
VOCATIONAL REHABILITATION AGENCIES HELPING PEOPLE WITH PSYCHIATRIC DISABILITIES GET EMPLOYED: HOW FAR HAVE WE COME? HOW FAR DO WE HAVE TO GO?

CASE STUDIES OF PROMISING PRACTICES IN VOCATIONAL REHABILITATION

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Introduction

The Vocational Rehabilitation Research and Training Center (VR-RRTC) based at the Institute for Community Inclusion at the University of Massachusetts Boston partnered with a national group of content experts to identify potential promising VR employment practices serving people with psychiatric disabilities. In funding the VR RRTC, NIDRR requested an emphasis on identifying promising practices for two particular populations (people with mental illnesses and people with intellectual disabilities) and to identify promising practices related to order of selection and the designation of most significant disability. This report provides a summary of case studies of VR employment practices for persons with mental illnesses.

This concern regarding employment deficits among segments of the U.S. disability population was buttressed in 2012 by two policy statements: one is the *Unfinished Business: Making Employment of People with Disabilities a National Priority* report issued by Senator Tom Harkin (D) of Iowa through his chairmanship of the Senate Committee on Health, Education, Labor, and Pensions (HELP) and the other a statement by Governor Jack Markell (D) of Delaware through his chairmanship of the National Governors' Association (NGA) headlined *A Better Bottom Line: Employing People with Disabilities*. Page one of the HELP report "...describes the dismal disability employment situation, points to some recent developments that create an historic opportunity to bring more workers with disabilities into the labor force" (HELP Committee Report, 2012). The NGA statement notes that: "According to the U.S. Department of Labor, only 20 percent of people with disabilities either are employed or are seeking employment compared to 69 percent of the population without disabilities. Of those individuals with disabilities seeking employment, 15 percent have not found employment — compared to 8 percent for everyone else. ... Historically, our country has made efforts to address this challenge, but there is more to be done" (National Governors Association, 2012, page 3).

There is a deep research base in the employment and mental health field that has supported the development of effective strategies for people with significant psychiatric disabilities, notably the work emanating from the Dartmouth (NH) Psychiatric Research Center, associated most strongly with the research of Robert Drake, Deborah Becker, and Gary Bond (c.f., Haslett, Drake, Bond, et al., 2011; Bond, 2004). So these case studies were not meant to replicate this knowledge base. Instead, they were designed to identify some creative and collaborative ways that VR agencies could develop improved strategies to improve employment outcomes for their clients using this most current knowledge efficiently and effectively. Summary reports of eight practices identified through a Modified Delphi Process included in the Appendix.

After examining the nominations and final candidates for the case study effort, the VR RRTC research and policy fellows determined that a summary report that clearly articulates a critical need to build a knowledge base and to identify common themes related to the innovations that might inform future efforts within the psychiatric public vocational rehabilitation arena. While each state VR agency profiled operates within a unique state government environment, there are commonalities in themes that emerge. Though we do not conclude that the information garnered through this process is an exhaustive look at the topic. Nor are all the activities described within the case studies ones that necessarily produced optimal results or should be replicated wholly. However, the collection of practices described as a group shed much light on methods VR agencies and personnel can use to bridge some of the systemic, policy, human resource, cultural, and

clinical barriers that impede the success of many economic engagement interventions targeted at benefiting people with significant psychiatric disabilities.

Abstracts of the Identified Promising Practices

The final set of eight promising practices out of the 58 nominated practices are summarized here and then described in more detail in the appendix. Each descriptive write up can be used independently and provides sufficient detail for review. A note from the VR RRTC Team: These are descriptions of practices in one snapshot of time. We acknowledge that by the time we are able to produce a summary report, practices may have evolved or modified, and new practices may have emerged. For more specific details or up to date descriptions we advise going to the source, the state VR agencies, directly. We did our best to honor the ongoing work in the state VR agencies and among their partners. The shortcomings of this report are the responsibility of the authors who welcome corrections, amendments, updates, and review. We humbly thank the many individuals that contributed to this effort by nominating practices, reviewing materials, participating in interviews, reviewing summary reports, and serving on expert panels. We applaud the ongoing work to innovate and advance employment outcomes of people with psychiatric disabilities and mental illnesses. The abstracts are in alphabetical order by state VR agency and thus order does not reflect any particular endorsement.

1. Vocational Rehabilitation and Mental Health Agency Collaborations with the Implementation of Co-located Counselors: The *Connecticut Bureau of Rehabilitation Services* (BRS) (now known as the Department of Rehabilitation Services) and the Department of Mental Health and Addiction Services (DMHAS) partner to jointly provide supported employment (SE) services to customers with mental illness (MI). The two agencies strive to provide a continuum of services and support to customers by co-locating Vocational Rehabilitation (VR) counselors in Local Mental Health Authorities (LMHAs), coordinating service delivery across agencies, collaborating with vendors, and coordinating joint training and monitoring efforts. The University of Connecticut conducted research and evaluation to measure the effectiveness of these practices in improving employment outcomes for people with MI.

2. Vocational Rehabilitation - Mental Health Agency Partnership: Coordinating Supported Employment Services Across State Agencies: The *Delaware Division of Vocational Rehabilitation* (DVR) and the Delaware Division of Substance Abuse and Mental Health (DSAMH) have been collaborating to provide supported employment (SE) services and supports to individuals with mental illness (MI) for several years in an intensive fashion. In 2006-2007, the partnership intended to jointly implement Evidence-Based Practice (EBP) Supported Employment (SE) programs in the 4 service areas of the state as part of the Johnson and Johnson – Dartmouth Community Mental Health Program. For a variety of reasons, this partnership ended before full implementation. Subsequently DVR contracted with the Institute for Community Inclusion (ICI) at the University of Massachusetts Boston to assist DSAMH and DVR in building on that start using braided funding from the two agencies. Since that time DVR has continued to build up the employment system for MH clients in DE and has been the primary intervention agent for this change. This represents an assertive approach that an SVRA can take to encourage, promote, fund, and advocate for its MH system partner to create more employment opportunities for joint clients.

3. Aligning Agency Policies and Procedures Through System Integration: The Maryland State Department of Education, *Maryland Division of Rehabilitation Services* (DORS) and the Maryland Department of Health and Mental Hygiene, Mental Hygiene Administration (MHA) have been collaborating to provide supported employment (SE) services and supports to individuals with mental

illness (MI) for over twenty years. In 2001, the partnership jointly implemented Evidence-Based Practice (EBP) Supported Employment (SE) programs, also known as IPS Supported Employment, in six community mental health provider agencies as part of the National Evidence-Based Practice Demonstration Project and the Johnson and Johnson –

Dartmouth Community Mental Health Program. DORS and MHA facilitate system integration by aligning policies and procedures (regarding referral, intake, eligibility determination, and data-sharing) as well as finances for SE services. The current SE programs in Maryland consistently yield comparatively higher competitive employment outcomes for individuals with MI than non-EBP SE programs, and the state's overall employment rate for people with mental and emotional (psychosocial) disabilities is above the national average.

4. An Evolving Partnership: Aligning Agency Missions and Integrating New Technologies to Streamline Agency Processes: The *Missouri Division of Vocational Rehabilitation (MDVR)* and the Department of Mental Health (DMH) have been partnering for over 20 years to coordinate supported employment (SE) service delivery to individuals with serious mental illness (SMI). The partnership specifically focuses on coordinating SE funding, streamlining eligibility requirements, and collecting data for shared customers. The MDVR-DMH partnership has positively impacted employment outcomes for individuals with SMI, as evidenced by above-average employment rates for people with mental and emotional (psychosocial) disabilities.

5. A Rural Model of Collaboration between a Vocational Rehabilitation Area Office and a Community Rehabilitation Provider: The *New Mexico Division of Vocational Rehabilitation (DVR)* Area IV office partners with a community rehabilitation provider (CRP) to coordinate Supported Employment (SE) services for individuals with mental illness (MI). The purpose of the DVR Area IV office – CRP partnership is to provide a continuum of care across agencies, including mental health care services and vocational rehabilitation SE services. The partnership focuses on several areas of collaboration, including: centralized communication, streamlined referral, expedited service initiation, coordinated service delivery, and coordinated SE funding. This collaboration model is now currently implemented in two additional communities in New Mexico and shared at statewide mental health conferences.

6. Creating a Sustainable Partnership: Utilizing a Medicaid Billing Code as a Stable Source of Funding for Supported Employment Services: The *Oregon Office of Vocational Rehabilitation Services (OVR)* and the Addictions and Mental Health (AMH) Division partner to provide Supported Employment (SE) services to shared customers with mental illness (MI). The partnership focuses on coordinating service delivery across agencies, utilizing a sustainable funding scheme, monitoring quality of services through fidelity reviews, and collaborating with a local university. OVR and AMH also utilize a cost-benefit analysis to measure the impact of SE programs.

7. Partnering from the Top-Down and Maintaining Fidelity to IPS using Jointly Funded Staff: Since 2002, the *South Carolina Vocational Rehabilitation Department (SCVRD)* and the Department of Mental Health (DMH) have collaboratively implemented the Individual Placement and Support (IPS) model of Supported Employment (SE) for people with mental illness in nine community mental health centers (plus one additional site) across the state. SCVRD and DMH jointly fund IPS staff to coordinate and deliver integrated vocational rehabilitation and mental health services to over 500 South Carolinians with significant mental illness each year. IPS programs across the state consistently earn high scores on Johnson & Johnson – Dartmouth approved SE fidelity reviews, and the employment rate for South

Carolinkans with mental and emotional (psychosocial) disabilities was above the national average reported by the Rehabilitation Services Administration (RSA) in 2009.

8. Interagency Collaboration through Shared Administrative Responsibility, Shared Staff, and Counterpart Supported Employment Coordinators: The *Vermont Division of Vocational Rehabilitation (DVR)* and the Department of Mental Health (DMH) have been partnering for over 20 years to coordinate supported employment (SE) service delivery to individuals with serious mental illness (MI). The partnership specifically focused on program eligibility and referral, program staffing, and incentive payments for SE providers. This has positively impacted employment outcomes for individuals with serious mental illness, as evidenced by an increasing number of successful closures of VR customers into employment and above-average employment rates for people with mental and emotional (psychosocial) disabilities.

Methods

The VR RRTC research and policy group used a case-study approach (Yin, 1994) to identify and describe promising practices that exist in VR agencies to provide employment services for people with psychiatric disabilities, people with intellectual disabilities, or to address order of selection issues and the definition of most significant disability. Specifically, the methodology for this study consisted of five steps: a) recruitment of an expert panel, b) solicitation of practice nominations and initial practice nominations, c) development of practice indicators, d) review of nominated practices (Delphi process) and selection of final set for case-study research, and e) case-study research. The case study was part of a larger project (VR-RRTC.org) that investigated public employment service systems and the role that VR plays within this constellation.

Recruitment of an Expert Panel: Researchers recruited a national panel of experts who had expertise in one or more of the following areas: a) VR policy and administration; b) other state agencies that focus on public services for persons with psychiatric disabilities; c) consumer and advocacy groups for individuals with psychiatric disabilities related to employment; and d) research and program evaluation in any of the previously listed areas. Panel members were expected to a) review and comment on a list of indicators of effective VR practices that the researchers had developed; b) review and rate the nominated practices; c) participate in a one-hour teleconference to discuss panel-members' ratings and feedback; d) review their initial individual ratings and make any adjustments based on the teleconference discussion; and e) provide feedback on a summary of study findings.

The VR RRTC Project Advisory Board, Senior Policy Fellows and project partners helped identify potential candidates. To the extent possible, researchers considered candidate diversity (in terms of their professional background, gender, race, ethnicity, and disclosed disability) when selecting individuals to target for recruitment. Researchers recruited 24 experts including five state VR agency personnel, four state mental health agency personnel, six community rehabilitation provider professional staff, six academic researchers, one disability advocate, and two individuals with other affiliations. Note that experts could have several affiliations and roles. The names and affiliations of the experts are listed in the Acknowledgements.

Solicitation of Practice Nominations and Initial Practice Investigation: Researchers conducted extensive outreach to solicit nominations for effective VR employment practices for people with psychiatric disabilities. The Project Director sent an information and nomination letter to all state VR agency directors, to the Council

of State Administrators of Vocational Rehabilitation (CSAVR) and the Rehabilitation Services Administration (RSA) personnel including but not limited to monitoring team members. Researchers also contacted their project officers at the National Institute on Disability and Rehabilitation Research (NIDRR), the funding agency, who distributed the call for practice nominations among all NIDRR grantees. Other channels and venues used for outreach included: the project advisory board, the expert Delphi panel, State Rehabilitation Councils, the regional Technical Assistance and Continuing Education (TACE) Centers, rehabilitation professional membership organizations (such as the National Rehabilitation Association), the National Independent Living Association, provider groups, advocacy and family groups.

Researchers developed an accessible web-based nomination form that individuals, agencies, and organizations could use to submit practice nominations. The submission form asked nominators to briefly describe the practice and, if available, any qualitative and/or quantitative evidence of its effectiveness. Nominators were also asked to provide a contact for the practice (if available) as well as their contact information. Nominators could submit more than one practice. There was also the option to upload documents to share with the researchers.

In addition to the national call for nominations, researchers reviewed existing research and reports including RSA monitoring reports, RSA Annual Reports, and the RSA promising practices website, state agency websites, and other materials to identify potential practices. ICI staff with expertise in the field of mental health and VR nominated practices.

Between May and October 2010, researchers received a total of 58 nominations including 22 nominations through the web-based nomination form, six from the review of RSA monitoring reports, 13 through RSA 2008 Annual reports, 1 RSA promising practice, and 16 nominations by expert ICI staff. In sum, 30 states received a nomination from at least one source, and some states had multiple sources of nomination. Blind agencies, D.C., and the territories received no nominations. Note that researchers used a rolling nomination process, meaning that there was no set deadline for submitting a practice nomination. Once a practice had been nominated, researchers together with project staff and partners used a set of indicators (described below) to review nominations and determine the potential as an effective VR practice. Of the 58 nominations, this process yielded nine nominations that met the criteria for further review.

Nominated practices were excluded from Delphi review if there was insufficient data to warrant inclusion (n=12), the agency nominated was not a VR agency (n=11), the practice was not aimed at improving employment outcomes for people with MI (n=3), or the practice was included in a related case study effort focused on order of selection (n=2). In some cases, one practice was nominated by multiple sources (e.g. Maryland), or the practice was collapsed into a broader nominated practice (e.g. Oregon) and included in the Delphi panel review. It is also important to note that nominations sourced from RSA 2008 Annual Reports were based on the employment rates for individuals with mental and emotional (psychosocial) disabilities. If cases where this was the sole nomination source, researchers considered this insufficient data to warrant Delphi panel review.

Following this initial review process, researchers contacted the respective state VR agency to request additional information and to schedule a key informant interview(s). Researchers investigated a total of nine nominated practices. They summarized the information from the interview(s) and related documents and then shared the summary, after it had been reviewed and approved by the key informant(s) with the expert Delphi panel (explained later).

Development of Practice Indicators: Researchers developed a set of 12 indicators of effective VR practices. The intent was for experts to use these indicators to review and rate the nominated practices and for researchers to select, based on these ratings, a final sample of practices that best met these indicators for case-study research. Indicator development was an iterative process, during which researchers drew information from a variety of sources, including existing research on and policy analyses of Order of Selection policy and related issues, annual VR state plans, RSA monitoring reports, and other sources. Researchers worked closely with Senior Policy Fellows including a former VR director and developed and piloted a process for using these indicators to rate the nominated practices.

Once the indicators had been developed, they were shared with the expert panel for review and feedback. Specifically, expert-panel members were asked to review the indicators, evaluate their usefulness (on a 3-point Likert scale, 1 = *very useful*, 2 = *useful*, 3 = *not useful*), and suggest how to improve the indicators or the rating process. Twenty-three of the 24 experts completed the task. The majority of experts rated all of the 12 indicators as *very useful* or *useful*. Based on experts’ feedback and suggestions, researchers refined the existing indicators. The final set consisted of 12 indicators shown in Table 1.

Table 1: Delphi Panel Indicators Rating Sheet for Nominated MH case studies.

Indicator	Agree	Disagree	Not applicable / Lack of information
The practice demonstrates an <i>increase in VR program access and engagement</i> for individuals with MI.	()	()	()
The practice demonstrates ways for facilitating <i>active participation</i> of individuals with MI in the rehabilitation process, specifically in the following five elements: 1. Assessment and employment plan development 2. Employment plan implementation 3. Job targeted skills development, education, and training 4. Post employment services aimed at employment retention 5. Post employment services aimed at career advancement	() () () () ()	() () () () ()	() () () () ()
Adoption of practice has resulted in improved and measurable VR employment outcomes for individuals with MI.	()	()	()
Adoption of the practice has resulted in improved and measurable <i>other employment-related outcomes</i> of individuals with MI, such as improved disability management, health status, self-advocacy, etc.	()	()	()
The practice demonstrates <i>long-term sustainability, such as incorporation into VR policy</i> .	()	()	()
There is evidence that the practice is <i>replicable / transferable</i> to another state VR agency.	()	()	()
The practice represents an <i>improvement</i> of an existing approach, strategy or process to improve employment outcomes of individuals with MI.	()	()	()
The practice is <i>innovative</i> , that is, it pilots a new approach, strategy or process to improve employment outcomes of individuals with MI.	()	()	()

Review of Nominated Practices: Researchers used a modified *Delphi method* — a “systematic procedure for obtaining the opinions and, if possible, a consensus from a panel of experts on a particular issue” (Helmer, 1967, p. 2) — to review and rate the nominated practices with the goal to select a final sample of practices that best meet the indicators for case-study research. Dalkey, Brown, and Cochran (1969) pointed out that the method is most appropriate when precise information and knowledge on the issue(s) under study is not available (see also Brown, 1968; Linstone & Turoff, 2002). Researchers thought the Delphi method to be appropriate for reviewing and rating the nominated practices and selecting a final sample. Dalkey, Brown,

and Cochran (1969) described the implementation of the Delphi method as a three-step process: “obtaining individual answers to pre-formulated questions either by questionnaire or some other form of communication technique; iterating the questionnaire one or more times where the information feedback between rounds is carefully controlled by the exercise manager; [and] taking as the group response a statistical aggregate of the final answer” (p.1; see also Dalkey, 1967). The Delphi process used in this study consisted of three rounds.

In the first round, researchers sent the summaries of the nine VR practices to the expert-panel members, asking them to use the indicators to review and rate the practices using the rating sheet displayed as Table 1. Each panel member was encouraged to add comments in the selected boxes and as relevant to the practice. Twelve of the 24 panel members completed the task in the stated time frame of five weeks. Researchers summarized the ratings and comments for each practice and shared this information with the expert panel in a one-hour telephone conference (second round). The telephone conference engaged the experts in a group discussion about the nominated practices and to what extent each practice met the indicators. Twelve of the 24 experts participated in this activity.

Following the teleconference, researchers summarized the main discussion points and shared this information with the expert-panel members, asking them to review and, if needed, adjust their initial practice ratings (round three). Experts had one week to complete this task and 13 of the 24 experts completed it within that time frame. For each practice, researchers generated a frequency table of ratings across the 12 indicators and 13 expert-panel members. The list of practices was then shared with RSA and the NIDRR project officers for review and input. Ratings from the expert panel suggested that seven of the nine nominated practices be included for case study research. The VR RRTC research and policy fellows disagreed with the panel on one excluded practice and included an additional site/practice for a total of eight. The final sample consisted of eight practices from the following state VR agencies: Connecticut, Delaware, Maryland, Missouri, New Mexico, Oregon, South Carolina, and Vermont. In general, the practices selected for the final sample were selected because they demonstrated some type of innovation and/or a piece of the practice could be easily transferred to other states. The tools used throughout the entire modified-Delphi process are available from the authors.

Sample, instrumentation, and procedures: Researchers used a case-study approach (Yin, 1994) to investigate the selected practices in more detail. Specifically, they used in-depth, qualitative interviews with state VR agency personnel and document review to collect case-study data. With the help of the key informants interviewed previously, researchers identified between three and five additional individuals who were knowledgeable about the respective practice for interviewing. Researchers developed an interview protocol to guide the interview process. The protocol consisted of nine sections: introduction, access and equity to supported employment services, referral, staffing, funding, joint training, evidence of effectiveness,

transferability, and future directions. The interviews were conducted via the telephone; they followed a semi-structured format and lasted approximately one hour. The interviews were digitally recorded with the permission of the interviewee. In addition, researchers asked key informants and interviewees for additional documents about the practice (such as manuals, cooperative agreements, documentation or data collection tools).

Data analysis: The interviews were transcribed by a transcriptionist and then synthesized into detailed descriptions of a practice. Delphi panel scores were compiled and averaged as appropriate. Findings were shared with study participants (interviewees and key informants) and the expert panel to verify the researcher's interpretation.

Results

The VR RRTC Team in partnership with the Delphi expert panel identified eight promising VR employment services practices specifically addressing the needs of people with psychiatric disabilities. Detailed summary reports are provided in Appendix A.

Discussion and Reflections

Some of the themes emerged mirror what many theorists have postulated over the years in regard to innovation, change management, and multi-system collaboration. Common concepts in both the business and human service research literature (Branch, Hanushek, & Rivkin, 2012); (Fedorowicz & Sawyer, 2012); (Kotter, 1995); (Lash, 2012); (Ozaki et al, 2011); (TCC Group, 2011); (Roger, Sargent, Stoddard, & Turem, n.d.); (Shook, 2010); (Stone et al, 2007) and in the states interviewed keep reoccurring. Some of the ideas supported within the case studies that also have been represented in other work by management theorists include issues such as:

- Top administration leadership in creating and sustaining partnership activities such as agreements to jointly fund high level staffing positions or funding and Memoranda of Understanding that identify specific activities rather than just statements of mutual values (e.g., Connecticut).
- Focusing on behavior as a method for creating cultural change rather than “attitude readjustment” (e.g., setting expectations for expedited joint referrals between MH and VR for those interested in employment (when in the MH system) or those needing clinical supports (for those in the VR system) (e.g., Vermont).
- Developing flexibility to foster creativity in implementing new models of employment assistance (e.g., providing guest access to a partner agency's database or encouraging multiple chances for people whose recovery may be interrupted by episodic illness).
- Offering local autonomy within larger organizations such as encouraging local offices to experiment with funding and intervention models that may meet local needs such as in rural or frontier areas (e.g., New Mexico).
- Bridging policy barriers or traditions held over a lengthy periods that impede current progress (e.g., Medicaid restrictions or VR regulations or specific days of sobriety required for referral to VR) (e.g., Missouri).

- Fostering partnerships that include agencies and constituents in planning innovation (e.g., often among VR, state and local public mental health agencies, local clinical and employment services such as community rehabilitation providers and local mental health centers) (e.g., Delaware).
- Using technological tools more effectively (e.g., creating mechanisms for efficient electronic transfer of records between agencies or using online decision support models to aid people in making sound financial decisions regarding income and benefits) (e.g., Missouri)
- Assisting people to overcome fears based on lack of self-confidence/self-efficacy or real barriers (e.g., using evidence based practices related to concepts like Motivational Interviewing or Illness Management and Recovery (IMR) or providing work incentives counseling).
- Braiding together multiple funding streams (e.g., Public VR, Medicaid, State MH Block funds, federal demonstration or research grants, SSA Ticket to Work payments or cost reimbursements) (e.g., Oregon).
- Using funding tied to outcomes more than processes per se (e.g., paying for career planning, employment, and client retention achieved rather than hours of service) (e.g., Oregon).
- Offering advice, consultation, training, and technical assistance to those staff affected by changes desired (e.g., adding to in house expertise by including support for capacity and skill building through use of federal RSA funded regional Technical Assistance and Continuing Education (TACE) centers, federally or foundation funded centers of excellence such as Dartmouth Research Center, use of consultative contracts with content experts).
- Offering clarity in terms of the changes desired and the outcomes expected (e.g., setting clearly measureable standards of employment outcomes expected).
- Creating a sense of excitement and/or urgency to the prospect of improving employment outcomes for people with significant psychiatric disabilities (e.g., starting the innovation with a statewide “kick off” conference or regular regional gatherings of partners).
- Providing a consistent focus on multiple customers for advice and input (e.g., developing person-directed career planning approaches or inaugurating business relations efforts that focus on employer customer service and directed consistently to employer partners).

The VR-RRTC was able to identify pockets of promising practices throughout the United States, yet the case studies also shed light on issues that need to be addressed in various ways by different organizations. The fact that progress has been made and as the case studies elaborate positive changes have occurred, much remains to be done. This judgment is not just that of the psychiatric rehabilitation academic community, but was also reiterated within the HELP Committee report and NGA statement cited earlier. Some of the barriers and issues to be confronted relate to all potential or current workers with disabilities but others are especially relevant if not unique to those with psychiatric disabilities. The paragraphs below are not meant to be exhaustive listing of new issues, but they identify commonly occurring issues that were communicated in the course of the case study interviews. Some matters require additional emphasis towards resolution and further innovations. There is great need for investing further in promoting innovation and measuring its impact on employment outcomes and poverty alleviation of persons with psychiatric disabilities and mental illnesses.

- Significant rigorous research demonstrates successful and robust evidence based employment interventions on behalf of job seekers with emotional/ behavioral disabilities, such as the work of

- Drake, Becker, Bond, Cook and their colleagues. These approaches show significant improvements over prior models of employment assistance. However, people with psychiatric disabilities as a collective group have not attained a level of economic engagement and fiscal self-sufficiency that provides a viable pathway out of poverty. Big issues are at play and the way forward means more innovation at research, practice, policy, and societal levels.
- Employment leading to self-sufficiency has not attained a level of priority within public mental health systems of care, even though employment is recognized as one of the linchpins of the movement towards recovery (along with housing and personal relationships). Employment outcomes within public mental health have not progressed and declined in some areas over the last decade. There are multiple reasons for this limited attention. In some states, Medicaid can pay for Supported Employment while in others it is seen as prohibited and thus not in the state's Medicaid plan even under waivers. Clients are ambivalent about achieving financial independence due to concerns over benefits or lack of self-confidence to enter or return to the workforce. Within some MH systems of care, there is a belief that public VR should take on the role and there is a lack of designated staff within MH state leadership that coordinate employment intervention development within MH systems. There has been a severely diminished set of resources for the broad array of community rehabilitation needs that clients of MH systems of care require. And, quite importantly, there is a lack of a sustained grassroots consumer advocacy movement that pressures state systems to embrace this outcome for more of their clientele.
- Although the ADA (with its enhancements under the ADA Amendments Act) and the more recent Office of Federal Contract Compliance Programs (OFCCP) intent to create a numerical goal for people with disabilities as a percentage of the workforce for federal contractors under Section 503 of the Rehabilitation Act, many instances get reported by people with psychiatric disabilities of what they perceive as overt or subtle discrimination in hiring.
- The social safety net exemplified by resources such as SSA benefits, Medicaid and Medicare coverage, Supplemental Nutrition Assistance Program (SNAP; formerly called "food stamps") resources, and Section 8 housing subsidies provide invaluable assistance to people with psychiatric disabilities. However, the broad scope of these supports also creates confusing and sometimes contradictory rules that inhibit people's capacity to seek employment, whether because of actual regulatory conflicts or perceived as such by people using them.
- Despite many examples of vibrant business and rehabilitation relationships, many psychiatric rehabilitation employment staff may not have adequate preparation or skills to make a strong enough business case for the incorporation of people with psychiatric disabilities within the business workforce. The case should incorporate financial advantages that may accrue to employers throughout the U.S. and state taxing authorities as well as tapping into the human resource potential that these job seekers possess. This competency acquisition is especially crucial given the negative images that permeate the media regarding few, but dramatic violent incidents, that offer inaccurate views of the stability and personalities of the vast majority of people facing mental health challenges.
- While financial incentives do exist to stimulate the building of structures to support those with psychiatric disabilities entering the workforce (e.g., the SSA Ticket to Work reimbursement program), incentivize employers to hire people with mental illnesses as well as those facing other barriers to employment access (e.g., Work Opportunities Tax Credit - WOTC), or allay the risk to people receiving benefits in seeking employment (e.g., Work Incentives through SSA or state

Medicaid Buy In Programs) most of them are vastly underutilized. The deficit can probably be traced to weak or limited information dissemination, lack of trust in options due to previous poor experiences of people with disabilities in using them, or structural issues that minimize their positive impact.

- The collaborations that the case studies have elucidated showed a variety of creative ways to create partnerships across system boundaries. Yet, many institutional silos still exist – some due to administrative rules (e.g., VRs definition of successful employment versus no commonly accepted outcome standards in MH system employment efforts) and some due to traditions that have become entrenched (e.g., some VR agencies or offices requiring a standard duration of continuous sobriety though such a policy may not exist in the state administrative manual).
- Even with the focus on outcomes that the states interviewed demonstrated, there is still a large gap in “hard” statistics regarding employment and income within the MH systems that interact with VR. The RSA 911 data system is much more reliable and accurate than the majority of in-house public MH MIS systems that include employment data, if at all. However, data sharing may not be occurring due to privacy rules and administrative barriers among various agencies. Cross-agency data sharing is not just a complex technological or technical issue; it is a very complex and sometimes contentious bureaucratic effort.

The intent of the case studies and this report about them was to examine pockets of excellence and promising practices regarding interventions to assist clients with psychiatric disabilities within state VR systems to attain and retain employment leading towards economic self-sufficiency. It was not meant as an exhaustive cataloging of all the possible innovations occurring throughout the country in this sphere. Nor, was it meant, as a review of the extensive literature within the MH research field regarding evidence based models of employment interventions for people with serious mental illness. The case illustrations and this summary report sought to offer some concrete examples of strategies that VR personnel at state and local levels have tried to implement as incremental steps towards dealing with the large scale societal problem that long term un- and underemployment of people with significant psychiatric disabilities represents.

This report also ended with some consistent problems that the case study participants either identified as resolving in some way with great difficulty or still representing consistent challenges to success of their efforts. These continuing issues require attention in a multitude of ways to make a meaningful impact. Some can only be resolved legislatively or through administrative policies (e.g., SSA or Medicaid rules); some through research (e.g., increased knowledge about assisting people off benefits like Social Security Disability Insurance (SSDI) and into financially remunerative and rewarding employment); some through human resource development (e.g., recruiting employment staff skilled in business relations or training VR personnel in using Motivational Interviewing to influence people to choose employment); some through Leadership and Management (e.g., VR and MH agency Directors establishing partnerships or Memorandums of Understanding (MOUs) creating jointly funded positions or using Performance Management techniques adapted from the private sector). It is beyond the scope of this paper to offer complex policy recommendations but ICIs VR-RRTC and companion projects will continue to provide national and state policy insights and recommendations in a plethora of academic, government, and business venues. Our rationale for these consistent efforts is perhaps best stated by the closing comment by Sen. Harkin in his Open Letter from the Chairman that prefaces the HELP Committee Unfinished Business report: “It is now time again to show the same kind of leadership and open wide the doors to better jobs and careers as well as create an accessible pathway out of deep poverty and into the mainstream of the American middle class for the more than 20 million working age American adults with disabilities.”

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Appendix A

Summary Reports of Promising Practices in Vocational Rehabilitation to Improve Employment Outcomes of Persons with Psychiatric Disabilities Served by the State VR Agency.



A Case Study of Promising Vocational Rehabilitation Agency Practices in Improving Employment Outcomes for Individuals with Mental Illness

Vocational Rehabilitation and Mental Health Agency Collaborations with the Implementation of Co-located Counselors

**Connecticut Bureau of Rehabilitation Services,
(as of 2012, the Connecticut Department of Rehabilitation Services)**

Abstract

The Connecticut Bureau of Rehabilitation Services (BRS) and the Department of Mental Health and Addiction Services (DMHAS) partner to provide supported employment (SE) services to customers with mental illness (MI). The two agencies strive to provide a continuum of services and support to customers by co-locating Vocational Rehabilitation (VR) counselors in Local Mental Health Authorities (LMHAs), coordinating service delivery across agencies, collaborating with vendors, and coordinating joint training and monitoring efforts. The University of Connecticut conducted research and evaluation to measure the effectiveness of these practices in improving employment outcomes for people with MI.

Background

In 2002, the Connecticut Bureau of Rehabilitation Services (BRS) and the Connecticut Department of Mental Health and Addiction Services (DMHAS) became one of three initial implementation sites for the Johnson and Johnson – Dartmouth Community Mental Health program on evidence-based supported employment (SE) services. Under this program, BRS and DMHAS jointly implemented SE services using the Individual Placement and Support (IPS) model in over one-quarter of the state’s Local Mental Health Authorities (LMHAs)¹. At the end of the three-year grant period, DMHAS assumed full funding responsibility for the IPS SE programs in order to sustain the services and continue the partnership with BRS. [Note that DMHAS has full funding responsibility for the services provided by the mental health employment staff. BRS funds purchase the CRP services that are provided in tandem to DMHAS consumers such as career advancement, intensive on-site assessment or the purchase of items such as licenses or clothing.]

In addition to the shared funding for IPS SE programs, BRS and DMHAS also co-fund an Education Consultant / Coordinator for the BRS-DMHAS employment services *Collaborative Employment Project* position (Kellett et al., 2011). The Education Consultant position is jointly funded by DMHAS (75%) and BRS (25%), however, the agency that formally employs this position is BRS. This consultant serves as the primary liaison between BRS and DMHAS staff and is responsible for facilitating SE trainings and technical assistance across VR and MH agencies. When this position was first created, the consultant was charged with facilitating systems change and standardizing processes across BRS and DMHAS focused on employment for people with MI. Since then, the role of the consultant has evolved into focusing primarily on relationship and team building across BRS and DMHAS, and specifically, strengthening the IPS approach within the LMHAs.

In 2004, BRS and DMHAS made an effort to standardize the employment services offered to include the evidence-based practice IPS model of SE. This included a philosophical shift towards integrated, competitive employment within the DMHAS system, at both the state agency level and the local level amongst the LMHAs. At this time, DMHAS and BRS separated pre-vocational and club house models from the employment system [Note that DMHAS’ role in this was the primary facilitator of the change within the mental health system] and established the requirement that all funds designated as employment services funds were to be used to purchase integrated, competitive employment services, which is consistent with the BRS approach. All 13 LMHAs were assisted to implement the IPS approach.

Purpose, Goals, and Implementation:

The purpose of the BRS - DMHAS collaboration is to provide a continuum of services across agencies with the goal of improving employment outcomes for individuals with MI. Key highlights of this partnership include access to supported employment services, coordinating referrals, coordinating service delivery and funding across agencies, and collaborating with vendors.

Access to supported employment services: There are currently three primary BRS offices, and 13 LMHAs in the state of Connecticut. Each LMHA is partnered with one of the main BRS offices to deliver supported employment services. There are some LMHAs that have more than one partnership with BRS, resulting in 21 interagency partnerships across the state. As our key informant explained:

¹ DMHAS operates and/or funds regionally-based LMHAs that provide MH services; customers can access private non-profit providers through LMHAs. See <http://www.ct.gov/dmhas/cwp/view.asp?a=2899&q=334082> for more information.

There are thirteen local mental health authorities, which are managerial mental health clinics. Each is teamed with the local BRS offices that serve that geographic area, which results in twenty-one partnerships because several have multiple sites and work with more than one BRS office.

Therefore, any person receiving services from one of the 13 LMHAs across the state has access to the joint services provided by BRS and DMHAS. The method of delivery of services may vary across the state, because each LMHA is different in how they operate their business and utilize funding. Specifically, some LMHAs are operated by the state, and others are non-profit agencies. As a result, some LMHAs purchase services from outside vendors, and some provide services directly. Not all outside vendors that provide service to LMHAs are CRPs. Some “have questioned the financial viability of being a CRP for BRS.” Regardless of the method of delivery, because Connecticut has made an effort to standardize their employment services, a customer could enter any LMHA and be offered the same services across the state.

Coordinating referrals and service delivery: Because joint services are offered across the state, the referral process becomes critical in the delivery of joint services. Individuals with MI who enter a community-based organization that holds a DMHAS employment contract generally receive services directly from that organization. [Note that DMHAS’s 25 employment contracts purchase IPS services and supports only from community-based organizations. Contractors provide the full array of IPS services including engagement, job search, and long-term supports]. However, the employment providers are only authorized to serve people in their own geographic area without the authorization of their original LMHA. As a basic tenet of the IPS approach these organizations partner with either a community-based or LMHA clinical team to provide employment services alongside clinical services. Note that a few community-based organizations also deliver clinical services and would be able to team their employment specialists with their internal clinical treatment.

There are two instances where a client may be referred from DMHAS to BRS. In one instance, a client will enter the mental health system, request employment services, and then be referred to BRS because he / she “had a strong employment background, is pretty clear on where [he / she] is going, and doesn’t need a lot of hands-on help to become more independent in the job search.” Other clients will begin to receive services from DMHAS, and after a period of time when the individual demonstrates that they are “more stable in the workplace, their foundational skills are stronger” and “the symptoms are not actively interfering with the job,” DMHAS will refer the client to BRS. BRS may collaborate with DMHAS to assist in “building better supports” for clients who enter LMHAs by conducting in-depth on-the-job assessments of the individual’s employment history. These individuals are provided the option of receiving services from BRS or staying within the LMHA and working with the clinician who initially took their case. All consumers that are referred to BRS continue to receive wraparound supports from their clinical treatment teams including the employment specialist during the time they are working with BRS.

Some individuals with mental illness begin to look for employment services at BRS, but may also qualify for services at DMHAS. Following a discussion of whether or not the individual wants the wrap-around supports and clinical case-management services provided by DMHAS, these individuals are given an the option to apply for DMHAS services. In the event that an individual does decide to pursue additional services from DMHAS, our key informant stated that it is common practice for VR counselors to physically walk a client from one office to the other:

We often would walk the person over and actually be at the first couple of meetings with them to make sure that they've made it and that they can build relationships and that kind of thing.

Similarly, another key informant, a VR counselor, stated:

I'm lucky enough to be here and know the people in the crisis unit, so I'll schedule an appointment with the client, the other VR client, and I'll walk them down to the crisis unit and basically hand them over because they might be intimidated to come to the center by themselves.

A key piece of the referral process lays within the close proximity of some the BRS and DMHAS offices, allowing counselors to physically walk customers over to their colleagues in the corresponding agency. Furthermore, when cases are shared between the agencies, an effort is made to make sure “parallel services” are not provided. Overall, our key informant indicated that regardless of which agency an individual started receiving services, “any of those doors of entry would offer a menu that would include the other agency, and it’s the person’s choice in the end if they want to access service from the other agency.”

To further build a strong relationship between the two systems, DMHAS is encouraging their vendors to become BRS vendors. To make this a simple process, both DMHAS and BRS provide technical assistance via telephone to assist the vendors with the application process. As of January 2011, all but three of the vendors in the DMHAS system are now BRS vendors as well. The informant says, “We believe that agencies that provide services both for BRS and DMHAS can close the loop where the same provider delivers the whole continuum of services, rather than bringing in another provider.” DMHAS has also been encouraging these same vendors to get involved in the ticket-to-work partnership plus model, which, according to the key informant, provides “another way to relate to BRS, to learn more about the BRS system, and to be more thoughtful about long-term planning and supports.” As of January 2011, many of the vendors are pursuing partnership plus relationships with BRS or are operating as stand-alone ticket models.

Coordinating staffing roles and funding

One of the first steps in putting the partnership to work was recognizing what services BRS could provide to customers that DMHAS could not, and vice versa. By doing this, it allowed the two systems to create a continuum of services to their customers including IPS, clubhouses, and career advancement services for individuals who may not require the level of support provided by IPS. Before any services are provided, the two agencies have a conversation with the customer and his / her family and peers to agree on common short and long-term goals. Then the agencies decide on what services can be provided by each agency to best meet those goals. An explanation of this process was given by one of the counselors:

I think it starts with one, everyone, putting the best interest of the client first, first and foremost. And then from there, understanding each other's system and then looking at what does the client need and who can provide that particular service.

DMHAS provides the initial engagement, early placement and supports in a job with a small number of hours, and long-term supports. BRS tends to act as a vehicle for moving customers forward in their employment and opens cases when customers are more stable and farther along in their recovery. While BRS may not open a case until later in the service delivery process, they are involved in the initial

discussions and can offer advice on activities a customer can be working on to continue progressing towards successful employment and building supports.

Our key informants have noted that collaboration does not come easy and takes hard work and dedication. This was highlighted when one of our key informants stated:

A few of the DMHAS providers are not vendors for BRS and as a result the employment specialists don't work for BRS. (...) [Because] the employment specialists don't work for BRS... I can suggest, I can strongly recommend, but I can't pull my case and go elsewhere and that really changes the dynamic of the relationship. We truly have to collaborate...

To ensure the joint provision of services runs smoothly, a common communication strategy is in place that allows each agency to know what is expected in different situations such as discussing issues or debriefing about past or on-going events. Specifically, one of the LMHAs created an electronic shared communication form, which is used to record any activities that have occurred with a shared client. Moreover, staff from both BRS and DMHAS meet regularly every one to three months to discuss on-going shared cases as well as potential referrals.”

If a BRS customer needs services that are not offered by BRS or DMHAS, BRS will pay for a vendor to provide those services. However, for services offered by one of the LMHAs, the BRS customer will be referred to the employment specialist, and those services will be funded by DMHAS. It must be remembered that there is no standardized process for funding joint customers as of yet; only flexible guidelines. , As one of our key informants said, “the rules are just different for each person and each LMHA.” But staff at both agencies continue to formalize protocols for the interagency teams with the understanding that the specific continuum of services will differ for each shared consumer.

In addition to the shared position of Education Consultant, BRS utilized funds from an Innovation and Expansion (I and E) grant, to embed three of their counselors into the MH system. Three state-operated LMHAs in large cities were chosen as the sites for these three VR counselors. BRS and DMHAS selected these agencies because they would have enough referrals to create a full-time job for the co-located counselors due to the large volume of customers.

As of May 2012, there is only one co-located counselor still working full time in the MH system. The major challenge for BRS in maintaining this co-located counselor role has been staff turnover at both BRS and the LMHAs, which makes it difficult to maintain a full-time VR counselor within the LMHAs. However, the BRS-DMHAS partnership is not limited to the co-located counselor position. For instance, there are currently three main BRS offices and 13 LMHAs, resulting in 21 agency partnerships (some LMHAs partner with more than one team from BRS). For these 21 agency partnerships, there are approximately 16 “liaisons” that “[serve] as the primary BRS link for the DMHAS system in their area” who then communicate back to BRS the needs of the LMHAs and coordinate any potential referrals. From there, BRS supervisors will assign caseloads and the liaisons, although the primary contact is “not the exclusive person within a BRS office that would be working with people with mental illness.” These liaisons are BRS counselors with Masters degrees and have an interest and/or background in mental health. As a result, BRS-housed counselors continue to meet regularly with the LMHAs to stay informed about potential referrals and customers in shared caseloads.

BRS and DMHAS continue to utilize the model under which a VR counselor works closely with the LMHAs but not in the physical office. The key informant reports that the model of having a BRS counselor work

closely with the LMHAs is feasible and works well. There are, however, challenges that arise when BRS counselors partner with LMHAs. One of those challenges is that each LMHA is unique in that some are run by the state and some are not-for-profits, Each LMHA was given authority to configure its service delivery system as long as it adhered to the IPS approach (e.g., employment staff sit on clinical treatment teams where all members have roles in supporting employment outcomes, employment programs have strong supervision and are endorsed by the LMHA leadership, etc.). As a result, each LMHA uniquely defines how they are staffed; the decision to use internal versus contracted staff to deliver employment services is left up to each local authority. The implications of having unique LMHAs mean that BRS counselors must “become [very] familiar with who it is that they’re working with and what the role is of each of those people in the state system.” Regardless of the differences found in each LMHA, each customer will receive a “standard menu of services” which will be delivered by a team of clinical providers and employment staff. In order to measure the effectiveness of this practice, the University of Connecticut was contracted to evaluate the impact of these staffing models on employment outcomes.

One area of collaboration that has been particularly fruitful is the access of DMHAS consumers to BRS benefits counselors. Now that the federal grant that supports their work has ended, DMHAS is contracting directly with DSS-BRS to purchase benefits counseling. DMHAS staff greatly appreciated this service and use it frequently.

There are various joint training efforts between BRS and DMHAS aimed at maintaining the VR-MH partnership at the local / service-delivery level. First, DMHAS runs eight training courses focused on the IPS model that have been developed from tools originally received from Dartmouth as part of the Johnson & Johnson-Dartmouth Community Mental Health Program pilot. These are provided free of charge to DMHAS employees through the DMHAS training academy. Topics include employment strategies for persons with co-occurring disorders, criminal justice involvement and building long-term partnerships with employers. To help the BRS system learn more about the IPS model, these trainings are made available for BRS counselors to attend on a limited basis. Secondly, a MIG (Medicaid Infrastructure Grant) from DSS-BRS [BRS was a bureau within DSS so the MIG grant went to DSS] to DMHAS, provided funds for statewide trainings facilitated by the Education Consultant and community employment providers. Trainings from this grant were geared toward the employment supervisors of DMHAS employment providers. The MIG-grant also funded trainings for “peer staff in the DMHAS system” and the development of a computer-based “soft skills” training for young adults.

The MIG also supported a daylong training that was conducted around the state and targeted at both DMHAS and BRS staff. The training looked at best practices discussed by local teams of BRS and DMHAS staff as well as potential conflict areas between the two agencies and strategies to work around those issues. Also, another purpose of this training was to increase the level of comfort among BRS counselors in working with individuals with MI on their caseloads. To kick off the joint training program, a breakfast was held with the CEOs of all of the provider agencies from the DMHAS side as well as managers from the BRS system. The informant felt that the training engaged these individuals and gained buy-in and support for this new model of collaboration.

Training and technical assistance is ongoing for the local interagency teams. The Education Consultant met with both the LMHA and BRS staff separately to discuss the elements of the teamed approach. She then attended the new teams’ initial meetings to develop collaborative protocols that focused on several key strategies; each system designating a point person to serve as the liaison for their agency, regular meetings where on-going cases and potential referrals would be discussed and joint employment plans initiated, training for the staff of both agencies, and a commitment to on-going communication. Where BRS

contracts with a Community Rehab Provider, that agency would also attend the meetings, as would other members of the consumer's treatment team, family members, and others they invite to the table

Although there are both formal and informal trainings occurring between BRS and DMHAS, our key informant noted: "What I think we really have to work on developing is a much more specific training for those liaisons and for the best practices coming out of the teams." A BRS-DMHAS best practices panel discussion that focused in more detail on collaborative practices was held for frontline DMHAS staff. This approach might also be useful for BRS staff.

Supporting Evidence:

BRS, DMHAS and the University of Connecticut Center on Aging signed a Memorandum of Understanding (MOU) under which the university collected data to evaluate the effectiveness of the co-located counselor model². In 2011, the University conducted a study to collect outcome data for customers receiving services from LMHAs that have co-located VR counselors (Kellett et al., 2011). As a part of this study, the University also evaluated the customers' level of satisfaction with services. Interviews with customers receiving employment services as a part of this co-located counselor model demonstrated that the majority of individuals who participated in this study reported to be "very" or "somewhat" satisfied with the employment and VR services provided as a part of this model; additionally, all study participants who were employed reported satisfaction with their current job (Kellett et al., 2011). According to the key informant, the findings from this study also demonstrated "that the consumers that had this wraparound service had higher rates of employment and also had higher wages." In addition to these evaluation efforts, DMHAS recently developed a comprehensive data collection system to collect employment outcome data using selected indicators that they think will be meaningful. The data points being collected are: placements, date of placements, date of the ending of a placement, number of hours, entry level wage, job title, and company title. All of DMHAS' provider agencies are now entering those data and DMHAS hopes to have mechanisms in place in the future for retrieving reports, reviewing data, and for agencies to review their own data.

DMHAS requires LMHAs to establish and submit employment plans biannually. One of the items in these plans includes goals and objectives focused on building relationships with each LMHA's local BRS office. These plans are reviewed by DMHAS and each of the LMHAs receives individual feedback on these goals and objectives. There are fidelity reviews conducted in the IPS model that include a question asking how the LMHA is working with BRS. Also, BRS staff have joined DMHAS staff to conduct fidelity reviews to help familiarize the BRS staff with the IPS model. Mechanisms such as these help build the relationship between DMHAS and BRS by promoting and measuring the progress of the partnership.

² Bureau of Rehabilitation Services, Connecticut Department of Social Services. (2010, June 29). *State plan for the state vocational rehabilitation services program and state plan supplement for the state supported employment services program: Connecticut dept of social services – bureau of rehabilitation services state plan for fiscal year 2011*. Retrieved from <http://rsa.ed.gov/view.cfm?rsaform=VR-State-Plan&state=CT&fy=2011&agency=G>

Future Directions:

The key informant from the BRS system hopes to continue the “concept of making sure that we’re providing joint services for shared consumers; not seeing it as one agency’s role or the other’s but rather as a partnership.” There is still room for development to further streamline the referral process, implement a shared electronic data outcome or case management system, and/or, as our key informant mentioned, to have shared intake paperwork. Other areas that need further development include creating uniform BRS strategies for working with DMHAS addictions agencies, including DMHAS addictions staff in the team meetings, and training for BRS offices on the inner workings of the DMHAS system. Recently BRS has moved from DSS to become a separate state agency called the Department of Rehabilitation Services. While this may have long-term implications for the two systems, both are fully committed to the collaborative model. The Education Consultant is also retiring. It is anticipated that the Education Consultant’s replacement, also to be funded jointly, will continue to build on the successes of the partnership.

Transferability:

For states looking to replicate the collaborative efforts of BRS and DMHAS in delivering SE services to individuals with MI, our key informant advises that creating a shared vision and a collaborative, communicative team across agencies needs to be prioritized. Examples of ways to implement such a strategy include: “identifying key liaisons from each system, looking for strategies for cross-training, [and] develop[ing] some helpful tools” such as their electronic communication tool. Streamlining the referral process by creating “referral packets” is another way to implement this practice in another state.

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A Case Study of Promising Vocational Rehabilitation Agency Practices in Improving Employment Outcomes for Individuals with Mental Illness

Vocational Rehabilitation - Mental Health Agency Partnership: Coordinating Supported Employment Services Across State Agencies

Delaware Division of Vocational Rehabilitation

Abstract:

The Delaware Division of Vocational Rehabilitation (DVR) and the Delaware Division of Substance Abuse and Mental Health (DSAMH) have been collaborating to provide supported employment (SE) services and supports to individuals with mental illness (MI) for several years in an intensive fashion. In 2006-2007, the partnership intended to jointly implement Evidence-Based Practice (EBP) Supported Employment (SE) programs in the 4 service areas of the state as part of the Johnson and Johnson – Dartmouth Community Mental Health Program. For a variety of reasons, this partnership ended before full implementation. Subsequently DVR contracted with the Institute for Community Inclusion (ICI) at the University of Massachusetts Boston to assist DSAMH and DVR in building on that start using braided funding from the two agencies. Since that time DVR has continued to build up the employment system for MH clients in DE and has been the primary intervention agent for this change. This represents an assertive approach that an SVRA can take to encourage, promote, fund, and advocate for its MH system partner to create more employment opportunities for joint clients.

Background:

Delaware Division of Vocational Rehabilitation (DVR) and the Delaware Division of Substance Abuse and Mental Health (DSAMH) have been collaborating to provide supported employment (SE) services and supports to individuals with mental illness (MI) for several years in an intensive fashion. In 2006-2007, the partnership intended to jointly implement Evidence-Based Practice (EBP) Supported Employment (SE) programs in the 4 service areas of the state as part of the Johnson and Johnson – Dartmouth Community Mental Health Program. For a variety of reasons, this partnership ended before full implementation. Subsequently DVR contracted with the Institute for Community Inclusion (ICI) at the University of Massachusetts Boston to assist DSAMH and DVR in building on that start using braided funding from the two agencies. Using this external assistance the two agencies joined into an interagency agreement that outlined each agency's funding responsibility for SE in an effort to avoid duplication. This interagency agreement was amended several times to refine the expectations of each for both fiscal and programmatic matters.

With the assistance of ICI in 2007-2009, DVR and DSAMH established an SE Coordinating Committee, hired an SE Coordinator who would be stationed within the central office of DSAMH, provided training to SE direct line staff and supervisors, reviewed policies from both agencies that might promote or inhibit successful employment, reviewed fidelity measures expected as part of Evidence Based Supported Employment through the J & J –Dartmouth initiative even though that formal arrangement was no longer operative with DVR-DSAMH in DE, and offered on site technical assistance from ICI and internal staff. While the ICI technical assistance effort ended in 2009, DE DVR has maintained its aggressive approach to and support of developing Supported Employment opportunities for helping consumers with significant disabilities due to serious mental illness achieve successful employment outcomes.

Since 2007, the two agencies have recruited 4 community mental health providers as pilot sites to implement EB-SE. These sites have undergone some changes in terms of providers and service areas. There are now 2 providers in each county. Several providers serve multiple counties. This is an important issue, as the lack of choice was raised as a concern in the prior MH service model. There were many operational issues that surfaced during this time and thereafter into 2012 including continued emergency situations with the Delaware Psychiatric Center, departure of the DSAMH SE Coordinator (who had replaced the original Coordinator), recent changes in the funding model of the cooperative agreement (whereby DSAMH has transferred its allocated funding for SE to DVR for oversight and management, administrative staff turnover (including a new DSAMH Director), a Department of Justice suit that resulted in a consent decree that specifies a DSAMH commitment (with DVR help though DVR is not a party to the suit) to provide 1100 clients with SE services over a multi-year period, and the restructuring of the entire DSAMH community services package into an ACT and a modified ACT treatment model. The changes within DSAMH have affected that system's ability to coordinate effectively and consistently. Yet because the DVR attention and staff to the SE project has remained quite stable, DVR has been a linchpin and a model for this effort. Now with some semblance of DSAMH stability's returning, the fact that DVR has managed to hold the course and continue to engage DSAMH senior management has proved beneficial to renewed DSAMH attention.

Purpose, Goals, and Implementation:

Coordinating staffing roles and funding: The purpose of the partnership between DVR and DSAMH has been and continues to be to enhance and streamline the delivery of EB-SE services across the state in order to improve employment outcomes for individuals with serious mental illness. DVR and DSAMH attempt to facilitate system integration by aligning policies and procedures (regarding referral, intake, eligibility determination, data-sharing), as well as finances for SE services. DVR and DSAMH seek to make employment services available to individuals with significant mental illness who are receiving mental health services using evidence-based practices. The rationale for the development of a Memorandum of Understanding (MOU) was to establish a collaborative framework for both agencies to establish and maintain an employment program for people with significant mental illness; identify eligibility criteria, to define agencies roles and responsibilities, and define each participant's contribution to this program. DVR and DSAMH have agreed to share resources and expertise, and thereby serve joint consumers more effectively and thus establish the terms and conditions for collaboration on the evidence based employment program in Delaware. In service to these goals DVR and DSAMH have worked out a series of cooperative agreements - MOUs culminating in the most recent of 2012 where the following implementation procedures have been agreed to, most of which echo the initial design initiated in 2007 through the leadership of DVR in coordination with the previous administration of DSAMH:

- Project Management for the Evidence Based Employment Program is coordinated jointly through a steering committee composed of representatives from both agencies, and representatives from the community based service providers. The steering committee plans to meet at least quarterly to discuss issues relative to program services, best practices, issues regarding coordination, and policy and procedural issues.
- DVR and DSAMH will continue to examine data collection, outcome measures, evaluation criteria and reporting procedures, with a goal to establish and monitor common measures of success.
- DVR and DSAMH will each identify a program liaison to lead and coordinate joint efforts in the areas of communication, quality assurance, training, and policies and procedures.
- The agencies wished to promote continuation and expansion of best practices of the SE cooperative program begun in 2007 based upon empirically validated results.
- DVR has entered into evidence based employment service agreements with community based service providers who have agreements with DSAMH to provide ACT Team services to DSAMH eligible individuals;
- DVR will establish eligibility for each applicant and funds evidence based employment services in a timely manner to all eligible individuals;
- DVR contracts with evidence based employment providers and requires providers to administer evidence based employment programs in accordance with the accepted SAMHSA SE fidelity principles
- DVR administers DSAMH funds contributed, as well as DVR funds, to maintain the evidence-based program for individuals found eligible to receive services from a DSAMH funded Assertive Community Treatment (ACT) and Intensive Case Management (ICM) Services Team.

- DSAMH will require participating mental health providers to integrate employment into mental health treatment services program;
- DSAMH will require participating mental health service providers to report key employment indicators as part of their contract performance measurement and quality assurance process;
- DSAMH will require participating mental health agencies to establish evidence based-employment programs to provide employment services to eligible consumers as part of provider agreement;
- DSAMH contributes \$176,000 (amount it had previously allocated to its support for evidence based Supported Employment for its clients) to DVR to fund evidence based employment and follow-along employment supports with service providers that receives a contract from DSAMH and DVR.

DVR has been funding the model through contractual arrangements with the mental health providers with 4 guaranteed quarterly payments (\$22,000, \$11,000, \$11,000, \$11,000) and a 5th payment of \$11,000 if they achieve their employment goals. If they exceeded their goals, they could get \$1,000 for every placement over the goal. There are also a couple other options for bonus payments, as well (high wages, 180 days of employment). The new MOU that has been negotiated for 2012 moves the payment structure to an outcome payment for individual clients now that the program appears to be well institutionalized and stabilized within the MH providers offering the SE service. The new milestone funding model based on individual client fee for service is set at: a) Vocational Support Services (\$1225.00); b) Placement (\$1435.00) and c) Retention and Stabilization (\$1700). **Note:** In the event that placement is made where that vendor becomes the employer of the consumer referred for placement, DVR pays the provider 65% of the total placement and successful closure rates if and when the DVR consumer has achieved ninety days of successful employment on the job.

The three service elements are outlined and defined as follows:

Vocational Support Services

Outcome: The initial payment for vocational support services shall be made by the DVR counselor upon receipt of a documented services report at a minimum of one month of vocational support services being provided to the consumer as described below.

Service Description: Vocational specialists initiate services within 14 days of receipt of referral by the VR counselor after a consumer has established an interest to work and pursue an employment goal. Vocational specialists working with consumers under this contract report on the following elements related to DSAMH and DVR:

- Assessment of job-related interests and abilities through a complete education and work history assessment as well as on-the-job assessments in community-based jobs. Assessment of the effect of the consumer's mental illness on employment with identification of specific behaviors that help or hinder the consumer's work performance and development of interventions to reduce or eliminate any hindering behaviors and find effective job accommodations.
- Job development activities including business engagement on behalf of the consumer, in addition to mental health awareness and educational activities offered to businesses in the community.

- Benefits counseling
- Development of a consumer-driven, on-the-job or work-related crisis intervention plan and ongoing individual supportive therapies to assist consumers with the symptoms of mental illness that may interfere with their work performance.
- Cross training to other team members on vocational and supported employment concepts for persons with mental health disabilities.
- Work-related supportive services, such as assistance with resume development, job application preparation, interview support, personal hygiene, wake-up calls and transportation.
- Job coaching and follow along supports.

II. Placement

Outcome: Job placement has been made and documentation has been received and verified by the VR counselor.

Service Description: Vocational specialists have face-to-face contact within 1 week before starting a job, weekly for the first month, and at least monthly for a year or more, on average, after starting a job. Clients are transitioned to step down job supports from the ACT/ICM teams following steady employment. The job in which the individual has been placed meets all DVR employment guidelines, and the consumer is satisfied and has begun work. Consumers are to be placed in jobs offering a minimum of 20 hours per week unless the nature of the individual's disability requires a lesser number of hours worked each week. (No placement will be accepted under a section 14C special minimum wage certificate issued by the United States Department of Labor.)

III. Retention and Stabilization

Outcome: 90 days of successful consecutive employment and documentation has been received and verified by the DVR Counselor.

Service Description: Ongoing monthly supports provided to assist the consumer in maintaining employment. Case meets all criteria for successful closure at 90 consecutive days of employment and the service provider has submitted all required documentation. Consumer must have received adequate training and support after placement.

Access to supported employment services: The products of the collaboration were not limited *geographically*. That is, such services were accessible to each of the 4 original providers that were serving the state's MH population during the development of the Supported Employment partnership. Currently, under the DSAMH redesign, two mental health providers search each area in order to enable enhanced client choice. However, not all the providers were equally focused on or skilled in delivering Supported Employment to their respective clients. Some improvements were made after the technical assistance intervention conducted by ICI as well as the continued assistance and training offered to all the providers by DE DVR staff but nonetheless disparities remained. The new configuration of MH community services buttressed by the added weight of the ADA settlement holds the potential for broadening access beyond the initial successes from the earlier funding and partnership collaboration.

Supporting Evidence:

While the statistical results in terms of the four designated agencies have been variable though improving, some key accomplishments include but are not limited to:

- Renewed emphasis on employment and economic engagement among community mental health service providers and within DSAMH;
- The concrete manifestation of DVR's interest in serving people with psychiatric disabilities through enhanced funding models;
- DVR's willingness and ability to be the primary instrument of change in terms of assisting DSAMH in creating an enhanced ability to assist its clients in terms of employment;
- The ability of the DVR Director to be a persuasive advocate for employment in her dealings with her administrative counterparts in the state, especially the former and current DSAMH Directors;
- The continued commitment to developing a viable joint funding model from both DVR and DSAMH;
- The development of a broader data system/ MIS to use in measuring employment success for the system, including employment strategies other than supported employment;
- The institution of leadership meetings that attempt to engage DSAMH, DVR, and CCCP leadership to discuss policy and fiscal issues;
- The highlighting of this effort at state leadership groups including the state MH Advisory Council and the Governor's Commission on Community Based Alternatives (the so-called Olmstead Commission);
- The development of a fidelity review process that has the potential to incorporate external assessment with more of an internal quality improvement focus;
- Some putative evidence that the community mental health service providers have in general developed a full understanding of evidence based supported employment and have been able to practice many of the techniques that the fidelity template puts forth;
- DVR's work in the 2007-2009 period in stimulating the offering of a locally designed and coordinated training series in employment and people with mental illness using the regional continuing education resources from George Washington University and Virginia Commonwealth University as well as creating more of a psychiatric disability focus through the University of Delaware Supported Employment Training for Employment Specialists
- The ability for DVR to stabilize and institutionalize the service with the DSAMH providers that offer SE to the point that it can move the funding model from an agency contract to an individual fee for service milestone approach.

Future Directions:

The major challenges facing the Delaware DVR in continuing to promote the cause of employment within the MH community and service providers revolve around the fact that it is difficult for the MH system of care to focus on employment given the multitude of changes it needs to make in response to the DOJ agreement and the financing limits imposed upon DSAMH regarding appropriate Medicaid usage. DVR has been an outstanding, cooperative, and flexible partner over the years and taken on the major leadership role in implementing SE for clients of DSAMH. It seeks to balance this willingness to be a good collaborator with ensuring that DSAMH continues to expand its ability to ensure that more of its clients are able to participate more fully in society through economic engagement. Some of the issues that DVR will deal with in the coming year relate to its ability to assist DSAMH in shoring up its commitment to employment while pursuing its own strategies to reinforce and sustain its efforts over the last five or more years. The standards DSAMH has adopted also assume that a core member of each community case management team (the vocational specialist) provides significant services in this arena and these should not be delegated to an outside agency such as DVR. Given the changes required within the service stream of DSAMH it would be very useful for DVR to encourage the administrators of DSAMH to issue some sort of policy statement in support of the employment interventions required. This policy would reiterate the importance of employment service as core elements of the new service design and the expected level of commitment/service intensity DSAMH and its contracted providers should exhibit as a concrete manifestation of this emphasis. One aspect of this public commitment and policy guidance would be DSAMHs working with the state Medicaid authority for official sanctioning to use Medicaid funds appropriately under the statutory authority of the Medicaid Rehabilitation Option for the variety of supportive services that can impact employment outcomes.

Transferability:

The innovation the DE DVR undertook in conjunction with DSAMH is replicable in most major respects for other interested SVRAs. It involves a value-based effort initiated by DVR to ensure that employment services are implemented through the mental health system of care for joint clients of both systems. The DVR used Section 110 funds not grants or special allocations and worked in conjunction with DSAMH to leverage funds that the MH agency used from their state monies to buttress supported employment for mutual clients across all the MH providers. DE DVR furthermore used a developmental cost based contractual approach with MH providers to get employment services established and then moved to a fee based, milestone model. In addition, DVR used both internal personnel resources as well as a 2 year consultation contract with ICI to provide training and technical assistance to each of the Supported Employment providers within the MH system of care. All of the foregoing is possible within the administrative parameters of both DVR and MH agencies, should they prioritize employment for the MH population and have funds available. Some key differences that might impact other VR agencies' ability to replicate include an agreement between DSAMH and the United States Department of Justice as part of an ADA settlement that commits it to provide at least 1,100 clients with supported employment services. DE DVR is fully matched with its state allocation and is not in an OOS, which might hinder some other states not in similar situations.



A Case Study of Promising Vocational Rehabilitation Agency Practices in Improving Employment Outcomes for Individuals with Mental Illness

Aligning Agency Policies and Procedures through Systems Integration

Maryland Division of Rehabilitation Services

Abstract:

The Maryland State Department of Education, Division of Rehabilitation Services (DORS) and the Maryland Department of Health and Mental Hygiene, Mental Hygiene Administration (MHA) have been collaborating to provide supported employment (SE) services and supports to individuals with mental illness (MI) for over twenty years. In 2001, the partnership jointly implemented Evidence-Based Practice (EBP) Supported Employment (SE) programs, also known as IPS Supported Employment, in six community mental health provider agencies as part of the National Evidence-Based Practice Demonstration Project and the Johnson and Johnson – Dartmouth Community Mental Health Program. DORS and MHA facilitate system integration by aligning policies and procedures (regarding referral, intake, eligibility determination, and data-sharing) as well as finances for SE services. The current SE programs in Maryland consistently yield comparatively higher competitive employment outcomes for individuals with MI than non-EBP SE programs, and the state's overall employment rate for people with mental and emotional (psychosocial) disabilities is above the national average.

Background:

The Maryland State Department of Education, Division of Rehabilitation Services (DORS) and the Maryland Department of Health and Mental Hygiene, Mental Hygiene Administration (MHA) have been collaborating to provide supported employment (SE) services and supports to individuals with mental illness (MI) for over two decades. The two agencies joined into an interagency agreement in 1987 that outlined each agency's funding responsibility for SE in an effort to avoid duplication (Reeder & Johnson, 2008). The interagency agreement was amended in 1995 and 2000, replaced by a cooperative agreement concerning SE services in 2007, and renewed again in December of 2011.

While DORS and MHA have had a longstanding relationship, the partnership between the two agencies crystallized in 2001 with the joint implementation of the Evidence-Based Practice (EBP) in Supported Employment (SE) Initiative. Maryland was one of the original three states to implement EBP SE as part of the National Evidence-Based Practice Demonstration Project, in conjunction with the New Hampshire Dartmouth Psychiatric Research Center (PRC). This demonstration project was designed to disseminate knowledge generated by empirical research related to EBPs for individuals with SMI, to facilitate their implementation in real world practice settings, and to evaluate the success of a large-scale, national EBP implementation effort in the participating states and sites. In the same year, the University of Maryland School of Medicine's Department of Psychiatry established, with funding from MHA, a Mental Health Systems Improvement Collaborative (MHSIC); its Evidence-Based Practice Center (EBPC) and Systems Evaluation Center (SEC) would provide technical assistance and consultation as well as program evaluation support to the DORS-MHA partnership, to selected community mental health provider agencies, and to others involved in this effort. One year later, DORS and MHA jointly applied for and were awarded a grant from the Johnson and Johnson – Dartmouth Community Mental Health Program (J & J – Dartmouth Program), which was designed to promote EBP SE services and to enhance state-level VR and MH collaboration in EBP SE implementation.

The two agencies competitively selected six community mental health providers as pilot sites to implement EBP-SE, three of which participated in the National EBP Demonstration Project protocol, and all of which received ongoing individualized training and technical assistance in EBP in SE implementation from the University of Maryland EBPC. As the three-year grant from J & J – Dartmouth Program was ending, DORS and MHA began to explore strategies for financing, sustaining, and expanding the EBP-SE program statewide. The number of SE programs grew quickly, and as of 2012, there are 57 community mental health providers across Maryland that provide SE services and supports to customers with MI, 39 of which have received training and technical assistance in EBP SE implementation, and 22 of which currently meet EBP SE fidelity standards.

Purpose, Goals, and Implementation:

The purpose of the partnership between DORS and MHA is to enhance and streamline the delivery of EBP-SE services across the state in order to improve employment outcomes for individuals with serious mental illness. Through this partnership, DORS and MHA have facilitated system integration by aligning policies and procedures (regarding referral, intake, eligibility determination, data-sharing), as well as finances for SE services.

Access to supported employment services: Supported employment services in Maryland are offered to both adults and transition-age youth. MHA funds supported employment to youth starting at age 16 and DORS

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funds these services approximately two years prior to graduation – funding for these programs comes from VR, state general funds, and Medicaid (explained below). One program under the auspices of two federal systems change grants, (one awarded to DORS from RSA and one awarded to MHA from SAMHSA), is pilot testing in two sites a multi-system integration and collaboration protocol for transition youth across mental health, VR, public education, social services, and juvenile justice service delivery systems. This pilot program is expected to yield additional administrative efficiencies specific to transition-age youth program services. As our key informant explained: “we’ve used [those sites] as a laboratory to pilot test all of these initiatives that we’ve done with our adult population with [the] transition-age population.”

Service providers can choose whether to provide evidence based or non-evidence based (traditional) supported employment. However, the usage of EBP-SE is incentivized through a milestone payment system through DORS, and an enhanced rate through MHA. All MHA SE service providers are required to have an approved cooperative agreement through DORS in order to receive payment for the service. As a result, all customers seeking supported employment have access to and can receive both MHA-funded and DORS-funded services from the same MHA provider/ DORS vendor, irrespective of whether the individual entered SE through the VR system or through the Public Mental Health System (PMHS).

Geographically, SE is offered by at least one provider in every county in Maryland and EBP SE is offered in every county of Maryland, except for the two most western counties of Garrett and Allegheny. Despite the incentives provided by the state to have providers adopt EBP SE, our key informant described that the state hasn’t “been able to get providers in the westernmost region to endorse this particular approach, and it’s much more challenging to do it in a rural area where there aren’t enough clinical resources (...) There’s a lack of psychiatric services in general in the westernmost region. Sometimes consumers have to travel an hour for a psychiatric appointment.”

Coordinating referrals and service delivery: This section focuses on how the two agencies aligned their agency policies and procedures concerning customer referral and intake, eligibility determination, and data sharing. DORS and MHA revised and signed a cooperative agreement concerning SE in 2007. The cooperative agreement outlines the purpose, legal basis, role and responsibilities of each partner, areas of cooperation, and definition of terms relevant to the partnership. Areas of cooperation include referral, service provision, fiscal resources, and exchange of information. The agreement includes a Joint Policy Statement: “Our collaboration and partnership is based upon the belief that federal and state resources must be directed to services that research demonstrates to be effective and efficient.”³ The key informant explained that the Joint Policy Statement reinforces the agencies’ commitment to employment for individuals with mental illness. He explained, “The vehicle to recovery was through evidence-based practice [supported] employment and the best utilization of limited state resources was to devote those services at both administrations to a service that has been proven to be effective.”

As DORS and MHA developed the partnership, the agencies examined the alignment of the two service delivery systems and identified areas of redundancy and duplication. In an effort to create systems with more seamless service accessibility, DORS and MHA worked to improve the customer application process, including restructuring eligibility and referral requirements. DORS and MHA cross-walked eligibility requirements and found that the agencies’ criteria for eligibility (but not the determination process) were

³Maryland State Department of Education, Division of Rehabilitation Services (DORS) & Maryland State Department of Health and Mental Hygiene. (2007). *Cooperative agreement concerning employment Services*. Retrieved from <http://www.dors.state.md.us/DORS/RehabResources/agreements.htm>

similar. DORS then revised the eligibility determination process, and deemed customers of the public mental health system who were eligible for SE services as automatically eligible for VR services and assigned to Category 1, most significantly disabled. MHA embedded the application for Vocational Rehabilitation (VR) services into MHA's Administrative Services Organization's web-based care management system as a part of the eligibility determination process conducted by the Core Service Agency (CSA), the local mental health authority, during the initial referral to the PMHS for SE services. MHA also mandated the referral to DORS (with the concurrence/agreement of the consumer) when a customer entered the PMHS and requested supported employment services.⁴ DORS' and MHA's efforts to improve the eligibility and referral policies and processes also involved making programming and procedural changes to Value Options', the Administrative Service Organization (ASO), electronic care management system. Our key informant described, "Value Options is an administrative services organization, a behavioral health care, managed-care organization that has the contract with MHA (...) to manage the public mental health system in conjunction with MHA and the CSA."

In order to streamline access to VR services for MHA customers, DORS and MHA restructured the referral and intake process by allowing DORS/VR counselors limited guest access to the ASO's web-based electronic case management system. When a customer enters the Public Mental Health System (PMHS) and provides consent for the referral to DORS, the MHA provider simultaneously requests the service authorization from the CSA and grants access to customer information electronically to the DORS/VR counselor. VR counselors can access the ASO's care management system to review case records. When the provider enters the data, the application for VR services is automatically populated. With this shared system, VR counselors can easily access customers' individual rehabilitation plans, individual vocational plans, treatment plans, or clinical information. When a customer enters the DORS system, referrals travel from a DORS/VR counselor, to a provider agency, and then finally to the Core Service Agency. As one key informant further explained:

[the customer's] information is then pre-populated onto a DORS application – that's available for the DORS counselor and also [as previously mentioned] that DORS counselor then is granted access to any treatment or rehabilitation records that are in the mental health system, they can use then to inform planning for the development of the IPE.

The DORS counselor is then able to print the application and enter the information into the DORS case management system. This system reduces administrative burden and duplication of effort for both the mental health provider and the DORS counselor and expedites SE service delivery. In addition to the partially shared case management system, each provider has a DORS liaison (who is a VR counselor), and each VR office usually has a person with "the developed expertise of the mental health population being their caseload." DORS does not always hire individual VR counselors with backgrounds in mental health, as one key informant described, however,

more times than not, [the DORS liaisons] are individuals who have a particular expertise in that direction, and who have a desire to work with [individuals with mental illness] (...) [and further], DORS often hires individuals who have worked at various community providers. So, it's very possible that we're hiring someone from a provider that has the experience working with that population on the other side of the fence.

⁴ Customer must provide consent for referral.

One of our key informants also informed us that all DORS liaisons are expected to be co-located on at least a part-time basis with office space at most of the mental health agencies. The amount of time that the VR counselor spends at the agency depends on the caseload size that the counselor is carrying at the agency and the number of agencies that counselor is assigned. Counselors who are co-located have the technological capabilities to work remotely as they have all been provided laptop computers and assigned VPNs. As a result, these VR counselors may make direct referrals to their contacts at each provider. Co-location has expedited the referrals and intake processes for both DORS and MHA.

With regard to the actual provision of services, as previously mentioned, in the state of Maryland, service providers are incentivized, but not required, to provide evidence-based supported employment. They may choose to provide traditional (or non-evidence based) SE services. One main difference between these two types of SE services is focused around exclusion. With EBP SE, there is zero exclusion: anyone who requests interest in SE services will receive them. On the contrary, non-evidence based (traditional) SE providers “[are] not required to serve everybody that’s referred to them. And [these providers] may also engage in step-wise employment, so there may be people that come to DORS for vocational evaluations, psychological evaluations, work-adjustment training – other forms of pre-employment kind of services – before they’re referred to supported employment.” The system and policy integrations mentioned in the paragraph above were not limited to providers who offer EBP SE, as our key informant explained that through a “system integration initiative (...) those kind of system changes and the policy changes that we did around eligibility and rapid engagement in services had an impact not just on the evidence-based practice programs, but the non-evidence-based practice programs as well.” Further, our key informant has stated that because some non-EBP providers have adopted a few of the EBP practices, their outcomes have improved.

Coordinating staffing roles and funding

All DORS liaisons are expected to be co-located, at least part of the time, at their local mental health agencies. The appropriate technological equipment has been set up for these counselors to work remotely from mental health programs, while still having VR as their home base. As a result of having these individuals work in the mental health agencies, one key informant explained that these counselors “...come to see that by being co-located and being involved with that provider and the consumers, they’re more likely to get the outcome that they need.” Another key informant explained that this staffing arrangement works best when,

[an] individual DORS counselor [is] seen as an adjunct to the agency. They’re really a part of the agency, and function as an agency staff member, and attend all the other trainings that the agency offers and [are a] part of the treatment team meeting. (...) It’s just a really high level of integration and coordination of services that can only happen when you’re in the same office together...

The result that this staffing arrangement has on the consumers is that “they see DORS [as] part of the process rather than a separate service that they’re receiving. And then that helps with retention of consumers who sometimes get lost in the shuffle between the two agencies.”

MHA and DORS collaborate with the University of Maryland EBPC to provide shared trainings to their staff. Specifically, employment specialists at the mental health agencies, and the DORS counselors receive training sessions on EBP SE, (titled, “EBP 101”) from the University’s EBP SE Consultant/Trainer. These training sessions are funded through MHA via a SAMHSA block grant. One key informant indicated that DORS offers shared trainings as well, but a specific training was not identified at the time of this interview.

Other trainings offered to DORS counselors include their QRT training (new counselor training), and their psychiatric affinity group. The psychiatric affinity group meets three times a year for a full day and brings together various trainers and representatives from DORS, MHA providers, and the University of Maryland to discuss and troubleshoot various issues (i.e. dispute resolution, case consultation), examine outcome numbers, and review any trends that may arise. Typically, the first half of the day is used to discuss current trends and issues, and the second part of the day is used for training. For example, in the past, NAMI has held trainings for this group. Our key informant has identified this group as one of various training opportunities that are offered to the DORS counselors and has indicated that this group has “been really instrumental in providing feedback [with regard to the] recent shift to milestone payments for all EBP providers.” Further, “the [psychiatric affinity] group [has also] put out a best practices manual in working with mental health supported employment consumers.” One key informant mentioned that this group in particular “facilitates the communication between all of the parties...”

DORS and MHA also coordinate with MHA’s ASO, Value Options to provide training to counselors on how to navigate their web-based care management system. Through this training, both DORS and MHA counselors learn all about Value Option’s online system, become familiar with and learn how to navigate the online system, and how to retrieve information from their system. This hands-on training has been offered to each individual DORS office throughout the state and continues to be available as an on-line training for new staff that require initial training and for seasoned staff that may benefit from refresher training.

In addition to coordinating staffing roles and training activities, DORS and MHA developed an integrated funding system for SE programs; the braided funding mechanism allows providers enrolled in both the VR and MH systems to offer both VR and MH components of SE. This means that a single provider can offer the full range of employment and MH services to customers.

The cooperative agreement between DORS and MHA defines each agency’s funding responsibility for SE services to avoid duplicative payments and ensure continuity of SE services. MHA is responsible for funding the following services: pre-placement services (including assessment and benefits/entitlements counseling), job placement, ongoing support to maintain employment, clinical coordination, and psychiatric rehabilitation services. DORS funds job development services and intensive job coaching services.⁵ SE program staff, including the MH provider staff and VR counselors, are responsible for documenting the services provided by each party. Each service is assigned a billing code that corresponds to a billing source and is processed at the administrative level. Both agencies also integrate funding to provide SE services to transition-age youth. In one jurisdiction, DORS provides these services through a federal grant from RSA, and MHA through a federal grant from SAMHSA. The high level of transparency in this braided funding system removes the burden of complex billing systems from the provider, allowing for more seamless service delivery.

In practice, the braided funding scheme translates to a clearly defined set of procedures at the service-delivery level. When an individual meets the criteria for SE services, the MHA-funded provider conducts a mental health vocational assessment, and provides benefits/entitlements counseling, the discussion of the risks and benefits of disability disclosure, and refers the individual to DORS. At this point in the process,

⁵ Reeder, S., & Johnson, C. (2008). Promising practices in home and community-based services: Maryland – encouraging evidence-based practices in supported employment. *Issue: Employment for People with Serious Mental Illness*. Baltimore, MD: Thomson Healthcare for the U.S. Centers for Medicare & Medicaid Services (CMS).

MHA gains customer consent for referral to DORS, at which time a DORS counselor determines eligibility, develops an Individualized Plan for Employment, and authorizes job development services. Once the pre-placement activities are complete, an EBP SE provider receives payment for job development services through a milestone payment system funded solely by DORS. EBP SE also receives reimbursement for monthly clinical coordination between treatment and rehabilitation and employment services. Non-EBP SE providers do not receive milestone payments, but may access 40 hours of job coaching (with an additional 20 possible) for job development and the remaining, up to 135 hours, for intensive job coaching services. When a customer begins working, DORS authorizes intensive job coaching to help customers adjust to the new position. The same SE program specialist job development and intensive job coaching services as provides MHA-funded SE services. Once the intensive job coaching funding through DORS has ended, the SE programs provides ongoing employment supports, funded by MHA, for as long as the person needs and desires the service.

The milestone system consists of three payments. The first authorization given to the provider is to begin job development services. The second authorization is sent to the provider when the counselor is notified that the consumer has obtained employment. Of the second authorization, the first payment is made upon initiation of intensive job coaching. The final payment is made after 45 days of job retention. This milestone payment system reduces the amount of paperwork required from providers. In the past, providers were required to submit two sets of documentation for reimbursement, but now with the milestone payment system there is integrated documentation, and providers can combine their monthly progress reports with their contact notes to serve as the one set of documentation that is required to receive payment from DORS.

Supporting Evidence:

According to the Rehabilitation Services Administration 2009 report, Maryland achieved a 61.22% employment rate for individuals with mental and emotional (psychosocial) disabilities. This rate was greater than the national average of 48.57% for this disability category in 2009.⁶ There has been a steady growth in the numbers of individuals with serious and persistent mental illness being served in SE. DORS and MHA collaborate to provide SE services at 57 community programs throughout the state, and estimate that 530 individuals will achieve a successful VR closure outcome through SE during 2011.⁷ The MHA website reports that EBP-SE programs consistently yield competitive employment outcomes, ranging from 60% to 70% for SE customers served by EBP-SE sites.⁸

⁶ Rehabilitation Services Administration (RSA). (2010, September 1). *Annual review report: FY 2009 Maryland division of rehabilitation services*. Retrieved from http://rsa.ed.gov/my_data.cfm?form__id=107&mode=view&grant__award__id=18840&std__format__for__printing=Y

⁷, ⁸ Maryland State Department of Education, Division of Rehabilitation Services (DORS). (2010, June 18). *State plan for the state vocational rehabilitation services program and state plan supplement for the state supported employment services program: Maryland division of rehabilitation services state plan for fiscal year 2011*. Retrieved from <http://rsa.ed.gov/view.cfm?rsaform=VR-State-Plan&state=MD&fy=2011&agency=C#ftn.id0003>

⁸ Maryland Department of Health and Mental Hygiene. (n.d.). *Mental health transformation project: Evidence-based practices*. Retrieved from <http://dhmh.maryland.gov/mt/recoveryandresilience/evidencebased.html>

DORS and MHA also work with the Evidence-Based Practice Center at the University of Maryland to promote the Evidence-Based Supported Employment initiative. The initiative now includes 22 of the community programs statewide that meet Evidence-based Supported Employment fidelity⁹. All of these EBP programs receive training, followed by ongoing consultation and technical assistance from the EBPC's SE Consultant/Trainer. Fidelity assessments, conducted by MHA Fidelity Monitors, begin once a program appears ready to meet the fidelity threshold established by MHA, which allows them to bill at the enhanced rate. Following fidelity assessment, the SE Consultant/Trainer then works with the program to develop a fidelity action plan to address any needed areas of improvement. Additional support is provided through a "Supported Employment Supervisors' Collaborative" which brings SE team leaders/supervisors together on a bi-monthly basis to provide ongoing training on issues such as documentation and successful clinical coordination; it also addresses common areas of concern, to share successful strategies, and to generally provide a supportive peer network.

The collaborative efforts of DORS and MHA have also earned national recognition. In 2007, DORS and MHA were awarded the *Science to Service Award* from the Substance Abuse and Mental Health Services Administration (SAMHSA) for Maryland's national leadership in providing recovery support services to people with mental illness.¹⁰ SAMHSA recognized MHA and DORS for integrating their funding and administrative procedures, and enhancing the quality of EBP SE services across the state. Additionally, the Johnson & Johnson Dartmouth Community Mental Health Program awarded DORS and Humanim, a Maryland community rehabilitation provider, with the J & J Dartmouth Achievement Award in 2011. This award was presented to three IPS SE sites nationwide, and recognizes the Maryland SE program for having a significant improvement in the number of individuals served in fidelity SE programs¹¹.

Currently in the works is a pilot study that aims to "fully triangulate" and "cross-match" all of the data that exists between VR and MH as a means to promote further systems integration and to inform data-driven, interagency policy development and program planning. In the future, a database will be created that houses both agencies' data and will be able to make comparisons in a more systematic fashion. Lastly, a form of data collection/analysis that has not yet started is to connect with Department of Labor earnings data, to cross-reference with the earnings data that is being self-reported by provider agencies.

Future Directions:

As the partnership between DORS and MHA continues to develop and mature, the two agencies plan to expand their collaborative efforts to include programs focused on long-term career development. Currently, MHA is structured in a way that does not provide incentives to providers serving customers who are employed to help them move into better jobs with higher wage earnings. The key informant described the current approach and the shift toward a focus on career advancement, stating: "...for the providers it is a different skill set, it's shifting your vision, looking beyond entry level jobs and helping consumers to begin to take risks and begin to build earnings and assets so they become more economically self-sufficient...we [DORS and MHA] are trying to provide those supports and infrastructure at the system level." DORS and

¹⁰ Maryland State Department of Education, Division of Rehabilitation Services (DORS). (2011). *Maryland's leadership in EBSE*. Retrieved from http://www.dors.state.md.us/DORS/ProgramServices/Mental_Illnesses/Leadership.htm

¹¹ Maryland Division of Rehabilitation Services (DORS). (2011). *About DORS: Awards – 2011 Johnson & Johnson Dartmouth Achievement Award*. Retrieved from <http://www.dors.state.md.us/DORS/AboutDORS/Awards/Jessica+Hawes.htm>

MHA have begun to build this infrastructure by piloting a program at five agencies, in which a local mental health provider is registered through the Maryland Mental Health Employment Network (MMHEN), a statewide consortium EN located at a local CSA, as part of the Ticket to Work (TTW) program administered at the state level. Consumers can “indicate their intent to assign [a] ticket through the [ASO] system, and it automatically formats an individual work plan.” DORS then sends data on the closure status of individual cases to MHEN, which are then imported into a proprietary “ticket tracker software system.” This software system tracks and imports these closure data and also data on earnings from Value Options, to indicate when a payment is due, which signals a request to be sent to the Social Security Administration. The MMHEN is the entity that collects these data, tracks the cases, and makes payments to the SSA – in doing so, 20% of the payments go to the MMHEN for administrative functions and 80% goes back to the provider agency. It is a future goal of this partnership to expand this pilot program and make it available throughout the state.

One key informant also described that MHA is “also a part of [a] Trusted Financial Partner arrangement with the Social Security Administration [and is working] directly with the SSA to get payment for services [in addition to] working on further ways to streamline [the] Ticket assignment and documentation requirements at the state level. DORS and MHA are shifting their reimbursement structures to milestone and outcome payments to the providers in order to reinforce the purpose/goal of the TTW program. DORS and MHA will continue to monitor the effectiveness of this program as it develops.

Transferability:

According to one of our key informants, one unique piece of this partnership is that MHA has supported employment regulations for its vendors. For instance, all service providers, EBP or not, must meet these minimum regulation standards set out in a separate and distinct regulatory chapter for SE:

So even to bill as supported employment, which is the non-EBP rate, you have to meet the minimum supported employment regulatory standards, and that's monitored every three years depending on how well a program does in compliance to those regulations... (...) and then to get EBP you have to get an additional fidelity assessment every year to evaluate EBP practice above and beyond what is required by the minimum supported employment regulatory standards.

In addition to these regulatory standards, there are Medicaid compliance audits administered by both MHA and their vendor, Value Options. Although DORS grants a “deemed” status to providers licensed through DHMH for Supported Employment services, periodic reviews of approval status are conducted to ensure current approval of each community rehabilitation provider offering supported employment. One piece of this partnership that can be replicated in other states is having champions at each state agency advocating for policy changes such as data sharing and braided funding.

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Maryland State Department of Education, Division of Rehabilitation Services (DORS). (2011). *About DORS: Awards – 2011 Johnson & Johnson Dartmouth achievement award*. Retrieved from <http://www.dors.state.md.us/DORS/AboutDORS/Awards/Jessica+Hawes.htm>

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A Case Study of Promising Vocational Rehabilitation Agency Practices in Improving Employment Outcomes for Individuals with Mental Illness

An Evolving Partnership: Aligning Agency Missions and Integrating New Technologies to Streamline Agency Processes

Missouri Division of Vocational Rehabilitation

Abstract:

The Missouri Division of Vocational Rehabilitation (MDVR) and the Department of Mental Health (DMH) have been partnering for over 20 years to coordinate supported employment (SE) service delivery to individuals with serious mental illness (SMI). The partnership specifically focuses on coordinating SE funding, streamlining eligibility requirements, and collecting data for shared customers. The MDVR-DMH partnership has positively impacted employment outcomes for individuals with SMI, as evidenced by above-average employment rates for people with mental and emotional (psychosocial) disabilities.

Background:

The Missouri Division of Vocational Rehabilitation (MDVR) and the Missouri Department of Mental Health (DMH) have a longstanding collaborative partnership that began over twenty years ago. The partnership was initiated when DMH and MDVR recognized they shared a customer base of people with mental illness (MI) and began to collaborate financially by sharing general revenue dollars. In the early 1990s, the two agencies partnered to deliver evidence-based supported employment (SE) services for individuals with MI. In 1996, MDVR used innovation and expansion funds from the Rehabilitation Services Administration (RSA) to develop a Request for Proposals (RFP) soliciting providers to deliver SE services to individuals with MI. The agency contracted 17 providers – including community mental health providers and VR comprehensive rehabilitation program providers – as a result of this RFP.

Initially, MDVR and DMH did not use the Individual Placement and Support (IPS) model to deliver SE services. Rather, the agencies used an approach based on MDVR's previous experience providing SE services to individuals with developmental disabilities. This approach included an extensive SE assessment and hands-on trial work phase that could take a customer up to six months to complete.

Over the next decade, the partnership recognized that the DD SE model was not as effective in improving employment outcomes for individuals with MI, who may have previous work experience and different needs in terms of the service-delivery timeline. As the DVR-DMH partnership evolved, the two agencies focused on improving SE services for people with MI by designating a key staff person to align the DVR and DMH missions, seeking training and technical assistance (TA) around SE for people with MI, and jointly pursuing grant opportunities to bolster funding for SE services.

In 2000, MDVR created the position of Supervisor of Mental Health Services and Data Reporting in order to “bring together the mission of the Department of Mental Health and MDVR and try to help influence and develop within DMH more specific services that could lead to employment outcomes.” Within this role, the Supervisor of Mental Health Services serves as the liaison between MDVR, the Department of Mental Health Divisions of Comprehensive Psychiatric Services, Alcohol and Drug Abuse, and Developmental Disabilities. As the primary liaison, the Supervisor of Mental Health Services was responsible for participating in the CPS State Advisory Council and DMH CPS work groups to introduce the possibility of employment as an outcome related to all facets of their mission. The Supervisor of Mental Health Services was also responsible for cross-agency coordination including program development and administrative data sharing.

MDVR sought support from the training and TA team at the Institute for Community Inclusion (ICI) at the University of Massachusetts, Boston, to develop a strategic direction toward evidence-based SE. ICI staff with expertise in employment and MH recommended that MDVR implement the evidence-based practice IPS model of SE as a way to help improve employment outcomes for people with MI. At this time, MDVR and DMH began to convert SE programs serving people with MI to IPS programs.

In addition to training and TA, MDVR also sought out external grants to bolster funding support for SE services. MDVR partnered with DMH and ICI to pursue a National Institute of Mental Health (NIMH) grant. In FY 2005 NIMH awarded the grant under the title of Missouri Mental Health Employment Project

(MMHEP)¹². The goal of the MMHEP was to improve the implementation of evidence-based SE services for people with MI. As part of this initiative, MDVR and DMH converted all original SE sites to full-fidelity IPS sites, based on the Johnson and Johnson – Dartmouth Community Mental Health evidence-based SE program.

In 2009, Missouri received a grant from the Johnson and Johnson – Dartmouth Community Mental Health Program. This grant allowed MDVR and DMH to make a commitment to meeting fidelity standards in all of the IPS sites across the state. Specifically, MDVR established a full-time staff position focused on fidelity SE training. In an effort to consistently increase fidelity scores across all SE sites, MDVR developed the position of State Trainer for the Johnson & Johnson – Dartmouth SE grant. This person is responsible for conducting SE fidelity training in community mental health centers across the state.

Purpose, Goals, and Implementation:

The purpose of the MDVR – DMH partnership is to coordinate SE services across agencies with the goal to improve employment outcomes for individuals with SMI. This section describes the main elements of the partnership including coordinating referrals and streamlining eligibility requirements, collecting data for shared customers, and braiding SE funding.

Access to supported employment services: As of May 2012, 7 out of 24 community mental health centers provide IPS services throughout the state of Missouri. There are plans to double this number within the next year. These programs will be primarily funded by VR with assistance from specific Medicaid services braided in.

For individuals who are not eligible to receive IPS SE services, they are given the option to receive an alternative to IPS, Employment Services (ES), from non-DMH community mental health centers across the state. According to our key informant:

We redesigned our general services for clients, all disability groups. If you look at it, it looks like IPS with one exception: it doesn't have the long-term continuing support piece at the end, and that's ok. This is not intended to be supported employment. The same philosophies of rapid job placements, taking people where they're at, rapid job placement attending to their preferences, getting to work rapidly, letting them assess themselves while on the particular job... that's what that [redesign] was all about and it's working (...) It allows the person to move a little bit more freely and rapidly.

Coordinating referrals and service delivery: Referrals for supported employment services are sent from the community mental health centers to MDVR and vice versa. According to our key informant, “very often times, the VR counselor is the only person that is in the state government where their business card says ‘counselor.’ ...[so], many people think that VR is the place where [one receives] mental health services.” As a result, the referral process becomes an integral piece of coordinating services.

¹² U.S. Department of Health and Human Services. (2005). *Research portfolio online reporting tools (RePORT) project information: Missouri mental health employment project* (Project No. 1R24MH074784-01). Retrieved from http://projectreporter.nih.gov/project_info_description.cfm?icde=0&aid=6961215

VR counselors and staff from community mental health centers also work together prior to the initiation of the referral process, so the instant a person receiving mental health services declares interest in employment, relationships are already established between the two agencies, thus making for a smoother process. As our key informant described:

...early in that process, we want the VR counselor being a part of that integrated mental health treatment team to start understanding who these individuals are, maybe chatting with them, prior to requesting a VR case open. (...) Then there will be a time when that person expresses, "I want to go to work!" VR will open that case immediately and determine them eligible for services.

To help facilitate coordination between the two agencies during the referral and eligibility process, MDVR has a long established Memorandum of Understanding (MOU) with DMH, which allows VR counselors access to customer mental health records at the community mental health center. MDVR uses the AWARE case management system and plans to add digital signatures to the case management system in the near future to expedite processes. Integrating other advanced technologies, such as tablets, into this process are also being explored. For instance, it might be possible for a counselor to be able to take a picture of a document, convert it into a PDF, add a digital signature, and then upload it directly into the AWARE system. The digitally signed authorization can then be sent directly to a vendor, thus streamlining the eligibility process even further.

For an individual to receive IPS services, they must already be receiving services from a community mental health center, and also eligible for Medicaid, as Medicaid is the funding source for long-term continuing supports through the integrated treatment team models of Comprehensive Psychosocial Rehabilitation (CPR), Assertive Community Treatment (ACT) or Comprehensive Substance Abuse Treatment and Rehabilitation (C-Star).

At the time of this research, MDVR in collaboration with DMH was clarifying policy regarding substance dependence and eligibility for individuals with co-occurring substance abuse and mental illness diagnoses requesting VR services. Specifically, MDVR was in the process of eliminating the sobriety requirement, previously requested by DMH in the 1980's, which states that VR customers must be sober for 90 days in order to receive VR services. The revised policy emphasizes recovery language and provides flexibility for individuals with substance dependence. The goal of this policy change is to streamline eligibility requirements for this particular population and to promote customer and treatment team engagement in obtaining or retaining employment.

MDVR tracks customers jointly served by MDVR and DMH. Data points include demographic information, disability status, VR disability, VR status, and age range, and county of residence for all shared customers. MDVR sends these customer data to DMH annually. DMH matches the data by social security number to identify the number of individuals served by both agencies. In FY 2002, MDVR found that the number of customers annually served by both MDVR and one of the three divisions of DMH ranged from 52% to 60% over the past 15 years.) This information helps MDVR and DMH quantify and describe the population of shared customers, and can inform decision making within the partnership. Moving forward, MDVR hopes to conduct more advanced analysis of this data set.

Coordinating staffing roles and funding: MDVR counselors with a background or interest in serving a MH-heavy caseload have the option to do so while holding office hours at their local community mental health center; their office hours can range anywhere between a half to a full-day per week in the community mental health center. These counselors work primarily out of an MDVR district office, but according to our

key informant, the program is “highly mobile, and [MDVR is] implementing more and more technology to support counselors in the field.” Caseloads for these counselors in urban areas are comprised primarily of mental health customers, and the type of customer served becomes more varied in rural areas.

MDVR has partnered with trainers from Washington State to provide customized trainings on clinical skills, specifically motivational interviewing, to their counselors. These counselors also receive training from the State Trainer for IPS. The State Trainer develops customized trainings to tailor to the needs of each site as necessary. These IPS trainings are offered to entire sites and thus are open to all staff at that particular site, including VR counselors and community mental health staff. The State Trainer’s position is currently funded through the fall of 2012 by the Johnson & Johnson – Dartmouth grant. Following the end of this grant, MDVR and DMH plan to fund this position equally.

MDVR and DMH braid funding for SE services, including clinical intervention services and SE services, in order to provide comprehensive services to an individual. The goal of braiding funding is to provide timely and appropriate services based on the individual’s service needs to obtain or retain employment. Non-profit community mental health centers provide both the clinical intervention and IPS SE services directly to individuals with MI who are concurrently eligible for VR. Medicaid and DMH typically fund these providers, however, they are also certified as VR vendors and bill VR for IPS services.

MDVR recently revised the fee schedule and adopted a milestone payment structure for SE providers. MDVR’s original payment structure was fee-based, meaning that the majority of MDVR’s payment to the provider for each customer served was issued during the initial assessment phase. Within this structure, SE providers received a lump sum up front for each customer being served, and subsequent payments were standardized rather than outcome-based. Under the new milestone payment structure, MDVR payments are entirely outcome-based. Within this structure, SE providers receive payments for target outcomes achieved in three phases: assessment, placement, and stabilization.

By shifting to a milestone payment structure, MDVR reinforced the focus on immediate placement and customer outcomes. The key informant explained that this payment structure fits well within the IPS model of SE, and encourages providers to “strike when the iron is hot” as customers express interest in work. Another benefit from the milestone payment structure is increased predictability of cash flow for the providers. Providers are motivated to provide timely placement services and ongoing support for customers because each customer’s employment milestone results in a subsequent payment from MDVR. At the time of this research, MDVR had been operating under the milestone payment structure for six months. Preliminary anecdotal evidence indicated that the new payment structure is successful in increasing employment outcomes for people with MI, specifically with regard to rapid placement into employment.

DMH’s funding responsibility in this partnership includes community mental health centers providing prevocational activities in order to support a customer’s interest in work. Community mental health centers are involved in individual treatment plans by developing and supporting employment goals and bridging them into an integrated IPS team. Community mental health centers provide “Long Term Support” for customers through continued maintenance of the individual’s medical needs simultaneously with VR funding for IPS activities of job development, placement, and retention until the VR closure as agreed by the customer. The Community Mental Health Center communicates with VR to develop additional services to support transitions to new employment responsibilities, support difficulties experienced while working, or transitioning to new jobs as their careers develop.

Supporting Evidence:

According to the RSA 2009 Annual Report, Missouri achieved above-average employment rates for individuals with mental and emotional (psychosocial) disabilities at 50.83%, compared to the national average for general / combined agencies of 48.57%¹³. Further, as reported by the key informant, an administrative data match between VR and DMH for FFY 2007 confirmed a total of 11,781 shared clients between MDVR and DMH in various stages of VR service. Of those exiting, 1,165 reached a successful VR outcome - closed rehabilitated. This reflects a 58.0% success rate applying the RSA formula. Individuals who are closed rehabilitated in this dataset also include individuals who are no longer engaged in DMH services; MDVR hypothesizes that many of these individuals are autonomous in their recovery and can manage their needs independently. The key informant reported that these outcomes have been consistent throughout the partnership.

Since the implementation of IPS in April 2009 through December 2011, 538 individuals with severe and persistent mental illness have been determined eligible for the VR program and receiving IPS Supported Employment. Of these individuals to date 80 completed services were closed 'rehabilitated' - successfully employed which reflects a 64% success rate. Anecdotal evidence from a period of 18 months (between 2011 and 2012), demonstrated a decrease in Medicaid costs for individuals receiving IPS services. These findings were found from data that was extracted from the AWARE case management system and is an analysis that MDVR would like to continue on a long-term basis.

Future Directions:

MDVR will continue to develop the partnership with DMH to improve employment outcomes for people with MI. One area of potential growth is shared electronic case management. With the recent installation of the AWARE case management system, MDVR will pursue a data-sharing system with DMH (DMH currently uses CIMOR). MDVR will explore ways to streamline services across agencies by cross-matching customer information, eligibility requirements, and authorizations for services through the AWARE system. If critical data fields can be shared, VR counselors and MH providers could share information across systems for customers receiving both VR and MH services.

Additionally, with the installation of AWARE, MDVR overlaid an electronic data-mining tool across the AWARE case management system, which allows users to access legacy data. MDVR aims to expand the analysis of shared VR-MH customer data, building from the hard match data analysis MDVR and DMH currently conduct. The data-mining tool available in the AWARE system will allow MDVR to compile eight years of historical shared customer data (FY 2002-2010) for analysis. MDVR and DMH will have the capacity to use the results of data analysis to broadly inform agency decisions.

¹³ Rehabilitation Services Administration (RSA). (2010, September 1). *Annual review report FY 2009: Missouri division of vocational rehabilitation – Department of Elementary and Secondary Education*. Retrieved from <http://rsa.ed.gov/view.cfm?rsaform=ARR&state=MO&fy=2009&grant=H126A090036>

Transferability:

One aspect of the MDVR and DMH partnership that our key informant has recommended for replication in other states is designating a staff person to serve as a liaison between both agencies. This person can be responsible for coordinating data sharing and program development, in addition to building rapport between the agencies.

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A Case Study of Promising Vocational Rehabilitation Agency Practices in Improving Employment Outcomes for Individuals with Mental Illness

A Rural Model of Collaboration between a Vocational Rehabilitation Area Office and a Community Rehabilitation Provider

New Mexico Division of Vocational Rehabilitation

Abstract:

The New Mexico Division of Vocational Rehabilitation (DVR) Area IV office partners with a community rehabilitation provider (CRP) to coordinate Supported Employment (SE) services for individuals with mental illness (MI). The purpose of the DVR Area IV office – CRP partnership is to provide a continuum of care across agencies, including mental health care services and vocational rehabilitation SE services. The partnership focuses on several areas of collaboration, including: centralized communication, streamlined referral, expedited service initiation, coordinated service delivery, and coordinated SE funding. This collaboration model is now currently implemented in two additional communities in New Mexico and shared at statewide mental health conferences.

Background:

In the 1990s, the DVR Area IV office in Roswell, Chaves County, New Mexico partnered with the CRP called Counseling Associates (CA) to improve the continuum of care for people with MI. CA is a Core Service Agency (CSA)¹⁴ in New Mexico that coordinates and provides a variety of services, including employment/vocational services, to individuals with serious MI (SMI). The DVR Area IV office in Roswell serves about 500 customers across four VR counselor caseloads. CA is the only CSA in the county. This partnership exists between the DVR office and the CRP, meaning that the Mental Health agency at the state level is not directly involved.

In 1998, the DVR Area IV office and Counseling Associates formed a work group composed of DVR and CA administrators, CA therapists, and VR counselors. The goal of the work group was to bridge the gap between shared customers' mental health care and vocational rehabilitation, specifically in the area of Supported Employment (SE). The work group collaboratively produced a document that serves as an interagency agreement for providing SE services to customers with MI in Area IV. Additionally, the partners established a full-time staff position (Supported Employment Specialist) dedicated to SE service provision.

Purpose, Goals, and Implementation:

The purpose of the DVR Area IV office – Counseling Associates partnership is to provide a continuum of care across agencies, including mental health care services and vocational rehabilitation supported employment services. The goal of the partnership is to improve employment outcomes for people with MI. The DVR Area IV office and CA partnership focuses on several areas of collaboration, including: centralized communication, streamlined referral, expedited service initiation, coordinated service delivery, and coordinated SE funding. Each of these areas of focus is outlined in detail in a written agreement titled *Supported Employment (SDMI) in Area IV: Operational Assumptions, Agreements and Commitments*. This document was produced during the interagency agreement meetings held by the work group in 1998 and is currently in use.

Access to supported employment services: The Area IV DVR – CRP partnership was replicated in three additional community mental health agencies, resulting in four counties that had initially tried to implement this program. After reorganization, the number of DVR - CRP partnerships was reduced to three total counties in South Eastern New Mexico.

VR customers living within these designated counties have access to the employment services delivered by the mental health centers, as long as they meet the eligibility requirements of being in category one¹⁵ (i.e. those with most significant disabilities) and have an identified source of long-term support. Our key informant has indicated that there are individuals who live outside of these counties who receive their mental health services from a different county. Moreover, the VR statewide program, which offers general employment services, allows customers to choose which office they receive services from.

¹⁴ The Core Service Agency system was developed in NM by OptumHealth New Mexico in 2010 to help customers find locate and receive services in a Comprehensive Community Support Services (CCSS) model. OptumHealth NM manages behavioral health services for NM's Behavioral Health Collaborative. See Core Service Agency Communication Team (2010) for more information.

¹⁵ New Mexico DVR implemented Order of Selection (OOS) in February, 2011, serving priority category one.

In addition to geographic access to services, access to different types of services varies based on eligibility requirements. As previously stated, individuals in category one have access to SE services, which include pre-vocational psychosocial rehabilitation (PSR) activities. Those who are not eligible to receive SE services, or do not have a source of long-term funding support, may still receive general employment services.

The Area IV supported employment program has also been replicated in the area's Center for Independent Living. As a result, our key informant indicated that individuals who are not eligible to receive mental health (or DD services) could receive supported employment services through independent living: "...because they can provide independent living services... that is our justification for long-term support for them." Our key informant highlighted that individuals with traumatic brain injury (TBI) can receive supported employment services at the Center for Independent Living, because that population in particular isn't necessarily served by state DD or MH agencies.

Coordinating referrals and service delivery

Communication between DVR and CA regarding shared SE customers is centralized through a full-time staff person in the SE specialist position. The DVR Area IV office and CA jointly established the SE specialist position during the initial interagency workgroup meetings. The SE specialist's primary responsibility is to operate as a liaison between CA and DVR. The SE specialist is housed at CA and supervised by the CA program manager, but partially funded by DVR resources provided to CA for SE. Each month the specialist and a VR counselor meet face-to-face to review each participant's progress report, agree on the next step of service delivery, and determine additional services or supports needed.

The specialist works with ten participants at a time as a ratio greater than that was found to be counterproductive. For each of these ten participants the specialist provides placement and short-term intensive support services and, under the supervision of a VR counselor, provides or coordinates job development, employer contact, on-the-job support, and coworker / employer education. DVR relies on the specialist to make appropriate referrals based on DVR eligibility requirements. By relying on the specialist's knowledge of VR services, DVR does not have to perform preliminary diagnostics or comprehensive assessments that are necessary with other referrals.

The DVR Area office and CA outline three referral situations for customers:

- Participants who are already open [receiving services] in both agencies;
- Participants who are already receiving services in the MH agency, but not DVR;
- Participants who are receiving services from DVR, but not MH.

In order for a customer to become co-enrolled (in VR and MH), the two partners make three assumptions at the time of referral: the participant wants to work, the participant is ready for placement (under the "place and train" model), and the participant is presumed eligible for both VR and MH services. The element of presumed eligibility is key: DVR presumes eligibility for customers meeting SDMI criteria and receiving services from CA. In short, DVR trusts the community agency to make appropriate referrals. As a result, DVR and the CRP have streamlined the referral process and promoted co-enrollment in VR and MH.

The mindset in this collaboration is to "strike while the iron is hot." In other words, when a participant indicates interest in work a referral should be made immediately. The key informant explained, "We [DVR

and Counseling Associates] have made it a priority to put energy and attention into getting people moved through the process quickly.” Ideally, following referral, DVR initial intake interviews occur within 10 working days and Counseling Associates will provide documentation of any physical and / or mental disability upon referral to expedite the eligibility determination. At the initial interview DVR will authorize diagnostic services for SE to the community agency and will proceed to determine eligibility and develop an Individual Plan for Employment (IPE) within the following month. The month time limit for the IPE to be developed is in place because of the mindset mentioned above, “strike while the iron is hot.” The key informant said, “If we drag it out, [the customers] are going to lose interest or they are going to lose confidence in us...and we lose our opportunity.” After the IPE is developed, Counseling Associates will secure competitive employment for the individual as indicated on the IPE as soon as possible and will then provide progress reports and authorization for payment vouchers from DVR.

DVR and CA share responsibility for SE service delivery, and have established clearly defined service delivery parameters for each partner. Counseling Associates is responsible for providing typical and traditional services such as therapy, medical checks, and case management. They also complete “pre-vocational training” prior to a referral, provide medical / psychological records at the referral, and provide a letter of long-term support.

DVR provides vocational counseling, guidance, and exploration with the participant. They are also responsible for coordinating any additional diagnostics that can not be completed by Counseling Associates along with providing any other extra services that can not be provided by another source that have been identified as necessary for the participant to obtain and maintain employment. Both DVR and Counseling Associates coordinate the “treatment” plans and objectives and are expected to share resources and participate in effective, proactive communication.

Coordinating staffing roles and funding: DVR and CA outlined a fiscal agreement for SE service provision. DVR pays CA a flat rate of \$300 per month, per participant. Based on a monthly average of 20 participants, this amounts to \$72,000 per year. Fiscally, this amount would support a full-time SE specialist position at CA. DVR provides authorizations on a monthly basis, with the first authorization designated as “diagnostic” during pre-placement activity. From that point forward, DVR provides authorizations monthly, based on the VR Counselor decision to continue funding for the SE participant. In making the decision to continue funding each month, the VR counselor works closely with the participant and the CA employment specialist.

The CA SE specialist “is the pivotal role, it’s the key player because that role represents their agency to DVR and represents DVR back to their staff – the therapists and case managers.” The SE specialist is also responsible for designating an individual responsible for signing, tracking, and returning all authorizations monthly. This person must also provide monthly invoices in order for authorizations to be vouchered for payment. As previously mentioned, the SE specialist provides PSR services to customers, and the supervisor of the PSR program oversees all of his/her activities. In addition to supervising the SE specialists, the PSR program supervisors will also temporarily perform the SE specialist’s duties if they are out of the office. Our key informant indicated that it is their goal to have two SE specialists in Area IV, serving a total of 20 people on average.

In Area IV, VR counselors who carry caseloads that include individuals with mental illness, provide generalized services and do not have specialized caseloads. During the recession, however, the Program Manager of Area IV temporarily picked up responsibilities of a vacant counselor position, and created a temporarily specialized caseload that included individuals receiving any type of supported employment.

In the past, the Area IV Program Manager and the Manager of the PSR unit presented trainings at statewide mental health conferences, of which included tracks dedicated to employment. These conferences were the only joint professional training that occurred between MH and DVR across the state. Due to the recession and limited fiscal resources, budgets around training and other professional development activities have been cut. According to our key informant, it is the goal of New Mexico's leadership to re-focus future efforts on professional development, and have similar activities occurring again within the next one to two years.

Supporting Evidence:

Anecdotal evidence suggests that the DVR – CA partnership has improved the continuum of MH and VR services through streamlined referral, expedited service initiation, and coordinated SE service delivery. Preliminary data provided by the key informant indicates that the 57.69% of individuals served in an IPE in this partnership were closed in employment. The collaboration between DVR and the local CRP shows evidence of transferability. Four communities in southeastern New Mexico are using the DVR / CRP collaboration model. According to the informant, the same model was also used to work with Independent Living to develop a similar SE program for individuals who do not meet developmental disability or mental health criteria. The model has also been presented at New Mexico's state MH conference and, according to the informant, at least two breakout workshops have been done at the annual MH conference.

Future Directions:

Looking ahead, the goal of the DVR – CA partnership is replication and a cultural shift. The key informant would like to replicate the Area IV practice to other areas around the state and would like to do so by getting buy-in from other program managers. Our key informant explained, however, that they anticipate this process to take a while because it will take a cultural shift to get these managers to believe that this type of partnership is worthwhile:

As I have seen, it's possible to grow things from the grassroots. I think that would be the first approach, and that the way to convince people is to show them the money or show them the evidence. (...) If we can show them what's been growing under their nose and say, 'Wow, this works!' then we'll get their buy-in.

The plan for replication will be to start small and have successes in several places around the state. At that point, our key informant believes there will be enough evidence to compel leadership to make this a statewide practice.

Transferability:

The partnership between NMDVR and a local CRP, Counseling Associates, is unique in this series of case studies because it demonstrates a type of partnership that is not being commonly practiced throughout the state. This grass-roots approach to employing SE services in a rural community has required constant effort and support from practitioners in the field who are dedicated to providing these types of services. According to our key informant, the Area IV DVR office would like to expand the DVR-CRP partnership throughout the state, but recognize that it will take a significant cultural shift to do so. As our key

informant explained, “people have to believe first and foremost that people with serious and persistent mental illness can work.”

While philosophies and cultural shifts aren’t entirely transferable to other state DVR offices, there are bits of information that have been learned throughout the duration of this partnership, including successes and failures, that other states wishing to start a similar partnership can take note of. One of those lessons learned is that a partnership, “needs to be constantly tended like any garden or relationship – it can’t just run by itself.” Therefore, communicating a shared vision, maintaining constant communication between DVR and the CRP, and keeping leadership engaged are critical pieces of keeping a partnership running.

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A Case Study of Promising Vocational Rehabilitation Agency Practices in Improving Employment Outcomes for Individuals with Mental Illness

Creating a Sustainable Partnership: Utilizing a Medicaid Billing Code as a Stable Source of Funding for Supported Employment Services

Oregon Office of Vocational Rehabilitation Services

Abstract:

The Oregon Office of Vocational Rehabilitation Services (OVR) and the Addictions and Mental Health (AMH) Division partner to provide Supported Employment (SE) services to shared customers with mental illness (MI). The partnership focuses on coordinating service delivery across agencies, utilizing a sustainable funding scheme, monitoring quality of services through fidelity reviews, and collaborating with a local university. OVR and AMH also utilize a cost-benefit analysis to measure the impact of SE programs.

Background:

When the Oregon Office of Vocational Rehabilitation (OVR) began providing evidenced-based supported employment (SE), these services were funded by two one-year grants. When evidenced-based supported employment was first implemented in OVR, SE services were provided to individuals with psychiatric disabilities. OVR did collaborate with the Mental Health Central Office, but at a lesser extent than it does today.

Since the 2000's, OVR expanded upon their SE services by partnering with the Addictions and Mental Health (AMH) division and by joining the Johnson and Johnson – Dartmouth Community Mental Health Program, becoming one of the first states to implement the Individual Placement and Support (IPS) model of SE. Ever since, OVR has collaborated with AMH and over 17 county mental health programs in developing and sustaining supported employment services for people with mental illness (MI). As part of the program in 2002, AMH received grant funds to partner with OVR and establish IPS programs in Oregon's Mental Health Organizations (MHOs) and community mental health programs.

When the Johnson and Johnson – Dartmouth funding ended in 2005, OVR and AMH stepped in to sustain the SE programs in two long-standing community mental health programs: Options for Southern Oregon and Lifeworks Northwest. This same year, OVR began the Oregon Competitive Employment Project (OCEP), funded by a Medicaid Infrastructure Grant (MIG). One of the primary objectives of OCEP was to expand SE services across the state.

In 2006, OVR, OCEP and AMH provided Medicaid Infrastructure Grant (MIG) supported “mini-grants” to local mental health programs in an effort to initiate and sustain SE programs in seven counties. OCEP also funded Options of Southern Oregon and Lifeworks Northwest to provide training and technical assistance on SE to local mental health providers. In 2008, AMH received funding through a Medicaid billing code, which allowed SE services through the IPS model to be billed to Medicaid by AMH, and a grant from Oregon's general fund to aid individuals without insurance. This money provided the stability for the IPS programs to expand and become more stabilized.

Purpose, Goals, and Implementation:

The purpose of the partnership between OVR and AMH is to sustain and expand the availability of SE services with the goal of improving employment outcomes for people with MI. The partnership focuses on coordinating service delivery across agencies, utilizing a sustainable funding scheme, monitoring quality of services through fidelity reviews, and collaborating with a local university.

Access to supported employment services: As of May 2012, IPS SE services are offered in 21 out of 36 counties across the state of Oregon. When asked about statewide access to SE services one of our key informants explained that first, it would not be likely for someone to travel from a county that did not offer SE services to one that did, and secondly, that “...it's not an even distribution around the state, as far as population. Some of our counties have a lot of people and some of them almost nobody lives in...” This statement underlines the notion that looking at statewide access services by number of counties with SE programs is just one of many ways to examine availability of SE across the state.

When using population to examine access to SE services, one key informant stated that the densely populated areas of Portland and Salem have, anecdotally, the least amount of access to SE services. These two cities, although offer supported employment, have the greatest need across the state and small SE programs that can't keep up with the demand for services. One key informant explained:

You could say, ok well, in this really rural county there's maybe a hundred people with serious mental illness and they have zero access to supported employment (...) but in the metro area there's like 5,000 people with serious mental illness and there's two employment specialists in town. They can only serve 20 people at a time, so, depending on how you look at it, the need is greater in one area or the other.

For the counties that do offer SE services, they are offered only to individuals who are eligible for Medicaid. Individuals who are not Medicaid eligible can receive general employment services from OVRs. These individuals are less likely to have serious mental illness (SMI).

One community mental health center, Central City Concern, delivers employment services to individuals with substance abuse issues. This center is located in Portland and includes a staff of ten employment specialists. As one of our key informants explained,

They're the only agency around the state that's really starting to offer [services] to people that don't have a severe mental illness. I guess we've softened that definition in Oregon a little bit, too. So...they use the word "serious" mental illness (...) so it's kind of like they've broadened the access to services to people that meet the federal definition of serious mental illness, which is almost any mental illness. (...) That kind of opens the door to people with...anything like depression or anxiety, or an Axis II diagnosis.

Employment services are also offered to high school-aged youth through a grant-funded program named, the Early Assessment Screening and Treatment (EAST) program. Modeled after a program that started in Australia, the EAST program targets adolescents who exhibit early signs of psychotic illness and/or major depression. One of our key informants described the results of the program as follows:

The results are remarkable because they do a lot of outreach, so they can educate people that when you see behavior that might look sort of like an unruly or a grouchy teenager, that something else might be going on. [And also, they get] involved very early with the family and the young person [to provide] these kinds of wrap around services and education. These young people are not progressing to another episode. They're not dropping out of school and they're moving toward employment.

The EAST program was first administered by a local mental health program, Mid-Valley Behavioral health, and has since expanded to over 20 sites around the state. OVRs provides funds for capacity building related to employment, of which are linked to a five-year innovation and demonstration grant from RSA. In sum, access to supported employment services is most dependent upon Medicaid eligibility, followed by geographic proximity to a center that provides IPS SE services. There are some areas, however, that are beginning to expand the populations that they are delivering services to, such as individuals with drug or alcohol issues, and high school-aged youth.

Coordinating referrals and service delivery: Supported employment is a Medicaid billable service, so, referrals for these services generally come from the mental health system to VR. For clients new to the mental health system, they must become enrolled in their community mental health center, along with having an initial assessment conducted by a clinician to learn about their history and diagnosis. As soon as an individual

indicates interest in employment, a referral should be made from the mental health center to VR for SE services. “From there it’s really straight forward. ...the employment specialist will follow-up on their referral and begin working with the client and they go into rapid job search...,” explained one key informant.

For individuals already in the mental health system, employment is offered during annual updates and further, “a client can be referred at any point in time during their service duration at the mental health center.” If an individual does not indicate interest in employment during an annual update, s/he may self-identify for services via self-referral forms. These self-referral forms ask if the individual is interested in some form of employment, and if so, to provide contact information.

Once referred to VR, an individual will receive services from a VR counselor who works part-time at their local mental health program (yet operates primarily out of OVRs). At this time, there is no shared case management system between OVRs and AMH, however, the referral process can work expeditiously if the VR and MH systems constantly work together. One key informant explained that “if you work your system out and you have trust between the two programs, this is a very slick way to serve people.” To provide an example of how expeditious this process can be, our key informant provided an example:

They may be doing placement services [to individuals] within the mental health system to get some things worked through before they come to VR (...) By the time they come to [VR], you’ve got information about what that person wants to do, what the support issues are, you’ve got your eligibility, and I certainly was able, when I worked a caseload to make the person eligible, [to] write a plan and get them back to the mental health program in about 48 hours.

The 48-hour turn-around was made possible due to this former VR case manager building rapport with the mental health system by working anywhere between a half-day to a full-day a week in the mental health clinic: “I knew them, they knew me, which set a really nice foundation to do the work.”

The VR counselors who serve joint AMH customers in IPS model SE programs often possess an informal specialty in MI and an MH-heavy caseload. OVRs and AMH refer to these counselors with demonstrated interest and experience with MI as “dedicated counselors.” This is an informal role (as opposed to a formalized specialty VR counselor position) and the VR counselor carries an average caseload of 80 individuals, which is consistent with non-MH specialty counselors. The VR counselor serving SE participants works closely with the SE specialists housed in the MH programs and meets regularly to discuss employment services and goals.

The SE specialists are responsible for job development and placement services, including contacting potential employers, scheduling interviews, and negotiating the terms of a potential job for the MH customer. SE specialists are able to provide intensive services to MH customers due to their small caseload size, usually around 20 individuals. When a customer has been working at a job for 90 days, the case is considered closed in the VR system and may request post-employment services at a later time. However, in the MH system, SE specialists continue to provide long-term supports while it is needed. This may take form as transportation services, benefits counseling, on-the-job training, or negotiating with the employer (e.g. negotiating promotions).

In 2008 (in response to news funds coming from AMH to support the SE program) the Director of OVRs fostered growth of Oregon's SE program by creating a standardized contract for all vendors. As a result, one of our key informants explained:

...we were able to get many of our mental health programs around the state into a contract with VR, and that really helped them. Many of them never had a contract with VR... So that was a huge deal and just that VR was ready to kind of step up at that level.

Coordinating staffing roles and funding: Since 2008, OVRs and AMH have utilized a Medicaid billing code that specifically covers the IPS model of SE for people with MI. Oregon wrote evidence-based practices into law in an effort to attach funding streams to services. In doing so, the IPS model of SE became the only employment service billable under Medicaid. The Medicaid billing code for SE services has proven to be a sustainable and stable source of funding, allowing OVRs and AMH to ensure continuity of service delivery for SE customers. In addition to Medicaid billing, OVRs is a consistent financial supporter of AMH SE programs. Most of the MH programs have outcome-based contracts with OVRs, under which OVRs provides a payment to the MH program when an individual receives a job placement. Payments are \$1,500 for a job placement and range from \$2,000 to \$3,500 when there is a successful closure with VR. Smaller payments, around \$200, may be given throughout this process for things like job preparation, but the large payments are saved for the milestones of job placement and closure. The amount given for outcome-based payment has increased since 2010 and according to one of our key informants, this increased reimbursement rate is "just a further indication of VR's commitment to supported employment."

Fidelity reviews are also conducted on the SE programs. One of the main goals of these reviews is to create consistency across the different MH programs. This is important due to the structure of the MH system. MH agencies are county-based (36 counties) and therefore are operated differently across the state (e.g., by county governments, by non-profit agencies, or by multiple providers). Therefore, the fidelity review has been set to a scale of 125 points with a benchmark of 100 points overall, not specifically contained to certain areas. MH programs that reach this benchmark will continue to receive funding. Reviewers from AMH and OVRs travel in pairs to the different agencies and compare scores to increase accuracy in the review process.

In 2007, the Oregon Supported Employment Center for Excellence (OSECE) was established as a statewide resource center on SE training and technical assistance (TA). OSECE provides technical assistance and training on evidence-based SE across MH programs in Oregon. As of 2010, OSECE has provided training and TA to 38 job developers with 17 county mental health programs, utilizing the Johnson and Johnson- Dartmouth Community Mental Health Program evidence-based IPS model¹⁶. The Director of OSECE is primarily responsible for developing working relationships between themselves, local VR offices, and local mental health agencies, in addition to clarifying the SE model that is currently being implemented by AMH. Other responsibilities of the Director include contract development for statewide policy decisions, creating a standardized approach to implementing supported employment, and providing TA to local VR agencies with the SE contract application process.

¹⁶ Oregon Office of Vocational Rehabilitation Services (OVRs). (2010, June 30). *State plan for the state vocational rehabilitation services program and state plan supplement for the state supported employment services program: Oregon office of vocational rehabilitation – DHR, children and family services state plan for fiscal year 2011*. Salem, OR: Author. Retrieved from <http://rsa.ed.gov/view.cfm?rsaform=VR-State-Plan&state=OR&fy=2011&agency=G>

Additional trainings overseen by the OSECE Director include IPS SE trainings for all of the VR programs that partner with MH. The VR staff are also asked to meet monthly with SE program staff about caseloads and blending service delivery. OVRs and MH staff also attend "Three Cups of Tea" development training, a specific training for job development, based on a model developed by Dartmouth. Employment specialists around the state of Oregon receive this training and learn how to conduct informational interviews with employers to determine their needs and propose potential employees that would be a good fit for the job. Further, OVRs has in-service training throughout the year that MH presents at and MH has an annual SE conference that VR staff are invited to attend. If there are specific issues at different sites MH aids in providing any necessary assistance, such as an overview of the IPS model. If a particular site is doing very well, they may be asked to share their experiences and reflect on what they have done to help the partnership operate in their area.

Currently, AMH contracts with the OSECE to provide assistance in the development of new SE programs as well as training, on-going technical assistance, and fidelity monitoring. According to a recent SE guide published by AMH, OSECE is assisting AMH (specifically mental health organizations (MHOs)) develop an SE implementation plan to meet the needs of MHOs in various service areas¹⁷. This may include regional programs and/or partnering with existing SE providers.

Supporting Evidence:

According to the key informant, this partnership has resulted in improved employment outcomes for individuals with MI. A cost-benefit analysis was conducted and examined the actual cost of providing SE services versus other services. Data from the employment department, the Medicaid service utilization records, and other similar sources were used in the analysis. The results of the cost benefit analysis demonstrated no decrease in hospitalization due to the provision of SE services. The reason for this being that "a lot of the people that were receiving services from a Community Supported Employment Program on their intake into supported employment were not people that were in and out of the hospital (...) it wasn't a population that was being hospitalized on intake." This result led Oregon to broaden the scope of their analysis; they looked into mental health centers' costs of providing SE services, along with outcome data: "[we saw] a significant jump in the number of hours that people worked and the hours that they worked after they had left the service", in addition to an increase in the earnings an individual received over a period of three months.

The OSECE plans to roll out a consumer satisfaction survey in the summer of 2012 as a follow-up to the previously mentioned study. The consumer satisfaction survey will reach out to the approximately 500 people who have graduated from the SE program with jobs in the last three to four years. In addition to client satisfaction, the survey will measure whether the individual is still employed. Additionally, MH collects data from their programs four times a year that reports on the previous three months about the number of customers who were served, who worked, who were in school, who graduated with their jobs, and the number of new job placements. Also, an individual who works for the state of Oregon tracks detailed information about each client's service utilization.

¹⁷ See: Addictions and Mental Health Division. (2011, June 29). *Supported employment guidance for the adult mental health initiative (AMHI)*. Salem, OR: Author. Retrieved from <http://www.oregon.gov/OHA/mentalhealth/adult-initiative/main.shtml>

All of these data are collected and provided to all staff around the state as part of data transparency. Data transparency provides an incentive to increase performance across all of the sites and also allows sites that need extra help to be easily identified. These data are also presented to state leaders and legislatures and used in such presentations as budget sessions.

Future Directions:

Future directions for supported employment in Oregon are currently unknown. Oregon has recently received approval from the Obama Administration to implement a plan as a part of the Affordable Care Act. This plan has received approximately \$5.6B and focuses on services provided by Continuing Care Organizations (CCOs). To clarify, one of our key informants explained:

In July of last year [2011] the Mental Health Division moved out of the Department of Human Services and moved to the Oregon Health Authority, and all of their services are contracted out to the county and now they'll be in the CCO.

The majority of Medicaid dollars received by the state will be split up between the CCOs. CCOs are new entities that will be introduced in the state of Oregon, and will be responsible for providing behavioral and mental health services, in addition to dental care. The amount of time and money that the CCOs will spend on SE services is currently unknown:

...supported employment has always been set aside, like fee-for-service, and it's no longer going to be set aside. It's getting lumped in with the bigger [funding] stream (...) These CCO's have more room for flexibility with the funds they receive because it's one big lump of money they get, and they get to decide where that goes.

Until the role of the CCOs is more clearly defined, OVRs and AMH will continue to partner to deliver SE services. One area of the partnership open to development is the establishment of data sharing mechanisms. Data points to track may include information about the number of shared customers, job placements, and job tenure. Additional future endeavors may include development of research studies that would be useful to the OVRs-AMH partnership such as examining the characteristics of successful job developers or identifying the long-term impact of services on transition-aged youth. Lastly, with regard to training and TA, the OSECE would like to expand upon their job development training efforts. According to one key informant, they would like to get “more in-depth with the different styles of job development; like job development to large corporations, small mom and pop stores, self-employment, or job proposals.”

Transferability:

According to our key informant, one piece of the OVRs – AMH partnership that is unique (and possibly more difficult to transfer to other states) is that Oregon works directly with private non-profits who are contracted to provide mental health services – they do not go through the counties to provide these services. One aspect of the supported employment program in Oregon that does have potential for replication is a work group that was formed between OVRs, AMH, and the OSECE. This work group has met periodically to address issues of concern throughout the state for about 25 years. The evolution of topics that this group has covered include: employment for people with disabilities, supported

employment, and IPS. According to our key informant, this work group has been “critical to [Oregon’s] success as a state.”

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A Case Study of Promising Vocational Rehabilitation Agency Practices in Improving Employment Outcomes for Individuals with Mental Illness

Partnering from the Top-Down and Maintaining Fidelity to IPS using Jointly Funded Staff

South Carolina Vocational Rehabilitation Department

Abstract:

Since 2002, the South Carolina Vocational Rehabilitation Department (SCVRD) and the Department of Mental Health (DMH) have collaboratively implemented the Individual Placement and Support (IPS) model of Supported Employment (SE) for people with mental illness in nine community mental health centers (plus one additional site) across the state. SCVRD and DMH jointly fund IPS staff to coordinate and deliver integrated vocational rehabilitation and mental health services to over 500 South Carolinians with significant mental illness each year. IPS programs across the state consistently earn high scores on Johnson & Johnson – Dartmouth approved SE fidelity reviews, and the employment rate for South Carolinians with mental and emotional (psychosocial) disabilities was above the national average reported by the Rehabilitation Services Administration (RSA) in 2009.

Background:

In 1995, South Carolina became one of the original sites to participate in the research on the Individual Placement and Support (IPS) model of Supported Employment (SE) conducted by the Johnson & Johnson – Dartmouth Community Mental Health Program (J & J – Dartmouth Program).¹⁸ After a small-scale pilot during J & J – Dartmouth’s first year of research, South Carolina was one of seven states that expressed interest in implementing the IPS model statewide. The full initiative began in 2002, when J & J – Dartmouth awarded South Carolina a three-year grant to implement supported employment programs in three community mental health centers (CMHCs). The Department of Mental Health (DMH) and the South Carolina Vocational Rehabilitation Department (SCVRD) partner to implement the supported employment programs. Note that the IPS model requires mental health – vocational rehabilitation collaboration to successfully implement the practice.¹⁹ The number of CMHCs that provide SE services using the IPS model has since increased to nine centers.

According to the key informants from SCVRD and DMH, commitment on the part of the SCVRD and DMH leadership to improving employment outcomes of individuals with disabilities has been key to successfully implementing IPS supported employment programs in South Carolina. The demonstrated commitment by the state agencies served as a model for the local VR and MH offices and their partners (CMHCs) to work together to help individuals with mental illness gain and maintain employment. “Because you see the commitment from the top, it really forces the local folks to make that commitment. I think that’s the uniqueness...VR involves MH in a number of things... This is really a true partnership from the top down, and I think that’s what makes it unique,” explained one key informant.

Purpose, Goals, and Implementation:

The goal of the partnership is to jointly implement the IPS model, based on the premise of supported employment as an evidence-based approach to vocational rehabilitation that has demonstrated positive competitive employment outcomes for people with significant mental illness. Through collaborative implementation of the IPS model, SCVRD and DMH intend to provide more integrated and seamless service delivery to people with mental illness resulting in improved employment outcomes for this population.

Access to supported employment services: Out of 17 Community Mental Health Centers in South Carolina, nine CMHCs (plus one additional site) provide SE services, resulting in ten SE programs across the state. CMHCs that do not offer SE services rely on traditional VR services for individuals interested in employment. One of our key informants estimated that about 500 out of 55,000 individuals served with mental illness receive SE services across the state of South Carolina annually. If a person with mental illness lives in an area that does not offer IPS services, they have the option of going to another catchment area to receive services; however, because South Carolina is a rural state, doing so would be difficult. SCVRD offers supported employment services statewide. Individuals who do not meet the criteria for IPS services or individuals who are in an area that does not offer IPS services, may be referred to SCVRD for supported employment services. Our key informant mentioned that traveling to another CMHC would not make sense because the individual would have to travel over an hour to receive services. *The Family Advocacy Project*, funded by Dartmouth and Johnson & Johnson, is a new initiative program whose goal is to

¹⁸ South Carolina Department of Mental Health (2006).

¹⁹ Bond G.R., Becker, D.R., Drake, R.E., et al. (2001).

advocate for more IPS SE programs. The main goal of the *Family Advocacy Project* is to “involve family members more in the supported employment program.” Although there are no exclusions to provide SE services beyond populations with severe mental illness (SMI), the SMI population is prevalent. One of our key informants estimated that between 85 and 88 percent of clients receiving SE services are a part of the SMI population.

Coordinating referrals and service delivery: Procedurally, either a case manager or therapist makes client referrals to IPS programs through the CMHCs. SCVRD does not refer clients to the IPS program; rather, the IPS program refers clients in need of employment services to SCVRD. Clients who express interest in employment services are either placed into IPS programs or referred to SCVRD for general vocational services. SCVRD may also refer clients to DMH for general mental health services. As one key informant noted:

The relationship between mental health and vocational rehabilitation goes way back. This isn't something we just started through the IPS program (...) we [VR] have an MOA in place with the Department of Mental Health, outside of the IPS program.

Both agencies exchange case-by-case information over the phone and/or on paper, granted that the VR customer has given permission for his/her information to be released to the other agency. There is no shared electronic case management system at this time. As one key informant explained, the absence of a shared case management system,

...does not damper or put a hindrance on our relationship, because (...) when the client gives us permission to talk to whomever, we [VR] provide that information instantly. If we need to request records, we get them almost immediately. There is no break in the process when we're trying to make our clients eligible on either side.

In addition to coordinating referrals, our key informants have emphasized that the relationship between SCVRD and DMH has enhanced the services that are provided to persons with disabilities. Specifically:

[The relationship is] from the top-down. The executive commissioners get along well, as well as the deputy commissioners, the assistant commissioners, on down to the program managers, the liaisons, and the counselors. Our staff [VR] is welcome at mental health; mental health staff is welcome at VR.]

It is also important to note that SCVRD does not contract out employment services to vendors. The employment services that are provided come directly from staff members at either SCVRD or DMH.

Coordinating staffing roles and funding: Partnership and collaboration between the two state departments has been key to implementing the IPS model for people with mental illness in South Carolina. Each participating CMHC houses an IPS team consisting of a team supervisor, a VR job coach, and a MH employment specialist. Additionally, it is by law that a Master's level counselor “is there to oversee the caseload that the employment coach is working with to sign off on the necessary documents and develop their plan of action.” Of the aforementioned positions, DMH funds 25 percent of the VR job coach position. The VR job coach assigned to the IPS team works 40 hours per week in the CMHC. Typically, SCVRD assigns staff to the IPS programs that have an interest or background in mental health. As part of the IPS team, the VR staff provide vocational services, including job placement and training. MH staff provide psychiatric supports to clients, including medication oversight if needed. MH staff are also responsible for providing follow along services to clients remaining on the IPS caseload following a VR case

closure (after 90 days of successful employment). SCVRD staff can also provide post employment services to clients if needed.

Overall, the supported employment program in South Carolina is state funded, and there is hope that those funds will increase as a result of efforts made by the previously mentioned *Family Advocacy Project*, which will advocate for additional state funding for supported employment. In addition to jointly funding IPS staff positions, SCVRD and DMH also share responsibility for the coordination of the IPS programs at the CMHCs. Specifically, each state department has an assigned staff member who serves as the statewide program director. The IPS program directors from SCVRD and DMH are responsible for providing joint trainings to VR and MH staff, collecting outcomes data, developing reports, and monitoring program fidelity including conducting annual fidelity reviews. With regard to staff training, DMH provided an all-day staff training, in addition to a separate two-day training provided by Dartmouth. The CMHCs that provide IPS services are invited to attend these trainings. To clarify, one key informant stated that DMH “train[s] as a group or, if there is new staff, [provide] a training specific to that center or site.” At this time, the influence of these trainings on employment outcomes has not been measured. However, written evaluations and verbal feedback are collected from training attendees to measure their satisfaction with the training provided.

Supporting Evidence:

SCVRD and DMH collect data on employment outcomes, number of referrals, number of individuals working, the number of individuals on the current caseload, number of new jobs, and the number of people being placed in education training programs, in addition to client satisfaction data for each of the CMHCs. For the 2011 – 2012 fiscal year, percentage of case closures is at 52%. On average, the centers serve around 500 South Carolinians with significant mental illness every year and have seen a steady increase (44% in 2003 to over 50% in 2009) in the percentage of individuals who have achieved successful community-based competitive employment.²⁰ According to our key informants, in April 2008, South Carolina won an award for their employment outcomes; South Carolina’s Charleston/Dorchester CMHC was selected as one of just two supported employment sites in the nation to receive the Johnson & Johnson-Dartmouth Achievement Award. Johnson & Johnson Inc. awarded the Charleston/Dorchester CMHC for their supported employment outcomes with a 68% employment rate. This award was won over 110 supported employment programs in 12 other participating IPS states. As reported by the Rehabilitation Services Administration (RSA) in 2009, South Carolina’s employment rate for people with mental and emotional (psychosocial) disabilities was 52.81%, compared to the national average for general/combined VR agencies of 48.57%.²¹

In December 2008, DMH launched a statewide effort to collect and analyze data from each CMHC with an IPS program in order to conduct a return-on-investment (ROI) study. CMHCs were asked to report client data on wages, hours worked per week, and SSI/SSDI earnings. The CMHCs also provided financial information for the fiscal year 2009 cost of conducting the IPS program. Data analysis was conducted using data collected on 598 clients enrolled in IPS programs across the state in 2008. According to the summary of findings in this report, the average person employed through the IPS programs earned an additional \$533.00 per month, compared to an average of \$17.10 per month earned prior to enrolling in the IPS program. The report concluded that the return-on-investment ratio is approximately one to six. For

²⁰ Rehabilitation Services Administration (2010). A key informant who nominated the practice reported the fact as well.

²¹ Rehabilitation Services Administration (2010).

every dollar invested on clients through the costs of operating IPS programs, clients earned approximately six dollars.²² In 2011, our key informants reported that the salaries of individuals employed, with the help of the IPS program, ranged from \$7.25 to \$24.00 per hour. As one key informant explained, the ROI study was “a one-time study sort of to try to help an organization, like NAMI [National Alliance on Mental Illness], when they go to advocate.”

South Carolina holds all participating CMHCs that implement evidence-based supported employment to the fidelity standards, as outlined by the J & J – Dartmouth Program. The evaluation process is standardized to meet the fidelity criteria, as prescribed by the IPS SE Fidelity Scale that measures program performance in three areas: staffing, organization, and services.²³ In South Carolina, IPS statewide program directors are responsible for collecting data on a quarterly basis, and co-conducting the fidelity reviews on an annual basis. As reported on the South Carolina DMH website, fidelity review results consistently indicate that all IPS program sites in South Carolina are successfully implementing the supported employment model.²⁴

As part of the fidelity reviews, the IPS program directors talk with the IPS team members at the participating CMHCs including supervisors, case managers, psychiatrists, and clients. According to our key informants, interviews with program participants demonstrate that they are satisfied with the program and their experiences. “They [the clients] are always telling us that this is the best program that ever happened – it has given them hope. It has allowed them to do things they never thought they would be able to do. [Being] out there in the community working, it is very therapeutic for them,” explained the informant. In 2005, DMH began to collect standardized consumer survey data using the Mental Health Statistics Improvement Program (MHSIP) Adult Consumer Survey instrument. The survey asks consumers about their perception of the care and treatment they received in the IPS program. DMH uses the reports for ongoing performance measurement in the state’s IPS programs.²⁵ Performance Improvement plans are developed as a result of the fidelity review, and DMH goes back to each site after six months to monitor the progress of plan implementation. DMH creates an additional annual report based on the data collected by SCVRD on the performance of the counselors and job coaches that receive referrals from DMH. As one informant explained: “*The data is used as accountability and performance improvement. If there are sites that are not meeting the state average, then that’s an area where we have to go in there and meet with folks and see what’s going on, and provide consultation to improve that site.*”

Future Directions:

SCVRD plans to continue their efforts in partnering with DMH to implement the IPS model in CMHCs. One of SCVRD’s goals is to have a person who is knowledgeable about both the IPS program administered at the CMHCs and supported employment services administered through VR. In SCVRD’s general supported employment service delivery, components of the IPS model, particularly rapid placement, are

²² Henderson, D. and Sparks, E. (2009). *South Carolina department of mental health: Individual placement and support/supported employment return-on-investment*. Internal report shared by key informant.

²³ Dartmouth IPS Supported Employment Center

²⁴ South Carolina Department of Mental Health (2006). This fact was also confirmed by key informant in interview on 10/20/10.

²⁵ South Carolina Department of Mental Health. (2005). *Individual placement and support (IPS) employment programs MHSIP survey outcome report*. Internal report shared by key informant.

being utilized. Moreover, DMH is considering plans to add a peer support specialist component to two IPS programs; at the time of our research these plans were still in development.

Transferability:

Suggested by our key informants, the piece of the program to be replicated in other states is to initiate a philosophy within both organizations (VR and MH) that trickles from the leadership to counselors in the field. Our key informants suggested that this philosophy should include components of no exclusion from receiving employment services (regardless of the type of disability), place then train individuals with disabilities, and cross-training VR-MH staff members. A piece of the SE program in South Carolina that may be more difficult to replicate in another state is the type of relationships that are formed between the VR and MH employment coaches. These relationships are developed because “VR very seldom contracts out for anything. [VR has] everything in-house, [making it] more unique than other states.”

“Our employment coach [and] mental health employment coach, they go out together. They develop jobs together, they provide supports together, and they’re pretty much in the community all the time together.”

SCVRD believes that this joint staffing is a critical, yet unique, piece of their SE model.

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A Case Study of Promising Vocational Rehabilitation Agency Practices in Improving Employment Outcomes for Individuals with Mental Illness

Interagency Collaboration through Shared Administrative Responsibility, Shared Staff, and Counterpart Supported Employment Coordinators

Vermont Division of Vocational Rehabilitation

Abstract:

The Vermont Division of Vocational Rehabilitation (DVR) and the Department of Mental Health (DMH) have been partnering for over 20 years to coordinate supported employment (SE) service delivery to individuals with serious mental illness (MI). The partnership specifically focused on program eligibility and referral, program staffing, and incentive payments for SE providers. This has positively impacted employment outcomes for individuals with serious mental illness, as evidenced by an increasing number of successful closures of VR customers into employment and above-average employment rates for people with mental and emotional (psychosocial) disabilities.

Background:

In the late 1980s, the Vermont Division of Vocational Rehabilitation (DVR) contracted with the Department of Mental Health's (DMH) designated community mental health agencies to provide supported employment (SE) services²⁶. Over the next two decades, DVR and DMH explored a variety of service delivery models, including clubhouses, work crews, and individual placement; however, none of the approaches were focused on competitive employment outcomes.

In 1999-2000, DVR received a state partnership initiatives grant from the Social Security Administration, and used a portion of the grant to work with the Dartmouth Psychiatric Research Center to research alternatives to existing service delivery models. In 2001, Vermont also participated as one of three pilot sites for implementation of the Johnson and Johnson – Dartmouth Community Mental Health Program Individual Placement and Support (IPS) model of Supported Employment (SE). In that same year, researchers at the Dartmouth Psychiatric Research Center conducted a statewide assessment of supported employment programs in Vermont and found a positive association between high fidelity scores (as measured by the Individual Placement and Support Fidelity Scale) and competitive employment outcomes in SE programs across the state. In the last ten years, DVR and DMH have continued to expand their collaborative efforts around SE, focusing specifically on program eligibility and referral, program staffing, and incentives payments for SE providers. As of 2012, DVR and DMH offer SE services to individuals with mental illness in ten community mental health agencies across the state.

Purpose, Goals, and Implementation:

The purpose of the DVR – DMH partnership is to coordinate SE services across agency and system boundaries with the goal to improve employment outcomes for individuals with serious mental illness. The partnership specifically focuses on shared administrative responsibility, coordinating service delivery across agencies, program eligibility and referral, and incentive payments for SE service providers.

Access to supported employment services: There are ten community mental health agencies that offer supported employment services across the state of Vermont. These agencies are a part of Vermont's Designated Agency System, "meaning that [they] don't have competing community mental health agencies in any community – [they] just have one, and they're responsible for all community mental health services in any particular county or set of counties." There is also one community rehabilitation provider (CRP) in Vermont. Vermont DVR partners with both the community mental health agencies and the CRP.

The community mental health system in Vermont has a program called the Community Rehabilitation and Treatment Program (CRT). The CRT program, in conjunction with the New Hampshire Dartmouth Psychiatric Center, provides intensive IPS SE services to individuals across the state of Vermont. The CRT program received a grant in the 2000's to fund statewide technical assistance (TA), leading to wide acceptance of IPS in the CRT program. In terms of numbers served, our key informant stated, "at any given time, there's about 2,500 to 3,000 people in that [community mental health] system. So, for those consumers we [VR] contract with the designated [mental health] agencies." Eligibility for the CRT program is determined by guidelines set by DMH; these guidelines are administered by the designated community mental health agencies. Furthermore, an individual's status as a consumer of VR services does not impact

²⁶ Vermont DMH operates under a designated agency system in the state – as opposed to contracting with community rehabilitation providers. There are ten state-designated mental health agencies that provide SE services to people with MI.

his/her eligibility for receiving mental health services. According to our key informant, “it’s not infrequent that our staff [VR] will advocate for individuals to be served by the CRT program.” For individuals who need less intensive services and do not meet the eligibility requirements of the CRT program, VR will partner with the state’s CRP to provide employment services. Eligibility to receive services by the state’s CRP is determined by referral or self-referral from individuals receiving outpatient mental health care. The services provided by the CRP are, however, time-limited supports.

For individuals that need the least amount of supports, they can receive general employment services from VR. There is no link to the mental health system or IPS for general services.

Coordinating referrals and service delivery: DVR and DMH partnered to improve access to rehabilitation services for individuals with mental illness by streamlining program eligibility and referral. Specifically, community mental health agencies directly refer customers receiving SE services to DVR. Once referred, the DVR counselors will conduct an intake meeting with the individual and an initial assessment of his / her vocational potential onsite at the mental health agency. In order to streamline eligibility and referral across agencies and systems, DVR revised its policy on sobriety with input from DMH and the community mental health agencies. The old policy required six months of sobriety prior to receiving employment services. In the new policy, DVR eliminated the sobriety / drug-free requirement to be more inclusive of individuals who actively use drugs or alcohol and who seek immediate access to SE services and supports. As of 2012, this policy has been in effect for about four years. The 2009 DVR Policy and Procedures Manual states: “In general, DVR counselors should not treat individuals with substance abuse issues in any different or special way than we [DVR] do for persons with other disabilities.”²⁷ DVR operates under the assumption that employment helps facilitate and motivate sobriety:

...if we can get them connected with an employment opportunity, it’s motivation for them to modify their behavior, because you have to get up for work (...) but obviously, if a person is so off the charts, you can’t send them to an employer. So, you might have to have some intermediate steps. (...) If they can show up to work and perform, and they’re not actually using in the workplace, then we would continue to support them.

This philosophy on sobriety has guided the partners in streamlining eligibility and access to SE services for this particular population.

DVR, DMH, and community mental health agency staff partner to coordinate services across agencies. Typically, a DVR counselor works with all of the SE customers from one community mental health agency. Counselors visit community mental health agencies to meet with customers on-site. This increases the physical presence of VR within the MH provider agencies, and serves to reinforce the mission of employment across agencies. Additionally, DVR benefits counselors are physically located in community mental health agencies across Vermont, providing services and supports specifically to SE customers.

Coordinating staffing roles and funding: DVR and DMH share administrative responsibility for the SE program. The two agencies designate staff responsible for the administration and provision of SE services across the state. A key feature of the DVR-DMH partnership is the permanent establishment of the SE Project Coordinator position, housed in DMH. DVR and DMH jointly funded this position following the end of the initial J & J – Dartmouth grant, in an effort to maintain DMH’s focus on employment²⁸. The key

²⁷ Vermont Division of Vocational Rehabilitation (DVR). (2009). *Policy and procedures manual*. Waterbury, VT: Author.

²⁸ DMH now funds the position 100%

informant described the importance of this position as the partnership grew in the early 2000's: "I think the key for us was getting the [SE Project Coordinator] position institutionalized in mental health, so there is a person over there who is always thinking about employment."

In addition, DVR created a counter-part position to the DMH SE Project Coordinator, called a VR Supported Employment Coordinator. This person is responsible for monitoring all SE grants and funding. The coordinator works closely with the DMH counterpart to coordinate quarterly cross-agency meetings. Together, both positions are also responsible for overseeing a mental health leadership team.

The mental health leadership team meets quarterly and consists of DVR, DMH, and SE provider staff. The goal of the leadership team is to maintain an employment focus and ensure that agency directors and all community-based SE provider staff are working toward the mission of improving employment outcomes for individuals with mental illness. One major accomplishment of this team was receiving funding for the establishment of Supported Employment Champions. "The Supported Employment Champions were case managers who were identified as folks who were going to promote employment for folks who weren't necessarily engaged in the employment programs," described our key informant. Our key informant also indicated the SE Champion role was a volunteer position that the case managers contributed to in addition to their regular duties. Further, the state provided \$5,000 to each agency that had an SE Champion. These funds compensated the agencies for the time that their case managers were required to attend extra trainings as champions. One such training focused on basic benefits counseling.

In addition to the employment coordinator roles, and the SE Champions, there are VR Counselors who work part-time at the mental health agencies. There is "usually a single liaison with the designated agencies, so they're [mental health agencies] not working with four or five different VR counselors." These liaisons have office hours at the MH agencies and "...in almost all cases [these liaisons] are folks who have a particular interest and like working with the Community Mental Health Agencies..." These VR counselors are all familiar with IPS, however they do not receive formal training in IPS SE.

DVR and DMH jointly fund SE programs housed in community mental health agencies. Historically, DVR's role in co-funding SE services was based on a fixed grant-funding model. That is, DVR paid community mental health agencies a flat dollar amount to provide SE services, but did not consider the overall employment rate achieved by providers when allocating funds. In 2010, DVR shifted to a new performance-based payment system.

DVR and DMH worked side by side to design a system that defines the performance payments based on employment outcomes. The key informant explained the impetus for change in the system: "We really try to make it a revenue issue for the [community mental health agencies]. The better they can do with employment the more revenue there is...if we can think of employment as a revenue generator – as well as the right thing to do – we are hoping that will have an impact [on employment outcomes]."

The new system offers two types of incentives: 1) incentive payments from DVR, and 2) an increased proportion of Ticket to Work (TTW) revenue. DVR's new payment system is called a "base plus model." DVR determines the amount of base payment a mental health agency receives by the number of customers served in the center's geographic area: "the base is intended to make sure they have enough funding for at least one full-time staff person, and then the rest of the funding is proportional [to the size of the agency]." In addition to the base payments, each center has the opportunity to earn incentive payments. In the past, the base-plus model determined incentive payments using a "point system." More recently however, a

legislative mandate required that all ten community mental health agencies demonstrate improved employment rates, with a target of 35%. As our key informant explained:

An agency had to show either a 1%, a 2%, or a 3% improvement in their employment rate depending on how far away they were from the 35% standard. If they don't meet that improvement rate, then a portion of their total CRT funding would be withheld.

To reinforce this mandate, Vermont implemented “incentives and funding holdbacks”, pending an agency’s performance in reaching the 35% benchmark. Overall, the main goal of this mandate is “to get [each agency] to get a higher percentage of their total population employed.” Anecdotal evidence suggests that since the implementation of this legislative mandate, “the agencies have been far more engaged around employment, and there’s far more energy around [meeting targets].” For example, data inquiries from the agencies regarding their performance have increased since the implementation of the mandate and its respective incentives and holdbacks. Our key informant has also noted that it is still too early to indicate whether this mandate has had any real impact on improving employment outcomes.

Community mental health agencies can earn payments based on three criteria: overall employment rate, customer earnings, and total number of people placed in employment without a previous work history. The second incentive opportunity comes from the TTW program. DVR operates as the agent for all of the community mental health agencies, and splits payments with DMH 50/50. Under the new incentive-based payment system, DVR adjusts the split in the community mental health agency’s favor based on their overall employment outcomes.

Supporting Evidence:

By sharing the administrative responsibility for overseeing SE programs, DVR and DMH have worked collaboratively to reduce the program-oversight burden on a single agency. By establishing a designated VR counselor on-site at community mental health agencies, DVR and DMH can efficiently coordinate services across agencies. Vermont cross-walked program eligibility and referral requirements to streamline access to both agencies. The restructured contracting procedure implemented on July 1, 2010 received positive reviews; however, DVR was not able to report evidence of effectiveness of this specific procedure. DVR will continue to evaluate the effectiveness of the new payment structure over the next fiscal year. There were indicators that Vermont is working to improve employment outcomes for people with mental illness in both the State Plan and RSA data. According to the DVR 2011 State Plan, the employment rate for individuals receiving both VR and MH services is more than twice the rate of individuals who only receive MH services.²⁹ Data on the agency performance improvement mandate is still anecdotal. Vermont has, however, been collecting Department of Labor (DOL) wage data for over 10 years, to measure employment outcomes for the CRT program. Variables in these data include individual quarterly earnings in addition to number of employers per individual. Our key informant indicated that DOL data serve as a baseline to compare outcomes of the performance improvement efforts.

²⁹ Vermont Division of Vocational Rehabilitation (DVR). (2010, June 30). *State plan for the state vocational rehabilitation services program and state plan supplement for the state supported employment services program: Vermont vocational rehabilitation division – agency of human services state plan for fiscal year 2011*. Waterbury, VT: Author. Retrieved from <http://rsa.ed.gov/view.cfm?rsaform=VR-State-Plan&state=VT&fy=2011&agency=G>

In the 2011 State Plan Goals and Priorities, DVR states that the agency is working toward “improving the outcomes of community providers serving individuals with severe mental illness.” DVR will measure this goal using the number of 26 closures achieved through supported employment programs for adults with mental illness. In FY 2008, the total number of people with psychiatric disabilities employed with supports (status 26) was 224. For State FY 2010, it was 260. In State Fiscal Year 2008, a total of 768 people with psychiatric disabilities were employed; these numbers decreased to 678 in FY 2009, 552 in FY 2010, and 516 in FY 2011. The total number of individuals with psychiatric disabilities receiving supported employment services in FY 2011 was 592 (DVR, 2012). It is unclear how these indicators are related to the DVR-DMH partnership in terms of employment outcomes.

Future Directions:

DVR is currently working to introduce a web-based case management system, set to roll out in the fall of 2012, that can share information with and add partners. A future goal is to add DMH, the Department of Corrections, and other Agency of Human Services (AHS) programs to this system. This system will be able to track employment services provided across various systems:

It would also allow us to say: Client A has been served by the mental health employment program (...) and maybe has also been served through a corrections employment program (...) we'll be able to track individuals at the person level as well as the program level.

In addition to developing the shared web-based case management system, DVR and DMH are also working to expand their partnership around SE. They collaborate, for example, with the Dartmouth Psychiatric Research Center on joint grant-writing initiatives. The three entities will work together to submit grant applications focused on topics of mental health and employment, including a recent grant focused on MH case management practices for employment services. Most recently, the DMH received a grant to support peer supported employment where individuals with “psychiatric disabilities provide the supported employment services for peers.” This grant initiative is aimed at increasing the amount of services provided to young adults with mental illness. As DVR pilots the restructured payment system for community mental health agencies, there may be opportunities to extend this approach to other providers. DVR is now legislatively required to examine performance-based grant funding for all providers, specifically those serving individuals with developmental disabilities. Current practices in the DVR / DMH partnership may inform these future endeavors.

Transferability:

Our key informant suggested a few components of Vermont’s supported employment program that could be replicated. First, our key informant suggested items of staff development such as creating roles for supported employment liaisons and supported employment champions. Secondly, our key informant suggested that “to have a single approach to supported employment is very effective and is definitely something that should be replicated (...) if you don’t have someone paying attention to it, it won’t happen.” Finally, our key informant suggested that other components of their program such as third-party TA, and performance-based contracting could be replicated by other states. Our key informant also indicated that due to the size of their state, that some of their practices in implementing supported employment may not be easily generalized to larger states. Specifically, “until recently, we [VR and MH] all

worked on the same campus and could walk across the lawn and chat and resolve problems”, hence the reason for the closeness of the two agencies.

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