



# Case Studies

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

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

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

## Abstract

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

## Background

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

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

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

In 2004, BRS and DMHAS made an effort to standardize the employment services offered to include the evidence-based practice IPS model of SE. This included a philosophical shift towards integrated, competitive employment within the DMHAS system, at both the state agency level and the local level amongst the LMHAs. At this time, DMHAS and BRS separated pre-vocational and club house models from the employment system [Note that DMHAS' role in this was the primary facilitator of the change within the mental health

system] and established the requirement that all funds designated as employment services funds were to be used to purchase integrated, competitive employment services, which is consistent with the BRS approach. All 13 LMHAs were assisted to implement the IPS approach.

## Purpose, Goals, and Implementation

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

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

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

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

**Coordinating referrals and service delivery:** Because joint services are offered across the state, the referral process becomes critical in the delivery of joint services. Individuals with MI who enter a community-based organization that holds a DMHAS employment contract generally receive

services directly from that organization. [Note that DMHAS’s 25 employment contracts purchase IPS services and supports only from community-based organizations. Contractors provide the full array of IPS services including engagement, job search, and long-term supports]. However, the employment providers are only authorized to serve people in their own geographic area without the authorization of their original LMHA. As a basic tenet of the IPS approach these organizations partner with either a community-based or LMHA clinical team to provide employment services alongside clinical services. Note that a few community-based organizations also deliver clinical services and would be able to team their employment specialists with their internal clinical treatment.

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

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

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

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

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

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

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

## Coordinating staffing roles and funding

One of the first steps in putting the partnership to work was recognizing what services BRS could provide to customers that DMHAS could not, and vice versa. By doing this, it allowed the two systems to create a continuum of services to their customers including IPS, clubhouses, and career

advancement services for individuals who may not require the level of support provided by IPS. Before any services are provided, the two agencies have a conversation with the customer and his / her family and peers to agree on common short and long-term goals. Then the agencies decide on what services can be provided by each agency to best meet those goals. An explanation of this process was given by one of the counselors:

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

DMHAS provides the initial engagement, early placement and supports in a job with a small number of hours, and long-term supports. BRS tends to act as a vehicle for moving customers forward in their employment and opens cases when customers are more stable and farther along in their recovery. While BRS may not open a case until later in the service delivery process, they are involved in the initial discussions and can offer advice on activities a customer can be working on to continue progressing towards successful employment and building supports.

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

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

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

If a BRS customer needs services that are not offered by BRS or DMHAS, BRS will pay for a vendor to provide those

services. However, for services offered by one of the LMHAs, the BRS customer will be referred to the employment specialist, and those services will be funded by DMHAS. It must be remembered that there is no standardized process for funding joint customers as of yet; only flexible guidelines. As one of our key informants said, *“the rules are just different for each person and each LMHA.”* But staff at both agencies continue to formalize protocols for the interagency teams with the understanding that the specific continuum of services will differ for each shared consumer.

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

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

BRS and DMHAS continue to utilize the model under which a VR counselor works closely with the LMHAs but not in the physical office. The key informant reports that the model of having a BRS counselor work closely with the LMHAs is feasible and works well. There are, however, challenges that

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

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

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

community employment providers. Trainings from this grant were geared toward the employment supervisors of DMHAS employment providers. The MIG-grant also funded trainings for “peer staff in the DMHAS system” and the development of a computer-based “soft skills” training for young adults.

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

Training and technical assistance is ongoing for the local interagency teams. The Education Consultant met with both the LMHA and BRS staff separately to discuss the elements of the teamed approach. She then attended the new teams’ initial meetings to develop collaborative protocols that focused on several key strategies: each system designating a point person to serve as the liaison for their agency, regular meetings where on-going cases and potential referrals would be discussed and joint employment plans initiated, training for the staff of both agencies, and a commitment to on-going communication. Where BRS contracts with a Community Rehabilitation Provider, that agency would also attend the meetings, as would other members of the consumer’s treatment team, family members, and others they invite to the table.

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

## Supporting Evidence

BRS, DMHAS and the University of Connecticut Center on Aging signed a Memorandum of Understanding (MOU) under which the university collected data to evaluate the effectiveness of the co-located counselor model<sup>2</sup>. In 2011, the University conducted a study to collect outcome data for customers receiving services from LMHAs that have co-located VR counselors (Kellett et al., 2011). As a part of this study, the University also evaluated the customers’ level of satisfaction with services. Interviews with customers receiving employment services as a part of this co-located counselor model demonstrated that the majority of individuals who participated in this study reported to be “very” or “somewhat” satisfied with the employment and VR services provided as a part of this model; additionally, all study participants who were employed reported satisfaction with their current job (Kellett et al., 2011). According to the key informant, the findings from this study also demonstrated “that the consumers that had this wraparound service had higher rates of employment and also had higher wages.” In addition to these evaluation efforts, DMHAS recently developed a comprehensive data collection system to collect employment outcome data using selected indicators that they think will be meaningful. The data points being collected are: placements, date of placements, date of the ending of a placement, number of hours, entry level wage, job title, and company title. All of DMHAS’ provider agencies are now entering those data and DMHAS hopes to have mechanisms in place in the future for retrieving reports, reviewing data, and for agencies to review their own data.

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

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

to help familiarize the BRS staff with the IPS model. Mechanisms such as these help build the relationship between DMHAS and BRS by promoting and measuring the progress of the partnership.

## Future Directions

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

## Transferability

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

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