

# Vocational rehabilitation and mental health employment services: True love or marriage of convenience?<sup>1</sup>

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**Abstract.** There is a deep research base in the employment and mental health (MH) field that has supported the development of effective strategies for people with significant psychiatric disabilities. However, overall employment outcomes for people with serious mental illness have not increased significantly. This is true even with the recent emphases on recovery and system change or transformation. While employment continues to be stated as one of the cornerstones of recovery within mental health, vocational rehabilitation (VR) remains a crucial resource through interagency partnerships, funding, training, and policy development. The Institute for Community Inclusion's Rehabilitation Research and Training Center on Vocational Rehabilitation (ICI VR-RRTC) did case studies with state VR agencies examining innovations in these areas. This article describes three VR agencies in particular (Delaware, Maryland, Oregon) that served in many ways as excellent exemplars of using the multiple resources, skills, and services models that produced better employment results. It describes each state's specific partnership strategies, then concludes with findings from each as well as an overall analysis of key issues that should be applicable more generally vis-à-vis VR-MH collaboration on employment interventions.

**Keywords:** Employment, vocational rehabilitation, mental health, collaboration

The Vocational Rehabilitation Research and Training Center (VR-RRTC) based at the Institute for Community Inclusion (ICI) at the University of Massachusetts Boston partnered with a national group of content experts to identify potential promising public state

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vocational rehabilitation (VR) employment practices serving people with psychiatric disabilities involving cross agency collaboration and partnership development. This research effort was buttressed by developing specific case studies of "best practice" examples of several state VR agencies' support for employment of people with psychiatric disabilities. Historically, much of the pressure to produce employment outcomes for this group of people fell on the public VR system.

There is a deep research base in the employment and mental health (MH) field that has supported the development of effective strategies for people with significant psychiatric disabilities, notably the work emanating from the Dartmouth (NH) Psychiatric Research Center, (Haslett, Drake, Bond et al., 2011;

Bond, 2004) in the development of Individual Placement and Support (IPS). The last decade has seen greater attention paid to recovery, evidence based practices, mental health transformation, attempts to solve Medicaid disincentives issues, etc. Consequently, there has been more emphasis devoted to this aspect of psychiatric services that falls more under the purview of community mental health. As Rapp et al. (2005, p.351) noted: "The bedrock of policy makers' efforts is the establishment and codification of client outcomes. They are the ends for which the service system is designed and for which consumers, providers and others work. 'Achieving consistently positive outcomes is at the heart of Evidence Based Practice' (Goldman & Azrin, 2003, p. 901)." Yet overall employment outcomes for people with serious mental illness have not increased significantly. This is true even with the recent emphases on recovery and system change/transformation described above. Nationally less than 17% of adult public mental health consumers are employed at any level (SAMHSA, 2012) More disturbingly, the number of people who even attempt or get access to evidence based supported employment through public mental health programs (<2%) or even are in the labor force, even if unemployed (<34%) remains quite low (SAMHSA, 2012).

While employment continues to be named as a cornerstone of recovery within mental health, VR remains a crucial resource through interagency partnerships, funding, training, and policy development. While each of the 8 state VR agencies with which ICI did case studies represented some innovative practices, three in particular, Delaware, Maryland, and Oregon, served as exemplars of using multiple resources, skills, and services models to produce better employment results. Delaware (DE) offered an example of a VR – MH agency partnership that emphasized coordinating supported employment services across state agencies. Maryland (MD) demonstrated how two state agencies and local service delivery funding and delivery structures could align policies and procedures through system integration. Oregon (OR) focused on creating a sustainable partnership by utilizing a Medicaid billing code as a stable source of funding for supported employment (SE) services in conjunction with VR and state MH funding. While each of the states received consultation and assistance from several resources in varying degrees of intensity (from both Dartmouth under its Johnson and Johnson (J & J) project (Drake, Becker, Goldman, & Martinez, 2006) and ICI through paid consultation arrangements as well as local universities)

the descriptions following highlight each state's transformative activities. These 3 states were selected as examples of integrated and effective partnerships, with each representing some differing pressure points that led to the current relationships. DE reflects a state where the VR has been in many ways the lead in developing a sustainable partnership; MD demonstrates a state where the MH commitment has been solidified by a willing partner (VR) that has committed to actively supporting this initiative, and OR VR and MH have created a joint partnership to jumpstart the employment efforts concurrently throughout.

### **1. The Delaware experience**

DE Division of Vocational Rehabilitation (DVR) and the Delaware Division of Substance Abuse and Mental Health (DSAMH) have collaborated to provide SE services and supports to individuals with mental illness (MI) for several years. DVR contracted with the ICI to assist DSAMH and DVR in building on that start using braided funding from the two agencies. The organizations created an interagency agreement outlining funding responsibility for SE. They established an SE Coordinating Committee, hired an SE Coordinator who would be stationed within the central office of DSAMH, provided training to SE direct line staff and supervisors, reviewed policies from both agencies, reviewed IPS fidelity measures, and offered on site technical assistance (TA) from ICI and internal staff.

There are currently at least 2 providers in each county as consumer choice is a key element for DSAMH. There were many operational issues that surfaced during the initiation of this process in 2007 and thereafter into 2013 including recent changes in the funding model of the cooperative agreement: DSAMH has transferred its funding for SE to DVR for oversight and management, administrative staff turnover (including a new DSAMH Director and the loss of the central office assigned SE coordinator within DSAMH), a Department of Justice suit's resulting in a consent decree that specifies a DSAMH commitment to provide 1100 clients with SE services over a multi-year period, and restructuring of the DSAMH community services package into an ACT and a modified ACT treatment model. While these changes have affected DSAMH's ability to coordinate effectively and consistently, DVR attention has remained quite stable. Thus, DVR has been a linchpin for this effort as DSAMH administrative issues stabilized.

DVR and DSAMH attempt to facilitate system integration by aligning policies and procedures (regarding referral, intake, eligibility determination, data-sharing), as well as finances for SE services. In service to these goals DVR and DSAMH have worked out:

- Project Management for the Evidence Based Employment Program coordinated through a steering committee composed of representatives from both agencies and community based service providers.
  - DVR and DSAMH seek to examine data collection, outcome measures, evaluation criteria and reporting procedures, with a goal to establish common measures of success.
  - DVR and DSAMH each identify a program liaison to lead and coordinate joint efforts in the areas of communication, quality assurance, training, and policies and procedures.
  - DVR has entered into evidence based employment service agreements with service providers who have agreements with DSAMH to provide ACT services.
  - DVR administers both agencies' dedicated funds to maintain the evidence – based employment program for those eligible to receive DSAMH community services.
  - DSAMH requires participating MH providers to integrate employment into their MH treatment services program.
  - DSAMH requires participating MH service providers to report employment indicators as part of their contractual performance measurement and quality assurance process.
- The development of a viable joint funding model from both DVR and DSAMH;
  - The development of a broader data system/ MIS to use in measuring employment success for the system, including employment strategies other than supported employment;
  - Institution of leadership meetings to discuss policy and fiscal issues;
  - Highlighting the effort with presentations at state leadership groups including the state MH Advisory Council and the Governor's Commission on Community Based Alternatives.

Major challenges remain in DE DVRs continuing to promote the cause of employment within the MH community. It is still difficult for DSAMH to focus on employment given the multitude of changes it needs to make in response to the DOJ agreement and the relatively low priority employment has historically been given within all MH systems of care. DVR seeks to balance its willingness to be a good collaborator with ensuring that DSAMH expands its ability to ensure that more of its clients are able to increase their economic engagement in society. The standards DSAMH has adopted also assume that the vocational specialist in each community case management team provides significant services in this arena and should not be delegated to an outside agency such as DVR. One aspect of this public commitment and policy guidance has been DSAMHs working with the state Medicaid authority to develop Medicaid funds under various statutory authorities for the variety of supportive services that can impact employment.

The statistical results in terms of the four designated provider agencies have been variable though improving. It is also noteworthy that the overall percentage of DSAMH clients employed (not just in SE) and DVR clients with psychiatric disabilities both exceed the MH and VR average national figures (Marrone, Smith, & Foley, 2008). Some key systemic accomplishments:

- Renewed emphasis on employment and economic engagement among community MH service providers and within DSAMH, including the creation of a central office DSAMH managerial level administration position to oversee its SE efforts;
- The concrete example of DVR's interest in serving people with psychiatric disabilities through enhanced funding models;

## 2. The Maryland experience

The MD Division of Rehabilitation Services (DORS) and the Mental Hygiene Administration (MHA) have worked together through a cooperative agreement since 1987. Beginning in 2001, that collaboration was enhanced by establishing a partnership implementing IPS. These efforts have achieved significant results including IPS community providers having competitive employment outcomes for 60–70% of their enrolled consumers, the state VR agency's achieving a success rate significantly higher than the national average for persons with mental illness, a strong growth rate in the overall number of competitive employment outcomes for this population, and a strong network of community providers focused on employment services. There

were four core components that led to this successful systems transformation in improving and expanding employment for persons with serious mental illness.

*A) Leadership* – One significant element in systems transformation is effective and committed leadership. While the VR and MH public agencies contained effective leaders and shared responsibility among key staff, the transforming nature of the MHA director, cannot be overstated. He moved a large, complex agency from one that saw employment as not within its purview to one that sees employment as a core element of recovery for persons it serves. This vision, constantly reinforced, was an important determinant in the success of the MD systems transformation.

*B) Messaging* – Clear and consistent messaging to MHA and VR agency staff, community providers, consumers and other stakeholders and constituents was the second core element:

- Work is an essential component of recovery.
- Work is the expectation for all adults who are able to work (and we make the presumption that everyone can work).
- Our system will encourage, facilitate and move towards paid, integrated employment.
- Our system will remove (and not create) barriers to work.

The messaging must be done consistently and in a variety of modalities (policy, procedures, resource allocation, public information announcements, internal agency memoranda, etc.) and venues (budget hearings, public meetings with consumers and other constituents, staff meetings, training conferences, etc.)

*C) Systems Alignment* – Aligned messaging must be followed with aligned systems including:

- *Braided funding* – permitting providers to draw upon MHA and DORS dollars in an integrated funding model. MHA provides cost reimbursement to providers at pre-placement (assessment and benefits/work incentive counseling), job placement, and long-term ongoing support services. DORS provides funding for job development and intensive job coaching using a milestone approach.
- *Designated liaison counselors* – VR counselors with a specialization in serving people with psychiatric disabilities are expected to be co-located at least part-time at the community provider. The VR counselor functions as adjunct staff to the provider agency and is not viewed as a separate service entity.

- *Streamlining and integrating policies and processes* – Examples include: mandated referral to DORS/VR (with consumer's agreement) by the MH agency when a consumer requests employment services; use of "presumed eligibility determinations" by VR counselors when individuals are referred by public MH for employment services; DORS liaison counselors have limited "guest access" to MHA's case management system to promote information sharing; cross-walked application processes between DORS and MHA to eliminate redundancies.

*D) Ongoing TA and Staff Development* – MD established a TA Center located at the University of Maryland School of Medicine, Department of Psychiatry. Also, the Human Resource Development staffs of both VR and MH are very active in providing TA to staff of those public agencies and personnel of the community providers: Application of IPS fidelity standards is supported through TA and training for the creation and monitoring of those practices within a community agency including:

- Establishment and support of an affinity group of DORS, MHA and provider staff
- Annual joint training conferences conducted by MHA/DORS
- Specialized trainings offered to VR and provider staff.

In summary, the MD VR/MH partnership has met with success due to a systems approach in transforming traditional service delivery approaches in both agencies. It established a strong partnership built on trust and commitment of agency leadership that was widely shared among staff; resources (money and people) were aligned and braided; policies and processes were aligned and integrated wherever possible, and a strong and ongoing training and TA plan supported the entire effort.

### 3. The Oregon experience

Statewide implementation of IPS is the outcome of decades of collaboration between community MH providers and local VR branch offices, the ability to access funding outside traditional funding, and the belief that individuals, including youth, experiencing psychiatric illness can work. Oregon's passage of a bill that required that 75% of state general funds invested

in mental health be expended on evidence based services over a several year period also stimulated this work. IPS was introduced to the state at a statewide MH conference in early years of the previous decade. Two programs, one in the Portland metropolitan area and the other in southern OR, each secured Community Action grants to explore IPS implementation. In Portland the grant and a related federal grant was used to build consensus, plan, train, and eventually leverage funding from the state MH authority. A Dartmouth-J & J grant followed and supported three sites statewide. The numbers of sites had grown to seven prior to the award of a Medicaid Infrastructure Grant (MIG) in 2005. Increasing the availability of supported employment for both individuals with mental illness as well as intellectual and developmental disabilities was identified as a priority under the MIG. There are now IPS supported employment sites all across the state.

Collaboration was critical to the successful implementation of IPS. It grew from decades of work at the community level between local MH programs and VR branch offices. Joint training in the early 1980's for the implementation of supported employment training set the foundation for the partnership. A key element was a discussion of the cultural differences between the two programs. This event also created the space where the partners could plan how they would work together. Another important facet of the systemic shifts that occurred was funding from the community action grants and Dartmouth-J & J. Investments by VR, using the "services to groups" modality under VR funding regulations, aided in building the capacity in local community MH programs to provide employment services. Third, was a shared belief that the target population could work. Finally, OR was fortunate in that it has experienced stability in terms of the state and local partners' key administrative personnel's tenure. Perhaps the most important outcome of this partnership has been the creation of the Oregon Center for Excellence for Supported Employment which provides TA, training, quality assurance and research to VR and mental health programs. Funding for the Center came initially from the VR managed state MIG and subsequently directly from the state MH entity.

#### 4. Discussion

Various factors important to effective inter-organizational collaboration have been identified over the years that each of these states' activities have

exemplified in practice (e.g., aligning goals, sharing resources and expertise, building trust and mutual respect, joint planning, shared leadership, minimizing duplication, sustainability, message consistency (Fleming, Del Valle, Kim, Leahy, 2013; Oulvey, Carpenter-Song, Swanson, 2013). The emphasis of the 3 state examples is on highlighting VR-MH system partnerships. However, it is important to understand that these collaborative efforts are driven by the need to create systemic change in terms of employment outcomes for people with psychiatric disabilities. Laying a New Foundation (Greiff, Proscio, & Wilkins, 2003, p. 7) identifies five signs by which one can recognize system change. Each of the interventions described while not explicitly using these areas as guides nonetheless have effected results touted by those authors:

- a) *Change in power* – People with formal authority are responsible or driving the employment intervention [re]design process
- b) *Change in money* – New funding was dedicated to employment
- c) *Change in habits* – New structures, policies, and expectations about employment priorities were put into place
- d) *Change in technology or skills* – Training and TA and personnel job descriptions were developed to support the employment initiative in each of the states profiled.
- e) *Change in ideas or values* – There is a new definition of performance or success, which would now include employment within the MH agencies involved. In addition, data systems were put into place to track employment outcomes.

Most of the common themes that emerged mirror what many theorists have postulated over the years in regard to innovation, change management, and multi-system collaboration. Common concepts in both the business and human service research literature (Fedorowicz & Sawyer, 2012; Kotter, 1995; Lash, 2012; Shook, 2010):

- Top administration leadership creating and sustaining partnership activities
- Focusing on behavior rather than "attitudes" as a method for creating change
- Developing flexibility to foster creativity
- Offering local autonomy within larger organizations
- Bridging policy barriers or traditions

- Fostering partnerships that include agencies and constituents
- Using technological tools more effectively
- Braiding together multiple funding streams
- Using funding tied to outcomes more than processes
- Offering extensive advice, consultation, training, and TA
- Offering clarity in terms of the changes desired and the outcomes expected
- Creating a sense of excitement and/or urgency to the prospect of improving employment outcomes for people with significant psychiatric disabilities

The intent of the state illustrations was to examine pockets of excellence and promising practices regarding interventions to assist clients with psychiatric disabilities within state VR systems to attain and retain employment leading towards economic self-sufficiency. These examples are not meant to deny the obvious barriers and problems that still exist within these organizations. Many have proven difficult if not intractable in terms of improving the overall employment rate for people with behavioral health impairments. It was not meant as an exhaustive cataloging of all the possible innovations occurring throughout the country in this sphere. Nor, was it meant, as a review of the extensive literature within the MH research field regarding evidence based models of employment interventions for people with serious mental illness. This paper sought to offer some concrete examples of strategies that VR personnel at state and local levels have tried to implement as incremental steps towards dealing with the large scale societal problem that long term un- and underemployment of people with significant psychiatric disabilities represents.

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