REPORT OF COMMUNITY OF PRACTICE ON VOCATIONAL REHABILITATION SYSTEMS AND SERVICES TO PEOPLE WITH PSYCHIATRIC DISABILITIES

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This is a summary of the Community of Practice (CoP) on Vocational Rehabilitation Systems and Services to People with Psychiatric Disabilities hosted by the Institute for Community Inclusion at the University of Massachusetts Boston as a project of its Vocational Rehabilitation RRTC during 2009. The intent of the CoP was to identify policy, program development, and human service development recommendations from the group on this topic that can be transmitted to all state VR agencies, CSAVR, RSA, and NIDRR at the conclusion of the process. Invitations were proffered to a group of VR agency directors and also central office VR mental health policy specialists. All invitees accepted with one refusal (Don Uchida, state director of the Utah State Office of Rehabilitation) due to pressing business in his state. Those who participated from outside ICI are listed below. An asterisk * is used next to names of people who were involved at limited times at the request of their agency director:

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ICI participants in the CoP were:
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Some specific relevant issues identified prior to group initiation as possible areas of inquiry included: joint funding of services, performance based contracting, influencing a mental health partner agency's vision of employment, incorporating the mental health Recovery model into VR program design, rapid/ presumptive eligibility determination, and the role of evidence based psychiatric rehabilitation practice in VR service delivery. Upon discussion of these preliminary concepts, a final version of topics to be addressed and a flexible schedule for discussing them was accepted. The final topical list was:

1. What are some good strategies for joint funding of services with MH, VR, as well as possibly Medicaid, Workforce/WIA, and Welfare (GA/ TANF)?
2. What are some good strategies for VRs developing performance based contracting/ milestone systems?
3. How can VR systems influence their MH partner agencies' vision of employment?
4. How can VR incorporate the mental health Recovery model into VR program design?
5. What are some strategies VR can use for rapid/ presumptive eligibility determination and concomitant speedier development and implementation of the IPE?
6. What is the appropriate role of evidence based practice information in VR employment service delivery?

7. What strategies can VR employ to do more effective business outreach dealing especially with issues related to stigma/ discrimination/disclosure affecting job applicants with psychiatric disabilities?
8. How can VR support on-going career development for its clients including assisting clients to adapt better to the social/ environmental demands of the workplace?
9. How can VR better assist people with psychiatric disabilities attend to issues of health and wellness and have a positive impact on mortality and morbidity for this group?
10. How can VR better assist its clients to access different forms of employment in addition to "traditional" employment and now "traditional" supported employment (e.g., home based work, entrepreneurship, employment quadrant (see attached graphic)?
11. How can VR address issues related to "employment readiness" (see attached article), including matters related to length of sobriety, commitment to Recovery, and harm reduction models?

The CoP was scheduled to last 6 months (January-June 2009) with a wrap up meeting planned for Oct 2009. This final meeting was intended to review this summary report, identify recommendations for promising or best practices in terms of VR policies and practices related to services to people with psychiatric disabilities, and discuss possible next steps for this or related CoPs. Not all these topics were eventually dealt with due to time limitations but each item was assigned a primary discussant whose task was to gather some initial information if possible and then lead the group in a brief dialogue around the relevant matter. The CoP often tried to highlight two issues each meeting but often the conversation around the first topic was so fruitful and extended that the second item would be tabled for future meetings. The questions that were attended to in some detail during the six month timeframe with the associated principal presenter noted were:

a. What are some good strategies for VRs developing performance based contracting/ milestone systems? **John Halliday, Joe Marrone**
b. How can a VR influence its MH partner agency's vision of employment?- **Stephaine Taylor**
c. How can VR incorporate the mental health Recovery model into VR program design?- **Stephaine Taylor**
d. What are some strategies VR can use for rapid/ presumptive eligibility determination and concomitant speedier development and implementation of the IPE?- **Maryland DORS staff – Bob Burns, Berenda Riedl, and Kate Drake**
e. What is the appropriate role of evidence based practice information in VR employment service delivery?- **Maryland DORS staff – Bob Burns, Berenda Riedl, and Kate Drake**
f. How can VR support on-going career development for its clients, including assisting clients to adapt better to the social/ environmental demands of the workplace? - **Andrea Guest**
g. How can VR better assist people with psychiatric disabilities attend to issues of health and wellness and have a positive impact on mortality and morbidity for this group?- **John Harper**
h. How can VR address issues related to "employment readiness", including matters related to length of sobriety, commitment to Recovery, and harm reduction models?- **Claire Courtney**

A brief overview of information that was presented is included below:

A) Strategies for VRs developing performance based contracting/ milestone systems
The discussion was framed around the following comments:
1] Performance based contracts need to flow from some policy decisions about what you want to reinforce and just as if not more importantly what you don't want to reinforce. Thus, deciding what not to fund is an important element.
2] In general the type of performance measures to fund are concrete outcomes and in some cases outputs, not just process. In this context, things like how many clients get served is one viable output measure to reinforce as well as jobs and salaries and employment tenure.
3] Performance contracting can be a traditional cost reimbursement contract with specific goal attainment required (perhaps with penalties for non performance?), a base plus approach, or milestones. Others? Pros and cons to use of each?
4] There is a growing movement to move towards a "milestone" approach rather than one "make or break" outcome measure. The milestones ultimately should reflect a reasonable compromise among disparate elements such as provider effort, agency priority attached to differing milestones, resources available, total amount available if all milestones are achieved, compatibility with similar services paid for by other systems, and some practical attention to historical context. What methods do (should) VR systems use to set the amount available per client or per achievement?
5] Almost all performance based contracts, especially in MH, have to include some base that providers can depend on as well as performance enhancements or bonuses. Down the road systems need to look at sanctions and disincentives as well as incentives as corporate entities, unlike people, respond as well or better to sanctions for poor behavior/ performance (i.e., losing money for not achieving certain specified results) as they do to incentivizing good performance. What examples do we know of where sanctions or loss of funding have been used in VR - MH collaboration? Any?
6] Are there examples we know of for MH and VR systems to develop mutually enhancing performance based contracting with joint providers of both systems?

B) How can VR influence its MH partner agencies vision of employment? and How can VR incorporate the mental health Recovery model into VR program design?
The discussion was framed around the following comments:
> One definition of Recovery is: Mental health recovery is a journey of healing and transformation enabling a person with a mental health problem to live a meaningful life in a community of his or her choice while striving to achieve his or her full potential.

> William Anthony, Ph.D., Executive Director of the Center for Psychiatric Rehabilitation at Boston University has said "For service providers, recovery from mental illness is a vision commensurate with researchers' vision of curing and preventing mental illness. Recovery is a simple yet powerful vision." Anthony describes recovery as a "deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills, and/or roles. It is a way of living a satisfying, hopeful, and contributing life even with limitations caused by illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness."

> Basic recovery-oriented principles need to be incorporated into *all* aspects of mental health service delivery, including those identified in this chart below that replicates SAMHSAs 10 Fundamental Components of Recovery and Bill Anthony's similar but not duplicative 8 Core

Elements of a Recovery belief system. The CoP discussion centered on a description of the Recovery paradigm overall with the querying of VR members on what VR policies or practices supported or potentially conflicted with a Recovery oriented mental health approach.

10 FUNDAMENTAL COMPONENTS OF RECOVERY	BILL ANTHONY'S 8 ELEMENTS	VR POLICY?	VR PRACTICE?
Self-Direction: Consumers lead, control, exercise choice over, and determine their own path of recovery by optimizing autonomy, independence, and control of resources to achieve a self-determined life. By definition, the recovery process must be self-directed by the individual, who defines his or her own life goals and designs a unique path towards those goals.	**Recovery is possible:** i.e., a meaningful life is possible despite catastrophic illness, and despite limitations of systems and symptoms. Services are delivered with a hopeful attitude toward the experience of illness, and "triggers"-- multiple sources and methods of providing motivation and hope -- must be present at every level of the mental health system.	Informed Choice is a key element of the Rehab law

Options for development of the IPE in VR by client's with their own choice of helpers and only needs ratification by VR counselor | Expanded utilization of the IPE options, particularly the consumer's utilization of persons they choose. |

| **Individualized and Person-Centered:** There are multiple pathways to recovery based on an individual's unique strengths and resiliencies as well as his or her needs, preferences, experiences (including past trauma), and cultural background in all of its diverse representations. Individuals also identify recovery as being an ongoing journey and an end result as well as an overall paradigm for achieving wellness and optimal mental health. | **Mental health consumers must be welcomed as partners in their care,** in assuming a significant degree of control in the development of their treatment plan, and in determining the goals toward which they choose to work. Consumer choice must exist! William Anthony, Ph.D., has said, "Critical to recovery is regaining the belief that there are options from which one can choose -- a belief perhaps even more important to recovery than the particular option one initially chooses." | The VR program's emphasis on informed choice and individualized services | Joint projects with MH programs on the integration of individualized services

The self – directed IPE |

Empowerment: Consumers have the authority to choose from a range of options and to participate in all decisions—including the allocation of resources—that will affect their lives, and are educated and supported in so doing. They have the ability to join with other consumers to collectively and effectively speak for themselves about their needs, wants, desires, and aspirations. Through empowerment, an individual gains control of his or her own destiny and influences the organizational and societal structures in his or her life.	▪ **A "Just Start Anywhere" mode of consumer action must be fostered.** Recovery does not have one starting point, or one destination. Whether it's number one, number five, or number thirty on the task list, the goal is to just start moving forward in any area, in any increment. Both staff and consumers must recognize that there are as many paths to healing as there are paths to illness.	VR has the most flexible funding for individualized services. The control of resources in employment programs seems to be the area with the least consumer control	How flexible could VR be with funding to allow direct consumer control while still exercising its fiduciary responsibility and accountability for public funding use?

Holistic: Recovery encompasses an individual's whole life, including mind, body, spirit, and community. Recovery embraces all aspects of life, including housing, employment, education, mental health and healthcare treatment and services, complementary and naturalistic services, addictions treatment, spirituality, creativity, social networks, community participation, and family supports as determined by the person. Families, providers, organizations, systems, communities, and society play crucial roles in creating and maintaining meaningful opportunities for consumer access to these supports.	▪ **A broad range of consumer run services is promoted.** These must be fostered and funded as the critical services they are. Not only are consumer run services a cost and therapeutically effective part of the service milieu, but they provide an atmosphere in which consumers can be recognized and paid for their expertise. Consumers in various stages of recovery can substantially aid the recovery process of others. It can be motivating to interact with others further along the road; it can be validating to interact with others who are somewhat in the same place; and it can be rewarding and serve as a critical reminder as to how far one has come to interact with others just beginning the process.	The VR focus on employment leading to financial independence needs to be reinforced.

Long term unemployment and poverty interferes with numerous aspects of a person's life and exacerbates mental illness | Financial independence leads to consumer control over many aspects of their lives, not just in the direction of service stream funding. |

Non-Linear: Recovery is not a step-by-step process but one based on continual growth, occasional setbacks, and learning from experience. Recovery begins with an initial stage of awareness in which a person recognizes that positive change is possible. This awareness enables the consumer to move on to fully engage in the work of recovery	• **Meaningful work/educational activities are valued and worked toward.** Meaningful work as defined by the consumer in the case of adult mental health consumers; the furthering of one's schooling, education and hobbies in ways that are meaningful to the individual in the case of children and adolescents; and fulfilling social and intellectual options in the case of retired persons. Meaningful work is work that increases self efficacy. Mental health consumers have a long history of being required or pressured to perform demeaning, humiliating work (or in the case of children diagnosed with severe emotional disturbance, segregated into ineffective special education classes) that not only does not build their self-efficacy but shatters it.	VR policy allows for considerable non-linear processes'	Despite federal policy, VR practice can be too often linear by tradition The structure allows for much more individual staff and client VR creativity in the process than is necessarily employed

Strengths-Based: Recovery focuses on valuing and building on the multiple capacities, resiliencies, talents, coping abilities, and inherent worth of individuals. By building on these strengths, consumers leave stymied life roles behind and engage in new life roles (e.g., partner, caregiver, friend, student, employee). The process of recovery moves forward through interaction with others in supportive, trust-based relationships.	▪ **Service providers must encourage and facilitate an increase in consumers' abilities to self manage disorders** in ways that are meaningful to the individual consumer. Consumers can significantly benefit from learning low-cost self-care skills to supplement and in some cases replace conventional medical approaches. Routine development of relapse prevention strategies, individual crisis plans, and advance directives are other ways to self-manage and control a disorder.	The whole modern concept of "handicap" as a disparity between a person's skills and the demands of a particular environment is itself a renunciation of the inherent deficit approach traditional in medical philosophy	The VR system and staff need more skills to better prepare individuals to use their personal strengths for their own economic good.
Peer Support: Mutual support—including the sharing of experiential knowledge and skills and social learning—plays an invaluable role in recovery. Consumers encourage and engage other consumers in recovery and provide each other with a sense of belonging, supportive relationships, valued roles, and community.	▪ **Use of community resources should be encouraged.** Much exists within the community that can help one move towards recovery. Whether it is volunteer work, community classes, the Sierra club, organized sports or church involvement, community involvement can be motivating, therapeutic, and cost effective. Assessing community resources is an excellent and low-cost way to develop highly individualized services that truly meet the goals and interest of the consumer.	The peer support movement has been ingrained in VR since 1973 law with its pronouncements on Independent living and support for IL Centers	While VR has not often employed designated "peer" positions it has had a much longer tradition than MH systems in including consumers on hiring committees and hiring people with disabilities as professional staff in equal status roles

Respect: Community, systems, and societal acceptance and appreciation of consumers —including protecting their rights and eliminating discrimination and stigma—are crucial in achieving recovery. Self-acceptance and regaining belief in one's self are particularly vital. Respect ensures the inclusion and full participation of consumers in all aspects of their lives.	▪ **Staff must be empowered and** encouraged to be flexible in the delivery of services. While managed care in the acute setting tends to utilize strict models, decision trees and mandates, etc., in the mental health setting outcomes will be dramatically improved if we recognize that the recovery process is a highly individual one. It is important that staff are not seen as automated deliverers of recovery-oriented services, but as valued partners with expertise and needs of their own. Staff members that are not respected and empowered will have a difficult time empowering others. One must be empowered in order to empower others.	IPE (and before that IWRP) is easily amendable and reviewable

IPE and IWRP were individualized structures in place since 1973 law.

Client Assistance Programs (CAP) a core part of the VR structure for many years | VR counselors have significant autonomy in plan development and service funding

Funding is usually outcome focused and based on individual need not "slots" |
| **Responsibility:** Consumers have a personal responsibility for their own self-care and journeys of recovery. Taking steps towards their goals may require great courage. Consumers must strive to understand and give meaning to their experiences and identify coping strategies and healing processes to promote their own wellness. | | | |

Hope: Recovery provides the essential and motivating message of a better future— that people can and do overcome the barriers and obstacles that confront them. Hope is internalized; but can be fostered by peers, families, friends, providers, and others. Hope is the catalyst of the recovery process. Mental health recovery not only benefits individuals with mental health disabilities by focusing on their abilities to live, work, learn, & fully participate in our society, but also enriches the texture of American community life. America reaps the benefits of contributions individuals with mental disabilities can make, ultimately becoming a stronger & healthier Nation.			

C) Strategies VR can use for rapid/ presumptive eligibility determination and concomitant speedier development and implementation of the IPE? and Appropriate role of evidence based practice information in VR employment service delivery?

The Maryland Department of Rehabilitation Services (DORS) team discussed how MD DORS and the MD Mental Health Administration (MHA) had collaborated on a variety of systemic changes to enhance employment services to clients with psychiatric disabilities and support the implementation of evidence based employment services by MH and VR providers in the state. Such policies that were implemented included developing a well integrated "braided funding" model for employment using DORS, MHA, and Medicaid monies, working out an electronic information flow process between DORS and MHA, presumption of and expedited eligibility for DORS of MHA Supported Employment clients, creating mandatory DORS applicants of MHA clients referred for employment services in MHA funded programs, creation of a evidence based practices workgroup in DVR, and the distribution of a joint statement of intent to enhance employment from the DORS and MHA Directors. Also to deal with a continuing "thorny" issue, the DORS Director emphasized in writing and direction the prohibition of any specific general timeframe for length of sobriety before entering DORS services as this judgement had to be rendered on an individual, client-specific basis and looked at in terms of "commitment to sobriety" rather than merely duration. Thus, this policy recognized that occasional lapses are normal and expected parts of the substance abuse recovery continuum. More recently, at the behest of one of the key DORS and MHA employment providers, DORS is piloting a milestone/ outcome based financing system to support evidence based supported employment for people with significant psychiatric disabilities. Furthermore, under a project in collaboration with John Halliday and Joe Marrone of ICI, MD MHA and DORS have developed an innovative statewide SSA employment network (EN) using one MHA county based fiscal provider as a statewide EN with various MH employment providers becoming part of that network, which will handle the fiscal processing and coordination.

D) How can VR support on-going career development for its clients including assisting clients to adapt better to the social/ environmental demands of the workplace?

Andrea Guest led the discussion concerning a 5 day pilot program developed by DVR in DE in conjunction with the state MH in assisting people who were formerly state hospital

patients enrolled in a patient employment program with the goal of building their confidence so that they would be able to move to community employment and career mobility.

Other pilot programs discussed included a MN attempt, using "Innovation and Expansion" money, at developing a "Voc[ational] WRAP" model that Claire Courtney felt was successful but never transitioned into a fee for service modality as DVR staff was not sure it was their role to fund and MH Medicaid rules precluded it.

Sean O'Brien mentioned the Discovery process that is used successfully in AK and which DVR is willing to pay for by using fee for service funding.

John Halliday spoke about the need to perhaps consider more informed use of "Services to Groups" as a technique where DVR wished to sponsor a pilot. It might even be worthwhile for RSA to consider sponsoring a formal research or evaluative study on the "Services to Groups" modality. Eventually however, especially in terms of MH and DVR collaboration, there needs to be a mutuality of interest as well as a commitment on both parties to put resources (financial and staff) into areas such as this that are related to DVR mission but cannot (nor should) be solely carried out by them.

There was also some general discussion related to DVRs comparatively limited resources but yet the need perhaps to get back to focusing more on career development and maybe even to actually plan for intermittent returns for clients until they are more stabilized in their careers.

E) How can VR assist people with psychiatric disabilities attend better to issues of health and wellness and have a positive impact on mortality and morbidity for this group?

John Harper led the discussion. The issue of co-morbidity is very "hot" in mental health. When VR gets involved, health issues come up because they have an impact on a person's capacity to work. Missouri has done a hard data match between the Missouri VR and Mental Health Authority for a five year period (2007 data presented). This looks at how many clients are shared between the two systems as well as at primary disability and secondary conditions. For many of these clients, the physical problems were not being addressed so Missouri has developed close relationship with federally funded community health centers (FQHCs). Dr. Joseph Parks, the MH director, also examining national data on mortality. People being served by mental health centers are dying 25 years younger than general population. Many of these clients have co-morbidity of mental health and health issues such as diabetes.

VR data underestimates the number of clients being served by DMH. States are not getting credit for serving as many people with MH issues. Criteria for severe mental health diagnosis by DMH do not always match the definition of "most significant disability" by the VR system. If Missouri is representative of other states, there may be an underestimation of the number of people served by VR because MH is not being listed as the primary diagnosis. Some individuals may not make it into a high enough priority under an Order of Selection in some states.

A. Questions
   a. How is this impacting the outcomes for a VR agency?
   b. Should there be an intervention by the VR system?
   c. What can be done in collaboration with the mental health system to address this problem?
   d. What is the mindset of a VR counselor when you start looking at primary disability and secondary disability in terms of impediments to work?

e. Is it important to assess health status? If it is important, should VR be involved or just encourage MH to do so? Is there a virtue in the context of employment in the broad sense to pay more attention to general health in supported work and are there strategies for accomplishing this? In MH there is a lot of pressure to coordinate MH and physical health care. How does VR move this along?

f. Have we moved away too far from the medical model? Should VR training have some attention to overall wellness? Creating a screening tool does not solve the problem.

B. Considerations

a. VR can advocate for health/MH to address. Mental health systems should look at general health issues. VR could use health checklists to encourage discussion and encourage clients to address these issues.

b. General medical requirement was dropped in 1992, but is there a need to reinstate some variation of this for the population of clients with psychiatric disabilities? Old forms/process was not helpful. Is there something else that could be used that would capture this information in terms of employment? Problem was time frame for eligibility and complex health information causing concern without any reasonable service recourse to VR counselors.

c. There is increasing attention in MH systems overall for integration of MH and physical health. There is no attention in data collection on how secondary health conditions impact employment. Health conditions account for more lost work days than MH issues and more insurance payments.

d. One problem is that many medical doctors do not look at overall health status as much as diagnosis and precipitating problem. This concern is exacerbated in the case of people with psychiatric disabilities in that there is often more attention paid to their mental health issues more than overall health and wellness. Health care system has good acute care but does not use a public health model.

C. Current status of represented states

a. MD moved away from the use of a health checklist because of the evolution of the evidence based employment model. As a best practice, collaboration with all parties will lead to successful outcomes.

b. Health checklists on file to support and document functional limitations by secondary disability. Staff are addressing secondary health conditions in the plans in terms of maintaining employment. No specific training for staff on impact of general health on employment. MD DORS employs a medical advisor for difficult cases / appeals and DDS services.

c. NM has a health questionnaire sheet that is available but not really used. Staff there rely on information provided by providers. The diagnostic process has become "water-downed". Due to streamlining systems, NM VR relies less on diagnostic evaluations. There is a need to look at trends that are evolving and develop tools that are going to help create more comprehensive plans. No specific training exists in NM for staff on the impact of general health on employment. NM VR has a consultant on contract for extreme and rare medical conditions.

d. AK has not used any health questionnaire. Uses referral information and clinical information, which that agency finds is more effective and part of what they see

as a wraparound service approach. Previously the MH system had vocational components; nonetheless it has become difficult to get this system to understand that they now need to be part of the employment process. AK DVR reinforces that employment contributes to stability. DVR there sees a need for a three pronged approach -- management, mid-level, and direct service implementer level. Seasoned counselors will utilize quasi-rapid deployment into the work setting as an assessment. There currently is no specific training for staff on impact of general health on employment but use a medical consultant.

    e. MO health assessment form is available and completed by all applicants, but not readily used in the context of overall wellness. It flags areas to pursue for eligibility. Some health issues are still not discussed or endorsed, possibly because of stigma. This reinforces the need for the MH system to concentrate more efforts towards clinical integration around wellness and recovery. VR is best equipped to focus on the employment piece and partner with MH to address this. There are times that VR has to educate and encourage MH to focus on both wellness and employment as an outcome. There is no specific training for MO staff on the impact of general health on employment. MO DVR does have medical consult option for "difficult" cases.

D. Research

    a. Rural Institute in Montana (NIDDR funded study) created Health Management / health stamina building exercises for VR clients. There is a premise that improving wellness will help with job retention. It is possible that a person's not lasting 90 days in a job has less to do with MH and more to do with other health conditions such as back pain. Questions exist about whether there a connection to the front end screening process or there any link between health status and job retention. That may help figure out what responsibility if any an organization has.

    b. There is some research in the spinal cord injury field that indicates people's perception of their wellness correlates with their entering employment.

    c. This data looks similar to the research on poverty and health. This is naturally bigger than just MH and health system and tied in to preventative healthcare and wellness. People in poverty do not usually have access to or when available do not normally use resources devoted to wellness and overall health maintenance and illness prevention.

    d. Possible research agenda suggested for VR RRTC or related projects could include:

        i. How do you collect better data on what clients are being shared by the system and how many clients have secondary health issues?

        ii. Possible case study of locations where these issues are being addressed?

        iii. What impact do physical health issues have on people losing jobs compared to the effects of psychiatric impairment?

F) How can VR address issues related to "employment readiness", including matters related to length of sobriety, commitment to Recovery, and harm reduction models?

Claire Courtney reviewed the readiness outline that she had prepared (below). She examined constructs of job readiness as outlined in the article "Putative Evidence of Employment Readiness" and compared it to VR policy and VR practice. There are variances on

how practices take place across the country. The Boston University model postulates that historical assessments of readiness are unrelated to employment outcomes. VR practices are very linear and do not always line up well with these constructs which are more fluid. The other contrast is that VR focuses on the work domain of people's lives and the readiness construct focuses on the individual and his/her life domain. There are other areas that are consistent with traditional VR philosophy in terms of informed choice and with the value of the individuals' perspective as being integral to rehabilitation planning.

<u>READINESS OUTLINE REFERENCED ATTACHED AS SEPARATE DOCUMENT</u>

I. MN continues to use these historical assessments and rely on them to determine if someone is ready to work with VR
- Staff is directed to spend a lot of effort in determining if a person is going to benefit from services. Clients have to demonstrate readiness through engagement and assessments
- They have increased funding for assessments in order to address limitation in resources
- Vendors doing situational and work based assessments in facilities to determine readiness prior to eligibility. An employment plan (IEP) is only developed for those who are ready
- MN has not seen change in outcomes yet; there is a workgroup that is looking at impact of this policy change
- This effort is an attempt to avoid waiting lists
- While this plan is not specific to clients with MH, it helps staff because these clients are seen as "risky"
- VR has done a little training on motivational interviewing and has a 32 question readiness checklist
- In order to avoid duplicating services provided by other agencies, counselors determine whether there is a unique service VR can provide; otherwise case is not opened and they provide consultation. This is driven by its agency capacity issue.
- There is no funding for MH specific for employment and long-term support.
- VR Innovation and Expansion (I & E) funds evidence based employment

II. OR is focusing on client motivation. Have been training staff on motivational interviewing so they can assess motivation
- Have been working with partners (MH) and work being done at both agencies is being mirrored
- Using instrument (5-6 questions) which is predictive of engagement
  - Childcare/family, transportation, income expectations, etc
- Stopped doing specialized caseloads due to capacity issue
- There is not sufficient funding for employment under VR
- Uses Services to Group authority extensively to build employment service capacities in community MH programs (Transitional Employment Programs).

III. MD was where MN is (traditional mode) when they started Johnson & Johnson/ Dartmouth (J & J) evidence based employment initiative
- Have moved away from upfront assessment. DORS only uses one question to determine readiness, "Do you want to work?" and gives clients benefit of the doubt
- Has found that traditional VR approach yields low outcome levels and frustration for the consumers, partner agencies and staff
- Have put the responsibility on the client and the community rehabilitation provider (CRP) for self assessment of "readiness for change.
- There is a lot of upfront work needed for a J&J state to implement services and Dartmouth and the University of Maryland have provided a lot of training.

- At one point MD had the second longest waiting list because they ran into capacity issues due to Order of Selection. MD DORS was able to secure additional state funding to address this issue.
- Has moved from general caseloads to specialized caseloads
- Important component is trust with partners and administration of other state agencies
- Has access to MH electronic documentation
- Community programs have a strong vocational component. They have the philosophy that employment is essential for overall health.
  a. Fortunate that there are no limitations in slots available
  b. Very strong employment commitment. They help cover funding if not available through VR.

IV. AK is working collaboratively with MH. Has a VR counselor in Juneau who spends time at the Club House weekly. This increases capacity and networking relationship.
- Has teamed up with local MH provider for supported employment. It takes some of this capacity to create supported employment positions. This helps decrease fear that counselors experience when taking clients that are considered "high risk".
- Working with MH providers on how to bill SSA for their services so they can get funding leverage
- The state MH Trust Fund is fairly substantial and has flexibility to leverage funds for system change
- Recently implemented a statewide training effort in six locations to help local mental health agencies build capacity to help their clients obtain and retain employment in conjunction with partnering with local VR and other agency staff
- Providing additional VR staff training on strategies to assist individuals with mental health challenges to obtain and retain employment.

V. NM goal is to establish better relationships but it is happening only in pockets
- Has three specialized MH caseloads in Albuquerque (most of the state is very rural) so very hard to have designated case loads for clients with psychiatric disabilities
- In these specialized caseloads, the counselors have more time to work with the clients. Less time is spent in eligibility. Finding it a challenge to generalize this approach to the general caseload.
- Has a robust state Developmental Disabilities system. VR has been establishing better relationships with other state systems, including MH.
- Has the AWARE system (electronic case management MIS that many VR agencies use) and it has capacity for more interfacing with other systems' data elements.
- Has purchasing collaborative as part of the NM Behavioral Health Purchasing Collaborative. Employment related issues do not get a lot of attention. Resources tend to go to medical treatment rather than rehabilitation issues.
  a. VR Director is attempting to "educate" members of the Collaborative on the relationship between employment and wellness

- Has established connections with local liaisons that coordinate services with DD. This process is much more fragmented with MH system. Part of the reason is that the NM DD system has been under a consent decree for a long time mandating better community services
- There has to be long-term support for individuals and at some point VR needs to step out.

VI. John Halliday noted that one of the issues is that the funding structure of MH varies from state to state, while VR basics look the same
  - Sources of money
  - Emphasis on employment differs
  - How can VR pool resources with MH?

<u>POLICY RECOMMENDATIONS EMANATING FROM THE VR- MH COMMUNITY OF PRACTICE</u>

One goal of the CoP, in addition to forming a learning community to meet and share ideas, is to use the collected wisdom generated by such a group on a specific topic to inform the broader community of interest. Therefore, some recommendations that grew out of the group discussions or analysis of this summary by the participants regarding how VR policy and practice could positively influence employment outcomes for people with significant psychiatric disabilities include:

1. The need for wider use of the deeming of eligibility – presumptive eligibility for more efficient and expeditious service delivery
2. The need for an expansion of data sharing, with clear federal guidance to support it for, individual consumer and program planning
3. The need for wider use of IPE options for consumer direction, including self directed IPEs using support personnel or advocates from the consumer's own network, not necessarily connected with VR. Some issues that need to be taken into consideration if this option is pursued aggressively would be:
   - How does that approach impact the VR role vis a vis other systems in the ongoing competition for adequate resources and scope of responsibility?
   - Does VR then only contribute money not expertise to the process?
   - Since most state VR counselors have more academic background in counseling and clinical interventions than the majority of MH Supported Employment or case management staff, why should they delegate more of the planning role?
   - Do MH systems have the capacity to assist people develop meaningful IPEs?
4. Support sensible employment readiness constructs through active interventions from VR and MH partners, not better "screening" tools. There are skills and processes that VR and its partners can utilize to support consumers moving forward in employment
5. The need for substance abuse guidance and practice in VR. There should be clear direction to end the inconsistency that VR programs have among intra- and inter-state offices regarding examining length of sobriety rather than a more functional approach emphasizing analysis of commitment to sobriety.
6. Clear partnership developed between VR and MH systems that should include a written Memorandum of Agreement (MOA) that outlines broad issues but does not, nor cannot micromanage operations. This should speak to both systems' belief in the importance,

desirability, and even responsibility of employment for people with psychiatric disabilities with structural improvements created in both to support this notion. Some detailed issues regarding funding responsibilities may need to be addressed but overall the MOA should focus on the building blocks of a relationship and not serve as an operational procedural document.

7. Development of braided, partnership funding options using VR, state MH, and where possible Medicaid funds, for successful employment services so that switching between streams is made relatively seamless and not continually dependent on individual staff or client negotiations in every instance

8. Exploration of Partnership Plus options for creative use of SSA Ticket to Work funding modeled on prospective models planned in MD and OR with a single state entity functioning as the EN

9. Put into place evaluative structures that assess VR and MH partnerships not just in terms of staff satisfaction and perception but documented positive employment and financial outcomes for clients as well as enhanced efficiency in service delivery in terms of speed of service, avoidance of unnecessary duplication of data collection from clients, and ease of use by staff of both systems.

10. Base core funding on outcomes/ milestone recognizing that for new programs some start up staffing might be needed. Consideration should be given to the percentage of milestone funding allocated prior to either placement or 90 day job retention. There currently exists a broad range of percentages at different stages of employment service across the states (20-60% funding before job placement) and there should be more attention to this balance through examination of data and outcomes across states and some economic analysis of the virtues of different funding weightings.

11. There should be more piloting of "Services to Groups" funding modality as an innovation strategy for developmental programs or directing interventions to particularly hard to serve groups.

12. Consider targeting program development funding for some locally identified subsets of the potential VR client with a psychiatric disability such as non English speaking, transition age youth with emotional behavioral problems, people with co-occurring disorders of substance abuse and mental health problems, an ethnic minority or immigrant/ refugee population, people who are homeless, etc.

13. Providing cross-agency incentives through performance measures that reward gradual, incremental movement toward improvement rather than only the employment outcome

14. There should be a focus on building a system that adopts mechanisms to foster, build and sustain interagency relationships and teams to create person-centered, wraparound type services, which are crucial in meeting the needs of people dealing with significant psychiatric disabilities.

15. There is general consensus in the MH and employment research literature that traditional "assessment" and "readiness" measure soften impede clients' progress towards employment because they can function as screening tools. Nonetheless, there are strategies that VR can use as supports for clients to be successful rather than divert them from employment options and more attention should be devoted to how these supports to help people identify and discover their strengths and capabilities ("assessment") and furthermore, use this information to create a more effective individualized job and career match ("readiness') can be applied effectively.