
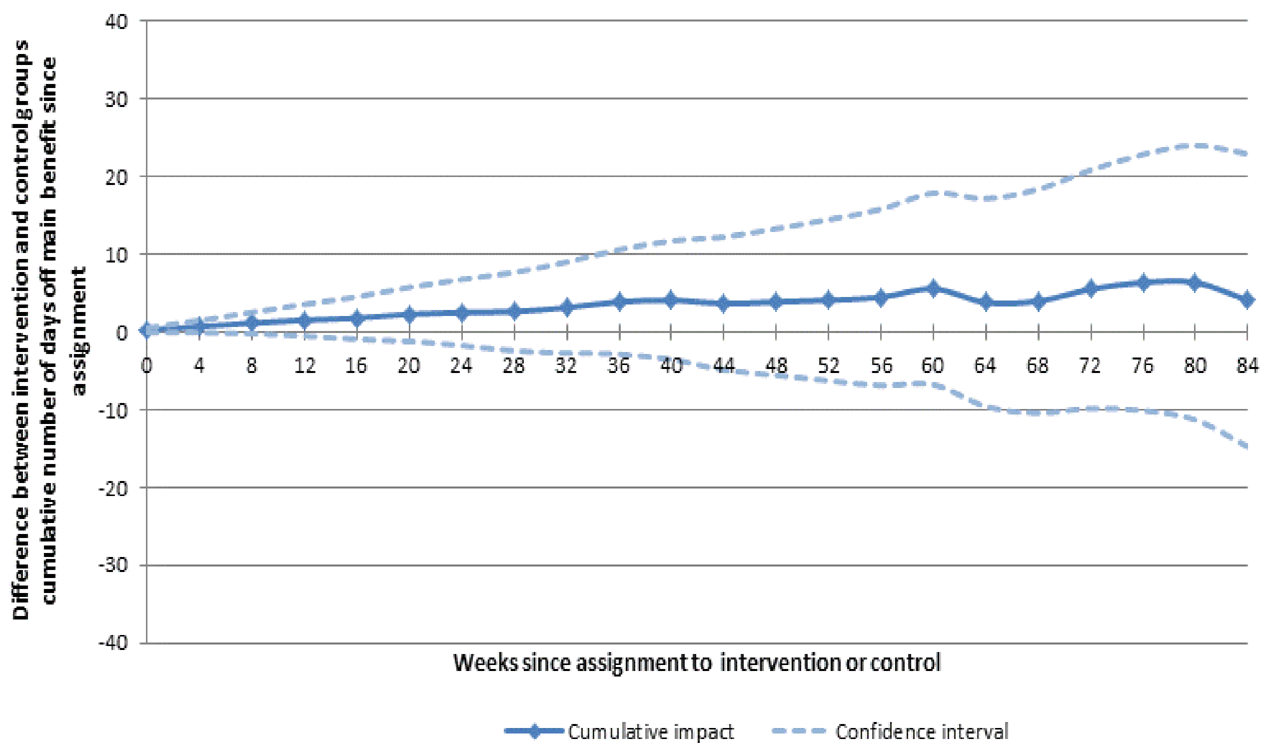


Figure 11: Difference between intervention and control groups cumulative number of days off main benefit up to the end of each four-week period (SPES evaluation)



Conclusions

The MHES and SPES trials tested new approaches for providing case management services to MSD clients with the aim of improving clients' employment outcomes. These trials were conducted as part of the Government's Welfare Reform package and associated investment approach.

The trials were evaluated using a randomised control trial (RCT) design using data derived from the MSD benefit system and Service Outcome Reporting Tool (SORT) which includes provider entered information. The evaluation used a proxy measure for employment outcomes which was the time clients' spent off main benefit. It was measured in two ways, through: (1) an interval outcome measure which was the percentage of time off main benefit for each four-week period after assignment to intervention or control group; and (2) a cumulative outcome measure which was the cumulative number of days off main benefit.

Main findings: Engagement and retention of clients was low and externally contracted case management was as effective as MSD-delivered case management

Results showed that the engagement and retention of clients in the services was lower than anticipated. Refining targeting, referral and engagement aspects of the services might assist in similar trials.

Results indicated that the SPES and MHES (case management services delivered by contracted providers) were no more effective than MSD-delivered case management. That is, the intervention and control groups' outcomes estimates were not significantly different from each other.

Initial results in the mid-trial report had indicated that the SPES service might prove effective. However, the final results showed that although the estimate for the cumulative days off main benefit for the intervention group compared with the control group tracked above zero (between 4 and 6 days above the control group from 40 to 84 weeks after allocation), the confidence intervals included zero. Hence, the difference between the groups was not statistically significant.

Part way through the SPES trial, the eligibility criteria for inclusion in the service were extended to sole parents with children aged between 5 and 13 years. It is not known whether the SPES for sole parent clients with younger children is more effective than MSD-delivered case management, as this group was not included in the evaluation due to a lack of suitable control group.

As with the SPES trial, results for the MHES trial showed that for clients with depression or a stress-related mental health condition, externally contracted case management was no more effective than MSD-delivered case management. For both the interval and cumulative outcome measures, results from the intervention and control groups were not significantly different from each other. As the mid-trial report indicated that there were difficulties in MHES providers' engaging clients and obtaining employment outcomes, the MHES was discontinued and the service redesigned.

Limitations

The RCT was an intention-to-treat design, which has considerable strengths in assessing effectiveness and minimising selection bias. However, it does mean that the specific components of the trial are not able to be evaluated separately and it also does not provide information on sub-groups of clients. That is, the evaluation tested the effectiveness of the service and processes that operated as a whole from the time of a client's allocation to intervention or control group to the assessment of outcomes. The analysis is confined to the impact of the two contracted case management services on the time spent off main benefit (excluding temporary suspensions to benefit entitlement).

Although time off main benefit was used as a proxy for employment, the evaluation does not confirm whether clients are in employment or not while they are off main benefit. However, information on employment outcomes will be available in the report *Effectiveness of MSD employment assistance: 2015/16*, available in 2018.

Where to next?

Overall, these two externally contracted case management trials did not show an improvement in outcomes for clients beyond what was achieved through MSD-delivered case management approaches.

Insights from the evaluation and the service redesign process contributed to the development of Work to Wellness, a specialised employment service for people with a mental health condition.

If similar trials are conducted in the future, refining the targeting, referral and engagement aspects of the services may help improve outcomes. Improvements in the monitoring information obtained from external providers may also assist with evaluation and subsequent service development.

MHES was discontinued and replaced by Work to Wellness

The evaluation and service redesign consultation indicated that there were difficulties in MHES external providers engaging clients and obtaining employment outcomes beyond what was being achieved through MSD-delivered case management. The MHES externally contracted service was subsequently discontinued, and from 1 July 2016 the service was replaced by *Work to Wellness*.

The redesigned *Work to Wellness* service has a different way of selecting and engaging with clients, as well as a different payment model and outcome measures compared with the MHES.

The outcomes sought for *Work to Wellness* are for 30% of participants to exit benefit as a result of employment, of which 90% will remain off benefit for 31 days and 60% will remain off benefit for 365 days. For those that do not achieve employment, the outcome sought is that 30% of participants will exit the service with increased work-readiness capacity.

Sole Parent Employment Service was discontinued

The final evaluation found that the SPES was no more effective than MSD-delivered case management services, yet is more expensive. MSD ceased funding for the SPES. The 15 SPES providers were informed of the decision and their contracts ceased on 30 June 2017. MSD will continue to deliver a range of existing initiatives for sole parents.

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Appendix 1: Core functions of contracted case management

The information contained in this Appendix was drawn from the Sole Parent Employment Service (SPES) Agreement and the Mental Health Employment Service (MHES) Agreement.

Core functions of contracted case management providers for sole parent clients (SPES)

The SPES contracted case management providers were responsible for the following:

- providing active case management of clients to support their achievement of employment outcomes aligning with their individual goals and benefit obligations.
- providing individualised needs assessment for each client, to identify their skills, barriers to employment and the supports required to overcome their identified barriers
- determining the level of service intensity required for a client
- developing an employment plan in conjunction with the client for the achievement of employment opportunities
- maintaining positive working relationships with existing services and organisations, including government agencies, community organisations, and family and whānau
- facilitating access to other services that can help provide further support for clients to overcome barriers to achieving and retaining successful employment outcomes.
- providing support and mentoring to clients including:
    - providing one-on-one career advice
    - outlining the benefits of employment, and increasing client's motivation and confidence to find employment
    - providing a comprehensive curriculum vitae and cover letter template for each client
    - providing opportunities for clients to practice interview techniques and learn about different approaches to responding to interviewers
    - coaching in job search techniques and understanding of job suitability; and
    - arranging employment positions for clients.
- actively assisting clients to find work quickly by:
    - supporting client's job search activities
    - identifying employment opportunities appropriate to the client's work preferences
    - brokering appropriate employment through their employer networks
    - assisting in the negotiation of any appropriate flexible working arrangements and training required, with employers
    - negotiating and funding any appropriate wage subsidy support with employers.
- providing on-going support to the client and their employer once the client has obtained employment to ensure that any issues or barriers that might impede the client's ability to remain in employment are addressed
- tailoring the degree of engagement and support to the needs of the client, their skills and preferences

- delivering the service in an environment that is positive, respectful and encourages the client to take responsibility for their actions and builds their capacity for achieving realistic goals.

Core functions of contracted case management providers for MHES clients

The MHES contracted case management providers were responsible for the following:

- providing active case management of clients to support them to achieve employment outcomes that aligned with their individual goals and benefit obligations
- seeking the client's consent to allow the sharing of client information between the Provider, MSD and the client's health and support providers
- conducting individualised needs assessment to identify a client's skills, barriers to employment and the support required to overcome these barriers
- confirming the client's service intensity rating
- developing a plan in conjunction with client to achieve employment opportunities aligning with the client's goals and obligations
- developing and maintaining positive working relationships with existing services and organisations, including government agencies, community organisations, family and whānau, and other services that can help provide further support for clients to overcome barriers to successfully achieving and retaining employment outcomes
- providing support and mentoring to clients including:
    - counselling on the benefits of employment
    - motivation and confidence building
    - resilience and personal development
    - skills and techniques counselling, including identification and management of any exacerbation of a condition and strategies for the management of these in the workplace.
- actively assisting clients to find work quickly by
    - supporting client's job search activities
    - identifying employment opportunities that are appropriate to the client's work preferences and obligations
    - brokering appropriate employment through their employer networks
    - assisting in the negotiation of any appropriate flexible working arrangements and training required, with employers; and
    - negotiating and funding any appropriate wage subsidy support with employers.
- providing on-going support to the client and their employer once the client has obtained employment to ensure that any issues or barriers that might impede the client's ability to remain in employment are addressed
- tailoring the degree of engagement and support to the needs of the client, their skills and preferences
- delivering the service in an environment that is positive, respectful and encourages the client to take responsibility for their actions and builds their capacity for achieving realistic goals.

Appendix 2: Recruitment numbers

Table 3: Mental Health Employment Service Recruitment for each four-week period since allocation

Time interval since allocation (28 days)	Number of participants in control group	Number of participants in intervention group
0	878	1785
1	878	1785
2	878	1785
3	878	1785
4	878	1785
5	878	1785
6	878	1785
7	878	1785
8	878	1785
9	878	1785
10	878	1785
11	878	1785
12	878	1785
13	878	1785
14	878	1785
15	878	1785
16	878	1785
17	878	1785
18	878	1785
19	878	1785
20	878	1785
21	878	1785
22	878	1785
23	878	1785
24	878	1785
25	878	1785
26	878	1785
27	878	1785
28	878	1785
29	878	1785
30	832	1693
31	777	1583
32	671	1371
33	568	1165
34	489	1007
35	415	859
36	344	717
37	229	487
38	45	104

Table 4: Sole Parent Employment Service Recruitment for each four-week period since allocation

Time interval since allocation (28 days)	Number of participants in control group	Number of participants in intervention group
0	1037	2113
1	1020	2079
2	1008	2055
3	999	2037
4	984	2007
5	950	1939
6	941	1921
7	941	1921
8	936	1911
9	924	1887
10	907	1853
11	896	1831
12	882	1803
13	870	1779
14	852	1743
15	838	1715
16	823	1685
17	806	1651
18	793	1625
19	774	1587
20	749	1537
21	733	1505
22	713	1465
23	693	1425
24	673	1385
25	669	1377
26	664	1367
27	645	1329
28	640	1319
29	616	1271
30	565	1169
31	539	1117
32	482	1003
33	437	913
34	341	722
35	315	670
36	258	556
37	186	412
38	67	146

Appendix 3: Exiting main benefit in first six months after allocation

Table 5 details the frequency and percentage of MHES clients exiting from the main benefit in the first six months after allocation to either the intervention or control group. The percentages across intervention and control groups are similar. Please note that the allocation ratio to the intervention and control groups was 2:1. Therefore, although the numbers differ, the percentages are similar.

Table 5: Frequency of MHES trial intervention and control group participants exiting main benefit in first six months after allocation to either intervention or control

	Intervention group		**Control group**	
	N	**%**	**N**	**%**
In employment/returned to work in first six months after allocation	105	5.9%	36	4.1%
Off main benefit for other reasons (not employment) in the first six months after allocation	425	23.8%	227	25.9%
Not off main benefit in first six months after allocation	1255	70.3%	615	70.0%
Total	**1785**	**100%**	**878**	**100%**

Table 6 details the frequency and percentage of SPES clients exiting from the main benefit in the first six months after allocation to either the intervention or control group. As for the MHES trial, the percentages across SPES intervention and control groups are similar.

Table 6: Frequency of SPES trial intervention and control group participants exiting main benefit in first six months after allocation to either intervention or control

	Intervention group		**Control group**	
	N	**%**	**N**	**%**
In employment/returned to work in first six months after allocation	414	19.6%	178	17.2%
Off main benefit for other reasons (not employment) in the first six months after allocation	487	23.0%	260	25.1%
Not off main benefit in first six months after allocation	1212	57.4%	599	57.8%
Total	**2113**	**100%**	**1037**	**100%**