

2005

30th
Institute on
Rehabilitation Issues

Innovative Methods for Providing Vocational Rehabilitation Services to Individuals with Psychiatric Disabilities

Rehabilitation Services Administration
U.S. Department of Education

The Council of State Administrators
of Vocational Rehabilitation

The George Washington University
Center for Rehabilitation Counseling Research and Education



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Foreword

The 30th Institute on Rehabilitation Issues (IRI) Primary Study Group (PSG) is pleased to provide this document, *Innovative Methods for Providing Vocational Rehabilitation (VR) Services to Individuals with Psychiatric Disabilities*. The membership of the PSG was comprised of a number of professionals from public VR, consumer organizations, and academic communities, all offering their individual expertise in working with individuals with psychiatric disabilities. The PSG provides a range of views offering alternative methods for providing VR services meant to be a user's guide for training and development, as well as a reference for current practices.

The monograph includes five chapters. Chapter 1 describes individuals with psychiatric disabilities, introduces common views on how VR provided services to this population, and identifies barriers preventing VR from providing services. Chapter 2 provides an overview of the history of the public VR programs serving individuals with psychiatric disabilities. Chapter 3 discusses current and best practices, in addition to presenting new and alternative methods. Chapter 4 addresses systemic issues impacting service delivery. Finally, Chapter 5 outlines implications for managing change and provides case study examples.

Each chapter concludes with a list of references and study questions related to the issues discussed in the chapter. Readers may go online to <http://www.gwu.edu/~iri/studycrs.htm> for an opportunity to earn CRC continuing education hours for answering the study questions.

Also included are three appendixes at the end of the document, offering readers a Glossary of Terms, Public VR data on serving individuals with psychiatric disabilities, and a list of RSA Special Demonstration Grantees.

Participation in an IRI study is an honor as well as a major commitment. The responsibilities require extensive literature reviews, research, and writing. The editors and PSG Members wish to express their appreciation to the Full Study Group; their input was most beneficial in developing this document. Participation in the IRI is an opportunity for learning as well as personal and professional growth.

—The Editors

Donald W. Dew, Ed.D., CRC

Greg Mandrake Alan, MRC, CRC

Chapter 1

People

By Marianne Farkas, Robert F. Kilbury, Kathryn Cohan McNulty, Kenneth R. Wireman, William A. Cochran, and Stephaine Parrish Taylor

Statement of the Problem

In framing this topic for the Primary Study Group, Rehabilitation Services Administration (RSA) Commissioner Joanne Wilson used the metaphor of “Seabiscuit.” In that story, an unorthodox trainer recognized the potential of both a jockey who was “washed-up” and a horse that was trained to fail. Deep inside this team of jockey and horse were courageous athletes who caught the attention of the American public during the Great Depression and became some of the greatest winners in racing history. An unusual combination of an unorthodox trainer and a jockey and a horse with great heart was the spark to cause the realization of their hidden potential. People with and without psychiatric disabilities are inherent winners who often simply need someone to offer encouragement and hope, to realize their potential.

The analogy for serving individuals with psychiatric disabilities in the vocational rehabilitation (VR) program seems obvious. It is the VR counselors’ job to see the vocational potential within their consumers; to help them pursue informed vocational objectives and develop plans for getting to the finish line of competitive employment, consistent with their abilities and interests; and to support individuals in their ultimate quests for independence, productivity, and self-worth.

Students of rehabilitation know that VR has not always embraced this subgroup as a disability population. In fact, the VR program began before 1920 as an

opportunity to help physically disabled war veterans gain work. Only with the enactment of the Barden-LaFollette Act in 1943 did it afford consumers with psychiatric or even developmental disabilities the opportunity to be served (Rubin & Roessler, 1987). While the provision to facilitate the ability of individuals with psychiatric disabilities to go to work has, therefore, been in effect for some 60 years, it seems fair to say that VR did not fully embrace this challenging expansion until the last two or three decades.

Why Should There Be A Focus on Individuals with Serious Psychiatric Disabilities

Psychiatric or mental health issues rank first among illnesses that cause disability in the United States, Canada, and Western Europe (World Health Organization, 2001). This serious public health challenge is under-recognized as a public health burden. In the United States, it has been estimated that 2.6% of the population have a serious psychiatric disorder (Substance Abuse and Mental Health Services Administration [SAMSHA], 1993). The group comprises approximately 18% of federal and state rehabilitation consumers and represents the second largest population served by this system (Baer, 2003). The issue of providing excellent treatment and rehabilitation for the estimated eight million Americans with psychiatric disabilities has received prominent attention during recent years. As President, George W. Bush indicated in his speech announcing the New Freedom Commission on Mental Health (President's Commission) "Our country must make a commitment: Americans with psychiatric disabilities deserve our understanding, and they deserve excellent care. They deserve a health system that treats their illness with the same urgency as a physical illness" (Albuquerque, NM, April 29, 2002).

According to the President's Commission report (2003), individuals with psychiatric disabilities are over represented among the homeless. Of more than two million adults in the United States with at least one episode of homelessness, 46% reported having had a mental health problem. In a NAMI: The Nation's Voice on Mental Illness (NAMI) Treatment/Recovery Information and Advocacy Database (TRIAD) report (Hall, Graf, Fitzpatrick, Lane, & Birkel, 2003, p. 20), it was reported that 31% of individuals with psychiatric disabilities lived alone and 9% lived in supervised community residences. On the NAMI Website, Koerber (2003) indicated that veterans made up one third of all homeless people; 43% of homeless veterans have a diagnosis of severe and persistent psychiatric disabilities, and 69% of the homeless have a substance abuse disorder (NAMI, 2003). The President's Commission report (2003) states that a University of Pennsylvania study found that homeless people who were placed in permanent supportive housing cost over \$16,000 less per person annually compared to previous costs for mental health, corrections, Medicaid, and public institutions and shelters. The Criminal Justice system also has an over representation of individuals with psychiatric disabilities. In the NAMI TRIAD report (Hall et al., 2003, p. 22), 44% of respondents to the survey reported being arrested or detained in their lifetime. Only 35% reported receiving services that could have prevented an unnecessary arrest, and only 60% reported receiving services following arrest and detention. The President's Commission reports that 7% of those who are incarcerated have serious psychiatric disabilities, which is three to four times that of the general population. In the Juvenile Justice system, 66% of boys and 75% of girls have a psychiatric disorder. An additional problem identified by the President's Commission report is service access in rural America. Rural America makes up 90% of the nation's landmass and is home to 25% of the population. Of over 1,600 federally designated mental health profes-

sional shortage areas, more than 85% are rural (Hall et al., 2003).

This President's Commission (2003), the first since the Carter Commission 25 years ago, pointed out that in addition to the tragedy of lost lives, psychiatric disabilities come with a devastatingly high financial cost. According to the 1999 Surgeon General's Report, the annual economic, indirect cost of psychiatric disabilities in the United States is estimated to be \$79 billion. Approximately \$63 billion reflects the loss of productivity as a result of illnesses, but additional costs also include almost \$4 billion in productivity losses for incarcerated individuals and for the time of those who provide family care (U.S. Public Health Service Office of the Surgeon General, 1999). In 1997 (the latest year comparable data are available) the United States spent more than \$1 trillion on healthcare, including almost \$71 billion on treating psychiatric disabilities.

The concept of disability associated with this varied target group has been dramatically changing due, in part, to the influence of the field of rehabilitation. Historically, the mental health system has held that serious psychiatric disability inevitably follows a course of increasing deterioration. More recently, recovery from psychiatric experiences has become the leading vision for the field (Anthony, 1993; Harding & Zahniser, 1994; Harding, Zubin, & Strauss, 1992; Spaniol, Koehler, & Hutchinson, 1994). Recovery has been described as a way of living a satisfying, hopeful, and contributive life even with limitations caused by the impairment (Anthony, 1993). Recovery is the process in which people are able to live, work, learn, and participate fully in their communities. For some individuals, recovery is the ability to live a fulfilling and productive life despite a disability. For others, recovery implies the reduction or complete remission of symptoms.

Definition of the Population: Who is Included?

Anthony, Cohen, Farkas, and Gagne (2002) review several definitions of severe psychiatric disability, which characterize the population of interest. These definitions share common elements that can be used to clearly identify the group in question: Adults with serious psychiatric disabilities are age 18 and over, who currently or at any time during the past year, have had a diagnosable mental, behavioral, or emotional disorder of at least two years to meet diagnostic criteria specified within the *Diagnostic and Statistical Manual of Mental Disorder IV-TR or DSM-IV-TR* (American Psychological Association, 1994), and have functional impairments which substantially interfere with or limit one or more major life activities (living, learning, or working).

Sub-Groups within the Larger Group

Within the group of individuals who have had psychiatric difficulties for two years or more, there is a wide array of sub-groups (such as, persons with dual diagnoses, people who are street dwellers, or young adults who have never been hospitalized). In addition, there are racial, ethnic, and rural minorities. An issue of *The Research Exchange*, published by the National Center for the Dissemination of Disability Research (1999), notes the following:

Concepts of race, ethnicity and culture are often intertwined and misapplied, and often in ways that result in stereotyped beliefs about groups and individuals. It is problematic to assume that minority groups share a common culture or other characteristics. Rather, it is important to look at subpopulations, seeking to identify commonalities and differences.

(<http://www.ncddr.org/du/researchexchange/v04n01/intro.html>)

Racial and ethnic minority Americans comprise a substantial and growing segment of the U.S. population. Current projections show that by 2025, these groups will account for more than 40% of all Americans (U.S. Census Bureau, 2001a). Manderscheid, Brown, Milazzo-Sayre, and Henderson (2002) describe the ways in which the mental health system has not kept pace with the diverse needs of racial and ethnic minorities, often underserving or inappropriately serving them. Specifically, the system has neglected to incorporate respect or understanding of the histories, traditions, beliefs, languages, and value systems of culturally diverse groups. Minorities receive inequitable treatment and services from both mental health and vocational rehabilitation. Findings from Section 21 of the 1992 Amendments to the 1973 Rehabilitation Act conclude that:

Patterns of inequitable treatment of minorities have been documented in all major junctures of the vocational process. As compared to White-Americans, a larger percentage of African-American applicants to the vocational rehabilitation system are denied acceptance. Of the applicants accepted for service, a larger percentage of African-American cases are closed without being rehabilitated. Minorities are provided less training than their white counterparts. Consistently, less money is spent on minorities than on their white counterparts. (Flowers, Edwards, & Pusch, 1996, p. 22)

The Presidents Commission (2003) reports significant barriers still remain in access, quality, and outcomes of care for minorities. As a result, American Indians, Alaska Natives, African Americans, Asian Americans, Pacific Islanders, and Hispanic Americans bear a disproportionately high burden of disability from mental disorders. This higher burden does not arise from a greater prevalence or severity of illnesses in these populations. Rather, it stems from receiving less

care and poorer quality of care (U.S. Public Health Service Office of the Surgeon General, 2001). Receiving appropriate mental health care depends on accurate diagnosis. Racial and ethnic minorities' higher rates of misdiagnosis may contribute to their greater burden of disability. For instance, African Americans are more likely to be over-diagnosed for schizophrenia and under-diagnosed for depression (U. S. Public Health Service Office of the Surgeon General, 2001). To compound this problem, physicians are less likely to prescribe newer generation antidepressant or antipsychotic medications to African American consumers who need them (Melfi, Croghan, Hanna, & Robinson, 2000).

Approximately 25% of the U.S. population lives in rural America, and the vast majority of these also experience disparities in mental health services (U.S. Census Bureau, 2001a). Despite these proportions, rural issues are often misunderstood and minimized. Policies and practices developed for metropolitan areas are erroneously assumed to apply to rural areas. Access to mental health care, attitudes toward psychiatric disabilities, and cultural issues that influence whether individuals seek and receive care differ profoundly between rural and urban areas (National Advisory Committee on Rural Mental Health, 2002). The Surgeon General identified the difficulties that those in rural and other geographically remote areas have in accessing excellent services many individuals with psychiatric illnesses have inadequate access to care, limited availability of skilled care providers, lower family incomes, and greater social stigma for seeking mental health treatment than their urban counterparts (U.S. Public Health Service Office of the Surgeon General, 1999). As a result, rural residents with mental health needs enter care later in the course of their disease than their urban peers; enter care with more serious and disabling symptoms; and require more expensive and intensive treatment response (Wagenfeld, Murray, Mohatt, & DeBruyn, 1994). Finally, for

People

rural, racial, and ethnic minorities, all of these problems are compounded by their minority status and the dearth of culturally competent or bilingual providers in these medically underserved areas (President's Commission, 2003).

Another issue that needs to be considered in service planning and placement is the issue of multiple co-existing disabilities. In the Employment Intervention Demonstration Program (EIDP) study (Cook, Carey, Razzano, Burke, & Blyler, 2002), which was an eight-state study with 1,648 participants, 40% of the participants had at least one co-existing disability. The largest groups were below average intelligence, head injury, and visual impairment. The Division of Vocational Rehabilitation in the State of Missouri indicated that of 4,567 clients with psychiatric disabilities, 39.2% received services from two or more other agencies in FFY02 (Phillips, 2003a) and 41.4% did so in FFY03 (Phillips, 2003b).

Where Do Individuals with Serious Psychiatric Disabilities Live?

Most residential data cannot be compared across studies, so we do not have information about where most individuals with psychiatric disabilities live (Anthony et al., 2002). Individuals live in apartments, private homes, boarding houses, group homes, foster care homes—in short, the gamut of what both the general housing market provides—as well as types of housing that supervised housing programs provide. Fewer and fewer individuals reside in inpatient facilities. With respect to housing preferences, most individuals prefer to live in their own apartments or houses, even though family preferences are for supervised settings (Corporation for Supportive Housing, 2002; Holley, Hodges, & Jeffers, 1998; Rogers, Danley, Anthony, Martin, & Walsh, 1994).

Do Individuals with Psychiatric Disorders Receive Higher Education?

Depending upon the sample, between 52% and 94% of individuals with serious psychiatric disabilities are high school graduates and 15% to 60% of these go on to college (Anthony et al., 2002). Concern over educational status has increased as individuals become more apt to pursue professional and managerial careers. Given that individuals with serious psychiatric disabilities represent the gamut of interests, talents, capabilities, and personalities, it is clear that some will have the requisite desire and intellectual ability to go on to higher education. Groups who were surveyed cited these barriers, in order of importance financial support, tutoring services, special classes, and transportation (Mowbry & Megivern, 1992; Mowbry, Brown, Sullivan–Soydan, & Furlong–Norman, 2003).

Do Individuals with Psychiatric Disabilities Work?

Unfortunately, the consistently low rates of employment among individuals with serious psychiatric disabilities make it difficult to envision vocational recovery. Compared to individuals with other types of disabilities whose unemployment rate is around 67%, the unemployment rate for individuals with psychiatric disabilities is 85% to 92% (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

individuals 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, policy makers, 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 vocational rehabilitation counselors view consumers' personal work goals as "unrealistic." Baron (1997) points out that the national system of supports, such as Social Security disability benefits, healthcare, 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, which make decent housing a possibility.

Despite these difficulties, research has demonstrated that the majority of individuals with psychiatric disabilities do want to have competitive employment, whether part-time or full-time (Rogers, Walsh, Danley, & Smith, 1991). Many rehabilitation programs, however, are not adequately funded to provide the array of vocational rehabilitation services needed to obtain even an entry-level position. In the general population and disabilities groups as a whole, the U.S. Census Bureau provides the following information (1997, Table 4; 2001b, Table P059). In 1997, in the age group 21 to 64 years of age, 84.4 % of persons without disabilities were employed compared to individuals with severe disabilities (31.4%) and individuals with psychiatric disabilities—excluding learning disabilities, mental retardation, and dementia (29.4%). In 2001, in the age group 16 to 64, 15.2% of men and 14.8% of women had a disability. In 2001, in the age groups 16 to 64, 49.6% of all men with disabilities were employed compared to men without disabilities 81.67%; 41.4% of all women

with disabilities were employed compared to women without disabilities 68.5%.

Researchers believed that by identifying those client characteristics that predicted vocational outcome, clients who would be more difficult to place and therefore would need more services and those who were "more ready" to begin work would be more easily identified. Over the last several decades, a variety of studies have examined the relationship between various client demographic and clinical factors and vocational outcome (Anthony, 1994). Individuals' previous work histories, their skills to perform work adjustment, and the capacities to control their symptoms were the most commonly cited predictors (Botterbusch, 2000a, 2000b; Knight & Aucoin, 1999; Collins, Mowbry, & Bybee, 2000; Tsang, Lam, Ng, & Leung, 2000). However, predicting who is likely to benefit from vocational services or achieve vocational outcomes based on demographic and clinical variables has proven to be a somewhat illusive exercise (Anthony, Rogers, Cohen, & Davies, 1995; Rogers, Anthony, Cohen, & Davies, 1997). There is some evidence to suggest that if a person seeks and is engaged in a vocational program, many of the variables thought to be related to unsuccessful vocational outcomes (such as, poor employment history, poor work adjustment skills, more hospitalizations, being unmarried, being black, receiving benefits, or being unskilled) are not actually related to vocational outcome (Anthony, 1994).

Recently, researchers have investigated factors associated with successful employment. They have begun to study those who have jobs and have kept them. A national, non-representative sample of 109 individuals with a self-reported diagnosis of a schizophrenia that met criteria for vocational recovery completed a survey on sustained employment of individuals with serious psychiatric disabilities. Eighty-two participants (75%) had uninterrupted employment during the two years prior to entering the study, while the rest sustained

employment for at least 12 months during the same period of time. Respondents worked from 10 to 64 hours per week in jobs ranging from unskilled to professional and managerial positions. Factors that were associated with vocational recovery among these respondents included previous work history and current receipt of Supplemental Security Income (SSI). The receipt of Social Security Disability Income (SSDI) seemed to have something to do with current work hours per week and how much a person was paid per hour; educational level and employment in consumer self-help/ help/ advocacy settings were associated with occupational status (Russinova, Wewiorski, Lyass, Rogers, & Massaro, 2002).

What are the Perceived Barriers to Employment?

According to the survey from NAMI, the barriers to employment for individuals with psychiatric disabilities 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 persons 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 et al., 2003).

Discrimination, Stigma, Myths, and Attitudinal Barriers

Discrimination against individuals with psychiatric disabilities is present today in the workplace. In addition to the complex divergence of systemic outcomes and individuals outcomes, there is the overlying fact that discrimination is at work in even the most enlightened of workplaces.

Moreover, the stigma that individuals internalize because of these attitudes and belief systems creates an additional hurdle in the realm of employment. Stigma is “pre-determined attitudes or beliefs, regarding an individual or a group, which disempower or devalue that individual or group and undermine relationships with them,” according to “The Anti-Stigma Project” (1994, p. 4).

It can be argued that individuals with psychiatric disabilities are a cultural minority; and, while VR counselors are not necessarily mental health workers, it is good practice to deliver services to individuals with psychiatric disabilities in a culturally competent fashion. According to the National Technical Assistance Center for State Mental Health Planning (NTAC) Report (2002), “Mental Health Recovery: What Helps and What Hinders?” “hope and recovery is retarded by staff who do not know about the latest or most effective treatments, who hold low expectations and are pessimistic about the expectations for their clients” (p. 43).

There are two components to changing counselors’ attitudes about work discrimination. First, they must gain an understanding of the discrimination faced by returning workers; and, second, they must explore the way stigma has affected their beliefs about individuals with psychiatric disabilities. Some common misconceptions that counselors may have about individuals with psychiatric disabilities are that they are not capable of recovering, cannot tolerate stress on the job, or are dangerous; and gainful employment is an illusive, unattainable goal. According to a newsletter article entitled “Embracing Recovery: A Simple Yet Powerful Vision” (1999/2000), “people with psychiatric disabilities want to be treated as persons of worth and dignity who have the right and ability to aspire to goals that they choose, not those chosen for them.”

(http://www.nasmhpd.org/general_files/publications/ntac_pubs/networks/mw00.html).

Attitudinal barriers are threefold. Individuals may have preconceived notions about their own capacity for work; counselors may have preconceived notions about how to interact with or help individuals; and the employment setting itself is likely to contain discriminatory barriers.

Employers may feel that individuals with psychiatric disabilities will be unable to work as hard or maintain their jobs.

The solution for many of the barriers faced by working individuals with psychiatric disabilities include reasonable accommodations such as flexible hours, job-sharing, private spaces, and diminished sensory stimuli. These accommodations are ones that counselors typically know how to create. To move forward with successful interaction in working with individuals with psychiatric disabilities, however, the VR counselor needs maximum flexibility from the organization's internal standards of productivity, such as case closures. The counselor has the capacity to assist in life-changing, recovery-oriented life work for the individual with psychiatric disabilities. The challenge in accomplishing this is making the recovery process fit within systemic goals of RSA. The counselor needs to understand recovery from the perspective of individuals with psychiatric disabilities, knowing that case closure may not be the inherent initial goal, and work to sustain the belief that the counselor's role is more than closure.

What Systems Changes are Needed?

People/Outcomes/Recovery

When looking at outcomes, the first major component of defining what is expected is to decide whether what is being measured is a systemic, organizational, or individual outcome. Often, VR counselors are subject to defining their work through the confines of systemic outcomes. During an interaction with consumers with psychiatric disabilities, it becomes clear that systemic

outcomes may often run counter to individual needs and desires.

The service system does not accommodate itself to the actual experiences of individuals with psychiatric disabilities. The systemic outcome of maintaining mainstream employment for a minimum of 90 days and the resultant closure of the case does not leave room for responsive, respectful interactions with consumers with psychiatric disabilities. The very nature of disability often does not follow a linear path; it is, rather, described in this way:

For us, and in the intimate conversations we have had with other mindful people who experience mood swings, fear, voices and visions, our lives seem not to follow a traditional linear path; our lives appear more to be like advancing spirals. (Cohan & Caras, 1999) (<http://www.narpa.org/transform.htm>)

Life with psychiatric disabilities may be subject to ebbs and flows of the capacity to sustain the demand of ongoing employment. On an individual level, there are differences in perception between individuals with psychiatric disabilities and the VR counselor. Individuals who work for one week and then lose their jobs may see this experience as the most valuable experience in their lives to date, while counselors may become discouraged and feel that the intervention was a failure. According to the NTAC report (2002), "Making recovery tangible through successfully taking many small steps increases hope" (p. 46), and hope is an integral part of the recovery process (Nunn, 1999).

In contrast, the outcomes that an individual desires can be something quite different. When working with individuals with psychiatric disabilities, there are multiple factors to consider. The most successful models that have been used espouse a consistent long-term and flexible support to assist individuals in attaining their goals. Moreover, how the individual defines success in

the work environment can be dramatically different than having gainful employment for a minimum of 90 days. Individuals who have spent many years outside of the workforce have a lot to contend with upon reentry, as do persons who may have no work histories at all. Issues of self-esteem, competency, and niche come to the foreground in establishing a work environment where individuals may find success. There is anecdotally a paradoxical relationship for individuals with psychiatric disabilities to go to work, in that while work can add a significant degree of stability in their lives, the very act of going to work may carry with it a risk of instability.

Ironically, there is no room for such a complex dynamic process for the individual to return to work when considering a minimum of 90 days and closure. The most successful cases of intervention are VR counselors who have decided that keeping cases open and seeing intermittent work as a step toward recovery is a desirable way to work with individuals with psychiatric disabilities.

Recovery itself is an important term that is generally misunderstood within a psychologically oriented framework. A traditional definition of *recovery* is the return to a level of functioning prior to disability onset. In looking at psychiatric disabilities, there is a complex way to see recovery. For instance, while the disability may not change, individuals' responses to their psychiatric disabilities may be characterized by marked increase in coping and restructuring.

The President's Commission report (2003) defines recovery as "the process in which people are able to live, work, learn, and participate fully in their communities" (<http://www.mentalhealth-commission.gov/reports/FinalReport/FullReport.htm>). For some individuals, recovery is the ability to live a fulfilling and productive life despite a disability. For others, recovery implies the reduction or complete remission of symptoms. Science

has shown that having hope plays an integral role in an individual's recovery (Nunn, 1999).

The meaning of recovery originated from the ideas, beliefs, and experiences of consumers and is centered on hope and the establishment of a meaningful life. Rather than a destination, recovery is seen as a journey that changes individuals' outlooks, how they perceive the world, and how they play a part in that world. It is a journey that transcends a medical, physical, or psychosocial model that defines psychiatric disability. A primary concept of recovery is based on individuals taking charge of their own lives (Wireman & Hoffman, 2002).

Incorporating recovery into outcomes is a significant challenge for the counselor who sees the systemic outcomes that they need to attain. It is important to understand that in helping individuals with psychiatric disabilities, closure does not equate to recovery, nor does recovery happen every time consumers meet closure. The role of employment is important to recovery, according to the NTAC (2002) report in the section on "Formal Services: What Helps."

People would be assisted to succeed in the world of work. Vocational services and supports would be available; people would have opportunities to learn job skills; people would have access to supported employment. There would be support for higher-level employment, and professional status employment rather than steering people exclusively into low-level jobs. (p. 58)

The processes are related, yet independent from each other. The counselor's role in helping an individual recover and become productive is far more dynamic than historically thought possible. The counselor can play an integral role in being a catalyst in helping the person recover without ever meeting closure. We have to remember that someone's first day of work may be the achievement of years of struggle and preparation. That first day of work, even if it also is the last, can be one of the best outcomes for an individual.

How has VR Done in Serving this Population?

More than a decade ago, the success rate with the State VR services program for this population had been estimated to be roughly half the rate of those with physical disabilities (Marshak, Bostick, & Turton, 1990). However, according to more recent statistics from Fiscal Year 2001, 31.5% of individuals with psychiatric disabilities had their cases *closed with an employment outcome*, compared to 36.5% for all disability categories served by VR. At the same time, 25.4% had their cases *closed without services* (RSA, 2001), while only 19.9% of the total VR caseload was closed in this manner. While both of these statistics would suggest poorer outcomes for the population of individuals with psychiatric disabilities, the success rate appears to have improved markedly since the Marshak et al. study, published less than a decade and a half ago.

In the TRIAD report (2003), it was stated that 20% of the survey respondents had incomes of less than \$5,000; 71% had incomes less than \$20,000; and 72% received SSDI or SSI as a source of income. Two thirds were unemployed and just 30% had income from wages, 17% of which were part-time and 14% were full-time. The President's Commission report (2003) indicated that 70% of individuals with severe psychiatric disabilities with college degrees earned less than \$10 per hour. Further, individuals with severe psychiatric disabilities represented the single largest diagnostic group (35%) on the SSI roles and over a quarter of all SSDI recipients (President's Commission, 2003).

In terms of earnings, in fiscal year 2001 those with psychiatric disabilities earned an average of nearly \$271 per week, while those consumers without psychiatric disabilities earned about \$292/week. For hours worked, those in the first category worked 31.28 hours per week, while those without psychiatric disabilities worked

32.26 hours. Interestingly, those with psychiatric disabilities were more likely to have worked in Clerical and Sales (25.54%) and Service occupations (27.57%) than were their peers with other types of disabilities (21.62% and 23.11%, respectively). They were also significantly less likely to be closed into the categories of Structural Work (4.71% vs. 6.61%) or as Homemakers (1.32% vs. 5.00%) (RSA, 2001). Studies of supported employment, including the EIDP, show 60% to 80% of individuals with severe psychiatric disabilities obtained at least one competitive job compared to 19% who remained in traditional vocational programs (President's Commission, 2003). Individuals with psychiatric disabilities earned median hourly wage of only \$6 per hour versus \$9 per hour for the general population (President's Commission, 2003).

Alternatively, Cook (2003) found more positive outcomes for individuals with psychiatric disabilities. "One year after closure, 71% of those who were employed when they exited the VR system were still employed" (p. 1). There was the tendency, according to the author, for these individuals to be disproportionately working in low paying, entry-level jobs. Of course, such a tendency compromises the ability of those served by VR to leave Social Security benefits and achieve the "American dream." It seems to be apparent, therefore, that while vocational outcomes must be improved for consumers with psychiatric disabilities, there has been a marked degree of improvement in recent years.

What Barriers have Prevented VR from Providing Services for Persons with Psychiatric Disabilities?

While there may be no definitive answers to this question, there are a number of possible reasons. The stigma that is attributed to many members of society in interacting with persons with psychiatric disabilities can also be evidenced, to some

degree, in the behavior of VR counselors, especially those who have had little formal training in psychology. Individuals from marginalized communities of color experience both the burden of the stigma associated with the psychiatric disability as well as those associated with their ethnic or cultural heritage. So, what is stigma exactly? Katz (1981) indicated that Irving Goffman defined stigma as “an attribute that is deeply discrediting—that reduces the possessor in our minds ‘from a whole and usual person to a tainted, discounted one’” (p. 2). Negative attitudinal patterns of professionals towards individuals with psychiatric disabilities serve to undermine the therapeutic relationship, and such tendencies on the part of professionals “serve to further diminish the rehabilitation and recovery of the person with a psychiatric disability” (McReynolds & Garske, 2003, p. 14). While today’s VR counselor is certainly the most highly-trained, educated professional in the history of the state-federal program, no doubt there is still some prejudice toward individuals with psychiatric disabilities.

Clearly, Congress recognized the degree that individuals with psychiatric disabilities were the objects of prejudice and discrimination by including them as a covered entity under the Americans with Disabilities Act (ADA). Some would argue that the prohibition against being able to ask applicants and employees about their mental health history is one of the most enduring legacies of the passage of the ADA, as outlined in the Title I Regulations (Public Law 101-336). Individuals with hidden disabilities, especially those with psychiatric disabilities, have certainly benefited from this important provision of the law. Further, the fact that employers of 15 or more now have to make reasonable accommodations to qualified applicants and employees with psychiatric disabilities unless doing so would constitute an undue hardship is another benefit of this important law. It is not always apparent what accommodation can be obtained for a particular

person, and this often puts individuals in the position of disclosing their disability when doing so may be problematic. Finally, several of the recent U.S. Supreme Court decisions have compromised these rights to some degree.

Another possible reason that VR has been slow in effectively serving this population is the fact that only in the past couple of decades has the symptoms of many psychiatric disabilities been controllable by medication. While Thorazine was the first such medication to be developed for an institutionalized population some 50 years ago (Falvo, 1999), many of the modern-day antipsychotics, antidepressants, mood stabilizers, and anti-anxiety medications have only recently been utilized successfully with this population. Medication stabilization is often seen as a prerequisite to the consideration of work as a possibility for individuals with psychiatric disabilities.

The importance of the interface between the mental health system in a particular state and the VR program is also of relevance here. The role that work plays in one’s mental health status only recently has been recognized. The positive contribution that work can play in the recovery of individuals with psychiatric disabilities has not been valued by the mental health system across the board. In states where the relationship between the two systems is strained or where there is less of a premium placed on work as a therapeutic factor, it is likely that there has been less progress made in helping individuals with psychiatric disabilities return to work. In the past, a referral from the mental health system to VR might only be made when the individual was deemed to be stable, or perhaps not at all if it were perceived to adversely affect their mental health status due to increased stress.

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Study Questions

1. The Barden-LaFollette Act afforded consumers with psychiatric disabilities the opportunity to be served with VR services in what year?
 - a. Prior to 1920
 - b. 1943
 - c. 1973
 - d. 1987
2. According Baer (2003), what percentage of clients served by federal and state rehabilitation programs are individuals with psychiatric disabilities?
 - a. 2.6%
 - b. 10%
 - c. 18%
 - d. 20%
3. According to the President's Commission report (2003), what percentages of boys and girls in the Juvenile Justice system have a psychiatric disability?
 - a. 50% boys & 55% girls
 - b. 60% boys & 65% girls
 - c. 66% boys & 75% girls
 - d. 76% boys & 85% girls
4. According to U.S. Public Health Service Office of the Surgeon General (2001) and Melfi et al. (2000), African-Americans are more likely to be which of the following?
 - a. Overdiagnosed with Schizophrenia
 - b. Underdiagnosed with Depression
 - c. Less likely to be treated with a new generation antidepressant
 - d. All of the above
5. In the EIDP study (Cook et al., 2002), what percentage of individuals with psychiatric disabilities had at least one co-existing disability?
 - a. 40%
 - b. 55%
 - c. 35%
 - d. 26%
6. According to the survey from NAMI (Hall et al., 2003), what was the largest barrier to becoming employed for individual with disabilities?
 - a. Inadequate treatment of disability
 - b. Lack of Vocational Services
 - c. Lack of transportation
 - d. Stigma and discrimination
7. A traditional view of recovery implies which of the following?
 - a. The return to a level of functioning prior to disability onset
 - b. While the disability may not change, individuals' responses to their psychiatric disabilities may be characterized by marked increase in coping and restructuring
 - c. The process in which people are able to live, work, learn, and participate fully in their communities
 - d. The ability to live a fulfilling and productive life despite a disability

People

8. While rural America makes up 25% of the population, what percentage of federally designated mental health professional shortage areas are in rural areas?

- a. 35%
- b. 50%
- c. 75%
- d. More than 85%

9. According to the President's Commission report (2003), what percentage of the homeless report having a mental health problem?

- a. 23%
- b. 33%
- c. 46%
- d. 53%

10. According to Anthony et al. (2002), while 67% of people with disabilities are unemployed, what are the percentages for individuals with psychiatric disabilities?

- a. 85% to 92%
- b. 75% to 82%
- c. 65% to 72%
- d. 55% to 62%

Chapter 2

History

By Claire Courtney

Evolutionary Review of Mental Health and Vocational Rehabilitation Services

Employment remains an important but elusive goal for many individuals with psychiatric disabilities. To understand the current state of vocational rehabilitation practice with individuals with psychiatric disabilities and the serious systemic challenges, it is necessary to understand the historical roots and current legislation influencing modern rehabilitation practices both from the perspective of the public mental health (MH) system and the public (federal-state) vocational rehabilitation (VR) program in the United States.

The Fifteenth Institute on Rehabilitation Issues (15th IRI) monograph (1988) focusing on “Enhancing the Rehabilitation of Persons with Long-Term Mental Illness” examined the evolution of vocational rehabilitation and community mental health concepts and treatment systems through the 1980s. Unfortunately, this document is no longer readily available. Therefore, highlights of this work are incorporated in this document.

During the 15 years since the 15th IRI (1988) concluded its work, the mental health and vocational rehabilitation systems have continued to evolve on paths that have not yet converged. It is promising that employment has come to be recognized as an important element of recovery for individuals with psychiatric disabilities in both systems. Unfortunately, efforts to coordinate between the two systems remain prob-

lematic due to the systemic differences between VR and MH in legislation, financing, mission, staff professional training, and service delivery philosophies (Accordino, Porter, & Morse, 2001; Bianco & Wells, 2001; Dellario, 1985; Ford, 1995; Katz, Geckle, Goldstein, & Eichenmuller, 1990; Marrone & Golowka, 1999; McReynolds & Garske, 2003).

This chapter traces the history of the public VR program and state MH systems relative to employment for individuals with psychiatric disabilities from the 1920s through today. The goal is to identify the evolutionary factors that contribute to a lack of coordination between the two systems and result in today's lack of a coherent and coordinated national policy that supports the employment goals of individuals with psychiatric disabilities. In addition, Appendix B includes the percentages of individuals with psychiatric disabilities rehabilitated by public VR programs. Data included ranges from 1946 to 2002.

Historical Roots

Large institutionally based treatment programs or mental hospitals, prompted by the work of mental health pioneers such as Benjamin Rush and Dorothea Dix, became the norm in mental health treatment from the mid 1880s up through the 1940s (Rubin & Roessler, 2001). Although the concept of rehabilitation was not the focus, many of these institutions were self-sustaining; and, therefore, engagement in work activity or work as therapy was promoted and encouraged (15th IRI, 1988).

Initially, the public VR program, created in 1920 by the National Civilian Vocational Rehabilitation Act (also known as the Smith-Fess Act, P.L. 66-236), focused on persons with physical disabilities. Employment opportunities afforded to persons with disabilities as a result of the labor shortage created by World War II demon-

strated the work potential of persons with disabilities who had not previously been in the workforce (Rubin & Roessler, 2001). Although the public became more aware of the ability of persons with disabilities to perform in the competitive labor market during World War II, unfortunately these attitudes did not seem to have a long-lasting impact after the war ended (Rubin & Roessler, 2001).

Barden-LaFollette Act

Congress first authorized public vocational rehabilitation services for individuals with psychiatric disabilities and mental retardation in 1943 with the passage of the Barden-LaFollette Act (P.L. 78-113). The Act also expanded services to include physical restoration, living expenses, and the provision of VR services to persons who were blind. Although the Act enabled the public VR program to serve individuals with psychiatric disabilities, little increase in the number of individuals with psychiatric disabilities served in the VR program was seen until the late 1950s. For example, in 1946, the percentage of individuals with psychiatric disabilities rehabilitated by the VR program was 2.9%; in 1955, the percentage was 3.5% (Rehabilitation Services Administration [RSA], 1970).

Deinstitutionalization Movement

Deinstitutionalization in the United States began in the 1950s with the goal of shifting the care of individuals with developmental and psychiatric disabilities to the community (U.S. Department of Health and Human Services [HHS], 1999). The National Mental Health Act of 1946 (P.L. 410), which provided funding for psychiatric education and research, encouraged the movement toward community treatment of individuals with psychiatric disabilities. As the federal government provided grants to states to support existing outpatient treatment centers or build new pro-

History

grams, outpatient clinics were established in each state and multiplied rapidly (Accordino et al., 2001). Emerging psychopharmacological treatment for individuals with psychiatric disabilities resulted in earlier treatment and more rapid hospital discharge. Improved control of psychiatric symptoms became the primary focus of most rehabilitation interventions (15th IRI, 1988).

VR Expansion

The 1954 VR Act Amendments (P.L. 83-565) expanded VR services to serve a broader population of individuals with psychiatric disabilities and mental retardation (Rubin & Roessler, 2001). Some of the significant provisions of P.L. 83-565 for individuals with psychiatric disabilities were the creation of rehabilitation research and demonstration grants, creation of extension and improvement grants, development of rehabilitation facilities, and the training of professional rehabilitation counselors. Funds authorized for development of rehabilitation facilities enabled state VR agencies to remodel and expand buildings used for sheltered workshops and other programs. VR funds could also be used for initial staffing costs of sheltered workshops. Accordingly, from the mid 1950s through the 1960s, VR became a significant provider of employment related services to persons with psychiatric disabilities. By 1965, the number of persons with “mental illness” rehabilitated by the VR program had risen to 13.6% (RSA, 1970).

Community Mental Health Centers

In 1963, the Community Mental Health Centers Act (P.L. 88-164) led to the establishment of Community Mental Health Centers (CMHCs). The goal of the CMHCs was to shift treatment for individuals with psychiatric disabilities from state mental hospitals to the community (Bianco & Wells, 2001). Subsequently, about 700

CMHCs were established across the country with assistance from this program (Tashjian, Hayward, Stoddard, & Kraus, 1989). In reality, individuals with more severe psychiatric disabilities tended to receive more acute services such as medication, crisis intervention, and screening, which were not necessarily the intensive long term supportive services required for maintaining community living; and CMHCs progressively became more oriented to promoting the private practice model for those persons who were able to benefit from psychotherapy (Accordino et al., 2001). The net effect of much of the mental health legislation in the 1960s was considerable diversity among states regarding responsibility for various segments of individuals with psychiatric disabilities in terms of where treatment was provided, the types of services developed in the community, the providers of these services and the intergovernmental arrangements required to pay for these services (Tashjian et al., 1989).

Medicaid and Medicare

In 1965, the amendments to the Social Security Act Amendments (P.L. 89-97) expanded income protection for persons with permanent disabilities and established Title XVIII (Medicare) and Title XIX (Medicaid) to provide insurance for persons with disabilities, and impoverished individuals, including those with disabilities (Bianco & Wells, 2001). These amendments also created the first linkage of Social Security to Vocational Rehabilitation as Congress mandated that the Social Security Disability Income (SSDI) fund cover the cost of rehabilitating disability beneficiaries through the state vocational rehabilitation agency (Rubin & Roessler, 2001).

During this time, amendments to the Vocational Rehabilitation Act in 1965 (P.L. 89-333) significantly increased the federal VR funding resources. Other provisions of the 1965 Act, expanded research and demonstration projects directed

toward services for individuals with psychiatric disabilities. These projects included replication of the psychosocial clubhouse model (as developed by Fountain House in New York). The 1965 amendments also implemented 6- and 18-month extended evaluation as a method for determining employment potential. In addition, federal regulations which implemented the 1965 amendments defined behavioral disorders without designating any specific psychiatric diagnosis, thus opening the program to many persons in social categories who would not otherwise have met previous program eligibility criteria, such as persons with alcohol and chemical dependency and criminal offenders (Rubin & Roessler, 2001).

VR Third Party Agreements

Given the significant increases in federal VR funding in the 1960s, state VR agencies were challenged to generate funds (non-federal share) that could be used to match the rapid and considerable increases in federal funding. Third party agreements with other agencies were widespread. These often involved the introduction or insertion of VR services into a cooperating agency's traditional services with the other agency providing staff and other resources to carry out the program that was administered under the auspices and control of the VR agency. Common "third party arrangements" included agreements between VR, schools, prisons, hospitals, and halfway houses. Relative to individuals with psychiatric disabilities, VR often established cooperative programs in state mental hospitals, e.g., the addition of a VR unit, including counselors and evaluators, which offered a full range of evaluation, counseling, and restoration and training services to a state mental hospital campus. However, as noted by the 15th IRI (1988) because MH professionals looked upon work adjustment and vocational rehabilitation as separate from mental health treatment and goals, public VR professionals often operated quite

independently within these MH settings. On the positive side, these third party agreements played a significant role by providing employment services to individuals with psychiatric disabilities in the 1960s and into the 1970s.

The Rehabilitation Act of 1973

In the 1970s, the emerging disability consumer movement influenced rehabilitation legislation (Rubin & Roessler, 2001). In VR, the 1973 Rehabilitation Act (P.L. 93-112) reflected a trend toward eliminating discrimination and integrating persons with disabilities into all aspects of society. Features of the Act that most clearly reflect this spirit include a focus on serving persons with severe disabilities, a mandate to involve consumers in the planning and delivery of services, initiation of the Individualized Written Rehabilitation Program (IWRP), program evaluation, a continued emphasis on research, and advancement of the civil rights of persons with disabilities (Sections 501-504). Additional features include authorization of long-term training in rehabilitation counseling, establishment of Client Assistance Programs or CAP, and the provision of post-employment services to help people maintain employment. Perhaps most significant to individuals with psychiatric disabilities, the public VR program, while keeping gainful employment as the goal, was required to provide services to persons with severe disabilities first, before providing services to persons with less severe disabilities.

The Act eliminated the "behavioral disorder" category as a qualifying disability in the determination of VR eligibility. In 1975, RSA issued an Information Memorandum (IM 75-39) titled *Efforts to Expand Psychiatric Rehabilitation Programs Serving Severely Handicapped Mentally Ill Individuals*, which discussed the increase in the

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number and percentage of persons classified as “mentally ill” whom the public VR program rehabilitated since the late 1960s. The memorandum noted that much of the increase in the category of “mental illness” was in the “behavioral disorder” category, which had been counted under the rubric of “mental illness” for statistical purposes. The memorandum further indicated that when the figures for persons in what the public VR program referred to at that time as the “psychosis” and “psychoneurosis” categories, were examined, virtually no gains had been made for over a decade. RSA’s program development office initiated several efforts at that time to increase emphasis on individuals with psychiatric disabilities and to more effectively engage other public mental health agencies, including establishing a Psychiatric Rehabilitation Task Force, awarding short-term training grants to develop materials on psychiatric rehabilitation, and establishing a working relationship with the National Institute of Mental Health (NIMH) (RSA, 1975).

In 1977, the RSA project-grant program included the additional category of “severe mental illness” (15th IRI, 1988). In 1978, P.L. 95-602 (Rehabilitation Comprehensive Services and Developmental Disabilities Amendments) amended the Act. These amendments included the establishment of the National Institute of Handicapped Research (known today as the National Institute on Disability and Rehabilitation Research [NIDRR]), and the establishment of independent living centers, which had been initially included in previous rehabilitation legislation (P.L. 93-112) but vetoed by President Nixon (Rubin & Roessler, 2001).

Collaborative Agreement between NIMH and RSA

In 1978, RSA and the NIMH developed and signed a model collaborative agreement between MH and VR on the national level. The purpose

of this agreement was to set forth principles and operating procedures to guide NIMH, RSA, and their state and local counterparts in establishing relationship and operational plans to facilitate services to individuals with psychiatric disabilities on an “effectively coordinated and integrated basis without duplication of effort” (NIMH, 1978, p. 12). However, implementation of state level agreements largely did not occur until the middle of the 1980s (Katz et al., 1990). Despite an emphasis on these agreements, a number of barriers continued to exist with and across VR and state MH agencies (Dellario, 1985; Kress-Shull, 2000).

Community Support Programs (CSP) and Psychiatric Rehabilitation

Trends begun in the 1960s by the CMHCs continued throughout much of the 1970s. In 1978, NIMH began the Community Support Program (CSP), designed to encourage a comprehensive approach to providing all needed community services to individuals with psychiatric disabilities. The focus was on those persons who were, or would be, inappropriately institutionalized and on the provision of supportive community services, including housing, employment-related services and social services (Bianco & Wells, 2001). In a number of states, CSPs developed close working relationships with their state VR agencies (Tashjian et al., 1989).

Mental health programs began providing data on the psychiatric rehabilitation approach. The psychiatric rehabilitation movement continued to grow with the establishment of research and training centers on psychiatric rehabilitation, including those at Boston University, Matrix Research in Philadelphia, and the University of Illinois, Chicago. The psychiatric rehabilitation research centers produced valuable information on effective practice in psychiatric rehabilitation; however, as noted by the 15th IRI (1988), most

of those who adopted psychiatric rehabilitation principles tended to be those workers in the community mental health field versus those working in or with the public vocational rehabilitation program.

Shifts in Public MH Funding

The 1980s brought improvements in treatment, diagnosis, and changes in the funding of services for persons with serious mental illness (SMI). This included publication of the third edition of the “Diagnostic and Statistical Manual” or DSM in 1980, which was intended to provide more reliable diagnostic criteria determined by observable symptoms (American Psychiatric Association [APA], 1980). Changes in mental health funding on the federal level, driven by the Omnibus Budget Reconciliation Act of 1981 (P.L. 97-35), eliminated the bulk of federal funding of community treatment for persons with SMI, further shifted the financial burden for MH services to states (Accordino et al., 2001). The Act also authorized states to develop home- and community-based waivers to provide services to persons who would otherwise be institutionalized. The federal government now provided funding to each state for community mental health services through the Alcohol, Drug Abuse and Mental Health Block Grant, which directly reinforced the notion that traditional treatment services were all that MH agencies must provide (Ray & Finley, 1994). The State Comprehensive Mental Health Services Plan Act of 1986 (P.L. 99-660) required states to submit comprehensive plans for mental health, expanded community mental health services by allowing community mental health providers to receive reimbursement from Medicare and Medicaid, established case management as a distinct benefit under Medical Assistance, and allowed states to add rehabilitative services (known today as the MRO-Medicaid Rehabilitation Option) as an option under the Medicaid program (Accordino et al., 2001).

During the 1980s, individuals with psychiatric disabilities, their families, and MH advocates continued to organize and learned to better utilize the political process for communicating their needs. Organizations such as the NAMI: The Nation’s Voice on Mental Illness (NAMI) and the National Mental Health Association, or NMHA, began to exert influence on the political and policy process. In the late 1980s, NAMI publicly voiced its concerns that neither VR nor MH was meeting the employment needs of persons with SMI and pointed out that the VR concept of “reasonable expectation” often was problematic for persons with SMI, and they emphasized the need for ongoing community supports for employed individuals with psychiatric disabilities (15th IRI, 1988).

A focus on Recovery and Consumer Empowerment and substantial consumer involvement in the field during the 1980s insured a continued emphasis on psychiatric rehabilitation models that reinforced a person-centered focus. Other positive changes for individuals with psychiatric disabilities included the development and expansion of networks of community-based providers as well as changes and enhancement in reimbursements from Medicare and Medicaid for mental health treatment services (Accordino et al., 2001). The Robert Wood Johnson Foundation (RWJF) sponsored projects designed to produce standards for psychosocial clubhouse models and provide training for establishing clubhouses (Bianco & Wells, 2001).

Supported Employment

In VR, RSA in 1985 provided discretionary Supported Employment Project Grants with specific projects focused on implementing supported employment for individuals with psychiatric disabilities (RSA, 1985). RSA also sponsored Joint Vocational Rehabilitation/Mental Health Agency Training, which was designed to facilitate cooper-

ative relations between these two agencies (Katz et al., 1990).

In 1985, the Consolidated Omnibus Budget Reconciliation Act (P.L. 99-272) authorized states to cover case management on less than a statewide basis to targeted groups under Medicaid and include supported employment and pre-vocational services to persons with developmental disabilities under home and community based waivers for those who had been institutionalized. In 1986, the Protection and Advocacy for Mentally Ill Individuals Act (P.L. 99-139) established a formula grant program for existing protection and advocacy systems, primarily focusing on the abuse and neglect of individuals with psychiatric disabilities. Development of mental health infrastructure at the state level continued with great variability among states in terms of the location of the mental health authority within state government, the overall scope and responsibility of the state agency in administering programs and the division of fiscal responsibilities between state, regional, and local authorities (Tashjian et al., 1989).

The 1986 amendments to the Rehabilitation Act (P.L. 99-506) made an even stronger commitment to persons with severe disabilities and authorized the provision of rehabilitation engineering (Rubin & Roessler, 2001). The 1986 amendments defined supported employment as an outcome for the VR program and included funding for the development and implementation of Supported Employment services (Title VI, Part C; now Title IV, Part B). The state vocational rehabilitation program regulations to implement these amendments (August 14, 1987), provided a definition of supported employment, which included transitional employment (TE) as a form of supported employment for persons with “chronic mental illness” (Section 103). The regulations also defined competitive work (used in the definition of supported employment) as working 20 hours per week at a minimum. Psychosocial

rehabilitation programs were also included in the definition of rehabilitation facilities. Additionally, System Change grants for supported employment were funded to allow states to focus on the development of supported employment programs for persons with severe disabilities, including those with psychiatric disabilities.

In the late 1980s, RSA conducted a study of the capacity of the VR program to effectively serve individuals with psychiatric disabilities. This report, *Best Practice Study of Vocational Rehabilitation Services to Severely Mentally Ill Persons*, analyzed current practices in the state-federal VR program, identified the VR-related service needs of “severely mentally ill” persons, examined relationships between VR and other service providers, and described effective practices and service models (Tashjian et al., 1989).

Among the many findings of this report, it was noted that VR’s rehabilitation rate for “mentally ill persons” was lower than the system’s rate overall (56% compared to 64%). RSA data indicates that the percentage of persons with “mental illness” who exited the system as rehabilitated in that year was 17.8% (RSA, 1988).

The Best Practice Study report also summarized a number of strategies that state VR agencies had implemented to improve services to individuals with psychiatric disabilities, including state-level interagency agreements, interagency committees and task forces with MH, interagency agreements, joint funding of specialized supported employment programs, co-location of VR staff at MH sites, and specialized counselor training. Factors found to pose the most serious interagency coordination barriers included differences in employment expectations across systems, different eligibility criteria, differing service delivery models, and shortages of funding and personnel (Tashjian et al., 1989).

Americans with Disabilities Act (ADA)

In 1990, the Americans with Disabilities Act (P.L. 101-336) was signed into law. Five titles of the ADA prohibit discrimination in the areas of employment, public sector services, private sector services, telecommunication, and miscellaneous areas. The passage of the ADA and subsequent court decisions affecting (and in many cases, limiting) its application represent a watershed in U.S. civil rights history for persons with all disabilities, including those with psychiatric disabilities. While many of the protections written into the ADA were foreshadowed in Section 504 of the Rehabilitation Act of 1973, this law, whose employment provisions went fully into effect on July 26, 2002, created a set of employment rights and expectations for persons with disabilities seeking governmental relief and protection from employment discrimination (Rubin & Roessler, 2001).

Unfortunately, the promise of the ADA, especially for individuals with psychiatric disabilities, has not been matched by results. In many recent legal cases, the group of people who could claim legal protection has been severely circumscribed. The overall effect of the U.S. Supreme Court's recent decisions has been to make it more difficult to establish a substantial limitation on a major life activity, a key component of the eligibility requirements for being considered a qualified disabled person under the law (National Council on Disability, 2003). As Hausman (2002) states:

The ADA's requirements and definition of disability make it difficult for people with mental illness to win ADA claims. Employees with disabilities, especially those with mental illness or substance abuse disorders, have little chance of prevailing when they file employment discrimination cases against their employer. In its fifth annual survey of such cases brought under the ADA, the American Bar Association's Disability Law

Reporter found that employers won nearly 96 percent of discrimination cases filed in courts and 73 percent of cases filed as administrative complaints with the federal Equal Employment Opportunity Commission. (p. 6-a)

Despite the potential of the ADA, its impact on employment for persons with significant disabilities has proven negligible (Harris, 2000). It would seem reasonable that the economic boom that fueled the U.S. economy during the decade of the 1990s should have improved the employment participation of persons with all disabilities, including individuals with psychiatric disabilities; however, as noted throughout this document, the unemployment rate of individuals with psychiatric disabilities remains unacceptably high.

1992 Rehabilitation Act Amendments

The amendments to the Rehabilitation Act in 1992 (P.L. 102-569) were of significant benefit to individuals with psychiatric disabilities. Most noteworthy was the elimination of the reasonable expectation criterion in VR eligibility, which was replaced with the presumption of ability to benefit. Previously, individuals had to demonstrate their rehabilitation potential and "feasibility" for employment. In assuming that all individuals have employment potential, the notion of feasibility was removed; and, instead, the rehabilitation counselor must demonstrate by clear and convincing evidence that no employment outcome is possible in order to determine a person ineligible for services. This had the effect of shifting the burden of proof for accessing the VR system away from the individual with psychiatric disabilities to the system and changed the evaluation of rehabilitation potential to an assessment of eligibility and rehabilitation needs.

The Rehabilitation Act Amendments of 1992 (P.L. 102-569) focused on the use of existing evaluation data, and time frames were established

regarding VR eligibility (60 days, unless an extension is mutually agreed upon by the person and the counselor). These amendments strengthened the involvement of the individuals served in developing their rehabilitation plans (informed choice). The Amendments of 1992 also provided several definitions to assist in establishing a common language and terminology within the rehabilitation community, including defining an employment outcome. The term *community rehabilitation program* replaced the term *rehabilitation facility* and recognized that medical, psychiatric, psychological, social and vocational services could be provided in one coordinated program.

The 1992 Amendments continued to focus on prioritizing VR services to persons with the *most severe disabilities* and required each State VR agency to develop criteria for determining which individuals were individuals with the most severe disabilities. The implementing program regulation further clarified that in making this determination, the state's criteria must be consistent with the statutory definition of *individuals with a severe disability*. An *individual with a severe disability* is defined as an individual with a disability:

- who has a severe physical or mental impairment which seriously limits one or more functional capabilities in terms of employment outcome;
- whose vocational rehabilitation can be expected to require multiple VR services over an extended period of time; and
- who has one or more physical or mental impairments resulting from amputation, arthritis, autism, blindness, burn injury, cancer, cerebral palsy, cystic fibrosis, deafness, head injury heart disease, hemiplegia, hemophilia, respiratory, or pulmonary dysfunction, mental retardation, mental illness, multiple sclerosis, muscular dystrophy, musculo-skele-

tal disorders, neurological disorders, paraplegia, quadriplegia, and other spinal cord injuries, sickle cell anemia, specific learning disability, end-stage renal disease, or another disability or combination of disabilities determined on the basis of an assessment for determining eligibility and VR needs to cause comparable functional limitation.

The Rehabilitation Act Amendments of 1998 later replaced the term *severe disability* with the term *significant disability*.

Revised regulations for the state VR program (June 24, 1992) emphasized that supported employment was a program for persons with the most severe disabilities but eliminated the minimum 20-hour-per-week work requirement, instead establishing an individual goal for hours worked per week on an individual's IWRP. The regulations attempted to address concerns of supported employment advocates that individuals with psychiatric disabilities were not being served in supported employment and the notable lack of extended service providers for such persons. Definitions relative to supported employment included a revised definition of ongoing support services that allowed exceptions to the requirement for twice monthly on-the-job monitoring of individuals in supported employment, if the individual plan reflected that off-site monitoring was more appropriate. However, a once monthly contact with the employer was required in addition to two meetings a month with the individual in supported employment. These regulations also allowed natural supports as an extended service. The definition of transitional employment was revised to clarify that ongoing support for TE included continuing sequential job placements, afforded by the extended services provider until job permanency was achieved, following transition from time-limited services.

In the early 1990s, RSA conducted a Program Administrative Review (PAR) on the “Provision of Vocational Rehabilitation Services to Individuals who have Serious Mental Illnesses.” The purpose of the PAR was to determine the extent to which “best practices” were associated with the achievement of employment outcomes by individuals with “SMI” and their use within the state agencies. The report indicates that in 1992, individuals with the primary disabling condition of “mental illness” made up about 19% of individuals who received services from the state vocational rehabilitation agencies and exited as rehabilitated and that persons with “mental illness” were the second largest disability group served by VR agencies (RSA, 1995). The report concluded that, overall, agencies and counselors appeared knowledgeable of and supportive of the best practices explored, but implementation of the practices varied considerably (RSA, 1995).

Employment Incorporated into MH Services

The advances in supported employment policy also reflected a growing emphasis on the need to evaluate the state-of-the-science in mental health and vocational rehabilitation. In June 1995, the Center for Mental Health Services, or CMHS, of the Substance Abuse and Mental Health Services Administration (SAMHSA) launched the first federally-funded, multi-site study of promising practices in supported employment, the Employment Intervention Demonstration Program (EIDP). Unlike the majority of previous studies of vocational rehabilitation services for individuals with psychiatric disabilities, the EIDP specifically focused on outcomes related to competitive employment, including salary at or above minimum wage and the level of integration within work settings (Cook, Carey, Razzano, Burke, & Blyler, 2002).

In 1996, the Health Insurance Portability and

Accountability Act, or HIPPA, (P.L. 104-191) was passed. This Act was designed to improve access to healthcare in a number of ways, including guaranteeing that health insurance was available, portable and renewable, and limiting pre-existing condition exclusions. Also, in 1996, the Mental Health Parity Act (P.L. 104-204) was passed, which included a prohibition against health insurance companies having lower lifetime caps for treatment of psychiatric disabilities when compared to treatment for other medical conditions. In 1997, the Balanced Budget Act (P.L. 105-33), among other things, permitted states to allow workers with disabilities with a family income below 250% of poverty to buy-in to Medicaid and eliminated the prior institution criteria for habilitative services under home- and community-based waivers (for persons with developmental disabilities). It also permitted states to mandate adults (including those with disabilities) into a managed care plan by amending their state plans.

In 1996, The National Association of State Mental Health Program Directors (NASMHPD) developed and disseminated a position statement on employment for individuals with psychiatric disabilities. This statement called upon state mental health authorities to take a leadership role in increasing the employment rate of individuals with psychiatric disabilities (NASMHPD, 1996).

In 1997, the Final Rules for the VR Program (February 11, 1997) further defined competitive employment as work that is performed in an integrated setting, indicating that individuals must earn at or above minimum wage, but not less than customary wage and benefits paid by the employer to other workers. Integrated setting with respect to an employment outcome was defined as a setting typically found in the community in which individuals interact with other non-disabled individuals (other than service providers). For supported employment, off-site

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support could be provided under special circumstances, especially at the request of the individual, and the previous requirement that off-site monitoring (minimum of twice monthly meetings with the individuals) also include one monthly contact with the employer was eliminated.

Workforce Investment Act (WIA)

The Workforce Investment Act of 1998 (P. L. 105-220) was intended to create a seamless system for employment and training program delivery and universal access to all persons, including persons with disabilities. For the first time in the history of the public VR program, the Rehabilitation Act Amendments and Title IV of the WIA were combined with enabling legislation for over 60 separate job-training programs. The overall purpose of the WIA was intended to meet the needs of America's employers for well-trained employees and America's citizens for improved access to employment, training, and other related services. The concept of the "one-stop delivery system" or the "one-stop shop" was the centerpiece of the WIA.

A subject of ongoing current public policy debate within the rehabilitation field is whether persons with significant disabilities can obtain appropriate services under a generic system of services such as that envisioned in the WIA. Many believe that it cannot adequately meet the needs of individuals with psychiatric disabilities; others believe that the One-Stop Center System, as institutionalized by WIA, provides a vehicle for creation of an integrated delivery system at the local level that can provide, through the collaboration of mental health, vocational rehabilitation, traditional employment and training programs, and the services required to meet the needs of individuals with psychiatric disabilities. The research on successful employment services for individuals with significant psychiatric disabilities (cited in chapter 3) emphasizes the specialization, intensity, and

long-term duration of supports needed for vocational success. This debate takes on added importance in the context of vocational rehabilitation of individuals with psychiatric disabilities. Mental Health advocates have pointed out that, historically, individuals with psychiatric disabilities as well as MH service providers have found that employment and training services at state labor departments, as well as public VR offices, do not serve them adequately (Bianco & Wells, 2001).

One salient result of the ADA that impacts individuals with psychiatric disabilities is what is known as the Olmstead decision. On that date, the U.S. Supreme Court ruled in *Olmstead v. L.C.* (1999) that under Title II, ADA institutionalization of a person with a disability who, with proper support, can live in the community is considered discrimination. At the time the suit was filed, both plaintiffs were receiving mental health services in state-run institutions, even though their treatment professionals believed they could be appropriately served in a community-based setting. Subsequent to this decision, the federal government has undertaken several efforts, including the President's New Freedom Initiative (Executive Order 13217), which called on states to swiftly implement the Olmstead decision. As a result of the executive order, state-specific Olmstead plans have been created to address the needs of persons still facing long-term placement in institutional settings, i.e., primarily individuals with either developmental or psychiatric disabilities.

In addition to linking VR to a State's Workforce Investment system, the 1998 amendments to the Rehabilitation Act and subsequent state vocational rehabilitation regulations to implement the amendments (January 17, 2001) expanded informed choice to encompass the entire rehabilitation process, renamed the IWRP the Individualized Plan for Employment Plan, or IPE, and established presumptive eligibility for VR applicants receiving SSI or SSDI, provided

that the person intended to achieve an employment outcome. Further, on January 22, 2001, the VR regulations revised the scope of *employment outcomes* under the VR program by redefining the term employment outcome to mean outcomes in which persons with disabilities work in an integrated setting, thus, eliminating the public VR program's ability to "take a successful closure" for an employment outcome in a sheltered workshop or any other non-integrated setting.

Public Policy and Mental Health

Stigma and discrimination against individuals with psychiatric disabilities have come to be recognized as significant barriers to the employment and integration of individuals with psychiatric disabilities. The Clinton administration sponsored a conference in 1999 on mental health issues that focused on dispelling the myths and prejudices about individuals with psychiatric disabilities and emphasizing the importance of mental health as an integral part of physical health (White House Conference on Mental Health and Working for a Healthier America, 1999). At the end of that year, *Mental Health: A Report of the Surgeon General* was published (HHS, 1999). This landmark document also sought to address and eradicate the stigma surrounding mental health and the treatment of psychiatric disabilities. It encouraged the use of innovative pharmaceutical and psychotherapy treatments. The report also highlighted the lack of comprehensive public mental health services noting that the U.S. mental health system remains multifaceted and complex and that agencies intended to serve individuals with psychiatric disabilities do not always function in a coordinated manner (HHS, 1999)

Mental health advocates supported and were encouraged by the passage in 1999 of a Social Security Administration program, the Ticket to Work and Work Incentives Improvement Act of 1999 (TWWIIA) (P.L. 106-170). It was hoped

that this legislation would improve employment options for individuals with psychiatric disabilities through (a) issuance of "tickets" that persons with disabilities could use to obtain vocational rehabilitation, employment or other support services from providers of their choice; (b) improvement of incentives for persons receiving SSA who return to work; (c) encouragement to states to develop Medicaid buy-in programs for working persons with disabilities; and (d) funding for the development of a provision of Benefits, Planning, Assistance and Outreach, or BPAO, to provide work incentive planning and assistance to individuals who are receiving SSA disability benefits. However, to date, MH advocates have identified many problems in the implementation of the Ticket to Work program for individuals with psychiatric disabilities (National Association for the Mentally Ill [NAMI], 2003).

In the late 1990's mental health advocates continued to publicly voice serious concerns that the VR needs of individuals with psychiatric disabilities were not being met by either the public VR program or state mental health agencies (Bevilacqua, 1999; Noble, Honberg, Hall, & Flynn, 1997). In a controversial report titled "A Legacy of Failure: The Inability of the Federal-State VR System to Serve People with Severe Mental Illness" (Noble et al., 1997), NAMI pointed out that based on a national survey they conducted, there was an "abject failure" on the part of the public VR program to improve the employment of individuals with serious psychiatric disabilities (Noble et al., 1997). At the same time, Bevilacqua (1999) pointedly stated that interagency collaboration between VR and state mental health agencies was all too often "cosmetic" and that the VR program had not changed to reflect newer approaches in mental health treatment (such as the Individual Placement and Support Model [IPS]) that had the potential to significantly improve employment rates for individuals with psychiatric disabilities. MH advo-

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cates called for drastic changes in the VR agency, including the closure of the VR program and the transfer of funds for the employment needs of individuals with psychiatric disabilities away from the public VR program to integrated mental health programs that could provide vocational and psychiatric rehabilitation services on a continuous, non-time-limited basis (Bevilacqua, 1999; Noble et al., 1997).

Supported Employment as an Evidence-Based Practice

Presently, in public mental health, emphasis is currently being placed on the integration of vocational services into community mental health treatment rather than reliance on other systems (such as the public VR program) or outside agencies to provide employment services. RWJF (2002) in conjunction with the Federal Substance Abuse and Mental Health Services Administration (SAMSHA) initiated its Evidence Based Practice (EBP) Project. Public MH authorities have been encouraged to develop strategies to promote evidence-based practices, especially in light of diminished resources for community mental health as a result of federal and state budget cuts.

As outlined in the EBP Toolkits (RWJF, 2002), an evidence-based practice is one that meets several criteria: (a) the practice is well defined with explicit program principles that have been operationally defined; (b) the practice has been studied in a number of rigorous research projects, including randomized controlled trials, and the findings consistently show that the practice is effective in achieving valued consumer outcomes; and (c) the practice has been replicated by different groups in different settings with similar results. Six mental health practices are identified as having met the criteria, and toolkits have been developed and nationally released for each practice. Supported employment currently is the only evidence-based

practice in the area of vocational rehabilitation (RWJF, 2002). The evidence-based practices outlined indicate that individuals with psychiatric disabilities achieve better employment outcomes with the support of mental health programs that integrate employment support services within mental health treatment rather than brokering services or relying solely on the public vocational rehabilitation program (RWJF, 2002).

New Freedom Commission Report on Mental Health

In 2002, President George W. Bush formed the President's New Freedom Commission on Mental Health, charging it to focus on the mental health service system and identify barriers to people getting needed services (HHS, 2003). Specific to employment, the report notes:

Even though supported employment is effective, few people with mental illnesses receive these services. One reason is that individuals with psychiatric disabilities often receive services that may be called supported employment, but are supported employment in name only. These vocational services lack the key ingredients that make supported employment effective. (p. 41)

The New Freedom Commission Report on Mental Health (2003) indicates that the low rate of employment among individuals with psychiatric disabilities is “alarming.” Additionally, the report notes that the public VR program services are funded for time-limited services and do not pay for ongoing support and that Medicaid does not reimburse specifically for employment and most typical vocational rehabilitation services. The report concludes that the lack of appropriate funding and state-of-the-art employment services remain barriers that prevent individuals with psychiatric disabilities from engaging in employment. The Commission's recommendations call for the restructuring of state and federal programs

to pay for evidence-based practices that are effective in helping individuals with psychiatric disabilities achieve employment (HHS, 2003).

Coinciding with the timing of the Commission's report in 2003, NAMI released its Treatment/Recovery Information and Advocacy Database (TRIAD) report. NAMI's results from a national survey of 3,400 individuals with psychiatric disabilities concludes that there remains rampant unemployment and poverty among persons living with psychiatric disabilities and that few individuals with psychiatric disabilities have access to effective vocational rehabilitation services (NAMI, 2003).

Conclusion

It is apparent based on this historical review that VR and MH systems have evolved, largely on parallel tracks without convergence. In some ways, despite their evolution, today the two systems remain more different than alike. Although the public VR program has had the legislative authority to serve individuals with psychiatric disabilities for over 60 years and annually significant numbers of individuals with psychiatric disabilities participate in and are rehabilitated by the this program, the public VR program continues to be criticized for contributing little to the employment of individuals with psychiatric disabilities. A commonly held viewpoint among MH professionals and advocates is that the public VR program does not serve the individuals with psychiatric disabilities as readily as persons with other disabilities. It is also not uncommon to find mental health professionals who continue to view work as an outcome to be achieved once mental health "stability" is achieved and/or as a threat to individuals' "stability" or something that is done outside the mental health treatment environment.

While deinstitutionalization of individuals with psychiatric disabilities has largely been completed

in most states, funding for community-based mental health services has clearly not kept pace with the demand for services (Accordino et al., 2001; Bianco & Wells, 2001). Subsequently, vocational services may not be considered as high priority services in an environment where funding for primary mental health treatment, housing supports, and crisis services compete with other community-based mental health services.

These present-day issues and challenges are directly linked to the historical factors reviewed in this chapter and contribute to the present lack of coordination between the public VR and MH systems. Mental health treatment today remains complex and fragmented, often due to a lack of adequate supports at the community level (Bianco & Wells, 2001; NAMI, 2003; HHS, 2003). Regulations for public VR and other job and training programs do not necessarily reflect the specific needs of individuals with psychiatric disabilities. This was most recently reflected by the New Freedom Commission on Mental Health, which indicated that the public VR system is viewed by mental health authorities and advocates as ". . . ineffective for the small proportion of people with mental illness who manage to get them" (HHS, 2003, p. 40).

On a positive note, many state mental health systems have begun to adopt and integrate employment into the array of community MH services. Funding through the Medicaid program has expanded significantly to encompass supported employment and employment-related services traditionally provided primarily by the VR program. The VR program's regulations have evolved to reflect an assumption that employment and personal growth potential is best achieved by assisting persons to aspire to, attain, and retain jobs in community-integrated settings rather than segregated environments. At the same time, in light of this increased emphasis on employment within the mental health treatment system, the role of the public VR program in providing services to

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individuals with psychiatric disabilities has become less clear, and the increasing numbers of individuals with psychiatric disabilities who seek public VR services, combined with relatively static funding for the program, continue to present a significant challenge to public VR agencies.

As a result of these significant evolutionary changes in the mental health system, public vocational rehabilitation counselors increasingly need to be aware of the evolving philosophies and services available through public mental health systems and community mental health programs. In addition, they must be aware of the best and most promising evidence-based principles and practices in psychiatric rehabilitation, many of which may now be provided within the mental health system. The challenge for both VR and MH in the near future is to incorporate evidence-based practices and principles into the diverse service delivery settings and systems, while at the same time ensuring greater coordination and collaboration among these settings and systems with the ultimate goal of meeting the employment needs of individuals with psychiatric disabilities.

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Study Questions

1. What is the significance of the Barden-LaFollette Act of 1943 for persons with psychiatric disabilities?
 - a. It authorized public vocational rehabilitation services for persons with mental illness and mental retardation.
 - b. It authorized public vocational rehabilitation services for persons with Traumatic Brain Injuries.
 - c. It authorized public vocational rehabilitation services for persons with physical disabilities.
2. True or False. The Community Mental Health Centers Act of 1963 and subsequent MH-related legislation in the 1970s and 1980s created an MH infrastructure that is consistent across states.
3. True or False. Collaboration between the public VR program (RSA) and National MH Authorities (NIMH and, today, SAMSHA) dates back over 25 years.
4. One of the main purposes of the Rehabilitation Act of 1973 was which of the following?
 - a. Serving veterans with disabilities
 - b. Developing grants to build rehabilitation facilities
 - c. Serving persons with severe disabilities and eliminating discrimination for persons with disabilities.
5. True or False. The Rehabilitation Act Amendments of 1992 established the presumption that individuals with significant disabilities could benefit from employment.
6. The Ticket to Work and Work Incentives Improvement Act (TWWIIA) of 1999 falls under the administration of which of the following federal programs?
 - a. Social Security Administration (SSA)
 - b. Rehabilitation Services Administration (RSA)
 - c. Substance Abuse and Mental Health Services Administration (SAMSHA)
7. True or False. The 2001 regulations for the state VR program eliminated the option for the public VR program to consider sheltered employment as a successful employment outcome.
8. According to the Robert Wood Johnson Foundation and SAMSHA, what are state mental health authorities encouraged to do in regards to employment of persons with psychiatric disabilities?
 - a. Refer solely to the public vocational rehabilitation program.
 - b. Promote evidence-based practices such as supported employment.
 - c. Expand the use of Day Treatment Programs.
 - d. Encourage the integration of employment support services within mental health treatment.
 - e. Both b and d are correct answers.
9. What was the main focus of the President's New Freedom Commission on Mental Health formed in 2002?
 - a. To focus on the mental health service system and identify barriers to people getting needed services
 - b. To research modifications to the Medicaid program for persons with psychiatric disabilities
 - c. To identify barriers associated with individuals receiving Social Security Administration disability benefits
10. True or False. The New Freedom Commission Report on Mental Health indicates that the employment rate of persons with psychiatric disabilities has been steadily improving.

Chapter 3

Practices

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Vocational Rehabilitation Practices and Psychiatric Disabilities

As addressed in Chapter 1, psychiatric disabilities are the second most frequent category of disorders served by state-federal vocational rehabilitation programs (Stoddard, Jans, Ripple, & Kraus, 1998; National Institute on Disability and Rehabilitation Research [NIDRR], 1992, 1997; Rehabilitation Services Administration [RSA], 1995; Andrews, Barker, Pittman, Mars, Struening, & LaRocca, 1992) and comprise almost 20% of the state vocational rehabilitation (VR) agencies' caseloads (RSA, 1995). However, data show that individuals with psychiatric disabilities are less likely to work competitively whether or not they receive VR services. For example, in an analysis of national surveys, Mechanic and his colleagues found that employment rates for individuals with serious psychiatric disabilities were between 32% and 61% and that for individuals with a diagnosis of schizophrenia, the rates were between 22% and 40% (Mechanic, Bilder, & McAlpine, 2002). In another study, Slade and Salkever (2001) found that individuals with schizophrenia had an average employment rate of 22%, but only half of those jobs were in competitive settings without job supports. In a large, longitudinal and population-based study conducted by the Research Triangle Institute for the Rehabilitation Services Administration, data suggest that individuals with psychiatric disabilities who received VR services were less likely to achieve a competitive employment outcome

and were more likely to drop out of services than individuals with other disabilities (Hayward & Schmidt-Davis, 2003).

Estimates have reported that few persons with psychiatric disabilities leave the disability rolls due to “work recovery”—ranging from 0.5% for Social Security Disability Income (SSDI) beneficiaries engaged in the state-federal VR system, to 3% of all new SSDI beneficiaries studied during a 1-year period after entitlement in the early 1980’s (National Academy of Social Insurance, 1994; Muller, 1992). Up to one third of those who leave the rolls due to work recovery are re-entitled to disability benefits, thus returning to the rolls. Hennessey (1996) reported in a New Beneficiary Follow-up study (a selected sample of those enrolled since 1972 followed for nine years after entitlement) that approximately 12% of SSDI beneficiaries attempted work after entitlement, and 24% of those who attempted work terminated benefits due to either medical or work recovery. In the RSA longitudinal study cited above, researchers found that being a recipient of SSI/SSDI meant that there is less likelihood that an individual will return to work after obtaining VR services (Hayward & Schmidt-Davis, 2003).

Taken together, these studies and data reveal that unemployment and underemployment of individuals with psychiatric disabilities poses a substantial challenge for the state-federal vocational rehabilitation programs. Clearly, vocational services are important for this group of individuals if their employment outcomes are to be positively affected.

As noted in the section on the history and evolution of mental health and vocational rehabilitation services, because of the changes in the vocational and mental health (MH) systems, VR personnel increasingly need to be aware of the services available through other agencies and systems and to have the knowledge and skills to authorize, advocate for, coordinate and compensate ven-

dors for these services, if they are to have a positive effect on the employment outcomes of individuals with psychiatric disabilities. They also must be aware of the best and most promising practices of vocational assessment and rehabilitation that may be provided outside of the state VR system. In the remainder of this chapter, we review vocational assessment practices, best practices in vocational rehabilitation services, as well as principles for vocational rehabilitation programs regardless of which model of service delivery they adhere to. We also discuss supported education services, disincentives to employment, and stigma and discrimination in the workplace. Our purpose is to convey information about rehabilitation practices that is current and useful to VR personnel. Chapter 4 contains information on system issues related to vocational rehabilitation, while Chapter 5 contains information on managers and change within the VR system.

Vocational Assessment and Instruments

Traditional approaches to assessing the vocational potential of individuals with psychiatric disabilities have relied on psychiatric/medical model constructs. In an early review of the predictive ability of assessments of the vocational capacity of individuals with psychiatric conditions, Anthony and Jansen (1984) discussed the limitations of assessments that utilize psychiatric symptoms; psychiatric hospitalizations; intelligence, aptitude and personality tests; and the diagnostic category of the individual.

The eligibility determination process currently under revision by the Social Security Administration (SSA) may better illustrate reliance on indices of impairment to assess work capacity. Once lack of employment and a severe medical condition are ascertained during this process, a person must then meet criteria for having an impairment. The List of Impairments is a

set of signs, symptoms, and functional deficits deemed by SSA to be disabling (MacDonald-Wilson, Rogers, & Anthony, 2001). Rating scales for assessing the signs and symptoms contained in the List of Impairments were developed by the SSA. When there was no clear-cut indication of a severe medical impairment, then work functioning was assessed by review of medical and other evidence in the file. Class action suits against SSA in the 1980s due to the ambiguous disability determination procedure, particularly of individuals with psychiatric conditions, led to a revision of the List of Impairments to include more evidence of functioning, and a mandate that SSA assess vocational as well as medical factors. Subsequently, the SSA developed guidelines for work evaluations that included simulated or *in situ* assessments in work environments (MacDonald-Wilson et al., 2001).

Ongoing research has both discounted and substantiated the ability of psychiatric constructs such as symptoms and diagnosis, other clinical and demographic characteristics to predict work capacity, and employment potential (Bell & Lysaker, 1995; Lysaker, Bell, Milstein, Bryson, Shestopal, & Goulet, 1993; Rogers, Anthony, Cohen, & Davies, 1997; Pietzcker & Gaebel, 1987; Bell & Bryson, 2001; Anthony, Rogers, Cohen, & Davies, 1995; Massel et al., 1990; Fabian, 1992; Tsang, Lam, Ng, & Leung, 2000). MacDonald-Wilson and her colleagues (2001) conclude, “no one variable, psychological test, or instrument has been found to be a strong predictor of work capacity among individuals with psychiatric disorders.”

As this research proceeded, a greater understanding of the components and determinants of vocational capacity for individuals with psychiatric disabilities that differs from traditional medical model constructs developed. By turning attention to the areas of *functioning* that are affected by psychiatric disabilities, consideration has been paid to the social/interpersonal, emotional, and

cognitive domains (Rutman, 1994; Wallace, 1986; Tsang & Pearson, 1996). In addition, there is greater awareness of the heterogeneity of disability associated with a given psychiatric diagnosis, e.g., that individuals with the same diagnosis can and do have significant variations in vocational functioning and capacity. Some research suggests a strong link between social and interpersonal skills and work adjustment skills and vocational outcomes (Tsang et al., 2000). Becker, Drake, Bond, Xie, Dain, and Harrison (1998) identified interpersonal problems as a major reason for job termination for individuals with psychiatric disabilities. MacDonald-Wilson et al. (2001) provide a review of studies concerning work function in relation to these areas. They conclude that further study of the relationship of these functions to vocational outcome is needed, including studies with larger samples, greater power, and of predictive validity for work outcome.

Functional Assessment of Work Capacity

The difficulties of using medically based assessments for work assessments or disability determinations are not limited to those with psychiatric disabilities. Matheson (2001) states “it has become clear that information about the person’s medical impairment is not a valid predictor of inability to work. Some persons with severe impairments are able to work, while others with relatively modest impairments are unable to work” (p. 137). He reports on an alternative approach in which functional limitations are viewed as having a stronger relationship to ability to work than do medical impairments. After extensive work undertaken to assist the Social Security Administration in a redesign of its disability determination process, he describes taxonomy of Functional Assessment with five domains. These include sensory-perceptual, physical, cognitive-intellectual, interpersonal and emotional, and

vocational (Gaudino, Matheson, & Mael, 2001). Matheson, Kaskutas, McCowan, Shaw, and Webb (2001) proceeded to develop a database of Functional Assessment Measures for various disability groups. In this database, 4,200 different measures were identified, of which 812 are used to evaluate adults in terms of work disability. However, information on the reliability and validity of these scales varied greatly. Despite the number of instruments found, very few have been developed for use with the psychiatric disabled population, nor were they normed on this population, and do not seem suitable for predicting work functioning (Center for Psychiatric Rehabilitation, 1999). The World Health Organization (2001) created another taxonomy of disability, titled the International Classification of Functioning, Disability and Health. While the items have undergone careful development, there has been no wide-scale testing of the predictive ability of work function in individuals with psychiatric disabilities.

Situational Assessment as a Promising Approach to Vocational Assessment

One of the first systematic approaches to developing work assessments was through work sample evaluation. These assessments occurred through observations of work products, but these methods were problematic for individuals with psychiatric disabilities due to the inconsistent nature of their disability and performance (Hursh, Rogers, & Anthony, 1988). This was partly based on the characteristics of psychiatric disabilities, being episodic and recurrent with fluctuating periods of disability and functioning complicating “slice in time evaluations” (McDonald-Wilson et al., 2001). Another method of work assessment, called on-site job evaluations, has been suggested to represent productivity at a job (Sax & Pell, 1987) but are criticized for being too job-specific

(Bryson, Bell, Lysaker, & Zito, 1997). As mentioned earlier, paper and pencil methods of assessing work capacity have been found lacking for decades (Anthony & Jansen, 1984).

One of the most promising methods for assessing work capacity is situational assessment. These assessments involve direct observation of behavioral skills and work performance either in a simulated or a real work setting. This approach has been suggested to be most promising for individuals with psychiatric disabilities because it measures actual work functions rather than proxy measures by symptoms or diagnosis, and because it goes beyond “paper and pencil” assessments or record review (Hursh et al., 1988; RSA, 1995; Tashjian, Hayward, Stoddard, & Krauss, 1989). In addition, several situational assessment instruments have been developed over recent decades specifically for individuals with psychiatric disabilities. Situational assessments are also criticized for being too costly, too labor intensive, and unwieldy to arrange, requiring vocational skilled staff and work environments in which to observe those being assessed (MacDonald-Wilson et al., 2001). To date, no single situational assessment instrument has been widely accepted in the rehabilitation community (Bryson, Bell, Kaplan, & Greig, 1998).

An early measure of work capacity is the 25-item Standardized Assessment of Work Behavior (Griffiths, 1973, 1977). While inter-rater and reliability tests were very good, with a successful factor analysis, and the instrument succeeded in validly predicting those who did and did not secure employment after their discharge, the scale is criticized for using a sample that lacked diagnostic specificity and that included a non-representative range of work sites (Bryson et al., 1997).

The Work Behavior Inventory is a 36-item work performance assessment with five subscales. It has shown acceptable inter-rater reliability, internal consistency, and concurrent validity. It was shown

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to predict hours worked and money earned as well as successfully discriminating those who did and did not work after the program intervention (Bryson et al., 1997; Bryson, Bell, Greig, & Kaplan, 1999). One limitation of the Bryson study is that it was tested on a sample limited to persons with military service backgrounds and who, therefore, may have had a better pre-morbid level of functioning. Generalization to women and those in community rehabilitation programs may, therefore, be problematic.

More recently, a measure for assessing the work-related social skills of persons with schizophrenia has been reported (Tsang & Pearson, 2000). This assessment is comprised of a simple self-administered checklist and a role-play exercise assessing the social skills needed for job acquisition and retention. In a Hong Kong study involving 140 individuals with psychiatric disabilities receiving rehabilitation services, results showed good internal consistency for the checklist and the role-play exercise, good inter-rater reliability, and acceptable test-retest reliability. The measure successfully distinguished two groups of participants and appears easy to use. This instrument needs further testing for predictive and concurrent validity, especially for relevance with an American or English-speaking audience.

Finally, the Situational Assessment Instrument (Rogers, Sciarappa, & Anthony, 1991) was developed to provide a valid and reliable situational assessment that is designed for and normed specifically on the psychiatrically disabled population. The scale is comprised to measure two central constructs considered essential to the work function of this population, i.e., work adjustment behaviors and interpersonal skills. The scale was tested on 50 subjects drawn from two psychosocial rehabilitation centers, therefore, using more “typical” community-based individuals with psychiatric disabilities. For 10 consecutive days, subjects were observed for two hours by two raters during performance of their normal work activi-

ties in Fountain House styled work units (clerical, food service, and janitorial). The scale has high levels of inter-rater agreement, internal consistency, split-half, and test-retest reliability. Predictive validity was tested based on follow-up of vocational status of subjects one year after assessment. Discriminant functions were able to correctly predict the employment status for between 54% and 86% of subjects. Concurrent validity was analyzed using the Griffiths Work Behavior Scale. Results suggested adequate concurrent validity for the Work Adjustment Subscale of the Situational Assessment Instrument. The scales are commended for appearing to be “the best available SAT (situation assessment tasks) for this population” and criticized for being standardized on a narrow range of work sites (Bryson et al., 1997, p. 48) and a homogenous sample of subjects supplying insufficient variability for proper discriminant function tests (MacDonald-Wilson, Nemeč, Anthony, & Cohen, 2001).

In summary, assessment of vocational capacity for individuals with psychiatric disabilities poses special challenges. Paper and pencil tests and tests focusing on work samples are lacking.

Assessments of psychiatric symptomatology and diagnosis are similarly lacking. Situational assessment approaches are promising because they can be combined with trial work periods and other unpaid work experiences to assess a person’s capacity to work using a realistic employment setting. However, these approaches, procedures, and instruments require more development and testing.

Vocational Interventions

Research from diverse fields in the behavioral sciences has provided abundant evidence supporting the importance of employment to individuals with psychiatric disabilities (Cook & Pickett, 1995; Crowther, Marshall, Bond, & Huxley, 2001). Individuals with psychiatric disabilities not

only are interested in working, but numerous studies demonstrate their successful participation in the labor market in a multitude of competitive employment settings (Bond, Becker, et al., 2001; Cook & Razzano, 2000; Crowther, Marshall, Bond, & Huxley, 2001; Rogers, Anthony, Toole, & Brown, 1991). Overall, work is an important goal for many individuals with psychiatric disabilities, and gainful employment opportunities afford the chance to promote economic independence, as well as enhance other factors related to overall well-being (Lehman et al., 2002). A substantial amount of research on individuals with psychiatric disabilities also has identified the benefits of working, including alleviation of poverty (Polak & Warner, 1996); higher levels of functioning (Bond, Resnick, et al., 2001; Lehman, 1995; Anthony, Rogers, Cohen, & Davies, 1995); improvements in quality of life (Arns & Linney, 1995); and self-esteem; and greater satisfaction with both vocational services and finances (Mueser et al., 1997). Work among individuals with psychiatric disabilities has positive social benefits, such as less reliance on public disability entitlements (Kouzis & Eaton, 2000; Polak & Warner, 1996) and the overall costs of care (Baron, 2000; Drake, McHugo, Becker, Anthony, & Clark, 1996).

Contemporary developments in both the social and scientific arenas have provided greater opportunities for individuals with psychiatric disabilities to enter and remain in the labor force (Cook & Burke, 2002). Past, as well as new federal initiatives, such as the Americans with Disabilities Act (ADA) (1990) and the passage of the Ticket to Work and Work Incentives Improvement Act (TWWIIA) (Public Law 106-170, 2000), which support persons with disabilities in the workplace and removes the financial and health coverage disincentives for employment among them, point to the value our society is now placing on employment of its citizens with disabilities (Cook & Razzano, 2000). Along with these develop-

ments, the advocacy movement among individuals with psychiatric disabilities, including community activism and training in self-advocacy and legal protections, has promoted the employment goal for a wider and wider range of clientele (Cook & Wright, 1995). Furthermore, advancements in psychiatric services, including formulation and use of new psychopharmacologic agents, have provided consumers with more treatment options and hope for recovery than ever before (Lehman, 1999; Meyer, Bond, Tunis, & McCoy, 2002). Despite these many developments, however, the vast majority of individuals with psychiatric disabilities in the United States remain outside of the labor force. By some estimates, 75-85% of individuals with severe psychiatric disabilities are unemployed in the United States (Anthony & Blanch, 1987; Lehman, 1995).

Promising Employment Interventions

In 1995, the Center for Mental Health Services embarked on the largest study to that point of vocational interventions for individuals with psychiatric disabilities. The study (named the Employment Intervention Demonstration Project [EIDP]) was designed to involve multiple-study sites (eight in all) and to examine the effectiveness of numerous vocational interventions on employment and other types of outcomes (Cook, Carey, Razzano, Burke, & Blyler, 2002). Supported employment services formed the basis for many of the EIDP interventions, but not all. Generically, supported employment models are based on a “place-train” approach, which helps consumers find integrated jobs which provide salaries at or above minimum wage, and then provides training and supports related to that job in particular (Anthony & Blanch, 1987). Supported employment was first developed in response to the delayed entry and “train and place” approach that was prevalent in the mental health and developmental disabilities service agencies. That model often required long periods of *training* in shel-

tered workshops and other non-integrated settings. In contrast to the “train and place” approach, supported employment was characterized by rapid entry into employment, minimal vocational assessment prior to placement, minimal assessment of generic vocational skills, flexible supports on the job (some of which can occur on the job and some of which can occur outside of the job site), a job coach, or someone particularly devoted to the individual’s vocational performance (Anthony, Cohen, Farkas, & Gagne, 2002).

Within the mental health system there are many definitions of models and approaches to supported employment. Within the VR program, supported employment is defined by the 1998 Amendments to the Rehabilitation Act, Title IV of the Workforce Investment Act as:

- Involving competitive work in an integrated work setting for individuals with the most significant disabilities, or employment in integrated work settings in which individuals are working toward competitive work;
- targeted toward individuals for whom competitive employment has not traditionally occurred, or for whom competitive employment has been interrupted or intermittent as a result of a significant disability; and
- for individuals who, because of the nature and severity of their disability, need intensive supported employment services or extended services in order to perform such work.

Within the VR program, supported employment is competitive work, performed on a full to part-time basis, in an integrated setting, for wages at or above minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by non-disabled individuals. In addition, supported employment should be consistent with strengths, resources, priorities, concerns, abilities,

capabilities, interests, and informed choices of individuals (Rehabilitation Act Amendments of 1998, 1999).

Also within the VR program, supported employment includes transitional employment, that is short term temporary jobs that enable individuals with psychiatric disabilities to gain work experience and confidence in their roles as workers and for an employment agency to access the individuals’ work stamina and capacities. Typically, transitional employment positions are “owned” by the employment agency and the individuals are placed into the jobs, paid, and terminated from the jobs by the employment agency, not the employer.

Within the MH system, supported employment has emerged as the form of VR services that is the most promising to improve employment outcomes for individuals with psychiatric disabilities. A variety of supported employment approaches have developed over the past decade, such as the Individualized Placement and Support (IPS) and the Choose-Get-Keep models. In one review within the field, Bond, Resnick, and their colleagues (2001) examined eight randomized and three quasi-experimental studies of supported employment and found significant differences in competitive employment rates favoring supported employment over control interventions. The multi-site EIDP also examined vocational rehabilitation service and employment practices that reflect many principles of supported employment as well as other interventions reflecting more traditional approaches to vocational rehabilitation. A word of caution: Many individuals use the terms *vocational models* and *vocational service programs* interchangeably. In fact, many vocational models can be implemented within differing service programs. For example, transitional employment is frequently associated with the clubhouse model; but, in fact, transitional employment as a model of service delivery can be implemented in a variety of service settings and does not particularly

require a clubhouse. With the distinction in mind about models vs. programs, we will discuss promising employment practices.

The Individual Placement and Support (IPS) Model

This is a supported employment approach that was developed and tested by Drake and his associates at the Dartmouth College Psychiatric Research Center. The Individual Placement and Support (IPS) program model is considered a supported employment approach and currently has the largest body of empirical evidence supporting it. The model emphasizes minimal pre-occupational assessment, rapid job searching, matching jobs to consumers' interests, shared decision making, integrated jobs in community settings, provision of unlimited time for 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 (Becker & Drake, 1993; Drake et al., 1996; Drake et al., 1999; Drake, Becker, Biesanz, & Wyzik, 1996; Drake et al., 1994). Taken together, the studies of IPS have found that IPS dramatically increases the percentage of persons employed. The positive effects of IPS on clinical outcomes, self-esteem, and quality of life are inconsistent and need further study (Drake, Becker, Clark, & Mueser, 1999). A recent cost analysis of the IPS model found equivocal results in terms of the costs and the benefits of IPS, suggesting that IPS participants engaged in competitive employment but at a somewhat higher cost. When only total earnings were considered as the outcome, regardless of whether they were from competitive or non-competitive employment, the results did not suggest the superiority of the IPS model. Cost-benefit analyses are complex, however, the interested reader is encouraged to examine the findings first hand (Dixon et al., 2002).

The Clubhouse Model

The clubhouse model of services and their associated standards of service delivery have been developed and widely disseminated by Fountain House (Propst, 1992a). The 35 standards of service delivery are grouped into categories, such as membership, relationships, space, work-ordered day, employment, transitional employment (TE), independent employment, funding, governance, and administration (Propst, 1992b). Underlying these standards are fundamental clubhouse concepts and principles, including the Work-Ordered Day Program, the Transitional Employment Program, and Independent Employment. These three facets of the clubhouse model all focus on work (Propst, 1992b).

There has been growing but mostly uncontrolled evidence of the effectiveness of the clubhouse model (Brinkman & Mastboom, 1989; Bilby, 1992; Noble, 1991). Some studies have reported competitive employment rates of 40% (Rehab Brief, 1986; Ruffner, 1986), but this percentage was for graduates only. On the low end, Connors, Graham, and Pulso (1987) found that 5% of individuals with psychiatric disabilities were placed in competitive employment in a 12-month period in the State of Maryland. A very early survey by Rutman and Armstrong (1985) found that while only 15% of participants converted their TE position into a permanent job, among individuals with psychiatric disabilities completing TE 35% were employed, and 16% entered another TE placement. In a report of a research program conducted at Thresholds (Bond, Dincin, Setze, & Witheridge, 1984), the authors found employment rates at nine months to be 39% and 37% in two different studies.

Program for Assertive Community Treatment (PACT)

This program began as a case management model (Phillips et al., 2001) but has progressed to encompassing vocational outcomes for individuals with serious psychiatric disabilities. An assertive community treatment team usually consists of 10 to 12 staff members from the fields of psychiatry, nursing, and social work and professionals with other types of expertise, such as substance abuse treatment and vocational rehabilitation. A small staff-to-consumer ratio is recommended, and the team is guided by several operating principles, such as direct provision of services; individualized, comprehensive, and flexible services; availability of services 24 hours per day; no time limit for services; and services provided in their natural location (Phillips et al., 2001). In the EIDP study, the PACT condition included a mobile team composed of a psychiatrist, nurse, clinicians, social workers, and vocational specialists who provided direct services to individuals with psychiatric disabilities in the community. The purpose was to integrate both mental health and vocational services within one team of providers and to promote job attainment and vocational outcomes.

Family-Aided Assertive Community Treatment (FACT)

This model of vocational services combines features of assertive community treatment with family psychoeducation, family participation in rehabilitation, and multiple family support groups (McFarlane et al., 2000). In the EIDP study, an employment consortium was developed to promote employment for individuals with psychiatric disabilities through participating employers who pledge a minimum number of jobs each year. Employment specialists on FACT teams work with the consortium to develop natural supports using family members as well as reason-

able job accommodations. FACT teams also apply more traditional job development approaches, such as individualized job placement and support.

The Choose-Get-Keep (CGK) Model

The CGK model (Danley & Anthony, 1987) is based on the values of psychiatric rehabilitation, including consumer choice, individual planning, and consumer involvement in the rehabilitation process (Farkas & Anthony, 1989) as well as the technology of psychiatric rehabilitation, including how to set goals with consumers; how to "connect" with consumers; how to teach skills to consumers; and how to develop resources with and for consumers (Cohen, Farkas, & Cohen, 1986; Cohen, Farkas, Cohen, & Unger, 1990). The underlying assumption of the CGK program model is that a person's disability or inability to perform a role (e.g., unemployment) can be positively affected by teaching skills and providing supports needed to deal with issues of disadvantage, dysfunction, and impairment. Much of the psychiatric rehabilitation practitioner-level technology incorporated into the Choose-Get-Keep Intervention Manual has been tested in various residential, vocational, and educational outcome studies (Shern, Tsemberis, Winarski, Cope, Cohen, & Anthony, 1997; Brown, Ridgway, Anthony, & Rogers, 1991; Rogers et al., 1991; Goering, Wasylenki, Farkas, Lancee, & Ballantyne, 1988; Unger, Anthony, Sciarappa, & Rogers, 1991; Danley, Sciarappa, & MacDonald-Wilson, 1992; Rogers, Sciarappa, MacDonald-Wilson, & Danley, 1995).

Integrated Employment

An integrated employment program is designed to allow recipients to receive a full array of case management and supported employment services from an integrated treatment team, i.e., a team that focuses on both vocational rehabilitation and mental health services. The purpose of such a

team is to optimize a person's vocational rehabilitation by insuring that treatment and medication issues are well attended to and that there is ample opportunity for team members to discuss and attend to the recipient's needs and progress. Such an integrated team is usually comprised of psychiatrists, case managers, rehabilitation counselors, employment specialists, job developers, and benefits specialists, all of whom are organized within a single administrative entity and within the same offices.

Other Vocational Models

Here, we discuss other vocational models that warrant further description and elucidation.

Traditional Vocational Interventions

Vocational rehabilitation agencies as well as psychosocial rehabilitation programs and supported employment programs offer traditional vocational interventions as part of their array of services. Section 103 of the Rehabilitation Act (1973 Rehabilitation Act as amended in PL-98-221) defines vocational rehabilitation services as follows "any services described in an individualized plan for employment necessary to assist an individual with a disability in preparing for, securing, retaining, or regaining an employment outcome that is consistent with the strengths, resources, priorities, concerns, abilities, capabilities, interests, and informed choice of the individual" (<http://thomas.loc.gov/bss/d098/d098laws.html>). These services include:

- Assessment for determining eligibility and vocational rehabilitation needs;
- Counseling and guidance;
- Referral and other services to secure needed services from other agencies;
- Job related services, including job search, placement, retention and follow-up services;
- Vocational and other training services;
- Diagnosis and treatment of physical and mental impairments if financial support is not readily available from other sources;
- Maintenance while receiving services under an individualized plan for employment;
- Transportation provided in connection with the provision of any other services;
- On the job or other related personal assistance services provided while an individual is receiving other services described in this section;
- Interpreter services and reader services;
- Rehabilitation teaching services, and orientation and mobility services, for individuals who are blind;
- Occupational licenses, tools, equipment, and initial stocks and supplies;
- Technical assistance and other consultation to eligible individuals pursuing self employment, telecommuting or establishing a small business operation;
- Rehabilitation technology, including telecommunications, sensory, and other technological aids and devices;
- Transition services for students with disabilities;
- Supported employment services;
- Services to the family of an individual with a disability necessary to assist the individual to achieve an employment outcome; and
- Specific post employment services necessary to assist an individual with a disability to, retain, regain, or advance in employment (<http://thomas.loc.gov/bss/d098/d098laws.html>).

The National Association of State Mental Health Program Directors (NASMHPD) has also developed an array of traditional vocational interven-

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tions which should be available to individuals with psychiatric disabilities. These include:

- Career planning;
- Job goal selection;
- Job placement;
- Self-presentation in writing and in person during pre-employment screening;
- Negotiating reasonable accommodations;
- Acquiring specific job skills;
- Obtaining transportation and clothing appropriate to the work setting;
- Estimating how earnings will impact entitlements, such as SSI, SSDI, Medicaid, and Medicare;
- Education in using existing Social Security Administration work-incentive programs to the greatest advantage;
- Establishing positive relationships with co-workers and supervisors;
- Assistance in changing jobs; and
- Assistance with job retention (NASMHPD, 1996).

Benefits, Planning, Assistance, and Outreach (BPAO)

BPAO is part of the Ticket to Work and Work Incentives Improvement Act, enacted in 1999 and was recently extended by Congress to 2010. This Act concentrates on providing work incentive planning and assistance to individuals with disabilities who are receiving Social Security Administration disability benefits.

Benefits counseling can range from a quick question and answer period over the telephone to an in-depth analysis of the person's current benefits

and how working at any level would affect those benefits, including cash benefits, health care coverage, and eligibility for other government support programs. Benefits counseling may also include collecting detailed information regarding an individual's present income, benefit and employment status, providing specific information on the effect of different employment alternatives on an individual's income and health care coverage, making specific recommendations regarding the applicability of various work incentives, assisting individuals in accessing those work incentives, and referring the individual to other government agencies or community resources. Benefits counseling may be repeated as warranted by changes in an individual's employment or benefits status (Kregel & Head, 2001).

Customized Employment

Customized Employment is a relatively new concept put forth by the Department of Labor, Office of Disability Employment Policy. Federal legislation defines *customized employment* as individualizing the employment relationship between employees and employers in ways that meet the needs of both. Customized employment is based on an individualized determination of strengths, needs, and interests of the person with a disability and is also designed to meet the specific needs of the employer. It may include approaches such as supported employment; supported entrepreneurship; individualized job development; job carving and restructuring; use of personal agents (including individuals with disabilities and family members); development of micro-boards, micro-enterprises, cooperatives and small businesses; and use of personal budgets and other forms of individualized funding that provide choice and control to the person and promote self-determination (<http://www.dol.gov/odep/tech/employ.htm>).

This customization results in jobs that are designed to match the skills of individuals with disabilities to specific jobs. Customized employ-

ment also includes the use of reasonable workplace accommodations and supports necessary for individuals to perform the functions of the job.

Self-Employment and Client-Run Enterprises

Self-employment, independent contractor, and entrepreneurship are part of a national effort to assist individuals with disabilities in entering the competitive labor market. According to the National Mental Health Self-Help Clearinghouse, "consumer-run businesses" means organizations planned, directed, and staffed by consumers, survivors, and ex-patients, whether or not the organization is run for a profit (National Mental Health Consumers Self-Help Clearinghouse, 2004). In 1998, the Small Business Administration began a campaign to educate individuals with disabilities to consider self-employment ventures, as recommended by the President's Task Force on Employment with Disabilities. Additionally, since the passage of the Americans with Disabilities Act in 1990, more individuals with disabilities are choosing independent-contractor and self-employment opportunities. According to the U.S. Department of Labor, Office of Disability Employment Policy (ODEP), there is a concerted effort to "offer people with disabilities the choice of pursuing self-employment through effective service systems that encourage and support business success" (<http://www.dol.gov/odep/pubs/business/building.htm>). The ODEP reviewed a variety of self-employment initiatives targeted to individuals with disabilities and suggested the following common set of building blocks for successful program design and implementation:

- Internal policies regarding entrepreneurship and self-employment;
- Counselor preparation for assisting clients in pursuing self-employment;

- Means to assess client potential vis-à-vis self-employment;
- Understanding market opportunities for self-employment;
- Availability of technical assistance in pursuing self-employment goals;
- Availability of financing for self-employment ventures; and
- Mechanisms for tracking and monitoring the success of such ventures.

They suggest that these self-employment initiatives are best shaped by local regulations, policies, and customs because there is no one ideal way to promote self-employment among individuals with disabilities (<http://www.dol.gov/odep/pubs/business/building.htm>).

The President's Committee on the Employment of Persons with Disabilities (PCEPD) initiated a project to help persons with disabilities obtain equal access to programs that support small businesses and entrepreneurs. The goal of the project is to ensure that public and private employment programs for persons with disabilities include training and assistance in self-employment and entrepreneurial activities. In 2000, the PCEPD released a report setting forth recommendations that addressed access to self-employment and small businesses for persons with disabilities (Blanck, Sandler, Schmeling, & Schwartz, 2000). The task force also recommended that the Small Business Administration (SBA) launch a campaign to educate Americans with disabilities who currently own or want to start their own businesses.

Self-employment and entrepreneurship are part of a nationwide strategy to help persons with disabilities transition from unemployment, underemployment, or entitlements-based programs to gainful employment and self-sufficiency. Blanck

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and his colleagues (2000) state that there are many reasons for pursuing entrepreneurship and self-employment activities, including the fact that persons with disabilities continue to be disadvantaged socially, vocationally, economically, and educationally. The 1998 N.O.D./Harris survey found that almost half (42%) of unemployed persons with disabilities reported they were unable to find work because employers did not recognize their capabilities. For these reasons, as well as others, self-employment and consumer-run businesses have gained more prominence. The Department of Labor, Office of Disability Employment Policy has a new Small Business Self-Employment Service (SBSES). The SBSES Web site (janweb.icdi.wvu.edu/sbSES) includes links to other entrepreneurship sites, including the SBA and state vocational rehabilitation programs. The site also provides technical assistance resources for writing business plans, financing, and other issues related to developing a small business. Unfortunately, there are few evaluation or demonstration studies examining the extent to which these new initiatives that are focused on self-employment are effective for individuals with psychiatric disabilities.

Work Crews

Work crews are not really a discrete service alternative but, rather, a structural technique used to deliver a variety of employment opportunities to consumers. In this context, the term work crew refers to any group employment activity used by a rehabilitation program. Typical work crews involve transitional or supported employment, enclaves, sub-contracts with various industries, affirmative industries, client-employing businesses, and "handyman" work crews. Typically, work crews involve several individuals with disabilities working together on a project or in a single location; thus, work crews are segregated from other workers. Work crews provide work experiences for individuals with psychiatric disabilities; but,

because these experiences are not integrated into the mainstream workforce, they are considered less desirable in the long term than supported employment approaches.

Sheltered Employment

Sheltered employment, while now a less frequently provided service for individuals with psychiatric disabilities, remains a part of the vocational service array in many locations, although it is not considered an acceptable long-term work outcome in the VR system. Typically, sheltered employment includes work in a segregated setting, i.e., only for persons with disabilities, and for less than minimum wage. The expectation is that a person can be assessed vis-à-vis their work skills, and that they can enter a period of "work adjustment training" to enable them to eventually secure competitive employment (Warner, 1985). Sheltered employment frequently involves a lengthy period of preparation (training) prior to transition to integrated community employment (placement). Some individuals remain in sheltered workshops after an assessment period because they lack the skills to work competitively.

Volunteer Work Experience and Paid Internships

Volunteer (i.e., unpaid) work experience options occupy a controversial niche in the array of vocational opportunities for individuals with long-term psychiatric disabilities. These, more than any vocational interventions covered vary greatly in their utility, based on the match between a consumer's needs and the specific form the volunteer work experience takes. The major dispute centers on whether it devalues persons to work without pay as a condition of their rehabilitation. In addition, the issue of whether an unpaid worker is being exploited by an employer is of great concern, not only to rehabilitation providers but, probably more ominously, to the U.S. Department of Labor. Despite these concerns,

volunteer work can be an important entree into the workforce and can assist individuals in making career choices. For that reason, it should not be discounted as a potentially important vocational intervention. A paid internship can also be somewhat controversial, unless it impacts concrete and marketable skills.

Supported Employment as a Best and Promising Practice in Vocational Rehabilitation

Although not all of the currently available vocational interventions or programs studied in the EIDP or other investigations incorporate all of the principles of supported employment, there is a growing emphasis on achieving work outcomes that reflect its core features. Most employment specialists agree that supported employment involves competitive employment, in integrated work settings, for at least minimum wage. Based on this definition, many, but not all, of the models previously described are intended to promote supported employment.

In addition to the basic goal of reducing unemployment among individuals with psychiatric disabilities, supported employment programs seek to improve other aspects of recovery. In particular, employment has been viewed as a means to foster improvement in other rehabilitation outcomes, including mental health symptoms, level of functioning, substance use, and self-esteem (Bond, Resnick, et al., 2001; Lehman, 1999; Mueser et al., 1997). Yet, despite targeted efforts to develop and implement evidence-based best practice programs designed to assist all individuals with psychiatric disabilities find work, the overwhelming majority of consumers still remain outside of the competitive labor force (Jacobs, Wissusik, Collier, Stackman, & Burkeman, 1992; Mueser et al., 1997). Although some studies suggest that concerns regarding the deleterious effects of work on other clinical factors and quality of life indicators

continue to loom (Blankertz & Robinson, 1996; Lehman, 1988; Marrone & Golowka, 1999; Schied & Anderson, 1995), other investigations report that there is no empirical evidence that participation in supported employment programs adversely affects clinical or other indicators, such as number of psychiatric hospitalizations (Drake, 1998; Bond, Resnick, et al., 2001), severity of psychiatric symptoms (McFarlane et al., 2000; Mueser et al., 1997), or quality of life (Fabian, 1992).

Research-Based Principles of Vocational Rehabilitation and Supported Employment

The existing literature on individuals with psychiatric disabilities provides support for a series of research-based principles related to vocational rehabilitation services. Although several of these principles have been demonstrated in the multidisability vocational rehabilitation field, others have emerged from specific efforts designed to address the unique employment needs of individuals with psychiatric disabilities. In order to provide the reader with an overall understanding of the evidence-based best practices in vocational rehabilitation among psychiatric populations, these principles will be reviewed and relevant supporting research discussed. However, as others provided comprehensive reviews of this research in the past (e.g., Bond, Resnick, et al., 2001; Lehman, 1995), this section seeks to present an overview of the critical issues related to these studies and their findings as well as the role of supported employment services within the larger context of vocational rehabilitation.

The first principle is based on the Rehabilitation Act, which states that individuals with psychiatric disabilities should be provided with *competitive* or *supported employment* services rather than programs leading to sheltered or unpaid work. In supported employment settings, individuals with

psychiatric disabilities are rehabilitated by being placed and trained in community-based jobs in integrated settings, where they earn minimum wage or above. In a series of studies, Wehman and others demonstrated that employment outcomes were significantly better for individuals with severe disabilities, including those with psychiatric disabilities and other behavioral health concerns, when individuals received rehabilitation services in community job placements at minimum wage or above in socially integrated settings (Kregel, Wehman, & Banks, 1989; Wehman & Moon, 1988). In a comparison of two different day programs that provided sheltered work to former psychiatric patients, Drake et al. (1994) also demonstrated that conversion of one program into a continuous supported employment approach yielded superior competitive employment outcomes than the intact sheltered work model.

One goal of supported employment programs—competitive work—also appears to offer several additional rehabilitative advantages over sheltered or enclave jobs as well as volunteer or unpaid work. In particular, work skills training occurring within integrated settings alongside non-disabled coworkers offers individuals with psychiatric disabilities positive role modeling opportunities (Cook & Razzano, 1992). Competitive employment at minimum wage or above also has been shown in several surveys to be preferred among individuals with psychiatric disabilities (Polak & Warner, 1996; Rogers, Walsh, Masotta, & Danley, 1991) and offers obvious economic advantages to individuals with psychiatric disabilities. Finally, the place-then-train approach provides on-the-job training, allowing workers to learn skills in the same environments in which they will later use them, and helping to prevent "transfer of training" difficulties that can occur when skills are applied in different settings (Cook & Hoffschmidt, 1993).

The next principle supports the use of *situational assessment* to evaluate vocational skills and potential. As described in the section above, this involves observation by trained evaluators who rate job behaviors and attitudes within actual or simulated work environments (Cook, Bond, Hoffschmidt, Jonas, Razzano, & Weakland, 1991).

The third principle involves *rapid job searching and placement* into paid community employment rather than undergoing lengthy periods of pre-vocational training. By placing individuals with psychiatric disabilities swiftly into community-based jobs, this principle acknowledges the importance of avoiding the demoralization that can accompany lengthy periods of job training and evaluation (Schulteis & Bond, 1993). Similarly, Bond and Dincin (1986) showed that when individuals with psychiatric disabilities were randomly assigned to an "accelerated" job placement model, they were significantly more likely to be employed at 9-month follow-up and to be working full-time at 15-month follow-up compared to those in a comparison group who underwent several months in unpaid, segregated work adjustment training. In another randomized study, Bond, Dietzen, McGrew, and Miller (1995) found that superior outcomes (higher employment rate, higher job satisfaction) were achieved among recipients of supported employment who were immediately placed in jobs compared to those receiving pre-vocational services prior to their first jobs. In an analysis of 602 individuals with psychiatric disabilities, those who had worked in sheltered workshops on their first paid placement following vocational rehabilitation were significantly less likely to achieve later competitive employment, even controlling for demographic factors (e.g., ethnicity, gender, education), functional impairment, illness severity, length of time receiving services, and the nature of employment services received (Cook & Razzano, 1995).

The fourth principle focuses on the availability of *ongoing vocational supports* that are appropriate to

individuals' needs and situations. Continuous availability of vocational supports following job placement is one hallmark of supported employment services (Wehman, 1988). Given the relapsing and remitting nature of severe psychiatric disability, this principle suggests that vocational supports should not be completely removed upon attainment of a job, creating a challenge for providers to avoid over- or under-serving successfully employed individuals (Cook & Razzano, 1992). In another study including 550 outpatients receiving vocational rehabilitation, Cook and Rosenberg (1994) used logistic regression analysis in a model predicting employment status at six-month follow-up after program exit. This analysis revealed that ongoing support was a significant factor, even when controlling for client demographic features (e.g., age, education, ethnicity), prior work history, degree of functional impairment, hospitalization history, length of time in treatment, and types of job supports received. In another study of a model program at the same agency, Cook and Razzano (1992) demonstrated that the addition of ongoing, as-needed employment support services resulted in an agency-wide increase in employment rates from 50% to over 80% throughout the 36-month program period.

Tailoring job development and support to *individual preferences* is yet another principle which, to some extent, grew out of a reaction against the “one-size-fits-all” approach in some vocational rehabilitation service delivery models in which individuals with psychiatric disabilities have little to say over the nature of the jobs they are offered and/or the level of intrusiveness of the job supports they receive (Danley et al., 1992; Mowbray et al., 1994). Contrary to this line of thinking, more contemporary research supports that individuals with psychiatric disabilities have better employment-related outcomes when their services are designed and delivered to coincide with their job preferences. For example, in one study by

Becker, Drake, Farabaugh, and Bond (1996) examining 143 individuals with psychiatric disabilities, findings suggested that the individuals who worked in their preferred fields reported job tenure twice as long as those not employed in their preferred area, as well as significantly greater levels of job satisfaction.

Another principle involves the use of *integrated treatment* (Drake, Becker, Bond, & Mueser, 2003). Recent research has demonstrated that integrated services, defined as closer coordination between clinical and vocational service providers leads to better employment outcomes for individuals with psychiatric disabilities (Bond, Resnick, et al., 2001). Mental health and vocational rehabilitation services have undergone varying degrees of integration and attempts at integration. For example, the Interagency Agreement between RSA and the Substance Abuse and Mental Health Services Administration suggested that state and local mental health authorities and vocational rehabilitation agencies work together in the treatment of individuals with psychiatric disabilities (see Chapter 2, History). More frequently, however, mental health authorities are providing vocational services, so the issue is less cross-agency integration and more within-agency collaboration and integration. Drake and his colleagues (2003) suggested that integrated mental health and vocational rehabilitation services produce better outcomes because they allow for greater communication across providers, a clearer focus on vocational outcomes among mental health practitioners, and more accurate and comprehensive assessment, treatment, and service provision.

A final principle involves the explicit acknowledgment of and planning for the ways in which changes in work status may alter disability income and associated health care coverage. This principle identifies the necessity to address potential *economic disincentives* to achieve certain levels of paid employment, inherent in the structure of disability entitlements (Noble, 1998). One

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study of vocational rehabilitation involving job-seeking skills training reported that Supplemental Security Income recipients were significantly less likely to become employed or enter job training than non-recipients of SSI; however, this was linked by the authors to the recipient group's poorer work histories and greater illness severity and chronicity (Jacobs et al., 1992). A multivariate study of 1,634 male Vietnam-era veterans found differences in likelihood and nature of employment according to the monthly amount the men were receiving (Rosenheck, Frisman, & Sindelar, 1995). Veterans who received Department of Veteran's Affairs disability compensation payments of less than \$500 a month were no less likely to work or earn less money than those who received no disability income (and presumably had no disincentive). However, even controlling for illness status, functional impairment, and traditional labor force predictors such as ethnicity and education, veterans whose compensation was greater than \$500 per month were significantly less likely to work and earned significantly less than all groups of eligibles. Interestingly, veterans with psychiatric disabilities were no less likely to be employed than their disabled counterparts with physical and other nonpsychiatric disabilities (Rosenheck et al., 1995). While research in this area has yet to persuasively answer many questions about the relationship between disability payments and employment activity, it *has* highlighted the importance of benefits counseling and financial planning to both service providers and recipients (Donegan & Palmer-Erbs, 1998).

Promising and Effective Practices in Supported Education

Post secondary education is the primary means in North American society for people to pursue a dream of vocational advancement (Mowbray, Verdijo, & Levine, 2002). Making a decision to pursue additional schooling is a step in the direc-

tion of taking back one's life (Farkas, 1996). Unfortunately, for individuals with psychiatric disabilities, this opportunity, though frequently desired, is seldom secured (Rogers, et al., 1991; Anthony & Unger, 1991). Psychiatric disabilities frequently strike when people are beginning their adult lives. Later in the course of the illness, people often try to reenter the schooling program that was previously interrupted but find themselves unable to do so. Although 35% of people sampled in a national survey indicated that they had attempted some form of formal education after illness struck, only 8% completed their course of study (Navin, Lewis, & Higson, 1989). Student services for students with other disabilities have been available at most universities and vocational training programs for more than 15 years. However, until a few years ago, individuals with psychiatric disabilities could not obtain a personal support person to help them pursue post secondary education.

Supported education provides people with psychiatric disabilities with the opportunity to attend "real" educational programs as regular students integrated into a particular school, rather than to attend classes run by mental health systems in which they are "patients" following a treatment plan. Supported education is defined by where it is provided (i.e., a normal educational setting) rather than a mental health setting. Two important texts defining and describing supported education philosophies and models are now available (Unger, 1998; Mowbray, Brown, Furlong-Norman, & Soydan, 2002). Among these authors, there is a consensus that supported education involves providing flexible, accessible, ongoing supports, in a normalized setting to assist individuals with psychiatric disabilities to partake of skill, career, education and interpersonal development opportunities (Unger, 1998; Mowbray et al., 2002). Unger (1998) further describes supported education as those that are individualized, promote self-determination and dignity, are coor-

minated, and of indefinite duration. A host of educational accommodations (e.g., notetaker services, changing test-taking times and modes, books on tape; extending timelines for assignments) and support services (e.g., registration assistance, counseling, providing assistance with financial aid) can form the basis of a supported education program, depending on the setting and supported education model. Supported education is not treatment, but rather is designed to provide skills and knowledge for career and interpersonal enhancement.

Typically, individuals with serious psychiatric disabilities do not require intensive on-campus support to succeed in school. Instead, they require help in applying social, emotional, and intellectual skills needed to meet the challenge of academic and social demands at school (Danley et al., 1992). A comprehensive array of services designed to support educational goals typically includes three prototypes of supported education: (a) the self-contained classroom (i.e., students attend a separate class with a specialized curriculum in a natural educational setting) (Unger, Danley, Kohn, & Hutchinson, 1987); (b) mobile support (i.e., students attend regular classes with support from mental health services staff (Sullivan, Nicolellis, Danley, & MacDonald-Wilson, 1993); and finally, (c) on-site support (i.e., students attend regular classes and receive support from on-site education staff (described in Furlong-Norman, 1990). While supported education began as a way of helping academically talented individuals with serious psychiatric disabilities return to universities, the options have since been extended to include the development of mobile teams to help people in any post secondary education setting (Sullivan et al., 1993).

The defining principles of supported education, regardless of program model, have been enumerated by Sullivan-Soydan (2002) as (a) *dignity* (delivering services in a manner and in an environment that protects privacy and enhances dig-

nity); (b) *self determination* (promoting choice and active student involvement); (c) *normalization* (providing services using the most non-stigmatizing integrated settings and methods possible); and (d) *reasonable accommodation* (educational settings should not be considered a treatment environment but as an environment in which to enhance skills, credentials, and professional advancement). An ongoing demonstration project at Boston University showed how supported education and supported employment approaches can be combined into a seamless education and employment program (Hutchinson, 1998). Other such model programs have been developed at the College of San Mateo (College of San Mateo, Transition to College Program, n.d.) and at the University of Michigan (Mowbray, Brown, et al., 2002).

The VR system can be instrumental in providing supported education services and facilitating access to those services, in certain states. Some state VR agencies may serve as models in that they regard supported education services as an important service in their array of services (e.g., Oregon).

We note that, often, discussions of supported education raise important issues related to the “school-to-work transition” for youth with psychiatric disabilities. These important issues were the subject of another IRI panel and document and, therefore, were deliberately excluded from this discourse.

Other Issues in the Vocational Recovery of Individuals with Psychiatric Disabilities

Work Incentives and Disincentives

There are a variety of systemic issues that keep individuals with psychiatric disabilities out of the workforce (MacDonald-Wilson, Rogers, Ellison, & Lyass, 2003). Recently, federal policy-makers have attempted to address work disincentives through federal legislation, in particular. The most important recent legislation of note is the Ticket to Work and Work Incentives and Improvement Act of 1999 (P.L. 106-170). The Ticket to Work program provides SSDI and Supplemental Security Income (SSI) beneficiaries with expanded access to employment services, vocational rehabilitation services, and other services designed to assist them to return to the workforce. The “Ticket” program is designed to enable Social Security recipients to obtain, regain, or maintain employment and reduce their dependency on cash assistance. Under this program, SSA pays providers of vocational services (called employment networks [ENs]) after the beneficiaries achieve certain levels of work and income.

In addition to the “Ticket” programs authorized under the Ticket to Work and Work Incentives Improvement Act, there is a variety of other work incentives offered by SSA for individuals with disabilities who are recipients of SSA disability payments. These incentives are designed to increase the likelihood that individuals with disabilities will attempt to engage in the workforce and be successful in maintaining employment. The extent to which these incentives are successful in that regard has not yet been fully demonstrated. Some of the more frequently used incentives include Impairment-Related Work Expenses, the Trial Work Period, the Extended Period of Eligibility, and the Continuation of

Medicare/Medicaid Coverage, to mention a few. A fuller explanation of such work incentives appear on the SSA Web site (<http://www.ssa.gov/work/ResourcesToolkit/work-incentives.html#ssdissi>). The TWWIA legislation is handled in chapter 2 (History) but bears repeating here because of the powerful effect economic disincentives can have on job seeking and employment outcomes for individuals with psychiatric disabilities.

Stigma and Discrimination in the Workplace

A full treatment of the stigma and discrimination experienced by individuals with psychiatric disabilities is beyond the scope of this manuscript. However, we note that beyond the individual person with the disability and beyond what the system can provide in the way of employment services, individuals with psychiatric disabilities face stigma and discrimination in the workplace that affect their abilities to obtain and retain employment (Hocking, 2003). In a study of perceptions of discrimination among approximately 1,800 individuals with serious psychiatric disabilities, Corrigan and his colleagues found that approximately half reported some experience with discrimination, with the most frequently reported sources of discrimination being mental disability, race, sexual orientation, and physical disability. Individuals also reported that they experienced discrimination in the areas of employment, housing, and interactions with law enforcement (Corrigan et al., 2003).

Authors have also examined the role of “self-stigma” among individuals with psychiatric disabilities in which individuals incorporate society’s negative attitudes towards psychiatric disability (Ritsher, Otilingam, & Grajales, 2003). Greater self-stigma has been found to be associated with depressive symptoms, lower self-esteem and empowerment, and lower recovery orientation.

Reducing internalized stigma through stigma reduction techniques may, thus, be as important a treatment goal as symptom reduction (Ritsher et al., 2003).

Conclusions

This chapter was intended to provide an overview of existing and promising vocational assessment approaches, vocational interventions, and supported education models. Since the last IRI manuscript on vocational rehabilitation for individuals with severe psychiatric disabilities, the field has evolved significantly. In summary, the following may be said of these changes:

- The preferred method of providing vocational assessment services to individuals with psychiatric disabilities now includes some form of in situ determination of work capacity, such as situational assessment.
- Supported employment or a reliance on a “place-and-train” rather than a “train-and-place” approach is now the preferred model of vocational rehabilitation for individuals with psychiatric disabilities.
- There has been a proliferation of newly developed vocational models, many of which rely on supported employment principles, including IPS, vocational PACT, etc.
- The empirical base for many vocational models is rapidly growing through the findings of the EIDP study and a variety of other studies.
- Supported educational models have developed and are being implemented in different locations around the country, but there are fewer studies examining the effectiveness of these models.

Observations of vocational rehabilitation program models suggest that these models should not be conceived of as fixed and rigid and that they will evolve and be adapted to particular sites, con-

texts, and circumstances. What may be important in the vocational rehabilitation research agenda as we move forward is an unbundling approach where we investigate essential principles and components rather than entire models of rehabilitation. To that extent, the evidence-based principles, as cited earlier in this chapter, rather than evidence-based models in their entirety may be most illuminating and useful for further study.

While we have witnessed eras where VR and MH systems have diverged in their missions and the VR system has assumed primary responsibility for employment services to individuals with psychiatric disabilities, more recently we have seen an upsurge of interest with mental health systems in providing employment services and improving the employment outcomes of the individuals served by those systems. Many MH systems now provide vocational assessment, vocational interventions, and supported education services as part of their array of services.

Unfortunately, much remains to be done in the way of further research and evaluation of the effectiveness of existing employment models in promoting the vocational recovery of individuals with psychiatric disabilities, particularly addressing the issues of “what works for whom and under what circumstances” (National Institute of Mental Health, 2002). Even the most promising vocational models rarely result in individuals leaving the disability benefit rolls and returning to full-time employment (MacDonald-Wilson et al., 2002). While there has been some progress in gathering empirical evidence for supported education models (Mowbray & Collins, 2002), there is still a lack of precise information regarding the effectiveness of those models. We hope that the next IRI monograph that focuses on vocational rehabilitation interventions for individuals with psychiatric disabilities will have a wealth of information to report about the development and testing of these new models and that a burgeoning number of individuals with psychiatric disabilities will be a part of the workforce.

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Study Questions

1. What are the key elements of benefits counseling?
 - a. It applies to recipients of SSA disability benefits.
 - b. It involves work incentives.
 - c. It involves healthcare coverage.
 - d. All of the above.
2. Which type of on-site job evaluations is suggested to well represent productivity at a job?
 - a. Vocational Assessment
 - b. Situational Assessment
 - c. Benefits Counseling
3. What vocational assessment inventory contains 36 work performance assessments with 5 subscales and has shown acceptable inter-rater reliability, internal consistency, and concurrent validity?
 - a. Work Behavior Inventory
 - b. Tsang and Pearson Measurement
 - c. Standardized Assessment of Work Behavior Measurement
4. What is the definition of Supported Employment according to the 1998 Amendments to the Rehabilitation Act?
 - a. Competitive employment in a non-integrated setting, or employment in integrated work settings in which individuals are working toward competitive employment, consistent with the strengths, resources, priorities, concerns, abilities, capabilities, interests, and informed choice of the individuals with ongoing support services for individuals with the most significant disabilities.
 - b. Competitive employment in an integrated setting, or employment in a non-integrated setting in which individuals are working toward competitive employment, consistent with the strengths, resources, priorities, concerns, abilities, capabilities, interests, and informed choice of the individuals with significant disabilities.
 - c. Competitive employment in an integrated setting, or employment in integrated work settings in which individuals are working toward competitive employment, consistent with the strengths, resources, priorities, concerns, abilities, capabilities, interests, and informed choice of the individuals with ongoing support services for individuals with the most significant disabilities.
5. Supported education occurs in what type of educational institution? (Please check one choice.)
 - a. Adult education
 - b. Post-secondary educational institutions
 - c. High schools

6. What are the principles associated with supported education according to the work done by Sullivan in 2002? (Please check one choice.)
- Dignity, self determination, normalization, and reasonable accommodation
 - Dignity, motivation, normalization, and assistive technology
 - Dignity, motivation, independence, and integration
7. In 1995, the Center for Mental Health Services embarked on the largest study of vocational interventions for persons with psychiatric disabilities yet to be conducted. What was the name of this study? (Please check one choice.)
- Employment Intervention Demonstration Project (EIDP)
 - Program for Assertive Community Treatment (PACT)
 - The Clubhouse Model
8. What employment setting includes work in a segregated setting where the salary is less than minimum wage? (Please check one choice.)
- Volunteer work
 - Sheltered employment
 - Client-run enterprises
9. Which program/model began as a case management model but has progressed to focusing on vocational outcomes for individuals with serious mental illness? (Please check one choice.)
- The Clubhouse Model
 - Volunteer Programs
 - The Program for Assertive Community Treatment (PACT)
10. Which model is based on the values of psychiatric rehabilitation, including consumer choice, individual planning and consumer involvement in the rehabilitation process, as well as the technology of psychiatric rehabilitation, including how to set goals with consumers, how to connect with consumers, how to teach skills to consumers, and how to develop resources with and for consumers? (Please check one choice.)
- Family-Aided Assertive Community Treatment
 - Choose-Get-Keep Model
 - Integrated Employment Program

Chapter 4

Systems

By Joe Marrone, Jacquelyn E. Tellier, Stephaine Parrish Taylor, and Laura DiGalbo

Why Should Direct Service Staff Be Concerned About "Big" System Issues and What Role Can They Play in this Regard?

This chapter encompasses broad policy and structural concepts that naturally fall within the purview of public administrators and supervisors, and researchers, policy analysts, and advocates. Because of this factor, sometimes there is a tendency on the part of staff who provide direct client services in large public systems, such as state vocational rehabilitation (VR) agencies, to consider “systemic” issues as outside of their scope of influence and, thus, not relevant to their concerns. Staff may feel they are only passive recipients of regulations and systems requirements and thus powerless to affect any change in these areas. However, the authors postulate that this exclusion is both inaccurate and not a responsible course of action for vocational rehabilitation personnel.

First, VR professionals have an ethical obligation to improve the way their services are delivered to the public beyond just their individual client contact. In addition, VR professionals can impact how policies are interpreted and implemented in their organization and how other systems, with whom they work, view and participate in vocational rehabilitation efforts to benefit individuals with psychiatric disabilities. As Reitan (1998) discusses, “human service professionals may, in fact, be the driving force in developing interagency relations” (p. 290) and “if organization and profession

are indeed contradictory entities, professionals are just as likely to transcend organizational boundaries” (p. 290). Systemic changes or improvements must begin at the grassroots level; individual professionals must begin the process to make the difference. Finally, even large scale social change, such as national liberation movements and civil rights efforts, are often initiated at the individual and micro levels, though their ultimate achievement may require major systemic restructuring

Scope of Issues

In 1978, a cooperative agreement was developed between the National Institute of Mental Health (NIMH) and the Rehabilitation Services Administration (RSA). The purpose of this agreement was to ensure that VR and mental health (MH) work collaboratively in the best interest of individuals with psychiatric disabilities. VR’s focus was on employment; MH’s focus was on treatment.

Twenty-five years later, there are still systemic issues that seem to impede the progress of individuals with psychiatric disabilities as they engage in and maintain employment. The purpose of this section is to review the following:

- Progress made by VR and MH in expanding and improving services leading to employment for individuals with psychiatric disabilities
- Initiatives undertaken by systems (e.g., Social Security, Medicaid, Education) to promote the expectation of employment for individuals with psychiatric disabilities
- Areas in which systems may continue to inhibit opportunities for individuals with psychiatric disabilities to go to work, and
- Some thoughts for continued systemic changes that will honor the idea that all indi-

viduals with psychiatric disabilities can and should work and become self-sufficient.

Some overriding contextual perspectives to explore are concepts, such as:

- The Recovery Model Philosophy;
- Discrimination, Stigma, and Myths;
- Disincentives;
- Diversity of Outcome Measures; and
- Expectations of the 21st Century Workforce.

Understanding psychiatric disabilities and the vocational rehabilitation process, as well as the mental health service delivery system, are key to the success of the VR counselor when working with individuals with psychiatric disabilities. The VR and MH systems each set their own parameters within which success may be attained. Therefore, VR counselor who understands the systems, their histories, and future plans, with respect to psychiatric disabilities and employment, can better serve consumers.

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 individuals with psychiatric disabilities. They assert that unemployment amongst 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. However, they believe that the lack of flexibility on the job can present barriers to entering or maintaining employment.

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 individuals with psychiatric disabilities to enter employment is integral to the overall mission of both the mental health and public vocational rehabilitation service systems and, thus, inherent to 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 and vocational rehabilitation systems communicate a belief that all people (including individuals with psychiatric disabilities) should be employed, have the citizenship right to equal 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 but also a responsibility of citizenship.
- The VR and mental health systems 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., spouses, lovers, family, and friends) as well as professional staff.
- It is the responsibility of VR and mental health systems to facilitate changes in environmental factors (anything outside the person) and skills (the person) to enable the person to pursue their job of choice.
- VR and mental health systems should all recognize that dangers attendant to long-term unemployment (Dooley, Catalano, &

Wilson, 1994; Kasl, Rodriguez, & Lasch, 1998; Lennon, 1999) almost always outweigh the dangers inherent to the stressors of working for persons with serious mental illness (SMI), especially in light of the absence of any valid scientific data that actively promoting employment as an expectation for all precipitates any psychiatric symptomatology or distress. Concomitantly, there are a plethora of reasons why individuals with psychiatric disabilities should not just be offered the opportunity to seek employment but should be strongly encouraged to do so as part their overall movement towards recovery (Marrone & Golowka, 2000).

Furthermore, the question often raised is: If informed consumer choice is a value that guides vocational rehabilitation and mental health policy, then should not both VR and mental health systems recognize that people may choose not to work or choose to work in segregated settings? 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. Societies are governed by laws and publicly stated values (e.g., U.S. Constitution, Civil Rights Act of 1964, Title IX, and Americans with Disabilities Act [ADA]). The funding agency or provider is part of a broader community context, whose values and actions are guided by public law and regulation and must reflect the core social values of the society of which it is a part. It is incumbent upon any funding or community service agency to clarify what activities it wishes to support and encourage, not merely identify what it will tolerate. 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 making such a choice.

Current System Issues that Impact Service Delivery

Workforce Investment Act (WIA)

Another element potentially affecting services to individuals with psychiatric disabilities is the Department of Labor's (DOL) new system that seeks to consolidate all workforce services, including public VR, into the One-Stop Center system. The Rehabilitation Act Amendments of 1998 was incorporated as a separate title (Title IV) under WIA. A subject of current public policy debate is whether individuals with significant disabilities can get appropriate services under a generic system of services. The research on successful employment services for individuals with significant psychiatric disabilities (cited in chapter 3 of this document) emphasizes the intensity and duration of supports needed for vocational success. This debate takes on added importance in the context of persons diagnosed with psychiatric disabilities.

Ticket-to-Work and Work Incentives Improvement Act (TWWIIA)

The passage of the Ticket-to-Work and Work Incentives Improvement Act (TWWIIA) of 1999 created more incentives for states to create Medicaid buy-in programs for working adults receiving Medicaid as well as creating more capacity to maintain medical coverage associated with receipt of Supplemental Security Income (SSI) or Social Security Disability Income (SSDI). In addition, TWWIIA authorized the embryonic Ticket-to-Work payment mechanism, under which the Social Security Administration (SSA) seeks to create competitive pressure in the provision of vocational rehabilitation services by allowing providers of services other than public VR to receive reimbursement under SSA funding mechanisms. TWWIIA has advanced two concepts: retention of medical benefits and competi-

tion. Retention of medical benefits has had significant impact on state systems. Even greater potential exists for impact on individuals' behavior. Although its impact to date is less clear. The effects of competition remain even murkier. The advent of state Medicaid buy-in programs, which TWWIIA has helped advance, avoids benefit loss and makes it demonstrably easier for individuals with psychiatric disabilities to obtain employment without jeopardizing medical coverage. This is often critical to an individual's ability to continue to get medication, especially the newer atypical prescriptions, which many private employer insurance plans may not cover. As noted, the degree to which individuals have used these improvements and sought employment as a result cannot presently be measured.

The other major provision under TWWIIA is the creation of the Ticket-to-Work. The assumption underpinning this change is that creating competition for SSA reimbursement funds would further promote individual choice and increase accountability for providers. Presumably, this would strengthen employment services for individuals with significant disabilities on SSI or SSDI, an increasing percentage who are individuals with psychiatric disabilities. This has elicited concern from some professionals in the VR system regarding undermining the role of vocational rehabilitation services for people receiving SSI or SSDI. Potential service providers have also expressed concerns. They are concerned that the reimbursement structure does not provide sufficient economic incentive to work with individuals with the most significant disabilities, including individuals with psychiatric disabilities, who require long-term employment support.

Health Insurance Portability and Accountability Act (HIPAA)

The passage of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) allowed many individuals with prior continuous health coverage to avoid being excluded from health coverage for “pre-existing conditions” when they switched employers or moved from Medicaid to employer-based coverage. While HIPAA has focused on the 2003 regulatory implementation of its medical records privacy protections, it, nonetheless, created another avenue of flexibility for those concerned with retaining medical benefits. Because of the intermittent and long-term nature of significant psychiatric disability, the ability to secure employer-based coverage for “pre-existing conditions” holds enormous potential for employment service provision, especially for those with a current employment history or those moving from Medicaid coverage to employer-based health insurance.

Many advocates argue that if psychiatric disabilities result in limitations that require remediation before a person can function successfully, then rehabilitation services focused on employment are medically necessary and should not be prohibited by Medicaid. If this reasoning is accurate, then it may be time for a federal mandate for state MH systems to incorporate employment as an expected, reportable outcome. This expectation is complicated due to the localized nature of most MH funding and the complexities of Medicaid funding mechanisms and waivers, but it should be explored more fully. Another argument is that the category of medical services does not provide the ideal construct under which to fund employment services (Hagner & Marrone, 1993). The support for this argument is that continuing to fund employment services as a “waiver” of existing authority, rather than as a discrete funding stream, devalues the services and, dilutes an already under-funded, fragile safety net of health care in the United States.

Increasing Ascendancy of Family and Peer Advocacy within MH

The publication in 1979 of *On Our Own: Patient-Controlled Alternatives to the Mental Health System* crystallized the increasing desire of psychiatric “survivors” to seize control of their own lives, especially to resist unwanted commitment and medication (Chamberlin, 1979). Out of this movement flowed court decisions severely limiting involuntary treatment. Grassroots political organizations were developed, such as the Mental Health Liberation Front and the National Association of Psychiatric Survivors. In the last 20 years, community program options have sprung up, including consumer-run, drop-in centers, using consumers as case aides, and consumer-run businesses (Hagner & Marrone, 1995). This form of grassroots self-advocacy has been accompanied by federally supported national technical assistance centers for mental health consumers in Philadelphia, Boston, and West Virginia, now threatened with cutbacks in funding. Self-advocacy provides additional pressure and accountability in increasing the ability of public VR to successfully meet the employment needs of individuals with psychiatric disabilities.

Since its inception in the 1970s in Madison, Wisconsin, and as demonstrated by its explosive growth in numbers and influence, NAMI: The Nation’s Voice on Mental Illness (NAMI) has increased the visibility of family members of individuals with psychiatric disabilities within the public policy debate. Both consumer and family advocacy groups have been increasingly critical of the manner in which VR and MH systems provide employment services to individuals with psychiatric disabilities. This sharp criticism was most recently enunciated in the NAMI 2003 TRIAD report, “Shattered Lives.” NAMI has even suggested the current state of the VR service system combined with the evidence of what works in employment for individuals with psychiatric dis-

abilities seriously considers redirecting money from public VR to comprehensive mental health systems for supported employment services for individuals with psychiatric disabilities (Hall et al., 2003).

Managed Care

The concept of *managed care* has grown exponentially within the management of the public mental health system in the last decade (Backlar, 1996). Much of the emphasis has been on issues of cost containment and efficacy of medical treatment rather than rehabilitation. To the extent that managed care helps systems look at improved outcomes, the cause of vocational rehabilitation will be helped; however, there has been equal or more attention under managed care to cost reduction than to quality improvement. The ability of managed care to further employment outcomes is limited by the ability to substitute employment services for other mental health services rather than add further services in this area to other comprehensive mental health services (Clark, 1998).

Related to the development of managed care as the preferred management model within public community mental health is the narrowing of the service population in most states to those individuals with serious psychiatric disabilities.

Declining human services budgets and less use of long-term-stay hospitals for psychiatric care contribute to this phenomenon. The VR-public MH collaboration mirrors this fact. Anecdotal evidence and discussions with personnel of both systems emphasize that the group of people seeking services through the multiple referral mechanisms between VR and public MH have very significant disabilities with multiple barriers to employment. While this population is consistent with the Act, emphasis on individuals with the most significant disabilities continues to present resource challenges for VR.

Evidence-Based Practice

The focus on evidence-based practices within mental health and the Individualized Placement and Support (IPS) model resulted in the Substance Abuse and Mental Health Services Administration funding a multi-state, five-year Employment Intervention and Demonstration Project (EIDP) (Bond et al., 2001; Drake et al., 1994). The EIDP was conducted by the Mental Health Services Research Program at the University of Illinois in Chicago. Preliminary results have been available since 2002 (Bond et al., 2001; Cook et al., in press).

Employment is not the most important aspect of life. Many individuals enjoy relationships, recreation, pets, and a spiritual dimension; however, employment is often one of the most significant parts of the multiple aspects of a fulfilling life. It is the least emphasized service in the overall design of recovery-oriented systems, to which most MH systems in the United States currently aspire. Despite the well researched and technically defined interventions noted in the scientific literature, supported employment for individuals with psychiatric disabilities is one of the relatively few evidence-based practices that SAMHSA identifies which mental health systems have not tried to implement. Greater attention has been devoted to other evidence-based practices (e.g., illness management, medication management, co-occurring disorder treatment, family psycho-education, PACT, etc.) than data generated through 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 it with other services prevalent in outcome-based care.

The EIDP study found:

- People with SMI 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 SMI 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 SMI should be helped to find jobs matching career preferences.
- VR services should explicitly and proactively address financial planning and provide education/support around disability benefits and entitlements.
- VR services should involve family and friends in supporting efforts to work.
- Vocational and mental health services should be integrated and coordinated.
- Vocational providers should work collaboratively with persons with SMI 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., in press)

This research base points to one of the key obstacles facing the collaboration between VR and MH systems. Much of the direct employment service delivery design within the MH services area has been predicated on interagency working relationships between VR and mental health systems. The research evidence within the psychiatric rehabilitation field demonstrates that effec-

tive 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 that the public mental health systems "own" vocational rehabilitation and employment outcomes outright rather than being a function of interagency agreements with state VR agencies. This conclusion can enhance the potential for collaboration. Rather than just outsourcing vocational rehabilitation to the public VR agency, 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 the 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 MH system may now provide vocational rehabilitation, its philosophical base is still driven by a medically oriented, diagnostic model. This approach looks at deficits rather than strengths, or imputes inaccurate functional characteristics or assessments to diagnostic labels, or adheres to psychiatric treatment.

Presidential Task Force on Employment of Adults with Disabilities

Gaps in employment services and generally poor vocational outcomes for people with psychiatric disabilities are broadly recognized as problematic by federal policy makers and advisors. Recently, the reports of the Presidential Task Force on Employment of Adults with Disabilities in 1998 and the President's New Freedom Commission on Mental Health in 2002 (Hogan, 2003; Presidential Task Force, 2002), both highlighted this issue. One outgrowth of the Presidential Task Force on Employment of Adults with Disabilities

was the creation of the Office of Disability and Employment Programs (ODEP) in the DOL charged with the responsibility of ensuring that the nation's workforce development system adequately addresses the needs of its customers with disabilities. As part of this strategy, ODEP created specialized funding for Customized Employment defined by ODEP (2002) as

. . . individualizing the employment relationship between employees and employers in ways that meet the needs of both. It is based on an individualized determination of the strengths, needs, and interests of the person with a disability, and is also designed to meet the specific needs of the employer. It may include employment developed through job carving, self-employment or entrepreneurial initiatives, or other job development or restructuring strategies that result in job responsibilities being customized and individually negotiated to fit the needs of individuals with a disability. Customized employment assumes the provision of reasonable accommodations and supports necessary for the individual to perform the functions of a job that is individually negotiated and developed (p. 43156).

Customized employment focuses on the employment needs of individuals with significant disabilities as well as employment projects dedicated to meeting the needs of people who are chronically homeless as well as 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 [1999])

Still other specialized projects were targeted towards the employment needs of chronically homeless persons, defined as persons without shelter who also have disabilities. Each of these three specialized demonstration categories (25 local projects funded as of October 2003) has impact on the vocational rehabilitation needs of individuals with psychiatric disabilities. While funded by DOL monies, these projects are expected to involve coordination with the local public VR entities in the states in which they operate. Appendix C provides a listing of projects funded by RSA that focus on serving individuals with psychiatric disabilities. Several of the projects target homeless individual and collaboration between VR and housing organizations.

Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA)

The passage and implementation of the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996 focused on employment activities and outcomes as an expected element of financial assistance for Temporary Assistance for Needy Families (TANF) recipients. While not directly related to psychiatric vocational rehabilitation, VR and MH systems can draw important policy perspectives from the implementation of PRWORA. This statute contains the most effective strategy for implementing broad system change initiatives that require system clients, staff, and the community to reframe their worldviews. Much has been written within the organizational literature in business about the importance of changing behavior as a precursor and a stimulus to changing values rather than vice versa (Beer, Eisenstat, & Spector, 1990; Marrone, Hoff, & Gold, 1999). Welfare reform, in its short history since 1996, has had a more drastic effect on how welfare (especially TANF) services are delivered than evidence-based

practices in mental health (Sanderson, 2002) or supported employment in the disability world (Mank, 1994) has had on their respective service systems. The reasons for this are speculative at this stage, but it is the authors' contention that (a) PRWORA has unequivocally made employment an explicit outcome for services in a way that mental health has not, and (b) the focus of the reform has been less on *practice* and more on a clear policy statement of expected outcomes with emphasis on flexible funding and experimentation, not on fidelity scales related to the process of implementation.

Focus on Recovery

There is no one accepted definition of “recovery” by systems and advocates, but there is a consensus on its basic tenets. NASMHPD (1996) defines it as follows:

The term “recovery” is used to acknowledge that people can successfully contend with severe and persistent psychiatric disorders, function well, and create positive lives. As such, recovery is a multi-faceted concept with a connotation that persons with disabling mental disorder and varying severity of disability can and do restore and/or generate to full human capacity. (p. 1)

The New York State Office of Mental Health in its *2001-2005 Strategic Plan* (2001) defines “recovery” as

...the process of gaining control over one's life in the context of the personal, social and economic losses that may result from the experience of psychiatric disability. It is a continuing, non-linear, highly individual process that is based on hope and leads to healing and growth. (p. 2)

The public mental health system has embraced *recovery* as a guiding principle. Anthony (1993) introduced recovery as the guiding vision for the

mental health system after reading and listening to consumers' personal accounts of their struggle through, and recovery from, psychiatric disabilities. He traced the progress of the mental health system from deinstitutionalization through the establishment of community support and rehabilitation services, with recovery envisioned as the next step in the process of evolution. This concept has been immeasurably aided over the last decade by the exponential increase in newer medications for the treatment of serious psychiatric disabilities. These medications have had a significant impact on reducing negative symptomatology and debilitating physical side effects. The mental health consumer/survivor movement, which emerged in the early 1970s, gave the early voice to the notion of mental health recovery and the related emphasis on self-determination and empowerment. Anthony (2000) notes that deinstitutionalization focused on new uses for buildings and facilities. The community support system was planned as a network of essential services to support individuals with psychiatric disabilities. The field of psychiatric rehabilitation emphasizes treating the consequences of psychiatric disabilities. Recovery, however, speaks to how people who are recipients of services will live and choose the services they need and want. Anthony published a set of suggested standards for a recovery-oriented service system with indicators in the areas of design, leadership, evaluation, management, integration, comprehensiveness, consumer involvement, cultural relevance, advocacy, training, funding, and access.

In a report for the NASMHPD, in an attempt to operationalize recovery, Onken, Dumont, Ridgway, Dornan, and Ralph (2002) state, "Recovery can be construed as a paradigm, an organizing construct that can guide the planning and implementation of services and supports with people with severe mental illness" (p. x). Additionally, the report states,

A shift to a recovery orientation will require

attention to wellness and health promotion, not simply attention to symptom suppression or clinical concerns. Attention must be paid to basic needs in safe and affordable housing, health care, income, employment, education and social integration. (p. xi)

The report defines “recovery” as

...an ongoing dynamic interactional process that occurs between a person’s strengths, vulnerabilities, resources and the environment. It involves a personal journey of actively self-managing psychiatric disorder while reclaiming, gaining and maintaining a positive sense of self, roles and life beyond the mental health system, in spite of the challenge of psychiatric disability. Recovery involves learning to approach each day’s challenges, to overcome disabilities, to live independently and to contribute to society. Recovery is supported by a foundation based on hope, belief, personal power, respect, connections, and self-determination. (p. 3)

The implication for vocational rehabilitation in this new emphasis on a recovery construct as a guiding principle for community mental health is salutary. First, one of the foci in recovery is that tangibly affects a person's well-being, quality of life, and capacity for independent living, not just amelioration of symptoms. Another is the implication of an asset/ strengths based approach so intrinsic to rehabilitation philosophy but relatively new in mental health interventions. In Kiernan, Marrone, and Van Gelder (1998), four core tenets of rehabilitation are identified, which directly influence practice in the community, as based on underlying assumptions about human behavior and the personal change process. Four major areas they identified reflected: (a) client control, (b) productivity as not solely related to employment but other levels of personal achievement, (c) support being willingly offered and accessible, and (d) the rehabilitation process

reflecting varying rates of advancement and times of plateau. These concepts are inextricably interwoven into the aforementioned definitions of recovery.

Disincentives

Within the last decade of the 20th Century, prevailing thought in the arena of disability policy appeared to have turned a corner. Persons with disabilities, their families and advocates, public policy makers, and providers of services and treatment have done much work, as evidenced by such initiatives as TWWIA, Olmstead, ADA, the President’s New Freedom Initiative, reauthorization of IDEA, development of the “Recovery Concept” in psychiatric rehabilitation, etc.

In spite of these efforts, there is much to be accomplished before realizing President Bush's vision “Achieving the Promise: Transforming Mental Health Care in America” (Hogan, 2003) whose vision statement opines that:

. . . a future when everyone with a mental illness will recover, a future when mental illnesses can be prevented or cured, a future when mental illnesses are detected early, and a future when everyone with a mental illness at any stage of life has access to effective treatment and supports, essentials for living, working, learning and participating fully in the community. (<http://www.mentalhealth-commission.gov/reports/FinalReport/FullReport.htm>)

Americans are charged with ensuring that all individuals with psychiatric disabilities have the essentials necessary for work. Work is perceived as an outcome of prevention, early detection, and treatment for individuals with psychiatric disabilities.

The ADA and the Olmstead Decision predate the values reflected in the President’s New Freedom Initiative. Work is still viewed as an outcome measure of non-discriminatory practice for per-

sons with disabilities, including individuals with psychiatric disabilities; but the struggle now is less around intent and philosophy than around highlighting employment in the mental health arena and disability remediation and accommodation in the employment arena. If the United States is to create a public system that supports the visions of the ADA, Olmstead, and the President's New Freedom Initiative, then disincentives in the mental health, employment, vocational rehabilitation, and financial support systems should be eliminated.

In spite of the potentially excellent inroads that could be made by such initiatives as Ticket-to-Work, there continue to be financial disincentives for private providers to enroll as Ticket providers based on the payment structure for successful outcomes. These disincentives limit their consumers' options and, therefore, conflict with the intent of the legislation. In addition, "Congress envisioned the Ticket Program as a freestanding program, not a replacement for other Federal and State programs" (Ticket-to-Work and Work Incentives Advisory Panel, 2003). Unfortunately, much of today's legislative discussion concerns the blurring of boundaries that exist between the two distinct options for consumers of private sector versus public sector VR services. Both the Olmstead court decision and the New Freedom Initiative support consumers' choice and, therefore, enhance their ability to be successful in all arenas of community life, including work. Choice is limited by the reimbursement structure to providers. Therefore, it is difficult for providers to serve individuals with significant psychiatric disabilities who will take time and intense services to overcome severe functional limitations. Limiting consumers' choice hinders their ability to have maximal independence (del Vecchio, Frick, & Johnson, 2000).

When considering a disincentive to consumers, financial is usually the first considered. For a long time, a legitimate concern of consumers with psychiatric disabilities has been the decrease or loss

of health care benefits, if they become gainfully employed. With enhanced state options for Medicaid buy-in programs, TWWIA has made great strides in attempting to overcome or lessen this deterrent. For the individual who is receiving SSI or SSDI, this legislation has reduced the concern over the possible loss of health care coverage for needed treatment and medications. However, consumers are wary of this *good news* feeling; it may be just too good to be true. Spurred on by the SSA's recent creation of Benefits Planning and Outreach projects (BPAOs), VR has been hiring Benefits Counselors to educate consumers as to how the Medicaid buy-in can help them maintain their health care and still go to work. Consumers are counseled on their individual financial benefits packages and how employment can be a viable financially risk-free endeavor and, more importantly, can be the road out of poverty. Although the Medicaid buy-in program has been designed to counter financial disincentives, benefits counseling is at risk of not being utilized due to consumer skepticism.

As VR and MH strive to work collaboratively with consumers, the clear delineation of roles has blurred. MH has taken on the challenge of providing vocational services to individuals with psychiatric disabilities. At the same time, VR has become more strictly focused on employment outcomes or entering or retaining full-time or, if appropriate, part-time competitive employment in the integrated labor market (the Act); that is, work as a self-sustaining activity.

There is both a philosophical and bureaucratic difference between the ways in which VR and MH view work. In the MH arena, work is often defined as meaningful activity, and the focus is on rapid placement to allow the consumer to take advantage of a window of stability. The consumer need not work for more than a few hours per week or for minimum wage. This process gives individuals with psychiatric disabilities an opportunity to ease into work as their symptoms per-

mit. VR does not disagree with the concept of transition, but the difference in philosophy is apparent when MH considers this type of employment a successful goal. Conversely, VR sees it as an initial step towards achieving an employment outcome. 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. Work is not merely an activity; it is an outcome.

Both perspectives have value. Individuals with psychiatric disabilities require flexibility to meet their needs in terms of desire and ability to work, and good vocational rehabilitation practice and mental health treatment promote that idea. Further, VR has set a high bar with its required performance standards and indicators, which define that success. The 1998 Amendments of the Rehabilitation Act (P. L. 105-220) established performance measures by which state VR agencies are evaluated for their achievements (Workforce Investment Act of 1998, 1999).

Standard 1:

- Performance Indicator 1.1. The number of individuals exiting the VR program who achieved an employment outcome during the current performance period compared to the number of individuals who exit the VR program after achieving an employment outcome during the previous performance period
- Performance Indicator 1.2. Of all individuals who exit the VR program after receiving services, the percentage that are determined to have achieved an employment outcome)
- Performance Indicator 1.3. Of all individuals

determined to have achieved an employment outcome, the percentage who exit the VR program in competitive, self-, Business Enterprise Program (BEP) employment with earnings equivalent to at least the minimum wage

- Performance Indicator 1.4. Of all individuals who exit the VR program in competitive, self-, or BEP employment with earnings equivalent to at least the minimum wage, the percentage who are individuals with significant disabilities
- Performance Indicator 1.5. The individuals who exit the VR Program in competitive, self-, or BEP employment with earnings levels equivalent to at least the minimum wage as a ratio to the State's average
- Performance Indicator 1.6. Of all individuals who exit the VR program in competitive, self-, or BEP employment with earnings equivalent to at least the minimum wage, the difference between the percentage who report their own income as the largest single source of economic support at the time they exit the VR program and the percentage who report their own income as the largest single source of support at the time they apply for VR services

The disincentive exists with the struggle to create a continuum from work activities to competitive employment, as defined by wages as the largest single source of support. Consumers want to work; however, the VR and MH systems struggle to create a seamless range of services to support that goal. Perhaps it is because the two systems place different values on work, have different perspectives on the risks of going to work, or VR and MH professionals are rewarded according to outcomes that are defined differently.

Stigma, Discrimination, Myths, Attitudinal Barriers

There are other factors, though not always visible, that may impede the recovery of an individual with a psychiatric disability. In his article “Stop Stigma,” Lilley (2002) believes that

There is a great stigma surrounding mental illness. When someone appears to be different we attach a stigma to them, we do not do it to be cruel, we simply do not understand their differences. Stigma is a reality for people with mental illness, and their greatest barrier to a complete and satisfying life. (Available from <http://www.cmha-tb.ca/stigma.htm>)

He believes that to overcome stigma, we need to consider psychiatric disability as a medical illness.

In June 2000, the White House Conference on Mental Health initiated a campaign to fight the stigma of psychiatric disability. When President George W. Bush announced the formulation of the New Freedom Commission on Mental Health, Health on April 29, 2002, he stated:

Stigma leads to isolation, and discourages people from seeking the treatment they need. Political leaders, health care professionals, and all Americans must understand and send this message: Mental disability is not a scandal; it is an illness. And like physical illness, it is treatable especially when treatment comes early. (Lilley, 2002) (<http://www.bipolarworld.net/Disability/stop-Stigma.htm>)

Stigma is not just a matter of using the wrong word or action. Stigma is about disrespect. It is the use of negative labels to identify a person living with mental illness. Stigma is a barrier. Fear of stigma, and the resulting discrimination, discourages individuals and their families from getting the help they need (U.S. Department of Health and Human Services, 1999; U.S. Public

Health Service Office of the Surgeon General, 2001).

Stigma is a primary barrier to the formation of successful employment relationships. People with psychiatric disabilities are viewed by society as less than full people, and are relegated to an impaired role that carries with it a loss of full human status. These attitudes have led to an inappropriate perspective that providers know what is best for the consumers (National Institute on Disability and Rehabilitation Research, 1992).

All too often, people living with a psychiatric disability feel lonely and isolated; they feel discriminated against. They often have inadequate housing and work in lower paying entry-level jobs. Stigma can interfere with an individual’s ability to succeed in meaningful activity or to achieve an employment outcome. An exacerbation of a psychiatric disability can result in coworkers treating the individual differently than prior to the episode. Human resource personnel can be instrumental in educating employees as to the myths versus facts about psychiatric disabilities.

Many misconceptions about psychiatric disability exist. Even within MH systems, individuals with psychiatric disabilities are too often seen as those who cannot think for themselves or make life decisions independently. MH professionals often make decisions for the individuals and, thereby, eliminate choice.

Further, because of ignorance or lack of personal experience, often the general public has beliefs that are not substantiated in fact. It is difficult for people living with psychiatric disabilities to “fit in” in the workplace. Individuals with psychiatric disabilities often are not tolerated, much less understood or accepted by their coworkers. There are many myths about mental health and the workplace that lead to this situation and that rehabilitation professionals can help to dispel with facts.

- Myth 1: Mentally ill and mentally restored employees (the term denotes when the disorder has been effectively treated) tend to be second-rate workers.
- Myth 2: Individuals with psychiatric disabilities cannot tolerate stress on the job.
- Myth 3: Mentally ill and mentally restored individuals are dangerous or violent. (Everybody Bulletin Board, 2001)

There are many government agencies that have enacted legislation to assist in the fight against discrimination of individuals living with a psychiatric disability.

- Section 503 of the Rehabilitation Act of 1973, as amended, requires certain employers with federal contracts or subcontracts to apply affirmative action when hiring, retaining, and promoting qualified individuals with disabilities.
- The Americans with Disabilities Act of 1990 (ADA) mandates that employers of 15 or more workers (Title I) and government agencies (Title II) adhere and enforce the provisions of the Act. However, the ADA has been more helpful to those with physical disabilities than mental disabilities. For example, this law does not address the issue of mental health parity with regard to health insurance coverage. Medical costs are so high as to dissuade individuals with disabilities from going to work if their wages interfere with their benefits.
- In 1999, RSA issued an Information Memorandum (RSA-IM-99-27) entitled “Changes to the Federal Schedule B Hiring Authority Pertaining to Individuals with Psychiatric Disabilities.” On June 24th of that year, Executive Order #13124 was signed; it requires the Office of Personnel Management (OPM) to apply the same guidelines when hiring individuals with psy-

chiatric disabilities as apply to individuals with mental retardation or severe physical disabilities.

- On September 26, 1996, the DOL signed into law the Mental Health Parity Act (MHPA). The law ensures that insurance companies must allow an equivalent dollar limit (lifetime and annual) on mental health benefits as they allow for medical and surgical benefits.
- The Centers for Medicare and Medicaid Services (CMS) in the U.S. Department of Health and Human Services operationalized the health care provisions of TWWIIA. With more flexibility, Section 203, Public Law 106-170 allows States to offer individuals with disabilities various options while employed, e.g., Medicaid buy-in, additional Personal Assistance Services, etc.

NASMHPD suggests that VR and State Mental Health Agencies (SMHA) work collaboratively to provide the necessary services to consumers with psychiatric disabilities to assist those individuals in attaining employment. Through coordination, VR and SMHA could develop programs and offer more of a variety of rehabilitation options to their customers and thereby create a continuum of work opportunities for individuals with psychiatric disabilities. Such a continuum could begin with minimal work involvement (e.g., an hour per week) and could eventually lead to full-time employment in integrated settings at competitive wages; employment development and job readiness could be addressed. SMHA could provide funding during the early stages, while VR could fund services for individuals as they progress in their rehabilitation programs. Such collaboration could allow both systems to maintain their diverse definitions of work while meeting the transitional needs of the consumer. This could appear seamless to the consumer.

NASMHPD believes that the ADA is a viable operative “to eliminate unfair treatment of and discrimination against qualified workers with disabilities, improve access to mainstream resources, and to mandate the assessment of disabled applicants’ qualifications with consideration of accommodations and support services” (NASMHPD, 1996). However, the organization also believes that the ADA has fallen short of adequately serving individuals with severe psychiatric disabilities. They stress the need for flexibility in services to address the episodic nature of the illness. In fact, they believe that VR should serve individuals with psychiatric disabilities differently than individuals with other disabilities. They hope for a service delivery system that will combine or integrate employment and recovery goals.

NAMI’s TRIAD Report discusses the barriers to employment caused by the disability income programs and imposed by the health insurance industry. Psychiatric disability treatment is not covered by private insurance. In addition, the public mental health system “erect[s] barriers to optimal employment services, housing, and jail diversion services” (Hall et al., 2003, p 34). These barriers are further strengthened by societal stigma and discrimination.

NAMI makes some recommendations in an attempt to alleviate the barriers and urges the government to enact legislation to address these concerns. The group also encourages federal agencies to enforce the law to see that employers, housing programs, and community service organizations are punished for discrimination against individuals with psychiatric disabilities.

Another barrier exists in the difference between the philosophies of the MH and VR systems and how they view job-readiness. While VR looks at symptomatology and relates it to job-readiness, MH looks at an individual’s symptoms in isolation, not in relation to how that person can perform in employment. In addition, MH profes-

sionals may see the time lag between VR application and eligibility (a maximum of 60 days) as a barrier for those living with psychiatric disabilities. Furthermore, the imposition of the public VR system’s Order of Selection and sometimes waiting lists for services in some states exacerbate this problem. Waiting for service provision initiation can leave a person idle or inactive and can be detrimental to an individual’s mental health and level of functioning.

Oftentimes, state VR programs develop and implement policies and practices that are not necessarily user-friendly to individuals with psychiatric disabilities. In fact, these procedures can sometimes be harmful to consumers. For example, some state VR programs utilize a “time in status” system (i.e., “average” time lines to which a counselor must adhere when serving consumers), originally put into place as a consumer protection so that clients of the system did not languish for long periods without attention or results. However, in its implementation in the field, many VR counselors see this standard as an impediment to serving consumers with significant disabilities because it is not perceived to allow enough flexibility to individuals who may require more than the average time to progress in his/her rehabilitation program. Often within a “time in status” system, a state VR agency does not allow for exacerbation of illness; instead closure occurs and the individuals have to reapply once their health is stabilized. While MH expects recidivism, VR makes it difficult for persons to re-enter the system; they may have to restart the process from the beginning (i.e., referral to application to eligibility, etc.).

In addition, each system has its own unique language and way of serving individuals with psychiatric disabilities, thereby making it confusing for consumers to benefit from a “seamless system of service delivery.”

Diversity

This section discusses diversity in how public policy is administered, diversity in availability of effective programming, and the difficulties large systems such as VR and MH have in reaching people from diverse backgrounds.

The TRIAD report “Shattered Lives” (Hall et al., 2003) clearly states that the dilemma faced by individuals with psychiatric disabilities is often compounded when they are people of color, from different cultural groups, or when they live in poverty. Services are not readily available for these groups. Because of the needs of these individuals, the VR and MH systems are forced to develop culturally competent, community-based and community-specific services. Since the 1980s both systems have known that the most effective method for ensuring success with people who have psychiatric disabilities is to deliver employment and treatment services in their communities. From 1996 to 2002, the Office of Special Education and Rehabilitative Services (OSERS) funded grants to study how VR could provide more effective services to youth with psychiatric disabilities transitioning from school to work. Two of these studies, “Jobs and More” and “Coordinated Employment Opportunities” (Espinola & Gomez, 2002), demonstrated the success of community-based VR and MH collaboration. Both studies served youth from poor, ethnically diverse communities. The results demonstrated significantly greater success in terms of employment and mental health functioning when providers (VR and MH) were from the same communities as the consumers. The control groups had the identical services delivered by providers in the generic systems. The key to increased success was a fundamental understanding of the issues faced by these youth beyond those of a psychiatric nature and the trust that was already in place because the provider was not only culturally competent but was known in the

community. Although the VR and MH systems agree that this is the most effective method of service delivery, it is not utilized consistently across the country. In some parts of the country, there is little or no access to services for individuals with psychiatric disabilities, especially those who are from racially or culturally diverse communities and live in poverty.

The MH and VR systems as a whole have struggled to effectively serve persons from diverse ethnic backgrounds. Outreach efforts often work best when both systems have personnel who share the same ethnic background as the individuals being served stationed in the communities. But this dual strategy is not as successful in reaching potential consumers as using staff who are actually from those specific communities. Graduate and undergraduate training programs for MH and VR professionals must address these recruitment needs. If all individuals with psychiatric disabilities are to be served equally, staff in VR and MH offices and training programs must be more diverse. Finally, there must be more flexibility in the way the “rules” of access to programs are administered and sensitivity to the differences between and within cultures in order to insure that no person is left out due to cultural misunderstanding or inequitable access.

State of the System

The Fifteenth Institute on Rehabilitation Issues (15th IRI) (1988) discussed employment for individuals with severe psychiatric disabilities in its monograph “Enhancing the Rehabilitation of Persons with Long-Term Mental Illness” (LTMI). The first chapter, entitled “History and Evolution of the Vocational and Mental Health Delivery Systems,” provides a thorough review of both systems from the 1940s through the late 1980s and warrants re-reading.

In brief, the chapter focuses on development of services for consumers in the mental health and

vocational rehabilitation systems as well as barriers within these systems that need to be changed. Attention is paid to amendments within VR legislation that have continually refocused on the provision of services and specific programmatic efforts targeting individuals with the most significant disabilities, including individuals with psychiatric disabilities. The chapter comments on the ongoing shift to community-based services within the mental health system that focus on the support needs of those individuals discharged from institutional settings. It also notes the emergence of the consumer movement during the 1970s.

Observations made during the 1980s seem as relevant today. The monograph reports:

As a group [consumers], they stated forcefully that neither of the service paradigms within VR and MH were meeting the needs of persons with LTMI. They were instrumental in focusing on the issues of symptom-reduction versus rehabilitation and fragmented, uncoordinated resources. (15th IRI, 1988, p. 9)

The chapter's concluding paragraph is a good starting point for a review of the last 15 years. The paragraph states:

To summarize, at the end of the 70s and during the 80s, the concept of the community-based programs with a psychosocial rehabilitation focus was established. It can be anticipated that this trend is not just another fad that will fade, but a significant evolution in the treatment and rehabilitation of persons with LTMI. (15th IRI, 1988, p. 12)

The trend referenced in the paragraph includes the following:

- Co-location of VR staff at community mental health clinics;
- Supported Employment Project Grants;
- Joint Vocational Rehabilitation/Mental Health Agency training;
- Expansion of private nonprofit programs;
- A Robert Wood Johnson Foundation project to produce standards for clubhouse models; and
- Consumer empowerment.

In the last 15 years the need for a comprehensive system of care for individuals with psychiatric disabilities has been recognized. Although such a system has been developed, it does not adequately serve consumers. Community support programs have faltered as funding continues to be a significant issue. Employment programs are not consistently a component of psychosocial rehabilitation programs.

One of the VR eligibility criteria, an expectation that the individual will benefit from VR services, was amended in 1992 so that all applicants, including SSI and SSDI recipients, are presumed able to benefit from VR services. The 1998 Amendments allowed for a presumption of eligibility for SSI and SSDI recipients.

The consumer movement continues in its evolution. Consumers are recognized as important contributors to the process of recovery. They are employed in a variety of capacities within the traditional mental health system. As program staff, they serve others with psychiatric disabilities. NAMI, which was formed as and remains primarily a family advocacy organization in the 1970s, does include a host of groups and coalitions that label themselves variously as consumers, survivors, and individuals with psychiatric disabilities.

While the trends of the late 1980s did not wind up as fads, they did not become part and parcel of the fiber of the MH or VR system. Some of the trends (e.g., supported employment) have become more sophisticated in their designs and implementations, while others (e.g., joint train-

ing) have languished to the point of extinction. The Surgeon General's recent report on mental health describes a system in crisis that is failing the people it was designed to serve. VR's ongoing fine-tuning of its legislation with regard to serving individuals with the most significant disabilities suggests that it has not yet accomplished this goal.

Individuals experiencing psychiatric disabilities encounter a virtual Rube Goldberg machine in terms of the multiple systems that they encounter in order to obtain mental and physical health care, financial assistance, housing, and employment. This is particularly true of those who rely on publicly funded programs of one type or another. What can be said of all of these systems is that they have differing eligibility criteria, unstable funding, and policies that make it difficult for individuals to effectively use all of the systems in a coordinated way.

Mental Health Treatment

The 1999 Surgeon General's report on mental health (U.S. Department of Health and Human Services/SAMHSA, 1999) notes the absence of a comprehensive system of care available to those with serious psychiatric disabilities. The services available do not necessarily embrace the values of recovery and self-determination. Consumers are not routinely included as equal partners in decision-making regarding their treatment goals.

Mental health care is often fragmented. In some instances, programs are focused on providing services only after psychiatric symptoms have deteriorated to a point that the persons are threats to themselves or others. In other instances there are more comprehensive services, but access to them is limited. Many systems are so overburdened and under-funded that the local correctional systems have become de facto mental health systems. All too often, employment-related services are not included in systems of care

because employment is not seen as an option. The reasons for the fragmentation include lack of funding, lack of a clearly articulated vision for care, and lack of coordination among the different systems and partners involved in the system of care. The most recent downturn in the economy emphasizes the vulnerability of service systems. Shrinking revenues are leaving states unable to provide funding for needed services, i.e., the crisis in Medicaid funding impacts the range and capacity of services.

Financial Benefits

Frequently, SSDI and SSI are sources of income for individuals with the most significant psychiatric disabilities. SSA's eligibility criteria require an individual to be completely and totally disabled for a minimum period of one year. Though the law requires that the period of disability be for a year, the process, which focuses on what individuals are unable to do in all aspects of their life, leads many individuals to perceive it as life-long. For individuals with psychiatric disabilities, obtaining benefits is often a multi-year process. So the thought of losing benefits when returning to work represents a significant deterrent. Also, while functionality is used as the criteria for eligibility and the initiation of benefits, income drives the termination of benefits.

In the past, access to medical benefits was often an issue for individuals who wished to work. Either medical coverage was not available through the employer, or individuals were not covered due to preexisting conditions. Often, the lack of adequate prescription coverage in available medical plans was an issue. Because ongoing entitlement to cash benefits and the associated medical insurance (SSDI benefits entitled individuals to Medicare; SSI benefits to Medicaid) are tied to income, individuals wanting to work had to be mindful of earnings. To maintain benefits, which include access to medical care, SSDI, and SSI

recipients formerly were limited to working part-time at low wage jobs.

TW/WIA is SSA's recent effort to address these concerns within its programs for individuals returning to work increasing income thresholds and providing routine updates without an act of Congress. In addition, the Ticket-to-Work program was developed to increase the number of programs and providers available to assist individuals receiving SSDI and SSI benefits in returning to work. It addresses the return-to-benefits concerns that many individuals had if they were unsuccessful in attempting to reenter the world of work. It encourages states to develop amendments in their Medicaid plans to insure medical coverage for consumers. Given that Medicaid has been identified as a significant budget issue in many states, it remains to be seen if these issues will, in fact, be addressed.

States may or may not provide temporary cash assistance to individuals attempting to obtain Social Security benefits or those individuals experiencing a brief episode of disability. Many individuals lack the financial resources to provide for most needs if this financial assistance is not available, thus, compounding the impact of their disabilities.

Housing

Stable, independent and affordable housing is a frequent goal for individuals with psychiatric disabilities. Stable housing allows an individual to focus on work. There is rarely sufficient housing available to meet the need in most locations.

Public housing, when available, may not be an option for an individual with a psychiatric disability who has a history of criminal behavior, drug abuse, or financial problems that resulted in prior evictions.

Funding may not be available for support services that individuals may need to live independently. This may occur because there is insufficient fund-

ing for a continuum of care or because individuals work their way off the entitlement that funds the needed services. In subsidized housing, rent is tied to income; so individuals returning to work will experience rent increases. They run the risk of working themselves out of subsidized housing only to find that affordable housing is not available. Therefore, for individuals with psychiatric disabilities work can become a barrier to a goal of affordable housing.

Access, Capacity, and Competence

Common to all these programs are issues around access, capacity, and competence. To the extent that staff and program managers believe that individuals with psychiatric disabilities are difficult to serve and require increased service dollars, thereby yielding fewer employment outcomes at lower wages and reduced benefit levels, consumers will find it more difficult to access programs for which high paying jobs with benefits are performance measures. Access to mental health programs, for which funding is limited, may be restricted to those with insurance coverage or the ability to pay. Level of functioning may limit access to other programs. For programs that are more broadly focused, the absence of focused or targeted services may be a barrier.

Capacity concerns are, in fact, funding issues. Funding provides for programs as well as adequate numbers of specialized staff. Many states are experiencing financial challenges that make it difficult to fund programs and still allow VR personnel to achieve acceptable levels on the state VR programs' Evaluation Standards and Performance Indicators. Difficulties around Medicaid funding only complicate the situation. Employment networks must find the resources up front to fund services and are dependent upon future reimbursements for a population that, because of the nature of the disabilities, may not be able to sustain work in a way that allows a net-

work to collect its reimbursements. WIA One-Stop Centers are experiencing reductions in the federal funding stream for these programs. Half of the publicly funded VR programs are in a current order of selection, an action required under the Rehabilitation Act whenever a State VR agency does not have sufficient personnel or fiscal resources to fully serve all eligible individuals. Individuals are assigned to priority categories based on significance of disability and those with the most significant disabilities must be served first.

Finally, competence in serving this population is a concern. Regardless of the programs in which they work, staff must understand psychiatric disabilities as well as the range of strategies and techniques available to effectively serve consumers. There is an increased need to know how to work collaboratively across programs to effectively serve individuals with psychiatric disabilities.

Workforce Issues of the 21st Century

The workforce needs of the 21st Century present both opportunities and challenges for individuals with psychiatric disabilities and vocational rehabilitation. By all reports, the worker shortages expected during the early decades of the coming century will create greater opportunities for employment. Employers will need to consider individuals for jobs that they previously felt able to overlook. However, the skill sets that 21st Century workers will be expected to possess, as well as the continuing trend of job change and transformation, will present challenges to both employees and the rehabilitation system.

Workers will be expected to have higher levels of educational achievement, i.e., technological skills as well as people skills. The rehabilitation system, if it is to assist consumers in obtaining these skill sets, will need to make greater investments in training and utilize supported education strategies for those individuals requiring that level of sup-

port. It is essential that we examine support needs and strategies around the interpersonal demands of the workplace as well as the rate of change within that environment. Until late in the 20th Century, we could place individuals into jobs with the expectation that they might, all things considered, retire from that same position. All predictions suggest that lifetime employment in the same job will be the exception, not the rule.

The VR consumer base will mirror the evolving workforce; serving more ethically and culturally diverse. Individuals who come to this country having experienced trauma in their homelands that resulted in psychological disorders will be included. Having a range of resources and providers to serve these individuals will be yet another challenge for the vocational rehabilitation system.

System Outcomes: Recovery

A precise, consensually validated and researched definition of “recovery” in terms of acceptable system outcomes still eludes the rehabilitation field; however, some guideposts exist to further this effort. Recovery has several dimensions, and it is beyond the scope of this publication to examine all of them. There is debate in the field on whether recovery can be measured or whether it needs to be totally self-defined by people themselves. Is it a process or an outcome measure? The catchphrase often used is: “Recovery is a journey, not a destination.” From a VR perspective, an attempt to quantify recovery, at least as far as employment issues are concerned, seems redundant.

This section will look at systemic implications for outcomes under the philosophy of Recovery that relate most directly to vocational rehabilitation and employment.

One scale that has been developed by the Ohio Department of Mental Health (1999) to high-

light best practices in recovery has an entire section devoted to work/meaningful activity. The practices included:

- Promote participation in meaningful activities on a regular basis;
- Involve consumer in groups to enhance self-confidence;
- Evaluate with consumer the ability and emotional skill level to participate in employment or meaningful activities;
- Support active development of needed skills for employment;
- Use understanding of ADA to benefit consumer;
- Use tours, speakers, and volunteer work to promote employment and meaningful activities;
- Maintain resource list of volunteer opportunities, recreation facilities, etc., for consumers;
- Support mental health providers who hire, train, and retain consumers;
- Provide groups to discuss benefits of employment and share successes with others in the recovery process;
- Ensure consumer understanding of Social Security and work-incentive programs;
- Involve consumer in groups for purposes of understanding expectations of “good employee” relationships on the job, productivity, and safety issues;
- Provide services through peer support providers, consumer-operated services
- Provide opportunities for work adjustment; and
- Advocate for consumer work rights and works to reduce stigma in the workplace.

The International Association of Psychosocial Rehabilitation Services (IAPRS), in its 1999 publication entitled *Rehabilitation Practices that Support Recovery*, mentions employment as an important outcome in several sections, including assessments of employment interests and functioning and the need to develop plans and interventions to support employment and/or education goals. Anthony (2000) identifies 12 areas with accompanying descriptors as strategies for ensuring the systemic implementation of recovery within community mental health. While many of these areas are fully compatible with employment and vocational rehabilitation, only two descriptors specifically mention employment. Under "Evaluation," Anthony highlights consumer outcomes that are measurable and observable. Under "Comprehensiveness," he includes the need to focus on consumer goals in four areas: live, work, learn, and love. It seems that a MH system with a recovery orientation should include, at a minimum, an expectation that it can and will assist individuals with psychiatric disabilities to succeed vocationally, as measured by one or more of the following:

- An increase in clients attending school;
- An increase in clients working; and
- An increase in clients referred to vocational services

Conclusion

This chapter reviewed how the MH and VR systems impact individuals with psychiatric disabilities. While some have more of a positive impact, others pose challenges for consumers. Systems are merely configurations of people, resources, and values (espoused in policies, guidelines, and practices) brought together to affect certain outcomes or the behavior of those being helped. While much has been made of “seamless” service delivery and elimination of funding “silos” as (often unattainable) goals within human services, the

reality that individuals with psychiatric disabilities face is much different. For the foreseeable future, such consumers will need to rely on the abilities of various helpers as well as their own personal strengths and skills in surmounting these gaps. In addition, they must concurrently contend with contradictory foci and conflicting goals of service systems with which they engage.

VR counselors have an ethical responsibility to assist individuals with psychiatric disabilities combat this dilemma. They have a professional responsibility to ensure that individuals with psychiatric disabilities receive the best possible services and are afforded the same opportunities as consumers with other disabilities.

Also, because of the increased likelihood that individuals with psychiatric disabilities involved with the public mental health and/or vocational rehabilitation systems are liable to be poor and without significant financial resources, they are much more susceptible to being buffeted by policies and staff philosophies that do not dovetail nicely with a comprehensive, consistent rehabilitation strategy. In such circumstances, it becomes especially difficult to foster the values of person-centered control of planning and service delivery that should be synonymous with exemplary psychiatric rehabilitation practice. Consequently, staff must accept some responsibility to assist people in navigating around, through, or over these obstacles or removing them, where it is in their control. Rehabilitation personnel as well as other helpers should develop an understanding of the multitude of forces within various systems (mental health, public vocational rehabilitation, workforce, etc.) that may impede or accelerate progress towards the vocational goals of individuals with psychiatric disabilities. Furthermore, they must remain cognizant of social forces (legislation, societal emphasis on diversity/cultural competency, Social Security regulations, etc.) that come into play that would positively or adversely

affect individuals' achievement of such goals. The differences in the systems require that there be inter- and intra-agency cooperation.

Rehabilitation professionals must work together to insure that programs or services meet the needs of individuals with psychiatric disabilities.

Professionals must advocate for consumers to fight societal stigma and discrimination.

Finally, rehabilitation professionals must attend to the consequences of all these diverse forces on the expectations and values (including the overall motivation to reach an employment goal as well as specific vocational interests) that individuals with psychiatric disabilities will bring to their developmental process. The role descriptions of vocational rehabilitation “counselor” or mental health “case manager” or “job developer/job coach” are then truly misnomers, if these aforementioned challenges are to be successfully faced. Staff must supplement these competencies beyond those usually associated with more traditional duties, such as listening skills, marketing, case documentation, etc., to include advocacy, analytical ability, understanding of political and social forces existent in society, cultural brokering, and at least a rudimentary understanding of various public systems' policies, procedures, traditions, and philosophies. This skill set must then be brought to bear on the problems individuals with psychiatric disabilities face so that the confluence of differing system structures and requirements does not exacerbate these life dilemmas. With such assistance, these multiple systemic resources can serve to exponentially increase vocational and life successes for individuals with psychiatric disabilities.

Systems have the responsibility to encourage individuals with psychiatric disabilities to become self-sufficient in society. VR and MH must work together to provide services so that individuals with psychiatric disabilities can be productive members of this society. This effort towards sys-

Systems

temic collaboration is an essential, if not totally sufficient, response to achieve the successful rehabilitation of individuals with psychiatric disabilities.

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Study Questions

1. There have been key policy changes affecting workers and potential workers with disabilities in the United States since 1990. Which item(s) below does not play a major role in employment of persons with disabilities?
 - a. Health Insurance Portability and Accountability Act (HIPAA)
 - b. Americans with Disabilities Act (ADA)
 - c. Title IV of the Workforce Investment Act
 - d. None of the above
2. True or False. The public VR system defines community-integrated employment, including supported and sheltered employment, as acceptable under the definition of a successful rehabilitation closure.
3. What was/were the piece(s) of rehabilitation legislation that the ADA language was closely modeled after?
 - a. Section 504 of the Rehabilitation Act of 1973
 - b. Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA)
 - c. Health Insurance Portability and Accountability Act (HIPAA)
 - d. All of the above
4. True or False. The Americans with Disabilities Act has proven to be instrumental and effective in protecting the rights of persons with disabilities—in particular, persons with psychiatric disabilities.
5. True or False. The Ticket-to-Work and Work Incentives Improvement Act (TWWIIA): Allows States to create Medicaid “buy-in” programs for working adults to allow them to maintain more medical coverage associated with SSI only and prevents individuals with continuous health coverage from being excluded from health coverage for “pre-existing conditions” when they switch employers or move from Medicaid to employer-based coverage.
6. True or False. The U.S. Department of Education’s Rehabilitation Services Administration was charged with the responsibility of ensuring that the workforce development system adequately addresses the needs of persons with disabilities and thereby earmarked funding for “Customized Employment” in its efforts to assist individuals with disabilities who have been affected by the Olmstead decision.
7. For psychiatric rehabilitation systems to be effective, employment must be an expected outcome for which of the following?
 - a. Vocational Rehabilitation
 - b. Mental Health Vocational Staff
 - c. Vocational Service Providers
 - d. Total System of Care
8. Anthony envisioned an evolution of the mental health system in which the next step is:
 - a. New medication
 - b. Deinstitutionalization
 - c. Recovery
 - d. Consumer empowerment

9. Which of the following is/are not a component(s) of customized employment?

- a. Enclave
- b. Self-employment
- c. Job carving
- d. Entrepreneurial initiatives

10. The multiple systems that a person experiencing a psychiatric disability encounter is described as a Rube Goldberg machine because it is:

- a. Well designed and efficient
- b. Complicated but efficient
- c. Overly complex and dysfunctional
- d. Simple but highly inefficient

Chapter 5

Managing for Change in the VR System

*By Joe Marrone, Thomas McCarthy, John G. Harper,
and Carolanne O'Brien*

Introduction

This monograph brings with it a presumption (coupled with ample evidence cited in earlier chapters as well as here) that the current public and private vocational rehabilitation (VR) systems and services have not been effective enough as currently constructed, funded, and delivered to assist the full constellation of individuals with psychiatric disabilities in need of fulfilling, career track employment (Bond et al., 2004; Crowther, Marshall, Bond, & Huxley, 2001; Mechanic, 2003; Rapp, Huff, & Hansen, 2003).

While the emphasis is on innovative practices and not change management, per se, the authors of this chapter and the primary study group of the IRI as a whole developed a consensus on the need to address change strategies to foster enduring systemic transformation.

The human services field as a whole and the psychiatric rehabilitation field in particular are rife with evidence-based and promising practices that still have not been implemented extensively, despite expert, empirically researched support for their adoption.

Employment for individuals with disabilities in integrated community settings (i.e., in jobs at or above minimum wage, working alongside coworkers without disabilities) has seen major growth in the last two decades. Despite this progress, unemployment rates for individuals with disabilities remain high.

Improvements in employment outcomes, in many ways impressive over the last 10 to 15 years, have not significantly improved for the majority of citizens with

serious psychiatric disabilities (Harris and Associates, 2000), especially when coupled with the effects of poverty, with which serious psychiatric disabilities often coexist (Draine, Salzer, Culhane, & Hadley, 2002). So, while progress has been made, the field of services for individuals with psychiatric disabilities has a long way to go before the vast majority of individuals are working in jobs of their choosing that provide financial independence, self-fulfillment, and full societal inclusion.

Several organizational change analysts have observed that a key component of real change is redesigning staff roles and responsibilities, much more than attending to staff attitudes, knowledge, and skills (Beer, Eisenstat, & Spector, 1990; Kotter, 1995). While this approach has not been tested empirically, administrators and supervisors are in positions where they are expected to influence behavior of the personnel they supervise and, thus, are in positions that not only should be able to, *but be expected to*, effect needed change in this area. To further illustrate some practical implications of this approach for VR supervisors and administrators, this chapter contains several case studies. These have been drawn from the authors' experiences in VR administration in using specific techniques for bringing about some of the changes this monograph espouses in public systems' implementation of innovative psychiatric vocational rehabilitation interventions.

Part A: Implications for Management

The specific implications for VR management and supervisory personnel's implementing innovative psychiatric rehabilitation practice are multifaceted. At one level, it is minimal in that it involves generic supervisory and managerial skills that are not necessarily situation-specific and can be applied in many venues for many activities. Therefore, a variety of management techniques

and styles must be brought into play. There is a presumption that the adoption of innovative psychiatric rehabilitation practices in vocational rehabilitation requires significant system change, so that the kinds of skills required are those of change agents and visionary leadership, and risk-taking. While it is not necessary for VR administrative and supervisory personnel to become technical experts in psychiatric vocational rehabilitation, those roles do demand some working knowledge of "best" and "evidence-based" practice in order to create structures and frameworks that work beneficially for clients with psychiatric disabilities.

Suggestions have been made in the business literature about ways to ensure that significant agency transformation happens. These recommendations have included the need to: (*Authors' Note: The sections in italics below are the authors' recommendations and not in the original text from which the citation is drawn.*)

- Mobilize commitment through joint diagnosis of problems from both direct service and management staff. *For VR agencies, it is important to include consumers, family, and other natural support system members within this diagnostic process.*
- Develop a shared vision of good process and outcomes throughout the whole organization and foster consensus, competence, and cohesion throughout all levels of personnel within the agency. *These two elements should include the involvement of people at all levels, including top management, direct service staff, and administrative/clerical personnel in understanding what the vision of the VR agency is and how it should translate into staff behavior (e.g., in terms of language used, vocational goals developed, programs funded, etc.).*
- Spread the message without just pushing from the top. *Administrators must set direction without trying to manage every decision or regi-*

ment every process. They must encourage staff discussion and advice regarding roles and responsibilities.

- Set in motion formal policies, systems, and structures that reinforce the outcomes desired. For VR, *this would include policies such as the recently enacted regulation of defining a successful VR outcome as employment in the competitive labor market and systems change interventions, such as co-funding staff positions or programs with the public mental health (MH) agency or community providers. For MH system administrators interested in vocational rehabilitation outcomes, this might involve setting clear expectations that all treatment plans include employment as an area of need for all clients who have been unemployed for over six months or in partnership with VR, co-funding staff positions or programs, and data matching between agencies to identify shared clients and benchmark outcomes.*
- Monitor and adjust in response to problems that occur. *Managers/supervisors must have a vision to strive for and hold a steady gaze on, but not make themselves slaves to interim plans of action that are necessarily developed with a faulty grasp of the future. For managers who exist as part of a larger bureaucracy, as all public VR systems must, this posits a challenge to their ability to render their fiduciary and administrative duties responsibly, while encouraging risk taking and innovation which inherently involves some chance of failure* (Beer et al., 1990).
- Some management theorists have speculated that in leading change efforts, some errors that are commonly made include:
 - Not establishing a great enough sense of urgency regarding the change;
 - Not creating a powerful guiding coalition of internal and external advocates who have

either influence or authority or both;

- Not forging a vision of an ideal outcome (what will be different for consumers and staff after all the changes are made);
- Not communicating the vision well enough inside and outside the organization;
- Not removing obstacles to the vision;
- Not creating short-term wins so staff, consumers, and family members can all be inspired and encouraged; and
- Not anchoring change to the culture of the agency. The change desired cannot be maintained if it is always dependent on *crash programs* or *glossy* change initiatives. Real organizational change eventually has to become routinized, be a part of the way the agency does its daily business, and be identified as its image in the community and among its entire staff (Kotter, 1995).

Some concrete examples of ways good supervisory change concepts can get implemented are:

- Treating errors of omission (e.g., not trying alternative strategies before encouraging a client to leave a job; not pursuing advocacy) as more serious than errors of commission (e.g., pursuing a risky job match that didn't work out; receiving a complaint from an employer that the VR counselor or placement specialist would not take no for an answer).
- Communicating to staff that doing things right is harder and that mediocrity will not be tolerated. Unfortunately, there is no clear body of research that indicates that satisfied personnel are more productive. Working with staff under your supervision that genuinely enjoy working with you and vice versa makes for a better job environment; however, this harmony should not be achieved at the expense of reaching good employment outcomes with consumers who are being served.

- Providing support and assistance to solve problems rather than condemnation for mistakes.
- Creating a culture where consumer benefit is the ultimate litmus test of agency policies, procedures, and behaviors.
- Having regular supervisory contacts with agendas for discussion—not just "checking in" without a focus.
- Giving staff regular feedback and getting regular opinions from them, their consumers, and other stakeholders.
- Being a buffer between pressures the agency may face due to funding exigencies, public demands, or governmental monitoring stresses. A manager/supervisor must be able to enlighten staff about these "big picture" concerns without merely passing them along with an unimpeded sense of urgency attached to their performance.
- Allowing opportunities for discussion of successes and challenges, and venting the frustrations inherent in the VR counselor position.
- Leading by example, with optimism and a positive outlook, even during times of seeming crisis or disaster.
- Providing regular opportunities for professional development and training, within and outside the agency.
- Creating an atmosphere that recognizes the seriousness of the work being done, but which also recognizes the need to not take ourselves too seriously, with humor and fun as part of our work.
- Providing outlets for staff socialization both on and off the job to promote a sense of teamwork and camaraderie.

Without values and outcome-based leadership, public VR organizations cannot make the commitment necessary to implement the serious changes in structures, supports, and skill development required to achieve better outcomes in psychiatric vocational rehabilitation. Nationally and internationally, employment outcomes that have been achieved with and for individuals with psychiatric disabilities have been poor and should be considered unacceptable. Leadership and vision alone are not sufficient to effect this change (it takes resources and community support as well), but they are essential. Though there is disagreement on whether values clarification precedes role realignment, i.e., behavior change, or vice versa (Beer et al., 1990), there is consensus in varied literature bases that mission and values are crucial (Corrigan, 1995; Hamel, 1996). While those in the human services field may view those in the business world as solely motivated by financial considerations, it is interesting to note how strongly the for-profit business literature emphasizes the need for strong values. As Drucker (1992) states, "For the organization to perform to a high standard, its members must believe that what it is doing is, in the last analysis, the one contribution to community and society on which all others depend" (p. 98). Concomitantly, Butterworth, Fesko, and McGaughey (1997) emphasize how important the commitment and values of staff are to the organizational change process, and how staff and agency needs must be met simultaneously. Each is a *sine qua non* of organizational change to enhance community employment results.

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 (Marrone, Hoff, & Helm, 1997).

A focus on innovative vocational rehabilitation methodology highlights the need for radical shifts in resources and organizational supports from those more traditional interventions that have not historically proven successful with clients with psychiatric disabilities. The dilemma this creates for managers/supervisors is one of participating in and, in some respects, leading significant social change. Such change:

- Is risky to both individuals and organizations;
- Is messy, because all change, positive and negative, is difficult to control and stressful personally;
- Always sets forces into motion that create unforeseen consequences that must be reacted to rather than proactively guided, as managers would like to be able to do; and
- Requires compromises based on reality, while always keeping a bottom line of values, as well as finances, in sight.

As the *Baldrige National Quality Program Criteria for Performance Excellence* (2004) notes:

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.” Organizations should stress ethical behavior in all stakeholder transactions and interactions. Highly ethical conduct should be a requirement of and should be monitored by the organization's governance body. (pp. 3-4)

Social forces are at play that will undoubtedly affect these options and invariably lead to others, are not yet fully developed. These forces include: greater numbers of individuals with disabilities in inclusive educational environments throughout their school years; improved transition services, the heightened visibility of for-profit competitors within the community rehabilitation field, the ascent of Managed Health Care in almost every state; greater implementation of the Americans with Disabilities Act of 1990 (ADA) in employment and public accommodations; the rise of the Internet; more movement towards including services for individuals with disabilities in integrated employment services within communities (such as One Stop centers in local labor markets); the creation of national Welfare-to-Work and Social Security Return-to-Work demonstrations; increased emphasis on supporting entrepreneurship for individuals with disabilities, and the incorporation of them within broad-based, instead of just disability-oriented, community economic development initiatives. Therefore, innovative service design will play a much greater role in management of community employment over the coming decade and must transcend simply choosing among a limited array of rehabilitation options. Options that, until recently, were considered *cutting edge* now must be evaluated by skilled managers/supervisors in light of the rapid environmental, technological, and social changes noted above.

Knowledge and Support of Effective Rehabilitation Practices

Following are some specific best practice issues that should affect management supervisory behavior in psychiatric VR. The authors recognize that merely because some interventions are identified consistently in the rehabilitation literature as *best* or *promising* practices does not indicate that all systems or practitioners necessarily utilize or even endorse them. However, this does not pre-

clude the responsibility of VR supervisory staff from understanding and implementing them, where called for.

Person-Centered Planning Concepts in Developing Individualized Plans for Employment (IPE) and in Broader Vocational Planning

The major challenge for managers/supervisors inherent in assisting their staff to use these ideas is the seeming ubiquitous and common sense of the term *person-centered planning*. People do not disagree intellectually with the concept of person-centeredness. However, what is the counterpoint to person-centered planning? Organization-centered planning? Who believes that what they do is not person-centered?

Person-centered planning (while not exactly a synonym, the closest analog to this concept in the literature on evidence-based practices in psychiatric vocational rehabilitation, often described as *attention to client preferences*) has risen almost to the level of rubric and mantra within the disabilities field.

The concepts that must be reinforced by managers/supervisors to ensure that more than lip service is given to person-centered career planning's implementation are:

- *Creating hope and providing personal support are under-emphasized in rehabilitation service delivery.* There is a heavy emphasis on functional assessment and problem solving within the rehabilitation community. Partly, this stems from the laudable intent to differentiate a rehabilitation approach from more traditional medical models. However, the goals that skills-based, outcome-oriented rehabilitation practitioners seek to reach in partnership with the individuals with disabilities they serve are unattainable without a concurrent commitment to the more intangible cur-

rency of hope and support strategies.

- *Self-advocacy and peer support sometimes rebound back against the agency administration.* Agency supported self-advocacy training and client-run, peer support groups are needed additions to a person-centered planning process. It would not be unusual if, after the inauguration of such approaches, challenges were made to the current system of services the agency delivers. These challenges might entail more human rights complaints, more appeals of service decisions, more conflict with direct service staff's clinical recommendations, more pressure for outcomes from the public funding agency, and more negative comments in client satisfaction instruments. In short, a manager/supervisor who supports this technique must be prepared to face more problems in the short term, not fewer; more challenges to the current order, not fewer; more dissatisfaction, not less.
- *Government agencies and other sources of funding typically are more comfortable with compliance with regulations and a straightforward systematized approach using a multitude of process requirements that they can closely monitor.* Individual professionals struggle with a more abstract and less straightforward way of doing business; funding agencies struggle with it even more. Managers/supervisors are faced with responding to the fact that funding agencies need to use outcomes for consumers, based on meeting individual choices and needs, as the ultimate litmus test concerning whether funds were well spent. Funding agencies should not be expected to provide funds for whatever whim a consumer and provider agency has, but a radical increase in the flexibility and user-friendliness of the funding mechanisms that are available needs to occur. The manager/ supervisor who supports this person-centered career planning

process within the organization must walk a fine line internally between pushing staff for concrete results and sustaining an idiosyncratic, non-bureaucratic approach to aiding individuals receiving services in making life decisions.

- *The difficulty of systemic implementation and systemization seems inherently equivalent to bastardization of a noble idea.* One of the conundrums of implementing the person-centered planning approach on a large organizational scale (e.g., as an approach to IPE development) is that advocates of this methodology want to ensure systemic impact, because this planning process is seen as a good way of interacting with individuals with disabilities. However, the requirements of the process itself seem to contradict this uniformity. How can a process devoted to individual problem solving, creative brainstorming, and inclusion of significant others in the person's life, whether they play a professional role in service delivery or not, fit within the confines of a formal service delivery system? This conundrum is not easily solved. Therefore, managers/supervisors must be willing to cope with ongoing uncertainty, the need for multiple individual judgments as to the adequacy of their staff's performance, and justifying that while there is no "one right way," there are standards to which professionals must adhere. Ultimately, what is required are distinctive, individualized planning processes that are judged in the harsh lights of both improved employment outcomes and customer/client satisfaction.

Encouraging Working as a Preferred Alternative for Clients with Psychiatric Disabilities

Perhaps the most fundamental issue that a VR administrator must confront in developing organizational marketing directed towards community employment of individuals with psychiatric disabilities is the belief system that staff hold vis-à-vis this topic. Not only should the provider's efforts demonstrate a core value that individuals with disabilities in our society *can work*, but an equal emphasis must be placed on the companion value, that people *should work* as part of their citizenship rights and responsibilities. For a manager/supervisor, this value translates into helping staff understand how they can reinforce employment as an expected and encouraged part of the lives of individuals with disabilities. A supervisor must consistently reinforce personnel's developing effective responses to the common ambivalence that many individuals with psychiatric disabilities express towards employment. Managers/supervisors should advise and monitor how staff members answer these questions:

- What do you do when individuals say they are not interested in working?
- What do you do to actively encourage working?
- What do you do when individuals say they are afraid of losing public assistance?

Opportunities for individuals with psychiatric disabilities to address these issues through job support groups, supportive counseling, and talking with other program participants who are successfully working must be provided, as well as experiential opportunities to explore interests and skills.

Partnerships with Business

Consulting with employers to assess and meet their needs through helping them find and accommodate qualified employees with psychiatric disabilities is part of a marketing approach. However, a manager/supervisor must help staff make the distinction between using a marketing/customer-service approach with employers versus viewing employers as their primary customers. Satisfying the needs of the consumer is the *goal* that drives the helping process; satisfying the needs of the employer is a *strategy* that is used to achieve the employment objective of the person. Usually, the employer and consumer needs can be met successfully. When there is conflict, it is the consumer's needs that must be the last to be abandoned.

An agency-wide commitment to customer service and business partnerships should reflect a *state-of-the-art* knowledge of what produces good employment results. The current state of the *wisdom* in assisting individuals with significant disabilities approaches definitiveness on only three things:

- A wide variety of strategies appear effective in securing employment.
- The magnitude of the effort, rather than the use of any one specific technique, is the primary determinant of job-hunting success.
- People using multiple approaches are more likely to be successful than those using only one.

Neither entire agencies nor individuals can necessarily control all the elements in the placement process. However, the one thing they can control is the image created in employers' minds of the job applicants and the agency's representing their interests. Successful employment will occur if the agency providing the vocational rehabilitation service is able to create a positive perception of

the individual and organization. Like any successful business, it is imperative that the individual and agency deal with the employer with all the elements of good customer service: courtesy, responsiveness, professionalism, providing value, etc. Through the relationship, learning how the business operates, the challenges it faces, and the direction in which it is headed, a vocational rehabilitation agency or service provider can develop an understanding of the employer's needs. Employers may not be able to readily identify their needs; it is the responsibility of the employment staff to explore potential needs with employers. Once a need is identified, then benefits can be presented and discussed to determine whether they match the identified deficit.

If the agency will be representing the individual to the employer, the features and benefits of the agency's services should be clearly understood. Managers/supervisors must be cognizant of how their organizational efforts either support or hinder this partnership with potential employers. Some questions for administrative staff to consider in light of this need are:

- Has your agency and/or office developed a marketing plan that includes employment outcomes?
- Has your office done a local labor market analysis?
- Is your main telephone number answered politely, professionally, and by someone knowledgeable about the agency's marketing efforts?
- Does your staff have access to a professional-looking brochure—it does not necessarily need to be costly, but is it error-free, grammatically correct, and focused on the employer's needs, not just a general brochure?
- Does your agency expect and encourage job development staff to be flexible in work hours and scheduling?

- How do you encourage all staff, not just those specifically in job development, to use their personal networks for the benefit of providing consumers access to the "hidden job market"?
- What do you and managers/supervisors above and below you in the organizational hierarchy personally do to model and reinforce all of the above behaviors and activities?

In summary, managers/supervisors have an obligation to prepare their VR counselor and job placement staff with adequate knowledge and skills in the areas of marketing, negotiating, advocating, and selling. A concomitant duty is to provide structures that reinforce the application of these skills.

Job Retention and Accommodation

Job retention is often cited as a major concern in helping clients with psychiatric disabilities achieve employment success (Bond, 1998; Danley & Anthony, 1987). Direct service skills seem far removed from the day-to-day purview of many direct supervisors, let alone mid- to upper-level VR administrators. What are some ways that managers/supervisors can reinforce acquisition, maintenance, and enhancement of these skills? These ways include:

- Expect VR counseling staff to be able to describe each client's learning style and how that affects their support and skill training strategies.
- Expect VR counseling staff to be able to describe what reinforcers are used with each individual and why these specific ones were chosen as appropriate.
- Encourage VR counseling and placement staff to take an active problem-solving role in work-site accommodation, not merely as a passive recipient of instructions from the employer. The rehabilitation professional's

role is not to demonstrate superior knowledge or problem solving; it is to help the employer and the worker with a psychiatric disability to reach a mutually satisfactory working relationship.

- Communicate consistently and clearly that job problems encountered by consumers are best solved early, before performance deteriorates further or is allowed to be seen as a "chronic problem."
- While early problem identification is important, make sure that task/job performance is seen as problematic by the employer, not just by the rehabilitation professional's judgment of performance below some ideal standard.
- Communicate consistently and clearly to personnel at all levels of the organization that job problems that consumers encounter are understandable and usually the reasons why the person with a psychiatric disability needs some form of rehabilitation support in the first place. When these problems do occur, staff should be expected to react in ways that facilitate job retention, not see these obstacles as providing justification why the consumer is not "job ready" or is too "needy." Managers/supervisors should concurrently model in their words and behavior this positiveness (e.g., when staff report a problem, the difference between reacting by asking "What can we do to make this situation work?" or "What needs to change" versus "Did we move too fast?" or "What about our relationship with the employer?")

Creative Problem Solving

Creative problem solving, much more important than skills or intelligence, requires a mindset that adheres to "take charge" and "can do" attitudes. It necessitates an approach that transcends agency policies and regulations or supervisory instructions. This situation presents managerial

dilemmas administrators need to consider in addressing these issues as they relate to their own agency:

- Newer staff in direct service positions may not have developed a significant enough depth of life and work experience that allows for effective problem analysis and resolution.
- Staff may be often drawn to human services to fulfill some inner “care-taking” role, usually prescribed within the context of the professional staff in control and the consumer with a need to be helped. When the parameters of the job and the relationship change, a role conflict is produced, such as community problem-solving vs. program fit or staff in charge vs. person with a psychiatric disability in charge.
- Staff often may be drawn to public vocational rehabilitation as a profession because of its seeming linearity in problem identification and problem solving. A person is assessed; a goal is identified; a plan is developed; actions are taken to further that plan; progress is evaluated; and an outcome is achieved. In practice, the course of a person's rehabilitation is usually not so neatly aligned and often has to move forward with a lack of goal clarity, is subject to multiple changes as situations arise, and requires overcoming unforeseen obstacles in the course of action implementation.

A person must take a positive approach to problem solving, showing a willingness to tackle issues with a fresh look and an expectation of progress. At the same time, the experienced manager understands that some problems are more amenable to remediation than others. The capable administrator also knows that sometimes situations arise that are best grappled with another day or by someone else or with different resources brought to bear. Without this ability to retreat on occasion, rehabilitation staff not only

put unreasonable pressures on themselves but run the common risk of turning this tension outside themselves and faulting the consumer as unrealistic, inappropriate, too disabled, or non-compliant.

Teamwork and Collaboration

There are multiple areas of collaboration that are necessary to incorporate within a successful psychiatric vocational rehabilitation network. Other stakeholders, in addition to the person with a psychiatric disability and the employer, whose needs must be factored into the community employment process, could include family members, other service agencies, and school systems. Families, while not the primary recipients of services, should have their needs attended to as an expected outcome of the service delivery process. Creating healthy distance and recognizing divergent interests between parent and adult child is often a function of those assisting individuals with psychiatric disabilities in organizing a community of supportive relationships within their work lives.

The manager/supervisor can set a tone within the VR agency so that family members' needs for reassurance that adequate consideration has been made of the potential downside as well as benefits of moving into employment are addressed. A typical area of potential conflict emanates from the emerging independence of the family member with a psychiatric disability which needs to be responded to and addressed; e.g., the use of public transportation, interest in obtaining a driver's license, or the development of intimate relationships. Less attention has been given to the need for the manager/supervisor and staff to inspire, motivate, and energize family members in support of the goal of employment. Another managerial issue is that of efficacy and efficiency. Apart from the philosophical issues contained in concepts like family versus professional control, fami-

ly versus professional knowledge, and family versus consumer needs, there lies a simple, practical problem—the more people staff involve and listen to, the harder it is to gain speedy consensus and take action. An administrator should help staff acknowledge, understand, and resolve the dilemmas that the intermingling of multiple needs of inclusiveness, consensus building, and problem resolution open up.

In examining collaboration with other professional partners, the same maxim applies as with the “customer service” concept noted earlier. The reason collaboration (or “customer service”) is used as a strategy in VR programs is to help the person with a psychiatric disability get the employment results desired. Any other measure of the utility of teamwork and collaboration, no matter how valuable otherwise (e.g., positive local press) should be seen merely as a surrogate indicator, unless it results in the client’s successful employment. The manager/supervisor has to ensure that every level of staff involved in collaborative efforts bring this perspective to the activity. However, just viewing cooperation in this light, does not make the process successful. There is a certain knowledge and skill base that VR managers should assist their staff in acquiring and honing to make successful collaboration more likely.

Effective teamwork can be defined by the following critical characteristics:

- The group, individually and as a whole, is presumed to have some expertise to offer in the problem area.
- Individual members still have to make decisions and assume responsibility (not everything has to be done by consensus).
- Every person and organization should bring resources (time, energy, ideas, related staff, money, etc.) of some sort to the “table.”
- The group shares a common purpose (based

on a culture of client benefit, not just getting along).

- The team has some measurable goals by which to judge success.
- Members of the team have clear roles and expectations of themselves and their organizations.
- A climate of trust and communication must be developed and maintained.
- Conflicts should not be avoided, but directly addressed.

The manager/supervisor must always balance the usual and laudable staff desire for input against the need to accomplish employment outcomes in the most effective manner. Faster is not always better. Conversely, more time spent processing data or problem solving does not universally result in more efficacious solutions. However, done well, teamwork certainly increases the capacities of providers to bring new energy and ideas into the problem-solving and service-provision arena.

The information cited above serves as a useful reference guide for vocational rehabilitation personnel to use in analyzing the various team endeavors with other professionals in which they are engaged. Given the vagaries and nuances of effective teamwork, it is often difficult for a manager/supervisor to establish protocols for staff that are not overly prescriptive, yet provide a reasonable measure of organizational direction and reflect agency values well enough. Several simple maxims of interagency team collaboration cover a multitude of situations. These are:

- Do not ask for something before you give something first.
- Always say yes to the first request made of you in any attempt at teamwork and collaboration.

- When looking at suggestions for changes, always use a three-step examination process:
 - What do **I** need to change?
 - What does **my organization** need to change?
 - What do **other organizations** need to change?

The public system VR counselor is often in the role of gatekeeper for the provision of specific services, a role that can place that person in conflict with the other team members who see needs that will have little, if any, relationship to a vocational or employment outcome.

There is a tendency with all large bureaucracies to make individuals with disabilities fit the system, not vice versa. However, the core of any vocational rehabilitation model is that individuals who are disabled are entitled to individual programs of services, based on their unique needs.

Employment services are, by definition, closure- and outcome-focused. What tends to happen is that by changing the client mix, problems in achievement are often addressed (i.e., the search for “more appropriate referrals”) rather than by improving individual skills or modifying the system. Needless to say, this tension is exacerbated when a team is trying to respond to a person with a significant psychiatric disability, in an era of dwindling (or non-existent) resources. Just as, if not more, important in examining the impact of the VR role as it plays out on interagency teams is looking at what issues occur in teamwork due to the philosophical underpinnings of the rehabilitation profession.

One area where rehabilitation values impact on team functioning is in the core premise that employment outcome is affected by interventions directed at both the person and the environment. A rehabilitation approach looks at the limitations present as caused not just by deficits in the person but also reflective of the barriers that may be

present in the setting. Often, the problem is identified as within the individual (i.e., an absence of skills or social competencies); thus, the intervention is directed at “fixing” the individual. In many instances, the barriers that exist in a setting or environment may inhibit the inclusion of the person with a disability. In such cases, the appropriate response may be to adapt the environment (e.g., job accommodation) rather than the individual. In all instances, there is a need to look at both the individual and the environment and consider environmental modifications as well as individual skill development to improve the fit of the individual to the setting.

In addition, the rehabilitation approach has a bias towards action, rather than talk, when interventions are needed. Other disciplines, especially in the mental health domain, may have a greater tendency to process, analyze, or assess before taking action. The rehabilitation approach can often be viewed by such professional colleagues as inordinately risky or not well thought through; but functioning, in a rehabilitation model, is seen as environmentally specific. Therefore, a rehabilitation practitioner may view the assessment and analysis of a course of action without taking some concrete steps towards the goal as essentially flawed or at least incomplete.

Finally, the rehabilitation emphasis on “functional capacity” as opposed to disability or dysfunction, is shared usually in spirit by all team members, but is demonstrated differently within the context of the demands of the various professional roles. Particularly in teams where the client and/or family members are not active participants, the focus of much team planning is usually on problem identification and problem resolution. The capacities of individuals with psychiatric disabilities to mobilize their personal resources as well as those within their natural support network are commonly overlooked in the desire of many teams to quickly analyze, assess, and prescribe. Also, especially in medical or educational contexts, the

client/student/ patient is often seen by helpers as part of the problem to be addressed rather than a resource to be accessed. In some instances, such natural resources can, in fact, be problematic and of limited utility in the development and implementation of the rehabilitation plan; though this is more the exception than the rule. It is up to the members of the team as well as the family and other natural resources to evolve a sense of coordination and cooperation, if a comprehensive rehabilitation plan is to be implemented effectively. A VR counselor should be trained to think in these terms and, thus, should play an advocacy role on behalf of consumer and family involvement in the interdisciplinary team process.

The following case studies are examples of common situations that vocational rehabilitation staff and systems commonly encounter. Based on these two brief case studies, and the discussion of management implications in this section and chapter, there are many strengths and weaknesses that can be identified.

Case Study I

A state VR counselor (VRC) arranges to meet with a client/customer, Mr. Smith, age 42, who is also being served by a private not-for-profit comprehensive psychiatric rehabilitation program (CPRP) contracted by the state mental health authority. This interagency team consisting of the client/consumer, Mr. Smith, VRC, and a Case Manager, has established their relationship during the initial interview. Mr. Smith is presumed eligible for VR services based on his receipt of Social Security Disability Insurance (SSDI) and Supplemental Security Income (SSI)—disability as well as diagnostic documentation presented by the Case Manager. VRC has further established that Mr. Smith should also be considered a person with a most significant disability.

Mr. Smith has stated during the ensuing discussion that he would like to go to work quickly. He

confirmed a consistent work history prior to the acute onset of his illness at age 26, having previously been employed as a certified mechanic. He indicated that he struggled through his illness while maintaining his job but could not continue working as a mechanic due to the pressure of completing automobile repairs within restrictive time lines, difficulty adjusting his medication schedule, and emotional discomfort dealing with customer complaints. Mr. Smith stated that he last worked as a mechanic at age 32, with his last taxable wage earned at age 36. Through the discussion, Mr. Smith stated that he wants to work with his hands and produce something by the end of his workday. He was indifferent to any other employment preferences and had no stated interests or knowledge of the types of employment available in the community. Mr. Smith does have reliable transportation in the form of an automobile, which he cares for himself. He states that working on his car is more difficult due to the increasing reliance on electronic modules and specialized diagnostic tools.

Mr. Smith reviewed the options available to enter into part-time work and decided through information with his VRC and Case Manager to explore his employment options placement services from a VR contracted Comprehensive Rehabilitation Program (CRP). Mr. Smith was provided information regarding the flexibility available for his scheduled attendance in order to accommodate his disability needs. Mr. Smith also agreed that these services should consist of individualized vocational counseling discussions, use of interest inventories, and hands-on “situational assessments” emulating possible jobs in the community. Prior to Mr. Smith and the Case Manager’s departure from the meeting, an appointment date and time had been confirmed with the CRP for his first session. Mr. Smith was comfortable with this, indicating he could adjust his scheduled appointments and activities with the assistance of his Case Manager.

Approximately three weeks after this meeting, the VRC received a telephone call from the CRP stating that Mr. Smith had decided to end his services. The CRP staff member stated that Mr. Smith did not keep his most recent appointment and when he was called, indicated that he "did not want to work without pay." The CRP staff had arranged, based on his agreement, for Mr. Smith to participate in several situational assessments in the community, specifically an automobile part store stock clerk at an automobile salvage yard as a part dissembler and mechanical maintenance worker at a medical facility. These were arranged as a series of four-hour blocks distributed over various days of the week based on Mr. Smith's schedule to expose him to various tasks and experiences of the jobs that were available in the community. The employers that agreed to Mr. Smith's participation in his situational assessment had expressed a need for an individual to be hired in these positions on a part-time to full-time basis in the near future. Prior to meeting with Mr. Smith, the VRC contacted the CPRP Case Manager who indicated that, in fact, they had agreed he would not return to the exploration of his interests. Eventually, the VRC had a personal conversation with Mr. Smith confirming that he did not intend to work without pay. He further explained the hands-on or situational assessments the CRP arranged for him were not paid.

Discussion Questions:

1. If you were in a supervisory relationship with this counselor, would you feel this professional was adequately involved in Mr. Smith's vocational counseling experience?
2. Do you feel that Mr. Smith was fully informed of what he should expect to experience from the CRP services?
3. Is there a partnering relationship between the

customer/consumer, CPRP Case Manager, VR counselor, and CRP staff? How would you describe this relationship?

Case Study II

John Jones' Community Treatment Team (CCT) case manager referred him to vocational rehabilitation to take part in a two-week VR pilot project on employment and opportunity. The pilot project was designed to give prospective referrals an opportunity to choose whether they felt ready to prepare for work and whether they would need VR services to assist them. The project was developed and facilitated by three Senior VR counselors, a VR employment specialist, the VR District Administrator and a VR program specialist. The curriculum and material were designed to foster choice and opportunity for each participant. Two of the strongest components were self-assessment activities and benefits counseling; these, along with guest speakers, including current and former consumers, employers, role play, transportation information, problem solving, tours of community rehabilitation facilities and job sites. Participants were asked to evaluate and provide feedback as to the value of each component and make suggestions regarding speakers and activities.

John was referred to the first group; and, for the first few days, he appeared bored and uninterested. The group dynamics changed when one person dropped out and John became more of a leader. After completing the two-week program, he indicated his interest in VR services for employment assistance, sharing his ideas and goals with the group and the VR staff. At the time of referral, John was in his mid 20s, with a diagnosis of paranoid schizophrenia and drug and alcohol use and abuse. Due to problems related to his illness as well as his co-occurring drug and alcohol abuse, he had not been able to maintain any employment for a significant period of time

and had lost the support of his family and, after a period of homelessness, was living at the YMCA. He had numerous hospitalizations, mostly due to non-compliance with treatment. The drug and alcohol issues caused numerous arrests and several periods of incarceration.

John was presumed eligible for VR services based on his receipt of SSI and considered to be a person with a severe disability. In a review of John's medical records and case notes during the assessment phase, the VR counselor noted minimal strengths (including the fact he graduated from high school), poor work history, few marketable skills, four hospitalizations, and a short period of time at a correctional institute. Initially, Mr. Jones was interested in going to college, but subsequent to a very positive situational assessment he decided short-term training and employment would be the best for him at that time. A comprehensive rehabilitation plan was developed to include 24 weeks of training at a local community rehabilitation facility in skills of data processing, Microsoft Word, and job seeking skills, with the VR counselor providing counseling and guidance, continued treatment and medication through the community treatment program, AA and NA counseling, transportation assistance, and job placement.

John successfully completed the program and within three weeks was placed at a local copying company as a document specialist. This was a particularly good fit for John, because he continued to live at the YMCA, and this company was within walking distance of the "Y." He started out part-time, 20 hours a week earning \$8 an hour. During the first two weeks of employment, he received a lot of support from his VR counselor and members of his group from the pilot project. Within a month, he was working full-time, 40 hours a week at \$8.75 an hour; and, at the end of 90 days, John had moved up the career ladder into a quasi-management position earning \$12 an hour. Health benefits kicked in,

and his case was closed in status 26.

John's rehabilitation was not all a smooth road to closure; but, when problems and issues arose, he discussed them with his VR counselor and CCP Case Manager and made the choices needed to continue toward his goals. A good example of a problem he had was one with his representative payee. Due to his many problems when he began to receive SSI, it was determined John would need a representative payee. During his training and early weeks of employment, the representative payee encouraged him to quit the program and then the job so he would not lose his benefits. This was an understandable concern based on his previous problems. It took a great deal of patience and counseling skills on the part of his VR counselor and the Benefits Specialist to encourage John to continue and to alleviate the fears of his family member. Three years later, John has had one inpatient hospitalization but has maintained his employment with the same employer and is now a manager. He has a lovely apartment, nice car, a significant other, and positive outlook for his future.

Overall, there were a number of successful outcomes from this project. Out of the initial 56 individuals completing the full two weeks, 27 chose to become VR consumers; and, eventually, 26 people were closed as successfully rehabilitated. Five of the graduates obtained employment on their own, and the other 25 chose not to pursue services at that time. However, since that time some of those have been referred and are currently receiving services.

When the pilot project started, the Delaware VR agency felt confident that its mental health partners would see the worth and incorporate part or all into treatment plans; but, until recently, it appeared to be only "a VR thing." While all the staff really enjoyed their involvement with the project, dealing with an average of 75 to 100 people at any one time was very time-consuming.

Thus, the project became very difficult to maintain without active mental health system collaboration and participation.

A recent positive note is that over the past year, a lot of attention has been given to employment of individuals with psychiatric disabilities, thanks to the President's New Freedom Initiative and other studies. The Division of Substance Abuse and Mental Illness (DSAMI) has shown a real interest in the project and has asked VR staff to provide training in their personnel-specific strategies, techniques, and structures they might employ to replicate this approach.

Discussion Questions:

1. If you were the VR supervisor of a counselor involved with the pilot project, what ideas would you have to ensure the continuation of the project?
2. Do you consider the pilot project successful? If yes, what elements made the pilot project successful? If no, what could have been done differently with clients to make it successful?
3. Why do you think the MH agency would see the project as a "VR thing"? What could you do to overcome that perception and create a stronger partnership?

Case Study III

Mary is a 34-year-old African-American referred to vocational rehabilitation by her Continuous Treatment Team (CTT) case manager. Mary's referral was given to a Senior VR Counselor who arranged to meet with her and her case manager. At time of referral, Mary's diagnoses were Personality Disorder, Learning Disability, Schizoaffective Disorder with Manic features, and possible AD/HD. During the intake interview, it was noted that Mary had been involved with VR on three other occasions. On two of those occasions the case was closed unsuccessfully (one 08, one 28); and on the third occasion, four years

ago, her case was closed successfully in status 26. Mary told the counselor she had quit that job because of child care issues related to her two young children.

Mary brought her Ticket to Work to the intake interview and indicated to the counselor she was not interested in working at any job where she may lose her benefits. Mary and her two children were living in Section 8 Housing, receiving SSI and Temporary Assistance for Needy Families (TANF). Her total family income was less than \$800 per month. Mary was adamant that she was only interested in training and a part-time job a few hours a day, based upon her child care schedule, and that her receipt of benefits was not to be interfered with. During the intake appointment, the VR counselor scheduled an appointment for Mary with a Benefits Specialist to assist with her concern around a possible loss of benefits.

After a review of the three previous case histories and a request for updated mental status information from the CTT, the counselor accepted Mary into service and an IPE was developed. Initially, Mary was interested in part-time employment as an administrative clerk. Since the consumer had previous work experience in this area, this was deemed to an appropriate vocational objective by all concerned. However, soon after entering into a community rehabilitation program to refresh her typing skills, Mary again began to have problems with child care. She and her significant other quarreled; he moved out; and Mary quit the program. Six weeks went by while VR counselor was trying to locate Mary and ascertain whether or not she wanted to continue her program or whether to close her case. Mary resurfaced and indicated she did not want to return to the CRP and no longer wanted employment as an administrative clerk, but requested a change in vocational objective to prep chef or manager of a restaurant. Mary's VR counselor took her on tours of a couple of community rehabilitation sites where food service training was available. Mary then

chose a vendor and entered training. Along with the training services, Mary was provided with bus tickets, mental health therapy through the CTT, extensive counseling and guidance by her VR counselor, and continued Benefits Counseling. Mary completed the food service training and entered placement services first with the training facility then with the VR Employment Specialist. It has been 18 months and Mary has not secured employment. Her job search activities have ebbed and flowed, according to the Employment Specialist at the community rehabilitation facility, prior to working with the in-house Employment Specialist.

The supervisor had the opportunity to observe Mary in the office when she met with the Employment Specialist and found her to be belligerent, very specific, and unyielding about the type of jobs and employers she would like to work with. It should be noted that over this span of time, Mary has dropped out of placement activities due to issues with her personal life. A review of her case record indicates that much of her inactivity with job search takes place when she has a new significant other; however, these relationships do not last for an extended length of time. The VR counselor is considering another unsuccessful 28 closure on this particular individual.

Discussion Questions:

1. If you were in a supervisory relationship with this counselor, what type of interventions would you use to prevent another unsuccessful interaction with VR leading to an unsuccessful closure?
2. How should the VR counselor deal with the issues related to this person's personal life?
3. Is there a "real" team or partnership that has been created among Mary, the DVR counselor, and the Community Treatment Team? If yes, what indicates this to you? If no, why not?

Case Study IV

The VR counselor received a community referral from a local physician on Ms. Wong, a 25-year-old Asian-American with the following diagnoses: Personality Disorder, Triangular Fibro Cartilage Complex of her right wrist, heart murmur, low back pain, Asthma, and a learning disability. Ms. Wong had been previously served in another VR office and closed in status 26 the previous fiscal year. The VR counselor met with her, completed the intake, and with a signed request reviewed the previous case record. Also during this process, the counselor learned the consumer was still employed with the same employer doing the same job she had when successfully closed the previous year. The consumer indicated she was not experiencing any problems on the job related to her disabilities but had re-referred herself for assistance to get another position because she wanted to spend more time with her two young children. On the surface, it appeared that Ms. Wong was not eligible because she did not possess an impediment to employment. However, upon further discussion with the VRC, Ms. Wong did admit that her husband would like her to continue working but does want her to spend more time at home with their two pre-school-age children. Ms. Wong became quite emotional with her desire to keep working, maintain her health, raise her children, and keep her marriage. She admitted she had cancelled several appointments with her psychiatrist.

Discussion Questions:

1. Do you feel this individual would be eligible for services based upon the information above?
2. How would you ascertain to what extent Asian-American cultural issues need to be explored?
3. If you feel this individual is ineligible for services, what advice would you give her?

Knowledge and Support of Effective Programmatic Interventions

Evidence-based practices, including supported employment, have been identified as having considerable promise. Nevertheless, access to services based on evidence-based and innovative employment practices remains a problem for many individuals with psychiatric disabilities (Bond et al., 2001, Drake, Becker, & Bond, 2003). The Surgeon General (U.S. Department of Health and Human Services [HHS], 1999) has lamented about the slow adoption of evidence-based practices and advanced forms of treatments. The Bazelon Center for Mental Health Law comments that “state mental health systems continue to rely on practices and models for which there is ample evidence of ineffectiveness . . .” while implementation of effective innovations is slow to occur (Bernstein & Koyanagi, 2002, foreword & p. 2). So, it is incumbent upon management/supervisory personnel within VR to have a working knowledge of what program type interventions are workable for specific needs of individuals with psychiatric disabilities.

At the top echelons of the system, this involves VR administrators and top management developing a willingness to fund the creation and sustenance of various models, usually in conjunction with public mental health systems. For public VR to play a significant and responsible role within the full panoply of psychiatric rehabilitation personnel across multiple systems, attention to how to assist in developing more effective programmatic options is crucial. At the first-line supervisory level, this knowledge must be imparted to direct service personnel and utilized in clinical supervision and case consultation. Following is a brief synopsis of suggested guidelines for use of different psychiatric vocational rehabilitation interventions. Chapter 3 of this IRI document has a complete review of the current state of evidence-based practice and also highlights practical

guidelines for usage of different types of employment interventions (practices and program models) for individuals with psychiatric disabilities that vocational rehabilitation practitioners might consider utilizing in their day-to-day work.

Part B: Job Placement/Marketing Implications for VR

Helping individuals with psychiatric disabilities find and keep good employment has been problematic, at best, and, arguably, one of the most significant failures of the public and private rehabilitation systems in the United States. Individuals with psychiatric disabilities still fare poorly in the labor market despite a variety of efforts (Bond, Drake, Becker, & Mueser, 1999; Crowther, Marshall, Bond, & Huxley, 2001; Marrone, 1993). The literature includes unemployment estimates for individuals with serious mental disabilities as high as 80% (Bond, Drake, Mueser, & Becker, 1997; MacDonald-Wilson, Rogers, & Anthony, 2001). Individuals with serious psychiatric disabilities are inordinately represented in terms of numbers receiving benefits and length of time receiving SSA benefits as well as tending to have an earlier age of entry onto the rolls (McAlpine & Warner, 2002). Figures available from the Rehabilitation Services Administration (RSA) on the performance of the VR system nationwide consistently show a lower successful rehabilitation rate (percentage of successful closures of all clients after they are made eligible) of VR clients with “Psychotic Disorders” (Status Code 500) compared with successful closure rates for all disability groups (MacDonald-Wilson et al., 2001; National Institute on Disability and Rehabilitation Research [NIDRR], 1997). Figures available from the RSA 911 closure data for fiscal year 2001 show that while clients with psychiatric disabilities represented 22% of all clients, they represented only 19% of employment outcomes. Concomitantly, their successful employment rate was only 31.5 % com-

pared to a successful rate of 36.5% for the entire universe of individuals with disabilities served (RSA, 2002). They often require extensive support provided creatively and intermittently to hold and maintain employment (Marrone, Balzell, & Gold, 1995).

The challenge that faces United States society is to develop structures and conceptual frameworks that reflect a shift from community vocational programming to helping people find and maintain employment and careers in the community. This section focuses on some strategies that should be used by public VR and its colleagues in community rehabilitation to market individuals with psychiatric disabilities to the employment community and methods to assist employers in accommodating them into the competitive workforce.

While the emphasis will be on techniques, it is crucial to initially contemplate the underlying values of activities that will be highlighted. First, any assistance rendered has to be offered in the context of a caring, hopeful, supportive relationship between the helper and the client (Byrne et al., 1994; Deegan, 1988; Marrone, 1993; McCrory, 1991). Although concepts like hope and support are sometimes denigrated as imprecise, they are, in fact, the cornerstones of any effective job placement effort. Another overall presumption that must be made is that assisting people to become employed is based on a consumer-driven, consumer-centered philosophy (Danley, 1993; Goldberg, Rollins, & Lehman, 2003; Marrone & Gold, 1994).

A vocational rehabilitation belief system has to include a core value that individuals with psychiatric disabilities in our society *can*, and *should*, work as part of their citizenship rights and responsibilities. There has been some emphasis on the former precept, that is, individuals with psychiatric disabilities can work (Drake et al., 1994; Becker, Torrey, Toscano, Wyzik, & Fox,

1998; Bond et al., 2001; Cook et al., in press) There has been much less focus in the rehabilitation, as opposed to the political, arena, on the companion premise, that individuals with psychiatric disabilities should work (Marrone & Golowka, 2000).

Disincentives are legitimate causes for concern. Yet, despite the numerous changes made to create incentives within the federal Social Security system, few people take advantage of them, and even fewer use them to win their economic freedom from Social Security benefits through working. Less than 1% of beneficiaries leave the rolls each year (Daniels, 1995). Individuals with psychiatric disabilities face numerous barriers to successful employment caused by societal discrimination (Granger, Baron, & Robinson, 1997; Mechanic, 1998), fear of them by others often based on images of violence (Marrone et al., 1995) effects of the illness on social behavior (Melle, Friis, Hauff, & Vaglum, 2000), and poor work history (Bond & McDonel, 1991; Marrone, 1993). The authors contend that effectiveness in helping people overcome these barriers is heavily dependent on staff's unwavering faith in employment as not just an achievable goal, but one which is valued, plus the ability to use this faith to motivate individuals with psychiatric disabilities to move towards this goal. Adults in our society have as one key piece of their identity, that of worker. It is only with individuals with disabilities, including psychiatric ones, for whom this is not taken for granted but, rather, debated under the guise of consumer choice and economic disincentives.

Premises about Helping People Find Employment

The first premise of the authors' approach to helping people gain employment is that the customer to whom the rehabilitation practitioner must attend is the client, the person with a psychiatric disability. Marrone, Gandolfo, Gold, and Hoff (1998) define a customer as "the person's being helped whose needs must be satisfied as a goal of the process and whose needs take precedence over others in the process" (p. 38). A key part of the marketing methodology is an approach that involves partnerships with businesses. Rehabilitation staff's consulting with employers to assess and meet their needs through helping them find and accommodate qualified employees with disabilities has been called a marketing approach (Owens-Johnson & Hanley-Maxwell, 1999; Vandergoot, 1992) or demand-side placement (Gilbride, Stensrud, & Johnson, 1994). However, the distinction is that satisfying the needs of the consumer is a *goal* that drives the helping process. Satisfying the needs of the employer is a *strategy* that is used to achieve the employment objective of the employer. Usually, both employers and consumers' needs can be met successfully; but, where there is conflict, the consumers' needs must be the last to be abandoned. The best analogy in the business environment is that of a real estate broker. A broker must satisfy both buyers and sellers of houses, yet most states require that a sales agreement clearly state that the broker is ethically bound to be a representative of the interests of the seller, not the buyer. Similarly, job developers must remember this vested interest.

An additional premise is that planning to create an exact job fit is not a crucial aspect of the job development process for those with limited work experience. Vocational assessment is continuous and relies on information gleaned from experience, not just sterile data collection (Drake et al.,

1994; MacDonald-Wilson et al., 2001). The intent is not to negate the value of career planning or choosing a goal consistent with a person's values, interests, and abilities. It is to emphasize the importance of the interplay between the planning and job search activity. Plans can and should be modified based on information obtained about the labor market and discussions with employers throughout the course of the job hunt (Hagner, Fesko, Cadigan, Kiernan, & Butterworth, 1995; Marrone et al., 1997) and through the consumer's early forays into the job force.

Fear of the unknown is a factor for individuals with various disabilities. The current stereotypes of individuals with impairments tend to produce reactions such as sympathy, pity, and over-protectiveness. In contrast, the community view of psychiatric disability is not just formed by wariness of people who act or look odd but is influenced by the unremitting media image of violence committed by "ex mental patients" or "the suspect with a history of mental problems." These images create concern about safety and potential for violence—what one of the authors refers to as the "Lizzie Borden Syndrome" (Marrone et al., 1995). Fear, stigma and guilt associated with psychiatric disability, are not always dependent on individual behavior (Link, Mirotnik, & Cullen, 1991). Unfortunately, community education is not often effective in changing beliefs and ameliorating concerns (Boehnlein, 1995; Kane, 1995; Kobe & Mulick, 1995). For the reasons stated above, employment advocacy to combat discriminatory hiring practices is a crucial skill to develop, hone, and consistently use for staff involved in marketing and job development. Whether the employment barriers are caused by fear, ignorance, personal dislike, lack of exposure, or the myriad other determinants of attitude and behavior is essentially irrelevant to the central tenet. Personnel whose job it is to help individuals with psychiatric disabilities gain employment must be willing to accept an advocacy role as a core component of their work.

Systemic Issues

Incentives and Disincentives

The topic of incentives and disincentives must be addressed from the point of view of both the employer and the person with a disability. Most of the professional debate has centered on using these terms in a narrow sense, either as synonyms for the concerns individuals with psychiatric disabilities have with losing their financial benefits (disincentives) or the Social Security Administration's attempts to assist its beneficiaries seek employment through the use of strategies to protect earned income and/or reduce loss of financial or medical benefits (incentives). The recent passage of the TWWIA and accompanying growth of Benefits Planning and Outreach (BPAO) projects has focused even more attention on this concept. Staff in the job development field must have a working knowledge of these programs and the capacity to communicate program implications to consumers.

Helping individuals obtain and retain good jobs requires a broader perspective in examining these issues. Marketing requires an understanding of individuals' (whether employer or job seeker) needs and values, which, by extension, translates into an awareness of what constitutes motivators (incentives) or barriers (disincentives) for these individuals. For individuals with psychiatric disabilities, incentives to employment can be increased financial security, improved self-esteem, and a sense of purpose and accomplishment (Rogers, 1995) as well as a way for them to get healthy, support their recovery, and empower themselves by becoming fully participating citizens in our society (Marrone & Golowka, 2000). Professionals assisting individuals in entering the workforce often do not focus their energies on helping inspire individuals to see work as a vehicle for achieving the foregoing. It is the rare person in our Western, free market society who does

not aspire to achieve at least financial security, if not betterment. A sense of productivity and goal attainment is an accepted value in United States culture.

An unreasonable amount of attention is directed to the disincentives in community employment causes. Since the concept of a disincentive is a personal attribution, it cannot be addressed merely through information dissemination, even though benefits planning is necessary (but not sufficient) for exemplary rehabilitation employment practice. The reasons individuals with psychiatric disabilities do not necessarily see working as a good personal outcome for themselves are well known: loss of financial benefits received directly through the public system (even though their total income might rise); loss of medical benefits; fear of failure; poor previous work experience; inability to imagine themselves working; concern about the impact of work on their mental status, i.e., increased stressors; and lack of faith in the ability of paid service providers to help. Helping individuals overcome these barriers requires support, information, positive thinking, inspiration, and hard work. Rehabilitation professionals who can use resources effectively on behalf of clients can only tackle these disincentives. Staff should not only listen and engage people based on their needs but advocate and argue a point of view (i.e., working is good for you) in a way that still respects individual autonomy and self-determination (Hagner & Marrone, 1995).

An understanding of incentives and disincentives for employers in the hiring process requires a concomitant analysis of individual requirements and values. Employers' perceptions of what motivates companies to hire individuals with disabilities follow some general trends. Employers' values influenced reported hiring decisions, as did perception of positive public relations, in addition to the obvious incentive of acquiring a good employee (Butterworth & Pitt-Catsouphes, 1997). Employers who have had previous positive experi-

ences with employees with disabilities show greater willingness to hire others with disabilities (Gervy & Kowal, 1995). Financial incentives do not appear to provide major impetus to the hiring of individuals with disabilities (Bullis et al., 1994).

The disincentives to hiring workers with disabilities can be seen in some ways as counterpoints to these incentives. If the employers perceive individuals as not being good prospective employees, then, obviously, hiring is less likely. What complicates this analysis is that the definition of "good employee" encompasses a range of factors, such as skills, personality, labor market conditions, business demands of the employer, etc. If employers do not expect to be able to support individuals to do a good job, then those employers might be reluctant to hire the workers. If employers, personally or corporately, do not value providing assistance to individuals with employment disadvantages, than workers with work limitations due to a disability, might not be seen as good employment candidates (Fabian, Luecking, & Tilson, 1995). Workers with psychiatric disabilities face the additional barrier of overcoming the prejudice and discrimination that often does not allow American society to view them as valued citizens or workers.

Accommodations

Negative attitudes, stereotypes, and fears about individuals with psychiatric disabilities form some of the major hurdles to their full participation within the labor force. Thus, arguably, direct employment advocacy on the part of staff to overcome these barriers is the prime accommodation to the needs of such workers. However, in addition, the concept of "accommodation" must take into account the legal exigencies generated by the passage of the two significant pieces of national legislation in the last 25 years that had a massive impact on the employment rights of this

group: the Rehabilitation Act of 1973 and the signing of the Americans with Disabilities Act of 1990, which took effect in 1992. Both of these pieces of legislation postulate the concept of "reasonable accommodation" to the needs of employees with disabilities, including those with psychiatric disabilities. Lawmakers saw this concept as an essential way of ensuring that an individual's capability did not languish because employers did not consider a wide array of ways to incorporate that person into the workforce.

By definition, "accommodation" is individual- and job-specific, so exact categorizations are hard to come by. It is a concept that must be used to help specific persons meet the requirements of specific jobs, not a categorical approach. Neither law puts any obligation on the part of an employer to accommodate an individual who is not identified as having a disability. Thus, the issue of disclosure also has to be considered in this requirement of self-identifying as a fundamental ingredient of the accommodation analysis mandate. For these reasons, the authors think of reasonable accommodation as a simple binary construct, essentially relating either to the job itself or the supervision provided.

Examples of supervisory accommodation that have been used include:

- Providing work requests and specifications of tasks in writing
- Making a concerted effort to give positive feedback more often or more explicitly
- Soliciting a worker's self-evaluation before providing critical feedback
- Applying flexible work policies, such as like sick leave, break schedules, and time schedules
- Providing more individual training, directly or with outside assistance
- Providing a coworker mentor to help the person become integrated into the workforce

Examples of job accommodation that have been used include:

- Changing the worker's office by a move or simple construction (e.g., partition)
- Changing the worker's schedule due to personal disability-related characteristics (e.g., lack of concentration) or treatment needs (therapy appointments)
- Changing the worker's job tasks through reassignment of duties
- Allowing the worker to work at home
- Job creation and job carving by making essentially a new job out of existing tasks done partially by others (often the path for this accommodation is paved by professional employment staff who have advocated successfully for this option using their knowledge of job analysis)
- Sharing a job with another worker, either with a worker with a disability (as in transitional employment) or a coworker without a disability who can serve as a paid supervisor to the worker or an unpaid, more informal, mentor. (England, 1994; MacDonald-Wilson, Rogers, Massaro, Lyass, & Crean, 2002; Mancuso, 1990; Nester, 1993).

Any of these accommodations is best developed in a spirit of cooperation, not conflict, with employers. The law does not seek to impose demands on employers, particularly smaller ones, which might interfere with their ability to compete in the market economy; and, even where required, enforcement is often slow. Therefore, it is incumbent upon advocates and individuals with psychiatric disabilities alike to approach the concept of reasonable accommodation as a joint problem-solving exercise with many possible solutions to any one problem.

Employer-Centered Approaches

Employment efforts continue to be viewed in many instances in terms of the ostensible business approach of selling individuals with psychiatric disabilities—convincing employers to hire them. This strategy is based on the concept of finding what job openings exist in the job market and finding individuals to fit those openings. Such strategies make the assumption that the job market is one arena, with limited flexibility, and with employers in the position of total power and authority. The job market is, instead, made up of a wide variety of isolated entities with a multitude of structures and points of entry. Employers may have only incomplete information about their labor market, and effective job development involves brokering an exchange process, providing usable information to both job seekers and employers (Hagner & DiLeo, 1993). 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 are:

Need: 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.

Feature: A feature is what a product or deliverable consists of.

Benefit: A benefit is what is gained as a result of that feature.

A relationship must be established with an employer that is viewed as mutually beneficial. In approaching employers, the goal should not be to sell them on why they should hire these individuals. Rather, initially, it should be to build up a relationship with the employer and obtain information, which will allow the individual or agency to gain an understanding of the employer. If the

rehabilitation staff person can create the perception with an employer that the benefits of hiring an individual outweigh the costs involved, then a successful placement will occur.

Through the relationship, learning how the business operates, the challenges it faces, and the direction in which it is headed, an understanding of the employer's needs can be developed.

Employer may not be able to readily identify their needs; it is the responsibility of the employment staff to explore potential needs with employers. Once a need is identified, then the benefits can be presented and discussed to determine whether they fulfill the identified need.

To identify how features translate into benefits for the employer, it is vital that the staff of a rehabilitation provider gain a well-rounded picture of the person with a psychiatric disability. This requires that staff work with individuals on identifying their interests, skills, positive personality traits, career goals, likes, dislikes, and a sense of the kinds of environments in which the person is most comfortable (Marrone et al., 1997).

Examples of presenting a feature and benefit approach are:

Feature: The individual has a degree in a specific technical area.

Benefit: The individual will be a well-trained employee, with expertise that will be useful to the organization.

Feature: The individual likes to spend time alone, with minimal interaction with others.

Benefit: The individual can be productive in an isolated work environment.

If the public VR staff will be representing the individual to the employer, the features and benefits of the agency's services should be clearly understood. Agency features may include: expertise in occupational training, employer consultation services specific to disability issues, knowl-

edge of other resources, and knowledge of accommodations. It has been the experience of the authors that employer and vocational rehabilitation staff relationships can last for many years. One example is a recent request by a small business owner whose last hire occurred in 1994 through vocational rehabilitation. This recent contact in the winter of 2004 was to solicit a potential new employee as a planned business acquisition. In addition to a placement, professional support regarding vocational rehabilitation and accommodation expertise due to changes in the needs of current employees was requested. This was not a spontaneous event; informal contact had been maintained intermittently through the years by telephone or in community service activities. The benefits of such features for the employer may include: saving time on training, a reliable source for good employees, increasing the diversity of staff, etc. How such benefits are presented to an employer will depend on the agency's needs. If an agency is approaching an employer to establish a transitional employment program, the emphasis will be on the benefits of working with the agency. If the goal is to place an individual into long-term permanent employment, then the emphasis shifts to what benefits the individual can provide an employer, with the features of the agency's services presented in a way that will increase the benefits the individual can provide. While it is essential for agency staff to focus on the positive attributes of the consumer, they should also examine potential barriers to employment and determine how these can be addressed, including through reasonable accommodations.

The individual and VR staff should communicate with the employer in a way that creates a positive impression. Prior to discussing a possible job with an employer, agency staff and the individual should discuss potential objections with this person and how they can be addressed. In developing relationships with employers, individuals and

agencies should be provided the opportunity to raise objections so that they can be addressed. Particularly with the advent of the ADA, employers may have a fear of asking the wrong question; so, while they have concerns, they may be hesitant to voice them. It is up to the individual and the VR staff to create an atmosphere of openness and honesty so that concerns can be discussed comfortably and the relationship can be built on trust.

In responding to employer objections, the following techniques common to the counselor skill set should be used:

Active Listening: Listen carefully to what the employer has to say, both verbally and non-verbally.

Repeating/Clarifying: Repeat or paraphrase to the employer what has been said to ensure that you both are clear on meaning.

Acknowledging Concern: Let the employer know that you understand that they are concerned

Offering Information: Provide information that addresses the concern that has been presented in a way that will mollify the objection that has been raised

Gaining Assent: Have the employer agree that the objection has been satisfactorily addressed (Marrone et al., 1998).

Disclosure is an issue in developing relationships with employers, particularly in responding to objections. Psychiatric disability often is misunderstood by the general public; and, unlike other disabilities, it is often not readily apparent to an employer. Under the ADA, the employer cannot ask about the nature of a person's disability, unless it will impact on the individual's ability to perform the essential functions of the job. However, it may be important for an employer to have certain information in order to provide for

the individual's support needs or to make a reasonable accommodation under the law. There should be a clear idea of what a job entails in order to assess whether it is necessary to disclose the disability. Prior to disclosing any information concerning disability, this issue should be discussed with the consumer, and the consumer's determination on what should be disclosed must be respected. If disclosure is necessary, rehabilitation agency staff should discuss with the consumer how the disability will impact the person's performance and determine what types of accommodations might be necessary. Disclosure should also be accompanied by an explanation of the implications of the information being disclosed and a positive discussion of strategies and accommodations available. Depending on individual needs, disclosure of such information may include emphasis on the availability of assistance from the rehabilitation provider for support, as needed. Maintaining confidentiality on sensitive issues is of paramount importance, but questions and fears should not be created in the employer's mind that are left unanswered (e.g., merely stating that the prospective employee may need time off for medical appointments leaves the employee with concern about the frequency and duration of these disruptions; letting the employer know that the job applicant would need a flexible schedule twice a month for two one-hour 8:00 a.m. doctor's visits puts parameters around the request and makes it a manageable concept).

“Readiness” Concepts

There is recent literature on *readiness* for personal change, best exemplified in the work of Prochaska and DiClemente (1993) and the analogous efforts around describing the components of “motivational interviewing” (Miller & Rollnick, 1991). The concepts require a great deal of explication and, as such, cannot be discussed fully here (the reader is encouraged to review the extensive work to be found in the reference sections). However,

there are some specific job placement issues concerning *job readiness* as a concept that this section touches on. Frequently, individuals with complex needs are labeled *not job ready*; however, many people with similar characteristics can also be found working in the community. How are these people able to work successfully when professionals say that they are not ready for jobs? One can also identify individuals who appear to be *ready* for employment but who cannot secure a job. It has been the experience of the authors that individuals with psychiatric disabilities are often tagged by the label not job ready by their medical model support system, i.e., psychiatrist, therapist, and case manager as well as vocational rehabilitation or other employment program from which they may benefit. It is often felt that better control over the disability issues needs to be established before individuals are considered employable. The end result is that employment is put off.

The readiness model has negative ramifications for the individual with a psychiatric disability. As a result, people have begun to question its basic assumptions and have drawn new conclusions:

- One cannot reliably predict who will be successful in employment;
- Community settings can accommodate a wide range of skills and behaviors;
- People with disabilities do not always generalize skills and behaviors;
- Some problem behaviors and skill deficits cannot be improved in segregation; or
- Real work situations can only be simulated to a limited extent (Institute for Community Inclusion, 1998).

Waiting to get all disability-related issues under control might mean that the person is never perceived as "ready." Having a parallel focus of employment, support, and work on disability

issues is a reasonable approach to take. Being in a work environment is beneficial to the individual and is a part of the support process for an individual. All individuals must find jobs that they can do and work cultures in which they can fit. Marrone et al. (1998) define *job readiness* as "creating a match among the skills, interests, values, and needs of a person with demands of a specific job and the values and needs of a particular employer" (p. 43).

There are many examples of creative job matching. A consumer whose presentation is sloppy or unkempt may look for a job in a setting where attire is less important. In another more complicated example, a young woman with schizophrenia, with an extremely loud speaking tone, a need to constantly move around while having a routine to follow, and a strong desire to work with people was tried in a number of employment settings. The problem was that she could not handle complicated instructions, intensely disliked working with food, and had no interest in working in environments, such as hospitals, schools, and/or nursing homes. The ideal work environment for her was the city's busiest, noisiest, and most hectic discount department store, where her loud voice, energy level, and ability to move around and not tire were all virtual pre-requisites for the job.

To create a good job fit, rehabilitation staff must:

- **Understand the consumer's** abilities, values, and needs
- **Understand the employer's** needs and values
- **Understand the job:** What skills are required? What is the work culture?

It is easy to label individuals who may not feel that they are ready to enter the work world due to inexperience, poor self-esteem, or fear as not job ready and do nothing to help them out of this mindset. The construct of not job ready is a dynamic not a static judgment. It would, perhaps,

be best stated in the affirmative of “ready for employment with the provision of the following supports” based on functional limitations that should and can be addressed in the certification of eligibility for the individuals served as well as in the services planned. In these instances, it is important to begin the exposure to the workplace to help the individuals develop confidence. They are prime candidates for informational interviews, tours, job shadowing, etc. Job readiness should be viewed as a dynamic, rather than a static concept. As time elapses, the various components may change. As a result, job matching will change. Assessing individuals for employability or job readiness should be used as an approach to assist with employment. It is not designed as an excuse for inaction.

Consumer Involvement in the Placement Process

An essential element of helping individuals with psychiatric disabilities obtain and retain good jobs is having the job seeker direct the job search and be involved in all aspects of the process. Successful employment, like any other aspect of personal change, requires that the individual take an active role in the process. Involvement by the job seeker helps to ensure satisfaction with the outcome and investment by the worker in staying employed. Involvement also makes finding the job the individual's success, contributing to the job seeker's self-esteem and confidence, and not as just a service that is being offered by the helping professional. Such involvement develops the skills of job seekers that will be needed to find other jobs and advance their careers.

A variety of factors make this seemingly simple approach to maximizing the active role of the job seekers with psychiatric disabilities in the employment process more problematic in practice. Figuring out what you want to and can do for work is perplexing for most people, and it is

made more challenging when dealing with major psychiatric disabilities. Finding a good job requires a high level of commitment and energy. Past failures and fears make many job seekers with psychiatric disabilities reluctant to seek employment and prone to give up early in the job seeking process at the first rejection. Past failures, lack of skills and/or experience, and manifestations of the disability itself can put job seekers with psychiatric disabilities at great disadvantage when competing with other job seekers. The prevalence of discrimination and the required skills and persistence needed to advocate successfully for opportunities, accommodations, and supports can be a challenge for the most seasoned veterans and sometimes overwhelming for persons who have not worked recently. These and other factors can limit the role and effectiveness of the job seeker in finding and maintaining employment, resulting in the individual job seeker acting as a passive recipient of employment services.

Job seekers with psychiatric disabilities will vary greatly in their capacities to seek and maintain employment, their willingness to accept professional advice and direction, and their willingness and ability to take initiative, develop, and follow through on any plan. Getting past the barriers of fear, pride, dependency, doubt, and embarrassment is difficult. Realizing one needs help and asking for it are signs of health, not weakness. Job seekers need to be encouraged to ask for help, and programs and services should be structured in a way that facilitates this effort. Marrone et al., (1998) offered five guidelines in thinking about designing services that actively promote and support involvement by individuals with psychiatric disabilities in getting and keeping good jobs.

1. **The job seeker must be perceived by professionals as an important member of the team whose involvement in the process is critical to overall success.** The responsibility is placed on the professional to seek input and direction from the individual and to

involve the job seeker in a process that enhances the skills, self-confidence and the success of the individual in obtaining and maintaining employment. Sometimes, too much pressure to be involved may deter the job seeker from continuing in the employment process.

2. **The level of involvement and support in finding and keeping a job needs to be matched to the abilities and preferences of the job seeker.** Often, clients perceived as "more capable" are expected to do most of their own job search. If they can't or won't, they are considered unmotivated or not ready to work. A "less capable" client is discouraged from finding his/her own job. Decisions about the role that the individual plays and the supports received in finding and keeping a job need to be worked out between the individual and the helper and based on that individual's wants as well as their abilities and needs.
3. **Involvement is not all or nothing.** Job seekers should be given active encouragement and support to be involved in any or all aspects of the job search. Program services should allow job seekers to be independent in one or more areas of the employment process while relying on professional support in another area. Flexibility needs to be built into the design of services, with the ability to readjust roles and supports as needed.
4. **The issue of disclosure of a disability is a personal decision that is made by the individual based on their particular situation.** To tell or not to tell, how and when to tell, and who tells should be discussed between the individual and professional with careful attention paid to the potential consequences of whatever action is decided upon. The professional needs to provide information and advice; however, the ultimate decision rests

with the job seeker and must be respected by staff. The agency staff should view themselves as information gatherers, obtaining information on the consumer's behalf, and then presenting options to a consumer and counseling them on the implications of options. The final decision concerning avenues to pursue and choice of jobs always remains with the consumer.

5. **Overt professional supports, similar to disclosure itself, have both potential benefits and drawbacks on the worker with mental illness and the relationships with the employer and co-workers.** It is important for the professional to discuss, prior to the employment search, what types of support the job seeker wants, who will help, and how this help will be delivered both during the job search and after employment has been obtained. If overt professional support will be seen as demeaning to the job seeker or increasing the chance of discrimination by informing the employer about the disability, ways for the professional to provide supports behind the scenes will need to be explored. On the other hand, if the job seeker needs intensive and direct supports in most areas, or has been unsuccessfully trying for many months to find a job, overt professional supports may be indicated. In all cases, overt supports need to be discussed and agreed upon beforehand by the job seeker.

Supports to job seekers with psychiatric disabilities and areas that need to be considered by the job seeker and the professional in defining the role each will play are career exploration and group experiences and peer supports.

Career Exploration involves looking at the interests, skills and aptitudes of the job seeker and the opportunities and expectations of business. A job seeker's involvement can include self-assessment techniques, interviewing significant others for

information and feedback, researching companies through local newspapers, journals and library resources, requesting informational interviews or tours of a variety of businesses, and talking with and observing employees at work through job shadowing (Bolles, 1994). Other resources include contacting local chambers of commerce, One Stop employment centers, and school career offices. The authors' experiences suggest that the vast majority of job seekers with psychiatric disabilities will need some level of support throughout this phase, such as assistance with calling and setting up informational interviews or going with the individuals to tour businesses.

Group experiences and peer supports, such as job clubs, job seeking skills, resume workshops, etc., can work very effectively to provide support and information sharing and can be helpful in other areas such as resume development, making contacts and learning and practicing advocacy, interviewing, job related social skills, and self-management techniques. VR agencies can provide many of these directly. This is also a fruitful area to explore collaborative relationships with One Stop centers, as almost all of them offer these sorts of group services to the community at large, including clients of the VR system. Four cautions are offered for job seeking and ongoing supports:

- Not everyone likes or wants to be involved in a group.
- Being involved in a group process should not be a requirement of receiving job placement assistance. Job seekers with more intensive support needs may not get the help, so it is important that more individualized services and supports are available.
- Group activities need to be time limited so that being involved in career exploration does not become a way of avoiding getting a job. Planning and exploring are good as long as they lead to action.

Sessions need to be more than opportunities to reiterate reasons it is hard to find a job. Though these may need to be discussed, groups need to focus on moving beyond this and not inadvertently reinforcing staying unemployed.

Dealing with Disclosure of Disability

An often difficult and emotionally charged issue for many job seekers with psychiatric disabilities is how much to tell a prospective employer about their disabilities. An employer is not entitled to information about a job seeker's disability unless it directly relates to the job seeker's ability to do the job or a need for reasonable accommodation. In the case of the stated need for an accommodation, disclosure can be at any time prior to or at the time of the request for that accommodation. For example, an employer cannot ask about the diagnosis of an applicant's disability or why an applicant was hospitalized. An employer can ask all applicants for a busy sales position how they would handle stress and customer complaints. Though this distinction is pretty straightforward, for the job applicant with a psychiatric disability who is trying to account for periods of unemployment or who will need certain supports/accommodations to be successful on the job, what to say about a disability may be less clear. This becomes even more difficult because by drawing attention to the psychiatric disability, the job seeker may lessen their chances of getting the job. On the other hand, if the job seeker does not mention the disability, the individual may not get the accommodations needed or be protected by anti-discriminatory laws.

Marrone et al. (1998) cite some questions that can be used to assist the job seeker to decide what to tell an employer regarding a disability.

Personal Ethics: Does the job seeker view non-disclosure as lying or simply omitting non-essential information?

Is the Truth Better? Can periods of unemployment be better explained by stating the job seeker had a problem and received help to overcome the problem or by other explanations, such as staying home to take care of family or was involved in a family business?

Is the Truth Relevant? If the job seeker can do the job and does not need extensive accommodations or support at the workplace, it is probably not necessary to inform the employer about the disability.

Can the Facts Be Checked? Past employment history and school records can be checked by employers, but other personal history (such as self-employment and medical leaves) is less likely to be scrutinized.

Effect on Job Seeker: Will telling (or not) cause more or less apprehension for the job seeker?

Consequences: What will increase/decrease the chances of getting and successfully maintaining employment?

Developing Employer Contacts and Interviews

Most people use personal contacts in finding employment (Bolles, 1994; Temelini & Fesko, 1996). Some of the reasons for encouraging the job applicant to use personal connections in job search include:

Builds in credibility by capitalizing on relationships: Employers are less suspicious towards job candidates whom they know directly or indirectly.

Creates a direct line to those who hire: Helps the job seeker bypass secretaries and personnel whose job it is to screen out applicants.

Improves chances of support: An inside contact can assist in making needed modifications and finding supports in the workplace.

Head-start on the competition: The job seeker can find out about openings before they are advertised, lessening potential competition (Hoff, Gandolfo, Gold, & Jordan, 2001).

Discrimination and Advocacy

Job seekers with psychiatric disabilities and the professionals who assist them need to be alert to the potential for discrimination. In addition to legal information regarding accommodations, job seekers should be supplied with guidance regarding acceptable job applications, interviewing practices, pre-employment testing, and other hiring activities. Staff should meet with job seekers to review what has occurred during telephone conversations and interviews and any documents, such as applications and written correspondence. Professionals need to not only be aware of the legislative protections available but also be able to offer support through agency resources or referral to other services, such as a university disability law center, public legal aid center, or mental health center legal advocacy. In addition, the professional might need to take a direct advocacy role with the employer or legal agency on behalf of the individual with a psychiatric disability.

Though the individual with a psychiatric disability makes the final decision whether to address discriminatory practices through advocacy or legal means, the professional in an advisory capacity can influence the decision. It is critical that the professional keeps in mind that the individual with a psychiatric disability is the customer whose needs must take precedence. After the professional has reviewed the situation with the individual, the professional must be certain that if professional advice is to discourage confrontation regarding

discrimination, it is done out of concern for the effect on the client and not because of professional time and effort or concern about relationships with the employment community.

Part C: HRD Implications for State Vocational Rehabilitation

This section provides a perspective on needed and valued psychiatric vocational rehabilitation competencies and the Human Resource Development (HRD) implications for state vocational rehabilitation agencies and rehabilitation education.

In terms of identifying psychiatric vocational rehabilitation competencies, McCarthy, Pelletier, and Accordino (2004) describe a process in which ten focus groups in a six-state area were convened in 2001 to identify competencies that would be the focus for curriculum development in a new psychiatric vocational rehabilitation training project for state vocational rehabilitation counselors. A total of 135 state vocational rehabilitation staff (90 counselors, 35 supervisors, and 10 managers) participated in the full-day focus groups.

Their charge was to identify psychiatric vocational rehabilitation knowledge and skills that state vocational rehabilitation counselors need to be able to provide individuals with significant psychiatric disabilities with the assistance and opportunities they need to actively participate through informed choice in developing IPE, engage in relevant and valued VR services, and attain and maintain high quality employment.

Based on the information and data that came out of these focus groups, 40 knowledge and skill areas grouped into four domains were identified as follows (McCarthy et al., 2004):

The Impact of Psychiatric Disorders on the Rehabilitation Process

- Knowledge of component services in a recovery oriented mental health/vocational rehabilitation network.
- Knowledge of the stages of the recovery process.
- Knowledge of the interacting and parallel features of the recovery and rehabilitation processes.
- Knowledge of cognitive, affective, and behavioral impairments of psychiatric disorders that impact on rehabilitation services.
- Knowledge of psychopharmacology as it relates to identifying side effects and/or medication related accommodations.
- Knowledge of psychiatric disability and coexisting disorders, such a substance abuse, Trauma Brain Injury, deafness and mental retardation.
- Knowledge of personality disorders: course of recovery, treatments, and impairments that impact on the rehabilitation process.
- Knowledge of anxiety disorders: course of recovery, treatments, and impairments that impact on the rehabilitation process.
- Knowledge of schizophrenic disorders: course of recovery, treatments, and impairments that impact on rehabilitation process.
- Knowledge of mood disorders: course of recovery, treatments, and impairments, which impact on rehabilitation process.

Help Consumers with Psychiatric Disabilities Develop Rehabilitation Potential

- Use a partnership approach with consumers to assess/develop personal readiness for vocational change and promote self-determination.

- Use career exploration strategies.
- Conduct a functional assessment of critical work skills.
- Use individualized, recovery-oriented assessment strategies and tools, which will lead to service opportunities.
- Implement experiential assessments (situational assessment, volunteer work, work units, job shadowing, etc.).
- Use career development counseling strategies.
- Use person-centered planning to gain support from the consumer's personal and professional support network.
- Assist consumers to determine their wanted and needed personal supports (type, location duration) for work/education.
- Implement strategies to help consumers develop work capacity (stamina, concentration, interpersonal skills).
- Know how and when to use employment program options (SE, TEP, etc.).

Relationship Building with Clients with Psychiatric Disabilities and Teams

- Assist/support consumers to exercise informed choices regarding their employment goal, vocational services, and service providers.
- Use effective communication and alliance building practices that engage consumers as active partners in the rehabilitation process.
- Communicate with consumers about the vocational and educational implications of their psychiatric disability.
- Assist consumers to gain an action-oriented understanding of the behavioral changes necessary to achieve a rehabilitation goal.
- Assist consumers to explore and resolve

ambivalence around vocational engagement and to elicit intrinsic motivation for change.

- Use advocacy and negotiating skills to gain consumer access to needed community resources.
- Use motivational practices to assist consumers to initiate and maintain goal directed activity.
- Coordinate rehabilitation services with treatment and community support services.
- Resolve disagreements in team decision-making.
- Assist consumers to be active participants in team planning.

Help Consumers with Psychiatric Disabilities Gain and Maintain Employment and Education

- Implement a job development and marketing strategy.
- Implement an individualized job placement strategy.
- Implement services that support consumer involvement in job-getting activities (job club).
- Implement an on-site job support strategy.
- Implement ADA and accommodations in the workplace.
- Implement off-site support (individual, group) strategies.
- Implement a strategy to use natural supports in the workplace.
- Implement a strategy to provide advocacy/support related to use of SSA work incentives.
- Implement different models of supported education to promote retention and success in education and training.

- Implement ADA accommodations and adjustments for consumers who are in college/technical school.

Based on the significant change in training effect measures involving these 40 competencies and on the overall program evaluation, McCarthy et al. (2004) concluded that these psychiatric vocational rehabilitation elements could form the base for curriculum development for pre-service rehabilitation education, continuing education (Rehabilitation Continuing Education Program [RCEP]), VR in-service training, and be the focus for casework supervision.

Based on the experience of conducting a two-course sequence in psychiatric rehabilitation for two cohort groups of 50 state vocational rehabilitation counselors coming from six states, McCarthy et al. (2004) identified Instructional Values and Principles that could enhance the effectiveness and usability of training/education interventions for State Vocational Rehabilitation (SVR) personnel. Among their recommendations were the following:

- Include in the training faculty, SVR counselors who can describe effective and innovative strategies and interventions that they use with SVR consumers with significant psychiatric disabilities and describe several case studies that provide a longitudinal perspective on SVR involvement and gain.
- Include in the training faculty, former SVR consumers who can provide a first person perspective on the recovery process and helpful elements of their participation in SVR services.
- Include in the curriculum a focus on addressing the perception of a pessimistic prognosis for SVR consumers with significant psychiatric disability through multiple opportunities for counselors to gain a more realistic optimism on rehabilitation poten-

tial.

- Include in the curriculum a focus on reconciling a nonlinear course of recovery and rehabilitation for consumers with service delivery systems that value and expect steady progress toward goal attainment.
- Include in the curriculum a focus on addressing the issue that often a consumer's increased function is coupled with transitional stress. Understanding this occurrence and knowing the steps to take to support consumers' move through transitions was valued by the rehabilitation counselor trainees.
- Include in the curriculum a focus on the role of a vocational rehabilitation counselor as a consumer advocate and the skills needed to be able to get community support resources to pull together and provide opportunities for VR consumers to access needed services and resources.

Based on the issues about the need and value for relevant and competency-based psychiatric vocational rehabilitation in state vocational rehabilitation raised in this section, it would appear that more collaboration between the federal-state VR program and rehabilitation education and Psychiatric Vocational Rehabilitation (PVR) training resources should take place. It also appears that there is a need for more PVR training resources, more PVR specialization in rehabilitation counseling Masters programs, more Regional Rehabilitation Continuing Education Programs (RRCEP) collaboration to increase PVR training capacity, and more VR/MH joint training on state and regional levels.

Conclusion

Many of the general components cited above as part of effective marketing and accommodation strategies are relevant for anyone seeking employ-

ment. The specifics of how they are applied, what information is used by job applicants and staff working with them to aid in the employment process, and the supports rehabilitation professionals and others in the community need to offer are affected by the mental health impairment. Sometimes the effects of the illness on the person cause this impact, often by the effects of the illness on the society around them. There is no magic. However, with clients who have psychiatric disabilities, societal fears and stereotyping are much closer to the surface than for individuals with most other disabilities, so the margin for error (and tolerance) is less. Rehabilitation staff's personal skill and comfort in working with clients who face these kinds of problems will in large measure determine their effectiveness in easing the employer's anxieties.

This chapter has offered a mix of strategies for individuals with psychiatric disabilities to use on their own behalf and for those charged with helping to deliver as part of advocacy and support efforts. If better employment outcomes and better quality of lives are ever to become a reality for consumers with psychiatric disabilities, then we must begin to develop structures and conceptual frameworks that reflect a shift from concerns primarily about processes and program design to helping people find and maintain outcomes in terms of enduring employment and career progression in the community.

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Study Questions

1. In the area of job retention accommodations, what are some of the ways that a VR Manager/Supervisor could reinforce and enhance counselor skills?
 - a. Expect VR counseling staff to be able to describe what reinforcing techniques are used with each individual and why specific ones were chosen as appropriate.
 - b. Communicate consistently and clearly that job problems encountered by consumers are best solved early before performance deteriorates or the problem becomes a “habit.”
 - c. Expect VR counseling staff to be able to describe each client’s learning style and how it will affect their support and skill training strategies.
 - d. All of the above.
2. What are the concepts that must be reinforced by managers/supervisors to ensure that counselors are providing person centered career planning?
 - a. Be sure each individual consumer has a functional assessment and is work-ready.
 - b. Support self-advocacy training and client-run peer support groups.
 - c. Since funding is always an issue, person-centered planning is not feasible with every consumer.
 - d. Person-centered planning is impossible with individuals with developmental disabilities.
3. Teamwork and collaboration are very important in the rehabilitation process. What are some of the areas where the supervisor/manager can assist the counselor?
 - a. Many individuals with chronic and persistent mental illness have lost the support of their immediate families; therefore, involvement of the families in the rehabilitation process is not necessary.
 - b. Creating a healthy distance and recognizing divergent interests between families and consumers is one of the ways of assisting people with psychiatric disabilities and organizing community support of relationships.
 - c. Since vocational rehabilitation counselors have high caseloads and many unreasonable pressures put upon them, they really do not have the time to work towards collaboration and teamwork.
 - d. Effective teamwork with families and mental health facilities requires a great deal of effort on the VR counselor’s part, and the burden should be on the VR manager/supervisor. All teams require measurable goals to judge success.
4. A feature-benefit approach is most applicable in what type of interaction in the rehabilitation process?
 - a. VR eligibility determination
 - b. Vocational assessment
 - c. Marketing to employers
 - d. VR-MH system team meetings

5. In assisting a person with a psychiatric disability in deciding whether to disclose the presence of a psychiatric disability to a potential employer in the job interview process, which of the following is most important to consider?

- a. Counseling philosophy of the rehabilitation counselor
- b. Preferences of the person with a psychiatric disability
- c. Type of industry the job is in
- d. The components of the local labor market

6. Which of the following is NOT a key facet of an effective style in answering objections an employer may have to hiring a worker with a psychiatric disability?

- a. Arguing about the perceptions the employer has
- b. Active listening
- c. Clarifying the objection
- d. Gaining the assent of the employer to a follow-up step

7. Using personal contacts can often be an effective job hunt strategy to use because of which of the following?

- a. It can create a direct line to those who do the hiring.
- b. The person with a psychiatric disability will not have marketable skills.
- c. People who work in personnel offices discriminate against applicants with psychiatric disabilities more than other people.
- d. VR counselors tend to know more influential people than other staff.

8. The potential for a good job fit is created when which of the following is considered by the rehabilitation staff?

- a. Understanding the job
- b. Understanding the employer's needs and value
- c. Understanding the consumer's abilities, values, and needs
- d. All of the above

9. Involvement by the job seeker in the placement process ensures the individual's satisfaction with the outcome and which of the following?

- a. develops job seeker's skills that are necessary for future recreational opportunities
- b. investment by the worker in staying employed
- c. contributes to the job seeker's self-esteem and confidence
- d. both b and c

10. Which of the following is considered a necessary competency for professionals to help consumers with psychiatric disabilities develop rehabilitation potential?

- a. Implement experiential assessments.
- b. Know how and when to use employment program options (SE, TEP, etc.).
- c. Use a partnership approach with consumers to assess/develop personal readiness for vocational change and promote self-determination.
- d. All of the above.

11. After a job seeker has completed an interview, the rehabilitation professional should do which of the following?

- a. Provide legal information regarding job accommodations.
- b. Provide guidance regarding acceptable job applications.
- c. Meet with the job seeker to see what has occurred.
- d. Assist the job seeker through referral to a disability law center.

Appendix A

Glossary of Terms

Client, Consumer, Consumer-Survivor, Ex-patient, Customer: The variety of terms referring to individuals receiving services reflect both the evolution of the field and the current debate within it (Farkas, Sullivan-Soydan, & Gagne, 2000). The debate centers on the question of what mode of identification most accurately portrays the individual's actual situation or enhances the individual's potential integration as a valued member of society (Caras, 1994; Fisher, 1994). *Consumer*, *consumer-survivor* or *ex-patient* is a generic term used to refer to the relationship of the individual to the mental health system. The term *consumer* (i.e., one who "consumes" or actively uses services) and/or "survivor" (i.e., one who has "survived" psychiatric treatment) invoke the personal experiences of the individual. "Ex-patient" is a term used by individuals who want to emphasize that while they were once perhaps incarcerated in a psychiatric facility, they are now free of it. Many, but not all, consumer organizations use one or other of these terms. *Client* is a term used to refer to someone's role in a specific helping relationship with a practitioner. *Customer* is a term used in the marketing and quality assurance fields that has been adapted by rehabilitation and mental health services to underscore the need for practitioners to be responsive to their customer base and change their product, if the customer is not satisfied with it, rather than blame the individual for poor performance.

Client Assistance Programs (CAP): Client Assistance Programs (CAP) as found in the Rehabilitation Act, 1973, Part B, Basic Vocational Rehabilitation Services, Section 112: Through grants provided by the Secretary of Education, programs have been created to "provide assistance in informing and advising all

clients and client applicants of all available benefits under (the) Act . . . assist and advocate . . . in their relationships with projects, programs, and services provided under (the) Act . . . including pursuing legal, administrative, or other appropriate remedies to ensure the protection of (their) rights . . . and to facilitate access to the services funded under (the) Act through individual and systemic advocacy. The client assistance program shall provide information on the available services and benefits under (the) Act and Title I of the Americans with Disabilities Act of 1990 (42 U.S.C. 12111 et seq.) to individuals with disabilities in the State, especially with regard to individuals with disabilities who traditionally have been unserved or underserved by vocational rehabilitation programs." The CAP "may provide the assistance and advocacy with respect to services that are directly related to facilitating the employment of the individual."

Comprehensive System of Personnel Development (CSPD): Comprehensive System of Personnel Development (CSPD) as found in Section 101(a)(7) of the Act: Each State VR agency is required to develop and create a personnel system that will "ensure an adequate supply of qualified State rehabilitation professionals and paraprofessionals" for the agency. The system must have certain checks and balances to determine "the number and type of personnel . . . including ratios of qualified rehabilitation counselors to clients . . . and a projection of the numbers . . . needed in 5 years." The system must be coordinated "with personnel development activities under the Individuals with Disabilities Education Act (20 U.S.C. 1400 et seq.)" It also must include "a description of the development and maintenance of a system of determining . . . information on the programs of institutions of higher education within the State that are preparing rehabilitation professionals."

Basically, the system must ensure that State agencies employ qualified rehabilitation professionals

and that there is a sufficient source of same to adequately provide vocational rehabilitation services to individuals with disabilities. The agency must set “standards to ensure that personnel . . . are adequately prepared and trained.” These standards must be “consistent with any national or State approved or recognized certification, licensing, registration, or other comparable requirements that apply to the area in which such personnel are providing vocational rehabilitation services.”

Or as found in 34 CFR 361.18 of the Regulations: State VR agencies are required to establish and maintain a personnel system “designed to ensure an adequate supply of qualified rehabilitation personnel, including professionals and paraprofessionals, for the designated State unit.”

Certain personnel standards must be met: The standards must be based on the highest requirements in the State, that is, “the highest entry-level academic degree needed for any national or State-approved or –recognized certification, licensing, registration, or, in the absence of these requirements, other comparable requirements that apply to that profession or discipline” (34 CFR 361.18(c)(2)).

Culturally Competent Services: Culturally competent services means the delivery of services that are responsive to the cultural concerns of socioeconomic status and racial and ethnic minority groups, including their language, histories, traditions, beliefs, and values (President’s New Freedom Commission on Mental Health, 2003).

DSM-IV-TR: The Diagnostic and Statistical Manual of Mental Disorders, Version IV-TR is a manual used by psychiatrists and other mental health professionals mainly to categorize symptoms of mental illnesses for clinical, research, and

educational purposes. It also includes global ideas of psychosocial stressors and functioning.

Employment: As found in the Rehabilitation Act, Section 7:

- (11) Employment Outcome
 . . . with respect to an individual—
- (A) entering or retaining full-time or, if appropriate, part-time competitive employment in the integrated labor market;
 - (B) satisfying the vocational rehabilitation outcome of supported employment; or
 - (C) satisfying any other vocational outcome the Secretary may determine to be appropriate (including satisfying the vocational outcome of self-employment, telecommuting, or business ownership), in a manner consistent with the Act.

Or as found in 34 CFR 361.5(b)(16) of the regulations implementing the Act:

...with respect to an individual entering or retaining full-time or, if appropriate, part-time competitive employment in the integrated labor market to the greatest extent practicable; supported employment; or any other type of employment, including self-employment, telecommuting, or business ownership, that is consistent with an individual’s strengths, resources, priorities, concerns, abilities, capabilities, interests, and informed choice.

Empowerment: Empowerment is a multidimensional process, rather than an event, that describes an individual’s experience of power. Some of the dimensions involved that have been suggested through research on empowerment include: having decision-making power; having access to information and resources; having a range of options from which to make choices; assertive-

ness; and feeling hopeful about making a difference (Chamberlin, 1997).

Evidence-Based Practices (EBP): Evidence-based practice (EBP) is defined by the Institute of Medicine as the integration of best-researched evidence and clinical expertise with patient values (Institute of Medicine, Committee on Quality of Health Care in America, 2001).

Emerging Best Practices: Emerging best practices, or promising practices are interventions that are promising but less thoroughly documented or subjected to rigorous research than evidence-based practices.

Mental Disabilities/Health/Illness/ Chronic/Severe and Persistent

Disability/Psychiatric Disabilities: The President's Commission on the New Freedom initiative for Mental health defined the population of interest in these terms: Adults with a serious mental illnesses are persons age 18 and over who currently or at any time during the past year have had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within DSM-IV-TR that has resulted in functional impairments which substantially interfere with or limit one or more major life activities (living, learning, or working).

Various terms have been used both in mental health treatment and rehabilitation. Besides the ones listed, other terms include *psychiatric impairment, emotional problems, psychiatric background, and psychiatric experiences*. This variety indicates varying points of view about the nature of the problem and the extent to which the problem is an illness or a sociopolitical issue (Chamberlin, 1990). Generally speaking, rehabilitation uses the language of disability. The term psychiatric disability is used rather than *mental disability* because of the stigma that the term mental carries with it. Also, the question of whether or not this problem is caused by a “bro-

ken brain” (associated with the term “mental”) is not raised when using the term “psychiatric” disabilities. The term “disabilities” does not speak to the issue of the cause of mental illnesses (whether it be some medical illness or a problem of type of experiences individuals have with services and providers). It does not imply that a particular diagnosis is useful or correct. (If one believes in *psychiatric experiences*, not *illnesses*, then a diagnosis means nothing.) Disabilities are restrictions in functioning, regardless of the cause. *Impairment* is the result of an *illness* and usually refers to what is typically thought of as psychiatric symptoms or personal distress that relate to a particular psychiatric problem. *Chronic/severe* and *persistent* are terms that were popular from the 1960s to the beginning of the 1990s. The impact of these terms was to give the impression that serious psychiatric disabilities lasted forever. As a diagnosis, it was usually a death sentence, condemning individuals to maintenance-level services appropriate because there was nothing that could be done (persistent). With the emergence of the vision of recovery and the recognition of research that had been carried out over the last 40 years (Harding, & Zahniser, 1994), it was no longer accurate to assume that individuals were “persistently” ill or hopeless.

Mental health issues are usually those that are less severe than the difficulties that are the focus of this document. Adolescent adjustment reaction, marital conflicts, the development of health lifestyles, etc., are usually thought of as “mental health issues. However, many psychiatric treatment services were located within the Department of Mental Health—which, until the 1980s, covered a vast array of problems. After the 1980s, these state systems were more and more focused on serious psychiatric difficulties, leaving private providers to deal with mental health concerns.

Readiness: Rehabilitation readiness is the extent to which an individual is willing to commit to a

process of change that involves setting and working towards attaining a living, learning, or working goal (Farkas et al., 2000).

Recovery: Recovery means a deeply personal, unique process of changing one's values, feelings, goals, skills, and/or roles. It is a way of living a satisfying, hopeful life with or without limitations caused by the illnesses or experiences. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illnesses (Anthony, Cohen, Farkas, & Gagne, 2002).

Recovery itself is an important term that is generally misunderstood within a psychologically oriented framework. A traditional definition of recovery is the return to a level of functioning that individuals had before they became disabled. In looking at psychiatric disability, there is a complex way to see recovery. For instance, a person's disability in and of itself may not change, but their response to this disability may be characterized by a marked increase in coping and restructuring.

Resilience: Resilience means the personal and community qualities that enable us to rebound from adversity, trauma, tragedy, threats, or other stresses and to go on with life with a sense of mastery, competence, and hope (President's New Freedom Commission on Mental Health, 2003).

Self-Determination: Self-determination refers to the right of individuals to have full power over their own lives, regardless of the presence of illness or disability. It encompasses such concepts as free will, civil and human rights, freedom of choice, independence, and individual responsibility. Self-determination in the rehabilitation or mental health system refers to individual rights to direct their own services, to make decisions concerning their health and well-being, to be free of involuntary treatment, and to have meaningful leadership roles in the design, delivery, and evaluation of services and support (adapted from UIC

National Research and Training Center on Psychiatric Disability and the UIC NRTC Self Determination Knowledge Development Workgroup, 2002).

Supported Education: Supported Education is defined by where it is provided (i.e., a normal educational setting) rather than a mental health setting. The person is supported in an array of methods to meet the academic and social challenges of education (Danley, Sciarappa, & MacDonald-Wilson, 1992). Anthony, Cohen, Farkas, and Gagne (2002) point out that a comprehensive array of services designed to support educational goals typically includes three prototypes of supported education: a self-contained classroom in a natural setting like a community college or university (Unger, Danley, Kohn, & Hutchinson, 1987); mobile support that permit students to attend regular classes (Sullivan, Nicoletti, Danley, & MacDonald, 1993); and, finally, on-site support where students attend regular classes with support from that particular educational institution.

Supported Employment: Supported employment is defined in the Rehabilitation Act, Section 7(35):

Supported employment means competitive work in integrated work settings, or employment in integrated work settings in which individuals are working toward competitive work, consistent with the strengths, resources, priorities, concerns, abilities, capabilities, interests, and informed choice of the individuals, for individuals with the most significant disabilities—for whom competitive employment has not traditionally occurred; or for whom competitive employment has been interrupted or intermittent as a result of a significant disability. The individual must need intensive supported employment services...and extended services after...transition.

Vocational Rehabilitation System: In the field of mental health, the term **Vocational Rehabilitation System** is used to refer to the state VR organization. The term “vocational rehabilitation services” often refers to all programs that serve individuals with serious psychiatric disabilities with the goal of developing work capacity. Federal Regulations (34 CFR 361.48) state that the scope of vocational rehabilitation services for individuals with disabilities:

As appropriate to the vocational rehabilitation needs of each individual and consistent with each individual’s informed choice, the designated State unit must ensure that . . . vocational rehabilitation services are available to assist that individual with a disability in preparing for, securing, retaining, or regaining an employment outcome that is consistent with the individual’s strengths, resources, priorities, concerns, abilities, capabilities, interests, and informed choice.

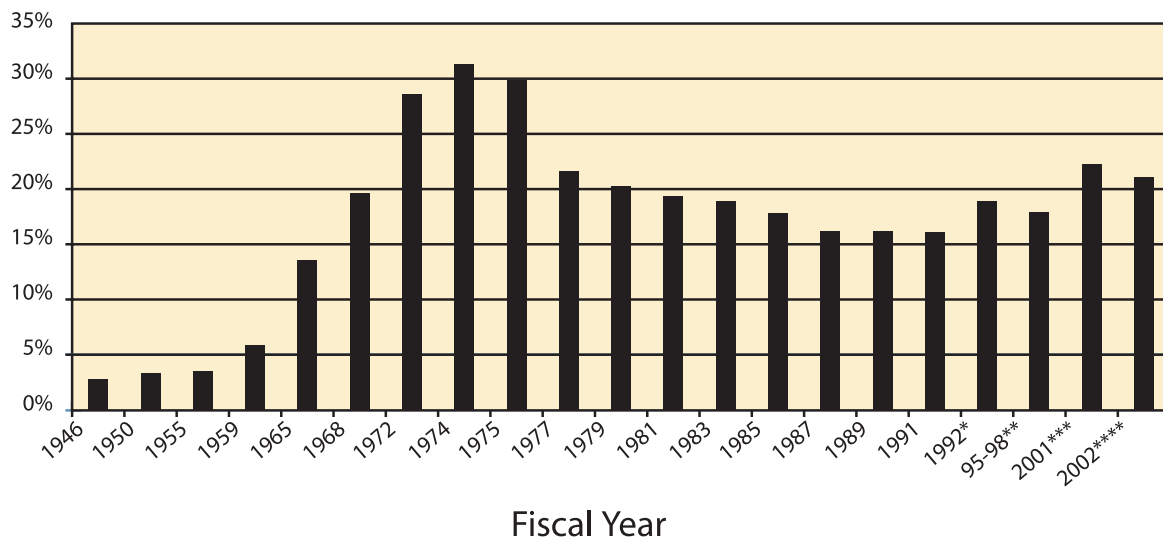
Services include assessment to determine eligibility; assessment to determine vocational rehabilitation needs; counseling and guidance; referral services; physical and mental restoration services; vocational and other training services; maintenance; transportation; VR services to other family members; interpreter services; reader services; job-related services; supported employment services; personal assistance services; occupational licenses, tools, equipment, initial stock, and supplies; rehabilitation technology; transition services; technical assistance and other consultation services to conduct market analysis, develop business plans, and otherwise provide resources to individuals who are pursuing self-employment or telecommuting or establishing a small business operation; other goods and services necessary for achievement of an employment outcome.

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Appendix B

■ Percentage of Persons with Psychiatric Disabilities Served by Public VR Program



*Data from RSA PAR—based on all eligible persons with psychiatric disabilities who exited the VR program after receiving services.

**Data from A Longitudinal Study of the VR Program: Third Interim Report—competitive employment outcomes for persons with psychiatric disabilities who exited the VR program after receiving services.

*** RSA 911 Data for FY 2001. Includes all persons with psychiatric disabilities exiting the VR program after receiving services.

****RSA 911 Data for FY 2002. Includes all persons with mental illness exiting the VR program after receiving services.

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Appendix C

RSA Special Demonstration Grantees Serving Individuals with Mental Illness

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The project consists of three inter-related service programs to assist adults with severe and persistent mental illness (SPMI) to obtain and retain employment. Four agencies participate in the project—University of Oregon, Lane Shelter Care (providing shelter and support services), Laurel Hill Center (providing social, vocational, and independent living services), and the regional office of the Oregon Vocational Rehabilitation Division—and will collaborate with employers from the private sector. *The New Jobs Program*, focused on chronically unemployed adults with SPMI, will provide intensive case management services, on-site vocational training, natural supports, peer support groups, and self-directed transition planning. The *Career Development Program* will provide individual career counseling and peer group activities to assist employed adults with SPMI to advance in their careers or to maintain a desired job if it may be in jeopardy. The *Employer Assistance Program* will generate new job opportunities for people with SPMI and create a workplace that supports all employees, including those with SPMI, by implementing a generic approach to natural supports instead of a unique system for people with disabilities.

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Rise, Inc., and a variety of collaborators will develop and operate a self-help career development program, *Career Trek*, for adults with serious mental illnesses (SMI). An ability-based employment model, the project will be operated by and for consumers with SMI, including its project management committee, professional staff positions, and associates (project participants). The project will initiate mentorships with business leaders in private industry; forge partnerships with secondary and post-secondary education programs to increase job skills and supported education programs; promote new business alliances, policies, funding strategies, and systems change within Minnesota's VR service network; and collaborate with consumer advocacy groups to offer self-help training, materials dissemination, and national presentations. Career Trek will integrate its career development services with other mental health treatment, residential, housing and supported living services, job training programs, crisis management, community support services, coordinated case management services, consumer organizations, and business leadership organizations.

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MHASCK is implementing CAREER (Career Achievement through Recovery, Education, and

Employment Retainment) SUCCESS to increase the duration of competitive employment for adults with SPMI from an average of 6 months in a single job to 12 months. The project is modeled after the Village, a program in Long Beach, CA, that successfully diverts consumers from long-term inpatient care. CAREER SUCCESS strategies include providing evening and weekend psychosocial groups designed to promote recovery and support career development; hiring consumers to serve as Life Coaches and provide Warm Line services as support for other consumers; and providing leadership on Treatment Teams to evaluate progress and meet consumer needs. An Advisory Committee includes representatives from state and local agencies, as well as the University of Kansas, Kansas Division of Health Care Policy, COMCARE, and the Kansas Division of Rehabilitation Services.

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The *Employment, Community, Support (ECS) Project* is a horizontally integrated system of housing, employment, and socialization services to improve employment outcomes and advancement potential for adults with long-term mental illness (LTMI) who are homeless or living in supportive or subsidized housing. The project will develop and test a new method for expediting the entry of the target population into existing VR, MH, and workforce systems. The goal is long-term retention and advancement of participants in supported, transitional, or competitive employment, as demonstrated by outcomes of improved job retention skills, improved social and psychological functioning, and entering a long-term vocational training program, or retaining a job for six months or longer, or receiving a

promotion. Service strategies include outreach; vocational, situational and personal assessment, job placement and development; case management and connection to other community resources; job coaching; placement in housing; socialization activities; and follow-along. Services will be looped—participants progress at their own pace, repeating any activities necessary to gain, regain, or retain employment.

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The Columbia River Mental Health Center operates over 150 transitional housing units. The project will use a partnership with a mental health center, its specialized employment program, and local housing resources to facilitate entry into work for persons with the significant disabilities of mental illness and/or substance abuse who are also in need of shelter or transitional housing. The project will also link with the State VR office, one stop career center, offices that administer TANF and GAU funds, community college, and local employers. Project strategies include person focused job planning and placement, rapid job entry, job accommodation and modification, human service training, transitional work experiences, natural supports, and ongoing employment supports. Housing incentives (Section 8 vouchers and extension of short-term shelter stays) will be linked with program participation and completion.

Appendix C

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The Corporation for Supportive Housing will implement *Stepping Up*, a place-based approach to steady employment and career advancement opportunities for individuals with disabilities who are homeless, at-risk for homelessness, or reside in supportive housing. Participants include individuals with disabling conditions resulting from serious and persistent mental illness, drug and alcohol addiction, HIV/AIDS, or other chronic health conditions. Project goals include: (a) increasing integration of employment services among homeless assistance providers, the supportive housing industry, and workforce development systems in Chicago; (b) using an electronic Internet-based application to expedite eligibility determination of project participants by Employment Networks and by the Illinois Office of VR and the Ticket to Work Employment Network; and (c) increasing the capacity of supportive housing providers to offer high quality employment services so that they may qualify as vendors for Illinois VR and the Ticket to Work Employment Network.

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TETRA Corporation will implement a *Career Retention and Advancement (CRA)* project for persons with severe physical and/or mental disabilities in two county areas in Arizona. The CRA will provide extended employment supports, including coordinated post-employment services, supportive counseling, vocational assessments, ongoing vocational and educational guidance and training, and technical assistance to employers and other organizations. Project services will be provided at three levels: on-site with the employer; through an agency-based, open-ended job club and group support meeting; and through case management services with the employee, family member, and other interested parties. CRA will establish service linkages with the Arizona State VR agency, community-based rehabilitation programs, and community employer, labor, educational, and health organizations. CRA will provide training and technical assistance in job accommodation, assistive technology, return to work and transitional work programs, developing standards of productivity, supervisor training, and how to include issues of career retention and advancement in vocational and educational planning, job development, and placement efforts.

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