Recovery with Results, Not Rhetoric

Report by Institute for Community Inclusion, UMass Boston on Promising Effective Practices, Barriers, and Policy Issues for Promoting the Employment of Persons with Psychiatric Disabilities

January 2005

Institute for Community Inclusion
University of Massachusetts Boston

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Report prepared by:

Joe Marrone, ICI
Heike Boeltzig, ICI

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EXECUTIVE SUMMARY

This report was undertaken by staff from the Institute for Community Inclusion (ICI) at the University of Massachusetts Boston pursuant to a task order from the Office of Disability and Employment Policy (ODEP) within the U.S. Department of Labor. While the great majority of the funding was provided by ODEP, with an additional small amount allocated by the Substance Abuse and Mental Health Services Administration (SAMHSA) of the U.S. Department of Health and Human Services, the intent of this report was to provide guidance to both ODEP and the U.S. Department of Labor Employment Training Administration (ETA). This focus is meant to assist them in their respective roles in ensuring that the workforce development system, as envisioned under the Workforce Investment Act of 1998 (WIA), promotes universal access to customers with disabilities, including those with mental illness. The purpose as delineated in the statement of work was to:

> Identify critical elements, systemic barriers, and develop policy recommendations that would assist One-Stop Career Centers and other employment and training agencies/organizations to provide effective, quality services to persons with psychiatric disabilities. These findings will be included in a written report. The report, delineating the elements of effective practices and programs/services, will be disseminated throughout the workforce investment system. The ultimate goal is to publish a TEGL and/or Training and Employment Notice (TEN), issued by ETA, in collaboration with ODEP, that identifies the critical elements that would enable One-Stop Career Centers to provide quality employment and training services to persons with psychiatric disabilities; and to encourage the workforce development system to use this knowledge to develop One-Stop Career Centers that are capable of proving effective employment and training services to this population.

The methodology included the following components:
1) Seek examples from a wide network of possible respondents of "best practice" sites. These included eight sites visited, seven sites interviewed using a telephone protocol, and four customers interviewed.
2) Develop an initial protocol for conducting on-site and telephone interviews, with the protocols refined on an ongoing basis.
3) Collect information from different locations by using both on-site visits and telephone questioning.
4) Compile a list of resources for One-Stop Career Centers.
5) Prepare a final report that identifies the critical elements that enabled the One-Stop Career Centers and other employment and training programs interviewed to provide effective employment services to persons with psychiatric disabilities.

The report is organized into the following areas:

- **Context and Background**: This section gives some context in two broad areas: 1) the overall interaction of WIA intent and implementation with effective services for customers with disabilities and 2) the current knowledge base (evidence-based practices) regarding effective employment services for people with psychiatric disabilities.

- Results of Site Visits and Interviews
  - o Commonly Identified Barriers
  - o **Promising Practices from Identified Sites, 1**: Broad-based, overriding issues
  - o **Promising Practices from Identified Sites, 2**: Specific effective practices, divided into Administrative-Level Strategies and Service-Level Strategies

- **Recommendations**: These are divided into **General Recommendations from a Variety of Disciplines** and **Specific Recommendations for Furthering Efforts in Developing Effective Practices in Workforce Development Initiatives and Customers with Mental Illness**.

- **References Used in the Report**

- **Appendices A-N**: A compilation of various resources, including other topical references, resource materials, examples of training agenda, and examples from specific sites. Appendices J and K contain selected **agency case studies of several sites** (Appendix J) and some **client/customer profiles** (Appendix K).

Summary of Findings and Recommendations

Commonly Identified Barriers
- Fragmentation and lack of seamless service delivery
- Tendency to see people with psychiatric disabilities as needing only disability-specific services
- Mental health systems of care often do not value employment as an outcome
- Need for increased staff knowledge and skills
- Need to understand the disability community
- Need for access to support services
- Need for baseline standards
- Need for customer marketing plan
- Marketing plan for employers connected to overall business services
- Social isolation
- Lack of access to health insurance
- Complexity of existing work incentives
- Limited skill sets in choice and control

Promising Effective Practices Issues from Identified Sites
Broad-based, overriding issues
- Certain common essentials of any good service philosophy are required: commitment to the work, compassion for the people served, competence of staff; coordination of service interventions, collaboration and partnership focus, and meeting client/customer needs as the primary goal.
- Directly confronting the often negative views of employment capacity and appropriateness that mental health systems of care and clinically trained personnel commonly hold about people with psychiatric disabilities.
- Providing training and technical assistance interventions focused on enabling workforce staff to: 1) develop methodologies and practices so customers can fully benefit from the

array of available resources; 2) identify disability-specific and generic local resources that can be accessed and leveraged; 3) deliver services in ways that are "user-friendly."

- Understanding the demands of the One-Stop system to meet the needs of the business customer as well as the job applicant customer, while using proven strategies to bridge these complementary but not exactly matched needs.
- Understanding and dealing with the impact of work on disability-related benefits.
- Assisting staff within the workforce system with how to best encourage people to self-identify the presence of a mental illness. At the same time, balancing this concern with the need to preserve confidentiality and focus on information most relevant to achieving employment success.
- Understanding the role of the VR agency within the One-Stop system in general and in regard to services to people with psychiatric disabilities in particular.
- Understanding the need for local workforce/rehabilitation/mental health employment partnerships to include concerted efforts to maximize funding through the use of different funding streams that can be combined to serve the complex needs of people with psychiatric disabilities.

Specific effective practices
Administrative-level practices
- One-Stop Career Centers in these sites sought out various agencies and providers, as well as consumer advocacy and family groups, to ensure that a variety of necessary supports and system integration activities are in place.
- Many sites implemented evidence-based practices in supported employment while enhancing it with links to the workforce system.
- When VR was engaged in the One-Stop at multiple levels, there was better coordination and integration of services.
- The workforce development system in the better-coordinated sites sought to engage VR in joint service delivery rather than considering them merely a referral outlet.
- Specific examples of coordination/collaboration include jointly funded services, serving the person in both systems simultaneously, creating a joint employment service planning team, using each other's staff to conduct joint training, jointly developing referral guidelines, involving both agencies' staff in administrative or staff committees of the other, jointly funding staff positions, and VR agencies' encouraging community rehabilitation providers to use the One-Stop Center's services.
- Partnerships can be created to assist consumers of state mental health services to secure competitive employment through One-Stop staff within a local center.
- Several sites developed specialized programs for subpopulations.
- Creation of statewide and local policy implementation initiatives.
- Focus on specific activities to better integrate mental health and workforce services.
- The partnership between the mental health organization and the workforce system expanded beyond the disability program into broader workforce activities.
- Assisting people individually can give the disability or mental health service provider insights into the overall operation of the One-Stop Center.
- Many sites had conducted a specific series of trainings focused on mental health.
- Many of the sites developed special relationships or outreach and/or support activities regarding "best practice" services to special populations of people who had a psychiatric disability complicated by other disability and/or social issues.
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<u>Service-level practices</u>
- Use of a Supported Employment/Individual Placement and Support (IPS) conceptual model to meet the needs of people with significant psychiatric disabilities.
- Provision of an employment approach that uses a strengths-based model of person-centered career planning.
- Organizations that have been historically successful in providing individualized supported employment interventions are able to understand and use the core concepts of Customized Employment since this model does not present any new clinical challenges to them.
- Provision of a "wraparound" model of services through specialized projects at the MH provider that include MH employment specialists and special vocational case managers.
- Hiring current or former consumers with mental illness to provide services as well as a broader emphasis on peer support as an intervention strategy.
- Involvement with advocacy groups can be helpful and often is essential to create full community partnerships.
- Use of a modified placement and employment support planning process in addition to any Individual Employment Plan (IEP) developed at the One-Stop or Individualized Plan for Employment (IPE) developed through VR.
- All sites used Benefits Planning assistance in some form.
- Creation of employment planning teams that provide intensive services to customers with serious mental illness.
- Identification of people with mental illness sensitively and with full respect for confidentiality, customer choice, and desire for privacy.
- Use of personal involvement and individual assistance to bridge gaps that exist between the demands of the universal access/self-service philosophy and the more intensive needs of the customer with serious mental illness.
- Use, within the ODEP-funded sites, of flexible, personally directed funding made available to clients for needs that could not be quickly accommodated otherwise.
- Designing simple ways for the disability and mental health community to access resources without visiting the One-Stop Center.
- Assisting the One-Stop business service or employer service teams to incorporate the needs of job applicants with psychiatric disabilities into their efforts.
- Highlighting the importance of job retention activities while also understanding that employment retention is usually more crucial than job retention.
- The development of specialized employment-related services for transition-age youth with emotional/behavioral disabilities.
- Engaging "hard-to-serve" populations by understanding the need to adopt specialized clinical as well as employment approaches.

<u>Recommendations</u>
General recommendations from a variety of disciplines
- Evidence-based principles of Supported Employment are the most thoroughly researched practices that produce good employment outcomes for people with psychiatric disabilities. However, they need to be examined in terms of their applicability to the interface with the workforce development system. ODEP should consider conducting a targeted evaluation of these sites vis-à-vis their ability to integrate IPS into their workforce partners operations, or ETA and SAMHSA might consider funding a joint project specifically to evaluate the use of the IPS model within the generic workforce/WIA system.

- Models of person-centered planning should be encapsulated in all these approaches, with unique modifications needed for people with psychiatric disabilities. ODEP should consider conducting a targeted evaluation of these sites vis-à-vis the modifications needed to ensure that the "Discovery" process proposed by ODEP as a core element of Customized Employment is relevant and adaptable to the needs of people with psychiatric disabilities.
- There are key principles offered in the academic literature to guide large-scale organizational change to affect employment outcomes for people with various significant disabilities that can and should be applied to system change activities within the workforce development arena. ODEP should consider conducting a targeted evaluation of these sites regarding their ability to affect systemic change within their workforce partners' operations. Alternatively, ETA and SAMHSA might consider funding a joint project specifically to rigorously evaluate organizational change or local planning strategies that can be used to support full inclusion of customers with psychiatric disabilities within the generic workforce/WIA system.
- There are generic issues involved in any sort of systemic collaboration and community agency partnership endeavors that should be encouraged. DOL could offer some guidance to workforce systems about effective strategies to accomplish the sort of inter-system partnerships it endorses for the One-Stop system.
- Workforce/MH system initiatives focusing on quality employment outcomes for people with psychiatric disabilities should take a Continuous Quality Improvement (CQI) approach.

Specific recommendations for DOL in furthering effective practices in workforce development initiatives for customers with mental illness
- DOL should issue policy guidance using findings from this report and other resources regarding evidence-based practices in serving people with psychiatric disabilities.
- There is a need for more concerted technical assistance on specific skills and systemic/administrative structures to further the employment of people with mental illness.
- There is a need for ongoing training to ensure staff competency. Training topics that should get addressed more aggressively are:
  1) Effective business services incorporating the needs of people with psychiatric disabilities
  2) Marketing workers with mental illness to employers
  3) Accommodations for job applicants/workers with mental illness
  4) Engagement and outreach strategies for potential customers with psychiatric disabilities
  5) Increasing staff expectations that work is a priority and the expectation for people with psychiatric disabilities in conjunction with local workforce's mental health partners in the community
  6) Management of performance standards in a workforce environment
  7) Motivational interviewing and personal "readiness for change" strategies
- DOL should fund a one- to two-day think tank focused on two primary topics: 1) identifying techniques for incorporating these best practice approaches nationwide and 2) looking specifically at funding/sustainability strategies for employment services for people with mental illness that examine the idiosyncratic funding streams that affect potential customers with mental illness.

- DOL should develop a targeted program/project evaluation on the outcomes achieved (looking at employment retention, measured in days of work in a specific period, in addition to job retention as one of the outcome elements) specifically with customers with mental illness served through its various projects. With SAMHSA, the Rehabilitation Services Administration (RSA), and the National Institute on Disability Rehabilitation and Research (NIDRR), DOL should also consider jointly funding a study looking at the issue of employment outcomes of individuals with psychiatric disabilities served in the One-Stop system versus those served in MH-related programs/services.
- DOL should identify the key role that concern over health and financial benefits plays for customers with psychiatric disabilities. Furthermore, it should issue some policy guidance highlighting this issue and direct workforce systems to seek out partnership agreements with the local Benefits Planning Administration and Outreach program (BPAO) in their state or other agencies involved in benefits counseling. It is also recommended that DOL coordinate with the Center for Medicare and Medicaid Services (CMS) and the Social Security Administration (SSA) on developing strategies for workforce systems to become cognizant of reasonably conversant with this issue as it is an important one in the lives of many potential customers with disabilities they will encounter.
- DOL should provide guidance to workforce development systems and Workforce Investment Boards (WIBs) on specific systemic outreach and coordination strategies with mental health systems of care.
- The issue of One-Stop and VR integration and coordination transcends this project and is an overall systemic issue. Both DOL and RSA must work together at multiple levels to provide guidance to their respective spheres of influence at federal, state, and local policy and program implementation levels.
- One-Stop and workforce staff should be encouraged to recruit personnel who not only represent ethnic, cultural, and gender diversity but also represent people with disabilities, specifically psychiatric disabilities. Outreach strategies should supplement the already existing requirements under the Americans with Disabilities Act (ADA) and Section 504.
- DOL should not waive performance outcome measures for customers with significant disabilities, including mental illness. Simply focusing on quantitative results without qualitative measures is unethical; producing high-quality outcomes without affecting significant numbers of people is self-indulgence. Enduring system change involves both quality and quantity. A pilot with rigorous evaluation to examine relaxing these performance criteria for customers with mental illness would be worthwhile. DOL also could examine some alternative methodology, such as using its existing work on regression formulae through the Michigan VAPIS (Value-Added Performance Improvement System) model to pilot approaches that would impact services to customers with psychiatric and other significant disabilities.

Conclusion

DOL should reinforce with WIA grantees/contractors, other funding recipients, and mental health systems themselves the need for integration and inclusion to the fullest extent possible of customers and potential customers with psychiatric disabilities in workforce services, especially at the core level. This report highlights many specialized strategies and interventions that make workforce services more amenable to the needs of people with mental illness. Nonetheless, the societal expectation for our citizens with and without disabilities still remains universal access. People experiencing the challenges posed by psychiatric disability have been victimized as much if not more by lowered expectations of many systems that purport to serve their needs, even

mental health specialty organizations, than by having these set too high. If the workforce/WIA/One-Stop system is to meet its abundant promise of seamless service delivery and universal access, key services must be programmatically as well as physically accessible. Due to the confluence of new psychiatric rehabilitation technology, mental health treatments, evidence-based practice in employment services for people with psychiatric disabilities, and the flexibility of a creative, newly reinvigorated workforce system, the potential exists for both the mental health and workforce systems to participate in breaking new ground in helping people with serious mental illness achieve a more fulfilling and complete life and reaping the benefits of full U.S. citizenship.

As Emily DeRocco, Assistant Secretary of Labor, ETA, said in her remarks to the Subcommittee on Social Security of the U.S. House Ways and Means Committee on September 30, 2004, "One of five key components of this [New Freedom] initiative is 'Integrating Americans with Disabilities into the Workforce.' This includes expanding educational and employment opportunities and promoting full access to community life for people with disabilities. ETA is committed to achieving this goal."

PROMISING EFFECTIVE PRACTICES, BARRIERS, AND POLICY ISSUES FOR PROMOTING THE EMPLOYMENT OF PERSONS WITH PSYCHIATRIC DISABILITIES (FULL REPORT)

Introduction

This report was undertaken by staff from the Institute for Community Inclusion at the University of Massachusetts Boston pursuant to a task order from the Office of Disability and Employment Policy within the U.S. Department of Labor. While the great majority of the funding was provided by ODEP with an additional small amount allocated by the Substance Abuse and Mental Health Services Administration of the U.S. Department of Health and Human Services, the intent of this report was to provide guidance to both ODEP and the Employment Training Administration. This focus is meant to assist them in their respective roles in ensuring the workforce development system as envisioned under the Workforce Investment Act of 1998, including within its Section 188 non-discrimination provisions, promotes universal access for customers with disabilities, including those attendant to mental illness.

The purpose as delineated in the statement of work was to:

> Identify critical elements, systemic barriers, and develop policy recommendations that would assist One-Stop Career Centers and other employment and training agencies/organizations to provide effective, quality services to persons with psychiatric disabilities. These findings will be included in a written report. The report, delineating the elements of effective practices and programs/services, will be disseminated throughout the workforce investment system. The ultimate goal is to publish a TEGL and/or Training and Employment Notice (TEN), issued by ETA, in collaboration with ODEP, that identifies the critical elements that would enable One-Stop Career Centers to provide quality employment and training services to persons with psychiatric disabilities; and to encourage the workforce development system to use this knowledge to develop One-Stop Career Centers that are capable of proving effective employment and training services to this population.

Methodology

The methodology, which was adopted and approved by ODEP with additional consultation with staff from ETA and SAMHSA as well as personnel from ICI, included the following components.

1) Site Selection
The project looked for examples from a wide network of possible respondents of "best practice" sites. Nominations were sought using a modified Delphi process (i.e., information from those knowledgeable about the topic) from a national network including WIBs, employment programs, ODEP and ETA disability grantees, mental health providers, public VR system personnel, state workforce systems, state/county mental health systems of care, disability consumer groups, and other federal technical assistance grantees such as the National Center for Workforce and Disability at ICI (NCWD/A), the Corporation for Supportive Housing, the Law, Health Policy and Disability Center at the University of Iowa College of Law and its companion RRTC on Workforce Investment and Employment Policy, and Advocates for Human Potential. Requests for nominees and site selection were solicited through email, telephone calls, and presentations

conducted by the primary author. Final site decisions were selected based on several factors: geographic diversity, variety in funding streams (using sites with ODEP funds, sites with Work Incentive Grant funding from ETA, and sites with no special federal disability and workforce funding), having multiple nominations during the selection process, being written up in psychiatric literature, and sites that the primary author had knowledge of personally.

NOTE: The ideal approach to such a nomination process would be to connect the sites to be selected under this Delphi process to more objective measures of success in terms of employment outcomes for customers with psychiatric disabilities. However, both the relative newness of the WIA system and ODEP itself (with the Chronic Homelessness projects representing first-year endeavors) and the limited financial resources and short turnaround time precluded this more extensive study. Therefore, while the report focuses on "best practices," there is no concomitant expectation that each of the sites visited and reported on represent "ideal" ways of doing business. Rather, these studies are meant to demonstrate various approaches to achieving results with customers with psychiatric disabilities with all the attendant challenges encountered.

2) Protocol Development
A protocol was developed to frame on-site and telephone interviews. While meant as a guide, the questions and process developed allowed for and encouraged wide-ranging and free-flowing conversation, and were not used as formal interview queries. Thus the discussions had different emphases based on local conditions and the composition of the group at the site. The basic interview protocol had the following lines of inquiry:
   a) What concrete employment outcomes has your One-Stop system achieved in terms of serving customers with psychiatric disabilities?
   b) How active and/or integrated have MH or VR staff been? How active or integrated have MH community providers dealing with people with psychiatric disabilities been?
   c) What has been the most surprising challenge in delivering services to customers with mental illness? How have you dealt with it?
   d) What has been the most surprising success in delivering services to customers with mental illness? How did it come about?
   e) What formal activities, including but not limited to training, have you used to integrate any specialized MH employment services into the One-Stop? How successful or unsuccessful have they been, and why?
   f) What more informal activities have you used to integrate any specialized MH employment services into the One-Stop? How successful or unsuccessful have they been, and why?
   g) Are there examples of blended or "braided" funding your system developed or used?
   h) What sorts of training have the customers served been involved in?
   i) What have you done to integrate business service activities and services to customers with psychiatric disabilities?
   j) What efforts has the One-Stop provider undertaken to encourage people with psychiatric disabilities to participate in One-Stop services?
   k) What efforts has the local MH system of care undertaken to encourage people with psychiatric disabilities to participate in One-Stop services?
   l) What efforts has the One-Stop provider undertaken to encourage its staff to understand the needs of customers with mental illness vis-à-vis the workforce system?
   m) What efforts has the local MH system of care undertaken to encourage its staff to develop collaborative employment interventions to serve customers with mental illness?

n) What changes have been made (if any) in either the existing workforce or MH structures in order to produce better services and outcomes for customers with psychiatric disabilities?

3) Data Collection Techniques

Information from different locations was collected using both on-site visits and telephone questioning. The information was collected for the on-site visits by Joe Marrone with one site visit conducted by Cori DiBiase, and the telephone inquiries were conducted by Heike Boeltzig. Ms. Boeltzig provided the information for all the client case studies and both Mr. Marrone and Ms. Boeltzig composed the program case studies used. The selected programmatic case studies and client profiles are included at the end of this report in Appendices J and K, respectively.

Lead informants for each site visit are listed in parentheses though in most cases there were several local informants interviewed and visited. The site visits conducted by Mr. Marrone were:
- St. Louis, MO, Work Incentive Grant (WIG) recipient (Amy Clinton, Independence Center)
- Vancouver/Clark County, WA, Workforce Action Grant and WIG grantee (Melodie Pazolt, Columbia River Mental Health Center)
- Portland, OR, ODEP-Housing and Urban Development (HUD) Chronic Homelessness and WIG grantee (Clover Mow, Portland WIB)
- Boston, MA, ODEP-HUD Chronic Homelessness grantee (Dennis Rogers, Boston WIB)
- Tucson, AZ, no special federal workforce grant funding (Bertha Villegas-Kinney, Arizona VR)
- Utica, NY, Customized Employment Grant (CEG) and WIG recipient (Michelle Barlow, NYS VR)
- Gloucester County, NJ, WIG grantee (Robert Gervey, Ph.D., University of Medicine and Dentistry of NJ [UMDNJ])

One additional site visit was conducted by Mr. DiBiase to Frederick, MD, CEG recipient (Anne Rea, WayStation).

The telephone interviews conducted by Ms. Boeltzig were:
- Boston, MA JobNet, no special federal workforce grant funding (Sharon Tulchinsky, JobNet)
- Anoka, MN, CEG grantee (Don Lavin, Rise, Inc.)
- Peoria, IL, Workforce Action Grant and WIG grantee (Mike Boyle, Fayette Company)
- New Orleans/Jefferson Parish, LA, no special federal workforce grant funding (Larry Dale, Jefferson Parish WIB)
- Wausau, WI, no special federal workforce grant funding (Linda Larson-Schlitz, Wausau, WI One-Stop)
- Napa, CA, CEG and WIG grantee (Donna Deweerd, Sonoma State U., formerly of North Bay Employment Connection)
- Fairfax, VA, CEG grantee (Carol Thacker, PRS, Inc.)

Ms. Boeltzig also conducted client interviews from four clients who were in Wausau, WI, Vancouver, WA (two clients), and Anoka, MN. *(NOTE: The intent was originally to include a customer from the Boston JobNet project, but this customer decided not to participate at the last minute.)*

4) Products Expected

- Compile a list of resources for One-Stop Career Centers (e.g., websites, available technical assistance information, training modules).
- Prepare a report that identifies the critical elements that enabled the One-Stop Career Centers and other employment and training programs interviewed to provide effective employment services to persons with psychiatric disabilities, including background, identification of the issues, description of effective practices, successful case studies, identification of systemic barriers, and policy recommendations.

Context and Background

One clear shift in the policy landscape for disability issues and employment over the last decade has been the increasing need to address the perspectives of systems other than public vocational rehabilitation. As the monograph *Disability Policy in the 21st Century* by the organization Half the Planet states,

> Nearly every disability organization that works with people with disabilities now states that its Mission focuses on getting people with disabilities employed. While the accuracy of the data we have on unemployment rates for people with disabilities (reported at approximately 70%) has been questioned, there has not been any overwhelming evidence of progress in disability employment rates since passage of the ADA in 1990. (Half the Planet, 2002)

More recent sophisticated data analysis confirms this anecdotal observation (Burkhauser & Stapleton, 2004). Work is a critical component to independence, but it is a goal that has not been realized by many individuals with disabilities. As President Bush stated in his announcement of the New Freedom Initiative,

> Americans with disabilities are poorer and more likely to be unemployed than those without disabilities with… over 33% of adults with disabilities living in a household with an annual income of less than $15,000, compared to only 12% of those without disabilities. (New Freedom Initiative, 2001, pp. 1-2)

Creating and equipping a range of resources and providers to serve these individuals will be yet another challenge for public policy. One major impact of the ADA has been the need for many aspects of U.S. society (employers, public accommodations, state and local governments, transportation providers, etc.) to consider the implications of their traditional ways of doing business. The ADA itself has been the major policy breakthrough of the 1990s for employment and disability in that it represents a strong governmental social policy commitment to full citizenship and equality for people with disabilities and has been the model for many similar legislative advances in other countries. What was in the past solely the province of the federal-state VR system and employers (i.e., employment issues affecting people with disabilities) must now be attended to in the context of other systems, including those projects funded under the auspices of DOL (WIA and other, related workforce development initiatives) that have to establish policies and practice guidelines to deal with these economic and labor market issues affecting citizens with disabilities, including those with mental illness.

Before presenting the report findings, there is a need to provide some context in two broad areas: 1) the overall interaction of DOL programs' intent and implementation with effective services for

customers with disabilities and 2) the current knowledge base (evidence-based practices) regarding effective employment services for people with psychiatric disabilities.

Interaction of U.S. Department of Labor Programs with Employment Services for People with Disabilities

Workforce Investment Act

The Department of Labor's emerging redesigned workforce development vision seeks to consolidate all workforce services, including public VR, into a "One-Stop Center" system. On August 7, 1998, President Clinton signed into law the Workforce Investment Act (WIA). In addition, the most recent amendments to the Rehabilitation Act under which the federal-state VR system operates and is funded was incorporated as a separate title (Title IV) under WIA. There are six key principles of WIA:

1) Streamlining services
2) Universal access
3) Increased accountability
4) Local board control
5) State and local flexibility
6) Improved youth programs

The overall goal of WIA is to increase employment, retention, and earnings of persons participating in employment-related activities supported by an integrated workforce investment system, and thereby improve the quality of the workforce, sustain economic growth, enhance productivity and competitiveness, and reduce welfare dependency. Successful implementation of the aforementioned policies and practices would be a definite boon to the population of working-age people with disabilities in the U.S. But questions abound, within both the disability and workforce communities, about whether this revamped landscape of generic employment services will prove fertile ground for advances in employment for citizens with disabilities. The actual application of these concepts will determine whether WIA truly delivers on its potential for people with significant impairments, including those with psychiatric disabilities.

If WIA fulfills its abundant promise, people with disabilities will receive the assistance they need to obtain quality jobs, side by side with individuals without disabilities. Essentially, when individuals receive employment services in an integrated setting with the rest of the general public, it normalizes the job search process and reinforces the concept of unemployment as an economic and not a mental health condition. The fact that high-performing One-Stops do provide significant opportunities for choice of services, control, and participation at a level which the individual controls potentially creates an atmosphere for better engagement of individuals in the employment process.

WIA's attempt at seamlessness has been supported further by the recent emphasis in funding projects through ETA, often under the rubric of WIGs that create a disability "navigator" position. The navigator is not meant to engage in direct disability service but rather to be an internal resource to assist One-Stop staff in ensuring universal access and easy use of services, including external disability-related resources, for customers with disabilities. It remains to be seen whether this approach will be the linchpin of effective service or a confusing redundancy to roles that already exist in the lives of many people with disabilities (e.g., VR counselor, human service case manager, service broker/advocate). One concern voiced by some is that creating this job description might become a method to avoid tackling the larger public policy question, namely: Why have we created a system supposedly focused on serving all customers that is too

complex (or not "user-friendly" enough) for people to understand without the aid of a "navigator"?

WIA specifies that the state plan must describe how the state will meet the needs of major customer groups (including individuals with disabilities) and ensure nondiscrimination and equal opportunity. The preamble to the final WIA regulations explains that the Departments of Labor and Education will work with the states as they develop and implement their plans to ensure the effective delivery of services under WIA to individuals with disabilities. The preamble also explains that DOL will conduct a study of WIA implementation that includes a review of the manner and extent to which VR programs are integrated in the workforce investment system and how effectively this system serves individuals with disabilities. As Silverstein (2002) states:

> To date, no conceptual framework exists for reviewing and determining the extent to which WIA, as interpreted by the DOL and implemented by the states and local communities, ensures the effective delivery of services for individuals with disabilities consistent with our Nation's goals regarding persons with disabilities as articulated in the ADA.

In a 2002 report, the University of Iowa Law, Health Policy, and Disability Center stated,

> More than 80% of the state plans include persons with disabilities and/or representatives of public and private agencies, such as vocational rehabilitation programs, that serve persons with disabilities in the state plan development process. However, the majority of plans did not describe the nature and scope of their involvement in detail.

While a full analysis of this interaction between the ADA and WIA is far outside the scope of this report, Silverstein's extensively detailed monograph is recommended for review as a companion piece as it describes essential provisions in WIA and the extent to which these provisions reflect the federal disability policy framework. These elements include:
- The WIA legal framework and goals
- Governance at the federal, state, and local levels
- The One-Stop service delivery system
- Youth activities
- Performance accountability policies
- Nondiscrimination and methods of administration

A subject of current public policy debate is whether people with significant disabilities can get appropriate services under a generic system of services. The research on successful employment services for people with significant psychiatric disabilities, described in a later section of this report, emphasizes the intensity and duration of supports needed for vocational success. DOL data itself demonstrates the challenges that the workforce system faces in meeting the needs of and changing the labor market dynamics for workers with disabilities. By design, the One-Stop system is intended to be a high-volume, easy-access system, and there is no expectation that everyone who comes through the door is going to get intensive individual assistance. Within such a system there needs to be a strong mechanism for identifying those individuals who require additional assistance and steering them towards the intensive services.

Another challenge is increasing the labor market activity of people with disabilities, because persons with significant disabilities report lower rates of any form of labor market activity. Among labor market participants, persons with disabilities—moderate or significant—were more likely than those with no disabilities to report that they were looking for work or on layoff rather than working. Persons with moderate disabilities were nearly twice as likely to be looking for work or on layoff as people with no disabilities, and those with severe disabilities were nearly three times as likely. Some labor market analyses show that of persons 20 to 64 years old with severe disabilities, approximately 30 percent either worked, looked for a job, or were on layoff during specific points in time. DOL describes these rates as being in "stark contrast" to the rates for those with moderate or no disabilities (82-85%) that almost triple that figure (U.S. DOL, 1999).

NCWD/A at the Institute for Community Inclusion has presented the following key principles that should govern WIA policy as it affects customers with disabilities who might be using or seek to use this system to meet their employment needs.

1) Develop a core level of sensitivity and knowledge for all One-Stop staff regarding disability issues, and incorporate this into standard staff development activities and requirements for staff competencies.
2) Develop intake and case management systems so that individuals may receive services from multiple partners—both disability-specific and "generic"—and develop mechanisms so services can be matched to the specific needs of individuals.
3) Conduct a complete review of the One-Stop facility and programs to ensure that they meet legal requirements for physical and communication accessibility.
4) In conjunction with #3, incorporate universal design and learning concepts throughout the One-Stop programs and service offerings and reduce the need for "specialized" services for people with disabilities.
5) Develop mechanisms for the One-Stop to identify and utilize the array of disability-related resources in its service area.
6) Incorporate services for individuals with disabilities into quality improvement and assurance processes.
7) Design data collection and measurement systems to determine system progress in meeting the needs of people with disabilities.
8) Incorporate disability policy issues into local and state WIB and One-Stop policy discussions and directives, including such items as managing performance measures in a way that does not exclude "hard-to-serve" individuals, such as people with disabilities; developing policies on reasonable accommodation; and the like.
9) Work with the various One-Stop service providers, including training providers, to ensure full access for people with disabilities to their services.
10) Incorporate people with disabilities into One-Stop outreach and marketing efforts, and conduct specific outreach to the disability community (ICI, 2001).

Another development regarding the incorporation of customers with disabilities into the WIA One-Stop system has been DOL's draft of new reporting formats (EMILE) in the Federal Register in July 2004. The draft format includes the opportunity for new registrants to voluntarily self-disclose by disability type instead of the more generic binary (Yes/No) format currently used in reporting. This format has been proposed by some as a way to more explicitly identify service delivery effectiveness and potential gaps. Others are concerned that this would be problematic for several reasons, including:

1) The information would be inherently inaccurate because of the various elements related to self-disclosure of disability identified in items two to five below.
2) The perception of "having a disability" tends to be only partially an objectively defined fact and often a function of self-perception as well as cultural norms, especially when it comes to non-apparent disability labels (such as mental illness, learning disabilities, substance abuse). Many people with non-apparent or "hidden" disabilities such as mental illness, learning disabilities, and substance abuse share the common societal view of disability as a matter of physical senses and skills (hearing, seeing, mobility, etc.). Furthermore, many people do not know they have a situation that could be classified as falling within the disability paradigm.
3) People dealing with impairments that often would cause more overt discrimination and stigmatization in society at large and in employment situations specifically (such as the labels of mental illness and substance abuse) would tend to be appropriately cautious about disclosing.
4) Certain types of impairments and disabilities are more liable to cause fear and concern and elicit stigma in the population at large, which, of course, includes as a subset personnel of workforce systems and the employers with whom they interact. Therefore, community advocates and disability service programs are often reluctant to encourage customers with whom they work to disclose these issues unless directly relevant to a specific accommodation need or essential job function or requirement.
5) Many people with disabilities who are not reticent at all about identifying themselves as such still would not self-identify in a workforce context as they may not see the relevance to collecting the information when they do not want a disability-related service.
6) There exist many legitimate privacy and relevance issues that many people with disabilities and disability advocates feel are not well addressed in the current local systems, which vary widely in their abilities to put adequate safeguards in place.

Presidential Task Force on Employment of Adults with Disabilities

In the same year as the signing of WIA, on March 13, 1998, President Clinton signed Executive Order 13078, which created a Presidential Task Force on Employment of Adults with Disabilities. Recognizing the important role of the ADA, the overarching purposes of the task force were twofold:

• To increase the employment of adults with disabilities to a rate that is as close as possible to the employment rate of the general adult population
• To support the goals articulated in the findings and purposes section of the ADA

The formation and subsequent report of this Presidential Task Force in 1998 (Presidential Task Force, 2002) by DOL with the purpose of examining all federal agencies' responsibilities in the resolution of the problem of unemployment and underemployment of people with disabilities highlighted the gaps in a variety of services related to employment for people with disabilities. One outgrowth of the task force was the creation of the Office of Disability and Employment Programs (ODEP) in DOL. ODEP was charged with the responsibility of ensuring that the nation's workforce development system adequately addressed the needs of its customers with disabilities. As part of this strategy, ODEP created specialized funding for customized employment, defined by ODEP (2004) as:

> A process for individualizing the employment relationship between a job seeker or an employee and an employer in ways that meet the needs of both. It is based on a match between the unique strengths, needs, and interests of the job candidate

with a disability, and the identified business needs of the employer or the self-employment business chosen by the candidate…. Negotiation strategies may include job carving, self-employment, or other job development or restructuring strategies. Customized employment assumes the provision of reasonable accommodations and supports necessary for the individual to perform the functions of the negotiated job (www.dol.gov/odep/tech/employ.htm).

These efforts demonstrate a commitment to the employment needs of people with significant disabilities, including those affected by the Olmstead Supreme Court decision, which states:

Under the Americans with Disabilities Act unjustifiable institutionalization of a person with a disability who, with proper support, can live in the community is discrimination… institutionalization severely limits the person's ability to interact with family and friends, to work and to make a life for him or herself (Olmstead v. L.C. [98-536] 527 U.S. 581, cited in Burkhauser, Daly, & Houtenville, 2000).

There are also employment projects dedicated to meeting the needs of people who are "chronically homeless."

Current Knowledge Base (Evidence-Based Practices) Regarding Effective Employment Services for People with Psychiatric Disabilities
Paradigms and principles
"Recovery"—i.e., the concept that people with serious mental illness can get better and lead productive, fulfilling lives as citizens—has become the dominant paradigm for community mental health policy (Anthony, 2001). While employment service has not emerged in the forefront of this societal shift, it appears to be an inevitable by-product of a revamped view of the human potential of people formerly felt to be on a lifetime, downward spiral whose only hope was for community support and maintenance outside a hospital setting.

In December 1996, the National Association of State Mental Health Program Directors (NASMHPD) released a statement of the organization's belief that competitive, integrated, paid, and meaningful employment is essential to the habilitation and rehabilitation of persons with psychiatric disabilities. The organization asserts that unemployment among those with severe psychiatric disabilities needs to be lowered and that, in fact, productive activity such as work can be instrumental in promoting good mental health. Such a strong stated commitment to employment, even if not yet followed by a significant direction of resources towards this end, represents a major shift in employment and disability policy.

For any psychiatric rehabilitation system to make effective inroads in long-term employment and career prospects, certain visible and operational principles must be in place and must guide overall policies within such systems. These policies should incorporate a coherent set of beliefs, such as:
- Assisting people with psychiatric disabilities to enter employment is integral to the overall mission of mental health systems of care and thus inherent in the responsibilities of its entire staff and providers, even those not explicitly charged with work service responsibility. This means that employment is an expected outcome for the total system of care, not just employment programs or those involved with public VR.
- Mental health systems must communicate a conviction that all people (including persons with psychiatric disabilities) should be employed, have the citizenship right to equal

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access to employment, and will be assisted to do so because employment is a way for people to become economically self-sufficient, healthier, and fulfilled. Work is not just an opportunity to be offered people to "take or leave" as they prefer; rather, it is a responsibility of citizenship.

- The mental health system of care should combat barriers to employment that individuals face, such as stigma, discrimination, and economic disincentives.
- People have the right and responsibility to choose and change employment consistent with their self-defined interests, values, and skills—aided by significant personal connections in their lives (e.g., significant others, family, and friends) as well as professional staff.
- It is the responsibility of mental health systems of care to facilitate changes in environmental factors (anything outside the person) and skills (within the person) to enable the person to pursue their job of choice (Marrone, Tellier, DiGalbo, & Taylor, in press).

Mental health systems are beginning to recognize that dangers related to long-term unemployment (Dooley, Catalano, & Wilson, 1994; Kasl, Rodriguez, & Lasch, 1998; Lennon, 1999) almost always outweigh the dangers inherent in the stressors of working for people with serious mental illness. There is a dearth of any valid scientific data that actively promoting employment as an expectation for all precipitates any psychiatric symptomatology or distress. Some relevant references regarding unemployment as a risk factor are included at the end of the report in Appendix B. Concomitantly, there is a plethora of reasons why people with psychiatric disabilities should not just be offered the opportunity to seek employment but be strongly encouraged to do so as part of their overall movement towards Recovery (Marrone & Golowka, 2000).

Access to employment in our society is both a right and a responsibility. We expect that citizens will be productive and participate in a society integrated by race, gender, age, ethnic origin, and disability. The fact that people have the right to choose not to work in a free society does not mean that public systems have to remain neutral about the merits of such a choice. A relevant analogy: Students have the legal right to drop out of school at age 16, yet we clearly have a social and educational policy that seeks to discourage people from doing so.

Supported employment for individuals with psychiatric disabilities is one of the evidence-based practices that SAMHSA identifies that mental health systems have not yet successfully implemented in a way that has had meaningful impact on employment outcomes for people with psychiatric disabilities. Greater attention has been devoted to other evidence-based practices (e.g., illness management, medication management, co-occurring disorder treatment, family psycho-education, PACT) than to data generated by employment research. The reason for increased attention is not to elevate the importance of employment services above other outcomes but, rather, to try to equalize the importance of employment with other services prevalent in outcome-based care.

Research base
One of the most salient empirically validated practices for the vocational rehabilitation of individuals with psychiatric disabilities is the result of the focus on evidence-based practice within mental health coupled with the understanding of Supported Employment, recently popularized within the mental health community as the Individualized Placement and Support (IPS) model (Bond, Becker, Drake, Rapp, Meisler, Lehman, Bell, & Blyler, 2001; Drake, Becker,

Biesanz, Torrey, McHugo, & Wyzik, 1994). The IPS model is a supported employment approach that was developed and tested by Drake and his associates at the Dartmouth College Psychiatric Research Center. It is considered a supported employment approach and currently has a large body of empirical evidence supporting it. The model emphasizes minimal prevocational assessment, rapid job finding, matching jobs to consumers' interests, integrated jobs in community settings, follow-along supports, and close integration with mental health services. IPS employment specialists are a part of the consumers' clinical treatment teams. Both experimental and non-experimental studies have been conducted on this approach (Drake et al., 1996; Drake et al., 1999; Drake, Becker, Biesanz, & Wyzik, 1996). Taken together, the studies of IPS have found that IPS dramatically increases the percentage of persons employed.

More recently, SAMHSA funded the development and completion of the multi-state, five-year Employment Intervention and Demonstration Project (EIDP) conducted by the University of Illinois at Chicago's Mental Health Services Research Program (Bond et al., 2001; Cook et al., 2002).

EIDP found:
- People with serious mental illness can be successfully engaged in competitive employment.
- VR services should involve employment in integrated settings at customary wages or above. (Note that "VR" in this context does not refer to the state VR agency but rather to vocational rehabilitation interventions as part of the comprehensive services offered by the MH system.)
- People with serious mental illness should be placed in paid jobs as quickly as possible and according to their preferred pace.
- Ongoing employment support services should be available as needed and desired by the person served.
- Persons with serious mental illness should be helped to find jobs that match their career preferences.
- VR services should explicitly and proactively address financial planning and provide education and support around disability benefits and entitlements.
- VR services should involve family and friends in supporting the person's efforts to work.
- Vocational and mental health services should be integrated and coordinated.
- Vocational providers should work collaboratively with persons with serious mental illness to address issues of stigma/discrimination, and help negotiate reasonable accommodations with employers.
- VR services should be made available to all mental health consumers.
  (Cook et al., 2002)

This research base points to one of the key obstacles facing collaboration between systems. Much of the direct employment service delivery design within the mental health services area has historically been predicated on interagency working relationships between VR and mental health systems. The research evidence within the psychiatric rehabilitation field demonstrates that effective practice should include collaboration but must also include more direct employment services integrated within the mental health service delivery system of care itself. There is an expectation under the second design that the public mental health systems "own" vocational rehabilitation and employment outcomes outright, rather than being a function of interagency agreements with more direct employment-oriented entities, (historically) state VR agencies, and (more recently) the workforce development system. This conclusion can enhance

the potential for collaboration. Rather than just outsourcing vocational rehabilitation, the mental health system and its contracted providers should assume more direct responsibility for service provision and resource allocation in support of employment outcomes. Conversely, this approach can cause greater tension in the relationship between systems in that rehabilitation practitioners within the mental health system might challenge VR's dominance over vocational rehabilitation expertise.

Another potential problem is that while the mental health systems may now provide vocational rehabilitation, their philosophical bases are still driven by medically oriented, diagnostic models. This approach looks at deficits rather than strengths, or imputes inaccurate functional characteristics or assessments to diagnostic labels or adherence to psychiatric treatment. As public systems (workforce, VR, and mental health) strive to work collaboratively with people with psychiatric disabilities, the formerly clear delineation of roles has blurred (Marrone, Tellier, DiGalbo, & Taylor, in press). Many mental health systems have taken on the challenge of providing vocational services to persons with psychiatric disabilities. At the same time, mental health staff often feel the need to protect their clients from mainstream services (such as the local One-Stop Center) for fear that this environment may prove too "stressful" for their clients.

There are several differences between the ways in which mental health systems and more traditional employment-focused systems (such as workforce development as well as VR) view work. In the mental health arena, work is often defined as "meaningful activity," and the person need not work for more than a few hours per week or even for minimum wage to be considered successfully employed. One consistent problem that has plagued the field in terms of evaluating effective employment services for people with psychiatric disabilities across various studies and models is that there is no common definition of employment by which success is measured (Bond & McDonel, 1991). The mental health system's primary concern is stabilization; therefore, work is an opportunity to enhance the consumer's life within the parameter of mental health maintenance rather than an outcome measure in and of itself. On the other hand, VR views work as an expectation, and the risk of undertaking employment is considered a normal path to recovery. For employment service providers, such as those funded under WIA, work is not merely an activity: It is an outcome. The WIA performance standards and government employment program common measures recently instituted give further weight to the inherent difficulties of melding disparate views of the construct of "work" or "employment."

A set of relevant references on the employment research in community mental health is included at the end of this report in Appendix A.

Results of Site Visits and Interviews

Commonly Identified Barriers
Each of the sites selected for visits and/or interviews faced unique local situations and issues. However, there were consistent themes voiced across sites regarding the systemic barriers that their work on developing more effective services for people with psychiatric disabilities had to confront. There was consensus among the sites as well as among national policymakers and researchers of all disciplines that people with psychiatric disabilities still have not realized the full economic benefits of community inclusion and citizenship. This has happened for many reasons and is compounded by the ongoing economic uncertainty in many areas (for example, Washington and Oregon still face some of the highest unemployment rates in the U.S., usually two to three points above the national average). Even with a robust economy many regions are

enjoying currently at a time of economic rebound, employment rates for people experiencing mental illness remain unacceptably high. Unfortunately, the consistently low rates of employment for people with serious psychiatric disabilities make it difficult for many staff and people affected themselves to envision vocational recovery. The unemployment rate for people with psychiatric disabilities is high—85% to 92%—compared even to individuals with other types of disabilities (Anthony et al., 2002). Nearly 70% of those with long-term psychiatric experiences in the United States are almost entirely dependent upon Social Security programs for financial and medical support, and few ever leave the Social Security rolls to move into competitive employment (U.S. General Accounting Office, 1996). Nearly 50% of those who do obtain jobs through rehabilitation programs lose them within a one-year period (Cook & Rosenberg, 1994). No more than 30% of those who work have been able to move beyond the entry-level positions that keep people with serious psychiatric disabilities at or near the poverty level (Kirszner, Baron, & Rutman, 1992). Baron and Salzer (2000) describe a "culture of unemployment" among consumers, policymakers, and providers that is both pervasive and persistent. In this culture, mental health professionals are accustomed to believing that work may be so stressful as to threaten the consumer's possibilities for progress. Many mental health professionals and VR counselors view consumers' personal work goals as "unrealistic."

According to a survey from NAMI: The Nation's Voice on Mental Illness, the barriers to employment for this population were reported to be stigma and discrimination (44.9%); fear of losing benefits (39.8%); inadequate treatment of disability (27.7%); and lack of vocational services (22.5%). Lack of transportation, always a significant barrier for people with disabilities, was rated as the fifth most significant barrier to employment, at 19.6% in the NAMI study. Consistent with previous national surveys with broader populations of Americans with disabilities, 71% of these individuals reported an annual income under $20,000 (Hall, Graf, Fitzpatrick, Lane, & Birkel, 2003).

The issues that the sites this study interviewed consistently identified are encapsulated below with supporting data from broader research.

1) Fragmentation and lack of seamless service delivery
When agencies fail to collaborate, the individual service recipient is affected. The entities interviewed all had to find ways to bridge the philosophies of different systems, including public mental health, workforce delivery, public VR, and community rehabilitation providers. In addition, the overwhelming majority of the customers with psychiatric disabilities were involved with the state public assistance or Social Security systems. Many were engaged with advocates and family members. Unfortunately, families of individuals with psychiatric disabilities are often characterized as part of the problem by staff, unlike families of individuals with other disabilities, who usually are seen as part of the client's support network. Parents, particularly mothers, have been scapegoated many times as causative factors in the development of the disease or as part of a "schizophrenic family." Creating healthy distance and recognizing divergent interests between parent and adult child is often a function of those assisting individuals with psychiatric disabilities to organize a community of supportive relationships within their work lives.

All this complexity was placed on top of the existing multi-systemic complexity of the One-Stop system with which all the sites were involved. Research has found that customers were most satisfied when their service delivery systems were in contact with one another (Timmons, Schuster, Hamner, & Bose, 2001). Interagency coordination has been impeded by competing missions, unclear roles, and incompatible procedures, processes, and data systems, leading to

service duplication and overlap as well as service fragmentation at the federal level (GAO, 2000) and state level for children and adults with significant disabilities. The traditional organization of human services has also rendered it difficult for agencies to collaborate efficiently (Mazzella, 2001).

2) Tendency to see people with psychiatric disabilities as needing only disability-specific services

People with disabilities, especially those with the significant challenges those with mental illness face, are normally directed towards disability-specific programming as many One-Stop Centers are often unable to identify and assist them to obtain necessary supports. The successful sites surveyed sought to make the disability-specific services part of the overall workforce system and concomitantly have tried to make the One-Stop system true to its goal of universal access by remaining flexible in serving all customers, including those with psychiatric disabilities. A related issue is what one site (Peoria, IL) saw as the "over-reliance on service" rather than individual problem-solving skills as one reason why job retention was an issue for people with serious mental illness.

3) Low value placed on employment as an outcome by mental health systems of care

One of the most significant barriers that all the sites faced in assisting customers with mental illness to secure the benefits of employment is the view that many mental health professionals hold regarding work capacity and people with mental illness and the role of work in their lives. The mental health systems and staff that support these customers in meeting their treatment or service planning needs often give lip service to the goal of "productive activity" but at the same time provide mixed messages to the person with mental illness about the possibility of "too much stress" or "moving too fast," even in the face of much scientific evidence to the contrary (Marrone & Golowka, 2000). The sites that were driven by the mental health provider itself (Vancouver, WA; Chicago, IL; Peoria, IL; Frederick, MD) stood out in that these systems actively promoted employment as part of treatment and spoke to staff regarding the dangers of long-term unemployment. Yet even these providers spoke of the difficulties of getting some of their own staff members who were more traditionally trained in mental health disciplines (such as therapists, psychologists, nurses, doctors, social workers) out of this mindset.

4) Need for increased staff knowledge and skills

One-Stop staff often state the need for consistent baseline knowledge and skills for meeting the needs of customers with psychiatric disabilities. The ability to respond to this staff request was often seen as problematic by many of the sites for several reasons. Perhaps the most significant one was that transmitting information about specific diagnostic criteria in mental health or providing a greater understanding of psychiatric pathology is not especially useful to workforce development staff when assisting people with mental illness to achieve successful employment. Mental illness symptomatology and work potential are not strongly correlated (Rogers, Razzano, Rutkowski, & Courtney, in press). In addition, staff members were often concerned, as are many in the society at large, about the potential for violence and the need to learn de-escalation techniques. This posed another problem for staff at these sites because although people in psychiatric rehabilitation understand that the potential for violence is less for people with mental illness than in the general population when unaccompanied by substance abuse, the mere reporting of this information does not generally ameliorate the concern. Somewhat counterintuitively, it may even heighten the fear (Corrigan, Watson, Warpinski, & Gracia, 2004). Sites tried to balance this concern for meeting the self-identified training needs of workforce staff

with whom they partnered with their own deeper understanding of the field regarding evidence-based practice and employment in psychiatric rehabilitation.

5) Need to understand the disability community

Many of the sites said that when their respective projects/programs were created, there had been limited direct outreach made to psychiatric survivor and advocacy groups due to a general lack of staff awareness about the diversity of the disability community and the capacity for people with mental illness to succeed in employment. Beyond collaboration with VR, there was a lack of understanding about the major role the WIA system could play in meeting those needs. Local WIBs were concerned about whether they could achieve WIA performance standards while addressing the needs of customers with disabilities and whether resources existed to provide quality services to these customers. It is exciting that the successful sites highlighted in this report generally chose to overlook these concerns and taken the lead in overcoming them in innovative partnerships. Local VR agencies are only one part of the disability service system. The other human service departments of the state and counties that administer MH funding, which serve a much larger portion of the population of those with psychiatric disabilities and through which most mental-health-oriented social services are delivered, have limited involvement. The inability of many One-Stops to broadly use the expertise and support services available from the state/county MH divisions (and vice versa) is a barrier to the ability of people with psychiatric disabilities to fully benefit from the WIA system.

6) Need for access to support services

The One-Stop system must assist people with psychiatric disabilities to access the support services necessary for job success, as the evidence-based literature on Supported Employment for people with serious mental illness cited above amply demonstrates. These services include post-placement counseling, benefits management, job coaching, accessible information, assistive technology, and transportation. All the CEG and Olmstead grant sites surveyed that focused on customers with mental illness provided on- and off-site support as core components of their DOL projects, and the generic workforce staff involved all cited this capacity as essential to the types of customers served. Perhaps even more significantly, the sites without specialized funding identified the inability to provide this level of intense support as a problem in their effectiveness serving customers with serious mental illness.

7) Need for baseline standards

The decentralized nature of One-Stop system management provides flexibility to respond to the diversity of socioeconomic conditions across the U.S., including the high-tech "meccas" of Boston, Northern California, and Washington State; the manufacturing areas in Peoria, IL and St. Louis, MO; and the agricultural sectors in Tucson, AZ and Gloucester County, NJ. However, a possible byproduct of local control is that people with psychiatric disabilities may have inconsistent access to and benefit from services. The most successful sites had developed a consistent outcome orientation. The disability providers (including VR) and other advocates at these specific sites all stated concerns that without a special emphasis derived from state or federal policy in meeting the needs of customers with disabilities, this group could often be marginalized from workforce system access and services because they were competing with a plethora of other interests represented by targeted groups such as dislocated workers, customers who did not speak English, migrant farm workers, TANF recipients, and the like.

8) Need for a customer marketing plan

A carefully researched and planned, culturally appropriate, and sufficiently intensive marketing plan is necessary for successful customer outreach. While many One-Stop Centers run generic marketing efforts stressing universal access, the value of targeted outreach is abundantly clear. Sites that were successful in recruiting customers with psychiatric disabilities worked with a panoply of human service systems, community rehabilitation providers, advocates, and the local WIB to create and implement a marketing plan for persons with psychiatric disabilities that dovetailed with overall strategic plans that were already well constituted.

9) Marketing plan for employers connected to overall business services

While the logic of hiring persons with disabilities, including those with mental illness, is clear, it is not intuitive. Successful sites did not rely on the assumption that employers would arrive at this conclusion unaided, especially in the face of continuing pockets of discrimination and stigma. Sites that engaged in activities to improve employer relations and met the needs of their business customers were also meeting the needs of job applicants.

10) Social isolation

Social isolation is common for individuals with psychiatric disabilities, which is why there has been a heightened focus on peer support within the psychiatric consumer movement. Research suggests that the social networks of individuals with disabilities are typically comprised of paid staff members as opposed to the norm for individuals without disabilities, whose networks consist of friends, relatives, and co-workers. Although recent public policy has held social inclusion as a clearly articulated goal, little has been done to ensure that people with disabilities are wholly and meaningfully included in their communities. Many of the surveyed sites that had a strong MH provider focus on employment explicitly acknowledged and recognized this gap and incorporated social supports as part of their delivery methodology. These interventions could include workers' groups, worker support dinners, use of peer staff for on- and off-the-job assistance, and development of linkages with consumer-run drop-in centers or psychosocial clubhouses based on the Fountain House model.

Work acts as a training opportunity for the enhancement and development of social skills. Bellack and Mueser (1993), Lieberman (1989), and Mosher and Burti (1992) have amply looked at social dysfunction and performance and the impact on independent living. Mental illness is a disease of losses. The individual can lose his or her family and friends, housing, income, appearance, skills, self-respect, and—most importantly—hope. Employment can limit these losses and provide an opportunity to do and enjoy more in life. There is mounting empirical support for the idea that improved functioning in one area does not necessarily balance with improvements in others. Thus, getting a job may not automatically translate into developing good social skills. But certainly the development of employment-based interpersonal relationships often involves finding closeness and love, enhancing life, and fostering opportunity (Marrone & Golowka, 2000). Robert Putnam (2002) notes that work-related ties are among the most common forms of civic connectedness and social capital. Lower rates of workforce participation indicate that people with psychiatric disabilities are at a substantial disadvantage for building social networks.

In an article titled "The Connection Gap," Laura Pappano wrote,

> More than ever, our lives are lived with fewer important connections. More of us live alone, eat alone, watch TV alone. We marry later and divorce more often. We work more. We travel solo, eat at the bar alone, and go to the movies by

ourselves. We bank and shop by phone. We look for love on the Internet. And we don't visit anymore on Sundays. No wonder one-third of Americans tell pollsters they are lonely (p. 14).

She talks about the lack of social interactions that "create social capital and trust among members of a community" (p. 20), concluding that "reconnecting is critical for our survival, both as individuals and as a society" (p. 23). The work experience begins to bridge the loneliness of living with a mental illness and the need to develop reciprocal and trusting relationships.

11) Lack of access to health insurance

All the grantees continually cited concerns about health care benefits as a major motivational impediment to job-seeking for their constituents with psychiatric disabilities. Nationally, this fear is well grounded: Among people with specific and chronic disabilities, three million non-elderly adults and 650,000 children are uninsured (Kaiser Commission, 1999). More than half of those with disabilities who are uninsured are working. Even when looking at people with severe disabilities, more than half a million are working but lack either private or public health insurance. Many individuals earn incomes that exceed Medicaid eligibility but are not offered affordable, employer-based health insurance (Kaiser Commission, 1999).

Access to health insurance is somewhat less of an issue since the advent of various federally funded MIGs and state-sponsored Medicaid buy-in programs. (The latter can be authorized under either the Balanced Budget Act of 1997 or the more recent TWWIIA (1999) legislation; it is very limited in states such as Oregon and Washington, more expansive in states such as Missouri or Minnesota.) However, losing health care is still a great fear that affects whether people with psychiatric disabilities choose employment. TWWIIA has enabled states to provide health care to individuals with disabilities who are working. The legislation also encourages states to allow individuals to purchase Medicaid coverage and provides the option of maintaining Medicare coverage while working (Silverstein & Jensen, 2000). Yet many individuals who want to work remain unaware of this option.

12) Complexity of existing work incentives

National Social Security statistics show that the number of Supplemental Security Income (SSI) recipients nationally who work and take advantage of work incentive programs remains low. This information is reinforced anecdotally by the specific experience of many of the sites and people visited and interviewed. These low rates are indicative of the complexity of existing work incentives. Baron (1997) points out that the national system of supports, such as Social Security disability benefits, health care, and housing subsidies, carry strong disincentives for anyone who wants to return to work. For some, returning to work can threaten the loss of good medical coverage for medications and therapy as well as the loss of housing subsidies that make decent housing a possibility. In addition, many mental health treatment and even psychiatric rehabilitation programs are not adequately funded to provide the array of vocational rehabilitation services needed to obtain positions beyond entry-level, non-benefited ones in traditionally low-paying industries such as food service and janitorial companies.

13) Lack of skill sets in choice and control

The theme of empowerment is increasingly prevalent in disability legislation and of course is well ingrained in WIA with the law's emphasis on accountability, universal access, and services such as Individual Training Accounts. The 1992 Rehabilitation Act Amendments solidified public VR's emphasis on consumer involvement in the rehabilitation process. Mental health systems have

increasingly preached the virtues of consumerism and person-centered treatment/service planning as part of the recovery paradigm (Marrone et al., in press). Research has found consumer-directedness to be a key component of effective job services (Timmons et al., 2001), where consumer-directedness entails active involvement, choice, and provision of individualized services. In a consumer-directed system, individuals can assess their own needs, determine how these needs should be met, and monitor the quality of these services (Nadash, 1998). Consumers can be empowered by choosing their service provider, deciding on a preferred field in which to search for a job, and helping design the services that will best fit their needs (West & Parent, 1992). The great majority of sites surveyed stressed the importance of assisting the individuals they served to develop problem-solving skills, comfort with the uncertainties attendant to real choices around life decisions, an acceptance of reasonable consequences, and an understanding of the responsibilities that real power and control confer on people exercising these rights.

Yet despite this public emphasis, many of the sites reported confronting what is commonly referred to in the psychological literature as "learned helplessness" (Peterson, 1993) in the customers with mental illness they served. Many misconceptions about psychiatric disability exist; even within mental health systems of care, individuals with psychiatric disabilities are too often seen as those who cannot think for themselves or make life decisions independently. Operating under that perspective, mental health professionals often make decisions for the individuals and thus eliminate choice or become protective for fear that the person with mental illness cannot handle the stress of life or employment decisions that do not work out successfully. Consumers' resulting fear and passivity can cause problems when staff at the One-Stop Center focus on the guiding self-service principles on which most One-Stops are based. As noted by the Presidential Task Force (2002), "The foundation of WIA workforce reform rests on 4 cornerstones: choice, integration, accountability, and local focus. The intent is that all people, including people with disabilities, are customers of this new system" (p. 13).

Effective Practices from Identified Sites
Broad-based, overriding issues
As noted in the Introduction, the practices identified through the site visits were gleaned from sites recommended by a variety of informed sources as well as from prior work done by the primary author at ICI and his colleagues at NCWD/A. The limits of funding and time precluded objective measurements of success within which to judge the accuracy of the nominations beyond self-reported data from the sites themselves. So while there is face validity to these chosen sites and concomitant best practices in which they engaged, there is no "hard" or research-based statistical evidence to directly support these findings, which, of necessity, are of an anecdotal nature. Further ideas to buttress this data in the future will be offered in the Recommendations section below.

Also, while the intent of the report is to provide a level of specificity about how what interventions have been used most successfully, it is unavoidable that many of the interventions noted appear to have a certain obviousness and "common sense" flavor. What distinguishes the way many of these practices got used was the implementation of these specific approaches with some common essentials of any good service philosophy, namely:
1) Commitment to the work to be done and the goals to be achieved.
2) Compassion for the people who need assistance.
3) Competence of staff and organizations delivering the service; i.e., having the individual expertise and systemic structures in place that are conducive to producing the positive outcomes sought. This level of competence extends to specific service delivery

approaches, cultural awareness, interpersonal skills, management practices with staff, and community engagement and information-sharing.
4) Coordination, both internal and external to the organization, to avoid resource-wasting redundancy or discordant goals among different agencies (or within the same entity).
5) Collaboration and a partnership focus that welcomes differing points of view and seeks to engage as many systems and people as useful and possible.
6) Client/customer needs serve as the goal of the enterprise; i.e., the services are being provided to benefit the customer (both job seekers and businesses) with the accompanying ownership of the primary responsibility to reframe the system where necessary to meet these needs, not expect the customer/client to adjust their needs for the ease of the system.

Specific concrete practices in the sites will be offered below, but some general themes emerged that should be highlighted at the beginning.

1) The sites that had **active mental health provider involvement as a driving force** rather than as one of the partners directly confronted the issue in mental health systems of care that viewed work as an atypical outcome for people with mental illness and not something that MH systems should support aggressively. This can be summarized as encouraging people to seek employment and structuring their systems to make it happen, rather than taking a more passive approach acquiescing to a minority of clients' stated interest in working. The sites where the mental health provider was an initiator of the process (Vancouver, WA; Peoria, IL; Frederick, MD; St. Louis, MO; Chicago, IL) tackled the most important yet most difficult practice issue to affect and monitor within community mental health system of care. Each in different ways, they set the expectation that staff at all levels of the mental health organizations involved with the workforce development systems would encourage employment in all the clients/members they saw and not accept long-term unemployment and a life dependent on Social Security or Public Assistance benefits as the norm.

More than just a reframing of mission statements or even concrete funding and policy changes, this requires the development of an overall systems change approach. Such a paradigmatic shift will require some complex, locally specific activity involving matters such as policy, funding, practice, training, marketing of ideas, and leadership vision; it is encapsulated nonetheless in the outline included in Appendix C. There are real system disincentives, such as loss of Social Security and medical benefits, to surmount. Yet the amelioration of disincentives in these systems, the creation of Medicaid buy-in programs, and even enduring partnerships with generic employment systems such as One-Stop Career Centers are necessary but not sufficient conditions to help clients/customers overcome the fears and legitimate concerns many hold. It is essential that all mental health and workforce staff take a positive view of employment potential.

2) The great majority of the sites visited and interviewed responded to the requests of workforce staff for **more training on issues pertaining to mental illness**. As noted above, sites tried to balance this concern for meeting the self-identified training needs of workforce staff with whom they partnered (specific diagnostic criteria in mental health and issues related to safety/potential for violence) with their more complete understanding of the field regarding evidence-based practice and employment in psychiatric rehabilitation.

The training and technical assistance offered by the best-functioning sites were interventions focused on enabling workforce staff to:

- Develop methodologies and practices so these customers could fully benefit from the array of available resources
- Identify disability-specific and generic local resources that could be accessed, leveraged, and blended to assist in meeting the needs of these customers
- Deliver services in ways that were "user-friendly" and amenable to individuals' negotiating a multitude of bureaucracies and funding streams

Each of these training events' foci was constrained by tight schedules and local conditions. Appendix D contains a suggested draft agenda for more fruitful and intense training time for staff, an issue that will be discussed more in the Recommendations section.

3) Each of the sites sought to understand the demands of the One-Stop system to **meet the needs of the business customer** as well as the job applicant customer. Many of the local partners within the mental health system that had long been in the business of job development and marketing to employers were actually sources of expertise and contacts to the workforce development staff, many of whom were relatively new at providing business services. Most of the workforce sites visited or interviewed had a specific business services or employer outreach team for marketing. In general, these teams did not do individual job development but rather broader marketing to businesses. The sites that were the most successful in terms of employment and people with psychiatric disabilities were able to provide the specialized support for job development and advocacy that many people with mental illness need to become successfully employed.

The mental health organizations that provided effective employment understood that employers may have only incomplete information even about their own labor market needs, and that effective job development required professionals to broker an exchange process, providing usable information to both job seekers and employers. In order to increase the chances for long-term employment success, a strategy is called for that incorporates marketing principles, rather than simply selling. The essential elements of such an approach, which are quite compatible with and supportive of the workforce development system's emphasis on employer services, are:
- **Needs**: A need can be characterized as an issue, situation, or problem that requires a solution. Once a need is identified and accepted as such by the person to whom marketing is directed, then features and benefits can be used to meet it.
- **Features**: A feature is what a product or deliverable consists of.
- **Benefits**: A benefit is what is gained as a result of that feature.
  (Marrone, Gandolfo, Gold, & Hoff, 1998)

A relationship must be established with an employer that is viewed as mutually beneficial. In approaching employers, the helper's goal should not be to sell the employer on why they should hire a particular individual. Rather, the initial goal should be to build a relationship with the employer and obtain information that will allow the individual or agency to gain an understanding of this employer.

4) Most of the customers with psychiatric disabilities served at these venues were financially supported through public systems such as SSA (Title XVI and Title XIX), state General Assistance funds, TANF, Medicaid, and Medicare. Therefore the issue of **the impact of work on benefits** becomes crucial. Despite the availability of numerous federal and state work incentive programs (Titles 1619a and b, Medicaid Buy-in, Impairment Related Work Expense income offsets, Plan for Achieving Self-Support and Individual Development Account asset accumulation

strategies), fear concerning the loss of both financial support and health insurance continued to be barriers to employment. This fear, which is common among many people with various types of disabling conditions, is exacerbated in the case of people with psychiatric disabilities, due to the intermittent and episodic, yet many times chronic, nature of their mental illness. Successful sites dealt with this issue aggressively and either provided directly or worked in close partnership with the MIGs and the state BPAO projects to ensure that individual customers with psychiatric disabilities received the information necessary to support their movement into employment.

5) Each of the sites dealt in one respect or another with assisting staff at the One-Stop with the issue of how best to **encourage people to self-identify the presence of a psychiatric disability**. Sites grappled with how to best encourage job seekers to disclose without compromising their rights around confidentiality and while staying focused on the information that was the most relevant, not extraneous to achieving employment success. One-Stop staff often promote disability self-disclosure precisely because they wish to provide services most appropriate to the customer's needs. However, they must not probe too deeply on their own due to the restrictions imposed on them appropriately by the mandates of Section 188 of the WIA and the ADA.

Mental health professionals involved with the workforce development system at most of these sites helped One-Stop personnel understand better why people might be reluctant to disclose for many of the reasons cited in the earlier section in discussing the possible implications of the new EMILE reporting system under consideration by DOL. Concurrently they demonstrated to many of their clients the possible benefit for some in acknowledging their psychiatric disability in order to obtain the more intensive services for which they might be eligible. Because the mental health organizations interviewed brought new customers to the One-Stop system together with support staff—thus in essence "disclosing" already—this issue was obviated for many. The Gloucester, NJ site was instrumental in assisting the state of New Jersey to develop a specific policy guidance regarding disability inquiries that seemed to serve the needs of both workforce staff and customers with disabilities. A copy of this state guidance is in Appendix E.

6) Another broad-based issue that transcended each of the specific sites to some extent was the role of the VR agency within the One-Stop system in general and in regard to services to people with psychiatric disabilities in particular. Each of the areas studied tried to **make VR a partner in the process**, with varying degrees of success. As noted earlier in this report, it is expected that the relationship between VR and the One-Stop system should be interactive in nature, with reciprocal referrals occurring between the two entities. In some sites VR took an active role. For example, in Utica, NY the CEG was managed for the WIB by the local VR regional marketing representative. In Tucson, AZ the local VR regional director was in many ways the linchpin of services that bridged the MH and workforce systems. In other sites, VR was a major partner in the initiatives serving people with mental illness through joint funding of services, including training and employment supports (e.g., Gloucester, NJ; Anoka, MN; St. Louis, MO; Peoria, IL; Tucson, AZ; Fairfax, VA). Many of the sites served as intermediaries in linking VR to workforce services for people with psychiatric disabilities. These sites also assisted One-Stop staff to serve customers with disabilities as effectively as they could using generic services without automatic referral to local VR.

Appendix F is a draft policy guidance developed by ICI on making appropriate referrals to VR. This was developed for the state of New Jersey workforce system (it is currently under review by the state) as part of a subcontracted technical assistance project under their statewide WIG. The

exhibit is offered here as a possible template for similar policy statements and memoranda in other states. As the guidance states in its introductory portion:

> This policy guidance is issued under the premise that the New Jersey One-Stop system will endeavor to serve customers with disabilities through the full panoply of services the One-Stop system offers and that the customer with a disability is (potentially) eligible for, whether or not they may also be (potentially) eligible for other employment-related disability-specific services. It is expected that, while the final decisions regarding which agency services the customer would choose to access would reside in the customer, as agency policy the NJ DOL would expect referrals to be made to the state VR agency primarily as a complement to One-Stop services and *not* as a replacement for such services.

7) The final issue is somewhat self-evident and implicit but worth noting as a separate item nonetheless. Whatever success each of these sites has been able to achieve systemically was aided by creatively **blending or braiding different funding streams together**. No one source can attend completely to forming the sorts of service packages required to help people with serious mental illness attain and retain employment that fulfills their personal, economic, and career goals. The ability to attract significant federal funding for these initiatives—as exemplified most dramatically in the Customized, Workforce Action, or Chronic Homelessness grants, and to a lesser extent in the more limited resources of the WIGs—contributed significantly to accomplishing the high goals many of these sites espoused. However, even this major infusion of funding could not meet the needs of the targeted people to be served, and in the case of sites such as Tucson, AZ or Boston, MA (JobNet) these additional sources of federal support were not available at all. Local situations will differ, so the multiple funding strategies must be idiosyncratic to fit the political, social, and economic realities of specific communities. Nonetheless, what is clear is that for the foreseeable future any local workforce/VR/MH employment partnerships must include a concerted effort to maximize funding through the use of different funding streams that can be combined in one fashion or another to serve the complex needs of people with psychiatric disabilities.

Specific effective practices
A note of caution must be given at the outset of this section. The sites in this study represented a broad mix, not just in location but also in terms of having a variety of specialized and generic funding streams. Some had a fair amount of specialized resources (e.g., the Customized, Olmstead, and Chronic Homelessness grantees). Some had more limited special project funding that was not targeted for services at all (e.g., the sites that had WIGs). Others had specialized project funding from non-DOL sources (e.g., Gloucester, NJ had DD Council funding for a project), while still others had no special funding at all (e.g., Tucson, AZ). Obviously, enhanced financial resources in and of themselves do not guarantee quality or innovation. However, some of the practices that required a more intense level of service delivery probably would not be possible to deliver without additional, specialized funding outside the normal WIA and VR appropriations, whether this money came from federal/state grant sources or redirected local funding within MH.

Almost all of the following concrete practices were identified by a great majority of the sites visited and interviewed in one fashion or another. Certain locations had idiosyncratic practices that seemed noteworthy or exemplary enough that they are included even though they were not generally used across the programs. In situations where such a practice is identified, it is noted.

The practices are grouped into two broad categories of **administrative-level practices** and **service-level practices**. These are not necessarily mutually exclusive. The researchers felt that this grouping would allow greater understanding of the major point of impact for the specific activities noted.

<u>Administrative-level practices</u>
1) One-Stop Centers in these sites aggressively sought out various public disability agencies and mental health systems and providers, as well as consumer and family support groups, independent living centers, SSA offices, homeless shelter and mental health housing providers, transportation providers, and the like to ensure that a **variety of necessary supports and system integration activities** were in place for job success. Both the mental health and workforce systems sought to actively involve the other in their activities regarding employment services for clients/customers with psychiatric disabilities. In some respect, the greatest anomaly was not the engagement of the One-Stop systems in such services to people with mental illness but rather active engagement of mental health providers who saw employment outcomes as a key success indicator. Together they developed systems, structures, and staffing to accomplish this goal.

2) Many sites implemented the **IPS evidence-based practice model** of supported employment while enhancing it with links to the workforce system. Peoria, IL; Chicago, IL; Vancouver, WA; Portland, OR; and Frederick, MD all essentially used this approach for many of their constituents through using ODEP funding while at the same time educating the workforce staff about the benefits of this model with people facing significant challenges due to their mental illness.

3) In the better-coordinated sites, the VR system was engaged not just at an administrative level in terms of WIA Memoranda of Understanding (MOUs) or, conversely, just at the service level with individual VR counselors. Rather, **VR was engaged at multiple levels simultaneously**. Sites that reported effective working relationships with VR partners cited the need for VR administrative commitment (usually at the local office level) to set the tone of the relationship between workforce, mental health, and VR. In these instances, the VR administration gave clear direction about expectations that VR and workforce staff would cooperate to serve specific clients. While VR must adhere to the mandates of its federal governing authority, the law itself is meant to be extremely flexible and focus on a variety of innovative methodologies to help VR clients achieve successful employment outcomes.

4) Conversely, in the better coordinated sites the **workforce development system sought to engage VR in joint service delivery** rather than considering them merely a referral outlet. Successful sites described the importance of working with their respective local workforce systems seriously to manage their Section 188 responsibilities. They did not assume that the presence or self-disclosure of a disability should automatically trigger a referral to VR. Even in the cases where a VR referral was made, the One-Stop system continued to serve the person in a combined fashion whenever feasible instead of using the VR referral as a reason to cease assistance.

Specific illustrations of points #3 and #4 above that were observed in one or more of the sites included:
- Jointly funding services (e.g., jointly sharing the cost of on-the-job training with workforce paying for training while VR paid for transportation and/or clothing)

- Opening the person in both systems simultaneously so the person received the normal range of VR services while getting intensive services under WIA
- Creating a joint employment service planning team consisting of workforce and VR staff, and using each other's staff to conduct joint training on disability and/or workforce development issues
- Developing referral guidelines jointly
- Jointly funding staff positions for services across the One-Stop
- Jointly participating on each other's administrative and staff-level committees and involving One-Stop staff in the administrative or staff committees of the state or local VR agency
- VRs agreeing to encourage community rehabilitation providers to use the One-Stop Center's services to assist clients whose job development services are being funded by VR

5) A **partnership** can be created to assist consumers of state mental health services to secure competitive employment through One-Stop staff at a local center. This activity was exemplified by JobNet in Boston, MA, where the state MH department funded part of a staff person's salary to work on the project and coordinate project activities.

6) The development of **specialized programs for subpopulations** was an important feature at some sites. Career Trek in Anoka, MN focused on the needs of people with mental illness who had post-secondary training and included outreach through the One-Stop system in greater Minneapolis. This specific program was originally funded through VR state grant resources but was kept afloat at the time of the research through fee-for-service funds. In Vancouver, WA; Chicago, IL; and St. Louis, MO, the mental health lead agencies provided a focus in their links with WIB partners on serving a large percentage of customers who were both homeless and had mental illness.

7) A number of sites created **statewide and local policy implementation initiatives** affecting employment and people with mental illness. In Louisiana, the state MH office helped establish the Louisiana Commission on the Employment of MH Consumers—a collaborative initiative led by the chair of the Jefferson Parish WIB to increase employment opportunities for people with mental illness in the state. The Frederick, MD local mental health/workforce project coordinator was extremely active in statewide advisory boards looking at Medicaid reform, state mental health funding policy, and review of state priority contracting procedures that gave precedence to work done through sheltered workshop contracts rather than through hiring individual consumers. The Vancouver, WA and Peoria, IL local mental health/workforce project coordinators were involved with advisory groups to state VR on reviewing its practices for serving people with mental illness. The former head of the North Bay Employment Connection (an arm of the Napa WIB), who is now at Sonoma State University but is still heavily involved with the Napa DOL projects, is an appointee to the California Governor's Commission on the Employment of People with Disabilities. The Jefferson Parish, LA and Peoria, IL projects were intimately involved with the local Business Leadership Networks (BLNs) in the state.

8) Focusing on **specific activities to better integrate mental health and workforce services**. Many sites used cross-system planning teams that included staff from workforce, VR, and community agencies that transcended individual client consultation and were looked to for guidance in resolving cross-system and possible conflicting policy/priority dilemmas. For example, in Fairfax, VA, the local mental health provider staff participated in One-Stop CQI meetings. In addition, all of the Customized and Workforce Action Grant sites had an

interagency project management team as part of their grant administrative structure. In Tucson, AZ the rapid response activity of having a One-Stop on-site at a company in advance of their closure was seen as an added opportunity for the workforce and VR systems to direct customers to additional resources early on. VR was one of the more common referral outcomes of this rapid response intervention. Having an Arizona VR counselor and disability navigator in-house gave them the obvious advantage of working as a team prior to the actual layoff date.

9) Several of the sites tried to ensure that mental health organizations and the workforce system **partnerships expanded into broader workforce activities**. Examples of this included:
- Having the mental health provider as a WIB member
- Participating in industry- or sector-based panels on health care, which many WIBs around the country have focused on as part of their economic development and incumbent worker mandates
- Assisting the workforce system's local business service team in identifying local employers to approach collaboratively.

One particularly close partnership approach occurred in Vancouver, WA where the local WIB paid 10% of the salary of the director of employment services for the local mental health provider out of WIA operating funds. This was not for disability service per se but rather for her work in jointly developing the workforce system's diversified funding base and for her marketing/outreach efforts to the community on behalf of the One-Stop system.

10) One outgrowth of a variety of service-level activity noted in the following section of this report at many of the locations studied is that assisting people individually gave the disability or mental health service provider **insights into the overall operation of the One-Stop Center**. This information often allowed staff from these organizations to provide a more refined level of technical assistance about system improvements to benefit other customers with psychiatric and other disabilities in the future. Activities included providing information about disability-oriented services as part of the overall orientation to One-Stop Center; giving people information about possible disability assistance in various formats so people would not have to inadvertently self-disclose; providing technical assistance on "Tour of Service" videos that would incorporate relevant information about disability-specific One-Stop services; and acting as advisors on the appropriate use of "person-first language" in written materials.

11) Many of the sites conducted a series of **trainings focused on mental health**. This was sometimes done as part of a regular series of workforce seminars that the One-Stop held. For example, St. Louis, MO incorporated mental health training into regularly scheduled lunchtime seminars; Vancouver, WA used the Local Planning Area Planning committee, which the MH provider co-chaired with workforce staff, to inculcate information from MH services providers. In other situations, the local MH organization, using its own expertise, did trainings for One-Stop staff based on specific requests. Chicago, IL did training on de-escalation strategies with any customer; Peoria, IL gave training on the specific mental health employment model used in their ODEP grant (the aforementioned IPS model); Portland, OR did training on using person-centered planning with people with mental illness in a customized employment context. Others used the lead author of this report (often through NCWD/A but in the case of non-grantees through contracting with ICI) to do targeted training on best practices in employment for people with mental illness (Napa, CA; Chicago, IL; Utica, NY; Vancouver, WA). Still others (e.g., Anoka, MN and Vancouver, WA) focused on the importance of people with psychiatric disabilities having employment allies as part of the recovery process.

In addition to providing disability training, most staff tried to reinforce the importance and urgency of connecting with the local mental health system of care. All sites focused—sometimes overtly, in other instances more indirectly—on the necessity to address the strengths and capacities, rather than deficits, of customers with mental illness, and the importance of providing hope and support strategies. Most of the sites saw the need for the WIB and One-Stop Center management to understand that the development of staff skills and expertise was not enough without substantial administrative attention also devoted to systemic barriers and ways to overcome them.

12) Many of the sites visited developed special relationships, outreach, and/or support activities regarding "best practice" services to special populations of people who have a psychiatric disability and also issues regarding **substance abuse, ex-offender status, homelessness/emergency shelter use, and/or TANF or General Assistance recipient status**. Outreach cannot just be limited to a specific client base; rather, there is a need to do targeted outreach and marketing to the systems that serve them (jails, shelters, substance abuse treatment facilities, medical detoxification programs, etc.). Some particularly notable examples of this multi-systemic linkage occurred in Vancouver, WA; Portland, OR (Chronic Homelessness grant); St. Louis, MO; Peoria, IL; and Chicago, IL, though any program that serves people with significant mental illness using the public mental health system, as all the sites visited and interviewed did, must address these issues to some extent. At a system/administrative level, what the sites noted developed truly integrated service delivery by bringing staff from the disparate systems together in programmatic planning and blended/braided funded for staffing and services in addition to developing various clinical intervention strategies, which are described in more detail below under service-level strategies, item 17.

The Vancouver, WA project was driven by a community mental health center (the Clearview Employment Services division of Columbia River Mental Health). The center had services specifically funded through DOL and other resources that provided specialized employment assistance to people in emergency shelters and transitional housing, ex-offenders in a transitional housing program, and people in an integrated substance abuse/mental health treatment program that the mental health center ran. The Portland, OR Chronic Homelessness project was run by a major housing and substance abuse treatment provider (Central City Concern) which also ran one of the One-Stop Centers that was funded under WIA by the Portland WIB. The St. Louis, MO WIG and Chicago, IL Customized projects were driven by two of the foremost psychiatric rehabilitation programs in the country (Independence Center in St. Louis and Thresholds in Chicago) which had long histories of running extensive employment, housing, and treatment programs for people with serious mental illness, including those who were chronically homeless and/or had co-occurring substance abuse problems, as well as many with a long history of incarceration.

Service-level practices
1) As noted earlier, each of the best practice sites adhered in one form or another to the need for the mental health system to use a **Supported Employment/IPS conceptual model** to meet the needs of people with significant psychiatric disabilities. This supported employment model could be financed directly in sites that had specialized funds through ODEP to provide customized employment, which essentially replicates this IPS approach (though customized employment methodology has a greater emphasis on niche marketing through job carving and job creation). Sites in this situation were Frederick, MD; Vancouver, WA; Anoka, MN; Fairfax, VA; Peoria, IL;

and Chicago, IL. (It is worth noting that each of these sites also provided this sort of intervention through their regular mental health funding and not solely through the additional financial resource that DOL provided.) In sites such as Gloucester County, NJ; St. Louis, MO; Jefferson Parish, LA; and Tucson, AZ, the ability to set up a structure totally conforming to this model while linking up with the One-Stop system was constrained because this type of assistance was not within the traditional purview of WIA or state labor exchange services and required additional personnel costs for the increased individual support. Therefore, in these latter sites, the services tended to be slightly more circumscribed and usually funding was "cobbled together" from a mixture of VR, local mental health, and some WIA supportive service monies.

2) Provide an employment approach that uses a **strengths-based model of person-centered career planning**. This model was initially piloted in the Developmental Disabilities paradigm (Butterworth et al., 1993; Marrone, Hoff, & Helm, 1997; Mount, 1993; O'Brien & Lovett, 1994) and adapted to a population of people with psychiatric disabilities. In customized employment practice terminology, this is often referred to as a "Discovery process." Vancouver, WA; Chicago, IL; Portland, OR; and Anoka, MN used this method extensively. The major difference in model adaptation was not so much the characteristics of the person who is being assisted as the pacing of the process, which usually needs to be speeded up to reflect the need for many people with psychiatric disabilities to engage in rapid employment and initial career planning which might entail numerous job changes rather than one exact fit. Moreover, people who are in transitional housing or emergency shelters or living on the street do not have the luxury of lengthy planning time before entering the labor force. Some sites used a formally structured process to create a portfolio that clients could use consistently (e.g., Portland, OR); others used a more dynamic process that relied more on interpersonal supports and connections (e.g., the Vancouver, WA "Rally" process).

3) As alluded to above, **the concept of "Customized Employment"** did not present any new clinical challenges to organizations that had been historically successful in providing individualized supported employment interventions to their clients over the years (e.g., Vancouver, WA; Anoka, MN; Chicago, IL; Peoria, IL; Frederick, MD). Each of these sites, in particular, felt that the principles and practices for which they were known nationally prior to the commencement of the CEG initiatives were in most cases easily adaptable to what they saw as the ODEP focus on Customized Employment. In fact, they identified that as a main reason why they were probably successful in getting their CEG and Olmstead awards. They did not see any significant difference between the customized employment concepts and those they had long practiced, with the exception of the aforementioned heavier emphases in customized employment on interventions such as job carving/job creation as well as some individuals needing quicker work experience options during planning. Even these practices had long been used where appropriate in their earlier work; however, the sites saw them as not necessarily the core issues in employment practice for their primary constituency, i.e., people with serious mental illness. In their eyes, the major obstacle was determining the feasibility of using a customized or supported employment approach consistently (i.e., person-centered career planning, individual job development and employer advocacy, on- and off-the-job support) within an environment funded primarily by WIA or workforce development.

Part of the challenge is clearly financial; hence the focus of grantees, NCWD/A, and ODEP on "sustainability" issues. However, even apart from the financial dilemma which the continuation of these approaches posed, the conceptual/philosophical conundrum remains. In essence, the workforce development system is not currently designed to support the type of intensity of

service that customized and supported employment require. Can a high-volume, easy-access system with no expectation of large-scale intensive individual assistance be expected to provide customized or supported employment? If so, how does this approach meld with the decidedly different basis for customized and supported employment? Also, one element that has been stressed with ETA is the mantra that older iterations of workforce development (i.e., MDTA, CETA, JTPA) were all conceived as human service systems with elements of workforce and economic development included; one paradigmatic shift in the authorization of WIA was that this new system was conceived to focus on workforce and economic development with elements of human service included. What remains unclear—and both a policy and clinical challenge for CEG/Olmstead grantees as well as other advocates—is how best to integrate these disparate approaches into a seamless system, even though there are indeed many areas of philosophical agreement in both psychiatric rehabilitation and workforce interventions (e.g., customer choice, flexibility, outcomes management).

4) People who have an abundance of service needs find it especially helpful when systems use a **"wraparound" model of services** through specialized projects at the mental health provider that include mental health employment specialists and special vocational case managers that provide intensive case management and treatment coordination as well as links to the workforce system. Both Vancouver, WA and Chicago, IL provided variations of this approach using ODEP project fiscal resources.

5) **Hiring current or former consumers with mental illness** to provide services through collaborative activities with the One-Stop and mental health provider organizations was another effective service-level practice. Many of the sites practiced this approach, with the most aggressive outreach conducted in Chicago, IL; Peoria, IL; Vancouver, WA; and Frederick, MD. This practice highlights the virtues of peer support, which permeated almost all the sites. Staff often cited this element as one of the efforts that made them the most proud.

Two different styles of managing this intervention occurred. One was to a hire people as designated "prosumer" or "consumer provider" staff; the other was to actively recruit former or current users of mental health services as professional staff within the mental health or One-Stop project but not for positions specifically labeled "peer support." In Wausau, WI, the disability navigator (who had a history of mental illness) piloted a peer mentoring program for participants of the state Medicaid Purchase Plan program—the majority of whom had psychiatric disabilities. In Fairfax, VA, the ODEP grantee subcontracted with one of its mental health partners (PRS, Inc.) to develop a mentor program for individuals with mental illness. Though this program was not directly linked to the One-Stop, mentors were former consumers of PRS mental health services and were paid for their services through the ODEP grant.

6) **Involvement with advocacy groups** can be helpful and often is essential to creating full community partnerships. Sites such as Anoka, MN and Vancouver, WA had strong relationships with national and local family groups. Others such as Napa, CA had developed strong linkages with local Centers for Independent Living.

7) All the sites used a **modified placement planning process** (in addition to any IEP developed at the One-Stop or IPE developed through VR) in order to specify the types of assistance and support needed. In Vancouver, WA, the project's MH provider, Clearview Employment Services of Columbia River Mental Health, used one of the most formal approaches in placement

planning. Plans were updated every 30 days, and a placement support plan was developed at the time of job acceptance. Examples of these planning formats are in Appendix G.

8) Each of the sites recognized the importance of **regular, ongoing benefits planning** and all used this type of assistance with all customers served, both under their own auspices and in their collaborative services with the One-Stop Centers. Benefits planning took various shapes, from having a benefits planner based at the One-Stop (usually as part of a specially funded project, as in Jefferson Parish, LA) to using local benefits planners available through county or state auspices. Every location served had some form of benefits planning project at the state level at least, usually through some form of federally funded state system change initiative through SSA, RSA, CMS, etc.

9) The creation of **employment planning teams** at One-Stop Centers was also cited as an important service-level feature. These teams provided the intensive services to customers with serious mental illness. They included mental health case managers and employment support specialists as well as other community providers of social services and ancillary supports. Sites using variations of this approach included the Napa, CA CEG, the Gloucester, NJ project (funded under a Disabilities Council grant, now a WIG), and the Portland, OR Chronic Homelessness grant. Other, more specific examples include:
- The chair of the Jefferson Parish WIB contracted with the state MH office to create collaborative groups/cross-agency teams comprised of MH-funded employment counselors and One-Stop/DOL staff. These teams functioned as a referral point for people with psychiatric disabilities who wanted to use workforce services.
- Gloucester County NJ had a project that originally began through a state disabilities council grant and was subsequently reinforced by the infusion of a DOL WIG. An employment planning team was created to provide intensive planning and service delivery to customers with significant disabilities, including those with mental illness, who used the One-Stop. This team was formed by a rotating group of human service agencies, the disability navigator at the One-Stop, the project coordinator through the university technical assistance arrangement (UMDNJ), VR staff, county WIA and state workforce staff, the customer, and any significant others the person wanted involved.
- The COMPASS process used in Napa, CA was described as a model of a consumer-centered and -driven service delivery that provided a continuum of services. Services were selected by the job seeker based upon identified needs to create an integrated One-Stop delivery system. As part of this approach, One-Stop staff, partners, and service providers/vendors met on a regular basis.
- The Chicago CEG restructured its employment team, as it found that many of the clients/customers were already involved with a variety of human service and mental health agencies but needed an intensive case manager on the project team from Thresholds (the CEG provider) to ensure that the employment services were effectively coordinated with these other forms of assistance.

10) All of the sites assisted their One-Stop partners in dealing with the issue of **identifying people with mental illness who used the One-Stop**. Each tried to help the partners understand some of the nuances and concerns that might inhibit people with mental illness from self-identifying. At the same time, the mental health service partners in these projects acknowledged the valid reasons why One-Stop staff might want to encourage greater numbers of people with disabilities to disclose. To this end, many of the MH agencies themselves took on the task of recruiting potential One-Stop customers with mental illness and, by assuring them of the level of

support needed, were able to encourage people to self-identify as having a disability on the intake/application form. Furthermore, many of the sites had extensive discussions with staff about how to identify people who might need some extra assistance—perhaps from specialized mental health resources in addition to One-Stop staff—without requiring them to undergo formal screening, which was seen as potentially invasive, intrusive, and not necessarily within the appropriate mandate of the One-Stop system.

One strategy used in Vancouver, WA was a simple identifying tool that attempted to give One-Stop staff some simple guidelines to highlight the potential needs of a new customer. This was not meant as a formal screening or assessment instrument but rather as some hands-on guidance for staff. The sample format is included in Appendix H, and a version was also included in the ICI *Access for All* manual (2001). Certain appropriate caveats apply:
- One-Stop staff are not intended to be diagnosticians.
- This information should be collected discreetly and in a way that respects the individual's right to privacy.
- To the extent possible, the information should be based on direct information from the person seeking assistance as well as the direct observation of staff.
- Saying "yes" to any of the items on the list, even in combination, does not necessarily indicate any form of emotional or mental health problem. An individual's responses could simply be signs of a bad day, legitimate anger at events, a specific problem troubling them, or physical disability. However, if the customer answers "yes" to most of the items, and experiences these difficulties to such a degree that they cause problems in employment, education, and/or daily living, it might be a sign that the person could benefit from further specialized assessment from a qualified professional. VR, the state or county mental health agency, local mental health center, or other disability organization should be able to assist in obtaining such an assessment.
- A specialized assessment from a qualified professional will help the One-Stop staff determine how best to support the individual's employment and training goals, and help the individual obtain additional support services. Such an assessment cannot and should not be used to exclude the individual from One-Stop services.

11) All the sites used much personal involvement and **individual assistance to bridge any gaps** that might exist between the demands of the usual One-Stop Center universal access/self-service philosophy and the more intense needs a customer with mental illness might have. This help included activities such as:
- Working side by side with the person to help him/her use the Resource Center
- Assisting the person to fill out required paperwork
- Reviewing written materials the One-Stop provided all its customers with the specific client
- Enabling the person to set up appointments with a One-Stop case manager or job developer, even in One-Stops where this service was usually only available on a first-come, first-served basis
- Getting identified employer information to use in conjunction with job development activities for the person, even in situations where that identifier information was not regularly made available to customers

12) Many of the ODEP-funded sites specifically included **flexible, personally directed funding** that was made available to clients/customers for needs that could not be quickly accommodated by existing systems. Examples included money for driver's license renewals or identifications,

clothing for job interviews, purchase of transit passes, and rent deposits for new apartments in addition to more conceptually complex arrangements involving hiring personal service brokers or purchasing personal job supports using individual, client-controlled funding. While it was possible for systems like VR and county or state MH to provide these through more formal channels, the ability to directly access them with little procedural complexity enhanced the ability of the projects to attend to the social needs of people who were disadvantaged in multiple ways and not always adept at maneuvering within the intricacies of existing systems.

13) Some of the sites looked for **concrete, easily achieved system successes to build momentum for more difficult, large-scale systemic change**. They sought to provide simple ways for the disability and mental health community to access resources other than going to the One-Stop. One small-scale yet quite effective collaborative effort occurred at the Vancouver, WA site: The local MH provider involved brokered an arrangement where the LWIB purchased laptop computers with wireless internet access for the local shelter and transitional housing programs serving people with mental illness, homeless people, and ex-offenders. These computers could be used appropriately for access to workforce services because the mental health provider, as part of this collaborative effort, assigned employment staff to each of the shelters to assist the residents and housing staff to understand the most useful ways to link up with the One-Stop, including the use of America's Job Bank.

14) **Assisting the One-Stop business service or employer outreach teams to incorporate the needs of job applicants with disabilities**, including resources available to employers to assist them in accommodating workers with psychiatric disabilities in their day-to-day efforts. Some sites, through specialized grant funding, were able to include a "disability and business expert" within the business service team (Vancouver, WA). This person's job was not to be a job developer or the only person who would discuss disability with employers, but rather to be an in-house expert and resource who would disseminate this expertise within the marketing team through direct assistance and more informal collaboration with ongoing employer service activities. Other sites (Utica, NY) created a specialized disability and business marketing representative on the WIB staff as part of a customized employment initiative to market directly to business needs in regard to hiring people with disabilities, including those related to mental illness. An additional approach was for the mental health employment partner to be the primary business representative (Peoria, IL; Chicago, IL; Frederick, MD).

15) Each of the sites realized the importance of job retention activities; however, most also understood that **employment retention** (i.e., maintaining oneself through being employed) was more crucial than job retention (i.e., staying in one specific job) per se. People with serious mental illness often do not have stable employment backgrounds and thus, whatever their age, may exhibit a vocational development pattern more typical of adolescents and young adults who may migrate through different jobs as "hands-on" career exploration. The programs more sophisticated in this nuanced view of career development tried to balance the important work of helping a person create a stable job history through the provision of easily accessible employment supports (on- and off-the-job employment staff, cell phone and pager contact with employment support staff, creation of individual support plans, etc.) while concurrently allowing the person to create a more naturalistic job trajectory, perhaps for the first time in his/her life. This acceptance might involve some fairly frequent job shifts early in the process that programs have to accept as routine, expected, and acceptable rather than as inherently problematic or dysfunctional.

16) Two of the sites (Vancouver, WA and Anoka, MN) had **specialized services for youth with emotional/behavioral problems** of transition-age related to employment and workforce. In the case of the Anoka site, the entire CEG was predicated on partnership with local school districts serving youth with a variety of problems, including a large number labeled with the "emotional/behavioral" tag. They developed a variety of short-term work experience options (ideal for youth) as well as in-school linkages, including involvement on IEP and transition planning. The Vancouver, WA site was working on a county-wide project, funded through a SAMHSA federal grant, serving youth with significant mental health problems who were 16-18 years old. Columbia River provided wraparound case management services, family support through workforce professionals and peer parent supporters, and employment, including links with the workforce development system. They also lobbied the county to engage the local WIB as part of overall planning for this grant, which heretofore the county MH bureaucracy had not done.

17) The sites most active in **engaging "hard-to-serve" special populations** (such as those who are homeless or ex-offenders, receive TANF or General Assistance, or have co-occurring substance abuse problems) understood the need to adopt specialized clinical as well as employment approaches. These sites developed a methodology to engage people "where they are," both physically (on the streets, in jail, in shelters) and emotionally. The latter calls for strategies such as rapid engagement, development of quick short-term work experiences or transitional employment, using the concepts of short-term goal success while focusing on long-term outcomes, and enhancing self-efficacy in people who feel their lives are out of their control. Programs such as these, which work with groups such as homeless, mentally ill persons or those with substance abuse problems, understand that they may better serve their clients by placing as great an emphasis on providing employment services as on providing housing, clinical, and substance abuse treatment. When employment services are provided, they must be integrated at the clinical as well as administrative program level to ensure coordination and consistency among the multiplicity of service providers and advocates who are usually involved.

In addition, because of the state of financial poverty in which they exist, many people with serious mental illness have primary health care problems that often go unaddressed by mental health practitioners. Programs directed under the auspices of innovative mental health providers such as those in St. Louis, MO, Chicago, IL, and Peoria, IL focused directly in one fashion or another on this primary health care issue. Directly or indirectly, each of the sites used the methodology—well grounded in the employment and psychiatric rehabilitation literature— about effective interventions with people with serious mental illness and other significant clinical or social problems:
- Engagement
- Exposure to work and work environments
- Real-world work experience
- Recognition that each individual they approach may be culturally different (in terms of ethnic background, personal life experience, referred from an organization with a different mission culture) from themselves in ways that are not always obvious (Shaheen, Williams, & Dennis, 2003)

Recommendations
In addition to the specific concepts that are outlined above for other workforce programs serving people with psychiatric disabilities to consider emulating, the authors offer the following broad recommendations for how ODEP and/or ETA could further DOL's work in providing more

effective services to customers with serious psychiatric disabilities. Please note that this recommendations section includes several references to DOL issuing "guidance" on certain matters. This term is intentionally used to refer either to both formal DOL communications such as Training and Employment Guidance Letters (TEGLs) and Training and Employment Notices (TENs), which serve as policy directives to the workforce field, and other actions DOL can take to highlight or clarify important issues, such as interagency MOUs, cross-system topical meetings, and more informal information memos. The specific strategy DOL might choose to employ would depend on its assessment of the most effective intervention to achieve the objective of the recommendation proffered at any given point in time for any particular issue.

General recommendations from a variety of disciplines

1) On a clinical level, the **evidence-based principles of Supported Employment**, which can be assessed using some standard templates available (as in Appendix I), are the most thoroughly researched practices that produce good employment outcomes for people with psychiatric disabilities. However, they have not been examined for their applicability to the interface with the workforce development system. Through the ODEP-funded customized employment and Workforce Action grants, sites in Vancouver, WA, Peoria, IL, Chicago, IL, and Frederick, MD used this approach in carrying out their respective project mandates. However, because of the intensity involved, the model itself had not been fully included, even in these sites, within their workforce partners' operations. Therefore, ODEP should consider either having WESTAT or NCWD/A conduct a targeted evaluation of these sites vis-à-vis their ability to integrate IPS into their workforce partners' operations. ETA and SAMHSA might consider funding a joint project specifically to evaluate the use of the IPS model within the generic workforce/WIA system.

2) Within this framework of supported or customized employment, the **best practice models of person-centered planning**, which the customized employment approach is meant to encompass, would be encapsulated. As highlighted in Marrone, Hoff, and Helm (1997), DOL should encourage variations (consistent with local resources, policies, and program design) on the following as an effective methodology for meeting the employment planning needs of customers with psychiatric disabilities:
- The process should not just be person-centered but person-driven.
- The process needs to involve people who are passionate about helping the person with a disability and who have at least begun to develop a relationship with that person—a facilitative advocate.
- This type of planning is a way of transforming the power relationship between a dominant helper and a person with a disability who is usually in a subservient role.
- Person-centered planning involves action as well as planning.
- Person-centered planning is based on positivity, dreams, and aspirations, not deficits, barriers, and problems.
- The most important thing to be facilitated is a process (planning, follow-up action, re-planning) not any sort of meeting itself.
- Getting multiple perspectives as a way of generating creative brainstorming forms the base of the process.

Similar to #1 above, ODEP might consider either having WESTAT or NCWD/A conduct a targeted evaluation of these sites vis-à-vis the modifications needed to ensure that the "Discovery" process proposed by ODEP as a core element of Customized Employment is relevant and adaptable to the needs of people with psychiatric disabilities.

3) Furthermore, looking at the issue as one of organizational change, there are key concepts that the academic literature offers in terms of guidance towards **large-scale organizational change to affect employment outcomes** for people with various significant disabilities. These concepts include:

- The importance of clear mission and values with a focus on employment.
- Consideration of economic factors, e.g., the public funding agency supporting fiscally the types of services it desires.
- The need to empower and support staff during the change process.
- An understanding that change requires creating a sense of urgency and attaching a sense of inevitability to the effort.
- Having clear, quantifiable goals to guide the change and define success.
- An understanding that extensive consumer and family involvement are crucial to meaningful change efforts in community employment.
- Understanding how a variety of internal/external forces affect the change process. Any significant organizational change is influenced by a plethora of factors, including such disparate issues as quality of leadership; organizational culture; level of client, family, and staff involvement in change efforts; consistent focus on vision and mission; realignment of roles and resources; political climate; funding; family and client attitudes towards the change; and public attitudes.
(Marrone, Hoff, & Gold, 1999)

In sum, any organization or individual that seeks to create a change must define the desired outcomes of that change. The more specific the outcomes sought, the easier it is to measure progress, problems, and ultimate success. The base of the change efforts that this section assumes managers must implement is predicated on the abilities of individuals with psychiatric disabilities to work successfully in the community, the necessity of environmental changes as well as changes in the person, the need for advocacy to counter employment discrimination, and the inherent worth of the goal of integrated community employment for all people. But, as with the clinical principles of Supported Employment for people with mental illness, this organizational change knowledge base has not been examined in terms of its applicability to the interface with the workforce development system. An ICI technical assistance planning form used with organizations seeking to enhance employment outcomes is included in Appendix M to illustrate how this sort of intervention might be approached, not as a specific model to be followed in toto. Similar to #1 and #2 above, ODEP might consider either having WESTAT or NCWD/A conduct a targeted evaluation of these sites regarding their ability to affect systemic change within their workforce partners operations or ETA and SAMHSA might consider funding a joint project specifically to rigorously evaluate organizational change or local planning strategies that can be used to support full inclusion of customers with psychiatric disabilities within the generic workforce/WIA system.

4) There are also generic issues involved in any sort of systemic collaboration and community agency partnership endeavors. DOL could offer some guidance to workforce systems about effective **strategies to accomplish the intersystem partnerships** it endorses for the One-Stop system. There are many academic studies of interagency teamwork, but an excellent simple checklist for DOL to consider as a template to endorse for assessing the state of local collaboration is offered by Borden and Perkins (1999):

- Communication—The collaboration has open and clear communication. There is an established process for communication between meetings.

- Sustainability—The collaboration has a plan for sustaining membership and resources. This involves creating membership guidelines relating to terms of office and replacement of members.
- Research and evaluation—The collaboration has conducted a needs assessment or has obtained information to establish its goals, and the collaboration continues to collect data to measure goal achievement.
- Political climate—The history and environment surrounding power and decision-making is positive. Political climate may be within the community as a whole, systems within the community, or networks of people.
- Resources—The collaboration has access to needed resources. Resources refer to four types of capital: environmental, in-kind, financial, and human.
- Catalysts—The collaboration was started because of existing problem(s), or the reason(s) for collaboration to exist required a comprehensive approach.
- Policies/laws/regulations—The collaboration has changed policies, laws, and/or regulations that allow the collaboration to function effectively.
- History—The community has a history of working cooperatively and solving problems.
- Connectedness—Members of this collaboration are connected and have established informal and formal communication networks at all levels.
- Leadership—The leadership facilitates and supports team-building and capitalizes upon diversity and individual, group, and organizational strengths.
- Community development—This community was mobilized to address important issues. There is a communication system and formal information channels that permit the exploration of issues, goals, and objectives.
- Understanding community—The collaboration understands the community, including its people, cultures, values, and habits.

5) The final recommendation of a broad nature is that the initiatives that focus on creating quality employment outcomes for people with psychiatric disabilities through collaboration with the workforce development system should **take a CQI approach**. This would align these projects philosophically with some of the CQI initiatives that the workforce system has sought to implement throughout, specifically via its emphasis on the Baldrige Criteria for Performance Excellence. These criteria are:
- Visionary leadership
- Customer-driven excellence
- Organizational and personal learning
- Valuing employees and partners
- Agility
- Focus on the future
- Managing for innovation
- Management by fact
- Social responsibility
- Focus on results and creating value
- Systems perspective
  (Baldrige National Quality Program, 2004)

As the 2004 Baldrige report states: "Organizations should not only meet all local, state, and federal laws and regulatory requirements, but they should treat these and related requirements as opportunities for improvement "beyond mere compliance" (pp. 3-4).

Specific recommendations for furthering efforts in developing effective practices for customers with mental illness

1) DOL should, and it is the understanding of the authors that it will, **issue a policy guidance to the field** using the findings from this report, as well as other available resources, regarding evidence-based employment practices in serving people with psychiatric disabilities. This guidance should identify possible administrative- and service-level practices that state and local WIBs should examine to positively influence employment outcomes for customers with mental illness who choose to use the resources of the public workforce development system as well as other technical assistance resources available (as noted in Appendix N).

2) There is a need for **more concerted technical assistance** to both ODEP and ETA Disability grantees on specific skills and systemic/administrative structures to further the employment of people with mental illness. One way to accomplish this goal is by targeting existing funds devoted to technical assistance/training through NCWD/A at ICI and the Institute for Educational Leadership as well as the Chronic Homelessness Employment Technical Assistance initiative (CHETA) and the WIG technical assistance through the University of Iowa Law, Health Policy, and Disability Center. The benefit of this approach is that it maximizes existing resources and uses structures already in place, including the services of personnel such as Joe Marrone from ICI and Gary Shaheen from CHETA, who are already on staff at these technical assistance centers. Problems with this occur in establishing some clear goals for this special effort and having to coordinate four centers, each of which has numerous partners and is funded by several funding streams (ETA, ODEP, HUD).

Another approach is to fund a new, more limited technical assistance effort specific to disseminating and implementing these best practices as widely as possible with a joint funding stream that incorporates both ETA and ODEP funds. While identifying and meeting training requirements should be a piece of this effort, the major need is not training but much more "on the ground" technical assistance to help people deal with specific matters related to mental health/workforce collaboration, identification of possible funding streams in addition to those under the DOL aegis, consultations on structural, administrative, and staffing issues, building broad-based community partnerships, and involving business and economic development entities in problem resolution. The major barrier to this second approach to more targeted technical assistance is of course the requirement for new funding, but it might be possible to finance this new intervention through reallocation of existing unspent funds.

3) Training is not in the forefront, as noted. However, **to the extent that training is supported** in some fashion by DOL to further the agency's efforts, the major topics that must get addressed more aggressively than is often the case at the present time seem to be:
- Effective business services that incorporate the needs of job applicants and workers with psychiatric disabilities
- Marketing workers with mental illness to employers
- Developing a working knowledge of accommodations for job applicants and workers with mental illness, both prior to employment and on the job
- Engagement and outreach strategies for potential customers with psychiatric disabilities
- Assisting in developing work as a priority and expectation for people with psychiatric disabilities in conjunction with local workforce entities' mental health partners in the community
- Management of performance standards in a workforce environment

- Motivational interviewing (Miller & Rollnick) and personal "readiness for change" strategies (Prochaska model)

Curricula developed by NCWD/A and others exist in all these areas noted. But heretofore there has not been a DOL-focused effort to design and endorse a panoply of acceptable training components for workforce boards to consider as part of a broader human resource development approach for the purpose of creating core competencies within staff carrying out WIA and labor exchange activities. It is strongly recommended that any such design sponsored or endorsed by DOL recognize this as a subset of overall workforce competency and whatever certification methodology the local boards use to assess staff capacity, and not see these skills as a disability specialist "add-on."

4) DOL should fund a **one- to two-day think tank** involving:
- Current grantees (CEGs, Workforce Action, Chronic Homelessness, and WIGs) that target customers with mental illness (the group surveyed for this report would be an excellent start)
- Representatives from ETA, ODEP, HUD, the Center for Mental Health Services (CMHS) at SAMHSA, CMS, the National Association of Workforce Boards (NAWB)
- Representatives from state and local MH organizations
- Staff from the existing technical assistance centers
- Key content experts such as Joe Marrone (ICI), Gary Shaheen (Advocates for Human Potential), Robert Drake, M.D. and Deborah Becker (Dartmouth Medical School), Gary Bond, Ph.D. (Indiana University-Purdue University Indianapolis), Judith Cook, Ph.D. (University of Illinois at Chicago), Charles Rapp, Ph.D. (Kansas University), Robert Gervey, Psy.D. (UMDNJ), Patrick Corrigan, Ph.D. (Northwestern University), and Virginia Selleck, Ph.D. (Minnesota DMH)

The two topics addressed would be 1) identifying techniques for incorporating these best practice approaches nationwide and 2) looking specifically at funding/sustainability strategies for employment services for people with mental illness that examine the idiosyncratic funding streams that affect customers (and potential customers) with mental illness. This would be ideal as the topic is quite complex and would require special invitees. But in lieu of this, DOL might consider as a first step devoting a section of Workforce Innovations on this or, perhaps more fruitfully, working with NAWB to develop a special section for the NAWB annual meeting.

5) DOL should **develop a targeted program/project evaluation** on the outcomes achieved specifically with customers with mental illness through its Customized and Workforce Action grantees and additionally for the WIGs, which have both different funding sources and different emphases. In addition to job retention, the outcome elements should look at employment retention, measured in days of work in a specific period. Essentially, the fact that individuals receive employment services in an integrated setting, side by side with the rest of the general public, can normalize the job search process and the concept of being unemployed. Also, the core constructs of the One-Stop system are in philosophical congruence with the tenets of consumer choice, greater opportunities for control of resources, etc., that are embodied in the federal Rehabilitation Act of 1973, as amended. Ideally, One-Stops should provide significant opportunities for choice of services, control, and full participation in planning and service delivery, which would potentially create an atmosphere for better engagement of individuals in the employment process. DOL should also consider jointly funding with SAMHSA and RSA and

NIDRR a study that examines employment outcomes of individuals served in the One-Stop system versus those in programs/services that only serve individuals with psychiatric disabilities.

6) DOL should identify the key role that **concern over health and financial benefits** plays for people who are in poverty and often in need of psychiatric care or medication only available through publicly funded Medicaid services. It is recommended that DOL coordinate with CMS and SSA on developing strategies for workforce systems to become cognizant of and reasonably conversant with this issue as it is an important one in the lives of many customers and potential customers with disabilities. DOL should issue some sort of policy guidance highlighting this topic and direct workforce systems to seek out partnership agreements with the local BPAOs in their state (or other agencies involved in benefits counseling) to make sure workforce staff are familiar with the general outlines of the service and can offer it to customers using the One-Stop system.

7) DOL should provide guidance to workforce development systems and WIBs on **specific systemic outreach to and coordination with mental health systems of care**, because of the unique barriers medically oriented systems' clients face in accessing any sort of employment service. DOL could suggest strategies to include these systems in various partnership activities. Examples include:
- Joint program development and/or joint funding of staff positions
- Involving these systems in generic WIA/One-Stop efforts such as health care industry skills panels
- Developing MOUs with mental health systems of care
- Memberships on WIBs or working subcommittees of WIBs
- Encouraging mental health providers to use the services of the One-Stop in conjunction with their clients
- Seeking their assistance in training workforce staff about the medical and psychosocial aspects of mental illness, etc., and conversely, having workforce staff offer training to mental health systems on employment and economic development issues in the local area

Furthermore, DOL and SAMHSA should consider the possibility of jointly funding specific local area planning projects involving one-year development processes for workforce and mental health systems of care to coordinate system enhancement and collaborative endeavors related to both policy creation and program design.

8) At the federal level, DOL should encourage RSA to issue a policy guidance to all VR state directors about how **VR systems should be comprehensively connected to the generic workforce system** beyond just the administrative mechanisms already in place such as membership on statewide WIBs and partnerships through MOUs. This guidance should encourage the implementation of local VR policies to ensure that customers with disabilities get served appropriately within the One-Stop environment—not just through the Section 188 mandate but through partnership activities that state VR should encourage and actively engage. Concomitantly, DOL should develop a policy guidance on effective partnership strategies with VR that emphasizes joint service delivery to the fullest extent possible, not referral out to VR. DOL and VR should encourage the development of a series of state-level meetings between state VR administrators and local office directors and local WIB and One-Stop staff as well as state WIB personnel to develop a set of best practice guidelines to inform successful partnerships at a local service level.

The issue of One-Stop and VR integration and coordination transcends this project and is, as noted earlier, an overall systemic issue in the emerging framework of WIA and ancillary workforce activities. However, it also is an issue identified in many of these sites visited and interviewed. While most of the sites had varying degrees of VR partnership and success, the Tucson, AZ and Utica, NY sites appeared to be the only ones where VR took a lead in the activities noted. However, it is worth noting in the context of this report that DOL must continue to discuss and troubleshoot this issue. Given the structure of VR (i.e., federally funded but locally controlled for all practical purposes) and the concurrent emphasis on local governance of the WIA system through the administration of local WIBs, DOL and RSA should engage in this discussion at multiple levels.

9) One-Stop and workforce staff should be encouraged to **recruit personnel who represent not only ethnic, cultural, gender diversity but also people with disabilities**, specifically psychiatric disabilities, with some strategies for reaching out to this group in the course of responding to the existing requirements under the ADA and Section 504. The reason for this additional emphasis on top of the abundant policy mandates currently in place is that peer support is a key element of engagement and service delivery for customers with mental illness to succeed in employment. As noted earlier in this report, compared even to individuals with other types of disabilities the unemployment rate for this group is quite high, so extraordinary efforts would be called for if workforce systems are to be a model for other business enterprises to look to in this regard.

10) **Performance measures** are always going to be an issue in systems that rely almost exclusively on WIA funds. The more funding streams and partnerships that exist within a system, the less of an issue performance standards are. The challenge for managers in the workforce (or any other performance-driven) system is to see the goals and standards established as measures of staff and system competencies, **not** of customer/client appropriateness for services (e.g., where goals are not being consistently met, identifying the problem as one the system needs to resolve through new policies, new funding streams, new staff skill sets, and the like, not through better screening).

A common concern alluded to several times in this report (and noted consistently in all the sites surveyed), as well as in numerous other analyses of the workforce system's capacity to serve customers with disabilities, was the feeling that DOL-mandated WIA performance measures (in addition to the cross-agency common measures being instituted) acted as barriers to serving customers with serious mental illness. This is certainly a valid concern to the extent it is widely held and reported consistently by workforce staff and disability advocates as well as customers themselves. However, DOL should not adopt a waiver of performance outcome measures for customers with significant disabilities, including mental illness. This runs the risk of creating a "ghettoized" service structure if implemented widely. Focusing only on quantitative results without qualitative measures is unethical; producing high-quality outcomes without affecting significant numbers of people is self-indulgence. Enduring system change involves both quality and quantity.

It is recommended that DOL consider doing a pilot in two or three sites that would be rigorously evaluated after a year to see whether relaxing these performance criteria in the case of customers with mental illness leads to greater access and better employment and earnings outcomes than previously. Concurrently, DOL could also examine some alternative methodology, such as using its existing work on regression formulae through the Michigan VAPIS (Value Added Performance Improvement System) model (Michigan Department of Labor & Economic Growth,

2004) funded through DOL and assisted in development by the Corporation for a Skilled Workforce, Public Policy Associates, and the W.E. Upjohn Institute for Employment Research, to pilot some methodological approaches that would impact services to customers with psychiatric and other significant disabilities.

There are ways to manage the performance standards that service areas must adhere to by applying them flexibly to specific grantees while managing the system as a whole to compliance. (In most service areas except the very smallest, there could be a "bell curve" approach whereby there are outliers on the high and low ends of the spectrum with the areas as a whole conforming to the required standards.) This is not always done due to the pressures of competing interests and the need for perceived equity among all contractors of WIBs (i.e., not having to deal with the question of why some contractors have lower standards to meet and others higher). This is an issue that transcends disability but would provide one concrete example for DOL to use as a rationale for why local systems must manage the standards flexibly in specific contract situations while maintaining the integrity of the system as a whole.

An illustration of an innovative and unique methodology for stressing the need to include a reasonable amount of services to people, including those with significant disabilities, while at the same time continuing to emphasize the importance of performance outcomes, is being piloted in the Vancouver, WA workforce area. An example of this performance measurement template is included in Appendix L. This is further explained in the case study on the Vancouver, WA site in Appendix J.

Conclusion

A potential threat to the movement towards inclusive employment service delivery is that in order to successfully obtain employment, people with significant disabilities, including many people who have been diagnosed and labeled as having a serious mental illness, often require a more intensive level of assistance, resources, and expertise than typical job seekers. In its efforts to meet the needs of all job seekers under WIA, there is concern that the specific and often unique needs of people with disabilities will be overlooked or not met effectively.

Also, what does "accountability for results" entail in practice? Are services that are provided and funded under WIA held accountable for meeting the needs of the entire customer base, including customers with disabilities? There is the potential that individuals with more significant vocational needs will be left unserved; certainly that is a concern heard often in discussions with workforce staff, including many of those interviewed in the site visits that this report has summarized. Many people view the emphasis WIA puts on successful performance outcomes in terms of earnings, job retention and the like, rather than process measures of services delivered, as mitigating against the ability of WIA-funded services to assist customers with disabilities well. DOL is aware of this concern and is in fact exploring alternative performance measures (such as applying regression formulae) for certain groups, including people with disabilities. However, this in turn raises the specter of "ghettoized" or substandard services in the minds of many disability advocates.

Another issue for people with disabilities is the role of the state VR program as a mandated partner in the One-Stop system. Will this mean that VR will collaborate more effectively with other agencies in the workforce development arena to better meet the needs of people with disabilities? Or will it mean that the targeted resources for people with disabilities under VR will

become diluted and less effective as they are combined with those of other agencies? A related concern is the need to make sure that VR is not considered the only option for service delivery under WIA for people with disabilities. Like any other members of the general public, people with disabilities are entitled to the full range of services available under WIA and not only those services available or funded by VR. While VR may (and should) not assist every person with a disability who comes in contact with the One-Stop system, it should be prepared to provide direction on service alternatives to VR. In states where VR has an order of selection in place, other One-Stop services can play a key role in helping customers who might not otherwise be able to get services. The intent of WIA is clear: Even if One-Stop customers qualify for VR services, they are not required to use VR services. Individuals who choose not to use VR services have the right to utilize any other One-Stop services for which they qualify.

Conversely, tension exists in many One-Stop environments over how best VR can fulfill its partnership role while concurrently abiding by the requirements of the Rehabilitation Act. This is another matter mentioned often in the site visits and telephone interviews, with some sites effectively surmounting this obstacle through effective collaboration. For example, VR staff at a One-Stop may do such things as determining eligibility for VR services, explaining VR services during an orientation session, conducting a workshop for VR clients, and providing direct assistance to VR clients. However, VR staff and funds cannot be used to meet the needs of non-VR clients. The relationship between VR and the One-Stop system should be interactive in nature, with referral of individuals by VR to other components of the One-Stop system and the One-Stop system similarly referring individuals to VR. Ideally, the One-Stop system can be designed in such a way that individuals will fully benefit from the potential of the One-Stop system through blending One-Stop partner services. An individual would utilize VR services as needed but also benefit from the wide array of other services available as well. One of the major challenges for the One-Stop system will be to do this in a way that creates the perception of seamless service delivery from the customer viewpoint.

In sum, DOL should reinforce the need for integration and inclusion for customers and potential customers with psychiatric disabilities to the fullest extent possible, and emphasize this point to all its WIA grantees/contractors, other funding recipients, and mental health systems. This inclusiveness can be most readily achieved at the core level. This report highlights many specialized strategies and interventions that have made workforce services more amenable to the needs of people with mental illness. Nonetheless, the societal expectation for our citizens with and without disabilities must remain **universal access**. People experiencing the challenges posed by psychiatric disability have been victimized as much if not more by the low expectations of many systems that purport to serve their needs—even mental health specialty organizations— than by having these expectations set too high. For many years, the professional mental health constituency has not been effective in developing a sense of hope or encouraging their clients/patients to step outside the artificial boundaries of mental health services and mental illness itself.

If the workforce/WIA/One-Stop system is to meet its abundant promise of seamless service delivery combined with universal access, then it must meet the challenge of making its key services programmatically as well as physically accessible. The confluence of new psychiatric rehabilitation technology and mental health treatments, evidence-based practice in employment services for people with psychiatric disabilities, and the flexibility of a creative, newly reinvigorated workforce system has created the potential at this point in time for both the mental health and workforce systems to participate in breaking new ground in helping people with

serious mental illness achieve a more fulfilling and complete life and reaping the benefits of full U.S. citizenship. This potential was succinctly endorsed by Emily DeRocco, Assistant Secretary of Labor, ETA, in her remarks to the Subcommittee on Social Security of the U.S. House Ways and Means Committee on 9/30/04:

> One of five key components of this [New Freedom] initiative is "Integrating Americans with Disabilities into the Workforce." This includes expanding educational and employment opportunities and promoting full access to community life for people with disabilities. ETA is committed to achieving this goal.

Site Case Studies and Client Profiles

To provide additional depth to this report, the appendices contain **selected agency case studies** of several sites (Appendix J) and some **client/customer profiles** (Appendix K). These agency case studies demonstrate creative solutions and promising practice activities in some situations; in others, they highlight problems that the system has or will have to confront. To date, no ideal systems have been found that can confront the complex issues that arise in trying to integrate workforce development, mental health, and VR systems into a seamless service delivery environment that produces positive employment outcomes for clients/customers with significant psychiatric disabilities. Therefore, an attempt was made to provide a representative array of site descriptions from those visited and interviewed to identify interventions to expand as well as additional barriers to circumvent. Similarly, the client/customer profiles are only meant to be four stories that illustrate personal experiences of people with mental illness with the workforce development and mental health systems. Their experiences, while informative relative to the types of issues such customers may face, are unique to each client in a certain time and at a certain place. They are not meant to be indicative of broader trends in and of themselves. Instead, they are meant to inform a fuller investigation of what is typical throughout the workforce development and mental health systems as a whole.

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APPENDIX A: REFERENCES REGARDING EVIDENCE-BASED PRINCIPLES OF SUCCESSFUL RECOVERY AND VOCATIONAL REHABILITATION FOR PERSONS WITH SERIOUS MENTAL ILLNESS

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APPENDIX B: REFERENCES REGARDING DELETERIOUS EFFECTS OF LONG-TERM UNEMPLOYMENT

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Dooley, D., Catalano, R., & Hough, R. (1992). Unemployment and alcohol disorders in 1910 and 1990: Drift versus social causation. *Journal of Occupational & Organizational Psychology.* **Increases alcohol use.**

Dooley, D., Catalano, R., & Wilson, G. (1994). Depression and unemployment: Panel findings from the Epidemiologic Catchment Area study. *American Journal of Community Psychology.* **Increases in depression.**

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APPENDIX C: ORGANIZATIONAL CHANGE STRATEGIES IN IMPLEMENTING A RECOVERY ORIENTED SYSTEM OF CARE

These questions are based on a large body of change management research summarized by John P. Kotter as well as the Prochaska research on personal "readiness" to change. They are taken from work done by a colleague and myself under contract to United Behavioral Health, Inc., the Administrative Service Organization (i.e., the managed care entity/gatekeeper) in an ongoing system change initiative promoting a Recovery orientation in the mental health system of care in Spokane, WA. We see "cutting-edge" employment initiatives within mental health as components within an overall rehabilitation/recovery approach. I would note here however that employment is perhaps the piece that is the least accepted element as anything other than an "optional" service.

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Errors

Kotter has identified eight major errors that consistently lead to failed attempts at organizational change.

Error #1: Not Establishing a Great Enough Sense of Urgency
- In the eyes of stakeholders, how important and urgent is the adoption of a rehabilitation and recovery model?
- Are people so comfortable with the status quo that they will not want to take the effort and risks associated with change?
- Are a significant portion of the key "stakeholders" (i.e., people with authority or influence or ideally both) honestly convinced that "business as usual" is totally unacceptable?

Bottom line: Is there a system-wide perception of urgency?

Error #2: Not Creating a Powerful Enough Guiding Coalition
- Which stakeholders are driving the system redesign? Which stakeholder groups are indifferent? Which are opposed?
- Do the people "pushing the change" have the means to create incentives and modify the organizational infrastructure to support the system redesign?
- Who are the strong, credible, and assertive leaders who will communicate the need for change to all in the system?

Bottom line: Do the people driving change have the means to make it happen?

Error #3: Lacking a Vision
- Is there a clearly articulated vision of what we are doing and why?
- Does the vision easily translate into actions?

- Is the vision concise and easily understandable? (The "rule": If you can't explain it easily within three to five minutes, you don't really know it.)
- Is there a clear link between the vision and each specific system redesign activity?

Bottom line: Is there a clear theme and blueprint showing how the various system redesign initiatives relate to a vision, or is system redesign perceived as a collection of disparate activities with no central theme?

Error #4: Undercommunicating the Vision by a Factor of Ten
- How has the vision been communicated? Do people "get it"?
- Are the day-to-day actions of the system's leadership and the guiding coalition consistent with the vision? Are we practicing what we preach?
- Are we using every possible communication channel to communicate the vision?
- Are we willing and able to displace nonessential, generic training programs and devote those resources to training specific to rehabilitation and recovery?

Bottom line: How effectively have we communicated the vision?

Error #5: Not Removing Obstacles to the New Vision
- Have we identified the obstacles?
- Are we willing to make changes in the existing organizational structures if those structures do not support system redesign?
- How will the system handle administrators, supervisors, and/or managers who do not support change and make demands on their employees that undermine system redesign?

Bottom line: Are we willing and able to take the actions necessary to manage organizational and personnel obstacles?

Error #6: Not Systematically Planning for and Creating Short-Term Wins
- What are some potential short-term wins that would get system redesign off to a positive start?
- Do we have the commitment to devote resources to creating short-term wins?

Bottom line: Are we willing and able to do what it takes to create short-term wins?

Error #7: Declaring Victory Too Soon
- Does the system have the long-term perspective to maintain the system redesign initiative over time?
- Do the stakeholders recognize that change requires years, not months?

Bottom line: Is there a plan to orchestrate a series of short-term wins so that momentum is sustained?

Error #8: Not Anchoring Changes in the Organization's Culture
- How can we create a rehabilitation and recovery organizational culture within the local MH system of care?
- How can we develop a broad base of support so that rehabilitation and recovery is not restricted to a small circle of advocates?

Bottom line: How do we make rehabilitation and recovery such an integral part of the mental health system that it is self-sustaining?

APPENDIX D: DRAFT MH AND EMPLOYMENT TRAINING AGENDA FOR ONE-STOP CENTERS

Day One Agenda

8:00-8:30   Coffee and hello

8:30-9:00   Welcome, introductions, training overview, and questions solicited

9:00-10:45   "I think you ought to work, that's what I think"
- What we know about employment and mental illness, including what role, if any, diagnostic information plays
- Why people with mental illness can and should work
- Evidence-based practices in employment service delivery for "hard-to-serve effectively" populations

10:45-11:00   BREAK

11:00-12:00   Do WIA and services to people with significant disabilities mix?
- Customized employment vs. "regular" employment services through the One-Stop Career Center
- What is special treatment vs. equal access?
- Making people feel welcome
- When should the One-Stop staff consult a "disability specialist"?

12:00-1:15   LUNCH

1:15-2:30   Helping and change strategies
- Disclosure: When? Why? How? At All? Both in using the workforce system and to employers
- Engaging the individual within the helping process
- "Readiness" constructs as an aid, not a barrier
- Prochaska model and motivational interviewing, and their applications to this population
- Dealing with stigma, discrimination, and advocacy

2:30-2:45   BREAK

2:45- 4:15   Marketing issues
- Why good marketing concepts apply to all
- Marketing potential employees with psychiatric disabilities to employers
- The role of the ADA and Section 188 of WIA in dealing with potential employers
- What specific marketing strategies have been successful in helping customers with significant disabilities find employment?

Day Two Agenda

8:00-8:30   Coffee and second-day welcome

8:30-9:30   Business services and customer service to employers and members
- Balancing customer service to potential employers with customer service to One-Stop Center members
- How to meet the needs of One-Stop Center members with mental illness in a business services environment

9:30-10:45   Issues in collaboration and teamwork between MH disability and workforce agencies—system needs and consumer/client/member needs
- Two or three local people with mental illness talk about their employment experiences (ideally some with the One-Stop Centers)
- Presentation by VR, one or two local MH community employment providers, and representatives from local MH authorities on their respective programs and supports for consumers with mental illness
- Lessons learned from other places
- Teamwork and seamless service delivery versus meeting together

10:45-11:00   BREAK

11:00-12:00   Accommodation issues in employment and service delivery for consumers/members with mental illness
- Examples of accommodations in different part of the employment process—application, interview
- Discussion on what role One-Stop Centers can play

12:00-12:15   Evaluation discussion and tearful good-byes

Or optional:

12:00-1:15   LUNCH

1:15-2:45   Case discussions of real people/situations/issues

2:45-3:00   Evaluation discussion and tearful good-byes

Exported trainers: Joe Marrone and/or NCWD/A staff. It should also include two or three local consumers with mental illness and staff from VR as well as local MH and workforce agencies.

APPENDIX E: DRAFT POLICY GUIDANCE REGARDING INQUIRING ABOUT THE PRESENCE OF A DISABILITY

TO: Workforce Investment Board Directors
                    One-Stop Career Center Operators
                    Workforce New Jersey Managers
FROM: Gary Altman, Director
                    One-Stop Coordination and Support
SUBJECT: Guidance Regarding Inquiring About the Presence of a Disability

1. <u>**PURPOSE.**</u> To provide guidance to local One-Stop Career Centers on how to create a culture within the One-Stop Career Center System that respects an individual's right to privacy, as it relates to individuals with disabilities.

2. <u>**REFERENCES.**</u> The Workforce Investment Act of 1998; 29 CFR Part 37; Title II of the Americans with Disabilities Act, and USDOL Training and Employment Guidance Letter No. 9-02.

3. <u>**BACKGROUND.**</u> The Workforce Investment Act (WIA) includes nondiscrimination and equal opportunity regulations for the provision of services to all customers. Included in those regulations is specific language regarding the service to individuals with disabilities:
   - Individuals with disabilities have a right to use the services of the One-Stop system
   - One-Stop Career Centers must be readily accessible to individuals with disabilities
   - Individuals with disabilities are entitled to reasonable accommodations and modifications when using One-Stop services
   - Individuals with disabilities should not be automatically referred to agencies providing services for people with disabilities.
   - Referral to other programs such as vocational rehabilitation should be based upon individual need and agreement by customers

   One-Stop staff **may not** make unnecessary inquiries into the existence of a disability. It is a completely voluntary decision by the customer to disclose any disability information.

   One-Stop staff **may ask** whether an individual has a disability, but there must be a specific reason for making such an inquiry and these inquiries must be made **for all customers of the One-Stop.**

   The One-Stop system may ask whether an individual has a disability for the following reasons: the collection of demographic information, to determine if the individual is eligible for special services or funding as a result of the disability, and to ensure that accommodation needs are met so the individual can fully benefit from services. Requests for information concerning the presence of a disability cannot be used as a basis for excluding individuals from receiving services. The information included in this instruction outlines basic guidelines for information collection and sharing as it relates to a customer's disability status.

4. <u>**INFORMATION THAT ONE-STOPS CAN INQUIRE OF CUSTOMERS REGARDING DISABILITIES.**</u> As a provider of services the One-Stop system is legally permitted to make inquiries of customers about the presence of a disability. Employers, however, are not permitted to ask about the presence of a disability prior to an offer of employment. The implication of this distinction is that One-Stop staff may have more information about a customer than they are permitted to provide to employers they contact on behalf of the customer. The uses for such inquiries are as follows:
   A. Collection of demographic information
   B. Determination of eligibility for special services or funding as a result of the disability
   C. Accommodation of needs are met so the individual can fully benefit from services

5. <u>**GUIDELINES FOR DISABILITY INQUIRIES.**</u> One-Stop Career Centers are advised to make any inquiries concerning disability with caution, limiting the request for information only to that which is absolutely necessary, and taking the necessary steps to ensure that the information is kept confidential. The following are suggested guidelines for inquiries about disability issues.
   A. At the Provision of Core Services
      i. At the time of registration and intake the request for information about the presence of a disability should be made only in writing, for example, as a part of the customer registration form (i.e., individuals should not have to verbally respond to questions such as "Do you have a disability?" Particularly in a public area, group setting, or area where they could be overheard).
      ii. If an individual requires assistance in filling out a registration form this should be done in a private area, where responses will not be overheard.
      iii. The reasons(s) for requesting this information should be made very clear (e.g., providing this information may make you eligible for services to which you may not otherwise be entitled).
      iv. It should be stated both verbally, and in writing that the decision to disclose any information concerning the presence of a disability is strictly voluntary.

   B. During Participation in Intensive and Training Services
      i. Discretion should be used in discussing disability issues with customers. If One-Stop staff anticipates that disability-related issues may arise during a discussion with a customer, staff should ask the customer if they would prefer to hold the meeting in an area where others will not overhear the conversation.
      ii. One-Stop staff should avoid asking about presence of a disability or specific questions about an individual's disability in a group setting.
      iii. Knowledge and access to information concerning an individual's disability should be limited only to staff who require this information for service delivery.
      iv. Staff should be respectful of privacy issues when discussing a customer's needs with other staff, particularly when discussing more sensitive issues (for example, mental illness). Only staff specifically involved in service delivery for the individual should be part of such discussion.
      v. The information requested and discussed with customers and One-Stop staff should be limited strictly to that which would impact the job search/placement process. For example, the full medical history of a person's disability is not necessary, when all that is needed is information concerning how the disability will impact the person's ability to obtain and retain employment.

6. **CONFIDENTIALITY.** Steps must be taken to ensure that records and case notes are kept confidential. This includes keeping paper files and records in secure places, and utilizing security levels in electronic information systems.

7. **INQUIRIES.** Questions concerning this issuance should be directed to Thomas Caldwell, Assistant Director, Division of One-Stop Programs and Services, NJDOL at (609) 292-2246.

APPENDIX F: DRAFT POLICY GUIDANCE REGARDING REFERRAL TO VR BY WORKFORCE SYSTEM STAFF

TO: Workforce Investment Board Directors
One-Stop Career Center Operators
Workforce New Jersey Managers
NJ VR Staff

FROM: Gary Altman, Director, One-Stop Coordination and Support
Tom Jennings, Director, NJ VR

SUBJECT: Guidance Regarding Referral of a Customer with a Disability for VR Services

DATE: 10/1/04

1. <u>PURPOSE.</u> To provide guidance to local One-Stop Career Centers and to the VR agency on how to determine whether it is appropriate for One-Stop Career Center System to refer a customer with a disability to the local VR office for assistance.

2. <u>REFERENCES.</u> The Workforce Investment Act of 1998; 29 CFR Part 37; Title II of the Americans with Disabilities Act, DOL Training and Employment Guidance Letter No. 9-02 and New Jersey DOL Policy Directive No. 1-04 and Institute for Community Inclusion Policy Brief, Vol. 3, No. 2: *Provisions in the Final Regulations Governing the State VR Program Describing the Interplay with WIA and TWWIIA* (February, 2001).

3. <u>BACKGROUND.</u> The Workforce Investment Act (WIA) includes nondiscrimination and equal opportunity regulations for the provision of services to all customers. Included in those regulations is specific language regarding the service to individuals with disabilities specifically:
   - Individuals with disabilities have a right to use the services of the One-Stop system
   - One-Stop Career Centers must be readily accessible to individuals with disabilities
   - Individuals with disabilities are entitled to reasonable accommodations and modifications when using One-Stop services
   - Individuals with disabilities should not be automatically referred to agencies providing services for people with disabilities
   - Referral to other programs such as vocational rehabilitation should be based upon individual need and agreement by customers

Collaboration between the VR agency and the WIA administering agency is intended to produce better information, more comprehensive services, easier access to services, and improved long-term employment outcomes. Thus, effective participation of the State VR program is critical to enhancing opportunities for individuals with disabilities in the State VR program itself as well as other components of the workforce investment system in each State and local area. {65 FR 10621, 10624 (February 28, 2000)}

All partner programs (not just the designated state unit implementing the State VR program) have a legal responsibility under Title I of WIA, the ADA, and Section 504 of the Rehabilitation Act to serve persons with disabilities. Some individuals with disabilities may receive the full scope of needed services through the One-Stop system without

accessing the State VR program at all; while others may be referred to the designated State unit for a program of VR services or receive a combination of services from the State VR program and other One-Stop system partners. Nothing in Title I or Title IV of WIA or the implementing regulations is meant to be construed to require designated State units to pay the costs of providing individuals with disabilities access to the One-Stop system. In fact, that responsibility falls to the One-Stop system in accordance with the ADA and Section 504. [66 FR 4425 (January 17, 2001)]. In addition, some individuals who are eligible for VR services may choose not to participate in the VR program and, therefore, also may be served exclusively by other partner programs of the One-Stop system. [66 FR 4425 (January 17, 2001)]

Therefore this policy guidance is issued under the premise that the New Jersey One-Stop system will endeavor to serve customers with disabilities through the full panoply of services the One-Stop system offers and that the customer with a disability is (potentially) eligible for, whether or not, they may also be (potentially) eligible for other employment-related disability-specific services. It is expected that, while the final decisions regarding which agency services the customer would choose to access would reside in the customer, as agency policy the NJ DOL would expect referrals to be made to the state VR agency primarily as a complement to One-Stop services and NOT as a replacement for such services. Also, since the VR agency is a partner in each One-Stop, it is strongly encouraged, that in addition to this policy directive, each Center develop a local referral protocol under the statewide parameters outlined below. Several Centers have developed Employment Planning teams involving VR, WIA staff, and other disability-specific partners and this may be a viable model to continue to expand in various parts of the state to assist in rendering assistance to customers with disabilities more effectively, especially in regard to the collaborative activities envisioned in specifically in the areas under Sections D.4, D.5, D.6, and D.8 below.

As noted in the Policy Directive No. 1-04, previously issued by the New Jersey Department of Labor, One-Stop staff may not make unnecessary inquiries into the existence of a disability but they may ask whether an individual has a disability, as long as there is a specific reason for making such an inquiry and these inquiries are made for all customers of the system. The One-Stop system may ask whether an individual has a disability for the following reasons: "… *to determine if the individual is eligible for special services or funding as a result of the disability* …." If using the previous guidance, Policy Directive No. 1-04, the customer is believed to be a person with a disability, then the following decision tree process should be used to determine the feasibility and appropriateness of a referral to the state VR agency. The information should be used consistently while, at the same time, recognizing that every situation that staff confront involves a multitude of factors that must be considered. But applying the decision making guidelines described below should help in assisting customers with disabilities more effectively and expeditiously.

4. GUIDANCE:

   Below is the decision tree protocol for considering whether a workforce customer should be referred for VR services. Nothing in the guidelines below is meant to contravene the Policy Directive No. 1-04 referenced above, which remains fully in effect and is expected to be adhered to in all respects. This guidance serves as a complement and supplement to that directive, not as a replacement in any form.

Questions to Consider in Deciding Whether a Workforce Customer Should Be Referred to the Local Office of the NJ State VR Agency for Assistance?
These questions below are developed in a decision tree format and should be applied in the order described.

1) Do you know that a customer has a disability? **Y/N**
   - If Y, did [s]he self-disclose? **Y/N**
   - If Y, on a form? Or to you directly? Or to others who informed you?
   - If N, what other factors lead you to believe this? How does this knowledge get incorporated into your decision given the requirement that it is up to the customer to voluntarily self-disclose disability status and not have that label assigned to him/her by external parties?

(**Note**: It would be useful and all NJ One-Stops are encouraged to incorporate as part of their general customer orientation several pieces of disability service oriented information, both in written material and oral presentations at general orientation sessions. This should include information about why One-Stops encourage customers to self-identify should they need disability-specific assistance, what disability-specific partners and resources might be available to help, and how customers might self-identify and with which staff should they be encouraged to connect. Where possible it is highly desired that NJ VR staff participate at some level in presenting a brief description of VR services to all customers attending orientation sessions.)

2) Does the customer have a disability that needs some special accommodations if [s]he is to successfully use workforce services **Y/N**
   - If Y, what leads you to believe this? (**SHOULD REFERENCE LOCAL NJ RESOURCES AND INFO RE: ACCOMMODATIONS HERE**)
     (**Note**: If staff believe an accommodation is necessary and staff broach the topic, then such staff should explain what leads them to arrive at this judgement and how such an accommodation might benefit the customer to derive the full benefit of workforce development services.)
   - If N, no other action regarding referral to VR is needed at this time, unless the customer specifically requests such service.

3) Does the customer believe [s]he needs and desires this accommodation? **Y/N**
   - If Y, what leads you to believe this?
   - If N, no other action regarding referral to VR is needed at this time, unless the customer specifically requests such service.
     (**Note**: If the customer believes an accommodation is necessary then staff should ask the customer what sort of accommodation might be needed and how such an accommodation might benefit the customer to derive the full benefit of workforce development services.)

4) Does the One-Stop Center have the ability to provide this accommodation service on its own without the assistance of VR? **Y/N**
   - If Y, what leads you to believe this?
   - If N, what leads you to believe this?
     (**Note**: Each One-Stop Center should have in place an MOA regarding the process in place for assessing and providing needed accommodations. The One-Stop staff should reference this policy at this juncture. However, it is also useful

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for the workforce staff to identify local resources or experts who may assist the Center staff in examining other creative problem-solving options that have not previously been acknowledged.)

5) Does the customer have some more extensive individual support needs related to his/her disability that should be attended to in order for the person to successfully attain and retain employment? **Y/N**
   - If Y, what information, in addition to the customer's own statements, leads you to believe this? Have you discussed this opinion with the customer directly?
   - If N, why not and what leads you to believe this? Do you need some assistance from someone else to discuss this with the customer directly? It is expected that there be both formal (through Memoranda of Understanding) as well as informal working relations established with NJ VR and other disability partners in the One-Stop so that this consultation can be accessed readily and effectively. (**Note**: Workforce staff should be clear when identifying the perceived need for extensive individual support that this judgement is rendered with the expectation that such support should be expected to assist the customer in achieving a successful employment outcome and is not being used to "screen the person out" of services.)

6) Does the customer wish to be referred to disability specialty services that VR provides? **Y/N**
   - If Y, what leads you to believe this? Staff should provide every opportunity to the customer to continue to use all appropriate workforce services, especially core and assisted self-service, even while discussing with the customer the possible need of disability specialty services.
   - If N, what leads you to believe this? If N, no other action regarding referral to VR should be undertaken, unless the workforce staff believe that this additional service is essential and without it, the customer can not get any further benefit from the other workforce services available. In that case, it is then incumbent upon the staff member to explain the rationale for this decision cogently in a manner that elicits a positive response and agreement to this referral from the customer, not merely acquiescence.
   (**Note**: Workforce staff should be clear when identifying the perceived need for disability specialty services that VR provides that this judgement is rendered with the expectation that such service is expected to assist the customer in achieving a successful employment outcome and is not being used to "screen the person out" of workforce services.)

7) Do you think [s] the person should still consider VR even if [s]he is not interested? **Y/N**
   - If Y, why do you believe this? Do you need some assistance from someone else to discuss this with the customer directly? As with #5 above, workforce staff should have a collaborative relationship established with disability partners in the One-Stop or the community at large so that this consultation can be accessed readily and effectively.
   - If N, then it is expected that the One-Stop Center will then seek to provide the service that staff felt the person needed, which they thought VR should provide. If this service provision is ascertained to be impractical or impossible without VR

assistance, then it is the responsibility of the workforce staff or supervisors to clearly explain their rationale and gain the customer's understanding (and ideally) agreement. This decision should only be rendered after full discussion with administrative staff at the One-Stop Center and with the local VR partner personnel.

8) Will you make the referral directly to VR if the customer agrees that [she] is interested in VR services? **Y/N**
   - If Y, does your One-Stop Center have a regular process in place to do this? As noted above in #5 above, each One-Stop Center is expected to have in place both formal (through Memoranda of Understanding) as well as informal working relations established with NJ VR so that this referral can be accomplished effectively and seamlessly.
   - If N, why not? Is this because the customer prefers to do it him[her]self? If so, then workforce personnel should offer advice to the customer on the most efficacious way to accomplish this self referral and proactively offer to assist if the customer changes his/her mind. Furthermore, workforce personnel are expected to ensure that the customer understands the situation fully, including the ability to continuing receiving all appropriate workforce services (the preferred mode) or the process in place to reaccess workforce services without prejudice at a future time.
   (**Note**: It is not acceptable to suggest the customer self refer to VR either because of workforce staff's other work requirements or because staff are not knowledgeable how to arrange such a transition. In either case, workforce staff are expected to do timely follow up to make sure the person is connected appropriately and that the customer is engaged in services that meet the needs assessed.)

9) If the customer with the disability will be getting assistance from VR, will the One-Stop Center workforce staff still continue to serve him/her with other (non VR funded) services? **Y/N**
   - If Y, how will this be communicated to and coordinated with VR staff? Procedures for providing joint services should be fully explicated in the Memoranda of Understanding between local One-Stop Centers and the state VR local service offices.
   - If N, why will the One-Stop Center not continue to assist the person? Is it because the One-Stop Center does not have any services the person needs? If so, how did you decide this? Core services or assisted self-service should be feasible alternatives in almost every instance. It is expected that that this assessment is done in partnership with the affected customer and explained clearly and in writing if the person requests it. If the customer still seeks One-Stop Center services, then there needs to be an administrative policy in place in writing regarding the process for why no further services would not be offered—a situation that should occur infrequently if ever.
   Is it because VR is better equipped to deliver all the services needed? If so, how did you decide this? It is expected that that this assessment is done in partnership with the affected customer and explained clearly and in writing if the person requests it. If the customer still seeks One-Stop Center services, then there needs to be an administrative policy in place in writing regarding the process for why

further services would not be offered—a situation that should occur infrequently if ever.

(**Note**: As noted in #8 above as well as in Section C of this document, the preferred mode for the system (and consistent with the spirit and the letter of the ADA and WIA legislation) is for the customer to be able to continue to receive all appropriate workforce services concurrent with participating in VR services wherever possible.)

APPENDIX G: PLACEMENT PLAN AND PLACEMENT SUPPORT PLAN

Placement Plan

Consumer: _____   Date: _____

Job Goal: _____

I have the following skills, experience, & personal qualities for this job:

These individuals have committed to do the following to achieve this goal:

Individual	Task	Date to be completed
Professional staff		
Consumer		
Family & friends		

When will this be reviewed again? _____

Signatures of:

Consumer: _____
Staff members involved: _____
_____
Others who have offered to help: _____
_____
_____

To be filled out after job offer has been secured

Placement Support Plan

Name: _____ Employer: _____ _____

What types of supports will the consumer need following job placement? (check all that apply)

Type of support	Assistance/coordination provided by:
__ On-site support (through project or worksite mentor)	
__ Regular contact with employer	
__ Transportation assistance	
__ Medical needs	
__ Medication	
__ Assistance with grooming & hygiene	
__ Therapy (psychiatric, physical, substance abuse)	
__ Supervision during non-work hours	
__ Communication with residential support or family	
__ Other (please specify)	

Summary of support to be provided by primary agency staff:

_____

_____

_____

_____

Summary of support to be provided by staff from other organizations:

_____

_____

_____

Summary of support to be provided by employer or worksite mentor:

_____

_____

_____

_____

Summary of support to be provided by other resources (family, state agency, VR, peers):

_____

_____

_____

What are the current support gaps and barriers?

_____

_____

_____

What is the plan to overcome them?

_____

_____

_____

Signatures

Consumer:_____   Staff: _____

Other(s) in support roles:

_____   _____

_____   _____

Date: _____

APPENDIX H: TEMPLATE FOR GUIDANCE TO ONE-STOP STAFF REGARDING POSSIBLE NEED FOR THE ONE-STOP TO ENGAGE A MENTAL HEALTH PARTNER ORGANIZATION IN THE EMPLOYMENT PLANNING

1. Does the customer report feeling worried about something wrong with their thinking or their mind? Yes _____ No_____
2. Does the customer report that they are taking prescribed medication to either help them be less anxious, help them with their thinking, or help them be less depressed? Yes _____ No_____
3. Does the customer exhibit any unusual physical movements such as facial tics, muscle spasms, drooling? Yes _____ No_____
4. Has the customer ever mentioned doing harm to themselves or others? Yes _____ No_____
5. Has the customer ever mentioned hearing voices in their head or seeing things that aren't really there? Yes _____ No_____
6. Does the customer seem extremely lethargic and uninterested in everything? Yes _____ No_____
7. Does the customer seem unduly distracted (acting as if they are not paying attention or do not hear you even when you are speaking directly to them)? Yes _____ No_____
8. Does the customer appear very angry even when there is no immediate problem? Yes _____ No_____
9. Does the customer appear to be speaking to themselves frequently or to others who aren't in the immediate area? Yes _____ No_____
10. Does the customer seem very distrustful for no good reason you can ascertain? Yes _____ No_____
11. Has the customer ever been arrested or had other legal problems? Yes _____ No_____
12. Has the customer ever gotten help from a community mental health center, a community counseling agency, or a private counselor for one or more of the following?
    - Depression   Yes _____   No_____
    - Drinking or drug problems   Yes _____   No_____
    - Doing harm to themselves   Yes _____   No_____
    - Doing harm to others   Yes _____   No_____
    - Disorganized thinking   Yes _____   No_____
    - Agitation or nervousness   Yes _____   No_____

APPENDIX I: CHECKLIST FOR QUALITY SUPPORTED EMPLOYMENT IN MENTAL HEALTH

Below is the checklist for Quality Supported Employment in Mental Health representing the ideal components. Some are more important than others, and not all are equally useful. This is adapted from the **Quality Supported Employment Implementation Scale (QSEIS),** which was designed to evaluate the implementation (fidelity) of SE program practices and policies for people with severe mental illness (Bond, Picone, Mauer, Fishbein, & Stout, 2000).

Percent fully met	Good supported employment (SE) checklist component
	SE programs use a **team approach for treatment**, as defined by: • Team size of at least three FTE members (i.e., employment specialists) • Team forms a distinct vocational unit, with shared office space • Team has shared caseloads for treatment planning and provides backup/support to other team members for treatment provision • Regular team meetings attended by all members
	SE services are **integrated with clinical treatment services** • Ideally, single agency provides both treatment and vocational services at same location • Employment specialists regularly attend clinical treatment team meetings (at least once/week) and have frequent contact with treatment team (average one contact/day) • Vocational and treatment team records are integrated (kept in same file)
	Employment specialists (ES) provide **continuous, intensive vocational services** • ES is responsible for carrying out all vocational services from intake through follow-along (not brokered) • ES responsibilities are limited to vocational services (e.g., no case management responsibilities).
	Clients have **minimal to no pre-screening requirements** prior to admission to SE • Consumers are not excluded based on vocational readiness or level of functioning • Consumers do not require case management approval prior to admission
	SE **engages clients in vocational services rapidly** • Rapid VR approval (on average, within two weeks of referral), or no approval required • Consumers meet with ES, on average, within one week of expressing initial interest in SE • Vocational assessment completed within one week, on average

	Rapid job placement • Vast majority of clients (more than 90%) receive **no** prevocational work-readiness training (e.g., TEs, job trials, classroom activities, sheltered work) • First job application typically within one month of program entry
	Job placements are **community-based** • That is, not in sheltered workshops competitive, in **normalized settings** • Most employees are not receiving SE services and utilize **multiple employers** • Less than 20% of jobs are with a limited number of employers
	Individualized job search, including: • Focus on consumer needs and preferences, not market requirements • Consideration of long-term career goals, including opportunities for advancement and possible future jobs
	Multiple jobs are permitted. • More than 90% of clients have no set clinical or prevocational preconditions, or waiting times before beginning next job search
	Long-term (at least one year) follow-along/support after job placement • Continuous and individualized (e.g., considers consumer preferences for involvement of coworkers in support) • Includes both consumer (e.g., crisis intervention, job coaching, job counseling) and employer supports (e.g., education, guidance)
	The SE team has a **small client: staff ratio** • Client: staff ratio ideally should be no greater than 16:1
	The majority of **treatment contacts occur in the home, at the job site, or in the community** (more than 55% of contacts), **not** in the office
	The SE team is assertive in **engaging and retaining clients in treatment**, especially utilizing face-to-face community visits rather than phone or mail contacts
	The SE team **consults/works with family and significant others** when appropriate

APPENDIX J: SELECTED SITE CASE STUDIES

Interview with Melodie Pazolt of Clearview Employment and Lisa Nisenfeld of the Southwest Washington Workforce Development Council, Vancouver (Clark County) WA

<u>"Best Practice"</u>
1. Workforce partnership led by mental health provider, who created an expectation of employment and employment support for citizens of Clark County with significant psychiatric disabilities.
2. Services for youth with emotional behavioral problems as part of county-wide federal demonstration grant.
3. Ability to leverage multiple funding streams—local, state, and federal including grant, contractual, and ongoing operational funding.
4. Creating performance measures targeted at people with disabilities. Developing these measures was a collaborative effort between the Southwest Washington Workforce Development Council (SWWDC), the One-Stop, and its partner Clearview Employment Services. The board developed local performance indicators or "productivity numbers." To better visualize the plan, the board developed a grid with two axes: one for job seekers and another one for job orders/employers. See Appendix L for more specific details. There is an ongoing emphasis on focusing resources to achieve a desired return in investment. One way to achieve this was by better connecting/matching job seekers and employers.

<u>Background Information</u>
Columbia River Mental Health Services, Inc. (CRMHS) of Vancouver, Washington, is a large 501(c)(3) community mental health center that provides services to Clark County residents. Founded in 1942, CRMHS offers a vast array of services in addition to Clearview Employment Services. These include residential facilities, case-managed housing, mobile crisis response, crisis case management, and crisis respite. Outpatient clinics offer case management, therapy, psychiatric and psychological evaluation, medication management and nursing. Services span all age groups, including child and family services and an Adult Day Health Center for older adults. CRMHS also provides alcohol and substance abuse treatment. Through its employment service arm, Clearview Employment Services, and in partnership with SWWDC (formerly the Southwest Washington Private Industry Council), CRMHS has extensive experience in serving consumers with significant mental health disabilities through a variety of local and national funding streams. These resources encompass:
- Federal ETA grants—as a subcontractor to Oregon Health Sciences University on a ETA multi-state disability and employment grant, as the primary implementer of a ETA WIG, and as a service contractor through WIA and ETA Welfare to Work funding
- An RSA federal grant, with the local One-Stop as a partner, to assist homeless people and women ex-offenders in transitional housing in entering human service/health care and other occupations leading to long-term career success
- As grantee, with SWWDC as a partner, in an ODEP grant serving customers with significant disabilities

Clearview serves a wide variety of clients who face multiple barriers to employment and life success, including mental illness, substance abuse, homelessness, a history of incarceration, victims of domestic abuse, low educational attainment, and receipt of public assistance. It operates a variety of targeted programs to meet the unique needs of these constituencies.

Clearview initially became engaged in the workforce system in 1999 as it set out to assist people who were long-term welfare recipients and had barriers to employment related to mental illness and/or substance abuse through a Welfare to Work contract from the (then) Southwest Washington PIC. The goals were ambitious given the nature of the target group. They were not only met but exceeded. After two years of operation (until the Welfare to Work funding stream ended) the program served well over 100 people and helped over 60 get permanent employment.

Whereas moving towards employment was an inherent expectation in Welfare to Work funding, work wasn't a clear expectation of clinical intervention within a mental health system of care but rather an opportunity for those who chose to seek it out. So Clearview became an advocate for workforce involvement within the entire mental health system as a whole, which was quite an unusual role. Clearview also served as a mental health and disability resource link within the workforce system in southwest Washington. This embryonic partnership, originally grown out of these specialized services to TANF clients, bloomed and prospered as WIA was implemented after its enactment in 1998, the Southwest Washington PIC became SWWDC, and the One-Stop system within Washington became branded as WorkSource. Out of this initial piloting grew collaborative endeavors that included the federal DOL (both ETA and ODEP) and Department of Education/RSA grants described above.

Current Situation
This now fully matured partnership between CRMHS and SWWDC led to SWWDC subsidizing the Clearview director's salary out of its regular workforce funding allocation for services relating to ongoing operations, including:
- Attending monthly SWWDC team meeting to advise on disability-related projects and issues
- Representing SWWDC within the community to pursue partnerships and new funding options
- Representing SWWDC in coordinating services with other community nonprofit organizations
- Coordinating efforts between SWWDC and the WorkSource contractor, Arbor, on ensuring seamless transition of specialized services for customers with disabilities
- Assisting SWWDC to disseminate "best practice" information regarding customers with disabilities
- Advising SWWDC on methodology for incorporating universal design into all workforce services.

A major change in One-Stop leadership in 2004 in Clark County was the introduction of Arbor A&T as the new operator of WIA funds. Because Arbor A&T was a for-profit agency, Arbor emphasized the business community as its primary customer. The Clearview director's approach was to start developing relationships with Arbor A&T as soon as they were awarded the contract. "I was immediately on the phone and saying, "I'd love to work with you guys. How can we? We have some opportunities to bring some additional resources into our community. We'd like to partner with you to do that." At the time of the research SWWDC even paid a small percentage of this administrator's salary to ensure continued development of relationships that facilitated the inclusion of individuals with disabilities into the workforce system.

Many hoped that the introduction of a for-profit entity would be a boon because Arbor took its relationships with employers seriously and added expertise in marketing to its targeted

customers. Others raised concerns that individual customers could get lost within this focus. The "jury is still out," as the current arrangement was less than a year old.

The chair of SWWDC in Clark County was an employer who had an extensive background as a private vocational rehabilitation counselor. Another board member owned a cleaning business and recruited employees through Clearview's supported employment program. A "disability liaison," who was involved in employment and mental health issues, did a great deal of work on educating the board and raising awareness among members through presentations, informal conversations, and attendance at board meetings. Representatives had come to board meetings to talk to members about the pragmatic aspects and financial benefits of hiring people with disabilities.

SWWDC was supportive of the grant development that went on in this region around supporting people with disabilities. Also, SWWDC used a Program Management Plan to conduct strategic planning. Underlying this plan was the assumption that greater consistency inevitably produced greater overall quality. Assessment and monitoring was part of this process. According to the One-Stop administrator, assessments were conducted to compare contractual performance measure with actual performance. This data was used to inform the strategic planning process at both the One-Stop and WIB levels. In addition, SWWDC had a specific mechanism for soliciting customer input into the five-year plan. The board held a meeting and invited customers to discuss their experiences.

In Clark County, a disability navigator position was established through a new WIG that funded three navigators in the state. The disability navigator was at the One-Stop two days per week and had several roles. Primarily, she was there to help navigate customers through the system, provide one-on-one consultation to staff around disability issues, and facilitate trainings. She organized a job shadowing program as well as extensive disability-related trainings with presenters from VR, Clearview, and community rehabilitation providers. She was responsible for keeping updated on resources for WorkSource staff around disability issues. She also educated employers on the benefits of hiring persons with disabilities, and provided outreach and marketing.

One-Stop partners across sites continued to be creative in developing mechanisms to provide more seamless services to job seekers. In addition to focusing on how customers moved through the system, Clark County created a greeter position to better respond to customers' immediate needs. Efforts had been made to create a workforce system that accommodated all types of job seekers. For example, Clark County used a series of trainings—the **Job Hunter Series**—to better structure the different services available to customers at the One-Stop.

Model Implemented in Clearview's Workforce and Other Projects
Clearview's approach focused on the importance of hope- and relationship-building strategies in engaging and motivating people. Its core program was an integrated part of the MH system of care within Clark County. Clearview itself marketed its specialized services to employers primarily via individual job development based on the consumer's expressed desires and capabilities, not general job prospecting. After specific job areas were targeted, a marketing plan, as well as individual placement and placement support plans, were developed by the individual and project staff. Once a job was identified, the job matching process (using a person/environment fit strategy) ensured that the job selected met the significant criteria

identified through the planning process. As the participant adjusted to the job, the levels and type of supports changed.

Clearview experienced success with individuals who had often been unsuccessful within the generic workforce system through innovative aspects such as carving jobs/tasks and focusing on the conditions/environment of the position and the person's interests and strengths. Clearview services included career counseling, vocationally related case management, support, job coaching, vocational assessment, and/or job development. The staff was dedicated to helping individuals develop greater self-esteem and self-confidence as they moved toward their employment and education goals.

Clearview's service design:
- Used a person-centered Personal Career Development Planning approach in the assessment of interests and abilities and the design of service delivery
- Emphasized rapid job entry and wraparound planning and supports
- Provided intensive on- and off-the-job supports by use of "vocational specialists" for personal support, advocacy, and community and personal resource linking
- Provided community-based vocational assessments through selected employers
- Used peer and natural supports such as peer support groups, personal networking for job acquisition, and worksite mentors
- Created entrepreneurial/self-employment options for people with disabilities

<u>Collaboration</u>
The core collaboration between CRMHS/Clearview and SWWDC, which has been described in some detail above, led to the leveraging of a variety of resources. This working partnership generated over five million dollars in federal grant funds (Department of Education/RSA, ODEP, two from ETA). It has led to ongoing administrative level links such as the inclusion of the CRMHS director on the SWWDC board and his participation on the SWWDC Health Care Skills panel. In addition, there was a broad collaboration that the partnership has used its base strength to expand. Partners involved in projects included traditional ones such as public VR, county government, human service entities, and state welfare authorities. In addition, more far-flung partners were brought into the fold, including a small business consultant under contract to Clearview who assisted customers with disabilities seeking entrepreneurship opportunities and provided consultation to the project on marketing issues and understanding the needs of the business, especially small businesses, which comprised a large segment of the businesses in southwest Washington.

The sum total of all these intertwined efforts as a system of seamless service delivery that has created a One-Stop **system** in southwest Washington rather than merely a One-Stop **center**. Customers could come in and receive services both on-site and in the community from workforce staff, Clearview personnel, and contractors based at WorkSource, who could provide services carved out from one or more of the following blended funding streams: ETA and ODEP, Department of Education/RSA, SAMHSA/CMHS (for youth transition funding for youth with emotional behavioral problems), TANF, and local county and state and federal human service budgets.

<u>Linking Services to Demand Occupations, Economic Development, and Community Benefit</u>
While disability is not necessarily highlighted on the workforce or business "radar screen," two key facts stand out:

1) The unemployment rate for adults with disabilities is the highest of any target group WIA serves, including urban, inner-city, minority youth. This makes disability a major national issue for the workforce development system.
2) Washington State has received some significant additional resources (over $8,000,000) for training, technical assistance, policy and infrastructure development, and some direct service demonstrations to serve customers with disabilities, indicating that to some extent, disability issues have been elevated over some other factors.

With these facts in mind, it is clear that the partnership met an emerging workforce need in southwest Washington and the state as a whole.

CRMHS, SWWDC, and WorkSource all had significant experience marketing to employers, and CRMHS developed specialized marketing strategies to this audience. CRMHS and its consultants worked with SWWDC to design and implement employer marketing strategies, including the recent addition of a disability and business marketing specialist to the core Business Services team at WorkSource Vancouver. The specific functions of this specialist included:
- Ensuring that WorkSource marketing plans to employers in the area were attuned to the needs of customers with disabilities
- Informing employers that one part of the WorkSource customer base was workers with disabilities
- Making sure that employers knew they could use WorkSource as a resource to complement the business services offered by the disability-specific employment agencies in the area, such as VR
- Connecting this project's overall marketing/business services efforts with work done at a statewide level through VR's two business service/marketing managers, who communicated with large and small employers throughout the state

In addition, the coordinator was responsible for trying to develop specific employers as potential partners for larger-scale projects to benefit people with significant disabilities.

Employers who have worked with individuals with disabilities have a positive perception about hiring employees with disabilities, and they also value attributes commonly associated with such workers. While businesses may be willing to sacrifice some productivity for reliable, dedicated employees who increase workforce diversity and demonstrate corporate social responsibility, the extent to which other factors (such as changes in economic conditions and labor market trends) influence these perceptions is unknown. A fundamental strategy within all the projects highlighted was to train WorkSource staff about ways to enhance the employability of individuals with disabilities, and to work within communities to dispel negative perceptions. Information about accommodations and universal design, for example, can help employers understand how individuals they may not have considered for employment can become productive employees.

The stellar work of Clearview in integrating service delivery to customers with disabilities in specialized projects led to the creation of a disability marketing specialist on the WorkSource marketing team. This specialized marketing expertise was **not** a "disability job developer" but rather a core member of the team, expected to infuse employer relations staff with skills to help employers understand:
- The business sense of hiring talented people who may have disabilities
- Reasonable accommodations

- Job restructuring/carving, which is often an employment intervention unfamiliar to employers
- Natural supports and employment support intervention methodologies
- Additional workforce resources available to the employer

The ODEP Workforce Action Grant provided funding for the "Working for Success" team that was comprised of three job developers to provide job carving and other customized employment strategies for people with significant disabilities. One developer came from Keys to Advancement (a CRP), one from the One-Stop, and one from Clearview. Keys and Clearview staff accompanied individuals they served to the One-Stop to introduce the services, register individuals into the system, and meet with the disability navigator. The job developers used job carving—creating a job by thinking creatively about the tasks left undone or currently associated with other positions at a work site. One respondent noted that although WorkSource was not originally set up to support a strategy like job carving, "There was a real receptiveness from WorkSource to say, 'Yes, we want to do the job better.'" This team of job developers was designed specifically to work with individuals with significant disabilities who were in segregated settings.

The Clearview/SWWDC partnership was also successful in collaborating on the regional (and national) emphasis on skill shortages in the health care industry. As noted above, several of the Clearview/SWWDC collaborative projects focused on training for and entry into human service and health care professions for customers with disabilities. Two of the federal grants obtained and detailed earlier had this area in their respective goal statements, and graduates of the training programs either run by or coordinated with Clearview used WorkSource in addition to Clearview as their primary means for entry into this field.

Replicability and Sustainability
The replicability of the strategies described above is at once simple yet complex. At its heart, the model calls for systems and individuals to reach out and merge what they do best to make a seamless system with strengths and resources that outstrip the sum of each of its parts. This sort of activity does not necessarily require a large infusion of funding (though that can expedite it) or system redesign (though that can support it), and is commonly espoused in a plethora of venues—in government literature, from the podium at conferences, and in academic articles and studies. Yet the achievement and actual implementation of such a common-sense approach remain elusive. So the dissemination and replication efforts are meant to be far-reaching and to continue at both a global level (through conferences and professional writing) and more grassroots-level activities (through training, technical assistance, and peer to peer outreach).

The model that has been developed through these demonstrations locally in Clark County, Washington and environs is intended for use by One-Stop Career Centers and disability agencies throughout the country. The strategies that have been developed as promising practices (person-centered planning, resource mapping, universal design, increased collaboration with non-mandated partners, and innovative funding strategies) will be tested, summarized and disseminated nationally through and ICI/NCWD. Presentations have been made in diverse national venues including the NAWB National Forum, the DOL national rural conference, state and local generic workforce conferences, national conferences related to psychiatric rehabilitation and employment, Department of Education/RSA national conferences, state WIG conferences in Washington and Oregon, and national events sponsored by NCWD/A.

Descriptive case studies of promising practices are being developed so that other sites can replicate the practices more easily.

VR and Other Linkages, Including Business Partnerships
At the leadership level, One-Stop managers sent a strong message about the collaboration's importance. For instance, the One-Stop director did not consider it a "referral" between the One-Stop and VR: "How can you be referring [to] WorkSource, when we are [all] WorkSource?" The VR office was physically located next door to the One-Stop, so while staff were not co-located, WorkSource staff noted that "whenever we need it, whatever we need… we can get it, because they are next door." Some positive links that had been built between VR and the One-Stops included plans for specific orientations for people with disabilities at the One-Stop that would include VR; a VR networking job club to be planned in conjunction with other One-Stop staff; and greater participation of VR in the resource room. As the partners took these initial steps, they looked forward to continued bridge-building.

A specific example was given by a job developer from Clearview who talked about a situation in which blended funding was successful. The developer spoke of a person who used CRMHS as their independent employment vendor. This person also had a state VR counselor as well as a navigator, also within the One-Stop, and a case manager at the One-Stop Center. All of those entities, including the supportive services, were coordinated well. The VR counselor was updated regularly so that he knew what was happening. VR got a copy of the customer's employment plan, which was integrated with the IPE. The customer received specialized training through an Individual Training Account (ITA). So funding was used from multiple streams.

The community partner meetings in Clark County gave staff and partners an opportunity to share ideas and jointly monitor the implementation of the grant activities. To improve collaboration between CRMHS and the Clark County welfare department, there was an opportunity for staff from both agencies to come together and get to know one another. Prior to the meetings, staff exchanged phone lists as a first step. These meetings facilitated communication among agency staff and also helped to change staff members' perceptions of one another.

A new addition to the local resource pool in the past year was that one of the Clark County One-Stop's business account representatives maintained a focus on disability and was responsible for training the other account reps and infusing an awareness of disability throughout outreach activities. She offered technical assistance and consulting services to employers while training other representatives to look at the possibilities for people with disabilities as they practiced the immersion technique (e.g., job carving).

Clark County workforce staff also engaged in resource mapping within their cross-functional teams to discuss customer flow and identify resource redundancies. A visual flowchart was created that mapped out the process. The chart was displayed in the conference room of the One-Stop. As part of this approach, management started to take a more thorough look at some of the problem areas in service delivery. One such area was customer referral, specifically referral back to the Department of Social and Health Services (DSHS). Staff met and discussed the referral process, including their understanding of "job readiness." Subsequently, they piloted a survey to better this process. From that time forward, all the job readiness refer-backs had to be agreed upon by both agencies involved in the referral.

Training of Staff

The WorkSource Disability Network in Clark County provided a range of trainings for frontline staff in the region. Through the leadership of the disability navigator, there was a wide array of formal training opportunities, which were positively received by frontline staff. Clark County had recently started to put its staff certification plans into practice. Initially, Clark County was one of three pilot projects in Washington State that participated in this training program. Now that Clark County had begun to fully participate in this program, One-Stop leadership intended to get all staff certified as National Certified Workforce Professionals, Level I by July, 2005. A group that included partner staff met weekly to work through the training modules. Completion of the training and certification program takes approximately three months.

To solicit feedback from staff, Clark County used a form entitled "Are we making a difference?" encouraging staff members to share their thoughts. Staff feedback was reviewed by the management team and/or the responsible cross-functional unit. In addition, the board also made efforts to collect data. The SWWDC program manager for adult and dislocated workers (who was also responsible for monitoring and performance measurement) sought to gather information on local demand occupations. The board hired a researcher who not only identified relevant data sources but also developed a tool that board staff used to collect the data.

In Clark County, formal satisfaction surveys were given not only to active One-Stop customers but to those who had exited the system. In addition to these formal procedures, staff members collected customer feedback informally by asking job seekers about their service experiences. Staff noted that customers were proactive in terms of getting their voices heard and bringing about change. For instance, initiatives such as the networking groups started because of customers' suggestions.

Challenges in Addition to Sustainability
Collaboration with VR

Many VR counselors reported that collaboration with VR in Clark County was stymied by a sense of being overwhelmed. There was a sense that collaboration with other One-Stop partners was just one more addition to an already full list. VR staff understood the potential benefits of the collaboration, but in practice felt that it was too difficult to implement. The state VR director recently issued a memorandum to staff that identified how VR personnel could partner more effectively with the local One-Stop system. While workforce staff saw this as a good step, many felt that the memorandum was offered more in terms of suggestions rather than a policy directive with clear expectations for adherence.

Collecting disability data

Data collection around disability was still a challenge for various reasons. In Clark County, disability data was only collected if a customer disclosed a disability to the case manager. Case managers were hesitant to ask customers about an existing disability because they did not want to offend the customer. To address this issue, Clark County configured its customer identifier swipe card system so that customers could access it through a touch screen, hoping individuals would be more comfortable.

Defining and identifying disability

Another issue concerned the way disability was defined and disability questions phrased in the registration process. The perception was that customers were put off by the word "disability" and

thus did not self-identify. There was some discussion, still in process, about changing the language to make the process more customer-friendly.

Data sharing

Barriers to data sharing continued to be a challenge for One-Stop partners, particularly due to incompatible data management systems and confidentiality issues. In Clark County, partners interested in accessing One-Stop data signed a SKIES (the MIS format used) data sharing contract, which outlined the conditions for using One-Stop data. According to the SWWDC information systems manager, although the system was built and implemented with all partners in mind, it was not being used very extensively. SKIES was used by CRMHS and to a certain extent by Clark College, the local community college. Some partners such as DSHS and VR could access SKIES but were not using it. Expanding its users was identified by management as an issue that still needed to be addressed.

Interview with Mike Boyle from Fayette Companies in Peoria, IL

"Best Practice"
1) Fayette Companies moved from providing sheltered employment to providing innovative employment supports (i.e., IPS) under an initiative funded by a Workforce Action/Olmstead grant
2) The organization used the Behavioral Health Recovery Management model/approach for service integration achieved by co-locating services (employment services were nested within MH and primary health care services) and data sharing (clients had one record that was used by their clinicians, psychiatrists, and employment counselors)
3) Fayette Companies and VR jointly funded a benefits specialist position at the One-Stop
4) Under the grant, Fayette Companies hired two consumers as job coaches (prosumers)

Brief Description and History of Fayette Companies
In 1976, four different not-for-profit agencies in Peoria that provided MH services were consolidated. Fayette Companies became the umbrella organization over all the direct services. In addition to MH services, management brought in substance abuse/addiction services. Fayette Companies employs over 370 people and has a budget of over 20 million dollars. The organization only provides mental health services to adults with serious mental illness. Employment services (i.e., supported and competitive employment) are part of the comprehensive services that the organization offers its clients. Fayette Companies is also the recipient of a Workforce Action/Olmstead grant, which the organization used to develop an on-site, innovative employment program for people with psychiatric disabilities.

The Workforce Action/Olmstead Grant: Developing an Innovative Supported Employment Program for People with Serious Mental Illness
Innovative (supported and competitive) employment services were not always been part of the organization's service spectrum. Prior to the grant, Fayette Companies contracted with a local sheltered workshop to provide employment services to clients with mental illness. The workshop employed a staff member/employment specialist who not only participated in Fayette's staff meetings (acting as a staff liaison) but also facilitated referral of clients to the workshop program.

This situation changed two years ago when Fayette Companies received a five-year Workforce Action/Olmstead grant. At the time of the interview, the organization was beginning its third year of the grant. Under the grant, the organization hired a full-time supervisor, a full-time job developer, and seven job coaches. Two of the seven individuals who were hired for this project were consumers of Fayette Companies. These individuals continued to receive psychiatric services while working as job coaches or "prosumers" under the grant (explained later in more detail).

The grant application was a joint of Fayette Companies (president Mike Boyle and director of research David L. Loveland) and the University of Chicago Center for Psychiatric Rehabilitation (Patrick Corrigan). Other grant partners included the Human Service Center, the local Workforce Development Board, the Illinois Department of Human Services, and the Illinois Office for Rehabilitation Services (ORS). One of the objectives of this grant was to use the IPS model combined with motivational interviewing as a gateway for individuals with serious mental illness into One-Stop Centers.

From 1998 on, Mike made an effort to move the organization towards using evidence-based practices. As a first step, Fayette Companies developed an integrated treatment model for persons with co-occurring disorders because the organization had a very high percent of persons with mental illness and substance abuse/addiction issues. Out of this initiative grew the Behavioral Health Recovery Management project.

The Behavioral Health Recovery Management (BHRM) project

BHRM was a partnership of Fayette Companies, Chestnut Health Systems headquartered in Bloomington, Illinois and the University of Chicago Center for Psychiatric Rehabilitation. Funding was provided by the Illinois Department of Human Services Office of Alcoholism and Substance Abuse. Mike served as project director.

> The Behavioral Health Recovery Management (BHRM) project seeks to apply the principles of disease management to assist individuals with chemical dependency and/or serious mental illness to engage in a process of recovery from these illnesses. The major components include the application of evidence-based treatments coupled with longitudinal recovery support as an alternative to the acute interventions that characterize traditional behavioral health approaches. In addition, the project emphasizes a consumer-centered, strengths-based service delivery model (Retrieved 11/20/04 from the BHRM website: http://www.bhrm.org).

Service integration through co-location

Using BHRM, Fayette Companies combined three main service components: MH/substance abuse treatment, primary health care, and employment services. Mike reported that the majority of clients served by Fayette Companies had issues in all three areas. The first step toward service integration was to put a clinic/medical facility inside the MH center so that clients could receive primary health care and see their MH counselor within the same building. The supported employment program was nested within the MH/substance abuse services and primary health care services.

Service integration through data sharing

Services were not only physically integrated (co-location) but also linked electronically. Mike reported that psychiatrists and the primary care physicians used the same records (one record per client) so they knew what medications had been prescribed.

Implementing the grant (staff training) and integration of services through creating joint staff positions

Mike reported that it was "amazingly easy" to implement the grant. The organization had the luxury of hiring new staff and providing them with intensive training before moving into the field of supported employment. The majority of training was provided by Patrick Corrigan and his colleagues from the University of Chicago Center for Psychiatric Rehabilitation. Training took the form of ten full days of intensive training on the IPS model and motivational interviewing.

In addition, an organization called Health and Disability Advocates (www.hdadvocates.org) partnered with the Benefits Planning Division of ORS (BRS) in Illinois and jointly trained Fayette Companies staff on the impact of benefits on health and income. Staff were trained to do all the up-front paperwork of benefits analysis, a training situation that Mike described as being unique to Fayette Companies. Prior to the grant, Fayette Companies already had a benefits specialist to

help clients apply for disability benefits as well as Medicaid and Medicare. This benefits specialist also went through the training provided by Health and Disability Advocates and training partners, although her primary responsibility was quality assurance. Due to the high volume of applications for benefits submitted by clients served by Fayette Companies and the need to expand BRS services/capacity, BRS offered to contract with Fayette Companies for a half-time position. Since April 2004, the benefits specialist has been working half days at the One-Stop doing benefits analysis.

Employment services: The IPS model

Fayette Companies's innovative supported employment program was based on the IPS model. IPS focused on client preferences, rapid job finding, continuous assessment, competitive employment, integrated work settings, and follow-along supports. Fayette Companies chose the IPS model because research showed that it was effective for people with serious mental illness. When Fayette received the grant, before starting training staff, the organization contacted Robert Drake from the New Hampshire-Dartmouth Psychiatric Research Center for a tool kit on how to implement IPS. Based on Drake's material, Fayette Companies wrote a policies and procedures manual, which was then used to implement the program.

At the time of the interview, Fayette Companies was working on a grant application for the National Institute for Mental Health. The project proposed focused on supported employment as evidence-based practice.

Alternative employment services: MH clients as prosumers/peer counselors

As mentioned before, two of the seven staff hired under the grant were consumers of Fayette Companies who successfully competed for the positions as job coaches. One of the prosumers served on the advisory committee during the time the grant application was developed.

For the most part, consumers with mental illness who are hired as professionals do not receive services from the same organization they work for. This was one of the issues/problems that Fayette Companies realized only after the clients had been hired. Clients continued receiving psychiatric services while working as job coaches. The organization shifted staff assigned to case management teams. Each job coach was assigned to one or more case management teams. Fayette Companies had to make sure that prosumers were not on the same case management teams as their psychiatrists. Note that this issue is handled differently by different programs surveyed for this report who actively hire current or former consumers of mental health services.

Outcomes achieved under the grant

The goal of the grant was to place 360 individuals (60% of 600) with serious mental illness in competitive jobs that paid above minimum wage, included benefits, and had potential for career advancement over a period of five years. As of October 2004, Fayette Companies had 37 people currently employed in the project, and 50 percent of active participants had found at least one job. Staff were working on job retention, which continued to be a challenge.

There was no information about outcomes achieved by the One-Stop related to customers with psychiatric disabilities. Mike said that Fayette Companies and the One-Stop were making a joint effort to better track customers with mental illness who used the One-Stop. One way of doing that was by matching Fayette's consumer lists with the One-Stop customer data (collected through the swipe card system). The One-Stops only tracked the information of customers who self-identified.

Outreach and education

Fayette Companies worked with the junior college in Peoria to establish an associate degree in mental health. Staff were using the psychiatric rehabilitation course written by the University of Chicago Center for Psychiatric Rehabilitation as a model/template to create a new curriculum to teach evidence-based practice. Mike served on the advisory committee of this project.

Integration of MH services into the workforce system

The One-Stop was located in a modern building in downtown Peoria, a building or place that (according to Mike) was physically intimidating and not necessarily a place where people with serious mental illness would go. Mike noted that MH clients had used core services at the One-Stop, and Fayette held job clubs at the One-Stop. Fayette Companies provided intensive services (i.e., IPS). ITAs were not available. At the time of the interview, Fayette Companies staff were planning on developing two support groups: one group for clients who were looking for jobs and another group for job seekers who had found employment and were trying to stay employed. Both the job club and the support groups were primarily targeted at clients with mental illness.

Fayette Companies bought computer software for the One-Stop. Mike noted that the many of his clients had issues with reading, writing, and the like. To address this issue, the organization bought a software package that One-Stop clients, including those with mental illness, could use to improve their reading, writing, and math skills.

Creative funding options

Early in the project Fayette Companies staff realized that once people had found jobs they needed money to bridge the time until they got their first paycheck (to pay for a bus pass, haircut, etc.). To address this issue, Fayette Companies started a fund: The organization loaned money to clients who signed an agreement to pay it back out of their first paychecks. Mike mentioned the example of a job seeker who needed to renew his driver's license in order to get a job as a forklift operator. Fayette Companies lent him the money ($75.00) which he paid back after he got a job.

Integration of VR

Mike noted that one of the most surprising successes was the relationship that Fayette Companies developed with VR. The state director for psychiatric services was involved in the project from the beginning, serving as a member of the advisory committee.

Mike also reported that in Illinois MH and VR had fought a long battle. The screening tool that VR had previously used was to screen out people with serious mental illness from receiving services. Mike noted that the cross-agency collaboration from the project helped to improve the relationship between MH and VR. Having a staff liaison also helped connect MH and VR. The local VR office had a counselor who was an MH specialist and had previously worked in the MH field. This staff person was not only the liaison to the agency but also sat on the advisory committee of the project.

Integrating VR/MH services into the workforce system: The referral process

Mike met with the VR supervisor to discuss service delivery, including client referral. Fayette Companies and VR divided the client/MH population based on the intensity of need. They came to an agreement that people with psychiatric disabilities who needed IPS/comprehensive types of employment support were to be referred to Fayette Companies; MH clients who did not need

that much assistance were to be referred to and served by VR or the One-Stop. Mike gave the example of a client with a recent onset of psychiatric disorder that was stabilized with medication. The client had held a job for twenty years and was functioning well. Fayette Companies staff referred this client directly to the One-Stop (instead of VR).

VR approached Fayette Companies to provide training on supported employment for central Illinois. The training (a one-day workshop) was planned for January 2005 and would be followed by monthly teleconferences for people who implemented IPS and motivational interviewing and a large conference in May 2005.

Illinois state VR and MH agencies had a joint task force/committee. Mike also noted that the director of consumer affairs for the state MH office was a former resident of Peoria and was very supportive of the project.

Involvement of MH
Mike noted that the MH system, including the MH service providers, had taken an interest in the project. Some providers brought their staff to Fayette Companies to learn about Fayette's innovative supported employment program. Illinois MH was organized around a system of what were called "networks," and most providers/agencies found out about Fayette's efforts through this information mechanism (www.dhs.state.il.us/mhdd/mh/networkInfoSystLiaison). Fayette Companies belonged to a network that covered a twenty-three-county area in central Illinois. The network (center directors, senior staff, advocates) met every three months. Fayette Companies presented on its project at one of the previous monthly network meetings.

The network also participated in an initiative to rewrite the Medicaid plan in Illinois. Mike noted that until recently VR services had not been funded by Medicaid. After the changes, supported employment services could be billed to Medicaid if the service was provided to meet a recovery goal. Mike noted that it was still unclear what sorts of Medicaid plans the state Medicaid authority would consider in terms of allowing agencies to provide employment supports under various options.

Integration of business services and services for people with mental illness
Fayette Companies was also involved with the local BLN. The BLN had one paid staff member whose position was funded by an organization called Community Workshop and Training Center. Fayette's job developer worked with the BLN staff person on employer outreach and marketing.

Surprising challenges and remaining barriers
When Fayette Companies and its partners wrote the grant they did not know that clients who lived in a nursing home of a long-term care facility in Illinois were not allowed to keep over $55.00 a month of earned income. People in nursing homes were one of the target populations served under the grant. Fayette Companies staff struggled with finding ways around this regulation, moving people from nursing homes to Fayette's residential facilities as a temporary solution.

Another issue staff struggled with was helping clients who had been living or were living in a nursing homes apply for Health Benefits for Workers with Disabilities, the Illinois Medicaid buy-in program. Mike was planning on "pushing a case" to enroll a client who was still living in a nursing home but worked and earned an income.

Sometimes Fayette Companies's own staff inhibited the project. Mike mentioned the case of a case manager who talked a client into beginning work at a sheltered workshop instead of taking a competitive job for $9.00/hour. To address this issue, Mike put together a Powerpoint presentation about the IPS model which he presented at an all-staff meeting. The presentation included existing research on the contributing factors to effective and ineffective IPS model and the role of case managers in implementing it. Mike noted that one significant challenge was that MH professionals often continued to be an obstacle, because many still believed that people with serious mental illness could not work.

Helping clients to remain employed—retention—was another challenge. Mike noted that staff unintentionally gave clients the message that supports were not available after getting employed. Clients' reliance on services was thought of as a reason for short retention. Fayette Companies brought in Patrick Corrigan from the University of Chicago Center for Psychiatric Rehabilitation to look at the issue of job retention. Patrick suggested "over-teaching" clients that services would be available after they had gained employment. In addition to training clients on what supports were available, efforts were made to increase communication between case managers and their clients. All staff received cellular phones from the company, and staff gave their cell phone number to their clients to facilitate communication.

Surprising successes and lessons learned

When Fayette staff had their first meeting with VR local staff, several were very pessimistic about the reception they would have from local employers regarding hiring persons with psychiatric disabilities. The local state psychiatric hospital was closing, and the paper had been full of articles and letters to the editor painting a negative portrait of those with mental illness, often a scare tactic from those losing their jobs. However, staff were pleasantly surprised when Fayette's job developer received a very warm reception from the vast majority of businesses she contacted. Some even told her to have applicants put her business card with their applications so they could flag them for special consideration. Mike mentioned one instance where a person "failed" a personality test but the HR person contacted the job developer and arrangements were made to retest. The person passed and was hired. Staff often found the same special consideration from employers when persons agreed to reveal their disability when problems on the job were encountered.

The organization's continued commitment to SE was important. This commitment needed to be continuously reinforced by leadership from the top. It was also important for staff to experience the success that came from seeing clients with serious mental illness work in competitive employment and retain their jobs.

Interview with Rosemary Alexander, Executive Director and Sharon Tulchinsky, Disability Navigator and Manager of VR Services at JobNet, Boston, MA

"Best Practice"
1) The Employment Connections project: A localized state agency partnership between the Department of Mental Health and the One-Stop system that has provided employment services to individuals with mental illness for over ten years (without federal funding).
2) The HomeWork project: One of five national demonstration projects to provide employment services to homeless/unemployed persons with mental illness. The project was jointly funded by ODEP and HUD.

Note: The title on Sharon's business card was "Manager of VR Services"; JobNet employed its own VR staff. According to Dennis Rogers, staff member of the Boston Private Industry Council (the local WIB), state VR was not a co-located One-Stop partner. Boston One-Stops had only informal connections with VR.

The Employment Connections Project
Established in 1994, Employment Connections was a unique partnership between the Massachusetts Division of Career Services (DCS) and the Massachusetts Department of Mental Health (DMH). The partnership was created to assist homeless and previously homeless consumers of DMH to secure competitive employment. This project targeted DMH consumers who resided in the Metro Boston area. DMH funded one part-time staff person (until recently it was 1.0 FTE) to work on the project and coordinate project activities.

History of the involvement between MH and the workforce system
The One-Stop director reported that it took her and her counterpart at DMH almost a year to get buy-in from the respective commissioners and deputy commissioners. The directors invited the commissioners to visit the MH centers in the region and JobNet; commissioners were also provided with opportunities to meet and talk with staff and consumers. Overall, it took the directors a year to get the two agency heads to connect with each other and start collaborating.

Prior to this initiative, there had not been any link/collaboration between DMH and the workforce system. Rather, staff at the respective agencies believed that no other agency was able to serve their clients as well as they did.

To better serve people with disabilities within the One-Stop system, JobNet hired a person trained in rehabilitation. This person also worked as the disability navigator. As such, she helped coordinate both Employment Connections and HomeWork. The Commonwealth Corporation also (www.commcorp.org) hired a clinical social worker to spend one-and-a-half days a week at each of the three career centers in Boston area.

Prior to the arrival of the disability specialist, customers with disabilities were mainly served by the center's senior employment counselor (assisted by an intern) who dealt with the harder-to-serve population. The One-Stop director reported that once the One-Stop recruited specialized/disability staff, services could be delivered more efficiently.

The program seems to have gone through different phases. When the navigator took on the responsibility for coordinating Employment Connections (in the fifth program year), the program was short one staff member and had been kept afloat by one person only. To "revitalize"

the collaboration/project, the navigator embarked on an intense outreach and marketing campaign targeted at the MH community. She visited and presented at all the MH centers that were part of the project; she talked to staff at different levels trying to "energize" them about the project. The navigator said that she rebuilt the initiative mostly through constant communication. There still remained some hesitation on the part of clinical staff within the MH system of care; however, most MH centers and their personnel knew that Employment Connections was a well established program that achieved good results. Communication also helped to establish links and contact points that became channels for client referral.

Referral process: DMH—DCS—JobNet—world of work

There were five major MH centers in the Metro Boston area that participated in this program: Bay Core MHC, Cambridge/Somerville MHC, Solomon Carter Fuller MHC, Eric Lindemann MHC, and MA MHC. According to the navigator, some MH centers were more involved in the project than others. These centers directly referred "job-ready" clients to the Employment Connections project/JobNet. It is important to mention that these MH centers were not the only referral source; job seekers with psychiatric disabilities were also referred to JobNet from other sources, including friends, family, and colleagues.

Each MH center had a point person/project liaison who reviewed the client's information and determined whether the client was job-ready. MH case managers and support staff assisted with the review. MH centers used the following criteria to determine whether a client was job-ready:

1) Customer must be motivated/wanting to work
2) Customer must have some type of work history
3) Customer must be stabilized/not actively engaging in substance abuse
4) Customer's psychiatric symptoms have to be managed
5) Customer must appear to the first appointment with the Employment Connections counselor

If a client as determined job-ready, he or she was referred to Employment Connections /JobNet. One-Stop staff (i.e., the navigator) worked closely with the MH referral staff. Job seekers with MH referred to JobNet met with the navigator, who determined what type of employment services the individual needed and should receive. The navigator reported that, for the most part, meetings took place in the community (e.g., at the MH center).

Once it was determined what kind of employment support the client needed, JobNet staff worked with individuals on the employment piece. Employment services and supports available to clients served under the Employment Connections project included assessment, career counseling, employment plan development, benefits counseling, interview skills enhancement, resume development, job development, individualized job referrals, computer and internet access, one-on-one management, job placement, mentoring, and post-placement support.

There was constant communication between the JobNet/employment staff and the client's treatment team. The navigator said that, for the most part, MH centers were actively referring clients to EC/JobNet.

Other related activities

Efforts have been made by workforce staff/navigator to help MH clients served under Employment Connections retain employment. For instance, a post-employment job club was developed, giving participants an opportunity to share information and discuss issues related to

how to stay employed, how to talk to one's employer, etc. Pizza and soft drinks were served to increase the informal character of the event. The navigator also invited speakers such as American Express/financial services to talk about saving and investing money. Participants found these activities very useful; however, due to funding shortages, they were discontinued.

Outcomes achieved
Average number of participants served: 75-90 per year
Placement statistics: 50-65% placement rate
Average time to placement: 12 weeks
Reasons for not retaining job: Layoff, company downsizing
Average length of employment: 9.3 months
Average wages:
      FY2002: $10.16
      FY2003: $13.37
      FY2004: $13.77
Range of wages:
      FY2002: $6.75 to $20.00
      FY2003: $7.00 to $60.00
      FY2004: $7.00 to $26.00

The HomeWork Project: ODEP Grant, Boston, MA

HomeWork was a demonstration project funded jointly by ODEP and HUD, one of five national projects funded to provide housing and/or employment for individuals who are chronically homeless and disabled. The project was administered by the Boston Private Industry Council (PIC). The navigator oversaw the grant. She reported that the biggest challenge was to keep all the partners on the same page and the grant moving forward.

Sixteen partnering agencies participated in this project: JobNet, Action for Boston Community Development, Project Place, the New England Shelter for Homeless Veterans, the AIDS Housing Corporation, Bay Cove Human Services, Community Work Services, the City of Boston Department of Neighborhood Development, DMH, the Commonwealth Corporation, the City of Boston Emergency Shelter Commission, Caritas Communities Incorporated, Pine Street Inn, Metropolitan Boston Housing Partnership, and state VR. Five of those agencies (employment service providers) received additional funding to conduct case management.

JobNet was the only career center in the Metro Boston area involved in this project. According to the One-Stop director, JobNet was asked by PIC to take the lead in terms of the operational aspects of this project because of JobNet's background, experience, and expertise in working with the population served under the grant.

The program targeted individuals who were chronically homeless, unstable, and unemployed. To be eligible for the HomeWork project, clients must be
1) Chronically homeless (i.e., living on the streets or in an emergency shelter)
2) Single individuals
3) May be disabled by mental illness, alcohol and/or substance abuse, chronic physical illness, etc.
4) Affiliated with one or more of the participating agencies
5) Receiving (or willing to receive) supportive services
6) Willing to engage in training or job search activities leading to employment

Referral process
There were various tracks within the program, one of which was the DMH track.

Track 1: Direct referral from DMH to HomeWork

DMH contracted with the Justice Resource Institute (JRI; www.jri.org) to provide housing to MH clients who were homeless. Initially, job seekers went through JRI to determine whether or not they were eligible for housing support. If they were, clients then needed to go to the Metropolitan Boston Housing Partnership to have their background (i.e., criminal history) checked. Housing services/supports funded under the grant included individualized housing plan, support services, one-on-one case management, mentoring, and post-placement support.

DMH had housing vouchers that had matched or in-kind support services attached. So DMH clients who had housing vouchers received support services in the same amount. DMH agreed to buy in-kind support services for the fifteen housing slots that are included in the grant/project. In other words, DMH had to serve an additional fifteen homeless job seekers with MH who came through the One-Stop.

Once a DMH client received housing support, he/she was seen by an intake committee that determined whether the client was eligible to receive services under the HomeWork project. The intake committee, comprised of representatives of the fifteen agencies, met every two weeks. At the meeting, staff talked about the individuals who had referred into the program as well as where people were in the program. After clients were accepted into the project/program, they then met with the navigator at JobNet.

Within the committee, one staff person was responsible for ensuring that clients had housing and that the agencies that were contracted to provide housing support did so. She also negotiated housing costs on behalf of clients. Another staff (navigator) was responsible for overseeing the employment piece of the project. Her task was to meet with clients at least once a week and to make sure that they did what they needed to be doing. It is important to mention that clients might or might not use JobNet—the majority of supports were provided in the community. Employment services and supports funded under the grant included assessment, career counseling, employment plan development, benefits counseling, interview skills enhancement, resume development, and job development.

According to the JobNet director, this collaboration would not have happened without funding. She said, "One could not pull anything like this off without funding because it's too big and complicated, too multi-problematic, too multi-faceted to be bought as an incentive."

Blended or "braided" funding
According to the disability navigator, there were instances where Employment Connection partners used blended or braided funding to better serve a client's needs. For instance, MRC covered a client's tuition and the One-Stop provided the client with a uniform, which the agency got from a secondhand shop called "Dress for Success." The navigator said that staff tried to help their clients in many ways, either by having the resources at hand or by having the knowledge of resources/sources.

Staff training and understanding of disability

There was ongoing staff training on disability issues provided by VR, NCWD/A, etc. The disability navigator/VR staff provided formal and informal training and functions in a consultant capacity to One-Stop staff. The navigator reported that, at any time, there was at least one VR staff person at the One-Stop. Through the disability navigator's outreach, JobNet connected with more resources to offer people with disabilities, including MH.

Marketing and community outreach
The navigator did outreach and marketing to the DMH community/population. MH case managers visited the One-Stop regularly.

Surprising Challenges and Remaining Barriers
Funding and specialized personnel helped the One-Stop to achieve better outcomes. According to the One-Stop director, it is very difficult to have an unfunded mandate to provide comprehensive services to customers with disabilities. Funding was needed because without it, one often could not get specialized personnel with specialized skills. This is not to say that only staff with a rehabilitation background can work with persons with disabilities, but it certainly helped to have staff with expertise in this area as a first step. Staff members under DOL were career/employment counselors who concentrated on career development and career exploration. Having the resources to hire specialized staff/VR background was considered a "step into the right direction." The One-Stop director noted that it could be done without funding, namely through partnerships.

Professional perceptions of clients with MH
Professionals (particularly those with clinical mental health training) often underestimated their clients' ability/potential to work. Clinicians' perceptions based on a medical model of mental health constituted a barrier to people with psychiatric disabilities finding employment.

Sustaining efforts without funding or with reduced funding
The JobNet director reported that the One-Stop was still able to provide a reasonable level of services by deploying other staff, but this was not a solution to the problem. JobNet could do that because it was able to hire qualified staff in the beginning. However, if the One-Stop did not get funding for the Employment Connections project next year, the director was concerned about the level of service it would be able to provide.

Surprising Successes and Lessons Learned
Commitment to helping people with disabilities is important
That commitment has to be communicated from the top leadership and management. All staff at JobNet knew that the One-Stop was committed to serving all customers. Leadership nurtured this "integration prospective" among all staff, including partner staff.

Importance of information-sharing
The One-Stop director noted that information-sharing had become a "routine operation." She referred to the career center as a "boutique" because of the complete and total integration of all programs. Staff had to be and were prepared to serve anybody, whether it meant helping a client in the resource room or holding somebody's hand. The philosophy was, "If it's a JobNet job, it's your job." Constant communication and information-sharing are important ingredients for creating such an integrated One-Stop.

Using a One-Stop Center that is a mainstream place may in itself be "therapeutic" for job seekers with disabilities

The One-Stop director said that specialized services were integrated to the extent that one could not see whether or not a client received specialized services.

Agency culture as a barrier to collaboration can be overcome

The One-Stop director reported that at the beginning of the Employment Connections grant, there was much fear on the part of the human service and mental health agencies. Efforts had to be made to dispel the myths and overcome barriers in order to work together on the project. Getting agencies together to talk honestly and openly about similar efforts, set aside their collective "egos," give up a little turf, and admit that each agency was not the be-all and end-all were all challenging.

Importance of having specialized disability staff located at the One-Stop

The One-Stop director advocated for the fact that there should be specialized staff (e.g., a disability navigator) at the One-Stop who understood the needs and barriers of people with disabilities. She highlighted the importance of incorporating unique knowledge and expertise into the fabric of the One-Stop. Having the disability navigator physically located at the One-Stop contributed to the breath and knowledge of the center and its staff. Also, it is not only people with diagnosed mental illness who may need specialized support. Many job seekers experience much emotional stress caused by long-term unemployment and/or unsuccessful job search. It was extremely helpful to have a qualified person who could deal with these issues and educate other staff on how to deal with them.

Interview with Donna DeWeerd, Director of the
North Bay Employment Connection (NBEC), Napa, CA
and with Eric Peterson and Wayne Nash
(CEG Coordinators at the Marin and Napa County One-Stop, respectively)

"Best Practice"

INCLUSION/CEG activities included COMPASS meetings, collaborative case management team meetings, and funding used for customers, including MH transition to VR (braided funding).

Brief Description of the North Bay Employment Connection

The North Bay Employment Connection (NBEC) is a collaboration between the four WIBs of Sonoma, Solano, Napa, and Marin Counties in the northern San Francisco Bay area of California. NBEC received a CEG and was in the fourth year of the grant at the time of this research. One staff person was assigned to each of the One-Stops to coordinate grant activities and build relationships with the agencies that joined the grantee at the One-Stop and provided services through the auspices of the One-Stop Center.

Coordinators were responsible for administering/coordinating the grant at the One-Stop level and monitoring service provision/service providers. Coordinators had a caseload and tracked clients' progress; however, they did not provide job development. Coordinators reported that the majority of the people served under the grant had mental illness. In the case of Napa and Marin, the coordinators also functioned as the disability navigators.

Integration of Services and Joint Service Delivery: Compass Meetings and Ad Hoc Meetings

NBEC used the Compass, "a model of a consumer-centered and driven service delivery system that provide[s] a continuum of services that can be selected by the job seeker based upon identified needs," (NBEC, 2004) to create an integrated One-Stop delivery system. As part of this approach, One-Stop staff, partners, and service providers/vendors met on a regular basis. In addition to the Compass meetings, there were other meetings that took place on an ad hoc basis. The purpose of the collaborative case management meetings was not only to discuss the progress of individual job seekers with disabilities in their job search process but to also talk about systems issues as a whole. According to the coordinators, the collaborative case management meetings were the place where connections were made for a person. Many of the providers were onsite, so the coordinators were constantly in contact with the providers. One of the coordinators said that it felt like "co-case management."

Involvement/Integration of MH and VR Referral Process

The level of involvement of community mental health/mental health service providers varied across counties, ranging from high involvement in the workforce system (Napa) to limited involvement (Marin).

Napa County

VR was a major source of client referral for the INCLUSION/CEG project. The One-Stop contracted with an MH provider to provide training to individuals under the CEG grant. The MH provider operated the so-called "Next Step Employment and Training Services," a sheltered training program that served persons with disabilities, including people with mental illness. In addition to the INCLUSION/CEG project, the DEVELOP program served youth with

disabilities transitioning from school to work. MH was one of the agencies that participated in developing transition plans for this population.

Sonoma County

VR staff were available at the One-Stop and were very active in attracting a special program through the Volunteer Center to place people with disabilities, including those with psychiatric ones, in volunteer positions as a first step towards employment. The One-Stop welcomed the assistance of Community Capers, a social group staffed by MH counselors, and encouraged group members to consider employment. An MH manager participated in the Universal Access Group. The navigator participated on a multidisciplinary team where most often the client had a psychiatric disability. Contacts were maintained through a listserv with various Department of Mental Health staff and community-based organizations.

Marin County

At the time of the interview, the One-Stop was without a weekly VR presence due to budget cuts and concomitant loss of staffing. MH participated in monthly team case management meetings. A partner agency was on site weekly to work with individuals with psychiatric disabilities; the agency provided orientation to its services and VR process, and offered a weekly job club. However, other than local community-based organizations participating at the One-Stop and a community mental health representative attending the One-Stop team case management team meetings, there did not appear to be much effort to encourage participation.

Blended/Braided Funding

The use of blended or braided funding to better serve clients varied among One-Stops. Because not all job seekers with disabilities received funds from or were connected to formal service providers, the Marin County One-Stop used a service-on-demand model with INCLUSION funding transitioning into VR services. The Sonoma County One-Stop used blended funds in a very limited way. Referrals could be made to SonomaWORKS mental health providers. This service was funded by state TANF monies.

Concrete Employment Outcomes Marin County One-Stop Achieved Serving Customers with Mental Illness

Approximately thirty-plus individuals with psychiatric disabilities have found employment, and approximately fifteen have maintained employment for at least six months. Customers served have been involved in work experience, on-the-job trainings, and a computer skills class. Efforts that the One-Stops have undertaken to encourage people with psychiatric disabilities to participate in One-Stop services included DPN outreach, orientation outreach, and speaking to various disability organizations.

Disability Staff Training

The One-Stops used training and partner presentations to encourage One-Stop staff to understand the needs of customers with mental illness. All staff received training on disability, including psychiatric disability. The INCLUSION coordinators reported that after participating in the training, staff felt more comfortable serving people with disabilities. They also reported that staff had become more knowledgeable about disability, including mental illness. The coordinators/disability navigators invited guest speakers to present on disability-related issues. For instance, one guest speaker from a college spoke about the value of the hidden labor market and the issues involved in changing employers' perspectives on people with disabilities. The speaker was an activist in demystifying disability in the employer community. Coordinators also

brought in the Legacy Training (www.employ-ability.org/legacy/help), an online disability training created by the EmployABILITY network in Los Angeles. Legacy had a module on mental health issues.

There was a strong MH presence at the One-Stop in Marin County, which frontline staff have used as a resource. MH agencies provided an orientation to all staff at the One-Stop. VR also provided training to One-Stop staff.

Disability Navigator Program
The disability navigators were part of two projects, CHOICE and COMPASS. (For more detailed information about the project, visit www.northbayemployment.org/projects.html) At Napa and Marin, two staff persons were assigned to each One-Stop: one worked as INCLUSION/CEG coordinator and the other as a disability navigator. Staff worked very closely with one another. In Sonoma and Solano counties, the INCLUSION/CEG coordinator and the disability navigator were the same person. Through disability navigator outreach, One-Stops connected with more resources to offer people with psychiatric disabilities and furthered the process of integrating specialized MH services into the One-Stop.

Efforts to Integrate Business Service Activities and Services to Customers with Psychiatric Disabilities
The INCLUSION job developer connected employers with individuals with psychiatric disabilities. The coordinator at Marin County One-Stop was looking to resurrect a job developer network to best handle employer needs.

Surprising Challenges and Remaining Barriers
Lack of connection to formal services
Staff were surprised at how many people were not connected to any of the formal services. Staff described the CEG money as "glue money."

Connection with and buy-in from the county/community MH systems and agencies
The level of involvement of county or community mental health varied across counties, from no involvement at all (Marin) to being somewhat involved (Napa and the other counties).

Retention
NBEC staff mentioned that helping clients with MH to retain employment continued to be a challenge. To address this issue, One-Stops had started to provide job coach assistance/support from the onset. It was hoped that constant communication with a job coach would have an impact on clients' job retention.

WIA performance standards
The coordinator serving Marin County One-Stop mentioned WIA performance standards as one obstacle to serving job seekers with psychiatric disabilities. He said that in a small county like Marin, this issue seemed to get magnified not only for persons with psychiatric disabilities but anyone with a perceived barrier to employment. There was reluctance to enroll individuals when program dollars and incentive monies were attached to positive outcomes. Any negative outcome could significantly impact a One-Stop in a small locale.

Surprising Successes and Lessons Learned

The numbers of **individuals on general assistance who were not connected to services** before were getting connected through the partner orientation and the job club. As INCLUSION/CEG contracted services with the partner agency, grantees/coordinators required an on-site presence to address One-Stop needs for individuals with psychiatric disabilities (the coordinator from Marin County). **Co-location of agencies** helped to better integrate services. There was a **critical mass of people**, and this kept the initiative alive.

Information from Sources Other Than the Interview

The Compass

JOBS   JOBS

JOBS   JOBS

JOBS   JOBS

Service Providers-Vendors

Menu of Services

Program Navigators

Individual

Napa Personnel Systems
Becoming Independent
P.S.I.
Caminar
I.S.P.'s
Co. Mental Health
Independent Living Centers

Counseling
Job Coaching
Clothes
Training
Social Security
Situational Assessment
Job Placement
Transportation
Micro Enterprise
Personal Agent

Job Shadowing
Tools
Housing
Equipment
Child Care
Work Exp.
Work Adjustment
Employment Prep
O.J.T.

Dream Catcher
Goodwill
T.P.P.
Pride Industries
Buckelew
Social Security
Integrated Community Services
Community College

Cybermill Club House
Workability III

Source: Document entitled "Compass Proposal," retrieved on 11/19/04 from the NBEC website:
http://www.northbayemployment.org/projects_full.html?ID=13

Sample of Local Collaborations as Part of the NBEC CEG

Agency	Contribution/relationship within the workforce delivery system
Independent Living Centers	Participated in regional planning, host agency to benefits planning workshops in the One-Stops, provided support groups for job seekers, link to additional supportive services, advocacy role, source of client referrals
County Mental Health Department, Next Step	Participated in regional planning, implemented customized employment strategies, source of client referrals, Universal Access Workgroup member, Mayor's Committee member
Developmental disability agencies/regional centers	Participated in regional planning, community advocacy and education, policy development, source of client referrals, Mayor's Committee member, Universal Access Workgroup member
State VR	Provided assessments and case management, supportive services, TTY, audio-video instructions and resources, staff and employer training, accessibility evaluations and support, Universal Access Workgroup member, Mayor's Committee member
County Alcohol and Drug Services	Universal Access Workgroup member, staff training and capacity-building
Community-based nonprofits: Goodwill, Becoming Independent, Integrated Community Services, Dream Catchers, Cybermill, etc.	Participated in regional planning, expanded the workforce development system and resources for people with disabilities, staff training and capacity building, source of client referrals, leveraged a number of grant-funded resources with those provided through multiple other partners, Universal Access Workgroup members, Mayor's Committee members
Social Security Administration	Participated in regional planning, provided benefit counselors for customers and Ticket to Work planning assistance, source of client referrals
Mayor's Committee on the Employment of People with Disabilities	Participated in regional focus groups and planning, community advocacy and education, link to Governor's Committee on the Employment of People with Disabilities, staff development and network capacity-building, source of client referrals, engagement and recognition of employers
Workability/School-to-Career	Provided young people with disabilities with an introduction to employment skills and exposure to various occupations, link to adult workforce development system in providing solid transition for newly entering workforce, source of client referrals
Access Ingenuity/assistive technology vendors	Provided information on latest developments in accommodations, equipment and corresponding training for One-Stop staff and partners
State Employment Development Department	One in-kind counselor funded by the governor's initiative with links to additional services, employer relations and services

County Transportation Districts	Participant in local discussions regarding the provision of transportation for people with disabilities
Napa Valley Unified SD	Co-located with One-Stop and provided wages for youth work incentives
College of Marin	Provided vocational training, curriculum testing, and testing development with One-Stop partners
Technical assistance groups: NCWD/A, World Institute on Disability	Provided latest research, information, and technical assistance to grantees to assist in achieving project objectives

Interview with Larry Dale, Chair of the Jefferson Parish (Louisiana) WIB, Director of the Louisiana Business Leadership Network and Pinnacle Employment

<u>"Best Practice"</u>
1) The state MH office helped establish the Louisiana Commission on the Employment of MH Consumers, a policy-level, collaborative initiative led by Larry Dale to increase employment opportunities for people with mental illness.
2) The state MH office contracted with Larry Dale to create cross-agency teams comprised of MH employment counselors and One-Stop staff. The teams functioned not only as a liaison to other MH/workforce personnel but also as a contact and referral point for people with disabilities who wanted to use workforce services.

<u>History of MH Involvement in the Workforce System</u>
Initially, there was very limited involvement of MH in the workforce system. The majority of people with mental illness were either unemployed or, if employed, working in transitional employment.

Larry entered the supported employment field by specializing in the employment of persons with mental illness. He was working as a vendor for Louisiana Rehabilitation Services (state VR) when he realized that an intervention for people with mental illness had to be built into the concept of supported employment, which had come out of the developmental disabilities field. He started Pinnacle Employment, the first supported employment program for persons with mental illness in the state. According to Larry, working with VR to put his ideas into practice was challenging.

Larry's initiative coincided with a shift in focus on employment within the Louisiana Office for Mental Health. According to Larry, two people within the state MH office started to understand the link between employment and fewer incidences of hospitalization. As a result, MH contracted with Larry to work on increasing opportunities for persons with mental illness in Louisiana.

<u>Using Collaborative Groups/Cross-Agency Teams to Better Connect MH and Workforce at the Service Delivery Level</u>
Initially, MH wanted to focus on persons with mental illness only, but Larry convinced the MH officials to look at employment more globally. The plan was to link the MH and workforce systems by creating collaborative groups or cross-agency teams. Comprised of MH employment coordinators and One-Stop employees, the teams functioned not only as liaisons to other staff but also as a contact and referral point for people with disabilities who wanted to use workforce services. The MH employment coordinators were located at the regional MH office in each of the regions in the state, while One-Stop staff worked out of the career centers. For instance, in Jefferson Parish a team was created that consisted of two MH employment coordinators and two One-Stop staff members. The MH employment coordinators received training on workforce issues. DOL staff identified two staff at the Jefferson Parish One-Stop who became the liaison to the MH system. Identified One-Stop staff were trained on MH-related issues.

At the time of the interview, collaborative groups/cross-agency teams had been set up in four of the eighteen areas (Jefferson Parish, Orleans Parish, Baton Rouge, Houma) of the state. Efforts were being made to expand this network and replicate the initiative in the rest of the state. Also, MH employment coordinators and One-Stop staff did not work full-time on this initiative. In

other words, participating in this initiative became an additional responsibility. Ongoing training and education helped to get staff to buy into this project.

Collaboration/Client Referral Process
Previously, there had been limited referral of clients from MH to the One-Stop Center. MH clients referred to the One-Stop were automatically referred to VR. This situation changed once the cross-agency teams were in place.

MH clients referred to the One-Stop met with one of the One-Stop staff liaisons. In most cases, the MH employment coordinator accompanied the MH client to the One-Stop (direct referral from MH to the One-Stop). The coordinator introduced the client to one of the two contact people at the One-Stop, who then worked with the client on the employment piece. In some instances, One-Stop staff referred clients to the Louisiana Business Leadership Network (LBLN; www.lbln.org). MH employment coordinators continued to meet with customers on an ongoing basis to do career exploration and help with the job search.

Some MH clients chose not to be accompanied by their MH employment coordinator. In this case, clients were given the information of the contact person at the One-Stop. Efforts were made by One-Stop staff to accommodate not only clients diagnosed with MH but also those who were unidentified. As the chair of the Jefferson Parish WIB, the director of LBLN, and an MH specialist, Larry had resources and contacts at hand who helped implement this initiative.

Integration of MH Services into the Workforce System
Formal activities
The MH employment coordinators engaged in a number of activities:
1) Accompanied individuals to the One-Stop and oriented them to available services
2) Called One-Stop staff, informed them of an individual's needs, and obtained the name of someone who could best help the person once they were at the One-Stop
3) Communicated with One-Stop staff on an as-needed basis about mutual clients via email and telephone as well as in person
4) Offered to provide MH training to One-Stop staff
5) Advocated for services such as transportation, training, individualized employment counseling, and individualized resume help
6) Assisted people with mental illness to navigate the One-Stop services and informed them of available services
7) Developed and distributed an employment resource directory that included detailed information about One-Stop services
8) Asked for and facilitated One-Stop staff presentations to the MH and addictive disorders staff on One-Stop services
9) Spoke to supported employment vendors and MH case managers about the services the One-Stop provided, and offered suggestions on how their clients could use the service
10) Participated in monthly employment partnership meetings
11) Participated in the Business Advisory Council and the Universal Access Committee

Integration of MH Services into the Workforce System
Informal activities
In addition to the formal activities listed above, the One-Stop (i.e., operations manager) made efforts to encourage people with psychiatric disabilities to participate in One-Stop services. The operations manager and others at the One-Stop were very welcoming to these customers. They

were willing to meet with them one-on-one on an ongoing basis to provide encouragement, support, and employment services. Customers were given advice on how to write a resume that minimized gaps in employment. Further, the MH employment coordinator advocated to the One-Stop's operations manager for transportation services for a customer who had an anxiety disorder and was unable to take the bus to the West Bank. The operations manager had one of his staff pick the customer up at her house on an ongoing basis. The customer is now employed and receiving training services.

Staff Training
According to Larry, who was contracted by the state MH office to provide training, One-Stop staff members' understanding of disability varied. Larry trained MH staff on workforce issues and One-Stop staff on disability issues. The training had the additional, informal purpose of giving staff an opportunity to meet and network with one another as well as staff from other (non-MH/workforce) agencies. As part of the training, Larry invited staff from other agencies to meet with MH staff. In these meetings, staff had to sit with their counterparts from other agencies instead of their own agency staff. This was an important move to facilitate linkage-building and networking.

Linking MH and Workforce: Louisiana Commission on the Employment of MH Consumers
The state MH office reached out to the legislature with a joint resolution. The resolution called for a year-long commission that involved the heads of all the major state agencies, the legislature, the employer community, and consumers with MH to provide recommendations on how to improve employment opportunities for people with mental illness. The deadline for submission of the report, including recommendations, was set for March 2005.

As a result, the Louisiana Commission on the Employment of MH Consumers was established. Agencies involved in this initiative included VR Benefits Planning, Association of Louisiana, consumers, Office of MH, SSA, the justice system, the Baton Rouge Area VR, HR Authority, Medicaid, LBLN, Legislature (on the commission), the Indian Tribe VR, DOL, Workforce Commission, and Jefferson Parish WIBs.

At the time of the interview, the commission had met twice and was led by Larry. The first step in developing a list of recommendations was to identify existing barriers in serving people with mental illness. To do so, the committee conducted a survey of agencies involved in service provision for people with mental illness as well as recipients of MH services. In addition, the committee conducted a national search on barriers to serving individuals with mental illness. To stimulate creativity among participants, the committee created three working groups, including the Education Cross-Training Subcommittee and the Specialized Service Options Subcommittee. Each committee had to look at the barriers and come up with suggestions for resolution. This information was incorporated into the recommendations included at the conclusion of this case study.

Other Collaborations/MH Initiatives
The Office of MH funded a similar initiative to stimulate collaboration among agencies involved in working with transition-age youth with disabilities. Developmental Disabilities and the Medicaid Purchase Plan joined the group of funders. Larry provided training on transition in Baton Rouge, bringing together staff from the school system, workforce, DOL, Developmental Disabilities, substance abuse/addiction, VR, and MH. The training was held at the One-Stop and was perceived positively by the participants. Larry noted that there was a real sense of

commitment on the part of participants to help young adults with disabilities transition into the world of work.

Integrating Business Services and Services for People with Psychiatric Disabilities

LBLN was established through a contract with the state Office of MH. The network operated at various levels, spanning local and state as well as service delivery and policy. At the local/service-delivery level, LBLN had staff members located at the New Orleans One-Stop to provide direct services to job seekers with disabilities. In addition, LBLN staff were actively involved outside the One-Stop, linking the career center with the local business community. At the state level, LBLN organized statewide job fairs with the agency that oversaw that Louisiana Medicaid Purchase. Finally, at the policy level, LBLN staff were actively involved in the Louisiana Commission on the Employment of MH Consumers, making recommendations for improving the workforce service delivery system for both job seekers with mental illness and employers.

Surprising Challenges and Remaining Barriers

There was a continuing need to **dispel the myth that people with disabilities cannot work.** Larry noted that working with professionals who still believed that people with disabilities including those with mental illness were not able to work was challenging. Agencies had **interagency agreements** mandated by law but without any practical use. Additionally, getting people to **meet with one another** on a personal level was challenging. Once people got to know each other, they started to identify similarities—a step toward working with one another. Larry identified a need to do inreach, not only outreach.

Surprising Successes and Lessons Learned

"Systems don't work together, people do." Systems were not set up to work with one another; instead systems separated staff (and their clients) from one another. According to Larry, it was important to get people at the local level to meet across systems and communicate with one another. This allowed people to develop ways to cut through barriers.

Education Cross-Training Committee
The committee met on Tuesday, October 5, 2004. The following members were present: Lanor Curole, Cheryl Steckly, Elaine Richard, and Larry Dale. David Lajaune with BPAO joined.

I. Areas of concentration

Five areas of concentration were identified based on the generalized list of barriers identified during the last commission meeting:
1) Outreach and education to consumers
2) Outreach and education to employers
3) Inreach (**def: education and the development of a sense of ownership from within an agency**) among agencies providing services to mental health consumers
4) Cross-training among agencies providing services to mental health consumers
5) Community education

II. Review of barriers

Each of the ten previously identified barriers was examined to determine if the barrier fit within one of the above areas of concentration. All but two barriers fit; however, the two that didn't were believed by the committee to not fit the purpose of the committee.

"If the employment does not offer a career opportunity with health benefits." This item was believed to be more of a concern with access to care. Recommended that Committee 3 revisit this barrier.

"Not enough entrepreneurship opportunities or training in entrepreneurship." This item was believed to be a better fit for either Committee 1 or Committee 3 as it appears to be more closely linked with service provision.

III. Solutions/problem-solving

After agreeing to the above areas of concentration, the following information was identified as solutions to overcoming the related barriers.
1) <u>Outreach and education to consumers</u>
   * Benefits planning awareness
   * Awareness of employment options, including supports and services available
   * Recognition of work as a therapy to good mental health, employment as part of recovery and wellness
   * Increasing a sense of self-worth
   * Training regarding disclosure to employers regarding condition and possible criminal history, acknowledging that disclosure may not be necessary but could be beneficial
   * Compliance with a treatment plan
2) <u>Outreach and education to employers</u>
   * Disproving myths of mental illness
   * Training focusing on the legal knowledge of disability employment laws presented non-threateningly, awareness of the 2nd Injury Fund
   * Approaching workman's compensation system as a partner (source of fear for employers)
   * Understanding a criminal history related to mental health consumers
3) <u>Inreach to agencies providing services to mental health consumers</u>

- Understanding how employment is a part of recovery and related to the individual agency's mission
- "Where does my job within my agency fit into the big picture?" Connecting the dots
- Understanding and clearly defining noncompliance and identifying the individualized reasons for noncompliance and finding solutions as opposed to automatic case closure
- Training on multicultural issues
4) <u>Cross-training among agencies providing services to mental health consumers</u>
    - Creating a pool of agency "menus" of services, eligibility criteria, conditions of service delivery, restrictions, mission, etc. (**The intent is to create a larger picture of how agencies are interdependent to effectively serve consumers**.)
    - Disproving myths of mental illness and perceptions of other agencies
    - Awareness of benefits planning services
    - Stressing a team approach to serving mental health consumers
    - Networking among agency staff on a local level
    - Training on multicultural issues
5) <u>Community education</u>
    - Disproving myths of mental illness (media campaign)

IV. Agency involvement and participation

The committee identified the below list of fifteen agencies and organizations that play a critical role in the complete delivery of services to mental health consumers. The belief is that these agencies' varied menus of services are interconnected to create a bigger picture for the consumer. When the agencies connect on behalf of the consumer, the consumer is better able to reach his/her goals and reach their employment potential. However, when these agencies do not connect, the individual can be impeded in moving forward.

1) Office of Mental Health
2) Louisiana Rehabilitation Services
3) Department of Labor
4) Department of Education/Transition
5) Benefits Planning, Assistance, and Outreach
6) Medicaid Purchase Plan
7) Workforce programs including parish-level Community Action and Block Grants
8) Social Security Administration
9) Families Helping Families
10) Office of Addictive Disorders
11) Office for Citizens with Developmental Disabilities
12) Office of Family Support
13) Department of Justice (penal system)
14) Governor's Office of Disability Affairs
15) Centers for Independent Living

V. Future plans and recommendations

The committee is seeking input from the Commission to ensure agreement with the previously listed areas of concentration and list of agencies playing a critical role in the employment success of mental health consumers.

In order to further develop the committee's recommended solutions, the committee is requesting the following information from the identified agencies:

1) A menu of services available including eligibility criteria, conditions of service delivery, restrictions, mission, etc.
2) Whether or not the agency conducts outreach and education to mental health consumers and employers. Agencies should indicate if funding is designated for this use.
3) Whether or not inreach and cross-training activities take place within the organization related to serving mental health consumers. Agencies should indicate if funding is designated for this use.
4) Whether or not cross-community education programs, campaigns, etc. are provided by the agency. Agencies should indicate if funding is designated for this use.

Louisiana Commission on the Employment of MH Consumers
Specialized Service Options
SUBCOMMITTEE MEETING
10-07-04

Specialized Service Options
- Focus on evidence-based practices
- More inclusiveness in all agencies (WIA, etc.)

Recommendations	Cost	Cost-neutral
LRS needs specialized "mental health" caseloads in each region of the state.	X	
Structured collaboration among the agencies facilitated through a central network such as Mental Health Association in Louisiana or LBLN.		X
Education/special service component for mental health consumers and mental health issues within the Office of Student Disability Services should be available on every public post-secondary education campus (e.g., colleges and universities, Louisiana technical college).	X	
Specialized vendorship in each region of the state with evidence-based practices/options/menu of services for individuals with mental illness (e.g., LA Hire in Baton Rouge region).		X
Address co-occurring disabilities (mental illness and addiction). Louisiana has received Access to Recovery grant of $22 million to increase capacity of services. Priority is to serve adolescents, women, and women with dependent children. Cosig grant of $3.2 million (Louisiana integrated treatment services) covers all populations. Need to ensure that Access to Recovery and Cosig grants work together.		X
Market to employers the benefits of employing persons with mental illness and marketing their product to persons with disabilities. LBLN is a nonprofit organization that addresses these issues in the New Orleans area. LBLN needs to be expanded statewide.	X	
Office of Mental Health (OMH) and Human Service Districts needs adequate funding to provide treatment and support services to the current target population.	X	
OMH needs the funding to expand support services to meet the employment needs of persons with mental illness (i.e., the IPS model/case management services as those funded by Capital Area Human Services District). Persons with mental illness can maintain access to psychiatric rehabilitation Medicaid money; however, they must maintain Medicaid eligibility to have access to the funds (see www.mhrs.la.org).	X	
Need to expand access to mental health treatment for adolescents and adults in the community who do not meet	X	

current, stringent (OMH) criteria for services.		
An integral part of ensuring success and employment for mental health consumers is training mental health consumers who in turn provide input and training to employment providers regarding the needs of persons with mental illness. See C-PASS, a three-year, $500k grant with two years remaining. Need the ability to continue funding this type of activity after the grant expires. Note: Medicaid also realizes that evidence-based practices to include peer supports are important, and wants to look at this in the future.	X	
OMH needs a permanent full-time employment coordinator in each region/human service district of the state. This person would be responsible for consumer/public education regarding employment-related issues.	X	

6) Interview with Don Lavin, VP of Rise, Inc. (Anoka, MN)

"Best Practice"
1) Multiplicity of funding streams
2) Funding white-collar positions
3) Links with schools and transition services to youth with emotional behavioral problems

Brief History of Rise's Involvement with the Workforce System

Rise is a private, not-for-profit 501(c)(3) corporation that organized in 1971 to meet the employment needs of people with disabilities in the Twin Cities and central Minnesota. The agency has a thirty-three-year history of providing person-centered services to improve the employability and community integration of adults with serious mental illnesses. Rise provides customized employment, housing, homelessness outreach, supported living, school-to-work transition, and community case management services.

In 1978, Rise launched the first supported employment program in Minnesota for adults with serious mental illness through the assistance of a community support grant. At the time of this research, the agency operated eleven autonomous programs for adults or youth with mental health or emotional disabilities. In 2003, these programs provided support services for 962 adults with serious mental illness, with 510 obtaining integrated competitive or supported employment.

Rise has had many years of experience managing job placement, employment, and community rehabilitation programs that include collaborative, interagency partnerships and operational designs. Rise seeks to create partnerships that offer opportunities to integrate, blend, and braid available expertise and funding to achieve high-quality employment outcomes for consumers of mental health services. This includes creating service delivery partnerships with federal, state, regional, and county agencies, secondary and post-secondary schools, regional treatment and mental health centers, consumer and mental health advocacy agencies, employer and business associations, and core workforce center partner agencies.

Rise is a long-standing partner of local workforce centers serving the regions and counties where the organization delivers its employability services. It maintains formal written interagency agreements, MOUs, purchase of service agreements, and program service contracts with local workforce centers, counties, state agencies, and other partners that serve the target disability populations. As Don stated, "Rise is committed to collaborative relationships with agencies that have a shared purpose and service philosophy to improve employment and other quality-of-life outcomes for adults in the communities where we deliver services."

Rise Program Accomplishments and Recognitions

Rise and its mental health employment programs have received numerous awards and recognitions for their efforts in developing supported employment for youth and adults with disabilities.

Areas of expertise and innovation
Supported employment
Rise's program featured rapid, individualized job placement and support methods to develop integrated employment for consumers with serious mental illness as possible. Rise also recognized the importance of customizing employment, educating employers, and planning for job accommodations to increase employment stability for participants placed. Rise was an active

advocate concerning the conversion of traditional mental health day treatment and sheltered employment approaches to customized and supported employment.

Assertive case management

Rise actively participated in a local assertive case management treatment team to ensure that supported employment was a core component of each individual's mental health treatment plan. One program, Custom Futures, ensured that supported employment expertise was available to the assertive case management treatment team as it planned and delivered services for individuals who were presently hospitalized or at highest risk of hospitalization due to serious mental illness.

Self-help employment strategies

For fifteen years, Rise served as the umbrella administrative agency for a self-help, national demonstration project for adults with psychiatric disabilities. Minnesota Mainstream offered job placement support for adults with serious mental illness who had post-secondary education and training. This supported employment program employed professional staff with mental illness and received national acclaim for breaking down barriers to career ladder employment, including self-employment. Many of the concepts pioneered by Minnesota Mainstream have been integrated within Rise's current mental health employability service model.

Career-ladder employment

Rise's Career Trek program was a five-year federal project demonstration grant funded by RSA. Career Trek, a collaborative partnership with the Consumer/Survivor Network of Minnesota, demonstrated that unemployed and underemployed adults with serious mental illness could work in career-ladder jobs with higher levels of pay when customized employment was available. Career Trek demonstrated the importance of using a career development service model and mentoring concepts for youth and adults with serious mental illness.

School-to-work transition

In the past ten years, Rise had been the lead agency for three school-to-work transition program demonstrations for students with serious emotional disturbances and emotional-behavioral disabilities. The organization developed expertise around strategies of interagency transition planning and engaging seamless employment services for young adults with disabilities leaving secondary education programs. This initiative included an ODEP-funded comprehensive interagency partnership with the Workforce Center serving Anoka County called Transition and Customized Employment. This project worked to improve job placement outcomes for youth and young adults with disabilities by refreshing agency policies, studying new service strategies, integrating cross-systems resources, and mapping new pathways to employment for 150 youth with disabilities annually, 65% of whom had emotional, behavioral, or mental health disabilities.

Disability program navigator

Rise was co-manager and partner in the Stearns-Benton Workforce Solutions program funded by ETA. Rise employed a disability program navigator at the Stearns-Benton Workforce Center in St. Cloud. The navigator was responsible for providing information, advocacy, and service systems support to Workforce Center customers with serious mental illness. The navigator helped connect customers to services they wanted or needed, whether inside or outside the Workforce Center system, so they could increase their opportunities to go to work. The program offered assistance with SSA work incentives and information about employment programs and services available to youth and adults with serious mental illness living in central Minnesota.

        <u>Blending and braiding funding streams</u>
The availability of supported employment often depends on the abilities of organizations to integrate and braid funding streams available to eligible individuals with serious mental illness. Rise developed expertise in broadening and managing multiple funding opportunities driven by complex disability and service eligibility criteria. This included funding mechanisms within the One-Stop public service system, state community rehabilitation, secondary and post-secondary education, state and county mental health, federal medical assistance, Social Security disability work incentives, county human services, industry, and private foundation sources.

        <u>Outreach to diverse service populations</u>
Rise delivered its program services to a wide range of youth and adults with serious mental illness within diverse education and human service systems. The agency drew upon its broad staff expertise and funding capacities to deliver employability services to individuals with serious mental illness from complex service delivery systems and networks. Populations included youth and young adults in transition from high school to employment and careers, college and other post-secondary education students, veterans, refugees and immigrants with limited English proficiency, welfare recipients, hospitalized or institutionalized adults, homeless individuals, high school dropouts, individuals with dual diagnoses of mental illness and chemical dependency, and other unemployed customers of Minnesota's workforce system.

Publications
Rise staff wrote and produced seven publications to share the agency's vision and experiences about the critical importance of integrated employment practices for adults with disabilities. One of these publications, *Working on the Dream: A Guide to Career Planning and Job Success,* was written specifically for adults who live with serious mental illness. This publication was co-authored by a Rise job placement professional who was also a mental health consumer.

Awards and recognitions
Rise was named Minnesota's Outstanding Community Rehabilitation Agency of the Year three times in a twelve-year span. In 1990, Minnesota Mainstream was cited as a promising employment service model in the *Torrey Report.* Minnesota Mainstream was awarded exemplary program status by the North Central Regional Information Exchange in 1993. Rise staff have received numerous awards, including the Empowerment Award by the Minnesota Association of Community Rehabilitation Organizations for contributions made to the delivery of career-ladder services and better wage outcomes for adults with serious mental illness. Rise received national recognition and was cited as a promising service practice for its school-to-work transition services for youth and young adults with mental health disabilities by the North Central Regional Information Exchange and the National Center on Secondary Education and Transition at the University of Minnesota. In 2004, Rise's Somali Employment Solutions program received an award from the National Association of Counties for its pioneering work in developing cross-cultural diagnostic disability testing, referral, and connections to supported employment for welfare recipients who are refugees with serious mental illness and limited English proficiency.

Barriers and Myths Concerning Adults with Serious Mental Illness and Employment
Don noted: "The unemployment and underemployment problems of adults with serious mental illness are not grounded in facts, but rather in a number of commonly held myths. These include the following: 1) mental health consumers don't want to work; 2) they can't work because of their illness symptoms; 3) they can't work because they will lose their public benefits; and 4) they can only work in unskilled jobs requiring low stress and technical skills sets. In Rise's long

history of experience, none of these stubbornly held myths are standing the test of objective scrutiny.

"Many people believe that adults with serious mental illness need to **recover** before they can go to work. However, many adults recover **because** they go to work, have structure in their lives, earn money, have opportunities to connect with others, and gain a sense of self-respect through personal achievement.… Most of these individuals can go to work and make a smooth transition from disability benefits if they receive expert planning to determine the impact of working and ensure basic living supports are in place. In the state of Minnesota, the Work Incentive Connection, a program funded by SSA, educates disability beneficiaries about SSA's work incentives programs and offers customized guidance about planning for self-support.

Finally, new customized employment initiatives such as the Rise Career Trek program are demonstrating that adults with serious mental illness need not be limited to unskilled or menial labor positions. People with post-secondary education, training, and skilled employment experiences are gaining access to well paid jobs in the range of $10.00-$14.00 per hour for all trial sites. In summary, the staggering unemployment of adults with serious mental illness is driven by a blend of unfounded fears, misinformation, and service delivery barriers. As the facts continue to accumulate, there is a moral obligation for communities serving adults with serious mental illness to use current and reliable information to improve basic quality of life factors. **The facts are now clear that working is fundamental to mental health recovery.**"

Policy Recommendations from Rise to Improve the Employment of Adults with Psychiatric Disabilities
Because Rise has such a longstanding commitment to excellence in this field and has undertaken such a wide variety of programmatic initiatives to enhance employment success, the primary author asked Don to offer some considered recommendations from his position as a senior administrator of long standing at Rise. He graciously offered to do so, and his recommendations are offered below. While not necessarily endorsing each one, the authors feel they deserve inclusion as they represent a thoughtful needs analysis from one of the established leaders in the disability, employment, and workforce development fields.

Based on its many years of experience in the delivery of job placement and employment services for adults with serious mental illness, Rise and Don recommended that the following policies and principles be incorporated into the design of local service delivery strategies:

- A **new community vision** about mental health recovery must be galvanized and embrace an unmistakable, clear expectation that a majority of people with serious mental illness can and should go to work.
- **Public education and training about mental health recovery and evidence-based practices** need to be communicated to all stakeholders, including MH consumers, family members, MH treatment professionals, community rehabilitation providers, employers, and government policymakers.
- **Consumer advocacy organizations need to assume a leadership role** in educating consumers and their families about mental health recovery principles and programs that work.
- **State and county governments need to participate** by helping to identify people with serious mental illness who are not presently working so baseline markers are established to document future mental health systems performance improvements.

- State, county, and community mental health service providers **must share job placement performance goals** so increased numbers of people with serious mental illness go to work.
- **Federal, state, and local public policies must be reformed** to maximize the enrollment of all eligible mental health consumers into job placement and supported employment services.
- **Public policies that restrict or discourage employment eligibility must be broadened** to the fullest extent possible so anyone who is unemployed or underemployed due to a mental illness is encouraged to work and rewarded by doing so.
- Secondary education and interagency **school-to-work transition policies need to be reformed** so young adults with serious emotional disturbances and emotional-behavioral disabilities can be connected to appropriate adult mental health treatment services and obtain sustainable competitive employment as the highest priority.
- **Traditional mental health service interventions need to be overhauled** (e.g., day treatment, sheltered employment) in favor of programs that embrace evidence-based practices including customized and supported employment strategies.
- Expert **Social Security disability benefits planning needs to be expanded and integrated** within existing community mental health service systems to increase consumer knowledge about work incentives and reduce fears about the potential loss of cash and health care benefits.
- Cost-efficient **funding models that maximize the use and braiding of federal, state, and local resources** need to be pioneered, communicated, and implemented at the community mental health systems level to increase job placement and customized employment outcomes for the greatest number of adults possible.
- Nationwide training and technical assistance need to be augmented **increase staff expertise about evidence-based practices in psychiatric rehabilitation and job placement strategies** for adults with serious mental illness. Audiences should include community mental health providers; state, county, and community case management agencies; VR and community rehabilitation agencies; and supported employment programs.
- The guidance and expertise of business associations such as state BLNs, Employers Associations, and other local employer groups (e.g., Chambers of Commerce) needs to be engaged to **marshal the technical support of businesses in improving training and job placement outcomes** for adults with psychiatric disabilities.
- Collaborative agreements with post-secondary education programs (including technical colleges, community colleges, and four-year universities) needs to be established to promote supported education opportunities, customized adult learning, and skills leading to **career-ladder job progression** and the diversion of potential long-term SSA disability entitlement applicants.
- **Job placement performance outcomes** for adults with serious mental illness **need to be objectively measured** and communicated by state and county authorities to increase accountability in relation to established goals.
- New methods to increase conversion of existing SSA beneficiaries need to be implemented by restructuring the delivery of mental health treatment and rehabilitation services and **using public entitlements as work incentive tools instead of models of long-term financial dependency.**
- **Evidence-based practices and employment outcome findings must be broadly communicated** by SSA and other federal agencies to public and private organizations to introduce new methods for improving the job placement and self-sufficiency of adults with mental illness, thereby improving diversionary techniques for future applicants of

disability entitlements and conversion strategies for existing SSI and Social Security Disability Insurance (SSDI) beneficiaries.

Interview with Carol Thacker from PRS, Inc.

"Best Practice"

1) MH agency (PRS, Inc.) acted as a liaison/conduit between the local MH system/Community Services Boards (CSBs) and the workforce/One-Stop system.
2) Activities to better integrate MH services and workforce services included PRS staff participation in One-Stop CQI meetings and a pilot project conducted by PRS and One-Stop partners to improve the identification of persons with mental illness as part of the One-Stop intake/referral process.

Brief Overview and History of PRS, Inc.

PRS was established in 1963 (CARF-accredited). The agency is headquartered in Falls Church, VA and provides community-based psychiatric rehabilitation, including day support, residential, and employment services to individuals with mental illness.

PRS started its work with people with psychiatric disabilities by helping them transition into the community. The agency soon realized that employment was a valuable treatment option that needed to be part of a person's recovery process. The founding executive director understood the concept of recovery early on and started implementing it.

At the time, PRS was still operating both supported and sheltered employment. PRS moved its sheltered employment program to a small business model, which was very limiting. What staff found was that clients would get comfortable working for PRS even at competitive wages and would not move on into the community. It was then that the agency decided to transition from providing sheltered or small business opportunities for these clients and provide competitive and supported employment instead.

PRS continued to provide enclaves as appropriate. The director of employment services reported that most of the clients preferred to work in supported employment or work independently. There were some NISH enclaves in the area and PRS referred some employment clients to those enclaves. At the time of the interview, PRS was in the NISH system but did not have a NISH contract. The director said that PRS would like a NISH contract because the organization wanted "a real spectrum of services."

Carol Thacker worked as the director of employment services at PRS. Initially, the organization had site-based directors, and she was one of them. Then PRS determined that there had been so much change (e.g., the day program had gone fee-for-service; employment services had grown exponentially; PRS had started providing employment services to TANF clients) that it was better for senior managers to focus their skills in a content area rather using than a site-based approach.

The MH System in Virginia/Employment Focus (Background)

Virginia had a very fragmented MH system. Local jurisdictions were allowed to govern themselves, and their mental health services were operated and managed by these CSBs. (For more detailed information about the CSBs, check www.wsh.state.va.us/CSB.com.) Several counties in the more rural areas joined together to develop a CSB. In the urban areas, each county was its own CSB system. CSBs had responsibility for some funding and the state facilities (state hospitals). Carol noted that Virginia had a very long history of utilizing state facilities as housing alternatives. The jurisdictions have been challenged—through the Olmstead Court

Decision and the President's New Freedom Initiative—to find the monies to provide residential housing. The cost of living/housing index in Virginia was one of the highest in the nation. Because of this, local jurisdictions had a hard time finding affordable housing and the services and supports to go along with that.

However, the state continued to "warehouse" clients at the state facilities, and the local CSBs took responsibility for providing the services they thought were needed. So the state only gave guidance as to what should be a best practice. The state did not determine what that best practice was. This was an ongoing challenge, especially in regard to employment. Some CSBs took employment very seriously, but others did not see it as a viable option. PRS dealt with several different CSBs, not all of which had a focus on employment.

Collaboration with the MH System and Workforce System/One-Stops
PRS worked with the following agencies:
1) Fairfax County (1.2 million residents) CSB—Fairfax One-Stop system
2) Lowden County CSB—Lowden One-Stop system
3) Arlington CSB—Arlington One-Stop system

PRS had different experiences with different One-Stops. Overall, One-Stops did not reach out to PRS as a partner. **Example of Fairfax County**: When the One-Stop system came to be, another MH agency (Service Source) in the Fairfax County area was given the funding to provide services to people with psychiatric disabilities at the One-Stops. PRS still made an effort and eventually became a One-Stop partner.

PRS was not given permanent space at any of the One-Stops. This was because One-Stops already had specialized/MH staff who dealt with individuals with psychiatric disabilities. As a result, PRS had to limit the kinds of services and supports provided to clients at the One-Stop. One of the major challenges for PRS, a private nonprofit agency operating on a fee-for-service model, was to provide support without any major funding. When PRS started partnering with the One-Stops, the organization had a county contract (block grant) and employment was part of the contract. PRS was able to use the time to support individuals with mental illness at the One-Stops; PRS staff also attended One-Stop partner meetings and gave input. As PRS saw its input not utilized and not paid for by the One-Stops, the organization decided to limit its involvement.

Communication and Collaboration with the One-Stops
PRS had three sites, which were located strategically near the One-Stop Centers. Subcontracted by Fairfax County, PRS was actively involved in the One-Stops (e.g., PRS staff participated in One-Stop CQI meetings). PRS staff had a good understanding of each of the One-Stop systems. However, when PRS switched to fee-for-service in July 2001, the agency had to narrow the scope of its One-Stop involvement. After that time, PRS staff only sporadically participated in the CQI meetings at the different One-Stops. PRS did not expect its managers to be completely on a fee-for-service mandate, but managers were responsible for having 35% of their time charged as billable direct services. PRS has been involved in CQI efforts/activities, which were part of the One-Stop certification process.

Integration of VR and the Referral Process
Partnerships (i.e., VR and its vendors) had been put in place by VR prior to the development of the One-Stop system. VR had historically been seen in Virginia as serving its clients with

psychiatric disabilities reasonably well. VR also reached out to the One-Stops, which became an important service piece for those customers who were not identified as carrying a mental illness diagnosis.

The regional VR manager in Fairfax County played an important role in integrating VR into the One-Stops. One-Stop frontline staff referred clients with mental illness either to Service Source (an MH agency contracted by the One-Stop under the ODEP grant to provide employment services to such customers) or VR (co-located at the One-Stop). In the latter case, VR counselors referred individuals with mental illness to PRS because PRS was a vendor in the VR system (third-party referral).

Identifying individuals with psychiatric disabilities who used One-Stop services continued to be a barrier to effective service delivery. At one of the One-Stops in Fairfax County it was the receptionist (an untrained clinician) who managed the referral process, a situation that caused concern to PRS and the regional VR manager. To address this issue, PRS in collaboration with VR and the One-Stop were planning a pilot to look at the intake system; the goal was to find ways to better identify and refer out people with psychiatric disabilities when needed.

PRS/One-Stop Service Integration
One-Stop Centers were stretched to their full capacity. According to the director, PRS thought of the One-Stop not as a resource but as a clearinghouse for providing services.

Blended/Joint Funding
The Virginia state government provided funding for long-term support that agencies could use to help people with disabilities maintain employment. The funding was managed by the state VR but was not part of the VR budget. PRS had a history of demonstrating the long-term need for those dollars. The agency continued to use the money, especially for those clients who did not need intensive case management but just some support to maintain employment. The director reported that this funding source had been extremely useful.

Staff Training
The Arlington One-Stop asked PRS to provide training on recognizing and supporting people with hidden disabilities. Training consisted of a Powerpoint presentation on recognizing a hidden disability and discussions with participants about what a hidden disability looked like diagnostically, including treatment options and how to support an individual with a hidden disability at the One-Stop. In addition to providing disability training, PRS staff tried to reinforce the importance of being connected with the local MH/CSB system. PRS offered the same training to the One-Stop Center in Fairfax County. Because of the ODEP grant (which provided funding for MH/Service Source staff to be co-located at the One-Stop) Fairfax County One-Stop management believed that staff was very well educated in recognizing hidden disabilities.

Mentor Program
Skill Source (an MH agency and ODEP grantee) subcontracted with PRS to develop a mentor program for individuals with psychiatric disabilities. This program was not directly linked to the One-Stop, a situation that the director described as problematic. Mentors were former mental health consumers of PRS services and provided support with identifying mentees. Mentors were paid for their services through the grant. According to the director, mentoring had been incredibly successful and had become a valuable part of clients' recovery process.

Efforts That the MH System/CSBs Made to Connect with the Workforce System
Overall, there was a lack of knowledge around recovery within the MH system of care. According to the director, Virginia was finally awakening to the idea of recovery. A conference on recovery was to be held in December 2004 at the state capital; PRS staff were planning to present on supported employment for individuals with serious mental illness at the conference. The director also mentioned that the state MH system had a CMS grant to look at best practices (including supported employment) and that the MH officials were aware of the need for more training and education around supported and customized employment in the state.

Relationship Between the CSBs and the One-Stop/Focus on Employment
The level of collaboration between CSBs and One-Stops varied depending on the county/region. For instance, Arlington was a large county with a well established One-Stop system. However, until recently there had been no links between the Fairfax MH system and the One-Stop system. The CSB operated its employment service out of a clubhouse, which it did not expand. VR used its own vendors (including PRS) to provide employment services to its clients with psychiatric disabilities. It was PRS that encouraged the One-Stop to connect with the CSB.

PRS was also involved with the Fairfax MH and workforce development systems. Previously, the Fairfax County/CSB had provided block grants to agencies including PRS to provide day and employment services. The county then decided to have more direct control over the recovery process and changed the contracting process to fee-for-service. As a result, PRS won the contract for day services (a psychosocial clubhouse) but was only awarded a small portion to provide employment services. A larger portion (a fixed-rate contract, not a fee-for-service contract) was awarded to another MH agency to provide employment services at the One-Stops.

How to Better Connect/Integrate the MH and One-Stop Systems
According to Carol, the systems were so entrenched in non-creative solutions to deal with limited dollars that demonstrated leadership was needed. Instead of brokering services/MH dollars to private providers, CSBs continued operating services, often focusing on self-preservation rather than outreach, collaboration, and service integration.

Involvement of Employer Services and Services to Customers with Mental Illness
Government contracts were one source of employment for PRS clients, some of whom were ex-offenders with MH. Since 9/11, security clearance was required not only for employees working under a "security contract" but also for those working under a "non-security contract." The dilemma was that government agencies needed job seekers but because of the nature of their contracts could not employ them. The PRS CEO linked up with the local BLNs to address this issue and hopefully "build a bridge."

APPENDIX K: SELECTED CLIENT/CUSTOMER PROFILES

Client Interview of Cathy L., Identified by
Linda Larson-Schlitz from the Wausau, WI One-Stop

<u>In a Nutshell</u>
Cathy was a single woman in her late forties who has been diagnosed with extreme anxiety and depression going back to childhood. She had been brain injured at ages four, 26, and 35, and had made multiple suicide attempts. She was working primarily with a Christian counselor (not a MH agency), the disability navigator at the One-Stop Center, and staff from the Client Assistance Program (CAP). The disability navigator had become her "case manager." She had a negative experience with VR and MH; she said, "[It's] thanks to the system that people will go out and commit suicide because they can't get the help and [the systems/staff/professionals] don't understand." Cathy had a college degree and work experience in the medical field, banking, etc. At the time of the interview, she was still looking for work. She was volunteering at the Youth Crisis Intervention Center and planning on getting a degree in social work.

<u>Questions</u>
1) Provide some brief background about the client and problems she had earlier in her life that interfered with her being successful in obtaining and retaining quality employment.
Cathy was single and in her late forties with a college degree and some work experience. Ten years before, Cathy had been injured on the job. As a result, she was diagnosed with repetitive motion injury. She reported having difficulty accessing services in Atlanta, where she lived at the time. She decided to move back to Wisconsin in the hope to find employment. She continued working with a physical therapist and a chiropractor; she also applied for Social Security but was denied the benefit.

After the accident, Cathy had a few jobs, which she described as below her skill level and not relevant to her college degree. She had a part-time job as a medical receptionist at an ophthalmologic clinic, where she worked for three-and-a-half years before being laid off. She then worked for a short time as a patient registration specialist entering data for a hospital department. Cathy applied for services and supports to VR but ended up being placed on a one-year waiting list for services. Not receiving Social Security and VR support, Cathy lived off workers compensation and her savings.

2) What led her to use the services of the workforce system?
A Christian counselor from the Center for Human Development, with whom Cathy had been working, referred her to the disability navigator at the One-Stop. The disability navigator (who had a history of mental illness herself) identified a possible psychiatric problem and connected Cathy with the Crisis Intervention Center at the MH center. Cathy was then connected with a MH counselor who, according to Cathy, did not choose to refer her to a psychiatrist for assessment. Cathy also went to see a VR counselor. She disclosed to the VR counselor that she had been having mental health issues for thirteen years but had never been formally assessed. According to Cathy, the VR counselor told her that VR could not cover those costs and that she did not need to be assessed. Cathy decided to contact her primary care physician, who set her up for a series of physical and psychological diagnostic tests. As a result, Cathy was diagnosed with extreme anxiety and depression.

Cathy told the VR counselor that she had been diagnosed with a mental disorder and had paid for everything herself; the VR counselor said that if Cathy had waited for a while, VR would have paid for it. In addition, Cathy contacted CAP, which advised her to call the VR counselor's supervisor. Cathy called the supervisor who told her that the person she was working with was one of the best counselors VR had. She was told to call back in three months if things had not changed. Cathy eventually managed, together with the disability navigator, to change her VR counselor.

3) What actions, if any, did the workforce staff the client dealt with take to coordinate with the MH system?

According to Cathy, the disability navigator was the only one who really helped her. The disability navigator connected Cathy with resources such as the Crisis Intervention Center, an aging and disability specialist, and medical assistance, as well as free clinics operated by churches. The navigator also encouraged her to apply again for unemployment benefits and Social Security. The navigator became Cathy's "case manager," though Cathy was aware that the navigator was not supposed to have a caseload. The navigator had some communication with Cathy's VR counselor, the MH counselor, and CAP staff.

4) Did the MH and workforce system work well together to assist the client in her opinion? If so, what did they do? If not, how would the client have liked them to work better?

There was some communication between agency staff and cross-agency coordination of services. Cathy would have liked staff from the different agencies (including VR, MH, One-Stop, CAP, and her social worker) to work together better.

5) Are there any types of supports or services that the MH or workforce systems could provide that would have been more useful to the client in terms of employment success?

Cathy would have liked the disability professionals (i.e., VR and MH) to make more of an effort to understand her situation, including the limitations posed by her mental illness, and to try to work with her within those parameters. She said:

> These people in VR and the MH field… do not understand that when you have no job and are self-supporting, you have not only have a physical disability, you have no benefits, but you also have mental health issues, they do not understand that you need money… to pay your bills and your debts.

She also said, "[It's] thanks to the system that people will go out and commit suicide because they can't get the help and [systems/staff/professionals] don't understand." Cathy had attempted suicide many times.

Cathy mentioned that help with career exploration would have been helpful. She said that she had expressed an interest in counseling and social work to her point persons at the different agencies (VR, CAP, MH counselor), but was told that that she was not yet ready for "those" kinds of jobs and that she only needed to get "some petty cash job." Instead of career exploration/person-centered planning, Cathy was sent to a psychosocial clubhouse. The disability navigator was the only person with whom Cathy felt comfortable talking about her career aspirations and personal goals.

6) What is the client doing now in terms of employment or career training?

At the time of the interview, Cathy was still in the process of looking for a job. She was working as a volunteer for the Youth Crisis Intervention Center at the MH center, a job that she enjoyed very much.

7) What employment or career plans does the client have for her future?
Cathy took a real interest in her work at the Youth Crisis Intervention Center. She was planning on going back to school to get a master's degree in social work—a prerequisite for applying for a full-time position at the center.

Client Interview with Melanie Brown, Identified by Melodie Pazolt from Clearview Employment Services/Columbia River MH (Vancouver, WA)

<u>Questions</u>

1) Provide some brief background about the client and problems she had earlier in her life that interfered with her being successful in obtaining and retaining quality employment.

Melanie had a degree in engineering and had worked as a contract engineer/consultant. She also had her own business—a small trucking company. Melanie said that she had so much success that at first she didn't recognize something was amiss. It took her a year to find out what was going wrong. For many years, she thought that alcoholism was the problem and kept trying to find a way to deal with that situation. She had also been involved in a domestic violence situation in Minnesota. She separated from her partner and moved to Clark County, Washington.

She entered therapy and was treated for depression and Post Traumatic Stress Disorder (PTSD). Through therapy, she found out that the depression and PTSD were the result of childhood abuse and not the domestic violence situation. She started to take medication and to educate herself about her mental illness. She described alcoholism as a "symptom of her mental illness" and that understanding/acknowledging this was a "breakthrough" for her.

2) What led the client to use the services of the workforce system?

She reported that she couldn't get any help from the "usual systems" such as welfare. It took her one-and-a-half years and three denials before being placing on general welfare assistance. She qualified for Unemployment and continued to seriously search for jobs. To do so, she used the One-Stop Center. She said, "I [used the One-Stop] because, you know, that is what you're supposed to do when you want a job." However, the regular employment office or One-Stop Center ignored the fact that she was not able to keep a job and wanted "to put her in a box where she didn't fit." VR required her to participate in workshops such as resume writing, etc. "But you know these weren't my problems, and the help I needed," she said.

Other supports she received included food stamps, and an organization for crime victims paid for her to see a psychologist. She found out about Clearview Employment Services in the course of doing the research for her handbook.

3) What information or support did the MH provider with whom the client is involved provide in terms of using the workforce system?

Melanie described Clearview as "one of the most exciting things and it still is." She said that Clearview staff didn't think that it was strange that she knew her limitations and her assets. What was unique about Clearview was that the organization didn't take the standard employment office approach to job search. Rather, Clearview staff together with Melanie explored avenues for employment that were "outside the box."

She described Clearview staff as being very attentive and really listening to what she had to say. It took Clearview a week to come up with what they thought would be a perfect fit for her—a job as information and resource developer at a nonprofit organization, which had just been listed under the AARP Senior Community Service Employment Program, a work training program of the AARP Foundation for low-income persons age 55 and older. (For more detailed info, see www.aarp.org/scsep.)

Clearview staff set up an appointment for Melanie to meet with AARP staff at the One-Stop. AARP staff, two of whom were located at the One-Stop Center, responded quickly and

contacted the employer. Melanie started working for the Disability Resource Center within two weeks after her initial meeting with the AARP staff. Melanie emphasized that Clearview staff had been open to new methods of employment support.

As part of her job, Melanie received training, including a two-day ADA training, which she found very useful. She also attended various conferences, including an independent living conference in Seattle. Melanie testified before the Joint Executive and Legislative Task Force on MH issues and services in Seattle. Her employer paid for the time that she was away; Clearview paid for the travel costs, hotel, and food.

4) What actions, if any, did the workforce staff and the client take to coordinate with the MH system?

There was ongoing communication between AARP and Clearview staff. The Clearview staff person who referred Melanie to AARP knew the AARP staff located at the One-Stop and had met them before. Melanie mentioned that although she had found a job she was still in contact with Clearview and AARP staff. AARP staff would visit her once in a while at her office to see how she was doing. It also happened that Clearview staff contacted her with a client that needed a referral whom staff didn't know about.

5) Did the MH and workforce system work well together to assist the client in her opinion? If so, what did they do? If not, how would she have liked them to work together better?

She said that the three agencies (i.e., Clearview, AARP, and her employer) "were tying in together really well" and that staff from these agencies had become "ongoing advocates" of Melanie's own nonprofit organization. "What these three organizations have helped me do, they're the key to it." She said that she couldn't have achieved all this without the support from these organizations.

6) Were there any special supports the client received from either the MH or workforce systems to help her be successful in getting or keeping a job?

The position of information and resources developer was a supported type of position. Overall, Melanie did not have many accommodations. Because of a back problem, she was not able to sit for a long time and needed to get up and walk periodically. Because of this she was only able to work four hours a day, a customized job modification that Clearview helped arrange.

Melanie also created her own nonprofit organization called The Alliance West, which, at the time of the interview, had been in existence for nine months. The corporation had a board of directors; a group of volunteers contributed their time to the various activities. The organization produced community resource handbooks. She described the handbook as "a definite change in methods in how to get information to people who needed." Initial information contained in the handbook was information that she found for herself. The handbook was available in English and Spanish, and was soon to be published in Russian also. It was free for low-income and homeless individuals, and in addition Melanie distributed the book to homeless shelters, food banks, and other organizations. She accepted orders from organizations that could afford to pay for printing. For instance, the local hospital ordered $1000 worth of booklets to give out to people in the emergency rooms. Melanie's employer also contributed to the publishing of the handbook. The Alliance West also published a quarterly newsletter.

In addition to helping Melanie find a paid job, Clearview helped Melanie expand her own business beyond the borders of Clark County. Her goal was to train people in other counties to

create their own resource tools. One way in which Clearview supported Melanie was to set her up with business consultants and accountants. Clearview also provided her with $3000 in start-up money to cover initial travel costs, the production and printing of a manual for training participants, and other related costs. Clearview staff also helped Melanie apply for additional funding and write grants.

AARP staff were also very supportive of Melanie's own business. After writing three grants and having no success in getting funded, Melanie decided that she needed to take a class on grantwriting. She located relevant classes online and approached her employer and AARP with this idea. AARP paid for Melanie to take the grantwriting classes and nonprofit management classes. At the time of the interview, Melanie had already signed up for advanced grantwriting classes as well as a class that taught how to write a successful business plan. As she was taking the classes, she was writing a grant that she hoped would provide the rest of the funding to expand her business.

7) Are there any types of supports or services that the MH or workforce systems could provide that would have been more useful to the client in terms of employment success?
Melanie couldn't think of any other types of supports or services that the MH or workforce systems could or should have provided.

The following types of support were important for her in order to be successful in the work world:
- It was important for her to be treated by a MH clinician who was specifically experienced in her needs. Melanie had made an effort to find a psychologist who had specific training and experience in domestic abuse, PTSD, etc. To do so, she contacted the Washington State Psychology Association and explained her needs. The association provided her with three names of psychologists, one of whom she contacted. She interviewed the psychologist and asked her about her methods and experience before she made a decision.
- According to Melanie, professionals need to hear what the client is saying. They should support the client in the process of making an informed decision.
- Melanie emphasized that agency staff should be open to new methods of employment support and mentioned Clearview as an example.
- Many organizations are territorial. However, in Melanie's case the three organizations shared information and assistance, a situation that she identified as a best practice. For instance, her employer didn't have the money for Melanie to attend a three-day conference on the Regional Independent Living Council in Portland. The employer contacted Clearview who agreed to cover the registration fee of $150.00.

8) What is the client doing now in terms of employment or career training?
At the time of the interview, Melanie had been employed for six months. She not only collected and compiled relevant information and resources but also provided assistance to people with disabilities in person and over the phone. The handbook she developed and the research she conducted for it had come into play. Her job paid minimum wage, and she lived in subsidized housing.

9) What employment or career plans does she have for her future?

Her job as an information and resource developer had been extended for another six months. Melanie was trying to expand her own nonprofit business beyond the borders of Clark County. Her goal was to train people in other counties to create their own resource tools.

Client Interview with Richard Y.,
Identified by Don Lavin from Anoka, MN/Rise, Inc.

In a Nutshell
Richard, a person with mental illness and an ex-offender, started using the One-Stop and Rise at about the same time. He had used the One-Stop Center prior to his imprisonment and found out about Rise while he was in prison. The disability navigator was a Rise employee located at the One-Stop; VR was also co-located. In addition to Rise and VR, Richard used supports from the Veterans Administration. He said: "[The agencies/staff] don't work together, but they know each others' office." At the time of the interview, Richard was still looking for work. His background was in food and nutrition, an area in which he wanted to work again.

Questions
1) Provide some brief background about the client and problems he had earlier in his life that interfered with him being successful in obtaining and retaining quality employment.
Richard was raised in rural Minnesota. After the Marine Corps, he moved to a small town called Marshall (40,000 pop.). He then served a prison sentence and he did not wish to disclose his reason for imprisonment or more specific details about his mental illness. After his release from prison he moved to St. Cloud.

Richard had a bachelor's degree in food and nutrition and related work experience. His plans to go back to school had been slowed down by personal problems. At the time of the interview, he had been using WIA core services for six months in addition to VR and Veterans Administration (VA) services.

2) What led the client to use the services of the workforce system?
Richard knew about the One-Stop because he had previously used its services to file for unemployment benefits and to access job lead information after his Marine Corps stint. While he was in prison, he found out about Rise and its services. A staff member from Rise gave a presentation as part of a transition class. After his release, Richard started using the One-Stop and Rise's navigator services there. Overall, Richard was familiar with the services available to him and used them as part of his job search.

3) What information or support did the MH provider with whom the client was involved provide in terms of using the workforce system?
Richard's contact at Rise was an MH specialist, who also worked as a disability navigator at the One-Stop. The disability navigator supported Richard in his job search. Further information about this is described below.

4) Did the MH and workforce system work well together to assist the client in his opinion? If so, what did they do? If not, how would the client have liked them to work together better?
        Service coordination at the client level
Richard worked mainly with three staff members: the One-Stop/Rise disability navigator, the VR counselor, and the VA staff person. Staff from the different agencies knew about one another and referred clients to one another. Because VR was co-located, the disability navigator had more direct contact with VR. Richard reported having seen his disability navigator meet with the VA staff person also. However, he saw himself as the only direct link between the agencies. He kept the point persons at the different agencies informed about his job search progress. From the client's perspective, there was not much direct communication and collaboration among the

agencies involved. Nonetheless, Richard was satisfied with the way agency staff coordinated services overall and thought that they were doing a "good job."

> Types of services received

The disability navigator was an MH specialist employed by Rise but located at the One-Stop. In addition, Richard worked with resource room staff as needed. He had not used specialized MH employment services. Rather, he did most of his own job search, which mainly involved checking job leads and communicating with staff (disability navigator, VR counselor, VA staff) about new job leads, contacts, or referrals. He described himself as computer literate but knew that if he had a question or needed help with a computer that he could approach staff in the resource room.

Overall, Richard appeared to be as an independent job seeker who was familiar with the resources and services available to him. He knew how to navigate the agencies that offered different types of support. The disability navigator not only connected him with resources, she also encouraged him in his job search—an aspect that Richard found very helpful in keeping him motivated in the job hunt. In addition to the navigator, Richard participated in a workshop on job development. He also attended the job club once a month, which he found useful because it helped him keep aware of where he was in his job search process. Job club attendance averaged from six to twelve participants who were at different stages in the job search process. He described the job club as a good opportunity to share information and learn from one another's experiences; it was also a source of encouragement. He had many interviews with temp agencies that recruited at the One-Stop, none of which proved successful.

The VA was helping Richard to "get established" by providing or connecting him with temporary work opportunities, mostly voluntary and unpaid work. At the time of the interview, Richard worked once a week on an unpaid basis for four hours at the consumer survivor network emptying trash cans, cleaning, filing, and the like. He also was on a waiting list for VR services; Richard knew that once he reached the top of the list (which might take up to eighteen months) VR would cover the tuition for training, etc.

5) Were there any special supports the client received from either the MH or workforce systems to help him be successful in getting or keeping a job?
Richard did not mention having received any special supports from either the MH or the workforce system. He said that the disability navigator was an important source of encouragement and motivation for him in his job search process.

6) Are there any types of supports or services that the MH or workforce systems could provide that would have been more useful to the client in terms of employment success?
He did not know what other services and supports MH or the workforce center could have offered him other then job leads and encouragement.

7) What is the client doing now in terms of employment or career training?
At the time of the interview, Richard was still unemployed and looking for a job. He was doing some unpaid voluntary work for the consumer survivor network. Not having a driver's license was another barrier to employment. So far, he had had two good interviews and had gotten positive feedback.

8) What employment or career plans does the client have for the future?

Richard planned to find a job, preferably in the area of food and nutrition. His ultimate goal was to go back to school. He knew that he needed to work for at least six months in order to have enough regular income to get a loan to cover the tuition.

Client Interview with Terry M.,
Identified by Melodie Pazolt from Clearview Employment Services/Columbia River MH
Vancouver, WA

<u>In a Nutshell</u>
Terry had a history of serious mental illness as well as a history of substance abuse and criminal offenses. The mother of a son with a disability, she had been using MH employment services primarily. She succeeded in getting a job as a parent partner/peer counselor and had been working for six months. Her primary MH health care provider (MH NorthWest) was another MH agency in Vancouver, WA that was funded to provide clinical case management and treatment and had only limited employment services. Clearview Employment Services provided employment assistance. The two MH agencies and VR collaborated with one another. Terry initially had a negative experience using the One-Stop and recommended that One-Stops should have a disability specialist focused on mental health to better accommodate people with psychiatric disabilities. At the time of the interview, Terry was studying for her Washington state MH peer counselor certificate.

<u>Questions</u>
1) Provide some brief background about the client and problems she had earlier in her life that interfered with her being successful in obtaining and retaining quality employment.
Terry had been working for six years when her symptoms began to interfere significantly in her life. She worked in quality control at one of the major printing companies in Washington State. She had hoped to work her way up to sales, but her symptoms, which she self-medicated through alcohol and other substances, were getting worse. She did not seek help for a long time. She knew welfare was there but "just to go there was way overwhelming, impossible." She did connect with the welfare office eventually and agreed to be treated at a hospital for her symptoms (three-day hospitalization).

Terry had a history of assault. She assaulted her mother and was prosecuted; the judge remanded her for her two years of mental health treatment instead of anger management, but, as she stated: "just because the court mandates MH services does not mean that facilities are required to provide MH services." Not being able to access MH services, she went through more turmoil and began to use drugs. She put herself into the hospital again and upon discharge started receiving treatment services. Accessing MH services was difficult, and it took her almost two years to do so. She said that only after she had assaulted her mother, went to court, and put herself into the hospital had she become eligible for MH services. Terry received MH services for one-and-a-half years before she "could even think about outpatient." After she became an outpatient, she started working with MH NorthWest for both her MH care and employment support.

2) What led the client to use the services of the workforce system?
Terry was working with a job coach from MH NorthWest, but the process was not going very well. She started using the One-Stop hoping that it would be more effective in helping her find work. Getting to the One-Stop was a challenge, as well as using One-Stop services. Terry found the One-Stop physically intimidating and the array of services and supports overwhelming. She did attend a one-week training/orientation at the One-Stop; she had twelve job interviews and succeeded in getting a job in the printing industry after the first interview. However, she lost that job because it did not accommodate her needs (e.g., flexible schedule/time to care for her son).

3) Did the client receive any employment services from the MH system before she used the workforce system?

Terry started using workforce services early in her recovery. Her welfare/TANF agency referred her to MH NorthWest, where she worked with an employment specialist on job placement, which she described as "unrealistic and totally overwhelming." Terry then started using the One-Stop Center. Terry found out about Clearview while she was living in transitional housing designed for female ex-offenders. Clearview came to the transitional housing provider, introduced the program, and offered residents an opportunity to be a part of the project (a federal RSA grant serving people with disabilities who were homeless and/or in transitional housing for ex-offenders). Terry joined the program and had been a part of it ever since. She said that Clearview was "god-sent." She had been looking for work for two years and finally found an agency that could actually help her find employment. She said, "It was everything that I'd ever prayed for."

Terry and her Clearview job coach met once a week. The job coach accompanied her to the welfare agency, helped her communicate, and showed her how to advocate for herself. Terry participated in various trainings, including a career exploration and human service training from Clearview. Clearview also referred her to VR. VR provided the following services:
- Covered the costs for a mental health clinical assessment
- Helped Terry get her GED by paying for a one-month training at Sylvan Learning Center
- Paid for Terry's peer counselor certificate training
- Bought her clothes and a cell phone, and upgraded her computer/software

4) What information or support did the MH provider with whom the client was involved provide in terms of using the workforce/welfare system?

The MH NorthWest job coach took Terry to the One-Stop and showed her how to use the different resources. Terry described the job search process at the One-Stop as very distressing and overwhelming. She tried to communicate her needs to staff, who were not very responsive. When her job coach at MH NorthWest communicated on her behalf, things improved somewhat. Also, the Clearview job coach accompanied her to the different agencies and helped her communicate her needs and advocate for herself. She taught Terry how to coordinate services and navigate the system.

5) What actions, if any, did the workforce staff take to coordinate with the MH system?

Terry reported that One-Stop staff was not very responsive to her needs and that no attempt or efforts had been made to accommodate her and her mental illness. Also, One-Stop staff had very limited understanding of disability in general and mental health problems in particular. Rather, they saw her invocation of her psychiatric disability as an "excuse." She said that at the time, the One-Stop had only just started to acknowledge that mental illness was an issue. The One-Stop has improved ever since.

(Note: With new operator Arbor A&T, the Vancouver Town Plaza One-Stop experienced a lot of change. The One-Stop took on a disability navigator who was a MH specialist as well as an account representative who worked with the business team. The employer account representative also has a background in MH and was a former Clearview employee.)

6) Did the MH and workforce system work well together to assist the client in her opinion? If so, what did they do? If not, how would the client have liked them to work better?

According to Terry, the MH agencies and VR worked very well together. Prior to getting services, Clearview organized a three-hour meeting (what she called the "rally") which is unique to Clearview. Participants included the caseworker from Terry's transitional housing agency, the MH NorthWest counselor, the Clearview job coach, Melodie Pazolt, and Terry herself. The team looked at a "picture of Terry's life" discussing negative experiences and challenges and identifying her strengths and the life skills she had learned. According to Terry, the meeting increased staff members' knowledge about her, her abilities, and future plans. goals, and aspirations. Terry had not had such a meeting since then, but she signed a release form so that the agencies could communicate with one another.

7) Were there any special supports the client received from either the MH or workforce systems to help her be successful in getting or keeping a job?

In the process of working with Clearview, Terry attended different trainings and participated in various activities. For instance, Clearview connected her with the Circulation Leadership Group. Organized by the ARC, the group participated in a one-year training during which participants were taught, among other things, how to advocate to the legislature. Terry also got involved in the Community Empowerment Project, specifically the Parent Partner training initiative. She met some of the parent partners. She applied for a position and one year later was invited to an interview. Before she filled out the application, she told her boss that she had mental health issues and a history of offending. Terry said: "I didn't want to set myself up for failure." The only accommodation that Terry had on the job was the option of temporarily transferring her caseload to her Clearview job coach while she was dealing with recovery issues.

8) Are there any types of supports or services that the MH or workforce systems could provide that would have been more useful to the client in terms of employment success?

She suggested that One-Stop staff needed to realize that everyone was unique and should be more sensitive to the diverse needs of different people. She also thought that One-Stops should have a disability or MH specialist to better accommodate individuals with mental illness and their needs.

9) What is the client doing now in terms of employment or career training?

At the time of the interview, Terry subcontracted with Clark County to work as a "peer support specialist" or parent partner. As such, she supported parents who had children with mental illness, teaching them the skills that her job coach previously taught her (e.g., how to advocate for oneself). She accompanied parents to their different appointments, helped them access services, connected them with resources, etc. She was on call 24 hours. Terry said, "This [job] is unlike anything I've ever done before… I feel I'm just being paid for being myself and that I'm able to give back what was given to me… and this is very healing for me." Terry had a caseload of five parents, two of whom had graduated. She was only allowed to work up to 20 hours a week (three hours with each client). She said that things had been going well and that she had nothing but compliments from her boss. In addition to working as a parent partner, Terry was studying for her peer counselor certificate.

10) What employment or career plans does the client have for her future?

Terry mentioned that the grant that funded her position had recently changed and that she needed to get certified as a counselor (which VR paid for). Sharing her experiences with other people had become an important piece of her life. Terry spoke at a federal RSA conference in Washington, DC (in conjunction with Clearview and ICI staff) and also at a mental health/substance abuse co-occurring disorder conference in Yakima, WA. She wanted to

continue being a speaker and hoped to get paid enough to make it at least a part-time career someday.

APPENDIX L: CLARK COUNTY/VANCOUVER, WA WEIGHTING PERFORMANCE OUTCOMES FORMULA

Note: A visual representation of this approach is in the chart immediately following this brief description

There were three types of job orders/employers: self-service orders referred to less desirable jobs or job orders by employer request; assisted job orders referred to account management services; and priority job orders, which were reserved for economic development projects and target industry employers. There were also three categories for job seekers: those who received core services (job seekers not registered in WIA); those who received intensive services (e.g., seminars, job search assistance, individual counseling) as well as other targeted populations (e.g., Veterans, UI recipients); and individuals who received substantial assistance in the form of ITAs or on-the-job training as well as populations designated as priorities, including individuals with disabilities. Point values were attached to different types of job orders and the different types of job seekers. High point values were attached to customers who received the most support. It is important to mention that the points were educated guesses and had not yet been finalized. Board staff also mentioned that there might eventually be more than three categories on each axis. The next step was to cross-reference the categories and to attach point values to the actual job placement. Placing a job seeker from a special population (e.g., an individual with a disability) into a high-priority job received the highest point value.

At the time of the site visit, the board was not yet able to measure results in this way, but board staff were working towards this goal. The board continued to measure One-Stop performance using WIA standards, and planned to incorporate the use of the grid once it was finalized. The board's approach to measuring performance (once implemented) was expected to have an impact at both the service and system levels. At the service level, the system would eventually be linked to staff performance measures. Attaching high point values to job placements for people with disabilities was seen as a way to encourage staff to serve individuals without concern about meeting performance goals. On a system level, the new approach was expected to allow a more meaningful distribution of resources.

Understanding Complex Workforce Goals

Employers job orders→ Job seekers↓	Self-service (10)	Assisted (40)	Priority (75)
Core (10)	20	50	85
WIA-enrolled (40)	50	80	115
WIA-trained, special populations (75)	85	115	150

APPENDIX M: TECHNICAL ASSISTANCE PLANNING FORM EXAMPLES

System Self-Assessment

Assessment of Current Performance: What Is Going Well and Not Going Well?

System/organizational considerations	Needs/implications for system change efforts
External influences	
Resource allocation and supports	
Structure and management	
Mission, culture, and practices	
Staff skill and knowledge needs	

Technical Assistance Resource Analysis

Need	Symptoms	Reasons	Change wanted	Methods	Sources of help

Technical Assistance Action Planning

Problem to be addressed:			
Action steps	Who's responsible	Time frame	Deliverables

In developing the action steps, the following should be considered:

__ Are the changes recommended consistent with mission of the systems/agencies involved?

__ Are the resource allocation and supports sufficient to achieve the stated goals?

__ Are the structure and management of the system change project currently designed to achieve these goals?

__ Are the changes planned consistent with the culture and practices of the systems involved?

__ Are the changes recommended supported by a high level of managerial and staff investment and support?

__ Are staff skill and knowledge needs adequately addressed?

APPENDIX N: TECHNICAL ASSISTANCE RESOURCES RELATED TO EFFECTIVE EMPLOYMENT PRACTICES FOR PEOPLE WITH PSYCHIATRIC DISABILITIES

This list is offered in addition to the respondents and sites visited, who can offer a great deal of help, as well as the more academic reference material listed in Appendix A.

1) ODEP
   www.dol.gov/odep
2) ETA: Disability Online
   www.doleta.gov/disability
3) National Center for Workforce and Disability/Adult
   www.onestops.info
4) National Collaborative on Workforce and Disability/Youth
   www.ncwd-youth.info
5) U.S. Department of Education/RSA
   www.ed.gov/about/offices/list/osers/rsa/index.html
6) Law, Health Policy, and Disability Center, University of Iowa
   http://disability.law.uiowa.edu
7) Center for the Study and Advancement of Disability Policy
   www.disabilitypolicycenter.org
8) SAMHSA/Evidence-Based Practices in Supported Employment and Mental Health
   http://mentalhealth.samhsa.gov/cmhs/communitysupport/toolkits/employment/
9) Job Accommodations Network
   http://janweb.icdi.wvu.edu
10) Employment Intervention Demonstration Program, University of Illinois, Chicago
    www.psych.uic.edu/eidp
11) NH-Dartmouth Psychiatric Research Center
    www.dartmouth.edu/~psychrc
12) Thresholds Psychiatric Rehabilitation Center
    www.thresholds.org
13) Boston University Center for Psychiatric Rehabilitation
    www.bu.edu/cpr
14) Supported Employment Education and Training Center, Anderson, IN
    www.sectcenter.org/index.cfm
15) Integrated Employment Institute, UMDNJ
    http://shrp.umdnj.edu/smi/employment_services/01_aboutus.htm
16) Center for Psychiatric Rehabilitation at Northwestern University-Evanston Health Care
    www.enhpsychrehab.org
17) Advocates for Human Potential
    www.ahpnet.com
18) Corporation for Supportive Housing
    www.csh.org