

Implementing the SSI/SSDI Outreach, Access, and Recovery (SOAR) Model with Justice-Involved Populations: A Survey of Practitioners

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ABSTRACT

Under the leadership of the Substance Abuse and Mental Health Services Administration (SAMHSA), the SSI/SSDI Outreach, Access, and Recovery (SOAR) program was developed as a national model to improve disability application outcomes for adults experiencing homelessness. Although SOAR has been increasingly implemented in criminal justice settings, the model remains underutilized in this setting. Insights from SOAR practitioners may inform facilitators and barriers to implementing SOAR in justice-involved populations. The purpose of this study was to describe how SOAR has been implemented in justice settings (*Aim 1*), to identify facilitators and challenges to the use of SOAR for justice-involved adults (*Aim 2*), and to evaluate the success of the SOAR model in this population (*Aim 3*). Eligible participants were SOAR-trained practitioners ($N = 79$) who had completed or supervised completion of a SOAR application for justice-involved adults. The survey was designed consistent with a mixed-methods approach and administered in an online format. Open-ended responses were coded by two raters using a content analysis approach to identify and assign conceptual categories across open-ended responses. Descriptive statistics were generated on all study variables. Although most agencies completed applications for justice-involved adults, only a third reported collaboration with a criminal justice agency. The most commonly cited barriers to a successful SOAR application included gaps in care for justice-involved populations and incomplete and unavailable medical records. Facilitators included strong agency leadership, communication and relationship building with criminal justice agencies, and access to medical staff at correctional agencies or in the community. The average reported approval rate (58.3%) was comparable to the SOAR model more broadly and most study participants rated the SOAR model as successful in facilitating access to benefits for justice-involved adults. Overall, despite obstacles to serving this high-risk population, practitioners have developed strategies to facilitate the successful use of the SOAR model in this population. Strategies are needed to support the broader dissemination of the SOAR model in criminal justice settings.

INTRODUCTION

Background

About 6.7 million adults in the U.S. are under correctional supervision at a given time, amounting to 1 in every 37 adults (Kaeble & Glaze, 2016). Justice-involvement is linked to many adverse health outcomes, including higher rates of chronic illnesses (Mallik-Kane & Visser, 2008), infectious diseases (Hammett, 2006; Vaughn, Salas-wright, Delisi, & Piquero, 2014), mental illnesses (James & Glaze, 2006; Steadman, Osher, Robbins, Case, & Samuels, 2009), and intellectual disabilities (Hellenbach, Karatzias, & Brown, 2017). Consequently, justice-involved adults experience higher rates of hospitalization and even death following incarceration (Binswanger, Krueger, & Steiner, 2009; Binswanger et al., 2007; Binswanger, Blatchford, Mueller, & Stern, 2013; Frank et al., 2013; Spaulding et al., 2011). Despite their medical needs, justice-involved adults are significantly less likely to be insured relative to adults who are not justice-involved, even following the recent expansion of Medicaid eligibility (Winkelman et al., 2016). Moreover, in the community, justice-involved adults report limited financial resources (James, 2004), experience barriers to employment (Pager, 2003), and are more likely to be recently homeless (Greenberg & Rosenheck, 2008).

Disability benefits, including Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI) are one avenue through which justice-involved adults with disabling conditions may access needed financial and medical resources. For example, receipt of disability benefits facilitates access to publicly funded health insurance, mainly Medicaid through SSI and Medicare through SSDI. In other populations, receipt of SSI benefits has been linked to key community outcomes such as greater access to mental health treatment among adults with mental illnesses (Elinson, Houck, & Pincus, 2007) as well as higher income and a greater quality of life among Veterans (Rosenheck, Dausey, Frisman, & Kaspro, 2000). Receipt of disability benefits also may be associated with reductions in recidivism for justice-involved populations, particularly for adults with substantial behavioral health and criminogenic needs (Lowder, 2015). Indeed, facilitating access to disability benefits has been identified as a best practice for criminal justice agencies providing reentry services (Blandford & Osher, 2013).

Yet, justice-involved adults face barriers to accessing disability benefits. For offenders who enter jails and prisons without benefits, institutions may not deliver comprehensive reentry services due to the constant changeover in inmate population or the belief that certain high-need groups, such as adults with mental illnesses, may not be responsive to services (Dennis, Ware, & Steadman, 2014). Furthermore, offenders entering institutions with disability benefits face possible termination of benefits or suspension of benefits depending on length of stay. If the Social Security Administration (SSA) terminates benefits due to incarceration exceeding 12 months, justice-involved adults or their representatives must submit a new disability application (Social Security Administration, 2015).

SSI/SSDI Outreach, Access, and Recovery (SOAR)

The SSI/SSDI Outreach, Access, and Recovery (SOAR) program is a national model designed to improve SSI and SSDI application outcomes for adults experiencing homelessness by training case managers on the disability determination process (Kauff, Brown, Denny-Brown, & Martin, 2009). Specifically, the SOAR process focuses on the case manager as the key representative of the client. As such, applicants are expected to complete an SSA-1696 Appointment of

Representative form. SOAR case managers are responsible for collecting medical records for the Disability Determination Services (DDS) office. This piece is critical because justice-involved adults may have separate or incomplete medical records that require more time and resources to collect. Finally, SOAR case managers prepare and submit a Medical Summary Report that details a client's life history (e.g., work, education, medical), describes the client's functional impairments, and explains how the impairments inhibit the client's ability to have gainful employment (SOAR Technical Assistance Center, 2016b). Together, these practices have shown to increase the likelihood of application approval (Lowder, Desmarais, Neupert, & Truelove, in press).

Since its creation in 2006, the total number of applications processed through the SOAR model has increased considerably, from 22,648 applications in 2012 (SAMHSA SOAR Technical Assistance Center, 2013) to almost 57,000 applications in 2016 (SOAR Technical Assistance Center, 2017). The SOAR model has demonstrated success for homeless populations, resulting in both a higher rate of application approval relative to all SSI/SSDI applications (65% versus 29%) and a faster time to decision (81 versus 120 days) (Dennis, Lassiter, Connelly, & Lupfer, 2011; SOAR Technical Assistance Center, 2016a). Among homeless adults, those assisted under SOAR were twice as likely to be approved (58% vs. 28%) relative to those applying for benefits without SOAR (Kauff, Clary, Lupfer, & Fischer, 2016). Overall, from 2006 to 2016, SOAR has facilitated receipt of SSI and SSDI benefits for 36,112 adults (SOAR Technical Assistance Center, 2017).

The SOAR model has been increasingly used in collaboration with justice agencies. For example, in 2014, 12 states reported collaborations between SOAR providers and justice agencies (SAMHSA SOAR Technical Assistance Center, 2015). In 2016, collaborations between SOAR providers and criminal justice agencies existed across 25 states (SOAR Technical Assistance Center, 2017). Access to disability benefits has been identified as a key component of successful reentry planning and experts agree that criminal justice agencies play a critical role in facilitating access to public benefits in this at-risk population (Blandford & Osher, 2013; Osher, Steadman, & Barr, 2002). However, the SOAR model is likely underutilized by criminal justice agencies in most states.

One reason why SOAR may be underutilized by criminal justice agencies is that these agencies face ongoing barriers to the successful implementation of reentry and rehabilitative programs (Rhine, Mawhorr, & Parks, 2006). However, collaborating and coordinating the implementation of interventions with other agencies—like SOAR providers—can enhance the implementation process by increasing the availability of resources and the diversity of perspectives to identify potential issues (Durlak & DuPre, 2008). Furthermore, successful implementation of interventions in social services and similar settings requires an active and dedicated practitioner for the intervention to be implemented with fidelity (Fixsen, Blase, Naoom, & Wallace, 2009). Indeed, the presence of dedicated SOAR practitioners has been shown to improve application outcomes in practice (Kauff et al., 2016). Thus, feedback from SOAR practitioners working in collaboration with criminal justice agencies may inform how SOAR has been successfully implemented in these settings and with justice-involved adults. Greater understanding of how the SOAR model has been implemented and with justice-involved populations and in current criminal justice settings may facilitate the dissemination of this model in other justice settings.

The Current Investigation

The purpose of this study is to survey SOAR practitioners working with justice-involved adults on the implementation and use of the SOAR model with justice-involved adults and in justice settings. To that end, the aims of this study were 3-fold:

Aim 1) to describe how SOAR has been implemented in criminal justice settings or with justice-involved adults;

Aim 2) to identify facilitators and challenges faced by SOAR practitioners completing applications for justice-involved adults; and

Aim 3) to evaluate the perceived success of the SOAR model for justice-involved adults.

METHOD

Sample

All participants were recruited to participate in the survey via email through select distribution lists maintained by the SOAR Technical Assistance Center. Participants were eligible to complete the survey if they were a SOAR-trained practitioner (i.e., case worker, supervisor, or executive agency staff) and had completed or supervised the completion of SOAR applications for justice-involved adults. A total of 79 eligible participants from unique agencies across 29 states completed the survey. Participants were an average age of 43.03 years old (Standard Deviation [*SD*] = 13.15, Range 24-80) and primarily female (79.7%). A small proportion identified as male (12.5%) or other (7.8%) genders. Most participants identified as Caucasian (76.6%) followed by African American (15.6%) and other racial identities (7.8%). Only 6.6% identified as Hispanic. Most respondents received some form of postsecondary education (42.9% bachelor level and 46.0% masters) from the academic disciplines of psychology (38.3%), social work (23.4%), and public policy or administration (10.6%). Participants were employed in their current positions for an average of 51.25 months (*SD* = 51.3, Range: 2-264) and employed in the field of social services for an average of 15.08 years (*SD* = 11.11; Range: 1-60). The majority of participants (79.7%) stated that they completed SOAR applications as part of their current position. Nearly a third were in a supervisory role (30.4%) and a small portion were in a director or executive role in their agencies (16.5%).

Survey

The study team designed the survey consistent with a mixed-methods, concurrent embedded approach (Creswell, 2013) in which qualitative data were collected simultaneously with quantitative data to provide insight into quantitative responses. The final survey consisted of 45 closed- and open-ended questions. By way of background, participants were asked to provide information regarding their positions and SOAR provider agency. In addition to reporting on their own career and demographic backgrounds, the survey prompted participants to describe the clients served and services provided by their agencies in two separate open-ended responses.

Additionally, consistent with Aim 1, participants answered questions on how SOAR has been implemented with justice-involved populations. First, participants reported on agency practices and community services available prior to the implementation of SOAR. Second, participants were asked to identify the nature of their agency's engagement with justice populations, including whether the agency completed applications, collaborated with a criminal justice

agency, received referrals from a criminal justice agency, or had practitioners who completed SOAR applications while physically located in a criminal justice setting. Follow-up open-ended questions allowed participants to describe their selection.

Consistent with Aim 2, the survey prompted participants to identify and describe barriers and facilitators to the use of the SOAR model with justice-involved adults. First, participants rated the relative difficulty or ease of completing SOAR critical components with justice-involved adults relative to other at-risk populations who are not justice-involved. Briefly, these critical components included collecting and submitting medical records, preparing a medical summary report, acquiring co-signature of a physician or psychiatrist on the medical summary report, and conducting a quality review of the SOAR application. Responses were rated on a 5-point Likert scale with 1 indicating much more difficult; 2, somewhat more difficult; 3, about the same; 4, somewhat easier; and 5, much easier. Second, participants endorsed barriers and facilitators to the use of SOAR with justice-involved adults from a preselected list. In separate open-ended responses, participants identified the most significant barrier and facilitator to a successful SOAR application in this population.

Finally, to address Aim 3, participants rated the perceived success of the SOAR model with justice-involved adults. To avoid neutral responses, we employed a 4-point forced Likert scale, with 1 indicating quite unsuccessful; 2, somewhat unsuccessful; 3, somewhat successful; and 4, quite successful. An open-ended response question asked participants to describe why they selected the rating. Participants additionally provided estimates on the number of justice-involved adults completing SOAR applications at their agency as well as an estimated approval rate for these applications.

Procedure

The research team developed the survey in a web-based format using Qualtrics software (*Qualtrics*, 2015). Qualtrics offers many advantages to the survey design and administration process, including its use of a secure server to protect personally identifiable information. Qualtrics software has been used successfully in previous research with both case managers (Jeon, Mahoney, Loughlin, & Simon-Rusinowitz, 2015) and criminal justice practitioners (Ward & Merlo, 2016). Because we anticipated that not all questions would be equally relevant to participants, the survey was configured with nonresponse options to minimize dropouts and maximize item-level responses. Following survey development, survey items were screened by a peer reviewer for overall comprehension, potential question bias, relevance, and flow. Subsequently, the survey was reviewed by staff at the SOAR Technical Assistance center for overall content and relevance to SOAR case managers.

The survey link was distributed along with a participation letter via email to a list provided by the SOAR Technical Assistance Center of SOAR provider agencies with known criminal justice collaborations. The survey was also distributed to SOAR state and local leads, who were asked to forward the survey to any agencies in their jurisdictions known to complete SOAR applications for justice-involved adults. Survey distribution followed the Dillman method (Dillman, Smyth, & Christian, 2014). Specifically, the survey link and participation letter were distributed on a Friday and follow-up occurred every two weeks. Data collection occurred from September 30th to November 30th, 2016. Participation in the survey was voluntary, and all respondents consented prior to participating in the survey. Study procedures were reviewed and approved by the Institutional Review Board at North Carolina State University.

Data Coding and Analysis

Data were downloaded from the online Qualtrics software and analyzed using a mixed-methods approach. First, quantitative data were exported into SPSS 24 for cleaning and analysis. There was a large and non-ignorable amount of missing quantitative data across study variables (18.2%) due to the availability of nonresponse options across items. A missing data analysis was conducted using the Missing Values package in SPSS 24 to examine patterns of missing data (i.e., missingness). Visual inspection of missing data patterns suggested most item nonresponse was generated from a group of participants ($n = 19$) who failed to complete the latter portion of the survey. Further investigation showed this pattern of missingness was unrelated to responses on all earlier items, $ps \geq .075$, except for likelihood of reporting disruption of care as a barrier, $\chi^2(1) = 6.20, p = .013$, providing limited evidence of systematic missingness. As a result, we employed pairwise deletion for all analyzes and reported valid frequencies where applicable. Descriptive statistics, including measures of central tendency and dispersion as well as frequencies, were computed for quantitative variables, as appropriate. Regarding reported SOAR application approval rates for justice-involved adults, both overall and weighted averages were computed. The weighted average was computed by first dividing the number of clients at a specific agency by the total number of clients served across agencies. The resulting quotient was then multiplied by the reported approval rate for that specific agency. Finally, resulting products for each agency were added to create a final weighted sum.

Second, open-ended response data were downloaded and imported into Excel for qualitative data analysis. Content analysis was employed to identify and assign conceptual categories across responses (Weber, 1990). Two coders separately created conceptual categories after reviewing responses to each open-ended question. A final list of conceptual categories for each question were created through a discussion and consensus approach. To establish inter-rater agreement, both coders coded the first five responses to each question. Then, an additional ten responses were coded and inter-rater agreement checked to ensure agreement did not fall below 90%. Following initial coding, responses yielding an agreement rate below 85% were resolved via consensus. Across all coded responses, final inter-rater agreement was high: 96.0%. Following coding, specific quotes were extracted to illustrate conceptual categories. In accordance with NIH best practice guidelines (Creswell, Klassen, Plano Clark, & Smith, 2011), qualitative data were transformed into quantitative responses to augment quantitative findings (Creswell & Plano Clark, 2011; Sandelowski, Voils, & Knafel, 2009). Frequencies were computed for all coded categories using SPSS 24.

Limitations

Study findings should be considered together with several limitations. First, the current investigation and reporting of results was purely descriptive in nature. The survey was intended to provide a snapshot of current practices rather than produce inferential associations between two or more study variables. Second, we relied on a modified snowball sampling methodology due to absence of a defined population of SOAR-trained practitioners. The SOAR Technical Assistance Center does not collect data on the number of community practitioners who complete SOAR training. As a result, we utilized a limited distribution list of agencies with known justice collaborations together with word of mouth and referral to reach our intended population. The

extent to which findings may generalize to all SOAR practitioners who complete applications for justice-involved adults is therefore uncertain. Third, data on the success of the SOAR model (e.g., approval rates) were self-reported by practitioners and may not reflect actual agency records. Fourth, although we employed a mixed-method approach to capture a wider range of information on the use of SOAR for justice-involved adults, it is possible that questions did not capture the universe of potential responses.

RESULTS

Agency Characteristics

Participants represented 79 agencies across 29 U.S. states. See Figure 1 for distribution of agencies by states. Clients served by agencies included adults with mental illnesses (60.5%), homeless adults (51.3%), adults with substance use (32.9%), justice-involved adults (19.7%), and other at-risk adults (15.8%). Less frequently served populations included youth (14.5%), adults with physical health problems (11.8%), low-income adults (10.5%), Veterans (9.2%), adults with intellectual disabilities (9.2%), and survivors of domestic violence (5.3%). Consistent with populations served, the most frequently provided services included mental health (54.2%), housing (51.4%), case management (43.1%), substance use (29.2%), employment (25.0%), and physical health (23.6%) services. Less frequently provided services included community outreach (13.9%), meal (11.1%), transportation (9.7%), education (9.7%), peer support (6.9%), and identification (5.6%) services.

Aim 1

In Aim 1, participants reported on how the SOAR model has been implemented in justice settings or with criminal justice populations. Only 11.4% of participants reported that prior to SOAR criminal justice agencies participated in the reinstatement or suspended SSI/SSDI benefits or reapplication of terminated benefits for adults leaving jail or prison settings. Less than half (38.0%) reported that criminal justice agencies did not participate in these practices; however, nearly half of participants (48.1%) did not know if criminal justice agencies participated in these practices prior to SOAR. When asked if community resources were available to support disability applications for at-risk adults prior to SOAR, only 40.5% of participants stated that such resources were available, 43.0% stated no resources were available, and 16.5% did not know. However, community resources were limited primarily to other agencies who helped participants apply for benefits (50.0%), case management services (20.0%), or Social Security

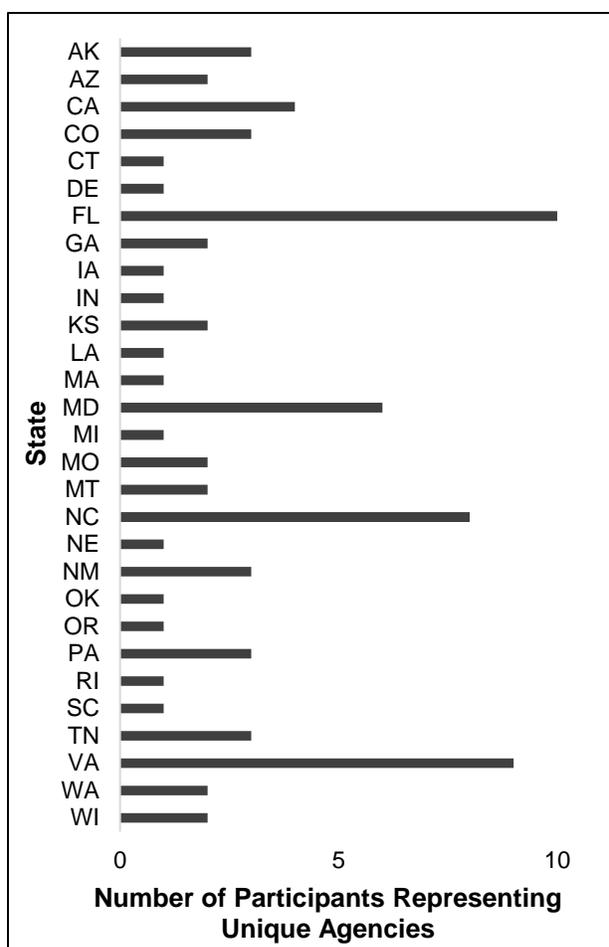


Figure 1. Agency Representation by U.S. State

disability law firms (13.3%).

Participants were asked to identify and describe the nature of their agency's engagement with criminal justice populations. The majority of participants stated that their agency completed SOAR applications for justice-involved adults (89.6%). A third of participants stated that their agency either collaborated with a criminal justice agency to complete SOAR applications (32.4%), received referrals from a criminal justice agency (33.8%), or had practitioners who completed SOAR-assisted applications while physically located in a jail, prison, or other criminal justice setting (33.8%). Most participants who reported a collaboration with a criminal justice agency stated that the provider agency had SOAR case managers who completed applications in a jail, prison, or other criminal justice setting (59.1%). Less commonly cited collaborations included receiving referrals from a criminal justice agency (31.8%), providing reentry services for recently released inmates (22.7%), receiving medical evidence from a jail or prison (13.6%), or a pre-release agreement between the criminal justice agency and SSA (9.1%).

Aim 2

To address Aim 2, participants identified facilitators and barriers to completing SOAR applications for justice-involved adults. Relative to completing SOAR critical components with other at-risk populations (e.g., homeless adults, low-income adults), participants reported collecting medical records (Mean [M] = 2.78, SD = 1.00), completing a medical summary report (M = 2.90, SD = 0.87), and conducting a quality review (M = 2.97, SD = 0.78) were of similar difficulty for justice-involved adults. Ratings were lowest for acquiring a secondary signature from a physician or psychiatrist (M = 2.73, SD = 0.87), suggesting this component was the most difficult to complete for justice-involved adults.

Figure 2 presents participant endorsement of several barriers to the successful preparation of a SOAR application for justice-involved adults. Experience of disruption in physical and mental

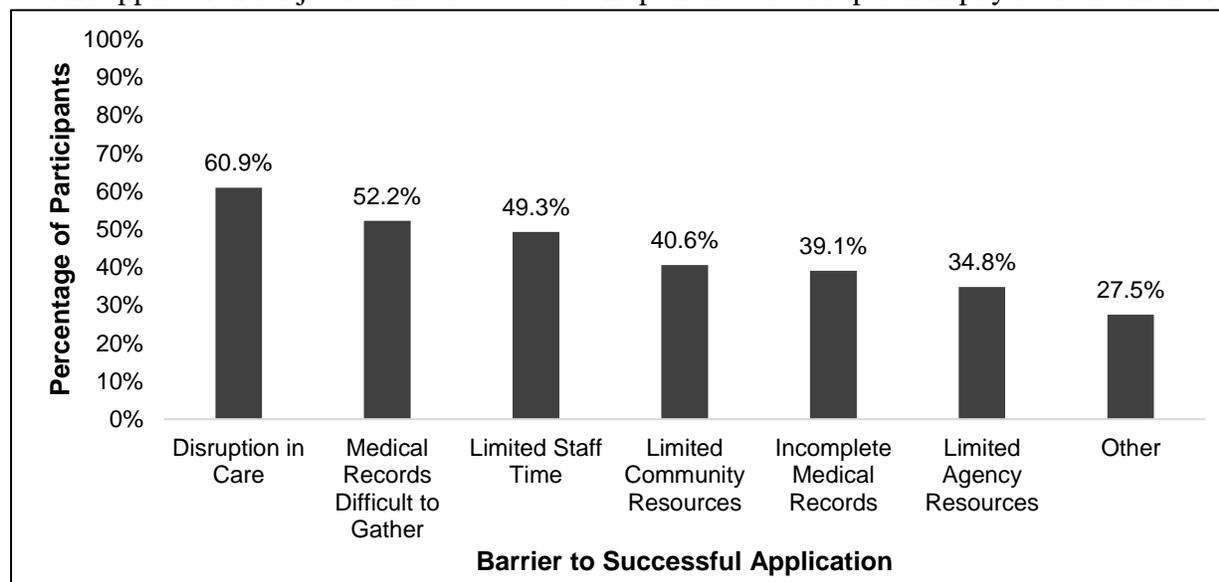


Figure 2. Participant Endorsement of Barriers to a Successful SOAR Application

health care by justice-involved adults was the most frequently endorsed barrier to a successful SOAR application (60.9%). Other barriers mentioned (27.5%) included client absconding (e.g.,

missed appointments, failure to appear for supervision, etc.) and reincarceration, limited treatment while incarcerated, client compliance, access to clients, transportation, barriers to stable housing and employment, and limited social support. When were asked to identify the most *significant* barrier to a successful SOAR application for justice-involved adults, participants reported access to medical records (28.3%), client absconding (16.7%), and incomplete medical records (16.7%) most frequently. In-depth examination of individual responses showed these concerns were often related to limited provision of services while incarcerated and difficulty accessing medical records from jails or prisons. For example, one participant stated:

“Individuals who are homeless and have spent a lot of time incarcerated often have a mental health (or physical) disability, but have not gotten nearly enough treatment while in jail/prison to have adequate records of their condition. Plus, obtaining what records do exist is incredibly difficult, and in some cases I have found it to be impossible.”

In a similar vein, another participant detailed,

“For individuals who have spent a significant amount of time in the justice system records are scattered throughout multiple facilities, the individual is a poor historian, and incarceration provides a static environment that may allow people to function better or worse than when out in the community.”

In another example, a participant described:

“Jail records are usually the least detailed of any medical records I read which makes it difficult to apply people when they’ve only been treated while incarcerated yet their records reveal very little about the severity of their condition, their symptoms, their functional impairments, etc. Jail records more often record that people are malingering, that people are not exhibiting any signs of serious and persistent mental illness, etc. which makes it extremely hard to get them approved; often people will have this in their records who have severe records with outpatient clinics and psychiatric hospitals which do not report that they think the person is malingering or otherwise does not actually need mental health treatment.”

Other significant barriers mentioned included the time commitment involved with preparing and submitting an application (11.7%), coordinating the submission with a client’s release from incarceration (11.7%), limited agency resources (10.0%), poor client cooperation (10.0%), and reincarceration (8.3%).

Figure 3 shows participant endorsement of multiple facilitators to the successful preparation of a SOAR application for justice-involved adults. Agency leadership was the most frequently endorsed facilitator to a successful SOAR application (51.5%). When asked to identify and describe the most significant facilitator to a successful application, participants responded that relationships with criminal justice agencies (33.3%), collaboration with other community-based agencies (25.0%), continuation of care for justice-involved adults (12.5%), and access to clients

while incarcerated (12.5%) were most important.

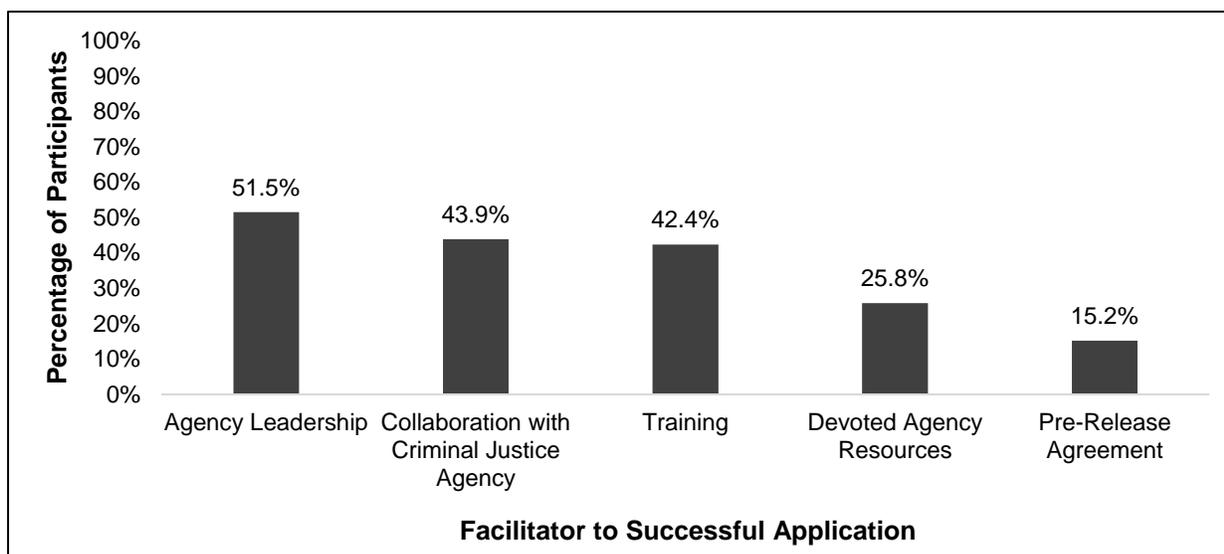


Figure 3. Participant Endorsement of Facilitators to a Successful SOAR Application

In individual responses, participants highlighted the role of key individuals within correctional settings. For example, one participant stated,

“It is convenient to have a psychiatrist in a jail who is willing to sign my Medical Summary Reports (MSR) because it means I can complete the entire SOAR process while someone is still incarcerated, while my coworkers who do SOAR with people who are living outside or in a shelter at the time of their referral usually have to schedule an appointment for them with a psychologist we contract with, transport them to that appointment, and wait multiple weeks to get the report back in order to have someone be qualified to sign off on the MSR.”

Participants also emphasized the key role of collaboration with specific community agencies, stating,

“[I receive] help from probation officers and other community service providers who are working with the individual. By the time I meet the client, they are homeless and in our emergency shelter. If they have no one else working with them, it is harder to get information.”

Another participant confirmed the important role of community efforts, detailing,

“I also found that when workers in the community make sure the ex-offender follows up or gets to appointments, this can make the returning citizen more successful in getting benefits. I have contact with the agency that handles the aftercare plans for those paroling - I trust they do their part by supporting the ex-offender in following up.”

Finally, responses were mixed when participants were asked to identify and describe the biggest difference in completing applications for justice-involved adults relative to other at-risk populations. Participants reported that obtaining medical records was more difficult (18.8%) and

the records obtained were less thorough (16.7%) relative to those received for other at-risk populations. In contrast, some participants reported that justice-involved adults were easier to locate (20.8%) while other reported that they were more difficult to access (6.3%). Less frequently mentioned differences included absconding by justice-involved adults (8.3%), limited time with the client while incarcerated (8.3%), and lack of client engagement (8.3%).

Aim 3

For Aim 3, participants were asked to evaluate the overall success of the SOAR model for justice-involved adults. As shown in Figure 4, responses varied considerably.

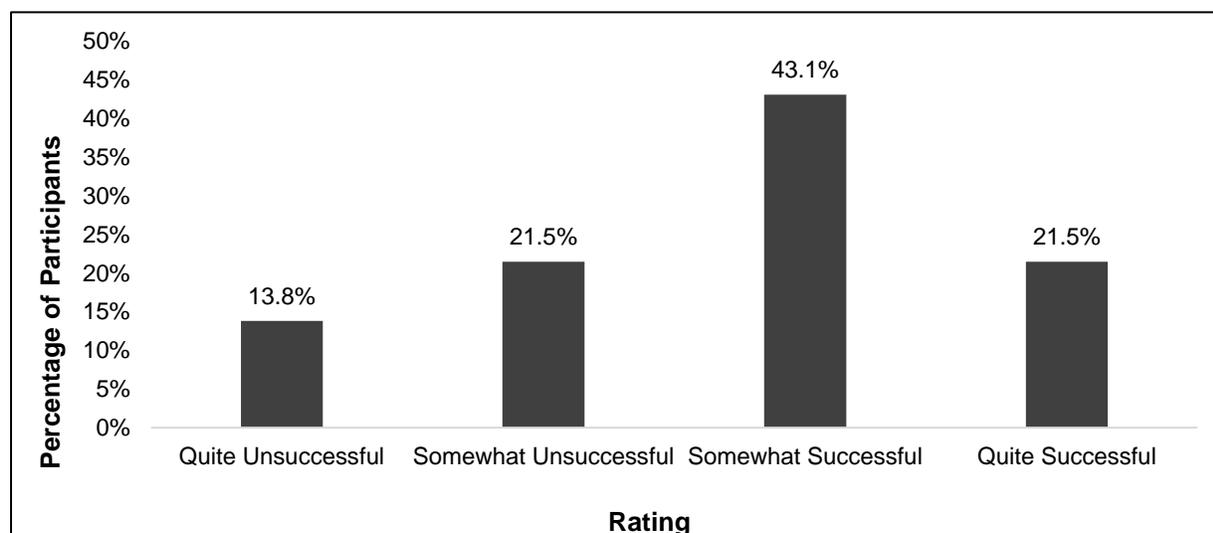


Figure 4. Participant Rating of Success of SOAR Model for Justice-Involved Adults

Although most participants (64.6%) rated the model as, to some extent, successful for this population, a considerable portion did not (35.3%). Participants who rated the SOAR model as unsuccessful cited limited communication between jails and SOAR agencies, lack of coordination with local SSA offices, limited experience applying the SOAR model to this population, lack of training, and challenges faced by justice-involved adults. Participants who rated the SOAR model as “Quite Successful” for this population cited effective communication between local criminal justice agencies and SSA offices as well as generally high approval rates.

Participants were asked to self-report the annual number of justice-involved clients served by their agency as well as an estimated approval rate for SOAR applications submitted for justice-involved adults. Agencies served relatively few justice-involved adults on an annual basis ($M = 13.33$, $SD = 18.67$, Range: 1 to 90). The estimated average approval rate for SOAR applications submitted for this population was 58.3% ($SD = 33.7$, Range: 0 to 100). However, among participants who reported both an annual number of clients served as well as an estimated approval rate, the weighted average approval rate was 69.2%, suggesting that agencies who served a larger number of justice-involved adults annually had higher approval rates for this population.

DISCUSSION

Justice-involved adults face barriers to accessing disability benefits. Yet, such benefits may provide crucial assistance for this at-risk population, including financial support, health care benefits, and access to treatment. The SSI/SSDI Outreach, Access, and Recovery (SOAR) program is a national model designed to improve SSI and SSDI application outcomes for adults experiencing homelessness. Although increasingly implemented in coordination with criminal justice agencies, the program remains underutilized for justice-involved populations in most states. Insights from SOAR practitioners may play a role in understanding the benefits and challenges to implementing SOAR in this population, which may facilitate the dissemination of the SOAR model in other settings. To that end, this study involved a survey of SOAR practitioners working in collaboration with criminal justice agencies or with justice-involved adults to inform how SOAR has been implemented in justice settings (*Aim 1*), identify facilitators and challenges to the use of SOAR for justice-involved adults (*Aim 2*), and evaluate the success of the SOAR model in this population (*Aim 3*). Below is a summary and discussion of key study findings.

Summary and Implications of Findings

In *Aim 1*, findings showed the SOAR model appears to fill a much-needed gap in providing disability application assistance for at-risk adults, particularly those who are justice-involved. Specifically, findings showed limited availability of services in the community in the absence of SOAR. Available services were limited to other social service agencies providing disability assistance and disability law firms. Following implementation of SOAR, most agencies (89.6%) merely completed applications for justice-involved adults; only a third reported a collaboration with a criminal justice agency. When collaborations were reported, they most frequently represented enhanced communication between jail, prison, or other criminal justice staff and SOAR providers. In most cases, communication was used to facilitate access to clients while incarcerated to begin the SOAR application process. These findings suggest in most cases, collaborations between SOAR providers and criminal justice agencies are relatively simple. Indeed, the presence of boundary spanners, or people who can communicate and liaise between systems with competing interest, has been called out for decades as a best practice for successful collaboration between criminal justice and mental health systems (Steadman, 1992) and may have a role to play in the successful integration of SOAR in criminal justice settings.

Consistent with *Aim 2*, practitioners identified multiple barriers and facilitators to a successful SOAR application for justice-involved adults. The most frequently mentioned barriers also represented the most significant and systemic obstacles to accessing care in this population. In particular, practitioners stated that medical records for this population were not only difficult to obtain, but when obtained they were often incomplete, limiting practitioners' ability to submit medical records with a disability application and complete a medical summary report. These gaps in care reflect broader issues such as access to health insurance in this population (Winkelman et al., 2016). Most importantly, these barriers highlight the need for more innovative and collaborative efforts to increase access to care in this population. For example, some practitioners reported collaborating with a psychiatrist or medical staff at the jail, or with a local community health center, to provide the necessary evaluations and medical evidence for the disability application. Providing referral and care coordination services to facilitate access to community-based health care should be an essential part of any reentry strategy (Patel, Boutwell,

Brockmann, & Rich, 2014), though current efforts are limited.

General resource shortages were another identified barrier to practitioners' ability to serve this population. To illustrate, many practitioners described time-intensive activities, like commuting to jail or prison, waiting for inmates at the jail or prison, and tracking down medical records. Indeed, there appear to be many ways in which the SOAR application process may be prolonged for justice-involved adults relative to all SOAR applicants. Some practitioners reported setting time limits (e.g., two weeks) for the submission of an application to reduce the likelihood of client absconding and create time pressure for the collection of medical records. More broadly, mention of resource shortages is not surprising given the myriad of co-occurring problems (e.g., behavioral health concerns, housing instability, low socioeconomic status) faced by justice-involved adults (Wolff et al., 2013). The SOAR process can be time-intensive, which may account for the underutilization of SOAR by practitioners who are trained in the model (Kauff et al., 2016). Above all, this finding underscores the importance of a dedicated SOAR position to allow a case manager to manage time more effectively, build the necessary relationships and collaborations, and ultimately prepare more comprehensive and successful applications (Dennis et al., 2014).

Among facilitators to a successful SOAR application, agency leadership emerged as the most frequently endorsed facilitator. In open-ended responses, practitioners described agencies as advocating for the SOAR model more generally, creating dedicated SOAR positions, and facilitating collaboration with criminal justice agencies. This finding supports the role of agency leadership as a best practice in the use of SOAR in criminal justice settings (Dennis et al., 2014). Although few practitioners mentioned the role of criminal justice agencies in facilitating collaborations, leadership on behalf of criminal justice agencies may enable more collaborative and successful initiatives with community-based providers (Wilson & Draine, 2006). Consequently, criminal justice agencies may have a role to play in the successful implementation of SOAR in justice settings.

In evaluating the success of the SOAR model for justice-involved adults in Aim 3, practitioners reported agency-level approval rates (58 to 69%) that were comparable to those that have been reported for SOAR applicants overall (65 to 73%) (Dennis et al., 2011; Kauff et al., 2016; SOAR Technical Assistance Center, 2017). These findings suggest SOAR is a promising intervention to facilitate access to benefits for justice-involved adults, despite significant barriers to serving this population. Further, approval rates may improve further as agencies find solutions to address primary barriers to successful applications (e.g., access to medical records). Despite the apparent success of SOAR for this population, agencies on average are providing services for relatively few clients (i.e., an average of 13 per year). This finding underscores the need for efforts to expand services on an agency-level, whether through improved leadership to facilitate collaborations with other agencies or through investment in dedicated SOAR positions to increase the volume of applications processed.

Overall, findings suggest that the SOAR model has promise as a strategy to increase access to SSI/SSDI benefits for justice-involved adults. The model may be most effective, however, when efforts are formalized via strong agency leadership and dedicated SOAR positions to establish necessary relationships between criminal justice agencies and community providers. Strategies are needed to address barriers to successful implementation, such as shortage of staff resources as well as availability and completeness of medical records. Relationship building and

collaboration between community-based providers and criminal justice agencies may be one way to leverage existing resources and facilitate more timely and complete applications for this population.

Future Directions

Findings suggest several directions for future research on the SOAR model. Primarily, there is a need for more rigorous, prospective investigations of the effectiveness of the SOAR model versus other traditional approaches to accessing benefits (i.e., case management). All studies to date on the SOAR model have relied on retrospective data (Dennis et al., 2011; Kauff et al., 2009; Kauff et al., 2016; Lowder et al., in press), limiting the validity of current findings. Additionally, there exists little empirical data on the use of the SOAR model in justice-involved populations. For example, it is possible that SOAR components may show differential utility for applications completed for justice-involved adults relative to other populations. Whether the SOAR model should be tailored for specialized populations remains to be seen. There may be advantages to structuring a medical summary report to address issues such as gaps in care while still providing sufficient evidence to establish evidence of a disability. Further, providing guidance on how practitioners can leverage medical evidence gathered during periods of incarceration (e.g., in the absence of substance use) to establish evidence of disability may assist SOAR practitioners in preparing more compelling applications. More broadly, there is limited evidence on whether receipt of disability benefits is linked to better community outcomes, in this or any population. Linking receipt of benefits through SOAR to key community outcomes and associated cost savings may encourage criminal justice agencies and funders to invest in SOAR as a strategy to rehabilitate this population.

Conclusion

Despite barriers to serving this high-need population, SOAR practitioners have developed strategies to facilitate successful preparation of applications. Although there is need to expand these strategies to other settings to successfully serve justice-involved adults, the SOAR model shows great promise, as confirmed by one SOAR practitioner's testimonial:

“[A prospective client] met with a SOAR case manager one time at our homeless shelter to inquire about applying for benefits. She was not seen again. About 6 months later she somehow kept the case manager's business card upon arrest and began writing postcards from jail. A year later, she was released and had been approved for SSI in just 27 days based on jail records alone. Not only this, but while incarcerated, [the client] had referred another inmate to this SOAR case manager and contacted him shortly around the time of her release. She too was approved for SSI in just 89 days based on records alone. Both have organizational payees and have housing vouchers, are connected to care, and are receiving income that has ended their chronic homelessness and improved their quality of life.”

Most importantly, SOAR has the potential to improve not only the likelihood of receiving SSI and SSDI benefits but the community functioning of justice-involved adults as well.

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