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POLICY AND PRACTICE: AN ANALYSIS OF
THE IMPLEMENTATION OF SUPPORTED EMPLOYMENT IN NEBRASKA

by

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A DISSERTATION

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POLICY AND PRACTICE: AN ANALYSIS OF THE IMPLEMENTATION OF
SUPPORTED EMPLOYMENT IN NEBRASKA

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Supported employment (SE) is an evidence-based practice (EBP) for persons with severe mental illness (SMI) aimed at competitive employment. SE has a large evidence base, demonstrating outcomes across settings and populations. SE has been promoted by the Centers for Medicare and Medicaid Services (in the U.S. Department of Health and Human Services) and widely disseminated through the internet via a “community tool-kit” sponsored by the Substance Abuse and Mental Health Services Administration.

The SE literature expresses the opinion that state governments can successfully implement SE. Researchers have developed implementation guidelines and identified stages of statewide implementation; however, most SE implementation studies have taken place with generous funding, full-time training/consultation from foremost SE experts, and supportive, knowledgeable top-level administrators. Much less is understood about EBP implementation in the absence of such resources. This is a critical issue: state mental health systems profess the delivery of evidence-based psychiatric rehabilitation services; yet most persons with SMI fail to receive evidence-based care. To address these questions, the present study examines one state mental health system to determine the populations served, fidelity to the evidence-based model, outcomes, relevant contextual factors, and comments on

current problems surrounding the implementation of recovery-oriented, evidence-based services for SMI into everyday settings.

Seven of the 9 Nebraska SE programs did not meet SE fidelity. Employment outcomes achieved were characteristic of traditional vocational rehabilitation programs. Over time, programs served a decreasing proportion of individuals with schizophrenia-spectrum disorders, the population for which this EBP has been validated. Assessment and treatment plan review procedures were driven by the reimbursement structure rather than the principles of psychiatric recovery and rehabilitation. Programs demonstrated limited understanding of EBP, recovery and psychiatric rehabilitation. The implementation of SE occurred within the greater context of a statewide trend of closing nearly all inpatient hospital units—despite recognition that effective mental health systems for persons with SMI must successfully implement EBPs *and* provide a comprehensive continuum of care to adequately address the multiple needs of this population. Careful consideration of implementation factors should be included in further research and policy pertinent to dissemination of EBPs to adequately address the research-practice gap.

DEDICATION

To my family:

奶奶, 爺爺,

爸爸, 媽媽, Edward, Siyareh,

and the newest member of our family, Kai.

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As the capstone requirement for graduate school, this work represents an entire intellectual journey rather than a single project. For this reason, I am uncomfortable identifying myself as the sole author of this work, for its intellectual progenitors are many. During the past few years, I have had the privilege of learning from a number of individuals whose generous guidance and instruction have indelibly shaped by thinking. It is a sizable debt that I have incurred—not one that will soon be paid in full.

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Policy and Practice: An Analysis of
the Implementation of Supported Employment in Nebraska

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INTRODUCTION TO THE STUDY

There is compelling evidence that psychosocial and rehabilitation services significantly improve the independent functioning and clinical outcomes of persons with severe mental illness (SMI) (reviewed by Dixon, Dickerson, Bellack, Bennett, Dickinson, Goldberg, et al. 2010; Mueser and McGurk, 2004; Miller, Crismon, Rush, et al., 2004). National directives subsequently mandated the widespread use of these interventions (U.S. Surgeon General, 1999; President's New Freedom Commission on Mental Health, 2003). Despite this, research continues to reveal that the great majority of people with SMI *do not* receive quality care (Lehman & Steinwachs, 1998; Drake, Bond, & Essock, 2009).

Supported employment (SE) is an evidence-based practice (EBP) that promotes the recovery and rehabilitation of persons with SMI, specifically through assisting an individual obtain and maintain competitive employment.¹ A large evidence base exists on the efficacy of evidence-based SE (for a recent systematic review see Bond, Drake, & Becker, 2008; Bond, 2004; Burns, Catty, Becker, Drake, Fioritti, Knapp, Lauber, et al., 2007; Gold & Waghorn, 2007; Lehman, Goldberg, Dixon, McNary, Postrado, et al., 2002). Effectiveness research on SE has demonstrated successful clinical outcomes across settings, such as the Veterans Affairs healthcare system (Resnick & Rosenheck, 2007). Successful employment outcomes have been achieved among difficult-to-treat populations, such as homeless persons with co-morbid substance abuse problems (Rosenheck & Mares, 2007) and those residing in the inner city (Drake, McHugo, Bebout, Becker, Harris, et al., 1999). There has been substantial endorsement of SE. The Centers for Medicare and

Medicaid Services (CMS), an arm of the U.S. Department of Health and Human Services, issued a report to encourage state governments to adopt and implement SE (CMS, 2009). SE has been widely disseminated through the internet via community tool-kits sponsored by the U.S. Substance Abuse and Mental Health Services Administration (Becker & Bond, 2002; Substance Abuse and Mental Health Services Administration, 2010b). Tool-kits are packages consisting of procedure manuals, assessment instruments and related materials, staff training and program development consultation.

The SE literature anticipates implementation and promotes SE as “implementation ready” (Drake, Goldman, & Leff, 2001; Drake, Skinner, Bond, & Goldman, 2009). SE researchers have published guidelines for the statewide implementation of SE (Becker, Lynde, & Swanson, 2008) and identified stages through which SE should be implemented (Rosenheck, 2001a). The resources available for SE appear adequate and conducive to the effective uptake and application of this EBP by state governments.

Nevertheless, whether the real-world implementation of SE programs by state governments can approximate the program functioning and outcomes demonstrated by the SE efficacy and effectiveness research is unclear. Despite several publications on the implementation of SE, relatively little is understood about this process by real-world implementers, especially by state governments. Although SE implementation studies have focused on the application of SE in real-world settings, these studies often emphasize rigorous control of the implementation process with training and consultation by recognized experts. Most of the SE implementation research has

taken place with large-scale federal grant funding, full-time training and consultation from foremost SE experts, and support from knowledgeable top-level administrators. These studies are therefore better understood as *effectiveness research*. Effectiveness research seeks to determine the impact of an intervention as it is implemented in a realistic or real-world setting, while implementation research seeks to identify the factors that facilitate or inhibit the implementation process itself. Although these are obviously closely related, they address two separable and equally important domains. A recent study illustrates this point. After demonstrating, using a “case study” analytic approach, that 9 programs could successfully implement SE after extensive training and consultation, Bond and colleagues (2008) surmise that their work may not necessarily reflect real-world implementation: “Their top-level administrators could be assumed to be highly motivated and that this affected the implementation. If so, attempts by states to implement evidence-based supported employment in non-volunteering sites may face different dynamics that could slow achievement of high fidelity. What impact did the quality of the consultant/trainers have on the success? The three consultant/trainers were exceptional professionals with much experience in supported employment and in providing consultation. Would the level of success achieved by these sites have been less with less qualified consultant/trainers? These questions must await future research” (Bond 2008 p. 304-305).

The National Institutes of Mental Health has recommended that studies addressing the gap between research and practice should be conducted in real-world settings and should target translational processes that enhance relevance for practice (National Advisory Mental Health Council, 1998). Although support from top-level

administrators is recognized as one of many factors involved in the complexity of implementation of SE by state governments, there has been relatively little consideration of the organizational and contextual aspects of the implementation process in the literature. Meanwhile, developments have been ongoing in implementation research, which has become recognized as a new branch of health services research. Implementation research incorporates program evaluation, process monitoring and an impact analysis, but also goes beyond—to address questions of context and organizational processes in order to understand how the greater system affects the implementation of evidence-based care.

The present study is an analysis of implementation of SE by one state government. In 2007, the Nebraska Department of Health and Human Services initiated statewide implementation of SE programs. This occurred in the context of a legislative mandate to downsize the state hospital system and shift resources to community-based mental health care. The primary purpose of the analysis is to measure the success of the state initiative, measured by successful implementation of SE programs. A secondary purpose is to identify factors that enhance or inhibit successful implementation. Although this analysis is restricted to 9 SE programs within a single state, the results are potentially generalized, to the degree that the factors that enhance or inhibit implementation are present in other venues.

The analysis begins with a description of the historical context of treatment for persons with SMI and the development of psychiatric rehabilitation and evidence-based practice, in Chapter 1. Next, Chapter 2 provides a critical analysis of the SE literature, including research on its efficacy, effectiveness, and implementation.

Chapter 3 includes an overview of the political and legal context within which this implementation occurred, as well as a description of the state-specific modification and training that characterized the implementation of SE in Nebraska. Chapter 4 includes a presentation of the major hypotheses of the study, followed by the methodology (Chapter 5), and the results of testing relevant hypotheses (Chapter 6). Finally, Chapter 7 provides a discussion of these findings, major strengths and limitations of the present study, and implications for future statewide implementation efforts and implementation research.

CHAPTER 1

Recent Developments in the Treatment of Severe Mental Illness

Deinstitutionalization and Community-Based Treatment

Understanding treatment for severe mental illness (SMI) requires an understanding of the organization and disorganization of the greater healthcare system, in ways that other health conditions do not. The category “SMI” is generally understood to comprise those individuals who have symptoms and functional disabilities most consistent with a broad spectrum of diagnostic categories of mental illnesses resulting in severe and persistent disabilities (Spaulding, Sullivan, Poland, & Ritchie, 2010). SMI might generally comprise diagnoses such as schizophrenia, schizoaffective disorder, bipolar disorder, and major depression with psychotic features (Lamb & Bachrach, 2001).

The most prominent change in the last half-century of mental health services for persons with SMI has been deinstitutionalization (Scott & Black, 1986). It seismically shifted the organizational arrangements through which mental health services were provided. Beginning in the 1950s, the locus of care shifted from centralized state hospitals to small, varied community-based settings (Scott and Black, 1986). With the shift has come the development of a variety of community-based programs (e.g., Dixon, 2000).

Lamb and Bachrach (2001) describe three main components of deinstitutionalization: 1) the release of individuals from hospitals and into the community, 2) their diversion from hospital admission, and 3) the development of

alternative community resources. Several state hospitals were closed and there was a subsequent effort to relocate people into alternative community-based settings. This process was driven mostly by economics (Hunter, 1999) but also by ideology—in particular, the principles of freedom and choice (Geller, 2001).

The rate at which hospitals were closed however, was much higher than the rate at which adequate and accessible community alternatives were provided (The past and future, 2000). As a result, large proportions of persons with SMI are now homeless or suffer from inappropriate incarceration (Lamb, 1993). The prison system has been identified as the largest mental health system currently available for persons with SMI (The past and future, 2000). Put another way, the effect of deinstitutionalization has been that “we tend to allow the provision of inadequate services to exist in the name of freedom and choice...and we have as a result a mental-health system in the 21st century that is looking more and more like the one we had in the 18th century (p.40)” (Geller, 2001).

Though the provision of community-based services was insufficient and largely inadequate, there was a growth in the *variety* of services being provided, many of which have never established evidence that they were effective (e.g., Catty, Burns, Comas, & Poole, 2008). These facilities include county and private psychiatric hospitals, general hospital psychiatric units, Veterans Administration psychiatric services, Community Mental Health Centers, residential treatment centers, and freestanding outpatient clinics and psychiatric day-night facilities (Geller, 2001). Non-mental health organizations also began to serve large numbers of persons with SMI. These included clinics and hospitals, nursing homes, board-and-care homes,

and halfway houses, (Geller, 2001). The mental health sector was being filled with an assortment of ever-changing organizations: “It is a massively expanded system, and it is massively disorganized” (Meyer, 1984, p. 24).

The underlying assumptions of community policies and services fueled the inadequate provision of mental health services. These included the following beliefs: 1) persons with SMI have a home; 2) persons with SMI have a supportive and sympathetic family or caregiver willing and able to assume responsibility for their wellbeing; 3) the organization of the household does not impede rehabilitation; 4) the presence of the person with SMI does not cause undue hardships for other family members; and 5) social support networks and occupational opportunities are available (Grob & Goldman, 2006). Research over the past decades has consistently challenged these assumptions: 1) many persons with SMI go homeless (Lamb, 1993); 2) expression of criticism and emotional over-involvement has been found in over half of caregivers (Marom, Munitz, Jones, Weizman, & Hermesh, 2005); 3) caregivers’ expressed emotion contributes to later relapse and re-hospitalization (Marom, et al., 2005); 4) the presence of a person with SMI places a significant burden on family caregivers (Winefield & Harvey, 1994); and 5) limited social support and occupational opportunities are perennial barriers to greater achievement of independent functioning among persons with SMI (Bowie, 2010). The last point has been driven home by journalistic accounts of the lack of adequate services, discrimination, and other societal and environmental barriers experienced by persons with SMI (e.g., New York Times, September 8, 2009).

A more fundamental error of these community policies lays in its conceptualization of SMI. Many policies assume homogeneity among the SMI population and impose a broad, “one size fits all” treatment approach, neglecting the well-acknowledged diversity on many dimensions relevant to treatment and policy. Yet, heterogeneity in SMI has been noted since the first conceptualizations of SMI. Blueler, the Swiss psychiatrist who first coined the term *schizophrenia*, described the clinical picture in this way: “no single unifying denominator could be discovered in the chaos of the variegated clinical pictures of the deteriorating process (p.ii)” (Blueler, 1911). The so-called “homogeneity myth” (p. 328) has significantly misguided policies and continues to undermine and compromise reform (Spaulding et al., 2010). The formation of SMI policies overlooks the heterogeneity that characterizes SMI and as a result, policies do not fulfill their intended function of meeting the treatment needs of persons with SMI.

The homogeneity myth led to the belief that all persons with SMI could be treated in non-institutional settings, which contributed toward the deinstitutionalization policies that continue to this day. Despite the variety of community-based services that developed over the years, one unrelenting concern was whether they would ever be able to meet the needs of *all* persons with SMI (Lamb & Bachrach, 2001). For example, community-based services might not be appropriate for a violent person who might be more appropriate for a traditional state hospital (Lamb & Bachrach, 2001). Considering the heterogeneity reflected in the SMI population, researchers have stressed that there are subsets who may not benefit from even the best community programs, highlighting that mental health services

must address the *entire continuum* of persons with SMI, who demonstrate various fluctuating levels of functioning, progress, and deterioration (Wasow, 1986). Experts in this area have called for an extensive continuum of effective care that reflects the diverse needs of the population (Wasow, 1986).

In summary, several major lessons were learned from deinstitutionalization that can inform care for persons with SMI (Lamb & Bachrach, 2001): 1) successful deinstitutionalization involves more than simply changing the locus of care; 2) service planning must be tailored to the unique needs of each individual; 3) hospital care must be available for those who need it; 4) services must be culturally relevant; 5) persons with SMI must be involved in their service planning; 6) service systems must not be restricted by preconceived ideology; and 7) continuity of care must be achieved.

Recovery and Psychiatric Rehabilitation for Persons with Severe Mental Illness

The need for overhauling the system that serves people with severe mental illness (SMI) was brought into sharp focus by a presidential commission report, The President's New Freedom Commission on Mental Health (2003), a scathing indictment and a call for federally sponsored reform. Traditionally, care for persons with SMI has largely rested in the domain of medical care with the use of antipsychotic medications alone (Levant, Reed, Ragusea, DiCowden, Murphy, Sullivan, et al., 2001). Although antipsychotic medication is generally considered a *sine qua non* in treatment of SMI, there are growing concerns about its true effectiveness. For example, questionable prescribing practices leading to the high rate of use of antipsychotic medications was recently examined in an article published

in the *Journal of the American Medical Association* (Kuehn, 2010), the premiere organ of the American medical establishment. The study suggests that the use of antipsychotic medications far exceeds their actual need and known benefits and risks, and further suggests that this has been driven by practitioners' misperceptions. It is highly likely that the aggressive and pervasive role of the pharmaceutical industry in research, marketing and practice has played a role in this misperception, as suggested in both scholarly and journalistic accounts (e.g., Elliott, 2010; Whitaker, 2010).

Recovery and psychiatric rehabilitation developed out of the service gaps in care for persons with SMI. Historically, it was derived from the physical rehabilitation model and highlighted several similarities between physical and psychiatric disabilities. These include handicaps in role performance, the need for a wide array of rehabilitation, medical and human services, and a subset of the group who may not experience complete recovery from disabilities (Anthony, Cohen, & Danley, 1988). Anthony and colleagues (1988) describe psychiatric rehabilitation as targeting psychiatric disabilities: "...the *impairment* of structure of function can lead to *disability*—that is, decreased ability to perform certain skills and activities—and limit the person's fulfillment of certain roles—in other words, create a *handicap* (p. 60)." By targeting the development of both client skills and environmental resources, individuals with SMI can perform activities necessary to fulfill the demands of living, learning and working roles (Anthony, Cohen, & Danley, 1988).

That recovery is possible for persons with SMI is fundamental to psychiatric rehabilitation. Research in this area was spurred on by longitudinal studies revealing higher than expected recovery rates among even the most chronic and disabled

populations (Harding, Brooks, Ashikaga, Strauss, & Breier, 1987a; Harding et al., 1987b; Harding, 1995; DeSisto, Harding, McCormick, Ashikaga, & Brooks, 1995; Harrison, et al., 2001). Although complex to measure, recovery is the primary focus of psychiatric rehabilitation (Anthony, 1979; Freese, Knight, & Saks, 2009; Liberman, 2008). Psychiatric rehabilitation is aimed at the maximization of self-sufficiency and functioning that is distinguished from symptom stabilization (Dobson, McDougall, Busheikin, & Aldous, 1995). Comprehensively integrating the biological, psychological, behavioral, and socio-environmental domains, it utilizes an armamentarium of *individualized* functional assessment and treatment techniques that provides a tailored prosthetic environment to reverse or compensate for impairments. It is aimed at developing the skills necessary for independent functioning to reduce disability and maximize environmental adaptation (Silverstein, 2000; Liberman, 2008) while simultaneously recognizing the diverse needs among this population (Spaulding et al., 2010). Psychiatric rehabilitation programs successfully restore functioning in even the most severe, treatment-refractory populations (Spaulding, Reed, Sullivan, Richardson, Weiler, 1999; Brekke, Hoe, and Green, 2009; Brekke, Hoe, Long, and Green, 2007).

Although antipsychotic medication is often thought to be the only treatment for these “brain disorders,” medication simply suppresses the symptoms of acute psychosis. Moreover, the proportion of individuals who experience no benefit from typical antipsychotics is estimated to be 20% or higher; almost none who do benefit from these medications undergo a complete remission of symptoms and recovery of functioning (Spaulding, Sullivan, Poland, & Ritchie, 2010). In contrast, the empirical

literature indicates that *psychiatric rehabilitation*—an array of recently developed techniques designed to access individual strengths and resources in order to build competencies for independent living, often used in combination with medication—actually holds out hope for recovery (Coursey, Alford, & Safarjan, 1997). As a profession, psychology has been identified as a field to make an extremely important contribution to the care and treatment of persons with SM (Levant, et al., 2001). Except for antipsychotic drugs, the specific techniques of psychiatric rehabilitation are essentially psychological in nature.

Clinical psychologists have led the effort to develop and evaluate psychological rehabilitation and recovery methods (e.g., Anthony, 1993) and is arguably the discipline best positioned to design and implement these methods and to supervise other staff members in providing them. Psychologists can also provide other evidence-based practices specifically designed for this population (e.g., Bellack, Mueser, Gingerich, & Agresta, 1997; Dixon & Lehman, 1995; LeCompte & Pelc, 1996; Scott & Dixon, 1995). Updating the list of evidence-based components in the rehabilitation armamentarium has been an important feature of the scientific literature (e.g., Dixon, Dickerson, Bellack, Bennett, Dickinson, et al., 2010).

Evidence-Based Practices (EBPs)

The original push to delineate evidence-based practices (EBPs) from non-EBPs has roots in the growing costs of health care and inadequacies of health care systems to meet health care needs. The growing costs but low quality of the American health care system has been documented by social scientists (Gelman, January 10, 2011). Its beginning is generally dated to 2001, when the Institute of

Medicine issued a call for the improvement of health care quality and the need to be evidence-based (Institute of Medicine, 2001). Quality regulations were mandated through legislation and many governments began to become more actively involved in regulating health care systems (National Committee for Quality Assurance, 2004).

Following suit, the American Psychological Association (APA) adopted the EBP guidelines by publishing a document indicating that guidelines for best practices would facilitate the implementation of EBP in health care systems (American Psychological Association, 2006). Clinical care guidelines were identified as the way in which systems attempt to standardize the quality and costs of care, stating that they are in some ways, assuming the place of law (Barlow, 1999).

The provision of EBPs by mental health systems also has significance for the consumers of mental health services. In addition to pushing for the provision of more efficient, cost-effective and high quality services, EBPs are a vital part of any mental health care delivery system for more social values. There is consensus that social values for consumers should guide mental health services for persons with SMI (Nebraska Department of Health and Human Services 2006). As described by the Academic Workgroup: “Services systems that do not use any particular Best Practice are not simply lower quality or less complete than those who use exclusively Best Practices. They are deficient, and in need of repair. In all aspects of healthcare, including mental health, consumers have a right to expect complete and comprehensive observance of Best Practices, to be treated with dignity and respect and to make informed choices (p.3)” (Nebraska Department of Health and Human Services, 2005).

There have been several efforts to disseminate EBPs so that they are widely available. The Substance Abuse and Mental Health Services Administration (SAMHSA), as part of its “8 Strategic Initiatives” has sought to actively share information about EBPs using web-based material to reach the general public and providers, among others (SAMHSA, 2010a). SAMHSA developed the community tool-kit to assist healthcare service delivery systems implement EBPs (SAMHSA, 2010b). The kit is geared towards program planners, administrators, project managers and professional care providers, with a focus on practice principles. Although intended to be a resource, SAMHSA does not explicitly state whether the kit alone is to be used as the primary source of implementation. Dissemination encompasses not only the ability to generalize a specific treatment shown to be effective in the lab towards community-based settings. An additional step is the adaptation of these treatments to be delivered in specific settings.

In particular, commercially developed bundles of services are provided in an entrepreneurial context and packaged and marketed and sold to service providers or service systems. One example of these packages is the or tool-kit assembled by researchers or government agencies for the purposes of studying dissemination, use and the effectiveness of modalities contained in the bundles (SAMHSA, 2010a). These tool-kits have produced several packages to assist mental health systems develop community-based EBPs for persons with severe mental illness (SMI).

In summary, the conditions created by deinstitutionalization have converged with the evolution of psychiatric rehabilitation, and with the emerging values of evidence-based practice, to produce a demand for specific rehabilitation modalities of

demonstrable effectiveness for enhancing the community functioning of people with SMI. The present study focuses on one such modality, the evidence-based individual placement and support model of supported employment (SE).

CHAPTER 2

Supported Employment:

Efficacy, Effectiveness, and Implementation

Psychiatric Rehabilitation and Vocational Outcomes

As described earlier, the psychiatric rehabilitation model focuses on skill development and the provision of adequate environmental supports. In the late 1980s, psychiatric rehabilitation researchers examined vocational outcomes in persons with SMI and called attention to the following: 1) psychiatric symptoms do not predict vocational outcomes; 2) psychiatric diagnoses do not predict vocational outcomes; 3) measures of psychiatric symptoms are not correlated with an individual's skills; 4) skills do predict vocational outcomes; and 5) training in critical vocational skills improves vocational outcomes (Anthony, Cohen, & Danley, 1988). Empirically supported psychiatric rehabilitation for employment recognizes relationships between vocational functioning, client characteristics and program ingredients (Anthony, Cohen, & Danley, 1988).

Five considerations have been proposed for the development of vocationally focused psychiatric rehabilitation programs for persons with SMI. These include: acknowledging client values and strengths, providing the client with access to a network of learning and working environments; providing the client with activities designed to increase vocational maturity; providing the client with activities and environments that enhance self-esteem; and the use of psychiatric rehabilitation approach of assessment, planning and intervention (Anthony, Cohen, & Danley, 1988). This three-pronged approach (assessment, planning, and intervention) is

critical to psychiatric rehabilitation targeting vocational outcomes (Anthony, Cohen, & Danley, 1988). Assessment in psychiatric rehabilitation for vocational outcomes is focused on a practical description of an individual's current level of skill functioning and environmental supports in relation to the environment in which the individual is functioning (Anthony, Cohen, & Danley, 1988). Planning consists with a rehabilitation plan that specifies how to change a person's skills or environment to achieve the vocational goals, and the overall goal specifies the specific environment or setting in which the work related to a desired outcome will be performed (Anthony, Cohen, & Danley, 1988). In this plan, planned interventions are directly related to the individual skills or resources a client will need to function successfully in a specified environment (Anthony, Cohen, & Danley, 1988). Finally, intervention consists of carrying out the plan with a focus on improving an individual's skills or providing supports in the work environment. When clients cannot perform a skill, they are taught this skill. When there are problems related to applying these skills in a particular environment, a step-by-step procedure is developed to overcome the specific barriers to applying these skills in this work environment (Anthony, Cohen, & Danley, 1988).

Supported Employment

Evidence-based supported employment (SE) focuses on helping persons with severe mental illness (SMI) obtain and maintain competitive employment. In SE, competitive employment is the rehabilitation goal, and a priority is placed on consumer job preferences (Anthony, 2008). Originally developed for people with

developmental disabilities (Wehman & Kregel, 1985), SE was later adapted for persons with SMI (Anthony & Blanch, 1987).

Evidence-based SE diverges from traditional vocational rehabilitation methods in several respects. Traditional vocational rehabilitation utilizes stepwise methods, brokered approaches, and the provision of generic employment training. In contrast, SE uses direct methods of intervention, integrated approaches, and assists individuals adapt to specific environments (Mueser, Drake, & Bond, 1997; Bond, 1998). A diverse group, supported employment programs that are not evidence-based are often more characteristic of the program originally developed for persons with intellectual disabilities. In this way, these programs may provide services more consistent with supported employment services for persons with intellectual disabilities (e.g., job coaching and job supports) but not unique to persons with psychiatric disabilities (e.g., no integration of vocational services with mental health treatment).

Evidence-based SE appears congruent with the goals of psychiatric rehabilitation (Anthony, 2008). The program is a response to the consistently expressed aspiration by people with SMI that they want to work (McQuilken, Zahniser, Novak, Starks, Olmos, et al., 2003) and that the jobs they desire generally correspond with those that they are able to attain (Becker, Bebout, & Drake, 1998). SE is also described as promoting consumer empowerment and decreasing both societal and self-stigma (Corrigan, Larson, & Rusch, 2009). For state governments, implementing SE provides evidence that the greater mental health system is characterized by recovery-oriented and rehabilitation-focused services, which is

consistent with the President's New Freedom Commission on Mental Health (2003). SE is also promoted as a program that can reduce disability among persons with SMI who receive Social Security benefits (Drake, Skinner, Bond, & Goldman, 2009), and by inference, reduce those who rely on these and similar benefits (e.g., Medicaid).

Efficacy and Effectiveness: The Individual Placement and Support Model

From its definition, SE is aimed at assisting individuals with SMI achieve and maintain competitive employment. As SE began garnering a strong evidence base in the 1990s, a fidelity scale was subsequently developed (Bond, Becker, Drake, & Vogler, 1997). The Individual Placement and Support model (IPS; Drake and Becker, 1996; Becker and Bond, 2003) is the standardized, evidence-based version of SE. It focuses on quickly placing individuals into competitive employment and provides them with environmental supports (e.g., job coaching, integration with mental health treatment, provision of support in the community) to help individuals perform successfully in the workplace.

Fidelity to the IPS model is identified as one of the most important predictors of successful outcomes in SE programs (Bond, 2004; Corbiere, Bond, Goldner, and Ptasinski, 2005; Burns et al., 2007). This evidence-based model of SE is associated with success in helping persons with SMI achieve and maintain competitive employment. Since the development of the fidelity scale, fidelity has been consistently associated with employment outcomes (Becker, Smith, Tanzman, Drake, & Tremblay, 2001; Becker, Xie, McHugo, Halliday, & Martinez, 2006; Catty, Lissouba, White, et al., 2008; Gowdy, Carlson, & Rabb, 2003; Hayward & Schmidt-Davis, 2003; McGrew & Griss, 2005; McGrew, 2007). Programs with high fidelity

demonstrate the most successful outcomes (Bond, 2004; Corbiere, Bond, Goldner, and Ptasinski, 2005).

There is a strong evidence base for SE. Studies consistently indicate superiority over traditional vocational rehabilitation interventions (Drake, McHugo, Becker, Anthony, & Clark, 1996; Bond, Drake, Mueser, and Becker, 1997; Bond, 2004; Burns, Catty, Becker, Drake, Fioritti, Knapp, Lauber, et al., 2007; Gold & Waghorn, 2007; Lehman, Goldberg, Dixon, McNary, Postrado, et al., 2002; Drake and Bond, 2008; for a recent systematic review see Bond, Drake, & Becker, 2008). Several randomized controlled studies reveal the efficacy of SE in producing competitive employment outcomes (for a meta-analysis, see Twamley, Jeste, and Lehman, 2003). For example, a multi-site randomized clinical trial of SE with 1,273 persons with SMI at seven sites in the U.S. demonstrated its effectiveness in achieving competitive employment outcomes that were maintained at 2-year follow-up (Cook, Leff, Blyler, et al., 2005). A review reports that approximately 40-60% of people with SMI obtained competitive jobs compared to about 20% of those in the control conditions (Bond, 2004). Compared to controls, those in SE programs achieved more competitive employment, higher earnings, and did not demonstrate higher stress levels and increased re-hospitalization rates (Cook et al., 2005). Moreover, when people transitioned from day treatment programs to SE programs, they did not have a higher rate of relapse than those in the control (Bond et al., 1997).

Effectiveness research on SE has demonstrated that it can produce successful clinical outcomes across settings, such as the Veterans Affairs healthcare system (Resnick & Rosenheck, 2007). Successful employment outcomes have been achieved

among difficult-to-treat populations, such as homeless persons with co-morbid substance abuse problems (Rosenheck & Mares, 2007), and those residing in the inner city (Drake, McHugo, Bebout, Becker, Harris, et al., 1999). SE services that meet high fidelity standards have been successfully delivered across several states in both rural and urban U.S., as well as across Europe (Catty, Lissouba, White, et al., 2008; Burns, Catty, Becker, et al., 2007).

Nevertheless, several challenges remain for SE. There is no theoretical framework about why or how SE works. Although a fidelity scale has been developed, this scale has changed over the years as researchers attempt to pinpoint core components of evidence-based SE (Dartmouth IPS Supported Employment Center, 2011). Researchers have attempted to define the critical ingredients of SE, especially to understand the degree to which evidence-based SE diverges from non-evidence-based versions of supported employment programs. Possible critical ingredients include general principles and practices associated with EBPs and assessment (Evans and Bond, 2008), but no research has identified specific principles and practices. In this sense, SE captures the pragmatic zeitgeist of current EBP development—because it works, it is applied.

Although the underlying principles of SE complement psychiatric rehabilitation and promotes recovery, no study has empirically examined the degree to which IPS adheres to psychiatric rehabilitation and recovery principles, described above (Anthony, 1988). The SE principle of continuous support (i.e., individualized, follow-along supports are provided to employer and consumer on a time-unlimited basis) is arguably at odds with the criterion of competitive employment, and outcome

studies have been criticized for exaggerating outcome in this sense. Thus, through this principle, SE appears to endorse limited expectations about the functional recovery of persons with SMI.

Another challenge for SE is the risk of losing benefits, which remains a major impediment for persons with SMI who desire to work. People with psychiatric disabilities comprise the largest and most rapidly growing subgroup of Social Security disability beneficiaries (Kouzis & Eaton, 2000). The risk of losing the benefits (e.g., losing Medicaid and the subsequent ability to pay for medications) remains a major concern for many persons with SMI. Persons with SMI might be concerned about working too many hours that would disqualify them for benefits and opt against considering employment altogether. Although the Substance Abuse and Mental Health Services Administration (SAMHSA, 2010b) recommends that benefits counseling be provided along with SE, the SE literature has not adequately addressed this major barrier. In one study, Social Security beneficiaries who received SE services achieved superior employment outcomes than those in traditional vocational rehabilitation; however the authors acknowledge that losing benefits remains a significant barrier to achieving good employment outcomes that impacts all persons with SMI enrolled in vocational programs (Bond, Xie & Drake, 2007). Thus, even the best, high fidelity SE programs may be unable to help individuals with SMI achieve full-time, competitive employment or reduce their reliance on benefits.

Implementation of Supported Employment

Any intervention aimed at modifying vocational outcomes also must be effective in supporting the adoption of changes into everyday clinical practice.

Although there is substantial literature on the implementation of SE, it is characterized by a significant amount of resources, which may not approximate real-world implementation.

Several guidelines have been published regarding the statewide implementation of the evidence-based version of Supported Employment (SE). SE researchers have published key strategies for the statewide implementation of SE (Becker, Lynde, & Swanson, 2008). Drawn from experiences assisting 9 different state systems implement the program statewide, researchers describe an implementation process that requires extensive time (requiring 4 years) and funding (supported by a 4-year grant from Johnson & Johnson) (Becker, Lynde, & Swanson, 2008). The four years include the following: the first year consists of building informed support for implementing the program and subsequent years focus on initial implementation with pilot programs and general training of all programs with videos and a full-time consultant (Becker, Lynde, & Swanson, 2008). The authors argue against broad-sweeping implementation without adequate preparation. The authors conclude that individual programs require ongoing assistance and team-based training to sustain high fidelity services, and state-administrators need consultation from SE researchers regarding the impact of the greater regulatory and mental health system (e.g., one that is conducive to the integration of services) (Becker, Lynde, & Swanson, 2008). The authors also conclude that states wanting to implement SE have the following resources: one state-level “champion” (p. 257) with leadership skills, advocacy and knowledge to faithfully guide the implementation process and one full-

time SE trainer and consultant to teach and train skills (Becker, Lynde, & Swanson, 2008).

Although less onerous than those published by the SE developers, the Community Mental Health Tool-Kit for Supported Employment published by the Substance Abuse and Mental Health Services Administration (SAMHSA, 2010b) requires similar requirements for implementation. SAMHSA highlights the need for a similar “champion (p.5)” of EBPs to guide a committee that oversees implementation, extensive training in SE and other evidence-based practices (EBPs), and continual guidance from knowledgeable persons to guide the implementation and participate in the evaluation of the EBP. The kit indicates that adequate implementation requires visiting other model SE programs, developing policies and procedures that are consistent with SE, and developing a training structure to implement SE (SAMHSA, 2010b). SAMHSA (2010b) also recommends a clear articulation of SE principles and goals, the formation of advisory groups, alignment of the funding structure and incentives to be conducive with SE implementation, the development of a training structure and monitoring of the program. SAMHSA (2010b) similarly recommends initially implementing SE in pilot programs and suggests that the first year of implementation should focus on booster training sessions, routine onsite training and telephone consultation and also suggests an annual state-wide conference on SE. SAMHSA (2010b) similarly suggests that agencies may require 2-3 years to become sufficiently proficient in the SE model. SAMHSA (2010b) also recommends a state- or county-wide coordinator who is experienced with the SE model and can help with ongoing contact, assessment and

troubleshooting. Although SAMHSA (2010b) does not require SE experts, it does recommend hiring external trainers for approximately 1-2 years or getting one person initially trained through visiting and observing other SE programs and undergoing extensive training in the SE model.

Adequate implementation of SE requires the coordination of services across agency boundaries and target population focused on persons with SMI (Isett, Burnam, Coleman-Beattie, Hyde, Morrissey, Magnabosco, et al., 2007). In documenting several programs that had undergone transition into SE programs, staff members were usually trained to implement SE, usually by an outside trainer who was knowledgeable about SE and the authors highlight the importance of the executive director being able to communicate recovery ideology and how SE actualizes this vision (Becker, Torrey, Toscano, Wyzik, & Fox, 1998).

As noted above, implementation in the state of Maryland included working closely with SE developers, the implementation of SE in the state of Maryland revealed that 62% of people receiving SE services achieved outcomes, which were defined as 90 consecutive days in competitive, integrated employment, at or above minimum wage, with the person satisfied with the job placement, whereas only 37% of people in other non-evidence-based supported employment programs had successful outcomes (Center for Medicare and Medicaid Services, 2009).

There has been substantial endorsement of SE. The Centers for Medicare and Medicaid Services (CMS; 2009) issued a report to encourage state governments to adopt and implement this evidence-based version of SE. The Substance Abuse and Mental Health Services Administration (SAMHSA) has established SE or the

evidence-based SE as an EBP and incorporated it into its Community Support Toolkit (SAMHSA, 2010), which has been widely disseminated through the Internet (Becker & Bond, 2002; Substance Abuse and Mental Health Services Administration, 2010b). SE researchers have published guidelines for the statewide implementation of SE (Becker, Lynde, & Swanson, 2008) and identified stages through which SE should be implemented (Rosenheck, 2001a). Advocates, policy makers, and administrators have called for the transformation of day treatment into SE programs (McCarthy, Thompson, & Olson, 1998; National Alliance for the Mentally Ill, 1999). The resources available for SE implementation appear adequate and conducive to the effective uptake and application of this EBP by state governments.

Nevertheless, it remains to be seen whether the real-world implementation of evidence-based SE programs by state governments can approximate the program functioning and outcomes demonstrated by the SE efficacy and effectiveness research. Researchers highlight that many agencies claim to offer SE services but upon closer inspection, the programs adhere to only a few components of this EBP (Becker, Lynde, & Swanson, 2008). A similar phenomenon occurred with psychiatric rehabilitation. As community-based programs proliferated, researchers in psychiatric rehabilitation were quick to note that some programs reported providing rehabilitation services for persons with SMI without actually providing them (Anthony, Cohen, & Farkas, 1982). Recently, a fidelity measure has been developed to assess the degree to which programs adhere in program theory and process to recovery and rehabilitation principles (Johnson, 2010).

Despite several publications on the implementation of SE, relatively little is understood about this process by real-world implementers, such as state governments. Although SE implementation studies have focused on the application of SE in real-world settings, these studies often emphasize rigorous control of the implementation process with training and consultation by the foremost experts in SE. The implementation of Rhode Island day treatment centers to SE programs, for example, was funded by a grant from the Rehabilitation Services Administration, and agencies invited the Dartmouth research group (SE developers) to train them (McCarthy, Thompson, & Olson, 1998). They summarize from this experience that the requirements of successful implementation requires the following components: 1) building consensus for a new paradigm, 2) developing funding mechanisms to support the new services, and 3) creating a team of skilled clinicians to implement the new service (McCarthy, et al., 1998). These implementation studies might be better subsumed under the domain of effectiveness research, primarily because they demonstrate an ability to apply SE in real-world settings but says little about the actual implementers and the real-world implementation process.

Implementation Research

Implementation research is a recently developed branch in health care services research. It is aimed at the understanding the facilitators and barriers of the implementation process. It incorporates program evaluation, process monitoring and impact analysis, but it also goes beyond—to address questions of context and organizational processes in order to understand how the greater system affects the implementation of evidence-based care. Implementation research has been identified

as an indispensable part of health research, and a new journal was created in 2006 (Implementation Science, 2011) to specifically address this topic. Implementation research focuses on understanding how research findings can be applied in clinical care settings. A formal definition of implementation research is the following from the website of the newly created journal *Implementation Science*:

“Implementation Research is the scientific study of methods to promote the systematic uptake of clinical research findings and other evidence-based practices into routine practice, and hence to improve the quality (effectiveness, reliability, safety, appropriateness, equity, efficiency) of health care. It includes the study of influences on healthcare professional and organizational behavior (Implementation Science, 2011).”

This new branch of health services research is related to translational research, which is generally defined as the translation of research into practice. It is further separated into two categories: T1 and T2 research (Woolf, 2008). T1 translational research refers to the process of transferring basic science knowledge into new drugs and technologies (i.e., “bench to bedside” research), whereas T2 translational research refers to taking current scientific knowledge and ensuring that it is applied in routine clinical care (Woolf, 2008). T2 research is of interest to health services researchers and public health investigators who focus on ensuring that research knowledge actually reaches the intended patients or populations and are implemented correctly (Woolf, 2008). The author notes that the “laboratory” for T2 research is the community and ambulatory care settings—specifically where the health care system

brings T1 research to the public (Woolf, 2008). Based on this definition, implementation research is best categorized under T2 translational research.

Implementation research also related to program evaluation, process research, and impact analysis. The primary difference between implementation research and these other terms is that the former goes beyond simply describing program experiences; implementation research may include a program evaluation, process research and impact analysis, but it is ultimately geared at both assessment and explanation (Werner, 2005). Whereas program evaluation is focused on the difference between what occurred and what would have occurred in the program's absence, the scope of implementation research asks additional questions about why the program was implemented in a certain way. Implementation research is sometimes used interchangeably with process research; however process research is the systematic and continual documentation of program performance and assessment of whether the program is operating as intended (Rossi, Lipsey, & Freeman, 2004). As such, process research is limited to a program's internal operations and relationships, whereas implementation research takes a step beyond the program and attempts to explain external factors that may also have influenced the program (Werner, 2005). A distinction is also made between implementation research and impact analysis. Again, implementation research is interested in the impact of a program, but only insofar as it assists in explaining whether it was expected or desired, along with addressing the question of why the program functions and impacts the way that it did, especially if this diverged from what was expected. Within this research context, implementation research can have multiple purposes, such as supporting the impact

study by describing the precise nature of the program being tested and explaining the pattern of impact findings over time or across program sites (Werner, 2005).

The core mission of implementation research is to describe, assess, and explain what occurred and why and may be especially compelling when brought to bear on major issues of program design, resources, administration, services and outcomes. A brief history of implementation science reveals four findings: 1) the standard approach of passive diffusion of research findings (i.e., publication of research findings in professional journals), including dissemination of findings on effective interventions, has little or no impact on routine practice; 2) more complex efforts to synthesize research evidence in the form of systematic reviews and disseminated guidelines also have little or no effect on practice; 3) adopting total quality management/continuous quality improvement techniques from industry has produced modest but disappointing results; 4) current attempts to complete systems reengineering using information technology have produced mixed results, including many prominent successes, which need to be understood in greater detail (Shojania & Grimshaw, 2005). Quality improvement focuses on training and education, using data to enhance the performance of an organization. In mental health treatment settings, quality improvement has taken the form of field-based supervision and systematic review of patient outcomes.

Implementation Research & Severe Mental Illness

SMI researchers have recently recognized implementation research in the mental health field as an important domain worthy of greater attention. Drake and colleagues (2009) identify implementation research in SMI as an area on which

researchers should focus their efforts, highlighting that “simple implementation efforts are fruitless and waste resources, while traditional continuous quality improvement approaches are costly and often only moderately successful” (Drake et al., 2009, p. 710).

Actual clinically applied treatment for persons with SMI has appeared to deteriorate in recent years. Despite the aforementioned research and government mandates, community-based care for persons with SMI seems to have worsened in recent years (Cunningham, McKenzie, & Taylor, 2006). Research suggests that up to 95% of people receive either no care or less than optimal care (Drake et al., 2009). In light of the many advances in psychiatric rehabilitation and EBPs for SMI, this deterioration must be understood as the result of dissemination and implementation barriers.

Psychosocial interventions are more difficult to implement than medical interventions (Backer, Liberman, & Kuehnel, 1986). For example, the implementation of Community Support programs produced disappointing results and identified contributing factors include poor model specification, inadequate implementation plans, lack of stakeholder support for the dissemination and inadequate leadership (Brekke, 1988; Noble, 1991; Rosenheck, Neale, Leaf, & Milstein, Frisman, 1995; McFarlane, McNary, Dixon, Hornby, & Cimett, 2011; Backer, Liberman, & Kuehnel, 1986).

To address these issues, researchers developed fidelity measures, which were built from the psychotherapy literature. This fidelity defined as methods to assess adherence to the standards of a program model (Moncher & Prinz, 1991; Waltz,

Addis, Koerner, Jacobson, 1993; Bond, Evans, Salyers, Williams, & Kim, 2000). Fidelity in psychosocial interventions for persons with SMI included fidelity to Assertive Community Treatment (ACT), a clearly defined of the psychosocial model (McGrew, Bond, Dietzen, & Salyers, 1994; Essock & Kontos, 1995). The behavioral fidelity in clinical practice has recently been adopted by medicine, such as the recently published book, *The Checklist Manifesto* by Atul Gawande (2009), which highlights the reduction in errors and complications in surgery as a result of using a behavioral checklist that reduces the complexity of the task.

The National Implementing Evidence-Based Practices Project was launched to address the problems with implementation (Drake, Goldman, Leff, et al., 2001; Mueser, Torrey, Lynde, Singer, Drake, 2003; Torrey, Drake, Dixon, et al, 2001; Torrey, Finnerty, Evans, & Wyzik, 2005; Torrey, Lynde, & Gorman, 2005). Drake and colleagues (2009) conclude several lessons learned from research on implementation strategies, highlighting the potential for use of information technology; however missing from their review and analysis is a review of the assumptions behind the implementation of the study, as well as the adequacy of the implementation in the presence of these technologies, in the presence of existing guidelines and formulas.

The information age of the current era with its availability of these materials online places the onus on providers and state administrators to adequately use the wealth of information in an appropriate way. There must be a continual sifting through of available information to understand which sources are the most important, the most relevant and the most helpful in the current situation. That this occurs has

yet to be seen. If this does not, we are back at square one: in essence we are asking providers and state administrators to take up the same task that health professionals have been shown time and time again to fail at: examine the literature and act in accordance with the evidence base. Evidence that health professionals do not consult the literature when guiding practice is best captured in an article by Isaacs and Fitzgerald (1999) published in the *British Medical Journal*. Clinicians need to focus on the evidence, but instead decisions are based on other factors such as eminence, vehemence, eloquence and confidence (Isaacs & Fitzgerald, 1999).

As described in Chapter 1, treatment for persons with SMI is intertwined with the greater mental health care system. A unique focus of implementation research is its incorporation of the *context* of the implementation of the program. Understanding how to effectively address health problems is critically important in settings where resources are scarce and the absence of effective clinical practice has dire consequences (Sanders and Haines, 2006). Often, new programs or policies are implemented on the basis of executive or legislative mandates, which may incorporate public attitudes or values and knowledge established through research. These mandates oblige federal, state, and local agency executives and program managers to implement new programs or to make changes in existing programs. Particularly when the mandates changes are extensive and/or lead to the creation of new programs, the biggest concerns may be to get the programs “up and running” and working well (Werner, 2005). In these instances implementation research separate from an impact study may be warranted and desirable (Werner, 2005).

Implementation research recognizes the important role of the greater health care system. As programs are not implemented in socio-political vacuums, implementation research should adequately incorporate the greater context. Several health problems can be directly attributed to health system failures, rather than the lack of availability of a solution. A case in point is childhood vaccination in Africa: although these vaccinations exist, African health reforms in the 1990s resulted in declining child vaccination coverage (Gilson & Mills, 1995; Simms, Rowson, & Peattie, 2001); as of 2001, almost half of African children were not adequately vaccinated (UNICEF, 2001). A better understanding of the context within which programs are implemented is currently a major focus of the implementation research agenda (Eccles, Armstrong, Baker, Cleary, Davies, Davies, et al. 2009).

Regarding implementation research in SMI, Drake and colleagues (2009) recognize the important role of state governments. The majority of statewide implementation studies have examined early stages of dissemination, “in which enthusiasm and other Hawthorne effects abound” (Drake et al., 2009). Much less is known about sustaining statewide efforts, especially in the face of the frequent and sometimes volatile leadership changes. Although it is widely understood that state mental health administrations critically impacts the implementation of EBPs, there is limited research on this topic. In the National Implementing Evidence-Based Practices Project, a state-level fidelity scale was developed for the to measure objective indicators of state actions (e.g., designation of a point person within the state agency responsible for dissemination, the establishment of a technical assistance center, state-level policies and regulations aligned to support the evidence-based

practices, and provision of financial incentives to implement the evidence-based practices). The state-level fidelity scale was strongly correlated with mean fidelity for the EBPs in each state (Finnerty, Rapp, Bond, Lynde, & Goldman, 2009).

SE researchers have also recognized the role of the greater mental health care system on implementation. Rosenheck (2001b) identifies the organizational process as “a largely unaddressed barrier and as a potential bridge between research and practice. Large human service organizations...are often characterized by multiple and often conflicting goals, unclear and uncertain technologies for realizing those goals, and fluid participation and inconsistent attentiveness of principal actors. It is in this field of competition, ambiguity, and fluid managerial attention that efforts to import research findings into practice take place” (p. 1608).

Particularly for the implementation of SE, regulatory policies can have a significant impact on outcomes achieved and services provided. As described earlier, persons with SMI are the primary group of disability beneficiaries. Therefore, the success of programs like SE that strive towards the attainment of employment would likely require an environment that is conducive to the goals of the program. Various strategies have focused on these barriers to the attainment of employment by disability beneficiaries. For example, Social Security Administration has also sought to incentivize employment services through its Ticket to Work program (Livermore, Goodman, Wright, 2007).

Implementing systems change is a complex and multifaceted construct and Corrigan and Boyle (2003) identify two approaches: evolution and revolution. The former is identified as “a necessarily slow and ongoing process that requires

consensus among all levels of stakeholders about change in attitude and behavior” (p. 380), whereas the latter “reflects stakeholder impatience with slow change, instead seeking to replace tortuous evolutions with more immediate and dramatic modifications in the status quo” (p. 380).

In summary, implementation research is a growing area of mental health services research for persons with SMI. Implementation research seeks to assess whether the core components of the original intervention were faithfully transported to the real-world setting (i.e., the degree of fidelity of the disseminated and implemented intervention with the original study) and is also concerned with the adaptation of the implemented intervention to the local context. An adequate understanding of the implementation of EBPs such as SE requires careful research of the greater context, organizational processes and policies in which implementation occur. Three questions remain about the implementation of evidence-based supported employment (SE) by state governments: 1) whether states can and do implement supported employment programs that are consistent with the evidence-based version of supported employment (SE), the Individual Placement and Support (IPS; Bond et al., 1997) model, 2) whether these programs approximate the process and outcomes demonstrated by the IPS efficacy and effectiveness research, and 3) the degree to which these program practices adhere to psychiatric rehabilitation principles.

CHAPTER 3

Policy and Practice: The Nebraska Experience

Nebraska Behavioral Health System: An Overview

The Nebraska behavioral health system was established in 1974. As stated in the Nebraska Comprehensive Community Mental Health Services Act (LB 302, 1974), “It is hereby declared to be the public policy of the State of Nebraska that all persons residing in Nebraska shall have access to mental health facilities, programs, and services” (Nebraska Legislature, 2011). The Nebraska behavioral health care system was designed with features of centralization and local control to meet the service needs of Nebraskans (Nebraska Legislature, 2010). In this way, the Nebraska system is congruent with President John F. Kennedy, Jr.’s Community Mental Health Act, Public Law 88-164, of 1963, which reshaped policy by creating direct links with local communities (Grob & Goldman, 2006). This act focused state authorities efforts on the applications conceived and developed at the local level as part of a comprehensive plan to regionalize mental health services (Kahn, 1969).

The current system in Nebraska is comprised of the Division of Behavioral Health (Division), clusters of counties that make up regional behavioral health authorities (regions), and behavioral health service providers, such as regions or private contractors. There are 6 regions in the state.

The Division

The Division of Behavioral Health (Division) provides funding, oversight and technical assistance to the six regions and contracts with local programs to provide services (Nebraska Department of Health and Human Services, 2011). The Division

makes top-level administrative decisions that influence the direction of care provided by the regions. In this way, the Division can be viewed as the top-level administrative body of the delivery of community-based services. By law, the Division must direct the administration and coordination of the behavioral health system. The Division oversees the regions, including approving regional budgets and auditing regions' behavioral health programs and services (Neb. Rev. Stat. 71-806(1) Nebraska Legislature, 2011). Additionally, the Division sets the reimbursement rates for services and consumer fees, and is required to conduct statewide planning to ensure that an appropriate array of community-based behavioral health services are provided (Neb. Rev. Stat. 71-806(1)). The Division is also responsible for adopting the rules and regulations to carry out the Act, which the regions must follow (Neb. Rev. Stat. 71-806(2)). It also developed service definitions for services that are reimbursed by the state.

The Regions

The state is divided into six behavioral health regions, as shown below. Acting under the Interlocal Cooperation Act, the counties in each region are required to establish a behavioral health authority (Neb. Rev. Stat. 71-808(1)). One county board member from each county in a region serves on the regional governing board. The counties must provide a portion of the funding for the operation of their region's behavioral health authority and for the provision of behavioral health services in the region (Neb. Rev. Stat. 71-808(3)).

Regional Governing Boards and Authorities

Each regional governing board oversees a regional behavioral health authority and is required to appoint a regional administrator to administer and manage the region (Neb. Rev. Stat. 71-808(1 and 2)). Each region is responsible for the development and coordination of publicly funded behavioral health services within its service area. In doing so, it must ensure that these actions follow the rules and regulations established by the Division (Neb. Rev. Stat. 71-809(1)). The regions sign contracts with the Division that provide further details about the regions' responsibilities in financing processes, oversight and other areas.

Evidence-Based Practices (EBPs) in Nebraska

The State of Nebraska also produced a “Best Practices” document, which was published by the Division of Behavioral Health Services of the Nebraska Department of Health and Human Services (2005). Developed by the Academic Support Workgroup of the Behavioral Health Reform Project, its purpose was to “ensure academic support” and “developed evidence based ‘best practices’ to improve access to and delivery of behavioral health services in urban as well as rural/frontier areas of the state (p.3).”

As stated in this document, one goal was to modernize the behavioral health system in Nebraska by maximizing alternative community-based services and reducing institutionalization. This document also acknowledges the role of the SAMHSA tool-kits and defined them as packages consisting of procedure manuals, assessment instruments and related materials, staff training and program development consultation. The Academic Support Workgroup discussed the commercial appeal of

the tool-kits as “a quick and straightforward way to reform or expand the capabilities of a service system” (Nebraska Department of Health and Human Services, 2005).

However, the Academic Support Workgroup also underscored the important limitations of such resources:

“While such packages may have value, they are typically developed for particular sub-populations in specific settings. Their scope of generalization is unknown. They all include specific services and treatment approaches that are variants of services and approaches found in other packages. There is no evidence on the superiority of any such package over any other, except for the general finding that packages that include active treatment and rehabilitation are more beneficial and cost-effective than those that do not...implementing a commercially packaged bundle of services is no substitute for developing a service array tailored to the needs, human resources and local characteristics of a mental health service system” (Nebraska Department of Health and Human Services, 2005, p.8).

The role of the context was identified as a major stumbling block, an important barrier to eventually overcome. As noted by the Academic Work Group: “It is critically important to distinguish between service arrays developed to serve specific populations in specific settings, vs. commercially developed bundles of services. The latter are provided in an entrepreneurial context, packaged, and marketed and sold to service providers or service systems. Researchers or government agencies sometimes assemble similar packages or “tool-kits” for the

purposes of studying dissemination, use and effectiveness of the modalities contained in the bundles” (Nebraska Department of Health and Human Services, 2005, p. 8).

The Nebraska Behavioral Health Services Act (LB1083)

The mental health services system in Nebraska has undergone significant reform in recent years with the passage of Legislative Bill 1083 (LB1083), also known as the Nebraska Behavioral Health Services Act. LB1083 was introduced by Senator Jim Jensen in early 2004, passed by the Nebraska Legislature and signed by Governor Mike Johanns in April of that year. Sections 1-20 of LB1083 adopt the Nebraska Behavioral Health Services Act, now codified at Neb. Rev. Stat., sections 71-801 to 1-820. The intent of the legislation is to focus the new public behavioral health system on ensuring the: 1) public safety and the health and safety of persons with behavioral health disorders; 2) statewide access to behavioral health services; 3) high quality behavioral health services; and 4) cost-effective behavioral health services (Laws 2004, LB 1083, section 3).

The implementation of LB1083 included several goals, including the following “(6)(a) Identify persons currently receiving regional center behavioral health services for whom community-based behavioral health services would be appropriate, (b) provide for the development and funding of appropriate community-based behavioral health services for such persons in each behavioral health region, (c) transition such persons from regional centers to appropriate community-based behavioral health services (p.4)” (Nebraska Behavioral Health Oversight Commission of the Legislature, 2004).

Similar to the goals of deinstitutionalization, the Act sought to address an over-reliance on the state's regional centers, and move toward community-based services. The new act mandated specific reforms in the development of community-based behavioral health services and decreased reliance on regional center services (section 10). LB1083 decreased inpatient services while increasing the number of persons served by the community-based behavioral health care by 9,000 in 2008 (*Daily Nebraskan*, March 8, 2009). The Nebraska Behavioral Health Oversight Commission reported in its 2008 report that, "Consistent with advances in research and treatment, evolving best practices, the legal and civil rights of those with mental illness or other disability as established in the U.S. Supreme Court Olmstead decision, and the advocacy of consumers, families, and professionals alike, LB 1083 envisioned and mandated the provision of services closer to home, family, and support services in the least restrictive setting."

Years after LB1083 was passed, local newspapers began to report on critiques of the actual implementation of this legislation. After the Legislature's Performance Audit Committee, Senators were reportedly "extremely concerned about audit findings" (*Lincoln Journal Star*, April 13, 2010). The commitment of the Nebraska Department of Health and Human Services to effectively implement evidence-based practices according to LB1083 was called into question in 2009 with the closing down of an effective psychiatric rehabilitation program that had demonstrated effective outcomes for over 20 years. It was highlighted that the actions of top-level administrators were not guided by an adequate understanding of the needs of a behavioral health system, as no state had ever completely eliminated its psychiatric

institutions and the heterogeneity of the populations served necessitated an appropriate array of services—both community-based and intensive inpatient (Spaulding, Sullivan, Poland, & Ritchie, 2010).

The kerfuffle that ensued was documented in local news sources (Lincoln Journal Star, September 9, 2009; Lincoln Journal Star, September 10, 2009; Lincoln Journal Star, September 15, 2009). Senator Bill Avery spearheaded an Interim Study, Legislative Resolution 136 (Nebraska Legislature, 2009a), which was aimed at investigating the closing of the Community Transition Program (CTP) and possible violation of the law, which required notification of the Governor and Legislature prior to the DHHS closing of the CTP (Avery, 2010). One of the primary purposes of Legislative Resolution 136 was to examine the impact of closing the CTP on community-based programs (Nebraska Legislature, 2009a). The subsequent audit report confirmed that the law was violated (Nebraska Legislature, 2009b) and that the clinical consequences of closing the program were significant (Nolting, 2010).

These events appeared to challenge what had been learned from deinstitutionalization, described above (Lamb & Bachrach, 2001), especially regarding a comprehensive continuum of care. By closing down inpatient units, the state was unable to provide inpatient hospital care for all who needed it. These events also went against the recommendations of the Academic Support Workgroup (Nebraska Department of Health and Human Services, 2005), which had forewarned the neglect of context. As noted by Spaulding and colleagues (2010), there was an immediate impact of closing this program on community-based services, which included rapid re-hospitalizations, acceleration of the revolving door phenomenon,

accumulation of persons in the state hospital who could not be discharged, and an unavailability of services that provided for the gradual transition to the community. Essentially, inpatient hospital care was not available for those who needed it and the impact of this closing reverberated along the entire Nebraska behavioral health system.

Implementation in Nebraska

Against this legal and political backdrop, the Nebraska Department of Health and Human Services initiated statewide implementation of SE programs in 2007. Under the Nebraska Behavioral Health Services Act, an emphasis was placed on care to be focused in communities rather than hospitals. Several goals and action plans were presented by the Nebraska Department of Health and Human Services (2004) to specifically achieve employment in the community, including the provision of evidence-based SE services, or the Individual Placement and Support (IPS) model of SE services. Programs like SE were a major source of optimism for the reform (*Lincoln Journal Star*, April 17, 2004). Prior to the implementation of SE in FY2007, employment services were focused on serving a narrow group. Under the SE Service Definition (Appendix A), this was expanded to include anyone with a primary Axis I diagnosis.

Similar to the ideological sentiments used to bolster support for deinstitutionalization, local news sources cited community-based care such as SE as pitted against inpatient psychiatric care—most clearly denoted in a portion of the title, “community care vs. psychiatric hospitals” (*Daily Nebraskan*, March 8, 2009). This article cites painful restraint procedures as evidence for supporting an increased

number of community-based services and a decreased number of inpatient services as the solution for improved services for persons with SMI (*Daily Nebraskan*, March 8, 2009). In the same article, Kelly Arends, a program manager for employment services stated, “Goodwill uses evidence-based employment support, and it provides a good outcome” (*Daily Nebraskan*, March 8, 2009). The programs were described as promoting a “model of recovery” (*Daily Nebraskan*, March 8, 2009). The same programs were eventually examined for the purposes of this study (see Appendices E-M).

In July 2007, the Division of Behavioral Health (DBH) at the Nebraska Health and Human Services (HHS) implemented the Supported Employment (SE) Program in the State of Nebraska. Prior to the implementation of SE, traditional vocational rehabilitation services were provided. The implementation of SE occurred at the beginning of fiscal year 2008 (July 1, 2007) and the services provided in Nebraska can be separated into the years:

- Pre-SE: fiscal years 2006-2007 (July 1, 2005 to June 30, 2007)
- Post-SE: fiscal years 2007-2010 (July 1, 2007 to June 30, 2010)

Training in the Individual Placement and Support Model of SE in Nebraska

The Division

According to administrators (J. Harvey, personal communication, February 2011), training provided by the Division of Behavioral Health during the implementation of SE included the following: recommendations to improve employment services (Nebraska Department of Health and Human Services, 2004), development of a service definition for SE, and a transfer of funds from behavioral

health to Vocational Rehabilitation VR). During the behavioral health reform planning process, a major strategy to increase employment opportunities was to expand employment programs within existing communities, such as existing day rehabilitation programs (Nebraska Department of Health and Human Services, 2004). Several existing programs such as Community Alliance, Liberty Center, Goodwill Industries of Greater Nebraska and Cirrus House included (Nebraska Department of Health and Human Services, 2004). In this document, Nebraska also stated eligibility criteria for potential clients, which included “readiness indicators,” which included the following: “already living outside the hospital, adjusted to medications, adjusted to community living, want to work, are willing to take the risk of losing some/all entitlements” (p.5, Nebraska Department of Health and Human Services, 2004, p.5).

The Regions

The Nebraska SE sites varied in the degree to which programs were trained in Individual Placement and Support (IPS) model of SE. Six of the 9 programs had existing supported employment programs that were not based on the SE model and employment staff at all 6 programs had undergone training in their respective models of supported employment. Programs with existing non-evidence-based supported employment programs were the Goodwill Programs and clubhouse model, such as that endorsed by the International Center for Clubhouse Development (ICCD). It is noted that of two programs that reported being clubhouse model programs, only one of these programs was certified by the ICCD; both programs however, endorsed supported employment programs consistent with the ICCD model of supported employment. The Goodwill Industries of Nebraska model of supported employment

was based on that developed for persons with physical disabilities, as this organization has historically served a large proportion of individuals with physical disabilities. There was no specific definition of supported employment provided by the Goodwill Industries of Nebraska; however it is noted that this version of supported employment provides those services that are consistent of persons with physical disabilities (e.g., on-going supports, job coaching, job training). Therefore, this program model of supported employment has components of SE but diverge significantly in those areas of SE related to mental health and psychiatric rehabilitation, which include the following: zero-exclusion criteria, integration with mental health treatment, individualization of treatment, community-based treatment, and diversity of jobs developed. These aspects are unique to persons with psychiatric disabilities, such as severe mental illness (SMI). These programs are called “supported employment” programs and offer general employment supports; however this does not imply that it requires training in the components of the SE or evidence-based SE model (Goodwill Industries of Nebraska, 2011a, Goodwill Industries of Nebraska, 2011b). Therefore, this model did not incorporate the same principles as psychiatric rehabilitation but included basic tenets of job coaching and on the job supports. All Goodwill employment specialists attended training in the Goodwill model of supported employment. Goodwill has engaged in several conversations with the Dartmouth J&J project staff and also attempted, earlier in this year, to participate in a funding proposal to SAMHSA to strengthen employment services. Goodwill looks forward to future dialogue and guidance.

In contrast, the ICCD, or clubhouse, model defines supported employment as one level in a three-tiered approach to employment. An important characteristic of clubhouse model employment programs is the 3- tiered approach to employment, which includes the following 3 levels: transitional employment (TE), supported employment, and independent employment (IE). The most basic level of employment is a TE, which is identified as time-limited, 6- to 9-month job placements in entry level positions to work in the labor market and diverge from day-programs or sheltered workshops, which tend to be segregated or limited only to persons with disabilities (Phillips & Biller, 1993).

Combining SE with clubhouse-based programs, the ICCD developed its own supported employment program that included several components of SE, such as ongoing supports, job coaching and job training (International Center for Clubhouse Development, 2009a). Documents from ICCD website indicate a belief that this Clubhouse-modified supported employment program would be more effective than SE: “Deep down, we knew that we could do even better than the SE programs, particularly if we combined their services with the Clubhouse philosophy and unit structure (p.2)” (International Center for Clubhouse Development, 2009a).

It was developed through exposure to clubhouse-model programs that had partnered with outside evidence-based SE program organizations (International Center for Clubhouse Development, 2009a). As such, there was expressed concern that incorporating full SE may “detract from [an] effort to maintain quality Transitional Employment Programs” (International Center for Clubhouse

Development, 2009a, p. 1). A definition of the clubhouse model supported employment program is defined as the following:

“Our Supported Employment Program is very simple, and profoundly effective. We have a weekly work meeting for members looking for a career or simply a job. We work individually with members to prepare resumes, practice interviewing, and organize their job search. When we are out, in the community, we are actively promoting our members who are looking for work. We often work directly with the member and the employer when the job starts. The entire Clubhouse shares the responsibility of training members on SE and providing on-going support as requested. We are open in the evening to support working members at the Clubhouse” (International Center for Clubhouse Development, 2009a. p. 1).

The third level of employment, IE, is defined as persons who are working independently and continue to have all of the available supports offered by the clubhouse (International Center for Clubhouse Development, 2009b). Based on these descriptions it would appear that the point of divergence between the SE model and the clubhouse-modified supported employment program is the integration with treatment that is required for providers. Moreover, the aims of SE also complement those of what is called IE in the clubhouse model. It is important to recognize that a distinguishing feature of SE was a move beyond the mostly TE opportunities provided by traditional vocational rehabilitation programs. One item of the SE Fidelity scale requires that “Employment specialists provide competitive jobs options

that have permanent status rather than temporary or time-limited status” (Bond et al., 1997).

On the other hand, the clubhouse model has been criticized for its potential towards fostering dependence. Persons in clubhouses are considered “members,” implying a lasting involvement, and as one became a “member” through having a mental illness (International Center for Clubhouse Development, 2011b), it also implies that mental illness is an enduring label, which diverges sharply with the recovery and psychiatric rehabilitation literature.

Fidelity to the SE model requires “on-going, time-unlimited supports” which are congruent with these clubhouse program goals, but also appear to be in conflict with psychiatric rehabilitation, which is aimed at recovery and independent functioning and thus, a lack of dependence on any particular program. All clubhouse model employment specialists underwent training in the clubhouse model of supported employment.

The remaining 3 programs experienced minimal formal training in SE or any other model of supported employment. It is noted however, that one program showed an exemplary knowledge of evidence-based practice and SE due to their proximity to other researchers and consumer involvement and key stakeholders in this area; however staff had not undergone specific SE training. Although specific training in the SE model was limited, there was significant communication and knowledge about SE principles. In contrast, another program demonstrated significant understanding of the SE fidelity items but employment specialists and staff had not undergone training in SE nor was there significant contact with key persons in rehabilitation and

recovery and SE. The final program reported no training in SE and limited connections to SE, consumer groups or other persons knowledgeable about SE.

In summary, training in the SE model of SE from both the Division and Regional levels was limited. The training described above diverges significantly from the stages of statewide implementation described by and Becker and colleagues (1998) and Rosenheck (2001a) and later reiterated by Becker and colleagues (2008). Several providers had pre-existing non-evidence-based supported employment programs, including the clubhouse and Goodwill models of supported employment. Thus, the SE implementation in Nebraska is best characterized as a broad-sweeping implementation of the program without significant training in the evidence-based model, which goes against the statewide implementation recommendations by SE researchers (Becker, Lynde, & Swanson, 2008).

Modifications to the Supported Employment in Nebraska

Nebraska made several modifications to its definition of SE for statewide implementation. For example, several meetings with regional service providers were held in order to come to an agreement regarding a service definition for SE. Some providers worked from a Clubhouse model of supported employment and argued for the inclusion of transitional employment (TE) as equivalent to the achievement of an outcome, that is competitive employment for 120 continuous days. Transitional employment (TE) is described as a job owned by the site for 6- or 9-month rotations. The outcome from these meetings between regional service providers and the Division was that Transitional Employment (TE) outcomes were included as an outcome (i.e., competitively employed for 120 continuous days) for the Nebraska SE

programs. Past research has identified the distinction between SE and TE outcomes (Anthony & Blanch, 1987). As noted by Anthony (2008), the merging of TE and SE outcomes has been an attempt to fund transitional employment interventions within SE legislative initiatives. Researchers in psychiatric rehabilitation (Anthony, 2008) argue that significant differences lay in goals, placement length, wages, job level, access to the work environment, and client disclosure (Anthony, 2008).

An additional change to SE for its implementation in Nebraska was that eligibility criteria for the SE programs were modified to meet the goals of LB1083. In the past, eligibility for the program required a diagnosis of state-based serious mental illness, which was defined as anyone with a diagnosis within 295-298 codes of the Diagnostic and Statistical Manual (DSM), Fourth Edition-Text-Revision (American Psychiatric Association, 2000), which includes Schizophrenia-spectrum disorders, psychotic disorders, and Bipolar Disorders. This is consistent with the federal Uniform Reporting System (URS).

Service Definitions

The full service definition produced by the Nebraska Department of Health and Human Services is provided in Appendix A. The fidelity measure was used to construct the service definitions for regulation in Nebraska (J. Harvey, personal communication). Meetings with providers were also held to consider various aspects of the service definition. There are federal, standardized of SE according to the Universal Reporting System (URS) guidelines, which require states to report the provision of SE services according to a uniform definition. The federal URS and Nebraska service definitions are provided in Table 3.1.

Table 3.1. <i>Comparison of Uniform Reporting System and Nebraska Department of Health and Human Services Service Definitions for Supported Employment</i>	
Center for Mental Health Services/SAMHSA Uniform Reporting System	Nebraska Department of Health and Human Services
<p>Mental Health Supported Employment (SE) is an evidence-based service to promote rehabilitation and return to productive employment for persons with serious mental illness' rehabilitation and their return to productive employment. SE programs use a team approach for treatment, with employment specialists responsible for carrying out all vocational services from intake through follow-along. Job placements are: community-based (i.e., not sheltered workshops, not onsite at SE or other treatment agency offices), competitive (i.e., jobs are not exclusively reserved for SE clients, but open to public), in normalized setting, and utilize multiple employers. The SE team has a small client: staff ratio. SE contacts occur in the home, at the job site, or in the community. The SE team is assertive in engaging and retaining clients in treatment, especially utilizing face-to-face community visits, rather than phone or mail contacts. The SE team consults/works with family and significant others when appropriate. SE services are frequently coordinated with Vocational Rehabilitation benefits.</p> <p><i>-Nebraska Department of Health and Human Services, 2010, p. 1</i></p>	<p>Supported Employment (SE) is an evidence-based service designed to promote rehabilitation and return to productive employment for persons with behavioral health disorders age 19 or older. Behavioral health disorders are mental illness or alcoholism, drug abuse, or related addictive disorder. Problem gambling is specifically excluded. The service employs a team approach for treatment with the employment specialists responsible for carrying out all vocational services from intake through follow-along. Job placements are: community-based (not sheltered workshops, not onsite at SE or other treatment agency offices, employment in enclaves or pre-vocational training), competitive (i.e., jobs are not exclusively reserved for SE consumers, but open to public), in normalized settings and utilize multiple employers. The team is assertive in engaging and retaining consumers in treatment, especially utilizing face-to-face community visits, rather than phone or email contacts. The SE team consults/works with family and significant others, as appropriate. SE services are coordinated with Vocational Rehabilitation.</p> <p><i>-Division of Behavioral Health, Approved January 5, 2007</i></p>

Regulatory policies

Regulatory policies are important considerations in implementation. As summarized by Tamblyn and Battista (1993), changes in clinical practice are most likely when interventions were targeted at the reimbursement policy rather than practitioner knowledge or skill. This reinforcement structure has a significant impact on the success of interventions in clinical practice, likely because it provides opportunities for practicing these interventions and receiving feedback (Tamblyn & Battista, 1993). Regulatory policies mandated that Day Rehabilitation programs provide a strength-based psychosocial needs assessment within 30 days, rehabilitation and support plan within 30 days and a relapse and crisis prevention plan (Nebraska Department of Health and Human Services, 2006). Nebraska regulations for SE services required that all programs assess goals and conduct a treatment plan review at 6-months. Relapse and risk assessment were also required by these regulations. It is noted that these service definitions and regulations are currently in the process of undergoing substantial revision and an updated list is not available at the writing of this draft.

Summary

In summary, this chapter provides an overview of the Nebraska mental health system, and highlighted the contextual factors and implementation characteristics relevant to the SE programs in Nebraska. Important contextual factors include the behavioral health reform policies that were originally intended to improve services for persons with SMI but in practice, contributed towards the continuation of deinstitutionalization and community policies described in Chapter 1. Specific characteristics of the SE implementation in Nebraska include minimal top-level

administrative or Division support in the form of the provision of state-wide training, existing non-evidence-based supported employment programs (e.g., Goodwill and clubhouse models of supported employment), minimal training provided at the regional and provider level, and Nebraska-specific modifications to the service definition and definition of employment outcomes for the SE programs.

CHAPTER 4

Hypotheses

As described in Chapter 1, effective community-based programs serve an important role in the continuum of treatment for persons with severe mental illness (SMI). As noted in Chapter 2, three questions remain about the implementation of evidence-based supported employment (SE) by state governments: 1) whether states can and do implement supported employment programs that are consistent with the evidence-based version, the Individual Placement and Support (IPS; Bond et al., 1997) model, 2) whether these programs approximate the process and outcomes demonstrated by the SE efficacy and effectiveness research, and 3) the degree to which these program practices adhere to psychiatric rehabilitation principles. Chapter 3 highlighted contextual factors and implementation characteristics relevant to the SE programs in Nebraska. Important contextual factors include the behavioral health reform policies that were originally intended to improve services for persons with SMI but in practice, appeared to contribute towards the continuation of deinstitutionalization and community policies described in Chapter 1. Specific characteristics of the SE implementation in Nebraska include minimal top-level administrative or Division support in the form of the provision of state-wide training, existing non-evidence-based supported employment programs (e.g., Goodwill and clubhouse models of supported employment), minimal training provided at the regional and provider level, and Nebraska-specific modifications to the service definition and definition of employment outcomes for the SE programs.

The present study includes an analysis of the statewide implementation of the SE program in Nebraska, including an analysis of populations served, program fidelity to the SE model, employment outcomes achieved by the programs, congruence of program procedures with psychiatric rehabilitation principles and service orientation of programs. In addition, the analysis addresses the degree to which contextual factors and implementation characteristics may have contributed to the implementation of the SE in Nebraska. Thus, the program and policy issues that can be examined in this study can be grouped across the following domains: 1) eligibility criteria and populations served, 2) program fidelity, 3) clinical outcomes, 4) program procedures, and 5) service orientation.

Eligibility Criteria and Populations Served

The following hypothesis was tested by conducting analyses of an archival database (i.e., the Nebraska Division of Behavioral Health database) to examine the impact of eligibility criteria in the course of policy changes related to Behavioral Health Service Act Legislative Bill 1083 (LB1083), which was intended to enhance services in community settings for people formerly in the state hospitals.

Hypothesis 1a: Nebraska SE programs will serve the same *proportion* of persons with Schizophrenia-spectrum disorders (the primary target population of SE) as prior to the implementation of the Nebraska SE programs.

As noted in Chapter 2, SE services were developed primarily for persons with severe mental illnesses (SMI), such as Schizophrenia-spectrum disorders. As described in Chapter 3, with the implementation of LB1083 and SE in Nebraska, the eligibility

criteria for Nebraska SE programs were expanded to include any persons with an Axis I behavioral health disorder rather than only those individuals who qualify for federal definitions of severe and persistent mental illness (SPMI). Despite this expansion of services, it is expected that the proportion of persons with SPMI served by the Nebraska SE programs will remain similar across the fiscal years. As described in Chapter 1, SMI consists of those individuals with symptoms and disabilities most consistent with psychotic disorders. For this reason, the proportion of individuals with SMI can be considered those persons with Schizophrenia-spectrum disorders.

State definitions of SMI include the Diagnostic and Statistical Manual—fourth edition (American Psychiatric Association, 2000) diagnostic codes 295-298 (Nebraska Department of Health and Human Services, 2010), which represent the Schizophrenia and Psychotic Disorders. For this reason, the proportion of individuals with SMI can be determined by calculating the proportion of individuals with Schizophrenia-spectrum diagnoses over the fiscal years 2008 – 2010.

In 2008, policy changes associated with LB1083 were enacted to expand eligibility criteria and thus increase the number of persons served in the SE programs. Originally, programs were aimed at serving persons who met criteria for federal definitions of SMI and severe and persistent mental illness (SPMI), which includes Schizophrenia and related disorders. For the 2008 state fiscal year, these eligibility criteria were expanded to include anyone with an Axis I diagnosis. It is expected that despite the expanded eligibility criteria and increase in number of people served, the Nebraska SE programs serve an equal proportion of this difficult-to-treat subset of

those eligible for services (i.e., those who qualify for the federal definition of SPMI, and those for whom the LB1083 mandate was intended) among persons treated in SE programs compared to prior to this change.

Program Fidelity

The following hypotheses was tested by conducting intensive semi-structured interviews with key HHS informants, consumers, program directors and staff; examining the policy intent in the Nebraska service definition and regulations; review of charts and program documents; and naturalistic observation of each SE program. These interviews were guided by standardized instruments developed for the purpose of assessing fidelity to the SE and psychiatric rehabilitation models of treatment. Trained raters (specific training is described in the Chapter 5) conducted the interviews.

Hypothesis 2a: Nebraska SE programs have achieved SE fidelity at the “Fair Implementation” level, or higher, of the SE fidelity measure.

Implementation can be quantitatively measured as program *fidelity*, adherence to an accepted operational manual for SE. Adherence to such a manual was intended to be a requirement for program funding. The implementation of these programs can be measured by the attainment of fidelity to the evidence-based version of the model, the Individual Placement and Support (IPS) model. As described in Chapter 2, fidelity to the SE model has demonstrated adequate discriminative ability based on the reported cut-off scores to identify SE versus non-SE programs. Moreover, outcomes achieved by programs are predicted by fidelity to the SE model. The fidelity measure created explicitly for SE programs, which was used to construct the service definitions for

regulation in Nebraska (J. Harvey, personal communication), is the obvious choice for objective measurement of fidelity in the present study. Scores on the SE Fidelity Scale can fall into the *Good Implementation*, *Fair Implementation* and *Not SE* categories.

Hypothesis 2b: Programs with similar, pre-existing models of supported employment will look more similar than programs without these pre-existing models.

Prior to implementation, several regional providers had pre-existing non-SE models of supported employment that are not evidence-based for persons with psychiatric disabilities (e.g., Clubhouse model, Goodwill model). Moreover, there was a lack of standardization through systematic training at both the Division and Regional levels. For this reason, program behaviors are expected to vary across the 9 Nebraska SE programs and programs operating under the same model of supported employment are expected to appear more similar in program behaviors, as defined by scores on the fidelity scale. This can be measured by examining the behaviorally anchored items of the SE fidelity scale.

Clinical Outcomes

The following hypothesis will be tested by conducting analyses of Division of Behavioral Health and Vocational Rehabilitation databases. Comparisons with findings in the research and program evaluation literature will be conducted, using studies whose employment outcome definitions are comparable to those used by Nebraska SE programs.

Hypothesis 3: Nebraska SE programs will achieve employment outcomes comparable to those reported in the research and program evaluation literature.

The expected outcome of SE is employment. Employment outcomes can be quantitatively compared to data reported in the research and program evaluation literature using similar definitions for an achieved outcome. Due to considerable data errors and missing data problems from the Nebraska Vocational Rehabilitation database, the originally proposed analysis of employment outcomes before and after the implementation of SE was not possible. It is noted that data from the DBH-CS and VR databases were expected to be collected as stated in a formal Memorandum of Understanding, so as to provide a link between persons served across a variety of the employment services in Nebraska, as well as provide greater information about relevant demographics and predictors of outcome achievement in SE programs (e.g., diagnoses, past hospitalizations, age and educational level). Further examination of these databases revealed several data errors that precluded linkage to the DBH-CS and VR databases. These errors include inaccurate reporting of outcomes, missing data (e.g., important data linking fields) and clerical errors. Therefore, full data are not available for all of the time periods of this study and precluded the formerly proposed pre- and post-SE analysis. The impact of the Nebraska SE programs can be assessed however, through comparison with SE outcomes reported in the research literature, especially studies examining statewide implementation. Comparisons will only be made with outcomes that are defined similarly to the Nebraska SE programs (i.e., employment outcome = obtaining and maintaining competitive employment for

120 continuous days). It is noted that Nebraska also modified this outcome to include transitional employment (TE) as an outcome as well. Because the data structure of the databases did not allow a distinction between TEs and competitive employment, the outcomes achieved by the Nebraska SE programs are expected to reflect a “best-possible” measure of actual employment outcomes that the Nebraska SE programs achieved. In the IPT SE model, true “best-possible” criterion would be 100% competitive employment and 0% transitional employment. Considering that past research and program evaluation literature demonstrates the successful implementation of SE by state governments and subsequent achievement of competitive employment outcomes, it is expected that the employment outcomes of the Nebraska SE programs will be similar to those reported in the research and program evaluation literature.

Program Procedures

The following hypothesis will be tested by conducting intensive interviews with key HHS informants, consumers, program directors and staff; examining the policy intent in the Nebraska service definition and regulations; review of charts and program documents; and naturalistic observation of each SE program.

Hypothesis 4: Nebraska SE programs will demonstrate assessment and treatment review procedures that are consistent with psychiatric rehabilitation. Assessment and treatment plan review procedures will guide treatment toward meeting vocational goals and the treatment plans will be revised as necessary.

As described in Chapter 2, Individual Placement and Support (IPS), or evidence-based SE programs, are grounded in principles that appear to complement those of psychiatric rehabilitation. As summarized by Anthony, Cohen, & Danley (1988), psychiatric rehabilitation programs aimed at vocational outcomes should incorporate assessment and planning procedures that guide the intervention. Program practices based on the three-pronged approach of psychiatric rehabilitation practice—assessment, planning and intervention (Anthony, Cohen, & Danley, 1988)—can be assessed using a measure developed specifically for this purpose. The Comprehensive Inventory for Mental Health and Rehabilitation Services (CIMHRRS) is a tool that adequately captures the use of assessment and treatment plan review practices for the purposes of guiding and influencing treatment that is consistent with psychiatric rehabilitation principles. Further, state policy (i.e., LB1083) mandated the provision of high quality mental health care services and it is expected that these policies were enacted, as measured by the adherence of these programs to recovery and rehabilitation practices.

Service Orientation

The following hypothesis will be tested by conducting intensive interviews with key HHS informants, consumers, program directors and staff; examining the policy intent in the Nebraska service definition and regulations; review of charts and program documents; and naturalistic observation of each SE program.

Hypothesis 5: Program directors and staff of the Nebraska SE programs will be able to follow the principles of evidence-based practice and recovery and rehabilitation.

As noted in Chapter 2, implementation studies highlight the importance of the knowledge of program directors. Programs implementing SE programs should embody the principles of recovery and rehabilitation and how the SE program actualizes those principles (Becker, Torrey, Toscano, Wyzik, & Fox, 1998). The principles are broader than the specific modality of IPT SE, but are widely understood in the larger psychiatric recovery and rehabilitation community. A simple operational definition to test this hypothesis is that programs embody the principles when their leaders and administrators can articulate what those principles are. In addition, programs can be systematically assessed for the degree to which their policies and procedures reflect the principles. A comprehensive instrument has been developed for the latter purpose, the Comprehensive Inventory of Mental Health and Recovery and Rehabilitation Services (CIMHRRS) (Johnson, 2010). The CIMHRRS was used in the present study to measure expression of the principles within the respective SE programs.

Therefore, to adequately understand the implementation of SE in Nebraska, an understanding of the extent to which program directors are able to articulate recovery/rehabilitation and EBP principles is imperative. It is expected that the directors and staff of the Nebraska SE programs will display an adequate understanding of the EBP and psychiatric rehabilitation principles that are congruent with the evidence-based SE programs they are implementing.

CHAPTER 5

Method

The present study includes an analysis of the statewide implementation of the SE program in Nebraska, including an analysis of populations served, program fidelity to the SE model, employment outcomes achieved by the programs, congruence of program procedures with psychiatric rehabilitation principles and service orientation of programs. In addition, it includes an analysis of the contextual factors that may have contributed towards the implementation of SE. Specific methods utilized to test relevant hypotheses related to these areas are described in the following sections.

Institutional Review Board (IRB) Approval

Final approval from the University of Nebraska IRB proposal was obtained, after securing agreements with appropriate HHS administrators to utilize the SE data for the present dissertation study. Benefits and risks, recruiting procedures, and compensation were all discussed in the IRB proposal. HHS and Vocational Rehabilitation (VR) were already collecting client and outcome data for program evaluative purposes. As such, no recruiting procedures or compensation were used, direct contact with all SE clients was not necessary, and there were no identified risks for the participants in this project. Because this study was archival, No informed consent was required. All participants completed consent for treatment forms when they were admitted to the SE programs.

Client confidentiality was maintained in several ways. No client identifying information was transferred from the Division of Behavioral Health Database to the

project data file. All client information was de-identified with a unique, 13-character identifying code. Information from site visits was kept confidential. No names and identifying information were obtained from interviews with program administrators, interviews with staff, or the chart review. Instead, anonymous codes were assigned to interviews and chart reviews in order to maintain confidentiality. All data were stored on a locked computer in the HHS building, for which key-access is required to enter all buildings and all computer access is password protected. Per agreement with HHS, individual site-reports are de-identified so that no individuals or programs can be linked to the data.

Participants and Settings

The present study included information from 9 individual SE programs of Nebraska and demographical and clinical information from a total of 1,919 individuals who were served by the SE program from fiscal years 2006-2010. Approximately 52% are women 49.4% have never been married. The average age is 38.8 ($SD=11.6$) years.

Outcome Measures/Client Data

- Employment Outcomes. Employment outcomes were extracted from the databases described in Table 5.1. Achieved employment outcomes were defined as those obtaining and maintaining competitive employment or transitional employment for 120 continuous days. Competitive employment was operationalized as the following: a) a job that pays at least minimum wage, b) in an employment setting that includes co-workers who are not disabled, and c) the position can be held by anyone (i.e., the person does not need to be a member of a population with a disability to hold that job).

Transitional employment includes 6- to 9-month employment positions that are owned by the program provider and guarantees employers that the position will always be filled (e.g., if the client does not want to go to work, the job coach will work in that position for the client).

- Client Characteristics. Demographic and diagnostic characteristics were extracted from the DBH and VR databases. Persons served in the 9 SE Programs in the State of Nebraska were examined using the Division of Behavioral Health (DBH-CS) and Vocational Rehabilitation (VR) Data Systems as of August 2, 2010. A description of these systems is provided in Table 5.1.

Data System	Description
DBH-CS	“Division of Behavioral Health (DBH) – Community Services (CS)” data system. The Nebraska Division of Behavioral Health contracts with Magellan for data collection and management of data relating to DBH-funded community behavioral health and substance abuse programs.
VR	“Vocational Rehabilitation” data system. The Nebraska Division of Behavioral Health entered a Memorandum of Understanding regarding the collection of data related to Supported Employment Services. A transition Memorandum Of Understanding (MOU) was in place from July 1, 2005 through June 30, 2007 to end the transfer of funds from the Division of Behavioral Health to VR.

Service Delivery and Program Fidelity Data

Fidelity and structural and organizational ratings were completed through day-long on-site visits at the 9 SE programs in Nebraska. A list of the location and name of each of these 9 programs is provided in Table 5.2. Two independent evaluators with over 40 hours of training in the assessments conducted all ratings. All discrepancies in ratings were reconciled by consensus. The on-site evaluations were conducted during April 1, 2010-June 30, 2010. The evaluation schedule at each site typically lasted from 9:00 am to 5:00 pm and consisted of interviews with staff, clients, consumers, family members of consumers, employers; observation of team meetings and activities; review of programs and procedures manuals; and review of case files. Please refer to Table 5.2 for a list of the 9 different SE Programs in the State of Nebraska that were evaluated for this analysis.

Table 5.2 <i>Region, Site, and Location of Supported Employment Programs in Nebraska</i>		
REGION	SITE	LOCATION
I	Cirrus House	Scottsbluff, NE
II	Goodwill Industries of Greater Nebraska-Lexington ^a	Lexington NE
III	Goodwill Industries of Greater Nebraska-Grand Island	Grand Island, NE
III	Goodwill Industries of Greater Nebraska-Kearney	Kearney, NE
III	Goodwill Industries of Greater Nebraska-Hastings	Hastings, NE
IV	Rainbow Center ^b	Columbus, NE
IV	Liberty Centre Services	Norfolk, NE
V	Mental Health Association	Lincoln, NE
VI	Community Alliance	Omaha, NE
<p>^aAlthough the site visit to Region II was originally planned for Goodwill Industries of Greater Nebraska-North Platte, the Program Director canceled this site visit due to insufficient staff at this site. The Region II site visit was later re-scheduled for the Goodwill Industries of Greater Nebraska-Lexington.</p> <p>^bRainbow Center data are not available in the VR database and are not reflected in the outcomes.</p>		

Assessments

- *Supported Employment Fidelity Scale (SE Fidelity Scale)*. The Supported Employment Fidelity Scale, previously named the Individual Placement and Support (IPS) Fidelity Scale (Bond, Becker, Drake, et al., 1997), is the measure of quality of SE implementation. This measure was obtained from the SAMHSA community tool-kit (SAMHSA, 2007; Becker and Bond, 2002). The 15-item SE Fidelity Scale has been used to assess various SE programs and consistently demonstrates that better employment outcomes are associated with adherence to the evidence-based SE model (McGrew and Griss, 2005). The items assess structural elements of program implementation in the domains of staffing, organization, and services. Each of the 15 items is rated on a 5-point behaviorally anchored scale ranging from 1(not implemented) to 5 (fully implemented). For example, *Rapid job search* is scored 5 if the first contact with an employer is on average within one month after program entry, whereas a score of 1 represents of a delay of up to one year after program entry. The 15 items are summed to give a total score ranging from 15 to 75. A score greater than 65 is regarded as high fidelity, i.e., *Good Implementation*, while a score of 65 or low fidelity, i.e., *Fair Implementation*. Any score below 56 is an absence of fidelity or *Not SE*. This scale adequately discriminates between programs adhering to the evidence-based version of SE and other vocational models (Bond et al., 1997; Bond, Vogler, Resnick, Evans, Drake, et al., 2001). A copy of this measure is provided in Appendix C.

- *Comprehensive Inventory of Recovery and Rehabilitation Services (CIMHRRS)*. The CIMHRRS (Johnson, 2010) is a 52-item instrument designed to assess the fidelity of various programs to particular service models for persons with SMI. It is used to both quantitatively and qualitatively characterize programmatic differences in service settings for people with SMI. This measure was developed out of attempts to articulate the essential ingredients that distinguish a rehabilitation program from non-rehabilitation programs. These include the following ingredients: 1) functional assessment in relation to environmental demands, 2) client involvement in the assessment and intervention phases of rehabilitation, 3) systematic individual client rehabilitation plans, 4) direct teaching of skills to clients, 5) environmental assessment and modification, 6) follow-up of clients in the real-life environments, 7) rehabilitation team approach, 8) rehabilitation referrals to comprehensive services, 9) evaluation of observable outcomes and utilization of evaluation results, and 10) consumer involvement in policy and planning (Anthony, Cohen, & Farkas, 1982). Through a structured site review and semi-structured interviews, evaluators assess the relative strengths and liabilities of service programs. The CIMHRRS examines the recovery and rehabilitation focus of programs, with a particular emphasis on structural and process components of a program's day-to-day functioning. As specific treatment models are associated with specific outcomes, it is expected that the outcome of any treatment can be achieved only when the treatment is delivered with high fidelity. In turn, the expected outcome of a treatment

program must be consistent with the mission of that program. Thirty-two of the 52 items on the CIMHRRS use a 5-point behaviorally anchored scale ranging from 1 (not applied) to 5 (fully applied). This scale adequately discriminates between programs adhering to the recovery and rehabilitation principles and practice (Johnson, 2010). It is noted that this is the first time that the CIMHRRS has been used to evaluate SE programs. A copy of this measure is provided in Appendix D.

Ratings for the SE Fidelity Scale and CIMHRRS utilized information comprehensively. Consistent with the assessment instructions for both of these scales, ratings of each item were conducted using information that was drawn from a variety of sources. For example, to determine the rating of the item pertaining to *Diversity of jobs developed* on the SE Fidelity Scale, raters utilized information from interviews with employment specialists, the interview with the Program Director, program documents and chart reviews. When there was discrepancy between the information provided (e.g., employment specialists reported spending 80% of the time in the community while the consumer reported spending 10% of the time in the community), information was taken from as many sources as possible and ratings were made based on an incorporation of all available information rather than any one source alone.

All initial drafts of individual site reports were reviewed and approved by all Nebraska SE programs. These reports are provided in Appendices E-M.

CHAPTER 6

Results

Eligibility Criteria and Populations Served

Hypothesis 1a: Nebraska SE programs will serve the same *proportion* of persons with Schizophrenia-spectrum disorders (the primary target population of SE) as prior to the implementation of the Nebraska SE programs.

Using the DBH-CS database, data were filtered to include only persons ever served in employment programs in Nebraska ($N = 1,884$). Data were excluded if they were not within the time frame of the study and repeat cases were excluded for demographic and diagnostic analyses. Because the data collection of client characteristics from fiscal year 2010 was not yet complete at the time of this analysis, only data from fiscal years 2006-2009 were included.

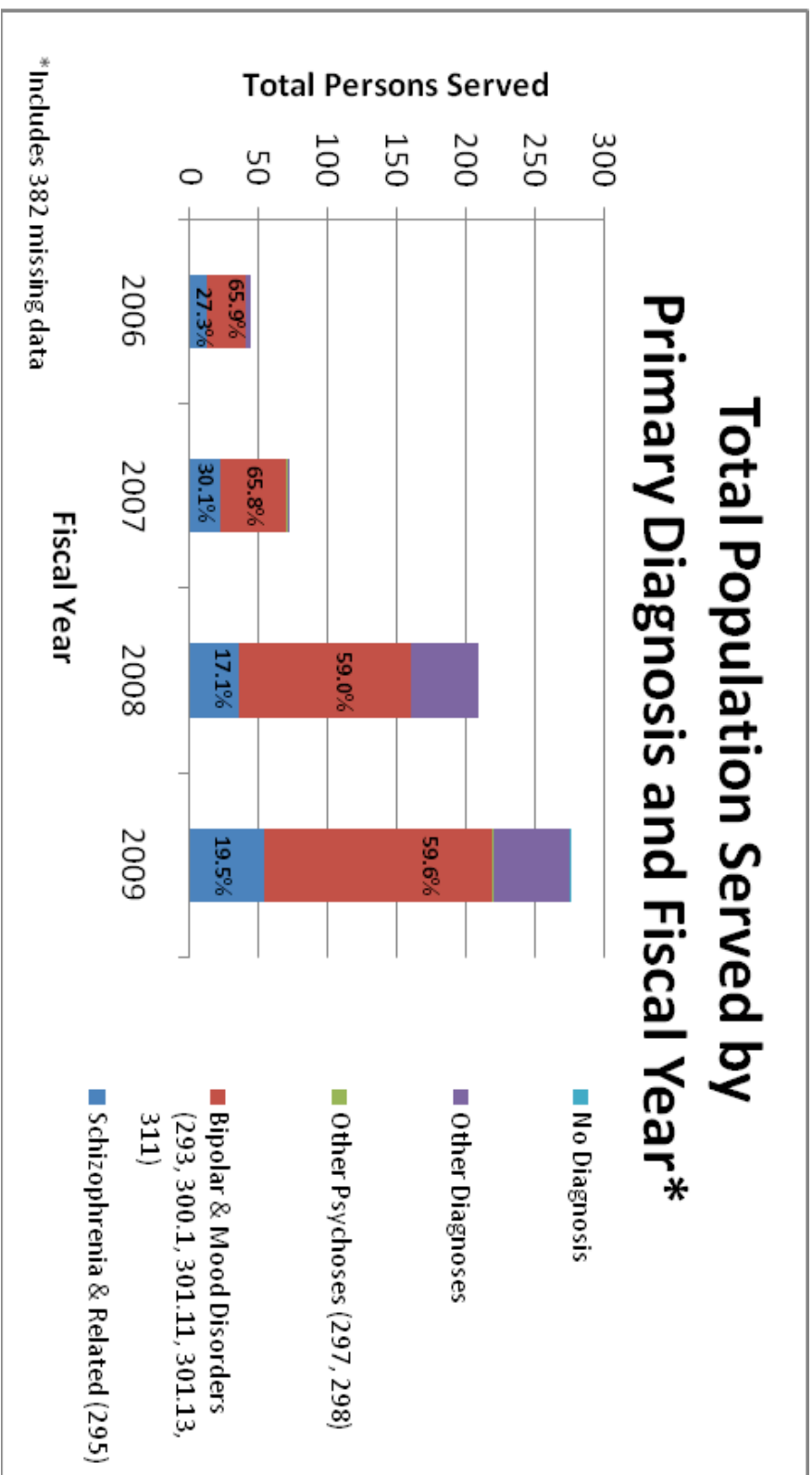
A total of 1,233 individuals received services from the SE program during fiscal years 2006-2009. The number of persons served by the SE program prior to the implementation of SE (fiscal years 2006-2007) was 423 individuals, whereas the number of persons served after the implementation of SE (fiscal years 2008-2009) was 790 individuals. Twenty additional persons were served within this time frame, but the exact determination of the fiscal year during which they received services was indeterminable and were thus excluded for this analysis. Of all individuals served by SE during fiscal years 2006-2009, 999 (81.0%) are different individuals and 234 (19.0%) were repeat cases, meaning they entered the SE program and returned again at a later date. Diagnostic information was missing for 382 individuals. The diagnostic groupings are presented in accordance with federal categorizations and

definitions of “SMI.” The total unduplicated (excluding those same persons who returned for services) count by diagnoses is provided in Figure 7.1.

As seen in Figure 6.1, the proportion of persons with Schizophrenia-spectrum disorders changes before and after policy that expanded eligibility criteria for the programs. In 2006 and 2007, the proportion of persons with Schizophrenia-spectrum disorders who were served by the Nebraska vocational programs were 27.3% and 30.1%, respectively. After the expansion of services to anyone with an Axis I diagnosis in 2008, the proportion of these individuals decreased to 17.1% and 19.5% for fiscal years 2008 and 2009 respectively.

Considering the total number of persons served in each fiscal year, the decrease in the proportion of persons with Schizophrenia-spectrum disorders does not appear to be attributable to a low base rate of unemployed persons with SMI. Reports indicate that evidence-based SE services are meant to serve the needs of approximately 85% of the population of adults with SMI who are unemployed (American Psychological Association, 2011). The total number of adults with Schizophrenia and related disorders in Nebraska in fiscal year 2010 was 3,531 and the number of those persons who were unemployed was 1,472 (Nebraska Department of Health and Human Services, 2010).

Figure 6.1. Total Population Served by Primary Diagnosis During Fiscal Years 2006-2009



Although absolute numbers are imprecise because of the large amount of missing data, the amount of increase in number of people with schizophrenia appears disproportionate to the transfer of funds from state hospital to community programs. The state hospitals were reduced by about 200 beds, while community SE services for people with SPMI increased by less than 50 recipients. The population discharged from the state hospitals was, almost by definition, 100% SPMI. Almost all of the SE recipients with SPMI were served in programs in urban settings.

Qualitative data from the semi-structured interviews indicated a reported tendency of some programs to “cherry-pick” or select only those with less severe disorders and/or higher functioning. Data from the semi-structured interviews also suggested that many of the SE programs had long waitlists of clients requesting employment services.

Summary

This hypothesis was not supported. Nebraska SE programs served a lower proportion of persons with Schizophrenia-spectrum disorders, the target population of SE, after the implementation of SE. The expansion of the eligibility criteria for the program appears associated with this decrease. The decrease does not appear to be due to a low base rate of unemployed persons with SMI in Nebraska. Qualitative reports from providers suggest that a decrease might be associated with a tendency to screen out persons who were perceived as more psychiatrically severe than other populations. Also, although more precise conclusions require further analysis of Nebraska Department of Health and Human Services databases, there is no support in this data for the conclusion that new resources, either liberated by closing the state

hospitals or from new sources, are now serving the people in the community who were previously in the state hospitals.

Program Fidelity

Hypothesis 2a: Nebraska SE programs will achieve SE fidelity at the “Fair Implementation” level, or higher, of the fidelity measure.

As seen in Figure 6.3, based on the total scores on the SE Fidelity Scale, 2 of the 9 Nebraska SE Programs achieved fidelity at the *Fair Implementation* level. It is noted that 1 of these 2 programs was 2-points above the range of *Not Supported Employment, on a 75 point scale.* . The other program that met SE fidelity scored within the *Good Implementation* category, indicating a strong adherence to the SE model. The remaining 7 programs fell within the *Not Supported Employment* category, indicating that these programs did not adhere to the SE model. It is noted that the 2 programs that achieved fidelity to the SE model were in relatively more populated areas (e.g., urban) than the remaining 7 programs.

Figure 6.3. Fidelity across 9 Supported Employment Programs in Nebraska

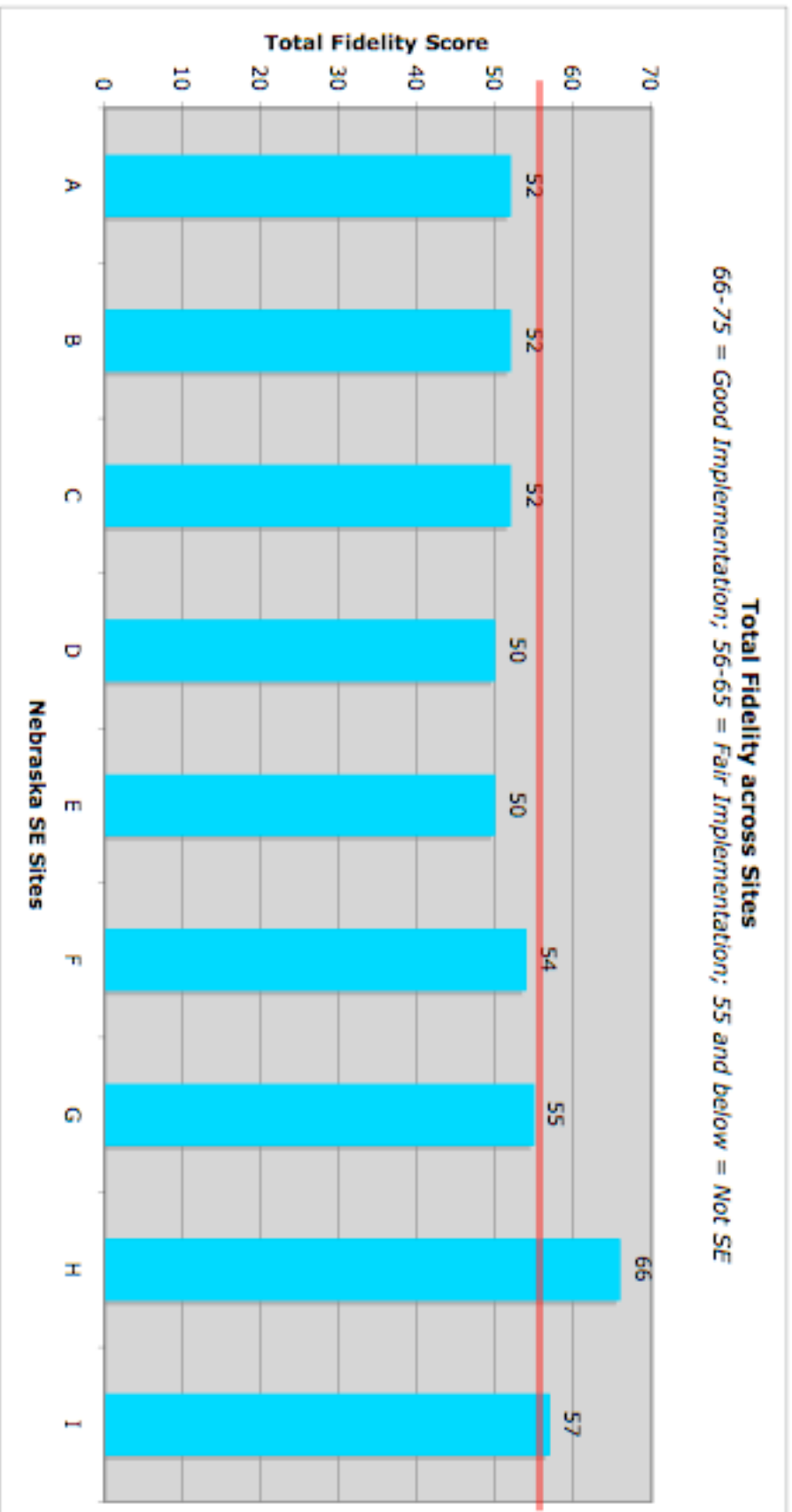


Figure 6.4. Fidelity Scale Item Means for the Supported Employment Programs in Nebraska

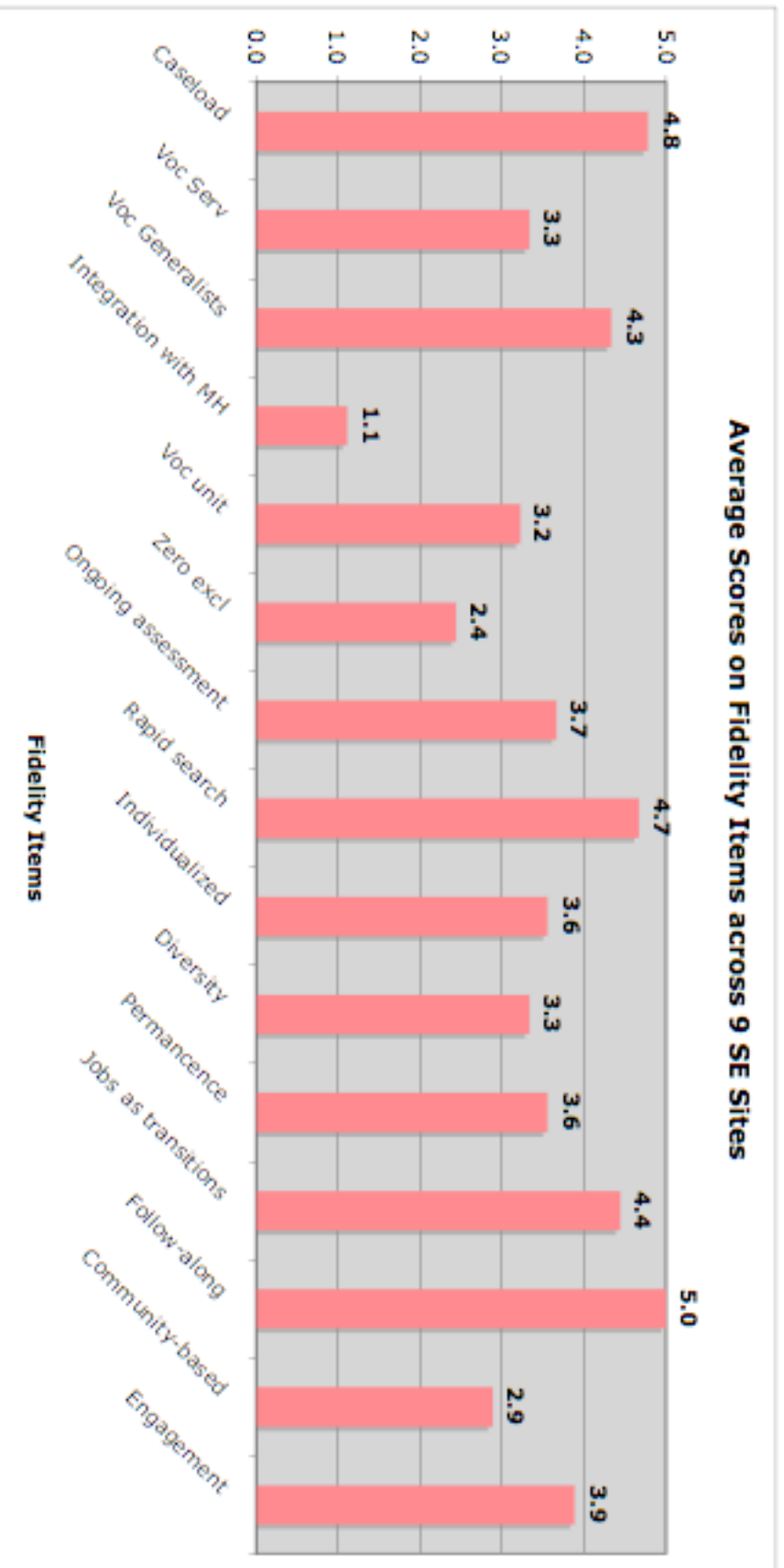


Figure 6.5. Variation in Fidelity across 9 Supported Employment Programs in Nebraska



As described in Chapter 5, fidelity items are rated on a scale from 1 to 5, with higher scores indicating greater fidelity to the evidence-based version of SE. A cut-off score of 4 or higher on each of the fidelity items was used to indicate relative strengths of a program. A cut-off score of 2 or lower was used to indicate relative weaknesses of a program. As seen in Figure 6.4, strengths of the Nebraska SE programs (defined as higher than 4 on the fidelity scale item) include the following: 1) *caseload size* (i.e., employment specialists manage caseloads of up to 25 individuals); 2) *vocational generalists* (i.e., employment specialist carries out all phases of vocational service); 3) *rapid search* (i.e., the search for competitive jobs occurs rapidly after program entry); 4) *jobs as transitions* (i.e., all jobs are viewed as positive experiences on the path of vocational growth and development; and 5) *follow-along supports* (i.e., individualized follow-along supports are provided to employer and individuals on a time-unlimited basis); Figure 6.4 also displays areas of the Nebraska SE programs that were low (defined as an average rating on this fidelity scale item lower than 3) on the Fidelity Scale include the following: 1) *integration with mental health treatment* (i.e., employment specialists should be part of the mental health treatment teams with shared decision-making); 2) *zero-exclusion* (i.e., no eligibility requirements such as job readiness, lack of substance abuse, no history of violent behavior, minimal intellectual functioning and mild symptoms); and 3) *community-based* (i.e., vocational services such as engagement, job finding, and follow-along supports are provided in community settings).

Regarding integration with mental health treatment, employment specialists in the Nebraska SE programs were rarely part of mental health treatment teams with

shared decision-making. Qualitative reports from staff indicated significant systemic barriers that precluded attendance of employment staff at treatment team meetings (e.g., no collaboration between organizations). Other reported barriers included difficulties due to physical location (e.g., separate from mental health services facility) and a broader mental health services culture that did not support the integration of non-mental health specialists on treatment teams.

Qualitative reports indicated that several employment specialists were unaware that evidence-based SE requires this integration of services. Several employment specialists considered it unnecessary to meet with the client's mental health providers, and endorsed the belief that employment was separate from treatment services. One employment specialist noted, "I don't need to hear about the issues they discuss with their therapist" and suggested that mental health treatment focuses on traditional talk therapy rather than psychiatric rehabilitation principles. On the other hand, it was also noted that several of the employment specialists indicated concerns such as personal hygiene deficits, social skills deficits, medication adherence and substance abuse (domains targeted by psychiatric rehabilitation practices) as barriers to the ability to achieve employment.

Regarding zero-exclusion, several Nebraska SE programs were characterized by specific eligibility requirements (e.g., job readiness, lack of substance abuse, no history of violent behavior, minimal intellectual functioning and mild symptoms). Several of the Nebraska sites visited for this report tended to screen out certain individuals, especially those with dual diagnoses or other co-morbid difficulties. Qualitative information from the semi-structured interview assessment included

reports that a likely contributing factor to low achievement of the zero-exclusion criterion for SE programs is the partnership of SE with the Department of Vocational Rehabilitation (VR). VR conducted several of the referrals to SE programs in Nebraska and typical VR services include initial assessments and screenings. Regarding the community-based provision of services, several of the Nebraska SE programs provided over 20% of services to clients in an office or agency setting rather than in the community. Information from the semi-structured interviews indicated that several programs did not recognize a need for service delivery to occur in the community.

Summary

This hypothesis was not supported. Seven of the 9 Nebraska SE programs demonstrated low fidelity to the evidence-based version. Two Nebraska SE programs achieved fidelity to the SE model. One program scored within the *Fair Implementation* range and another program scored within the *Good Implementation* range. All programs scored low on the SE item measuring integration with the greater mental health care system.

Hypothesis 2b: Programs with similar, pre-existing models of supported employment are more similar to each other than to programs without these pre-existing models.

As shown in Figure 6.5, there was variation across the 9 SE sites on the services provided that are scored by the SE Fidelity Scale, suggesting that the SE programs may differ across Nebraska. Several Nebraska SE programs used SE-incongruent practices (e.g., exclusion criteria, transitional employment) and these

appear to be associated with the presence of a non-evidence-based supported employment model. These include the 4 programs run by the Goodwill Industries of Nebraska (Programs B-E in Figure 6.5) and the 2 programs that operated under the International Center for Clubhouse Development (ICCD) definition of supported employment (Programs A and F in Figure 6.5).

As seen in Figure 6.5, those programs providing the Goodwill model of supported employment tended to score low on the following SE practices: zero-exclusion criteria, integration with mental health treatment, individualization of treatment, community-based treatment, and diversity of jobs developed. As described in Chapter 3, these programs are distinct from the SE model in that they are not specifically targeted for persons with psychiatric disabilities. Although these programs are also called “supported employment” and offer general employment supports, this does not imply that they provide the components of the SE model of service.

Similarly, as seen in Figure 6.5, those programs providing the clubhouse model of supported employment program tended to score low on the following SE practices: zero-exclusion, vocational unit, and integration with mental health treatment. As described in Chapter 2, in some respects, the clubhouse employment model contrasts with the principles of the SE model. For example, clubhouse model programs provide transitional employment services. Interestingly, the two Clubhouse model programs differed on SE practice related to the permanence of jobs developed; however there was only a 1-point difference between the two ratings. Program A provided competitive job options rather than temporary or time-limited status jobs

about 50% of the time, whereas Program # provided options for permanent, competitive jobs about 75% of the time. It is noted that these two clubhouse model programs also differ in the degree to which they adhere to the accreditation standards of the International Center for Clubhouse Development (ICCD). Also, although a low score on the SE practice related to integration with mental health treatment was noted by all programs, qualitative reports from one clubhouse model program might suggest incongruence between the SE and clubhouse model at a more fundamental level. Program A (Appendix E) highlighted that one specific standard of the clubhouse model is that staff persons are not identified as “employment” staff; rather all staff are “generalist” staff. Therefore, assistance that members receive from staff is due to the good working relationship members have with staff rather than any “expertise” in this area. Part of the reasoning behind this model is that this particular program strives towards an egalitarian atmosphere—that is, there is no hierarchical structure that is reminiscent of the medical model, where staff persons are considered “experts” and members are “receivers of services” and otherwise conjure up past experiences of the hierarchical physician-patient relationship. It would appear that this model may conflict with the specific roles and duties outlined for an employment specialist in the SE model. Nevertheless, one caveat is that the two clubhouse model programs in Nebraska differ in their accreditation with the International Center for Clubhouse Development (ICCD). Therefore, although they are both reportedly Clubhouse model programs, they may not be operating under a standardized definition of the clubhouse model supported employment program, and this may contribute to this minor difference in SE practices noted between the two programs.

One point of conflict between one Clubhouse program and both SE and psychiatric rehabilitation is the utilization of assessments and technologies to determine the level of an individual's disabilities and current functioning. For instance, Program A stated that as a Clubhouse model, it does not focus on assessing disabilities and impairments. Although some assessments were completed by Program A staff, these were mainly conducted due to a requirement of the funding sources. Qualitative interviews also revealed that Program A reported beliefs against their provision of "treatment," as this reportedly conflicts with what the Clubhouse attempts to achieve. As described earlier, the Clubhouse model attempted to move away from the hierarchical model of the medical system by creating a more egalitarian atmosphere focused on "membership" rather than patients and providers.

Summary

This hypothesis was supported. The Nebraska SE programs varied considerably on the behaviorally anchored SE fidelity scale, which suggests that the services provided by the programs vary across the state. As hypothesized, consistency across certain programs that operate under a similar model reveal that these program behaviors appear similar in the presence of training in a specific program model.

Clinical Outcomes

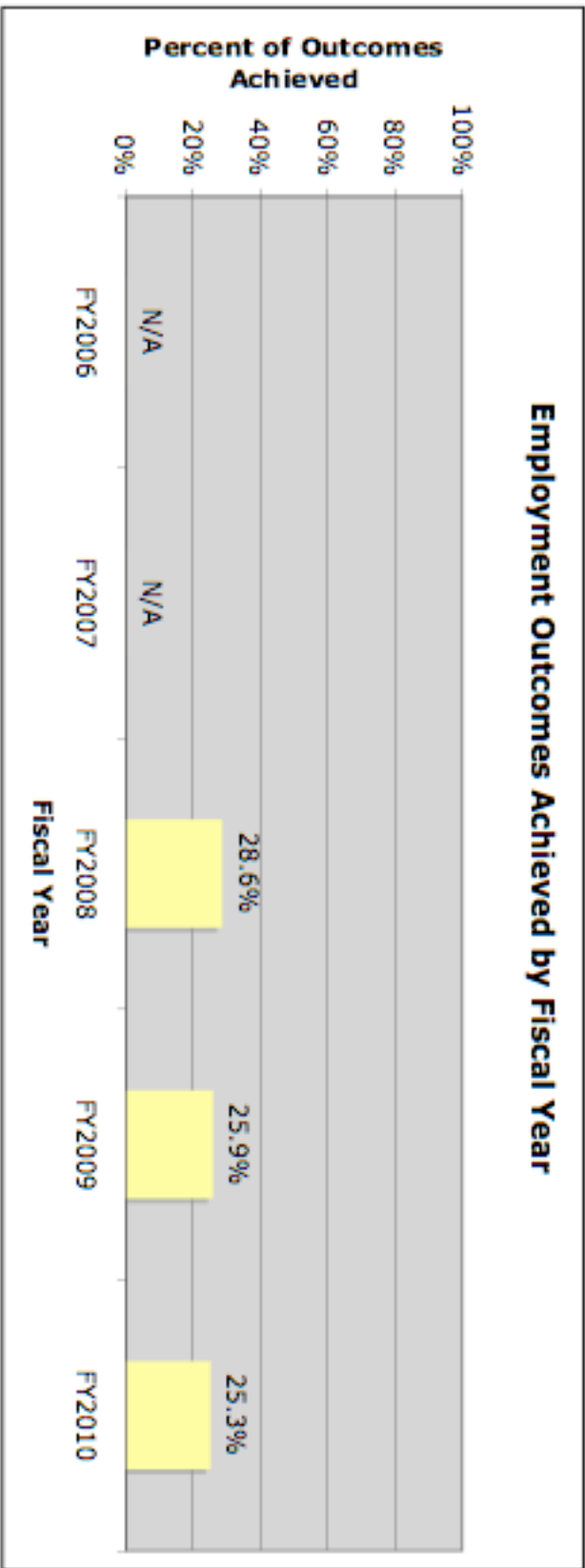
Hypothesis 3: Nebraska SE programs will achieve employment outcomes similar to data reported in the research and program evaluation literature.

Due to considerable data errors and missing data from the VR database, data were unavailable for fiscal years 2006-2007. Therefore, an analysis of employment

outcomes before and after the implementation of SE was not possible. The impact of the Nebraska SE programs was assessed through comparison with SE employment outcomes reported in the research literature, especially studies examining statewide implementation. As described in Chapter 5, an achieved employment outcome was defined as obtaining and maintaining competitive employment for 120 days. Also as described in Chapter 3, the Nebraska SE programs differed from past research in that TEs were considered the same as competitive employment outcomes typically associated with SE.

In fiscal year 2008, a total of 755 consumers were served and 216 (28.6%) of those reached an outcome. In fiscal year 2009, a total of 786 consumers were served and 204 (25.9%) achieved outcomes. In fiscal year 2010, a total of 738 consumers were served and 187 (25.3%) of achieved employed outcomes, suggesting similar employment outcomes at fiscal year 2009. Employment outcomes achieved (%) by fiscal year is provided in Figure 6.2. The overall impact of the SE programs over these 3 fiscal years is that 26.6% of the individuals served achieved an employment outcome.

Figure 6.2. Employment Outcomes Achieved by Fiscal Year



Source: Vocational Rehabilitation as of August 9, 2010

Comparing achieved employment outcomes in Nebraska compared with other studies, Nebraska SE programs appear to be achieving lower employment outcomes. The following is a review of achieved employment outcomes from the research literature, beginning with the most stringent research (e.g., randomized controlled trials) to effectiveness research (e.g., outcomes achieved in past state-implemented SE programs).

Past SE research indicates that employment outcomes achieved in stringent, randomized controlled trials of SE hover around 60-70%, whereas past state-based implementation examples reveal employment outcomes around 50%. In several randomized controlled trials and meta-analyses of these studies, SE programs have achieved the following competitive employment rates: 56% (Bond et al., 2004), 58% (Burns et al., 2007), 55% (Cook et al., 2005), 34% (Crowther et al., 2001), and 61% (Bond et al., 2008). In a review of 11 randomized controlled trials, the combined employment rate was 53% for SE and 16% for traditional vocational rehabilitation, with an effect size of 0.82 (Bond et al., 2007). Averaging across 7 of these RCTs, all study participants worked at competitive jobs for an average of 12.1 weeks, and this was an aggregate of all SE participants (Bond et al., 2007). In contrast, control groups typically included vocational rehabilitation and outcomes achieved by these programs are 19% (Bond, 2004), 21% (Burns et al., 2007), 34% (Cook et al., 2005), 12% (Crowther et al., 2001), and 23% (Bond et al., 2008).

The outcomes of these studies were similar to the operational definition in Nebraska of an SE outcome (outcome =120 days of successful employment). Burns and colleagues (2007) defined an SE outcome as working at least 1 day, with an

average of 130 days employment. In the European effectiveness study conducted by Cook and colleagues (2005), the outcome definition was considerably more rigorous, defined as achieving competitive employment and cumulatively employed 40+ hours over a 24-month period. Crowther and colleagues (2001) defined the study outcome as being competitively employed at 12 months follow-up.

Data from non-randomized controlled trials that approximate real-world settings and populations reveal similar findings. Examining only those persons who were receiving benefits, Bond and colleagues (2007) found that of SSI/SSDI beneficiaries receiving SE services 65%-71% attained competitive employment. In contrast, of those receiving traditional vocational rehabilitation services 19%-21% achieved competitive employment and 43% of the above groups achieved competitive employment (Bond, Xie, Drake, et al., 2007). In a statewide implementation study, Becker and colleagues (2008) reported that 9 programs in 3 different states were able to achieve employment outcomes that hovered around 50% and these programs adhered to the federal definition of being competitively employed for 130 continuous days.

One early study does report outcomes only slightly higher than the Nebraska SE programs, however these programs served long-term day treatment clients (e.g., average of 500 days receiving services in day programs). The implementation of these programs was conducted through converting day programs to SE programs and outcomes achieved were 36.6 % of persons working for at least 90 days and 30.0% of persons working for at least 180 days; however it is important to note that these

individuals reflected a more severe and chronic population than those served by the Nebraska SE programs.

Summary

This hypothesis was not supported. Employment outcomes achieved by the SE programs were considerably lower than those reported in the research literature, as well as those reported in other statewide implementations. Instead, the outcomes achieved by the Nebraska SE programs tend to be more similar to the outcomes achieved by the traditional vocational rehabilitation programs for participants with SPMI. Outcome for non-SMI groups would generally be expected to be significantly better, arguably even obviating the need for SE in non-SPMI psychiatric groups.

Program Procedures

Hypothesis 4: Nebraska SE programs demonstrate assessment and treatment review procedures that are consistent with psychiatric rehabilitation.

Assessment and treatment plan review procedures will guide treatment toward meeting vocational goals and the treatment plans will be revised as necessary.

As seen in Figure 6.6, all Nebraska SE programs reported the assessment of goals; however the degree to which this assessment conformed to recovery and rehabilitation practices varied. In contrast, the regulatory language did not mandate the assessment of symptoms, cognition and behavior, which are core features of comprehensive psychiatric rehabilitation. As seen in Figure 6.6, use of assessments of symptoms, cognition and behavior was variable across these sites and in some cases, assessment in these other domains were non-existent.

As expected, assessment of various domains of functioning were present in all sites; however the use of assessment as measured using an operationalized definition of assessment of skills that meets the standards of recovery-based programs reveals that assessment in these domains is quite variable across sites. Regarding assessment of risk and use of a relapse prevention plan, consistent with the hypothesis that use of assessment would conform to regulatory standards, all programs indicated use of assessment in these domains; however, regulatory standards required only minimal assessment of domains and some programs fell below the average use of assessment. It is also noted that most of these assessments were conducted in a way to meet regulatory standards for reimbursement purposes and rarely was this information incorporated into treatment, as would be expected from recovery-based programs.

As noted in Figure 6.9, for most programs, the process of treatment plan reviews features conformed to those required by regulation (i.e., 6 months) or slightly exceeded regulatory standards; however no programs conducted treatment plan reviews that allowed for a quantitative determination of (or lack of) progress or directs follow-up and documentation of progress.

Figure 6.6. Assessment of Goals, Symptoms, Cognition, and Behaviors across 9 Supported Employment Programs in Nebraska

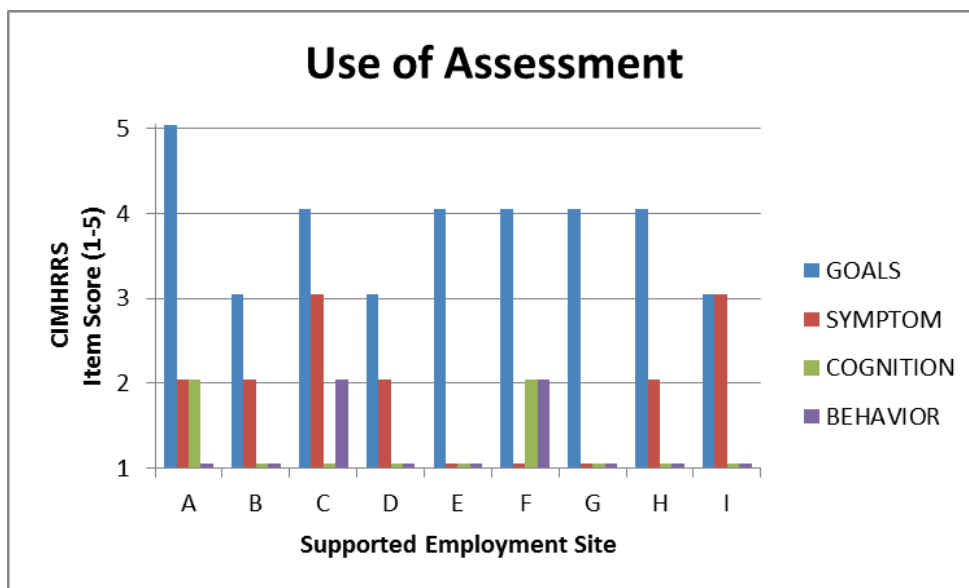


Figure 6.7 Assessment of Independent Living Skills, Social Skills, and Occupational Skills across 9 Supported Employment Programs in Nebraska

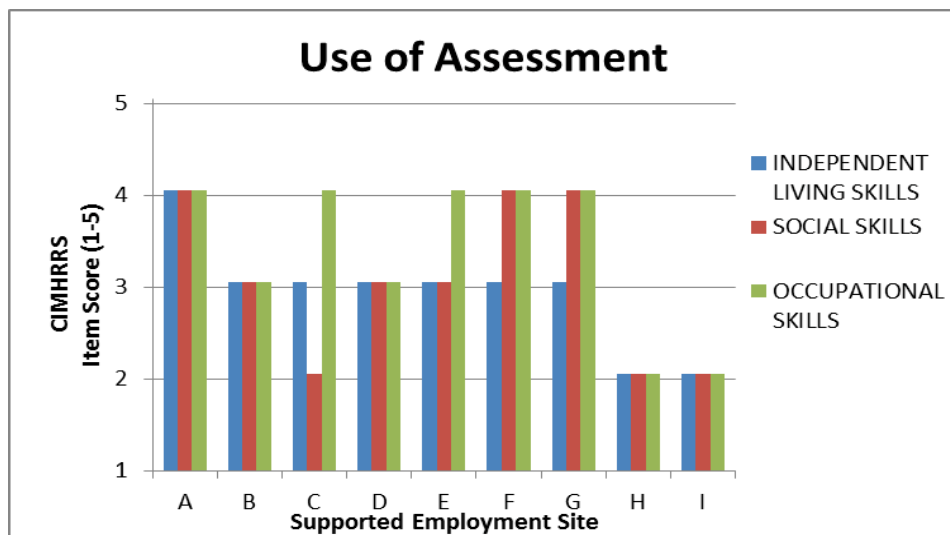


Figure 6.8. Assessment of Risk and Relapse Prevention across 9 Supported Employment Programs in Nebraska

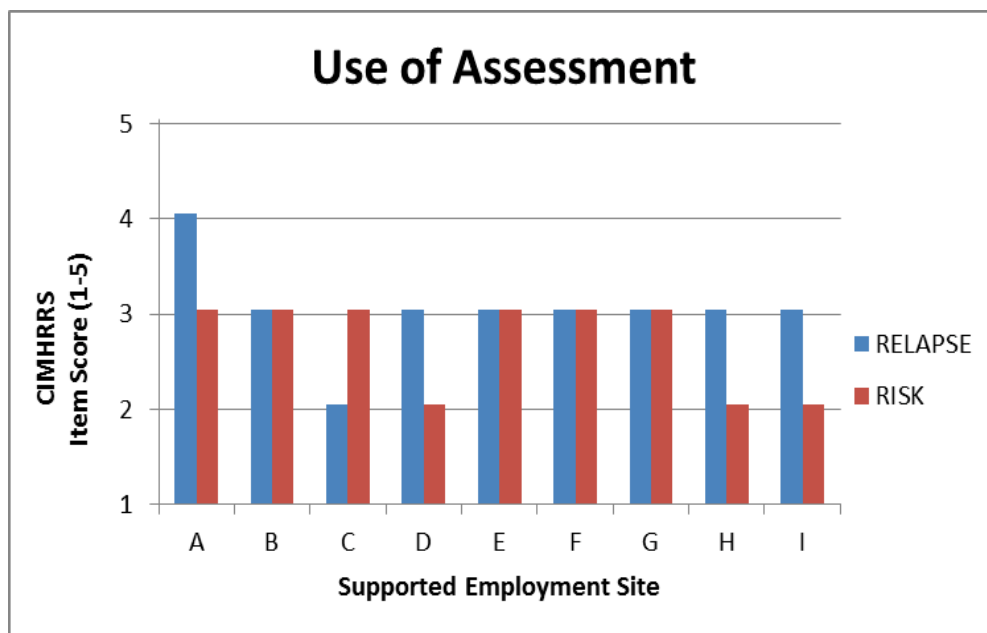
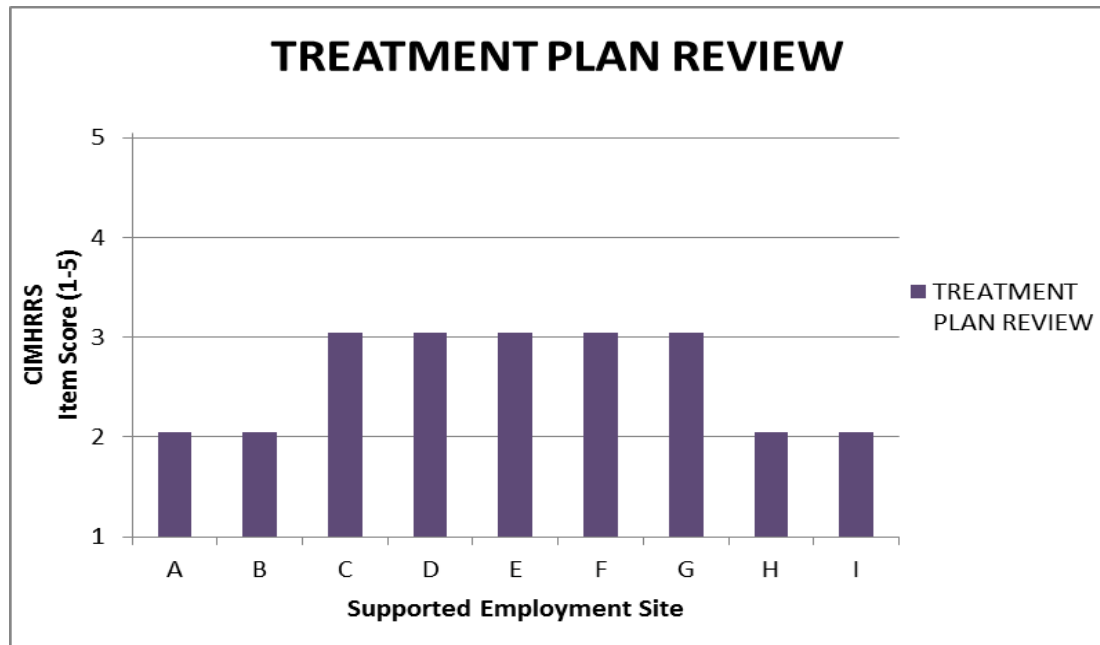


Figure 6.9. Treatment Plan Reviews across 9 Supported Employment Programs in Nebraska



Summary

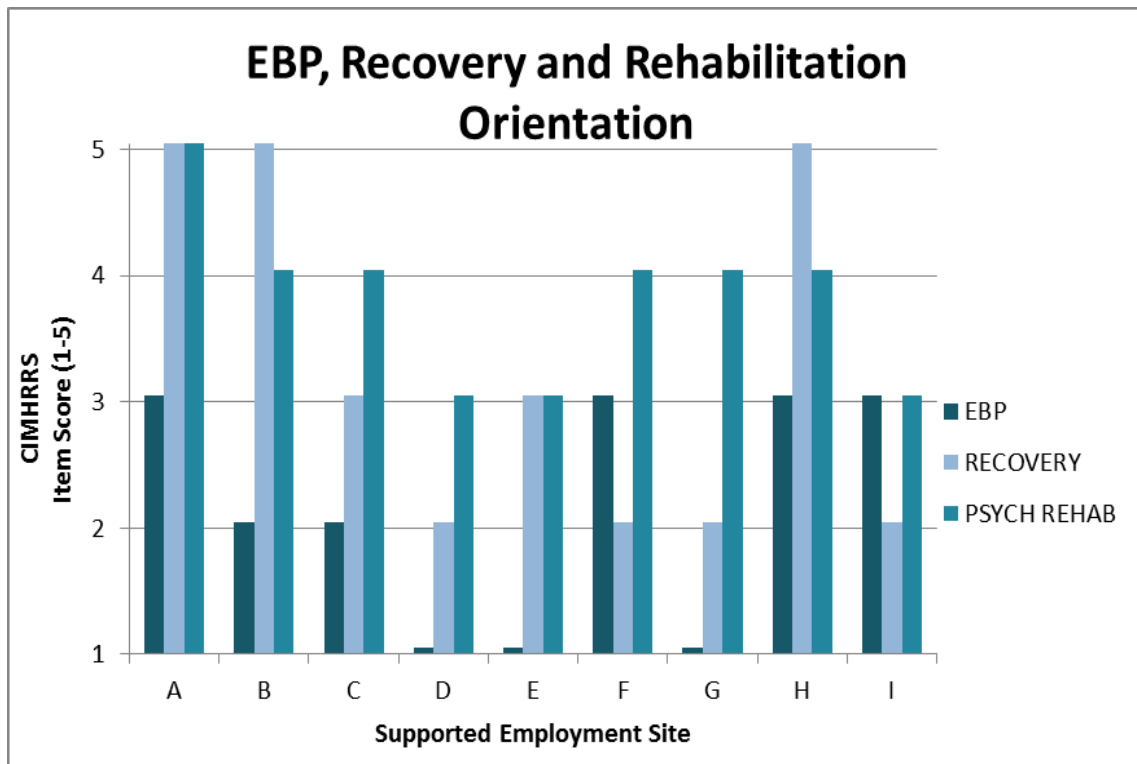
The hypothesis was only minimally supported. The use of assessments in the domains of skills, relapse, and risk appeared to conform to regulatory standards with most assessment being conducted systematically to assess performance without the data actually influencing treatment; however use of assessment in skill-based domains (i.e., functioning, social, occupational) varied considerably. Treatment plan reviews tended to occur at or beyond the frequency prescribed by regulatory standards; however use of treatment plan information to quantitatively assess progress or lack of progress was not present in these programs. The treatment plan reviews are conducted, but they appear to minimally affect the content or implementation of treatment.

Service Orientation

Hypothesis 5: Program directors and staff of the Nebraska SE programs will be able to follow the principles of evidence-based practice and recovery and rehabilitation.

As seen in Figure 6.10, the Nebraska SE programs endorsed varying degrees of an understanding of evidence-based practice, recovery and rehabilitation principles varies considerably. The presence of a prior existing model of employment services may have decreased receptiveness to a new understanding that incorporated orientation to EBPs, recovery, and rehabilitation principles. For example, programs C, D, E, and F shared a similar program model and these programs endorsed a relatively low understanding of these principles. It is also noted that high fidelity to the SE model did not guarantee a recovery-oriented and rehabilitative program. In particular, Programs H and I were those that met criteria for *Fair Implementation* of the SE program. Two programs scored relatively high on all 3; and 1 of these 3 programs was also a program that met SE fidelity standards that qualifies in the range of *Fair Implementation*.

Figure 6.10. Program Orientation towards Evidence-Based Practice, Recovery, and Psychiatric Rehabilitation



Summary

This hypothesis was only partially supported. SE programs in Nebraska demonstrated varied understandings of EBPs, recovery and rehabilitative practices. Further, a discrepancy between high fidelity on one SE item and discharge planning suggests a potential conflict between evidence-based SE and psychiatric rehabilitation and recovery practices.

CHAPTER 7

Discussion

The implementation of SE in Nebraska was aimed at transforming community-based employment programs for persons with severe mental illness (SMI) into evidence-based practice (EBP); however this study suggests that variance in the implementation procedure can impact the quality of services provided. This work highlights the role of the implementation process in the research-practice gap. Despite the research literature detailing successes of statewide implementation of SE by state governments, the provision of recovery and rehabilitation services to persons with SMI may remain limited if the implementation process is not adequately monitored.

Eligibility Criteria and Populations Served

This analysis suggests that the Nebraska SE programs did not adequately reach the primary target population of SE. After implementation of SE, the programs appear to be serving a smaller proportion of persons with Schizophrenia-spectrum disorders. This finding also diverges from the goals indicated in the SE research base. As noted in Chapter 2, SE programs in mental health were developed specifically for persons with SMI, such as Schizophrenia and other psychotic disorders. As noted in Figure 1, in the Nebraska SE services the proportion of persons served with diagnoses of Schizophrenia-spectrum disorders ranges from 23.5% to 30.1% in the years prior to the implementation of SE and decreases to 1.1% and 19.5% in the years after the implementation of SE. These numbers appear quite low when compared with prior research on SE. Systematic reviews report samples for whom the majority has

Schizophrenia-spectrum disorder, including 50% (Cook et al., 2005) and 60% (Crowther et al., 2001). In a randomized controlled effectiveness trial conducted across Europe, 80% of the sample had a diagnosis of Schizophrenia-spectrum disorder (Burns et al., 2007). Even in studies in which a well-defined diagnostic group is not of primary importance however, the majority of persons served have SMI. In an effectiveness and implementation study of persons receiving disability benefits, approximately 65-67 % of the population had a primary diagnosis of a psychotic disorder (Bond, Xie, Drake, et al., 2007).

This finding also goes against the aims of Nebraska's state policy. The Nebraska Behavioral Health Oversight Commission of the Legislature (2004) highlighted that community-based behavioral health services like SE should be ready and appropriate for persons who were transitioning from regional center behavioral health service to the community-based behavioral health centers. As noted in Chapter 3, LB1083 (the Behavioral Health Services Act) was targeted at improving community-based services for persons with SMI, considering the concurrent downsizing of the inpatient hospital system. The inpatient unit that was closed served the most treatment-refractory subset of the population of persons with schizophrenia-spectrum disorders and other SMI (Spaulding et al., 2010). The combination of reduced availability of inpatient beds for the most severe patients with SMI and a decrease in the proportion of individuals with SMI served by SE suggests a gap in services reminiscent of the deinstitutionalization movement.

Possible strategies to ensure that these programs serve persons with Schizophrenia-spectrum disorders include imposing quotas or other stipulations in

order to encourage outreach to populations towards those for whom SE was developed, persons with severe and persistent mental illness. Specifically incorporating these quotas into the service definition of SE have the potential to ensure that future state implementation efforts are directed at serving persons with SMI.

It is noted that a major limitation to this finding is the significant number of missing data in the current cases ($N = 382$) over the years of the implemented programs examined for this study. Nevertheless, the low average score on the SE fidelity scale item associated with exclusion criteria supports the practice of this selectivity. Qualitative reports from providers also indicate that the decrease was associated with a tendency to screen out persons with SMI because they were perceived as more psychiatrically severe than other clinical populations. This “cherry-picking” by programs may reflect the wider perceptions of providers, especially regarding stigma associated with beliefs about the ability of persons with SMI to work. This perception goes against the empirical findings summarized by Anthony and colleagues (1988) on the lack of a relationship between psychiatric symptoms and work functioning and are indicative of structural stigma and a provider culture characterized by beliefs about SMI that are incongruent with the research on evidence-based care, psychiatric rehabilitation and recovery.

It is plausible that the SE programs might not have been directed at serving persons with SMI. The goals of the Nebraska SE programs as stated by the Nebraska Department of Health and Human Services do not oblige these programs to serve only persons with SMI. The policies of LB1083 only stated the goal that an

expansion of services to all persons with a behavioral health disorder (i.e., Axis I diagnosis) would occur. It could be argued that although the proportion of persons with SMI served by the SE programs decreases after the enactment of these policies, there is no certainty regarding whether this is discrepant with the stated goals.

However, an examination of past federal and state experiences reveals that one major result of deinstitutionalization and subsequent proliferation of community-based services is that services are not provided to the persons who need this treatment most, including those with severe and persistent illness, which includes persons with SMI (Grob, 1991). Historically, this phenomenon has been identified as arising from several concurrent influences. The collapse of disordered and non-disordered populations (e.g., in depression) has contributed to inflation in the persons in the mental health service system (Horwitz & Wakefield, 2006); as a result, persons with SMI actually end up receiving fewer services (Grob, 1991). What has resulted in the past, as well what appears to have happened in Nebraska, are practices and policies that run counter to the expectation that health care systems “provide mental health services to persons who are most in need of them” (Horowitz & Wakefield, 2007, p. 141-142).

In sum, Nebraska SE programs appears to be serving a decreasing proportion of the target population of evidence-based SE. Serving a lower proportion of persons with SMI over time appears to go against the aims of LB1083, especially when these trends are concurrent with the closing down of intensive inpatient programs and their subsequent discharge of persons with SMI into the community. After deinstitutionalization there was an expansion of those categorized as persons with

mental disorders, and as a result, there were fewer services for persons with SMI (Grob, 1991), which appears to go against the aims stated by social policies. Persons with SMI (as defined by the literature, not by the state of Nebraska health system) require an array of services; the community-based employment services for persons with SMI appear to be serving a lower proportion of persons with SMI than in previous years.

Program Fidelity

Overall, fidelity to the SE model of evidence-based SE in the Nebraska SE programs was low. Only 2 of the 9 SE Programs achieved fidelity that qualifies as adequate implementation. One program scored within the *Good Implementation* category and one program achieved fidelity within the *Fair Implementation* category. Of the 2 programs that achieved fidelity, 1 achieved fidelity that was within one point of inclusion in the range of *Not Supported Employment*. The remaining 7 programs fell within the *Not Supported Employment* category, indicating that these programs did not adhere to the evidence-based version of this program.

The 2 programs that achieved fidelity were in relatively more populated areas than the other 7 programs. Although it is difficult to determine the specific reasons for this, it is worth noting that the program that achieved the highest fidelity of the Nebraska SE programs was a consumer-run group. It is possible that the relatively higher populated areas of Nebraska are also in closer proximity to consumer groups, which may contribute to greater adherence to evidence-models of treatment. Moreover, the program with the highest fidelity rating had significant connections to national EBP organizations. Connections to resources beyond those provided at the

administrative level appeared to have assisted this program's achievement of fidelity. Corrigan and Boyle (2003) note that significant changes in mental health systems can occur when consumers and other key members of the community have the attitudes and knowledge about psychiatric rehabilitation services. Future research should examine associations between consumer advocacy and the provision of evidence-based and recovery-oriented care.

Seven of the programs did not meet fidelity as required with the SE or evidence-based version of SE. Confusion may have arisen from the presence of both evidence-based and non-evidence based supported employment program models. As described in Chapter 3, several of the programs had versions of supported employment that are not evidence-based.

Regarding the pattern of fidelity that was achieved, Nebraska SE programs achieved high ratings on 5 of the 15 items. These include caseload size, vocational generalists, rapid job search, jobs as transitions, and follow-along supports. Although these five comprise a third of the total scale, it is important to recognize the limitations of this fidelity instrument. The scoring guidelines of the fidelity scale utilizes a sum of item scores and uses this summed score to categorize programs based on the quality of the program implemented. One of the limitations of this fidelity approach is that it ascribes equal value to each of these items.

All Nebraska SE programs were rated highly on several items on the fidelity scale. For example, the average score for SE programs on the item *jobs as transitions* was 4.4 out of 5. At first glance, this would appear high and suggest that the Nebraska SE programs are doing quite well. It is worth noting that several

consistently highly rated items do not necessarily guarantee the delivery of high quality services. Upon closer inspection of the item *jobs as transitions* however, one notes that this is described as viewing jobs as “positive experiences on the path of vocational growth and development” (SE Fidelity Scale; Bond, Becker, Drake, et al., 1997). The rating for this item is behaviorally defined as helping a person find a job. Because vocational programs are aimed at assisting individuals find employment, it would be surprising that any program would score extremely low on this item.

Contrast this with another item on the scale, *integration of rehabilitation with mental health treatment*, which is described as employment specialists being part of mental health treatment teams and have frequent contact with treatment team members. This item is a critically important feature of the organization of an evidence-based SE program, as this focuses on recognizing and targeting mental health problems when they interfere with treatment. For example, an individual may have severe deficits social skills or substance abuse problems that significantly impede successful occupational functioning. Working collaboratively with the mental health treatment team, employment specialists can address this problem directly by ensuring that the client’s psychologist, for example, can focus on social skills training or maladaptive coping using substances, to ameliorate this problem and improve the chances of successful functioning on the job. Yet, the scoring system of the fidelity scale is such that the two items just reviewed, *jobs as transitions* and *integration of rehabilitation with mental health treatment*, items are equivalent in importance. An inadequate understanding regarding the core features of SE, as illustrated by the imprecision of the scoring of the SE fidelity scale, may limit a clearer understanding of the core

features of a program that contribute towards its ability to assist persons with SMI achieve their functional independence goals associated with employment.

All of the Nebraska SE programs scored low on the item related to the integration of SE services with mental health treatment, which may indicate that a system-level change and a greater culture of psychiatric rehabilitation might improve fidelity to the evidence-based model of SE. In addition to the barriers reported above, another factor that may have contributed to the lack of fidelity on this item is the population who was served by the Nebraska SE programs. Less severe populations may require less integration of treatment providers, which may describe the apparent confusion about this item on the fidelity scale, as reported by employment specialists. Most employment specialists regarded employment and treatment as separate rather than integrated domains, which may reveal that the focus of the SE programs was on employment alone without consideration of other mental health factors, and also that the focus of the other treatment providers is to provide traditional therapy techniques that are not focused on psychiatric rehabilitation practice. On the other hand, it was also noted that several of the employment specialists indicated concerns such as personal hygiene deficits, social skills deficits, medication adherence and substance abuse as barriers to the ability to achieve employment. Taken together, this may suggest that an integration of services would have potential to contribute to improving at least a subset (i.e., those with more severe impairments) of clients' ability to achieve employment.

Minimal administrative support of the implementation of the SE program in Nebraska (as evidenced by minimal training in SE prior to implementation) may have

impacted the low fidelity of these SE programs to the evidence-based version. Past implementation studies have highlighted the importance of support at the administrative level (Bond, McHugo, Becker, et al., 2008).

The relatively low fidelity achieved by the Nebraska SE programs may also be attributable to the implementation process. SE implementation researchers have admonished against the broad, one-time implementation that characterized the Nebraska SE implementation procedure (Becker et al., 2008). Instead, researchers argue for an implementation process that is conducted in stages (Rosenheck, 2001b). Becker and colleagues (2008) illustrate examples of successful implementation where four years of training were necessary. The first year includes building informed support or implementing SE services in a sustainable way, creating a state-level SE steering committee, developing in-state technical assistance capacity, and carrying out a competitive site selection process to select a few sites to pilot the implementation (Becker et al., 2008). The remaining 3 years are devoted to implementing SE and developing plans to expand SE statewide (Becker et al., 2008). It is arguable however, that this recommended implementation process is too time, money and labor intensive for chronically under-funded state mental health systems.

In addition to time, money and labor, the organizational structure between the Nebraska Division and Regions may not have been conducive to the implementation of SE. Based on the statutory definitions of responsibilities of the Division and Regions in Nebraska, it would appear that the onus of providing SE services and monitoring quality of services is on the Regions; however the Division initiated the SE implementation process. This separation of roles is distinct from the 4-year

implementation process described by Becker and colleagues (2008) assume greater integration between the state and regional levels. The SE implementation process in Nebraska was further complicated by the presence of existing non-evidence based supported employment programs in some regions over others. As a result, regional providers may have different training needs based on their prior experience with evidence-based and non-evidence based supported employment services. SE implementation researchers have not adequately addressed these real-world implementation barriers.

The different locations in which SE services were provided (e.g., day rehabilitation programs versus existing vocational rehabilitation) may have also contributed to the low fidelity of the Nebraska SE programs. As described above in Chapter 4, the roles of Nebraska Vocational Rehabilitation (VR) and Nebraska SE programs were separated such that in some programs, VR staff conducted some assessments related to work and, at times, prolonged the time between entrance into the program and initiation of the job search, which reduced against fidelity scores. In contrast, Maryland's implementation experience indicated the presence of a braided mechanism between Vocational Rehabilitation and Supported Employment services that led to a single provider who offers the full range of employment and mental health services (Centers for Medicaid and Medicare Services, 2008), which was consistent with the evidence-based model. Adequate planning and structural adjustments conducive to the delivery of evidence-based SE may be necessary for successful statewide implementation.

There were two non-evidence based models of supported employment variety of program models that existed prior to the implementation of the SE program in Nebraska. These include the Goodwill and Clubhouse models of supported employment. The Goodwill model focuses on persons with physical rather than psychiatric disabilities and the Clubhouse model focuses heavily on a three-tiered employment model that includes transitional, supported and independent employment. The Clubhouse model is especially known for its transitional employment program, which focuses on developing skills in a job owned by the program and then moving on to competitive employment. Both the lack of statewide training in SE and the presence of training in these other models of supported employment, likely contributed towards the pattern of fidelity across the Nebraska SE programs. These results indicate that divergence from a standardized implementation process can have a result on programmatic functioning. Although the SE implementation research indicates that the SE model can be implemented, much less has been discussed about the transformation of non-evidence based models of supported employment towards SE models. It is plausible that non-evidence-based supported employment models are either similar to or in conflict with the SE model, which might result in greater resistance in the implementation process.

Training in the SE model might offer improvements with specific implementation issues across the state (e.g., difficulties integrating mental health treatment with SE services). Past research has demonstrated that implementation can be improved using a sustained training program (Rosenheck & Mares, 2007). Nevertheless, the extant research has not yet determined whether the quality of the

training/consultants has an impact on the implementation process (Bond, McHugo, Becker, et al., 2008). At minimum, this case study reveals that among other factors, the absence of training during the implementation process can produce programs of low fidelity.

Over the long run, training appears to have the potential to improve fidelity. In a longitudinal study with fidelity monitoring using 3-time-points of, significant improvements were made on a variety of fidelity items. It is worth noting that several of the items that were lower at baseline and more resistant to change in this analysis of Nebraska SE programs (e.g., integration with mental health treatment) were the same as that found by Bond, McHugo, Becker and colleagues (2008), which might suggest that these problems are not necessarily endemic to the Nebraska. Instead, this might reflect a problem regarding the greater generalizability of SE programs into existing mental health systems.

In sum, although the research literature on SE indicated that statewide implementation by state governments can result in successful implementation, the Nebraska experience reveals that the implementation by state governments can be complicated by structural arrangements, existing vocational models and the lack of adequate resources (e.g., training, money, time, administrative support and knowledge). Training would likely improve the provision of SE services specifically, as well as help foster a provider culture that emphasizes recovery and rehabilitation for persons with SMI. Fidelity monitoring, such as what was conducted in this study, will also protect from program drift (i.e., drift from program fidelity) over time.

Although training may improve SE and other community-based services, it may be unable to address the gap in services for persons with SMI left from the closing down of inpatient units. As mentioned earlier, even the best, high fidelity SE programs will not meet the full range of treatment needs of this heterogeneous population. There is a subset of the SMI population for whom intensive inpatient care is necessary. As noted by Lamb and Bachrach (2001) and Spaulding and colleagues (2010), a perennial concern about services for persons with SMI is the neglect of the broad needs of the entire spectrum of persons with SMI. Evidence-based community programs like SE are beneficial, but mental health services need to be able to discriminate and decide who can best use them (Wasow, 1986). Predicting who can and cannot benefit from programs is important and it is possible that not all people are benefiting from these services (Wasow, 1986). Researchers agree that some proportion of persons may not benefit from even the highest quality, evidence-based community-based programs and the greater mental health care system should be better equipped to address the needs of this heterogeneous population (Lamb & Bachrach, 2011; Wasow, 1986; Zipple, Carling & McDonald, 1987).

Employment Outcomes in Nebraska

Employment outcomes achieved by the Nebraska SE programs were significantly lower than those demonstrated in the literature. They are also significantly lower than those achieved by other states that have demonstrated the successful implementation of SE. In Maryland, for example, 62% of people receiving SE services achieved outcomes (defined as 90 consecutive days in competitive, integrated employment, at or above minimum wage, with the person satisfied with the

job placement); whereas only 37% of people in other employment programs achieved successful outcomes (Center for Medicare and Medicaid Services, 2009). These outcomes remain considerably higher than the outcomes achieved by the SE programs in Nebraska that were described as being evidence-based.

Considering the populations served by the programs, it is surprising that the Nebraska SE programs achieved relatively low outcomes. Nebraska SE programs reported serving a less disabled and less psychiatrically severe population than that reported in the literature. It is possible that low fidelity was associated with the low outcomes achieved by the Nebraska SE programs. As described in Chapter 2, fidelity to the IPS model of SE has been consistently associated with outcomes achieved; however the data available limited an empirical answer to this question.

The differences in employment outcomes achieved do not appear to be attributed to other demographic or clinical differences. Past research and program evaluation studies report serving persons of similar demographic backgrounds, such as age. The average age of persons served in this study ($M=38.8$ years) was approximately the same age on average as those in other studies compared to 38.5 years (Cook et al., 2005) and 37.8 years (Burns et al., 2007). Similarly, most persons served in this population were receiving benefits of some kind, similar to the results produced by Bond, Xie, & Drake (2007).

It is also possible that the late-2000s national recession may have contributed towards the employment outcomes achieved by the Nebraska SE programs; however the annual average Nebraska unemployment rate has been among the lowest in the nation for years (Nebraska Department of Economic Development, 2011). Data from

the Bureau of Labor Statistics (2011) indicate the following state Nebraska unemployment rate at the beginning of each fiscal year: July 2006, 3.3%; July 2007, 3.2%; July 2008, 3.4%; July 2009, 4.7%; July 2010, 4.7%. Comparing these rates with the outcomes achieved by the Nebraska SE programs, it does not appear that unemployment in the state of Nebraska would have impacted the ability of SE programs achieve employment outcomes. There is a slight decrease in the outcomes achieved by SE programs noted from fiscal year 2008 to 2009, from 28.6% to 25.9%, respectively; however this impact appears minimal at best. Although no base rates of employment among persons with SMI during this time are available, Anthony and colleagues (1988) report that no more than 20-30 percent of persons with SMI will be working after hospital discharge. These numbers suggest that the outcomes achieved by the Nebraska SE programs are similar to a base rate of employment expected among a general population of persons with SMI.

The Nebraska inclusion of transitional employment (TE) as an outcome for the SE programs provides further evidence that the Nebraska SE programs were not having the expected impact of evidence-based SE programs. The inclusion of TE as an outcome for SE suggests that a more accurate depiction of the impact of the Nebraska SE programs would be substantially lower. Data limitations restricted the ability to estimate the outcomes of the SE programs with and without TEs included as an outcome; however data from other studies are telling. TEs do not appear to lead to steady employment in the labor market (Pirttimaa & Saloviita, 2009). TE outcomes were common in Nebraska because 2 programs conformed to an employment program model that provides TE services (i.e., clubhouse model programs). As

described earlier, these programs use a graded approach to employment and qualitative reports indicated that these programs viewed the graded approach as indispensable to a person's ability to reach supported employment. Thus, the beliefs and principles underlying SE and TE may be incongruent. Differences between SE competitive employment outcomes and TE lay in goals, placement length, wages, job level, access to the work environment, and client disclosure (Anthony, 2008). As noted in Chapter 3, past researchers have discriminated between SE and TE outcomes (Anthony & Blanch, 1987). As noted by Anthony (2008), the merging of TE and SE outcomes has been an attempt to fund transitional employment interventions within SE legislative initiatives. The extant SE implementation research has provided minimal guidance on the transformation of programs that provide TE, and how to transform the greater provider culture that endorses TE as a prerequisite to competitive employment.

Because there is a strong relationship between SE Fidelity and outcomes, it is possible that the relatively low outcomes achieved by the Nebraska SE Programs might be due to the low fidelity scores. As noted in the Limitations below, an analysis of outcomes by programs was not possible due to data errors and insufficient error.

In sum, the outcomes achieved by the Nebraska SE programs appear to be more similar to those produced by traditional vocational rehabilitation programs. These outcomes do not appear to be attributable to other factors, such as the Great Recession or clinical or demographical differences. Considering both the less severe diagnostic populations who were served by the SE programs and the inclusion of TE

as an outcome in these programs, the impact of the SE programs in Nebraska appears to be minimal.

Program Procedures

The use of assessments in the domains of skills, relapse, and risk tended to conform to regulatory standards with most assessment being conducted systematically to assess performance without the data actually influencing treatment; meanwhile the use of assessment in skill-based domains varied considerably. This contrasts significantly with the principles of psychiatric rehabilitation, which focus on the use of assessment to inform planning and intervention to reach vocational goals (Anthony, Cohen, & Danley, 1988). This may have been attributable to imprecise and sometimes conflicting regulatory language regarding the use of skill-based assessment (especially vocational assessment). For example, In the domains of functioning and skill acquisition, it is noted that the SE fidelity scale requires “ongoing on the job assessment;” however the parameters around such assessment of skills were not clearly defined, which appears to be reflected in the CIMHRRS item related to assessment of this domain. In addition, aside from the service definition of SE, program in Nebraska did not appear to have specific regulations related to SE programs, as SE was provided by existing community-based services. Based on results demonstrating assessment behaviors, SE programs appeared to follow the regulatory procedures of day rehabilitation programs rather than assessment associated with the service definition. The day rehabilitation programs are required services assess “psychosocial skills” (Nebraska Department of Health and Human Services, 2006); however which specific domains of psychosocial functioning are

required remains unclear and this appears to be reflected in the actual program procedures. Imprecise language in the regulations may have contributed to the disparate assessment practices seen across programs.

Nevertheless, these data are consistent with the findings summarized by Tamblyn and Battista (1993) that reinforcement structures (i.e., through regulatory standards) have a significant impact on clinical practice and the provision of evidence-based care over and above those factors that directly target clinical competence (i.e., provider skill or knowledge). Regulatory policies provide for opportunities for practicing interventions and receive feedback (Tamblyn & Battista, 1993). The regulatory policies guiding the Nebraska SE programs were not specific to evidence-based SE or psychiatric rehabilitation services; rather they were reflective of more general community-based services (e.g., day rehabilitation programs). As a result, in practice, clinical care was more similar to general community-based services than SE or psychiatric rehabilitation.

It is difficult to determine whether the SE regulations specifically influenced the poor implementation of recovery and psychiatric rehabilitation practices (in the areas of assessment across several domains) in these programs in Nebraska. Regulatory specificity also appears to be a concern with LB1083. In a legislative auditor report, several concerns were noted, including one finding that “Clarity of the responsibilities between the Division and the regions is likely harmed by the weaknesses in the Division’s planning efforts identified by Behavioral Health Oversight Commission (BHOC) and the absence of updated regulations. Discussion: Comprehensive planning for the delivery of an appropriate array of services across

the state was a critical element of LB 1083's vision for shifting behavioral health care to community-based services. Similarly, properly promulgated regulations would provide uniform definitions and processes for the regions to follow (p.3)" (Nebraska Legislature, 2010).

Treatment plan reviews tended to occur at or beyond the frequency prescribed by regulatory standards; however use of treatment plan information to quantitatively assess progress or lack of progress was not present in these programs. It is possible that the minimal use of a treatment plan review, other than updates at the mandated frequency, may be due to the lack of integration of these SE programs with mental health treatment teams. The organization of services delivered in the community appears to represent a fragmented and discontinuous provision of services, such that mental health treatment is separate from employment services like SE. The development of a separate treatment plan for each program a person is in (mental health, employment, day rehabilitation, etc.) may result in a diluted version of each treatment plan, rather than a full treatment plan that integrates care across the various domains of consumer functioning. The common theme across the use of assessment and treatment plan reviews is that these were being conducted systematically but were rarely used to make clinical decisions that would inform or impact treatment.

The role of funding mechanisms, managed care and private behavioral health service providers has been recognized as a more recent change in care for persons with SMI which has major implications for treatment for persons with SMI (The past and future, 2000). This analysis reveals that reimbursement regulations appear to have greater influence than principles associated with the evidence-based program

and recovery and rehabilitation practices. This is consistent with the implementation literature on transforming clinical practice through reinforcement and feedback rather than clinical competence (Tamblyn & Battista, 1993).

Knowledge about Evidence-Based Practice and Psychiatric Rehabilitation

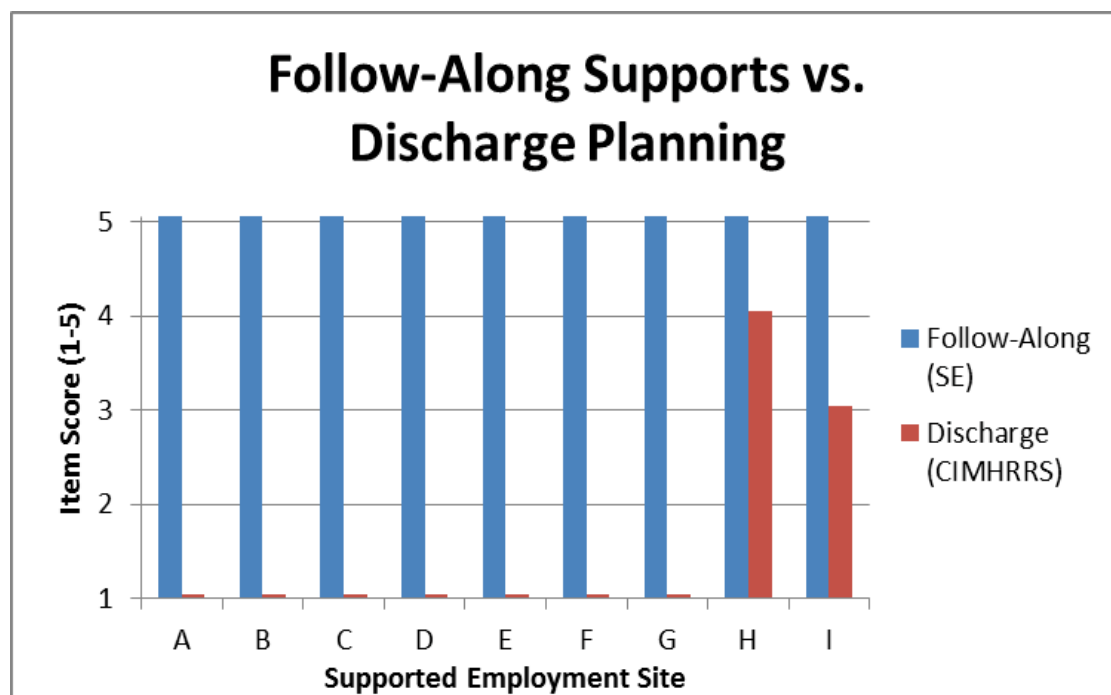
Many Nebraska SE programs demonstrated a limited understanding about evidence-based practices (EBPs) and psychiatric rehabilitation principles. Several authors have noted the importance of attitude change with mental health systems transformation (Corrigan & Boyle, 2003). Past implementation studies have highlighted the importance of support at the administrative level (Bond, McHugo, Becker, et al., 2008). SE implementation researchers also highlight the importance of the executive director being able to communicate recovery ideology and how SE actualizes this vision (Becker, Torrey, Toscano, Wyzik, & Fox, 1998). The lack of understanding among administrators and directors may have contributed to the quality of services implemented in Nebraska.

It is also possible that some aspects of SE are incongruent with a recovery-orientation. To draw the discrepancy between SE fidelity and a recovery-based orientation, Figure 7.1 depicts the contrast between two items (one from the CIMHRRS and one from the SE Fidelity Scale) denoting a point of potential conflict. Recovery and rehabilitation services are generally aimed at discharge planning that begins at intake; however the evidence-based version of SE requires that follow-along supports are provided continuously (i.e., time-unlimited). This might be indicative of a problem inherent in evidence-based model of SE that might conflict with recovery and rehabilitation services. A high score on this CIMHRRS item indicates that

discharge planning begins at intake into the program, whereas this item on the SE Fidelity Scale indicates that follow-along supports should be provided in a time-unlimited manner. Qualitative data from the semi-structured interviews revealed that several programs endorsed the idea that participants of their programs would be considered life-long “members” of the program, and this was especially true of programs that conformed to the Clubhouse model. Discharge, in these programs, was not considered appropriate. Only two programs acknowledged the use of discharge planning in their programs. The SE Fidelity Scale requires that SE programs provide time-unlimited supports, which renders a discharge from the program ambiguous and open to interpretation. The discrepancy between the goals of independent functioning and recovery and the time unlimited supports was noted by some programs. All programs appeared to provide follow-along supports however not all programs required discharge planning that begins at intake. Research on the core principles of SE indicates some ambivalence about the need for time-unlimited supports (Bond, 1998). This was initially included as a core principle in the SE model due to the reportedly arbitrary nature of the 90-day cut off VR.

The SE principle of continuous support is arguably inconsistent with the criterion of competitive employment, and outcome studies have been criticized for exaggerating outcome in this sense. One can compare the SE principle with the Fountain House model of perpetual membership and no expectation of functional change, although there are differences too.

Figure 7.1. Comparison of Items Related to Discharge Planning and Time-Unlimited Follow Along Supports



Conclusions

In summary, the Nebraska SE programs do not appear to be meeting the goals endorsed by the policy. The Behavioral Health Services Act mandated high quality and cost-effective behavioral health services (Laws 2004, LB 1083, section 3) and results from the program fidelity indicate that SE programs may not be providing behavioral health services that are consistent with the evidence-based version of SE. Thus, the Nebraska SE programs may not be producing the clinical impact expected of the evidence-based SE, which is not the most cost-effective option for the state and may not be the best provision of services for persons with SMI in the state.

Past researchers have described what is called “symbolic action” (Rosenheck, 2001a, p. 814). An SE researcher, Rosenheck (2001a) uses this term to call attention to the distinction between what is said is implemented versus what is actually implemented. This phenomenon describes the tendency of many healthcare systems and organizations to declare new programs implemented because funds have been allocated and directives have been issued, despite the lack of empirical evidence that the program has actually been implemented (Rosenheck, 2001a). Scholarly description about this phenomenon has been used to explain policy implementation by large organizations (Meyer, 1986; March, 1994). “Symbolic action” may be relevant to the Nebraska SE implementation process, the fidelity monitoring supported by DHHS, or both. No one has yet combined implementation research with the concept of “symbolic action,” despite recognition regarding its ubiquity. A major SE researcher has described the current health systems and organizational context as “an era when neglect masquerades as efficiency” (Drake, 1998, p. 1). Regardless of the actual intent of the implementation of SE services by the Nebraska Health and Human Services, based on its policy, it would be expected that practice should take the shape of its policy. In this case, there appears to be a discrepancy between the stated policy and the actual implemented services.

Meanwhile, each year, the National Alliance on Mentally Illness (NAMI) produces a “report card” to grade how states are doing in terms of the services that are provided. In 2006, there was optimism about Nebraska’s provision of supported employment services (National Alliance for the Mentally Ill, 2006). Interestingly, Nebraska received a “D” score in 2006 and the same score in 2009 (National Alliance

for the Mentally Ill, 2009). Nevertheless, Nebraska was not rated on SE services in the 2009 NAMI report and it is noted that NAMI uses in its criteria the provision of evidence-based SE services (National Alliance for the Mentally Ill, 2009). NAMI recognizes the limited number and variety of services for a specific subset of persons with SMI. NAMI states as one of its policy recommendations to increase services for persons with SMI who are most at risk and highlights the trends in state after state towards shortages of inpatient psychiatric beds, which accounts for a significant cost to states (National Alliance on Mental Illness, 2009).

Recently there been a greater recognition of the role of organizational processes and context on the implementation process. Implementation research is an area in which psychologists should have a prominent role. Implementation research is inherently multidisciplinary, “encompassing both the quantitative and qualitative approaches that require expertise in epidemiology, statistics, anthropology, sociology, health economics, political science, policy analysis, ethics, and other disciplines” (Sanders and Haines, 2006. p. e186). Psychologists are adequately equipped for this research because they are trained to think comprehensively, integrating the complexity of functioning at the genetic, biological, individual, social and environmental levels (Spaulding, Sullivan, & Poland, 2003).

Lehman (1998) highlighted early on that mental health service research should play an important role in closing the gap between research and everyday clinical care. He called attention to the need for mental health services research to facilitate the translation of science to practice by examining the patterns of usual care in relation to

scientifically established standards of efficacious care and examine the impacts of the organization and financing of services on outcomes (Lehman, 1998).

This study suggests important findings about the implementation of SE. There was large variation in the implementation of this EBP and significant divergence from recommended guidelines, which appeared to have an effect on the quality of SE services provided. Providers endorsed the provision of EBPs without actually providing them. A better understanding of the real-world implementation process and factors that impact the divergence from recommended guidelines may provide valuable insight to ways to close the research-practice gap for persons with SMI. These results have important implications for clinicians, providers, policymakers and most of all, patients with SMI.

Limitations

Missing Data. As noted above, diagnostic information was unavailable for 382 unduplicated persons served by employment services provided through DBH. As diagnostic information will remain important and relevant to understanding the populations served by the SE programs, it is recommended that the data systems require the inclusion of important data (e.g., mandatory data input fields) to improve problems related to missing data.

Data errors. The inability to link the DBH and VR databases means that full data are not available by program the time period for this study. This problem limited an ability to analyze the relationship between fidelity and achievement of outcomes. This also presents significant challenges for an accurate reporting of data for the Federal Mental Health Block Grant. Another concern related to the outcomes

reported in this study might be the artificial inflation of outcomes due to clerical errors. The current VR database contains many clerical errors, including several errors that could artificially inflate the outcomes achieved by SE programs. For example, the data reported to VR for FY2008 and FY2009 by one SE program visited for this report contained several individuals who had achieved employment in FY2007 but had remained in the system as an outcome for the following Fiscal Years, even though the outcome date had remained the same through the various Fiscal Years for which this case was counted as an outcome. Such errors artificially inflate outcomes and obscure a clear and accurate reporting of outcome data for the SE programs in Nebraska.

Assessments. The CIMHRRS is a relatively new measure and although initial analyses have demonstrated the validity and utility of this instrument, there is still room for alternative interpretations of the CIMHRRS data. Assessment procedures in the Nebraska SE programs were very different from those required by a comprehensive psychiatric rehabilitation program. It may speak to the difference between SE and psychiatric rehabilitation and the lack of a theoretical underpinnings of these days. Post-hoc analyses of the data do reveal that there was a discrepancy between the item related to discharge planning on the CIMHRRS and unlimited follow-along supports on the SE Fidelity Scale. This might reveal a point of divergence between SE specifically and psychiatric rehabilitation and recovery principles.

Relevant clinical factors. In addition to high fidelity, several client factors have been identified as predictors of successful outcomes in SE programs. In his

manual on psychiatric rehabilitation, Liberman (2008) summarized several client factors that predict work functioning: good cognitive functioning; realistic family support; prior work experience; good pre-morbid social and educational attainment; good current social functioning; younger age; fewer and less intense mood, anxiety, conceptual disorganization and negative symptoms; abstinence from illicit drugs and alcohol; expressed desire to work and willingness to expend effort to find work; and few or no disincentives from social security or other disability entitlements.

Examining 24-months of longitudinal data from a multisite study, results showed that even when controlling for an extensive series of demographic and work history covariates, clinical factors remained significantly associated with individuals' ability to achieve competitive jobs and work 40 or more hours a month (Razzano, Cook, Burke-Miller, et al., 2005). Factors most consistently associated with failure to achieve employment outcomes included poor self-rated functioning, negative psychiatric symptoms, and recent hospitalization (Razzano et al., 2005). For example, persons with physical comorbidities had lower earnings, worked fewer hours and were less likely to work competitively (Cook, Razzano, Burke-Miller, et al., 2007). The attainment of competitive employment was also less likely among those with intellectual disability, visual impairment and human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS) (Cook et al., 2007). While there is a growing literature on individual predictors of success within an SE program, there is a need to clarify individual differences that may serve as significant predictors of response (Twamley, et al., 2003). Moreover, the interaction of program

and individual characteristics may provide further information on successful implementation and attainment of employment outcomes.

As a comparison of fidelity and outcomes was not possible for this study due to the data limitations, it remains possible that client factors may have contributed to the relatively low outcomes achieved by the Nebraska SE programs, especially considering the closing of an inpatient unit which overlapped with the duration of this study.

Other limitations. No randomization was possible for this study, as it was a naturalistic study. In addition, past research has shown that certain neurocognitive variables, such as working memory, are relevant to employment outcomes in SE program (Evans, et al., 2004). In addition, it is well-acknowledged among employment specialists and clinicians that incentives for working may be low, as working a specific number of hours may disqualify them from receiving disability benefits. It is possible that this may be a significant force in a client's motivation (or lack thereof) to work, which may subsequently impact our results. Although it is beyond the scope of the study to examine specific motivational factors of individuals with SMI to work, this important factor should be addressed in future research examining employment outcomes.

It is also important to address the maintenance and quality of employment activity. Despite the researcher's repeated attempts to request that more meaningful outcome data be collected (e.g., number of hours worked and change in outcomes over time), the State was not willing to incorporate these data collection given the time demands of employment specialists. However, at a town hall meeting with

regional providers *before* the official implementation of the Supported Employment program in the State of Nebraska in Fiscal Year 2008, the researcher actively voiced this need for better quality data to regional providers. A limited number of regional providers were in agreement and stated that they would try to collect these more detailed outcomes (e.g., number of hours worked weekly). On-site visits will include inquiries about whether more detailed outcome data were collected.

Future Directions

Psychologists have a role in acting as “local clinical scientists” (Stricker & Trierweiler, 1995) and can provide consultation and direction for local public policy, planning, implementation, and evaluation of programming (e.g., see Phillips, Boysen, & Schuster, 1997; Sheras, Cornell, & Bostain, 1996; Wandersman & Nation, 1998). Implementation research is an important area for future research in SMI. Persons with SMI come into frequent contact with the mental health service settings, so this is the optimal place to implement EBPs (Drake, Goldman, & Leff, 2001). This research should also address issues related to the greater context, and in particular, the greater mental health service delivery system, including state administration and regulatory policies and their role in statewide implementation efforts. As Klerman (1985) notes the “current pluralism, diversity, and deinstitutionalization in mental health care are in sharp contrast to the centralization, isolation, and institutionalization that characterized [the organization of care in] the 19th century” (p. 585). As mental health services has shifted into community settings, organizational researchers are required to adapt their level of analysis and their concepts and methods in order to accommodate the newly evolving, more loosely coupled intra- and inter-

organizational systems of care. This project represents a first step in the direction of conducting implementation research as a “local clinical scientist” focused on understanding factors in the organizational context that might improve the implementation efforts by mental health care service systems that strive to serve the treatment needs of persons with SMI.

In discussing the impact of George Bush’s President’s New Freedom Commission on Mental Health in 2002, two SMI mental health policy scholars observe with cautious optimism future services for persons with SMI:

“Much remains to be accomplished in terms of implementing these recommendations. The next decade will tell us whether transformation will mean radical or incremental change or simply remain as a political slogan... Will states transform their mental health systems, pooling resources across the many state agencies that affect individuals with mental illness? Will new evidence-based service programs be implemented (p. 184)?” (Grob & Goldman, 2006).

The results of this case study suggest that there are limitations to the implementation of evidence-based practices, especially for persons with SMI. Future research should be directed at comparing policies endorsed by state governments with the actual implemented program services for persons with SMI. Such research is necessary to ensure that mental health service systems are held accountable for the services that they say they are providing, especially for persons with SMI. The gap between policy and practice should be examined, as well as clarification regarding the factors that assist administrative bodies to ensure that what stated in policy is enacted in practice.

Moreover, since the time of deinstitutionalization, researchers have called attention to the *continuum of care* required for persons with SMI. No single evidence-based practice, SE or otherwise, will ever be able to meet the variegated needs of a population as heterogeneous as persons with SMI. Inpatient, outpatient and community-based care all serve an important role in the continuum of treatment required for the recovery of persons with SMI. The implementation of single evidence-based practices for persons with SMI will only ever be effective when provided within the context of comprehensive mental health care system. The SMI population is extremely heterogeneous and mental health systems are required to delivery services that meet this range of disability and treatment needs. Successful implementation an EBP will only fulfill its purpose in the presence of a comprehensive continuum of care.

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APPENDIX A

DBH Service Definition of Supported Employment

As Approved By:

Ronald E. Sorensen, Behavioral Health Administrator
 Division of Behavioral Health Services
 NE Department of Health and Human Services

As Approved on
 January 5, 2007

Service Name Supported Employment (SE)

Setting	Community based setting, contacts most frequently provided in the home, at the job site, or in a neutral community setting away from the work place selected by the consumer. Minimal services provided in an office-based setting.
Facility license	None; Not facility-based
Basic definition	Evidenced-based service designed to promote rehabilitation and return to productive employment for persons with behavioral health disorders age 19 and older. Behavioral health disorders are mental illness or alcoholism, drug abuse, or related addictive disorder. Problem gambling is specifically excluded. The service employs a team approach for treatment with the employment specialists responsible for carrying out all vocational services from intake through follow-along. Job placements are: community-based (i.e. not sheltered workshops, not onsite at SE or other treatment agency offices, employment in enclaves or pre-vocational training), competitive (i.e., jobs are not exclusively reserved for SE consumers, but open to public), in normalized settings and utilize multiple employers. The team is assertive in engaging and retaining consumers in treatment, especially utilizing face-to-face community visits, rather than phone or mail contacts. The SE team consults/works with family and significant others as appropriate. SE services are coordinated with Vocational Rehabilitation.
Services	<ul style="list-style-type: none"> - Personalized Benefits Counseling are provided by Vocational Rehabilitation for consumers who are eligible for or potentially eligible but not receiving benefits from Supplemental Security Income (SSI) and/or Social Security Disability Insurance (SSDI). - The Employment Specialist collects information and develops an individualized employment service plan within 2 weeks. - There is an individualized and customized job search with the consumer. Employer contacts are based on consumers' job preferences and needs. The first contact with an employer about a competitive job is typically within one month after program entry. - Job development. Provide diversity in job options that are in different settings and may include self-employment - With consumer consent, the Employment Specialist participates on clinical/program team meetings or otherwise facilitates communication with other treatment or rehabilitation providers to promote an integrated plan for the consumer. - Individualized follow-along supports are provided to employer and consumer. - A crisis/relapse prevention plan is in place and can be implemented.
Commitment Requirements (BH Division contractors)	Not Applicable

APPENDIX A (continued): DBH Service Definition of Supported Employment

Programming	<ul style="list-style-type: none"> - Personalized Benefits Counseling by Vocational Rehabilitation - Initial and ongoing work-based vocational assessment - Employment plan reviewed / updated as needed, but no less than every six months with measurable goals and objectives. Initial Plan is completed within 2 weeks of admission. - Frequency of face to face contacts based upon need of the consumer and the employer. - Job Development - Services reflect individual preferences with competitive employment as the goal and are integrated with treatment services
Length of Stay	<p>Based upon consumer need for continued supports</p> <ul style="list-style-type: none"> - Employment Specialists provide only vocational services. - The Employment Specialist carries out all phases of vocational service (e.g. engagement, assessment, job development, job placement, job coaching, and follow-along supports). - Knowledge of homelessness, substance abuse, mental illnesses and their impact upon employment; Evidence-based employment practices; Motivational interviewing/stages of change;
Staffing	<ul style="list-style-type: none"> - Ability to create a connection with customers by engaging in dialogue with another person; characterized in thought, word, and behavior by respect, safety, trust, affirmation, open-endedness and hope; gather pertinent information in a respectful manner that helps the practitioner and consumer develop insight into skills, strengths and goals; Provide relevant information, support and assistance that respects a person's right to guide her/his own employment plan; Understand cultural and ethnic considerations and their effect upon employment; and Participate as a member of a program / clinical team. - No Professional Licenses required
Staff to Client Ratio	One full time employment specialist supports up to 25 consumers (1:25).
Hours of Operation	Given jobs can be day, evening, or night, the program is flexible enough to serve the consumers' employment needs. Services are provided weekends, evening, and holidays as needed.
Consumer Need	<ul style="list-style-type: none"> - Consumer states he/she wants to work. There are no eligibility requirements such as job readiness, lack of substance abuse, no history of violent behavior, and mild symptoms. - The consumer has a behavioral health disorder (i.e. mental illness, alcoholism, drug abuse or related addictive disorder).
Consumer Outcome	<ul style="list-style-type: none"> - Consumer maintains employment (full time or part time) as part of his/her sustained, stable community living. - Rehabilitation plan goals and objectives are substantially met. - The consumer has a crisis/relapse prevention plan in place and can be implemented if needed.
Rate	<ul style="list-style-type: none"> - Capacity Expense Reimbursement – The provider is paid actual expenses with appropriate documentation up to 100% of the contracted amount in 12 monthly payments. - The budget follows Nebraska Vocational Rehabilitation financial guidelines including Interpreter Service costs. - The budget is designed to make available to the behavioral health provider sufficient funding to engage in the Supported Employment Program.

- No expenses paid for prevocational training, sheltered work, or employment in enclaves.
- Transitional Employment Program (TEP) is acceptable when part of a clubhouse certified by the International Center for Clubhouse Development (ICCD) and is used to help the consumer move toward competitive employment. TEPs can be no more than one third (1/3) of the jobs in the program.

APPENDIX A. DBH
Service Definition of Supported Employment (continued)

UTILIZATION GUIDELINES

ADMISSION GUIDELINES

All of the following must be present:

- a. The person has a diagnosis under the Diagnostic and Statistical Manual of Mental Disorders (current version) consistent with “behavioral health disorders” (i.e. mental illness, alcoholism, drug abuse or related addictive disorder).
 - b. Individual states he/she wants to work.
 - c. Consumer requires supports to secure and maintain competitive employment.
2. Zero exclusion – This means every individual who wants employment is eligible.
 3. There are no eligibility requirements such as job readiness, or history of violent behavior.

EXCLUSIONARY GUIDELINES:

Any of the following are sufficient for exclusion from this level of care:

1. The individual does not have a behavioral health disorder diagnosis under the Diagnostic and Statistical Manual of Mental Disorders (current version).
2. The individual has a primary diagnosis of problem gambling.
3. The consumer does not state he/she wants to work.

CONTINUED STAY GUIDELINES: The individual continues to meet admission guidelines.

All of the following are necessary for continuing this level of care:

1. The individual continues to meet admission guidelines.
2. The individual is making progress towards vocational goals.

DISCHARGE GUIDELINES:

All of the following are required for discharge from this level of care:

1. Maximum benefit has been achieved and consumer can maintain competitive employment without supports.
2. A crisis/relapse prevention plan is in place.

OR The consumer expresses an interest in having SE services ended.

CONTRACTS:

1. There is a contract between the Division of Behavioral Health Services and the Regional Behavioral Health Authority. The Region will sub-contract with a qualified local behavioral health provider.
2. The Supported Employment Provider will also have demonstrated working relationships

with the Nebraska Vocational Rehabilitation and the Nebraska Department of Labor. There is an assumption that all Supported Employment consumers under this Behavioral Health Service Definition are eligible for Vocational Rehabilitation Services.

DBH Service Definition of Supported Employment (continued)

SUPPORTED EMPLOYMENT FIDELITY MEASUREMENT

(minimum standards for Quality Improvement)

- **Competitive employment:** Employment Specialists provide competitive job options that have permanent status rather than temporary or time-limited status. Employment is competitive so that potential applicants include persons in the general population.
NOTE: Transitional Employment Program (TEP) is acceptable when part of a clubhouse certified by the International Center for Clubhouse Development (ICCD) and is used to help the consumer move toward competitive employment. TEPs can be no more than one third (1/3) of the jobs in the program.
- **Integration with treatment:** With consumer consent, the Employment Specialist participates on clinical/program team meetings or otherwise facilitate communication with other treatment or rehabilitation providers to promote an integrated plan for the consumer. For example, the Employment Specialists are part of the mental health treatment teams with shared decision making and frequent contact with treatment team members.
- **Rapid job search:** The search for competitive jobs occurs rapidly after program entry.
- **Eligibility based on consumer choice (not consumer characteristics):** No eligibility requirements such as job readiness, lack of substance abuse, no history of violent behavior, minimal intellectual functioning, and mild symptoms.
- **Follow-along support:** Individualized follow-along supports are provided to employer and consumer on a time-unlimited basis. The Employer supports may include education and guidance. The Consumer supports may include crisis intervention, job coaching, job counseling, job support groups, transportation, treatment changes (medication), networked supports (friends/family).
- **SUPPORTED EMPLOYMENT IS NOT:** prevocational training, sheltered work, or employment in enclaves (that is in settings, where only people with disabilities are employed).

DATA COLLECTION

- All consumers need to be reported on Magellan Behavioral Health data system.
- Transitional Employment Program (TEP) job placements are to be reported separately from other Supported Employment placements.

APPENDIX B.

Sample SE Program Interview Schedule
9:00 am to 5:00 pm
May 2010

- 9:00-10:45 Interviews with Program Director(s)
- 10:45-12:00 Interview with Employment Specialist
- 12:00-1:00 Lunch Break
- 1:00-1:45 Interview with Consumer or a Family Member
- 1:45-2:30 Observation of treatment team meeting
- 2:30-3:15 Interview with Employment Specialist
- 3:15-4:00 Interview with Program Director(s)
- 4:00-5:00 Review of Charts and Program Policies and Procedures Manual

APPENDIX C.

Supported Employment Fidelity Scale

Supported Employment Fidelity Scale						
Criteria	Ratings / Anchors					
	1	2	3	4	5	
Staffing						
1.	Caseload: Employment specialists manage caseloads of up to 25 consumers.	A ratio of 81 or more consumers per employment specialist, or Cannot rate due to no fit	A ratio of 61 to 80 consumers per employment specialist	A ratio of 26 to 40 consumers per employment specialist	A ratio of 25 or fewer consumers per employment specialist	A ratio of 25 or fewer consumers per employment specialist
2.	Vocational services staff: Employment specialists provide only vocational services.	Employment specialists provide nonvocational services such as case management 80% or more of the time, or Cannot rate due to no fit	Employment specialists provide nonvocational services such as case management about 60% of the time	Employment specialists provide nonvocational services such as case management about 40% of the time	Employment specialists provide nonvocational services such as case management about 20% of the time	Employment specialists provide only vocational services
3.	Vocational generalists: Each employment specialist carries out all phases of vocational service including engagement, assessment, job development, job placement, job coaching, and follow-along supports.	Employment specialists provide only vocational referrals to other vendors or programs, or Cannot rate due to no fit	Employment specialists maintain caseloads but refer consumers to other programs for vocational service	Employment specialists provide 1 aspect of the vocational service	Employment specialists provide 2 or more phases of vocational service but not the entire service	Employment specialists carry out all phases of vocational service
Organization						
1.	Integration of rehabilitation with mental health treatment: Employment specialists are part of the mental health treatment teams with shared decisionmaking. They attend regular treatment team meetings (not replaced by administrative meetings) and have frequent contact with treatment team members.	Employment specialists are part of a vocational program, separate from the mental health treatment. No regular direct contact with mental health staff, only telephone or 1 face-to-face contact per month, or Cannot rate due to no fit	Employment specialists attend treatment team meetings once per month	Employment specialists have several contacts with treatment team members each month and attend 1 treatment team meeting per month	Employment specialists are attached to 1 or more case management treatment teams with shared decisionmaking; attend weekly treatment team meetings	Employment specialists are attached to 1 or more case management treatment teams with shared decisionmaking; attend 1 or more treatment team meetings per week and have at least 3 consumer-related case manager contacts per week
2.	Vocational unit: Employment specialists function as a unit rather than a group of practitioners. They have group supervision, share information, and help each other with cases.	Employment specialists are not part of a vocational unit, or Cannot rate due to no fit	Employment specialists have the same supervisor but do not meet as a group	Employment specialists have the same supervisor and discuss cases between each other; they do not provide services for each other's cases	Employment specialists form a vocational unit and discuss cases between each other; they provide services for each other's cases	Employment specialists form a vocational unit with group supervision at least weekly; provide services for each other's cases and backup and support for each other

Supported Employment Fidelity Scale						
Ratings / Anchors						
Criteria	1	2	3	4	5	
3. Zero-exclusion criteria: No eligibility requirements such as job readiness, lack of substance abuse, no history of violent behavior, minimal intellectual functioning, and mild symptoms	Consumers are screened out based on formal or informal eligibility requirements, or Case managers first screen referrals, or Cannot rate due to no fit	Some eligibility criteria, or Vocational staff who make consumer referrals to other vocational programs screen referrals	Some eligibility criteria, or Vocational staff who provide the vocational service screen referrals	All consumers are eligible and services are voluntary. Referral sources are limited	All consumers are encouraged to participate, and Several sources (self-referral, family members, self-help groups, etc.) solicit referrals	
Services						
1. Ongoing, work-based vocational assessment: Vocational assessment is an ongoing process based on work experiences in competitive jobs.	Vocational evaluation is conducted before job placement with emphasis on office-based assessments, standardized tests, intelligence tests, and work samples, or Cannot rate due to no fit	Consumer participates in a prevocational assessment at the program site (e.g. work units in a day program)	Assessment occurs in a sheltered setting where consumers carry out work for pay	Most of the assessment is based on brief, temporary job experiences in the community that are set up with the employer	Vocational assessment is ongoing and occurs in community jobs. Minimal testing may occur but not as a prerequisite to the job search. Aims at problem-solving using environmental assessments and considering reasonable accommodations	
2. Rapid search for competitive jobs: The search for competitive jobs occurs rapidly after program entry.	First contact with an employer about a competitive job is typically more than 1 year after program entry, or Cannot rate due to no fit	First contact with an employer about a competitive job is typically at more than 9 months and within 1 year after program entry	First contact with an employer about a competitive job is typically at more than 6 months and within 9 months after program entry	First contact with an employer about a competitive job is typically at more than 1 month and within 6 months after program entry	First contact with an employer about a competitive job is typically within 1 month after program entry	
3. Individualized job search: Employer contacts are based on consumers' job preferences (relating to what they enjoy and their personal goals) and needs (including experience, ability, how they affect a good job and setting match) rather than the job market (that is, what jobs are readily available).	Employer contacts are based on decisions made unilaterally by the employment specialist. These decisions are usually driven by the nature of the job market, or Cannot rate due to no fit	About 25% of employer contacts are based on job choices which reflect consumers' preferences and needs rather than the job market	About 50% of employer contacts are based on job choices which reflect consumers' preferences and needs rather than the job market	About 75% of employer contacts are based on job choices which reflect consumers' preferences and needs rather than the job market	Most employer contacts are based on job choices, which reflect consumers' preferences and needs rather than the job market	
4. Diversity of jobs developed: Employment specialists provide job options that are in different settings.	Employment specialists provide options for either the same types of jobs for most consumers, e.g., janitorial, or jobs at the same settings, or Cannot rate due to no fit	Employment specialists provide options for either the same types of jobs, e.g., janitorial, or jobs at the same work settings, about 75% of the time	Employment specialists provide options for either the same types of jobs, e.g., janitorial, or jobs at the same work settings, about 50% of the time	Employment specialists provide options for either the same types of jobs, e.g., janitorial, or jobs at the same work settings, about 25% of the time	Employment specialists provide options for either the same types of jobs, e.g., janitorial, or jobs at the same work settings, less than 10% of the time	

Supported Employment Fidelity Scale					
Criteria	Ratings / Anchors				
	1	2	3	4	5
5. Permanence of jobs developed: Employment specialists provide competitive job options that have permanent status rather than temporary or time-limited status.	Employment specialists usually do not provide options for permanent, competitive jobs, or Cannot rate due to no fit	Employment specialists provide options for permanent, competitive jobs about 25% of the time	Employment specialists provide options for permanent, competitive jobs about 50% of the time	Employment specialists provide options for permanent, competitive jobs about 75% of the time	Virtually all competitive jobs offered by employment specialists are permanent
6. Jobs as transitions: All jobs are viewed as positive experiences on the path of vocational growth and development. Employment specialists help consumers end jobs when appropriate and then find new jobs.	Employment specialists prepare consumers for a single lasting job, and if it ends, will not necessarily help them find another one, or Cannot rate due to no fit	Employment specialists help consumers find another job 25% of the time	Employment specialists help consumers find another job 50% of the time	Employment specialists help consumers find another job 75% of the time	Employment specialists help consumers end jobs when appropriate and offer to help them all find another job
7. Follow-along supports: Individualized, follow-along supports are provided to employer and consumer on a time-unlimited basis. Employer supports may include education and guidance. Consumer supports may include crisis intervention, job coaching, job counseling, job support groups, transportation, treatment changes (medication), and supportive networks (friends and family).	Follow-along supports are nonexistent, or Cannot rate due to no fit	Follow-along supports are time-limited and provided to less than half of the working consumers	Follow-along supports are time-limited and provided to most working consumers	Follow-along supports are ongoing and provided to less than half the working consumers	Most working consumers are provided flexible, follow-along supports that are individualized and ongoing
8. Community-based services: Vocational services such as engagement, job finding, and follow-along supports are provided in community settings.	Employment specialists spend 10% of time or less in the community, or Cannot rate due to no fit	Employment specialists spend 11–39% of time in community	Employment specialists spend 40–59% of time in community	Employment specialists spend 60–69% of time in community	Employment specialists spend 70% or more of time in community
9. Assertive engagement and outreach: Assertive engagement and outreach (telephone, mail, community visits) are conducted as needed.	Employment specialists do not provide outreach to consumers as part of initial engagement or to those who stop attending the vocational service, or Cannot rate due to no fit	Employment specialists make 1 contact to consumers as part of initial engagement or to those who stop attending the vocational service	Employment specialists make 1 or 2 contacts as part of initial engagement or within 1 month when consumers stop attending the vocational service	Employment specialists make multiple contacts as part of initial engagement and at least every 2 months on a time-limited basis when consumers stop attending the vocational service	Employment specialists make multiple contacts as part of initial engagement and at least monthly on a time-unlimited basis when consumers stop attending the vocational service, and Employment specialists demonstrate tolerance of different levels of readiness using gentle encouragement

APPENDIX D.
Comprehensive Inventory of Mental Health Recovery and Rehabilitation Services
(CIMHRRS)

**COMPREHENSIVE INVENTORY OF MENTAL HEALTH
&
RECOVERY AND REHABILITATION SERVICES
(CIMHRRS)**

SCORING BOOKLET

PROGRAM MISSION

		Rate on Likert scale. Choose the <i>one</i> item that best represents the program.				
		1	2	3	4	5
1. Identifiable Program Mission Statement:	Program has no identified program mission statement.	Mission statement is that of a larger organizational entity (and does not separate mission for the program).	Mission statement is specific to the program but contains less than 4 of criteria listed in administration booklet (purpose, approach, population, and outcome).	Mission statement is specific to the program. Meets all four criteria identified in administration booklet (purpose, approach, population, and outcome) but does not have 100% endorsement by staff.	Mission statement is specific to the program. Meets all four criteria identified in administration booklet (purpose, approach, population, and outcome) and receives 100% endorsement by staff.	
2. Articulated program theory /model:	Program theory or model for fulfilling program mission is not identified or program theory or model is that of the larger organizational entity.	Program theory or model is in the process of being developed but is not consistently implemented in policy or action.	Program theory or model is articulated but staff provides mixed endorsement.	Program theory or model is articulated and endorsed by staff.	Program theory or model is not only articulated and endorsed but has credence in program functioning.	
3. Problem Identification and Resolution:	There is no formal or informal process identified.	Utilizes an informal process, or has a plan in the process of being developed but not in use.	There is a formal process identified (e.g. suggestion box, policy manual) but the process it is not well understood by staff.	There is a formal process identified and is understood and used by staff.	Program has demonstratable actions and outcomes that stem from identified process.	
4. Program Monitoring:	Program does not conduct program monitoring.	Program is not capable of assessing fidelity to mission, theory, or effectiveness of program's implementation at this time. Extent of program drift unknown.	Program is familiar with concept and has capacity of assessing fidelity to mission, theory, or effectiveness of program's implementation but struggles to consistently utilize program monitoring. Extent of program drift remains unknown.	The program consistently uses the concepts and technology associated with program monitoring. Program is able to monitor program drift but is unable to facilitate pertinent changes in the program.	The program is able to utilize the information gathered from the program monitoring process to facilitate pertinent changes in the program to avoid or minimize program drift.	

PROGRAM DEMOGRAPHICS & COMPOSITION

5. What is the population of the city / town in which services are received?

6. Where does the program provide the majority of services? (Please provide a percentage. All areas should total 100%)

a	Inpatient – Locked – Maximum Security	
b	Inpatient – Locked	
c	Inpatient – Unlocked	
d	Residential Locked	
e	Residential – Unlocked	
f	Residential - 24 Supervision	
g	Residential – Partial Supervision	
h	Community Mental Health Center	
i	Partial Hospitalization Program	
j	Day Treatment Program	
k	Job Site	
l	In home	
m	In vivo community setting	
n	Drop-In Center (peer ran)	
o	In jail / prison (non SMI focus)	
p	Probation office	
q	Mental Health Court	
r	Drug Court	
s	Substance Abuse Treatment Center	
t	Other (List)	
TOTAL		

7. What is the capacity of the program (e.g. number of beds, average program caseload)?

8. Total number of clients currently being served by program?

9. Number of clients currently with a substitute decision maker?

10. Number of clients with a deferred or withheld adjudication status?

11. Number of clients under civil commitment?

12. Number of clients with mental health advance directives?

13. What is the total number of clinical staff currently working within the program?

Scoring Booklet

14. What is the formal educational levels of paraprofessional and professional staff? Currently, what is the number of staff with:

a	Less than a high school education	
b	High School diploma or equivalent	
c	Professional License (LPN, etc)	
d	Associates degree	
e	Bachelors degree	
f	Masters degree	
g	Doctoral degree	
h	Other (List)	

ORGANIZATIONAL BOUNDARIES

Choose the *one* item that best represents the program.

	1	2	3	4	5
15. Explicit Admission Criteria:	Program has no set criteria and takes all types of clients as determined outside the program.	Programs admission process is dominated by organizational convenience. No explicit criteria identified.	Implicit criteria identified by program. Accepts most referrals.	Explicit criteria identified. Program actively seeks and screens referrals carefully and occasionally bows to organizational pressure.	The program actively recruits a defined population and all clients meet explicit admission criteria.
16. Integrated Service Provision:	Program is isolated from other treatment providers; concentrating only on the parameters of the service it provides with little to no assessment of other treatment parameters that may affect the client's psychological well-being. No contact with other service providers.	Program staff recognize that client has additional service needs. Client's multiple needs are addressed with serial or sequential modes of treatment.	Client's multiple need are addressed through isolated use of serial or sequential modes of treatment OR multiple parallel treatments	Isolated use of parallel services	Provides all treatment in an integrated format. All services (internal or external) are reflected in the client's treatment plan.
17. Responsibility For Crisis Services:	Program has no responsibility for handling crises after hours.	Emergency service has program-generated protocol for clients.	Program is available by telephone, predominantly in consulting role.	Program provides emergency service backup; e.g., program is called, makes decision about need for direct program involvement.	Program provides 24-hour coverage

Scoring Booklet

18. Intake Rate:

➤ What is the monthly total of admissions per month in the last twelve-month period?

--	--	--	--	--	--	--	--	--	--	--	--

12 months ago 6 months ago Last Month

19. Discharge Rate:

➤ What is the monthly total of discharges per month in the last twelve-month period?

--	--	--	--	--	--	--	--	--	--	--	--

12 months ago 6 months ago Last Month

19a. What is the number of current clients expected to be discharged in the next twelve months? _____

PROGRAM FUNCTIONING

20. Clinical Staff Capacity: What is the total number of staff vacancies for each month for the past 12 months?

--	--	--	--	--	--	--	--	--	--	--	--

12 months ago 6 months ago Last Month

Staffing percentage that program has operated at in the past 12 months _____

21. Continuity of Staffing: What is the total number of staff who have left the program over the last 12 months?

--	--	--	--	--	--	--	--	--	--	--	--

12 months ago 6 months ago Last Month

Percentage that the program has maintained the same staffing over the past 12 months _____

22. What is the number of training(s) / in-service(s) provided or supported by organization (or parent organization) in the past 12 months?

Scoring Booklet

23.	How many hours of trainings / in-services provided or supported by the program (or parent organization) in the past 12 months (by subject)	
a	Psychotropic Medication	
b	Psychological Treatments	
c	Combined Psychopharmacological Treatment	
d	Psychiatric (Psychosocial) Rehabilitation	
e	Recovery	
f	Integrated Treatment Modalities	
g	Co-occurring Serious Mental Illness & Substance Use	
h	Evidence-based practice (process not interventions)	
i	Empirically Supported Treatment (specific interventions)	
j	Organizational Mission / Improvement	
k	Trauma Informed Services	
l	Relapse Prevention	
m		Psychiatric
n		Substance Abuse
o		Integrated
p	Risk Management	
q	Other (List)	

- 24. The organization supports “off-site” training for staff.
- 25. “Off-site” training facilitates the program’s mission or theory/model
- 26. The program attempts to integrate “off-site” trainings into the current program

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree

TREATMENT TEAM STRUCTURE & PROCESS

27.	Within the program, what is the current number of positions	Slotted	Filled
a	Administrator		
b	Psychiatrist		
c	Nurse practitioner		
d	Physician assistant		
e	Other prescribing professional		
f	Psychologist		
g	Psychology Intern		
h	Psychology Extern		
i	Psychometricians		

Scoring Booklet

j	Other Psychology extenders		
k	Nursing staff		
l	Vocational staff		
m	Substance abuse staff		
n	Social Workers (Masters level or higher)		
o	Para-professionals (Technicians, Case Managers / workers, etc.)		
p	Peer providers (specify position / duties)		
q	Other		
TOTAL(S)			

28. Who in the program fulfills the roles outlined below? Ask the program point of contact for the pre-site visit checklist as the program need to complete this task for standardization purposes. Use identifiers from question 27. Multiple identifiers may be used as needed.

a	Administrator		
b	Supervising Independent Practitioner		
c	Case Coordinator		
d	Skills Trainer		
e	Change Agent Coordinator		
f	Psychopharmacotherapist		
g	Consultant		

Rate on Likert scale. Choose the *one* item that best represents the program.

	1	2	3	4	5
29. Evidence-based practice orientation:	Program does not recognize definition of EBP orientation (i.e. process vs. singular intervention).	Utilizes 1 of the 3 components of EBP orientation. List _____	Utilizes 2 of the 3 components of EBP orientation. List _____	Utilizes 3 of the 3 components of EBP orientation but does not consistently integrate all of the components into cases.	Fully integrates all components of EBP orientation. Consistently integrates all of the components into cases.
30. Recovery Orientation	No policy statement or internal documents to support claims of recovery orientation care.	Explicit statement in policies or internal documents that supports recovery orientation but does not demonstrate a recovery orientation in practice (i.e. services are exclusively focused on symptom or risk management; people are referred to by diagnosis).	Recovery orientation is evident in treatment planning and staff interactions (i.e. recovery oriented language in clinical documents, consumer strengths & desires are incorporated into treatment planning process; staff utilize person-first language).	Program facilitates the shedding of patient role (e.g. replacing passive recipient role with role of active consumer of mental health services).	Program assists in developing activities outside the mental health service system (i.e. career development, community integration, or development of leisure activities).

		Rate on Likert scale. Choose the <i>one</i> item that best represents the program.				
		1	2	3	4	5
31. Psychosocial (Psychiatric) Rehabilitation Orientation	Psychosocial rehabilitation is not a service option.	Program reports rehabilitation focus but services focus on symptom reduction and psychiatric stabilization.	Program reports rehabilitation focus but services are maintenance focused (i.e. medication adherence, staying out of the hospital).	Program reports rehabilitation focus but services promote social activities in the community but client remains dependent on provider to organize activities (i.e. does not develop clients ability to carry out activity).	Services promote the acquisition of new skills or coping abilities that supports independent functioning in the community.	
32. Team Approach (Horizontal agreement):	Members of the provider group operate independently of one another with little knowledge of other treatment provider activities or overall treatment plan.	Team attempts to function as a unit but primarily operates as a group of individuals, providing an array of services. Decisions made by individuals contradict consensus approach or a developed treatment plan.	Team operates within a consensus model. There is an implicit understanding to follow the consensus approach outlined by the team. Team utilizes the developed treatment plan to guide clinical decision making.	Team operates within a consensus model and has an identifiable, explicit policy which outlines the consensus approach. Policy includes a formal process to resolve clinical disagreements among team members.	Team uses consensus process to resolve disagreements, and when needed a formal mediation process. Upon identifying a plan of action, team members follow decision of mediation process.	
33. Team Approach (Vertical agreement):	Administration fails to recognize the importance of providing support in developing vertical agreement and how it will support the identified program theory or model. This score may be used if there is no verbal or written program theory or model.	There is an identified program theory or model with implicit support.	Training of staff has begun; however, there appears to be a lack of consensus among leadership about program mission and theory / model of service provision.	There is consensus among leadership about program mission and theory / model. A majority of clinical staff have been trained in the model.	There is consistent agreement across levels of leadership supporting model. Most staff are fully trained and are providing services that fall in-line with the model.	
34. Role of consumer in service provision:	Consumer(s) have no formal involvement in service provision within the program.	Consumer(s) fill consumer-specific but <i>unpaid</i> service roles with respect to program.	Consumer(s) <i>paid</i> to work <i>part-time</i> in roles with reduced responsibilities (e.g. driving clients around, courier, confirm appointments miscellaneous tasks, etc.)	Consumer(s) <i>paid</i> to work <i>full-time</i> in roles with reduced responsibilities (e.g. driving clients around, courier, confirm appointments miscellaneous tasks, etc.)	Consumer(s) employed full-time by program and functions as full member of the team in addressing client treatment issues.	

Rate on Likert scale. Choose the *one* item that best represents the program.

	1	2	3	4	5
35. Organizational concept of case management:	Program provides no case management services.	Case management is performed by 1 person, not identified with a formal treatment team, implementing a list of services that do not constitute an integrated treatment plan.	An identified case manager oversees the implementation of an integrated individualized treatment plan but not as a member of a formal treatment team (i.e. the plan was provided to them, they had no input on the development of the plan and no role in assessing progress or outcome).	An identified case manager oversees the implementation of an integrated individualized treatment plan, as a member of a formal interdisciplinary treatment team that continuously evaluates treatment response and progress in recovery.	Although there may be a single identified case manager or treatment coordinator, specific case management functions are shared by members of a formal interdisciplinary treatment team, based on individual considerations and circumstances, e.g. rapport with staff or time availability.
36. Approach to Co-occurring SMI & Substance Abuse:	Program has no identifiable process to address these comorbid issues. No formal, individualized substance abuse assessment or treatment provided.	Variably addresses substance abuse concerns with clients. Separate assessment and treatment (sequential or parallel services without coordination between providers).	Importance of integrated treatment recognized but not formalized in policy. Parallel treatment occurs with coordination between providers. All of substance abuse services referred (persuasion groups; uses hospitalization for rehab.; refers to 12-step & self-help groups)	Recognition of importance of integrated treatment in policy. Program has an integrated approach but substance abuse program is primarily based on traditional models of substance abuse treatment: (confrontation; mandated abstinence; traditional 12-step models; etc.).	Recognition of importance of integrated treatment in policy. Program provides assessments and integrated approach is reflected in treatment plan (services provided by program or outside services are highly integrated). Identifies with a stage-wise model and seeks to modify use behaviors (harm-reduction) on the way to sobriety.

ASSESSMENT PROCESS

Rate on Likert scale. Choose the <i>one</i> item that best represents the program.	No availability	Limited or anecdotal (informal)	Systematic access or performance of assessment but data does not influence treatment	Systematic access or performance of assessment; influences treatment AND progress evaluation; limited in scope / monitoring	Full range of assessment integrated with tx. planning AND progress evaluation
37. Does the program assess clients' goals?	1	2	3	4	5
38. Does program conduct symptom assessment?	1	2	3	4	5
39. Does program conduct neurocognitive assessment?	1	2	3	4	5
40. Does the program conduct functional behavior analysis?	1	2	3	4	5
41. Does the program assess basic independent living skills	1	2	3	4	5
42. Does the program assess wellness management / relapse prevention skills?	1	2	3	4	5
43. Does the program assess social / interpersonal skills?	1	2	3	4	5
44. Does the program assess occupational skills?	1	2	3	4	5
45. Does program conduct risk assessment?	1	2	3	4	5

TREATMENT PLANNING

Rate on Likert scale. Choose the *one* item that best represents the program.

	1	2	3	4	5	
46. Origin and scope of treatment plan	Does not conduct	treatment planning and there is no identifiable treatment plan OR program does not operate from a treatment plan.	Program operates from a treatment plan that is developed outside of the program without program staff involvement.	Program operates from a treatment plan that is developed outside of the program with program staff input.	Treatment plan is developed within program but does not comprehensively include all relevant services	Treatment plan is developed within the program and includes all relevant services, with links to other programs where needed.
47. Individualized treatment plan	Does not conduct	treatment planning and there is no identifiable treatment plan OR program does not operate from a treatment plan.	There is no indication that any personal information about the client has been incorporated into the treatment plans.	Treatment plans incorporate only anecdotal personal information that guides treatment selection.	Treatment plans incorporate formal assessment results that are logically linked to treatment selection, but similarities across treatment plans are greater than the range and diversity of assessment results indicate.	Diversity across treatment plans reflects the diversity of assessment results found in the program's client population.
48. Client role in treatment plan development	Does not conduct	treatment planning and there is no identifiable treatment plan OR program does not operate from a treatment plan.	Treatment plan is developed in the absence of consumer input.	Treatment plan is provider driven but based on consumer preferences	Client actively collaborates with provider to develop treatment.	Treatment plan is client driven.
49. Treatment plan review (TPRS) process	Does not conduct	treatment planning and there is no identifiable treatment plan OR program does not operate from a treatment plan.	Only prescribed feature of TPR are those required by regulation (e.g. frequency)	Policy and procedures manual outlines features in addition to those required by regulation (e.g. who must attend TPRS) and/or a mechanism for a meeting schedule that exceeds regulatory standards	Process allows for quantitative determination of progress (or lack) and distinguishes between areas of lesser or greater progress.	There is a mechanism and procedure in policy and directs follow up and documentation on findings of insufficient progress.

50. Discharge planning	Services are time unlimited OR Program does not have any formal discharge criteria.	Program mission / policy indicates discharge criteria. Discharges from program are atypical e.g. resulting from unmanageable risk factors, client moving, treatment non-compliance, client entering a different service system (jail, etc.), or death.	Program mission / policy indicates a discharge criteria. Discharge from program is expected. ?Discharge process begins when client <i>meets criteria</i> . (i.e. toward the end of treatment).	Program mission / policy indicates a discharge criteria. Discharge from program is typical. Discharge process begins at various points in treatment as client progresses in treatment.	Discharge process begins at intake. Program actively identifies barriers to treatment and discharge at intake and on an ongoing basis.
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TREATMENT PROVISION

Rate on Likert scale. Choose the *one* item that best represents the program.

	PROVIDES	COORDINATES	N/A
51. Does program provide or coordinate these services?			
a) Collaborative Psychopharmacotherapy	3	2	1
b) Rehabilitation Counseling	3	2	1
c) Social Skills Training	3	2	1
d) Problem-Solving Skills Training	3	2	1
e) Independent Living Skills Training	3	2	1
f) Supported Employment	3	2	1
g) Illness/Wellness Management Skills Training	3	2	1
h) Family Consultation, Education, and Therapy	3	2	1
i) Contingency Management	3	2	1
j) Supported Housing	3	2	1
k) Specialized Integrated Treatment for Co-occurring Substance Abuse	3	2	1
l) Cognitive Rehabilitation	3	2	1
n) Specialized Models for Service Integration and Provision	3	2	1
m) Trauma-based services	3	2	1
n) Peer Support (specify service)	3	2	1
52. Does program provide these specific Psychotherapies	PROVIDES	COORDINATES	N/A
a) Cognitive Behavioral Therapy	3	2	1
b) Dialectical Behavior Therapy	3	2	1
c) Psychoanalytic / Psychodynamic	3	2	1
d) Personal Therapy	3	2	1
e) Integrated Psychological Therapy	3	2	1

APPENDIX E. Individual Site-Visit Report: Program A

Program A:
A Fidelity, Structure and Process Analysis

Date of site visit:
June 17, 2010

Date of report:
August 30, 2010

Report prepared by:
Nancy H. Liu, M.A.

Program Evaluation Tools:
--Supported Employment Fidelity Scale (SE Fidelity Scale)
--Comprehensive Instrument of Mental Health & Recovery and Rehabilitation Services (CIMHRRS)

Program Evaluation conducted by:
Nancy H. Liu, M.A.
Paul Nabity, B.S.

Supervision provided by:
Jim Harvey, MSW
William D. Spaulding, Ph.D.

For further information on the SE Fidelity Scale, please consult:
Substance Abuse and Mental Health Services (SAMHSA) Community Mental Health Tool-Kit Evaluating Supported Employment Programs:
http://download.ncadi.samhsa.gov/ken/pdf/toolkits/employment/SE_Evaluating_Your_Program.pdf

For further information on the CIMHRRS, please contact:
Robert W. Johnson, Ph.D.
rwjohnson01@gmail.com

APPENDIX E.

Individual Site-Visit Report: Program A (continued)

Executive Summary:

This report describes an analysis of the program fidelity, structure and organization of the Employment Program at Program A, an employment program aimed at helping individuals with severe mental illness (SMI) achieve and maintain competitive employment.

The purpose of this analysis is two-fold. First, this analysis is aimed at determining the fidelity of the Employment Program at Program A to the Individual Placement and Support (IPS) model of Supported Employment (SE), an evidence-based practice (EBP), which is aimed at helping persons with SMI achieve and maintain competitive employment. A second, and no less important, goal is to determine whether the Employment Program at Program A conforms, in structure and operation, to the particular treatment model on which it is based. The Comprehensive Inventory of Mental Health Rehabilitation and Recovery Services (CIMHRRS) examines the recovery and rehabilitation focus of programs, with a particular emphasis on structural and process components of a program's day-to-day functioning. As specific treatment models are associated with specific outcomes, it is expected that the outcome of any treatment can be achieved only when the treatment is delivered with high fidelity. In turn, the expected outcome of a treatment program must be consistent with the mission of that program. The CIMHRRS is used to examine the organizational structure and approach of service providers to facilitate recommendations outlined in the 2003 President's New Freedom Commission Report. Specifically, this report mandates the transformation of the mental health services system for people with SMI to a rehabilitation focused, recovery-oriented and consumer and family driven system at the national, state, and local levels.

I. Description of the evaluation and instruments

The Supported Employment Fidelity Scale, previously named the IPS Fidelity Scale (Bond, Becker, Drake, et al., 1997) is based on the SE implementation and evaluation measures from the SAMHSA community toolkit (SAMHSA, 2007; Becker and Bond, 2002). The SE Fidelity Scale has been used to assess various SE programs and consistently demonstrates that better employment outcomes are associated with adherence to the SE model (McGrew & Griss, 2005).

The Comprehensive Inventory of Mental Health and Recovery and Rehabilitation (CIMHRRS) is a 52-item instrument designed to assess the fidelity of various programs to particular service models for persons with severe mental illness (SMI). It is used to both quantitatively and qualitatively characterize programmatic differences in service settings for people with SMI. Through a structured site review, evaluators assess the relative strengths and liabilities of service programs.

The on-site evaluation was conducted on June 17, 2010 at Program A. The evaluation schedule lasted from 9:00 am to 5:00 pm and included interviews with the Program Director, Employment Specialists and Consumers. In addition, the evaluators observed a

treatment team meeting, reviewed charts and conducted a thorough review of the program's Policies and Procedures Manual. Two independent evaluators conducted all ratings. All discrepancies in ratings were reconciled by consensus.

II. Program Description

Program A today operates as a clubhouse model program with the most recent ICCD Accreditation being 1-year in 2006. It is currently a 3-year CARF-certified program. One of the major goals of the Program A is to recognize the rights of persons with mental illness and help them to find self worth and wellness through meaningful work.

APPENDIX E. Individual Site-Visit Report: Program A (continued)

The Employment Program at Program A reports in its Policies and Procedures Manual that its mission is to “focus on providing quality of life and independence for people disabled by mental illness in the Nebraska Panhandle through opportunities for advocacy, housing, employment and education” (Program A Program Brochure). Employment services at Program A are *primarily* described as Transitional Employment services, but it notes that “support is also provided when a member is ready for their own full time job.” As advertised to employers, Program A guarantees reduction of hiring costs because the entry-level job will always be filled and promises 100% attendance, on-site training and supervision, high quality and productivity and no employee benefit costs. Transitional Employment is described as an entry-level position in order to have a productive, fulfilling role in the community and a powerful and valued means of achieving the major goal of Program A, which is recognizing the rights of consumers and improving their self worth.

III. Overview of Results

Supported Employment Fidelity

Supported Employment Fidelity was measured using a standardized and validated tool (see below). Fidelity scores can fall into one of three possible categories: 1) Good Implementation, 2) Fair Implementation and 3) Not Supported Employment.

As noted in Figure 1, the results of this analysis indicate that the Employment Program at Program A scored within the *Not Supported Employment* category of the SE program, considering a number of factors. Specific domain scores are found in Figure 1.

Strengths of the program that are in keeping with the SE model include the following:

1. *Caseload.* The Employment Program at Program A maintains a ratio of 25 or fewer consumers per employment specialist, which is consistent with high fidelity ratings on the SE Fidelity scale.
2. *Vocational generalists.* Employment specialists at Program A carry out all phases of vocational service including engagement, assessment, job development, job placement, job coaching and follow-along supports.
3. *Rapid search for competitive jobs.* The first contact with an employer about a job is typically within 1 month after program entry.
4. *Individualized job search.* Most employer contacts are based on job choices, which reflect consumers’ preferences and needs rather than the job market.

APPENDIX E.
Individual Site-Visit Report: Program A (continued)

5. *Follow-along supports.* Most consumers are provided flexible, follow-along supports that are individualized and ongoing. This includes crisis intervention, job coaching, job counseling, job support groups, transportation, treatment changes and supportive networks.

Needs of the program to improve adherence to the SE model include the following:

1. *Integration of rehabilitation with mental health treatment.* Employment specialists should be attached to 1 or more case management treatment teams. To improve fidelity, this would include weekly treatment team meetings with shared decision-making and 3 consumer-related case manager contacts per week.
2. *Vocational services staff.* Employment specialists should provide only vocational services. To improve SE fidelity, employment specialists should spend less than 10-20% of their time on non-vocational services, such as case management.
3. *Diversity of jobs developed.* Employment specialists should provide job options that are in different settings. More specifically, high SE Fidelity requires that employment specialists provide options for either the same types of jobs, e.g., janitorial, or jobs at the same work settings, less than 10% of the time.
4. *Permanence of jobs developed.* Employment specialists should provide job options that have permanent status rather than temporary or time-limited status. To improve fidelity, the Employment Program at Program A should offer permanent, competitive jobs most of the time.
5. *Community-based services.* Vocational services such as engagement, job findings, and follow-along supports should be provided in community settings. To improve fidelity, employment specialists should spend 70% or more of time in the community.

Recovery and Rehabilitation of Services

The goal of the CIMHRRS is to determine how well the Program A Employment Program conforms, in structure and operation, to the particular treatment model on which it is based. This is important because specific treatment models are associated with specific outcomes and these outcomes are achieved when the treatment is delivered with high fidelity. In turn, the expected outcome of a treatment program must be consistent with the mission of that program.

APPENDIX E.
Individual Site-Visit Report: Program A (continued)

As noted in Figure 2, the results of this analysis indicates that the Program A Employment Program has reached minimal integration in the five domains of the CIMHRRS: 1) Program Mission; 2) Organizational Boundaries; 3) Treatment Team Structure & Process; 4) Assessment Process; and 5) Treatment Planning.

Assets of the program which contribute to the successful realization of its mission include:

1. *Identifiable Program Mission Statement.* The mission of the Program A Employment Program is clear and operationalized, focusing on helping individuals with disabilities, and in particular, those with SMI, obtain and maintain competitive employment.
2. *Articulated Program Theory/Model.* The Program A Employment Program and its staff operate from an understood and articulated model, namely the clubhouse model. It is noted however, that SE Fidelity and recovery and rehabilitation orientation of services can be improved if employment staff are trained specifically in the Supported Employment program, a standardized employment program that has been replicated across the country and the world.
3. *Support and Integration of Off-Site Training.* The Program A Employment Program strongly supports off-site training in the clubhouse model and readily attempts to integrate training in this model into the day-to-day operations of the program.
4. *Admission Criteria for the Appropriate Delineation of Organizational Boundaries.* Admission criteria are well-defined and contribute towards appropriate organizational boundaries.

Characteristics deemed most crucial to successful realization of its mission include:

1. *Thorough training of all staff in the program model and approach.* An articulated program theory or model should adhere to the specific SE Fidelity program model to ensure the delivery of Supported Employment services. Staff training in the specific SE program model will likely improve achieved employment outcomes.
2. *Systematic program process monitoring and evaluation.* The continuing monitoring of fidelity and outcomes will improve the program's ability to address program drift from its mission goals and model. As noted above, this can be conducted using SE Fidelity materials found on the SAMHSA website.
3. *Integration of treatment in both the treatment plan and provision of services.* The

Program A Employment Program can improve its ability to effectively address clients' multiple service needs (e.g., co-morbid substance abuse, independent functioning) that may be challenging for one employment specialist alone to handle. This can be completed through regular (i.e., on a weekly basis) interactions with case managers and mental health providers and shared decision-making on mental health treatment team meetings.

4. *Staff development in the areas of recovery, recovery-oriented services, Psychiatric Rehabilitation and personalization of treatment and individualized treatment planning.* The Program A Employment Program can improve the individualization of treatment geared towards recovery. Staff should be well-versed in concepts such as evidence-based practice, recovery, and psychiatric (or psychosocial) rehabilitation, which are major movements and aptly describe the foundation from which the Supported Employment model (as defined by SAMHSA) is based. Staff should be trained specifically in these models of treatment to more effectively deliver SE services.
5. *Development of comprehensive assessment and treatment technologies relevant to the impairments, disabilities, and goals of its identified population.* Although the Program A Employment Program completes a variety of assessments, the utilization of these assessments on a more regular basis will inform the best provision of services and subsequently, outcomes achieved. The assessments could also be more comprehensive to include interpersonal skills, basic independent living skills, cognitive functioning and symptom assessment will provide a more comprehensive understanding of the consumer's functioning and, combined with integrated service provision, will improve the overall employment outcomes achieved by the program.

IV. Concluding Remarks

It is noted that Program A, based on a Clubhouse model, notes several conflicts with the Needs noted above for adherence to the Supported Employment model. Regarding the first improvement recommendation, Program A reports that it values "human-to-human" relationships with members, rather than staff-to-client relationships. Therefore, the program states that it does not provide treatment or manage individuals' caseloads; rather it provides a non-clinical working relationship that focuses on valuing the person instead of managing their illness.

Regarding the second improvement recommendation, Program A notes that as a Clubhouse, Program A staff are meant to be generalist staff. Their main duty is to work alongside members to complete the tasks in each unit (or department). Program A notes that one of the most important elements of any clubhouse is the Employment Program, and all staff share the duties of managing specific job placements and helping the individuals they relate well with find the right employment for the individual. A specific standard of the Clubhouse is that there are no employment staff; rather all staff are generalist staff. Therefore, assistance that members receive from staff is due to the good

APPENDIX E.

Individual Site-Visit Report: Program A (continued)

working relationship members have with staff rather than any “expertise” in this area. It is noted that this same principle also conflicts with the fifth recommendation for improved adherence to the SE model, namely that staff should be in the community over 70% of their working time.

Regarding the fourth recommendation for improvement, Program A notes that Clubhouses have 3 types of employment: Transitional Employment (TE), Independent Employment and Supported Employment. Program A notes that while TE placements are very important to a clubhouse, the staff believe that they do a good job in offering and developing permanent and competitive jobs while sufficiently following the needs of the membership.

Another point of conflict of the Clubhouse model with the recommendations for greater adherence to the SE model is the recommendation to utilize assessments and technologies to determine the level of an individual’s disabilities and current functioning. Program A states that as a Clubhouse model, it does not focus on assessing disabilities and impairments. Some assessments are completed by Program A staff, but these are mainly due to a requirement of the funding sources.

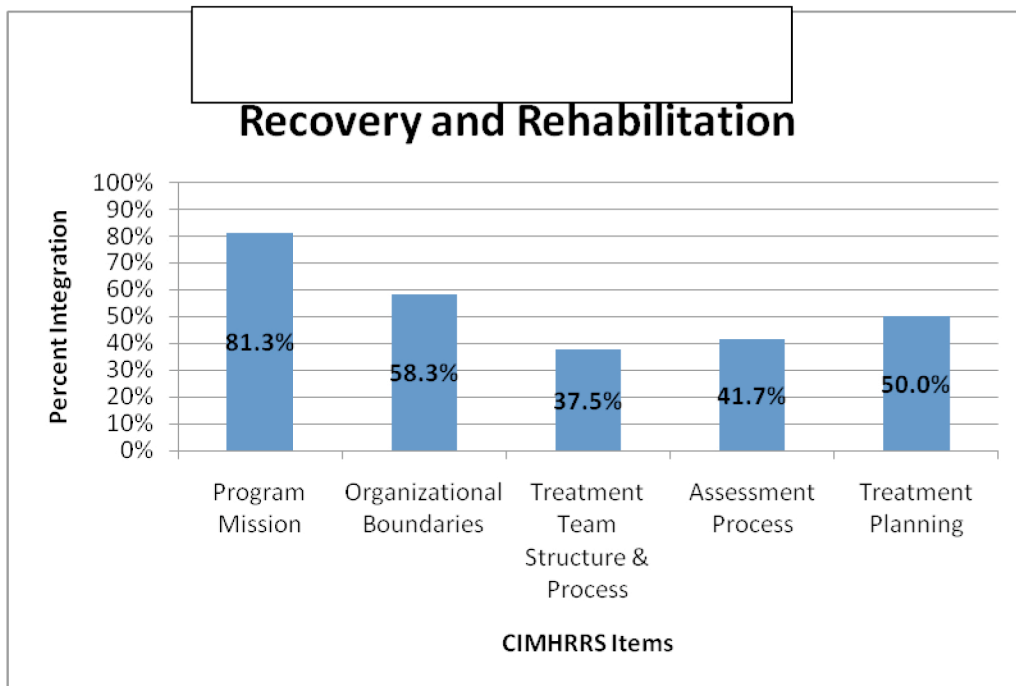
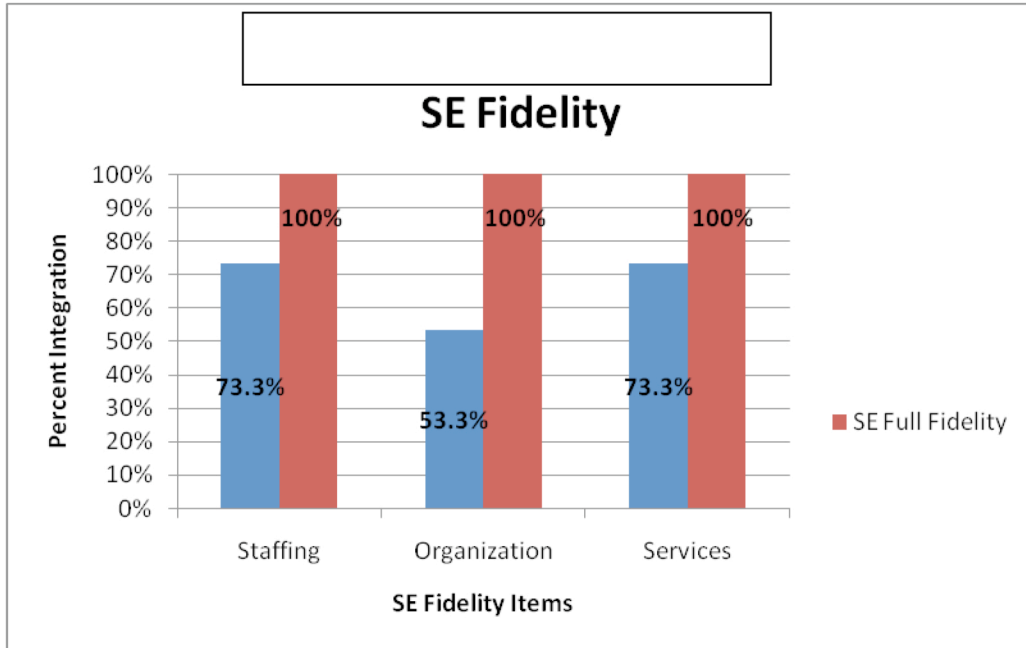
Finally, Program A notes that the idea of “treatment” directly conflicts with what the Clubhouse attempts to achieve.

V. A Word of Thanks

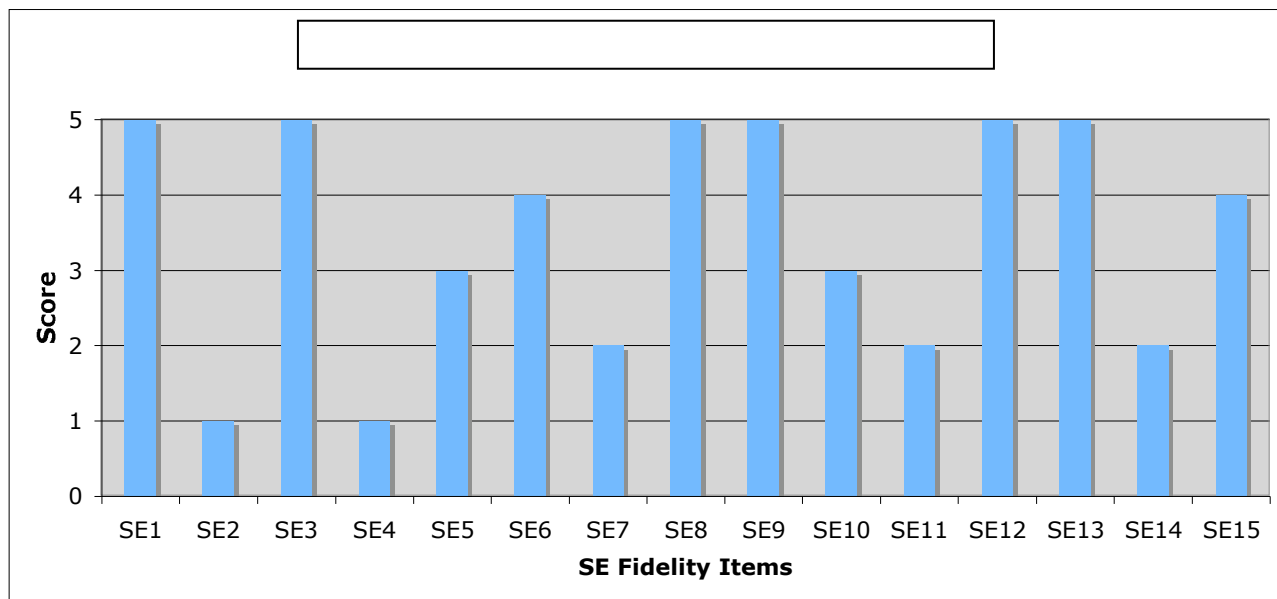
Program A staff were extremely hospitable during the site visit. Individual Program A staff were especially helpful in assisting with organization and scheduling of our site visit. Thank you for the quality services that you provide to persons with SMI.

VI. Appendix

Individual Site-Visit Report: Program A (continued)



APPENDIX E.
Individual Site-Visit Report: Program A (continued)



APPENDIX F.
Individual Site-Visit Report: Program B

Program B Employment Program B:
A Fidelity, Structure and Process Analysis

Date of site visit:
June 16, 2010

Date of report:
September 27, 2010

Report prepared by:
Nancy H. Liu, M.A.

Program Evaluation Tools:
--Supported Employment Fidelity Scale (SE Fidelity Scale)
--Comprehensive Instrument of Mental Health & Recovery and Rehabilitation Services (CIMHRRS)

Program Evaluation conducted by:
Nancy H. Liu, M.A.
Paul Nabity, B.S.

Supervision provided by:
Jim Harvey, MSW
William D. Spaulding, Ph.D.

For further information on the SE Fidelity Scale, please consult:
Substance Abuse and Mental Health Services (SAMHSA) Community Mental Health Tool-Kit Evaluating Supported Employment Programs:
http://download.ncadi.samhsa.gov/ken/pdf/toolkits/employment/SE_Evaluating_Your_Program.pdf

For further information on the CIMHRRS, please contact:
Robert W. Johnson, Ph.D.
rwjohnson01@gmail.com

APPENDIX F. Individual Site-Visit Report: Program B(continued)

Executive Summary:

This report describes an analysis of the program fidelity, structure and organization of the Program B Employment Program, which is aimed at helping individuals with mental illness achieve and maintain competitive employment.

The purpose of this analysis is two-fold. First, this analysis is aimed at determining the fidelity of the Program B Employment Program to the Individual Placement and Support (IPS) model of Supported Employment (SE), an evidence-based practice (EBP), which is aimed at helping persons with severe mental illness (SMI) achieve and maintain competitive employment. A second, and no less important, goal is to determine whether the Program B Employment Program conforms, in structure and operation, to the particular treatment model on which it is based. The Comprehensive Inventory of Mental Health Rehabilitation and Recovery Services (CIMHRRS) examines the recovery and rehabilitation focus of programs, with a particular emphasis on structural and process components of a program's day-to-day functioning. As specific treatment models are associated with specific outcomes, it is expected that the outcome of any treatment can be achieved only when the treatment is delivered with high fidelity. In turn, the expected outcome of a treatment program must be consistent with the mission of that program. The CIMHRRS is used to examine the organizational structure and approach of service providers to facilitate recommendations outlined in the 2003 President's New Freedom Commission Report. Specifically, this report mandates the transformation of the mental health services system for people with SMI to a rehabilitation focused, recovery-oriented and consumer and family driven system at the national, state, and local levels.

VII. Description of the evaluation and instruments

The Supported Employment Fidelity Scale, previously named the IPS Fidelity Scale (Bond, Becker, Drake, et al., 1997) is based on the SE implementation and evaluation measures from the SAMHSA community toolkit (SAMHSA, 2007; Becker and Bond, 2002). The SE Fidelity Scale has been used to assess various SE programs and consistently demonstrates that better employment outcomes are associated with adherence to the SE model (McGrew and Griss, 2005).

The Comprehensive Inventory of Mental Health and Recovery and Rehabilitation (CIMHRRS) is a 52-item instrument designed to assess the fidelity of various programs to particular service models for persons with severe mental illness (SMI). It is used to both quantitatively and qualitatively characterize programmatic differences in service settings for people with SMI. Through a structured site review, evaluators assess the relative strengths and liabilities of service programs.

The on-site evaluation was conducted on June 16, 2010 at the Program B Employment Program, located in Nebraska. The evaluation schedule lasted from 9:00 am to 5:00 pm and included interviews with the Employment Specialist, Consumers, Family Members of Consumers and Employers. In addition, the evaluators observed a treatment team

APPENDIX F.
Individual Site-Visit Report: Program B (continued)

meeting, reviewed charts and conducted a thorough review of the program's Policies and Procedures Manual. Two independent evaluators conducted all ratings. All discrepancies in ratings were reconciled by consensus.

VIII. Program Description

The Goodwill Industries of Nebraska Employment Services reports in its Policies and Procedures Manual that its primary goal is to help persons with disabilities obtain and maintain employment. Employment services are advertised as free to employers, with the provision of additional benefits, including recruitment assistance; job retention and services support; job development; ongoing support and consultation; and tax credits. For program participants, an emphasis is placed on special Goodwill training and supervision and offer participants skill and vocation strength assessments; job skills training, including job coaching, communication and time management; retention support through Employment Specialists, person-centered planning; and employer contacts. Goodwill only accept those who are also working with Vocational Rehabilitation Services. Once a person is referred to Vocational Rehabilitation, the participant and counselor will complete a written individual plan for employment by doing vocational/career exploration, an assessment of work readiness skills, determination of an appropriate job goal, and definition of the services necessary to reach that job goal. Eligibility for the Goodwill Employment Program is explicitly stated as determined by the Vocational Rehabilitation counselor and must include a DSM Axis I or Axis II diagnosis of mental health or substance abuse. Once eligibility has been determined, there is no waiting list for services. Goodwill Employment Specialists assist participants with job placement, specifically: job leads, completing applications, resume development, job search activities, employer contacts and interview skills. Once placed, Employment Specialists can provide assistance with communicating with employers, problem solving, and conflict resolution. Employment Specialists utilize community resources for everyday living situations or problems that may inhibit the participant's employment opportunity. Employment Specialists will assist with various participant needs, such as transportation, daycare, and housing. Specifically, Behavioral Health Employment Services are aimed at the following goals: preparing individuals for competitive employment; providing support both on and off the job; increasing employment retention; enhancing an individual's ability to functioning in community settings; decreasing the need for more intensive levels of behavioral health services; providing transitional employment opportunities through Goodwill retail stores and funding is provided through a contract with Vocational Rehabilitation services.

**APPENDIX F.
Individual Site-Visit Report: Program B (continued)**

IX. Overview of Results

Supported Employment Fidelity

Supported Employment Fidelity was measured using a standardized and validated tool (see below). Fidelity scores can fall into one of three possible categories: 1) Good Implementation, 2) Fair Implementation and 3) Not Supported Employment.

As noted in Figure 1, the results of this analysis indicate that the Program B Employment Program achieved a score that falls within the *Not Supported Employment* category, considering a number of factors. Specific domain scores are found in Figure 1 and specific item scores are found in Figure 3.

Strengths of the program that are in keeping with the SE model include the following:

6. *Caseload.* Employment specialists manage caseloads of up to 25 consumers per employment specialists.
7. *Rapid search for competitive jobs.* First contact with an employer about a competitive job is typically within 1 month after program entry.
8. *Follow-along supports.* Most consumers are provided flexible, follow-along supports that are individualized and ongoing. This includes crisis intervention, job coaching, job counseling, job support groups, transportation, treatment changes and supportive networks.

Needs of the program to improve adherence to the SE model include the following:

6. *Integration of rehabilitation with mental health treatment.* Employment specialists should be attached to 1 or more case management treatment teams. To improve fidelity, this would include weekly treatment team meetings with shared decision-making and 3 consumer-related case manager contacts per week. It is noted that Goodwill, as a provider of community based behavioral health services, does not have the structure or resources of a licensed mental health center. Goodwill requests guidance from the Division of Behavioral Health to develop an effective method for achieving a higher fidelity rating on this criterion.
7. *Zero exclusion criteria.* All consumers should be encouraged to participate and should not be screened out or referred out of the program based on eligibility requirements such as job readiness, lack of substance abuse, no history of violent behavior, minimal intellectual functioning and/or mild symptoms. It is possible

APPENDIX F.
Individual Site-Visit Report: Program B (continued)

that the lack of integration of employment services with mental health treatment may be contributing towards the inability of the Program B Employment Program to be able to serve all consumers. It is noted that Goodwill's understanding of Nebraska's current service structure has been (1) that Vocational Rehabilitation funding is for the purpose of serving consumers from the point of referral through successful employment closure, and (2) the funding from Behavioral Health Regions 2 and 3 is for the purpose of providing long-term support. Based on this understanding, Goodwill directs BHEP program referrals from all sources to Vocational Rehabilitation for eligibility determination. Goodwill has very strong and consistently applied practice of referring all consumers to Vocational Rehabilitation immediately at the point upon which the consumer expresses an interest in work. Goodwill's BHEP serves all individuals referred to the program from Vocational Rehabilitation.

It is also noted that the Nebraska's current SE service definition states that individuals with a mental health diagnosis or substance abuse will be admitted; however, SE as a service was primarily developed for persons with severe mental illness (SMI).

8. *Vocational unit.* Employment specialists should form a vocational unit with group supervision at least weekly and provide services for each other's cases and backup and support for each other. It is noted that the Program B Employment Program had only 1 Employment Specialist; however supervision and greater contact with other Employment Specialists will improve fidelity to this particular item.
9. *Vocational generalists.* Each employment specialist should carry out all phases of vocational service including engagement, assessment, job development, job placement, job coaching, and follow-along supports. Although employment specialists at the Program B Employment Program did provide a number of these supports to consumers, several of these items were not, including vocational assessment and job development.

Recovery and Rehabilitation of Services

The goal of the CIMHRRS is to determine how well the Program B Employment Program conforms, in structure and operation, to the particular treatment model on which it is based. This is important because specific treatment models are associated with specific outcomes and these outcomes are achieved when the treatment is delivered with high fidelity. In turn, the expected outcome of a treatment program must be consistent with the mission of that program.

As noted in Figure 2, the results of this analysis indicates that the Program B Employment Program has reached minimal integration in the five domains of the

APPENDIX F.
Individual Site-Visit Report: Program B (continued)

CIMHRRS: 1) Program Mission; 2) Organizational Boundaries; 3) Treatment Team Structure & Process; 4) Assessment Process; and 5) Treatment Planning.

Assets of the program which contribute to the successful realization of its mission include:

5. *Identifiable Program Mission Statement.* The mission of the Program B Employment Program is clear and operationalized, focusing on helping individuals with disabilities, and in particular, those with SMI, obtain and maintain competitive employment.
6. *Support and Integration of Off-Site Training.* The Program B Employment Program strongly supports off-site training for staff that facilitate the program mission and there is evidence that the program attempts to integrate these trainings into the current program. Specifically, the Goodwill--Lexington Employment Program regularly encourages Employment Specialists to attend trainings related to provided services; moreover there is support from the program to integrate these trainings into current practice.
7. *Admission Criteria for the Appropriate Delineation of Organizational Boundaries.* Admission criteria are well-defined and contribute towards appropriate organizational boundaries.

Characteristics deemed most crucial to successful realization of its mission include:

1. *Thorough training of all staff in the program model and approach.* Although the Program B Employment Program has a clearly defined and operationalized mission, there is less specificity regarding the particular model and approach the program applies in order to successfully realize this goal. Moreover, it appears that staff are not able to articulate the specific model from which the Program B Employment Program works. An articulated program theory or model will assist in this area and should, by regulatory standards, adhere to the specific SE Fidelity program model to ensure the delivery of Supported Employment services. Staff training in the specific SE program model will likely improve achieved employment outcomes.
2. *Systematic program process monitoring and evaluation.* The continuing monitoring of fidelity and outcomes will improve the program's ability to address program drift from its mission goals and model. As noted above, this can be conducted using SE Fidelity materials found on the SAMHSA website.

APPENDIX F.
Individual Site-Visit Report: Program B (continued)

3. *Integration of treatment in both the treatment plan and provision of services.* The Program B Employment Program can improve its ability to effectively address clients' multiple service needs (e.g., dual disorders, independent functioning) that may be challenging for one employment specialist alone to handle. This can be completed through regular (i.e., on a weekly basis) interactions with case managers and mental health providers and shared decision-making on mental health treatment team meetings.
4. *Staff development in the areas of recovery, recovery-oriented services, Psychiatric Rehabilitation and personalization of treatment and individualized treatment planning.* The Program B Employment Program can improve the individualization of treatment geared towards recovery. Evidence-based practice, recovery and psychiatric or psychosocial rehabilitation are major movements in current mental health treatments, of which Supported Employment is one. Staff should be trained specifically in these models of treatment to more effectively deliver SE services.
5. *Development of comprehensive assessment and treatment technologies relevant to the impairments, disabilities, and goals of its identified population.* Although the Program B Employment Program completes a variety of assessments, the utilization of these assessments on a more regular basis will inform the best provision of services and subsequently, outcomes achieved. The assessments could also be more comprehensive to include interpersonal skills, basic independent living skills, cognitive functioning and symptom assessment will provide a more comprehensive understanding of the consumer's functioning and, combined with integrated service provision, will improve the overall employment outcomes achieved by the program.

X. Conclusions

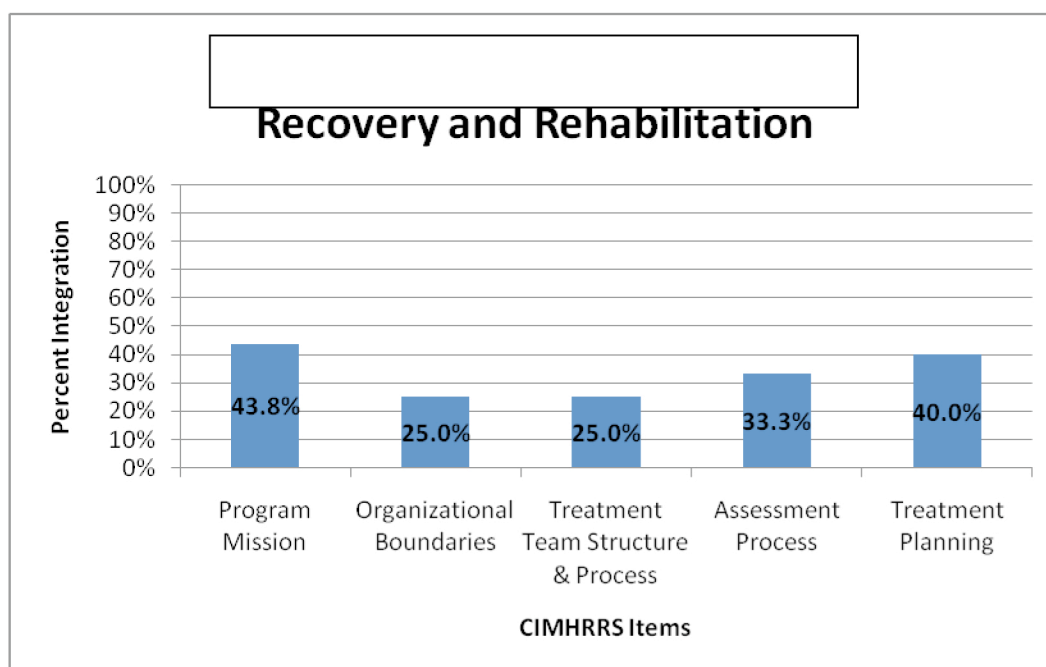
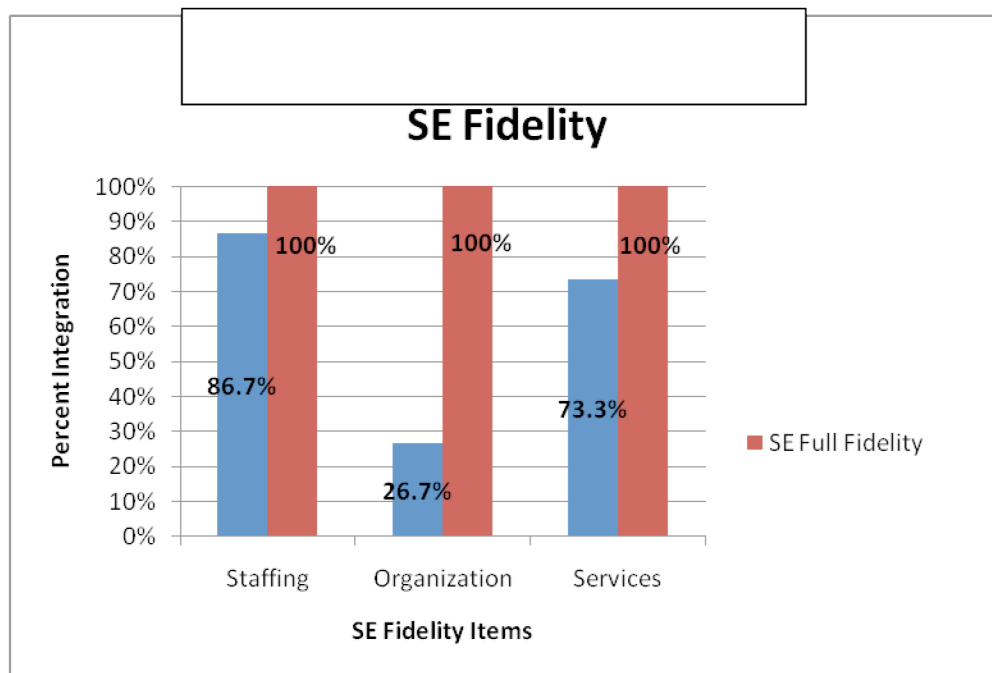
Goodwill notes that it is very interested in developing a deeper understanding and more complete implementation of an evidence-based Supported Employment Program. Goodwill has engaged in several conversations with the Dartmouth J&J project staff and also attempted, earlier in this year, to participate in a funding proposal to SAMHSA to strengthen employment services. Goodwill looks forward to future dialogue and guidance.

XI.A Word of Thanks

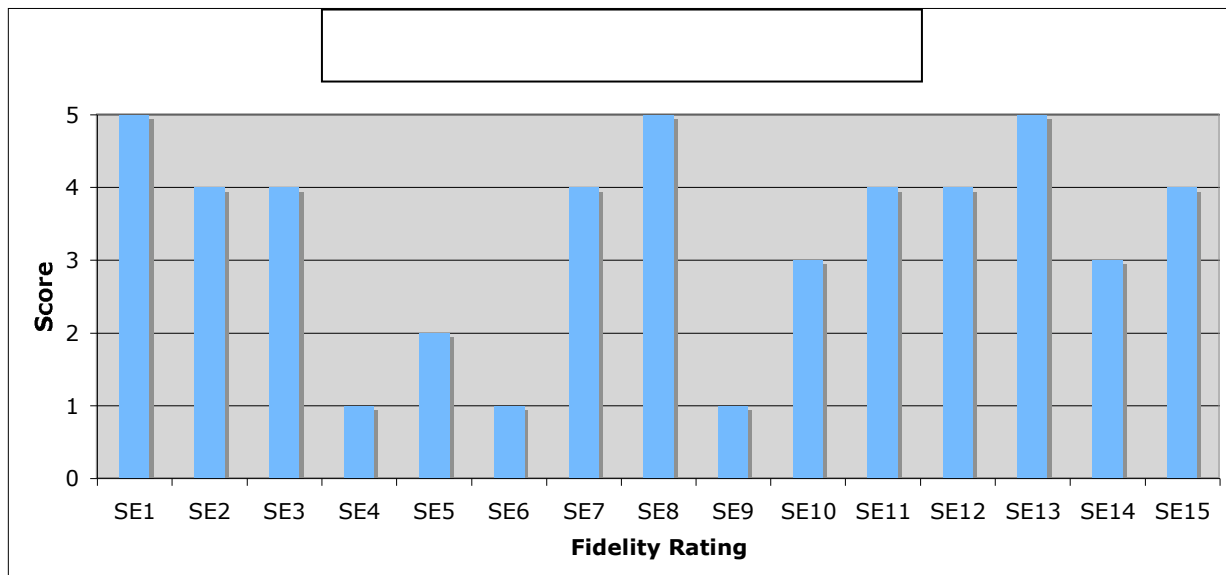
Goodwill staff were extremely hospitable during the site visit. Specific individuals were especially helpful in assisting with organization and scheduling of the site visit. Thank you for the quality services that you provide to persons with SMI.

**APPENDIX F.
Individual Site-Visit Report: Program B (continued)**

XII. Appendix



APPENDIX F.
Individual Site-Visit Report: Program B (continued)



APPENDIX G.
Individual Site-Visit Report: Program C

Program C Employment Program:
A Fidelity, Structure and Process Analysis

Date of site visit:
May 24, 2010

Date of report:
September 27, 2010

Report prepared by:
Nancy H. Liu, M.A.

Program Evaluation Tools:
--Supported Employment Fidelity Scale (SE Fidelity Scale)
--Comprehensive Instrument of Mental Health & Recovery and Rehabilitation Services (CIMHRRS)

Program Evaluation conducted by:
Nancy H. Liu, M.A.
Paul Nabity, B.S.

Supervision provided by:
Jim Harvey, MSW
William D. Spaulding, Ph.D.

For further information on the SE Fidelity Scale, please consult:
Substance Abuse and Mental Health Services (SAMHSA) Community Mental Health Tool-Kit Evaluating Supported Employment Programs:
http://download.ncadi.samhsa.gov/ken/pdf/toolkits/employment/SE_Evaluating_Your_Program.pdf

For further information on the CIMHRRS, please contact:
Robert W. Johnson, Ph.D.
rwjohnson01@gmail.com

APPENDIX G.

Individual Site-Visit Report: Program C (continued)

Executive Summary:

This report describes an analysis of the program fidelity, structure and organization of the Program C Employment Program, which is aimed at helping individuals with mental illness achieve and maintain competitive employment.

The purpose of this analysis is two-fold. First, this analysis is aimed at determining the fidelity of the Program C Employment Program to the Individual Placement and Support (IPS) model of Supported Employment (SE), an evidence-based practice (EBP), which is aimed at helping persons with severe mental illness (SMI) achieve and maintain competitive employment. A second, and no less important, goal is to determine whether the Program C Employment Program conforms, in structure and operation, to the particular treatment model on which it is based. The Comprehensive Inventory of Mental Health Rehabilitation and Recovery Services (CIMHRRS) examines the recovery and rehabilitation focus of programs, with a particular emphasis on structural and process components of a program's day-to-day functioning. As specific treatment models are associated with specific outcomes, it is expected that the outcome of any treatment can be achieved only when the treatment is delivered with high fidelity. In turn, the expected outcome of a treatment program must be consistent with the mission of that program. The CIMHRRS is used to examine the organizational structure and approach of service providers to facilitate recommendations outlined in the 2003 President's New Freedom Commission Report. Specifically, this report mandates the transformation of the mental health services system for people with SMI to a rehabilitation focused, recovery-oriented and consumer and family driven system at the national, state, and local levels.

I. Description of the evaluation and instruments

The Supported Employment Fidelity Scale, previously named the IPS Fidelity Scale (Bond, Becker, Drake, et al., 1997) is based on the SE implementation and evaluation measures from the SAMHSA community toolkit (SAMHSA, 2007; Becker and Bond, 2002). The SE Fidelity Scale has been used to assess various SE programs and consistently demonstrates that better employment outcomes are associated with adherence to the SE model (McGrew and Griss, 2005).

The Comprehensive Inventory of Mental Health and Recovery and Rehabilitation (CIMHRRS) is a 52-item instrument designed to assess the fidelity of various programs to particular service models for persons with severe mental illness (SMI). It is used to both quantitatively and qualitatively characterize programmatic differences in service settings for people with SMI. Through a structured site review, evaluators assess the relative strengths and liabilities of service programs.

The on-site evaluation was conducted on May 24, 2010 at the Program C Employment Program, located in Nebraska. The evaluation schedule lasted from 9:00 am to 5:00 pm and included interviews with Program Director, Employment Specialists,

APPENDIX G.
Individual Site-Visit Report: Program C (continued)

Consumers, and a Peer Specialist. In addition, the evaluators observed a treatment team meeting, reviewed charts and conducted a thorough review of the program's Policies and Procedures Manual. Two independent evaluators conducted all ratings. All discrepancies in ratings were reconciled by consensus.

II. Program Description

The Program Employment Services reports in its Policies and Procedures Manual that its primary goal is to help persons with disabilities obtain and maintain employment. Employment services are advertised as free to employers, with the provision of additional benefits, including recruitment assistance; job retention and services support; job development; ongoing support and consultation; and tax credits. For program participants, an emphasis is placed on special Goodwill training and supervision and offer participants skill and vocation strength assessments; job skills training, including job coaching, communication and time management; retention support through Employment Specialists, person-centered planning; and employer contacts. Goodwill only accept those who are also working with Vocational Rehabilitation Services. Once a person is referred to Vocational Rehabilitation, the participant and counselor will complete a written individual plan for employment by doing vocational/career exploration, an assessment of work readiness skills, determination of an appropriate job goal, and definition of the services necessary to reach that job goal. Eligibility for the Goodwill Employment Program is explicitly stated as determined by the Vocational Rehabilitation counselor and must include a DSM Axis I or Axis II diagnosis of mental health or substance abuse. Once eligibility has been determined, there is no waiting list for services. Goodwill Employment Specialists assist participants with job placement, specifically: job leads, completing applications, resume development, job search activities, employer contacts and interview skills. Once placed, Employment Specialists can provide assistance with communicating with employers, problem solving, and conflict resolution. Employment Specialists utilize community resources for everyday living situations or problems that may inhibit the participant's employment opportunity. Employment Specialists will assist with various participant needs, such as transportation, daycare, and housing. Specifically, Behavioral Health Employment Services are aimed at the following goals: preparing individuals for competitive employment; providing support both on and off the job; increasing employment retention; enhancing an individual's ability to functioning in community settings; decreasing the need for more intensive levels of behavioral health services; providing transitional employment opportunities through Goodwill retail stores and funding is provided through a contract with Vocational Rehabilitation services.

APPENDIX G.
Individual Site-Visit Report: Program C (continued)

III. Overview of Results

Supported Employment Fidelity

Supported Employment Fidelity was measured using a standardized and validated tool (see below). Fidelity scores can fall into one of three possible categories: 1) Good Implementation, 2) Fair Implementation and 3) Not Supported Employment.

As noted in Figure 1, the results of this analysis indicate that the Program C Employment Program achieved a score that fell within the *Not Supported Employment* category, considering a number of factors. Specific domain scores are found in Figure 1 and specific item scores are found in Figure 3.

Strengths of the program that are in keeping with the SE model include the following:

1. *Follow-along supports.* Most consumers are provided flexible, follow-along supports that are individualized and ongoing. This includes crisis intervention, job coaching, job counseling, job support groups, transportation, treatment changes and supportive networks.

Needs of the program to improve adherence to the SE model include the following:

1. *Integration of rehabilitation with mental health treatment.* Employment specialists should be attached to 1 or more case management treatment teams. To improve fidelity, this would include weekly treatment team meetings with shared decision-making and 3 consumer-related case manager contacts per week. It is noted that Goodwill, as a provider of community based behavioral health services, does not have the structure or resources of a licensed mental health center. Goodwill requests guidance from the Division of Behavioral Health to develop an effective method for achieving a higher fidelity rating on this criterion.
2. *Zero exclusion criteria.* All consumers should be encouraged to participate and should not be screened out or referred out of the program based on eligibility requirements such as job readiness, lack of substance abuse, no history of violent behavior, minimal intellectual functioning and/or mild symptoms. It is possible that the lack of integration of employment services with mental health treatment may be contributing towards the inability of the Program C Employment Program to be able to serve all consumers. It is noted that Goodwill's understanding of Nebraska's current service structure has been (1) that Vocational Rehabilitation funding is for the purpose of serving consumers from the point of referral through successful employment closure, and (2) the funding from Behavioral Health Regions 2 and 3 is for the purpose of providing long-term support. Based on this understanding, Goodwill directs BHEP program referrals from all sources to

APPENDIX G.
Individual Site-Visit Report: Program C (continued)

3. Vocational Rehabilitation for eligibility determination. Goodwill has very strong and consistently applied practice of referring all consumers to Vocational Rehabilitation immediately at the point upon which the consumer expresses an interest in work. Goodwill's BHEP serves all individuals referred to the program from Vocational Rehabilitation.

It is also noted that the Nebraska's current SE service definition states that individuals with a mental health diagnosis or substance abuse will be admitted; however, SE as a service was primarily developed for persons with severe mental illness (SMI).

4. *Diversity of jobs developed.* Employment specialists should provide job options that are in different settings. More specifically, high SE Fidelity requires that employment specialists provide options for either the same types of jobs, e.g., janitorial, or jobs at the same work settings, less than 10% of the time.
5. *Individualized job search.* Employer contacts should be based on consumers' job preferences (relating to what they enjoy and their personal goals) and needs (including experience, ability, how they affect a good job and setting match) rather than the job market (that is, what jobs are readily available. More specifically, high SE Fidelity requires that most (over 85%) of employer contacts are based on job choices which reflect consumers' preferences and needs rather than the job market.

Recovery and Rehabilitation of Services

The goal of the CIMHRRS is to determine how well the Program C Employment Program conforms, in structure and operation, to the particular treatment model on which it is based. This is important because specific treatment models are associated with specific outcomes and these outcomes are achieved when the treatment is delivered with high fidelity. In turn, the expected outcome of a treatment program must be consistent with the mission of that program.

As noted in Figure 2, the results of this analysis indicates that the Program C Employment Program has reached minimal integration in the five domains of the CIMHRRS: 1) Program Mission; 2) Organizational Boundaries; 3) Treatment Team Structure & Process; 4) Assessment Process; and 5) Treatment Planning.

APPENDIX G.
Individual Site-Visit Report: Program C (continued)

Assets of the program which contribute to the successful realization of its mission include:

1. *Identifiable Program Mission Statement.* The mission of the Program C Employment Program is clear and operationalized, focusing on helping individuals with disabilities, and in particular, those with SMI, obtain and maintain competitive employment.
2. *Admission Criteria for the Appropriate Delineation of Organizational Boundaries.* Admission criteria are well-defined and contribute towards appropriate organizational boundaries.

Characteristics deemed most crucial to successful realization of its mission include:

1. *Thorough training of all staff in the program model and approach.* Although the Program C Employment Program has a clearly defined and operationalized mission, there is less specificity regarding the particular model and approach the program applies in order to successfully realize this goal. Moreover, it appears that staff are not able to articulate the specific model from which the Program C Employment Program works. An articulated program theory or model will assist in this area and should by regulatory standards, adhere to the specific SE Fidelity program model to ensure the delivery of Supported Employment services. Staff training in the specific SE program model will likely improve achieved employment outcomes.
2. *Systematic program process monitoring and evaluation.* The continuing monitoring of fidelity and outcomes will improve the program's ability to address program drift from its mission goals and model. As noted above, this can be conducted using SE Fidelity materials found on the SAMHSA website.
3. *Integration of treatment in both the treatment plan and provision of services.* The Program C Employment Program can improve its ability to effectively address clients' multiple service needs (e.g., dual disorders, independent functioning) that may be challenging for one employment specialist alone to handle. This can be completed through regular (i.e., on a weekly basis) interactions with case managers and mental health providers and shared decision-making on mental health treatment team meetings.

APPENDIX G.
Individual Site-Visit Report: Program C (continued)

4. *Staff development in the areas of recovery, recovery-oriented services, Psychiatric Rehabilitation and personalization of treatment and individualized treatment planning.* The Program C Employment Program can improve the individualization of treatment geared towards recovery. Staff should be well-versed in concepts such as evidence-based practice, recovery, and psychiatric (or psychosocial) rehabilitation, which are major movements and aptly describe the foundation from which the Supported Employment model (as defined by SAMHSA) is based. Staff should be trained specifically in these models of treatment to more effectively deliver SE services.

5. *Development of comprehensive assessment and treatment technologies relevant to the impairments, disabilities, and goals of its identified population.* Although the Program C Employment Program completes a variety of assessments, the utilization of these assessments on a more regular basis will inform the best provision of services and subsequently, outcomes achieved. The assessments could also be more comprehensive to include interpersonal skills, basic independent living skills, cognitive functioning and symptom assessment will provide a more comprehensive understanding of the consumer's functioning and, combined with integrated service provision, will improve the overall employment outcomes achieved by the program.

IV. Conclusions

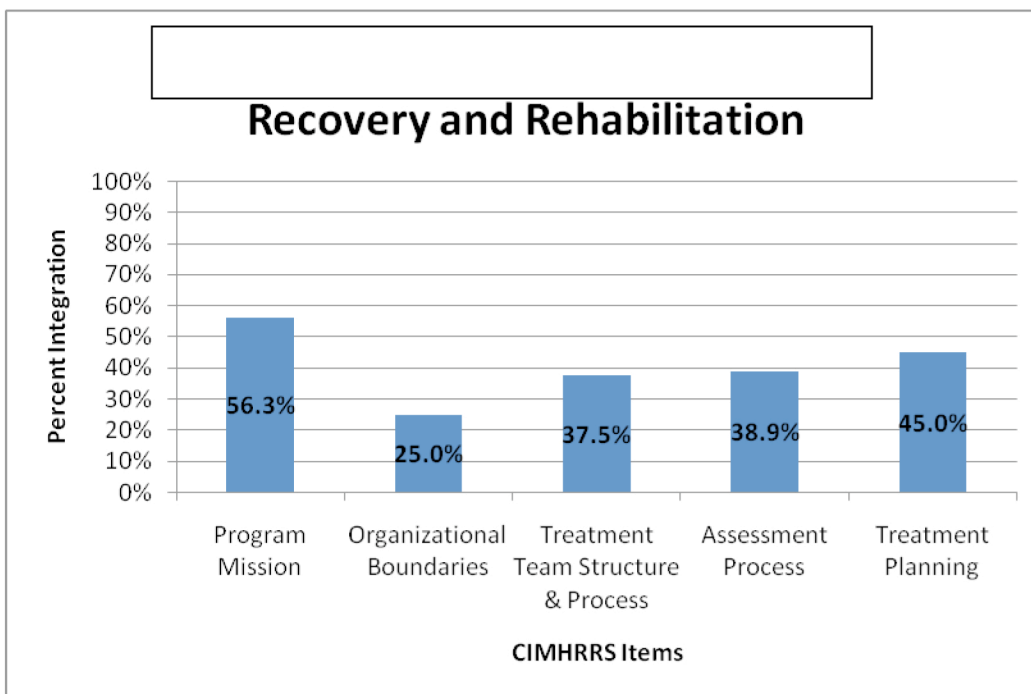
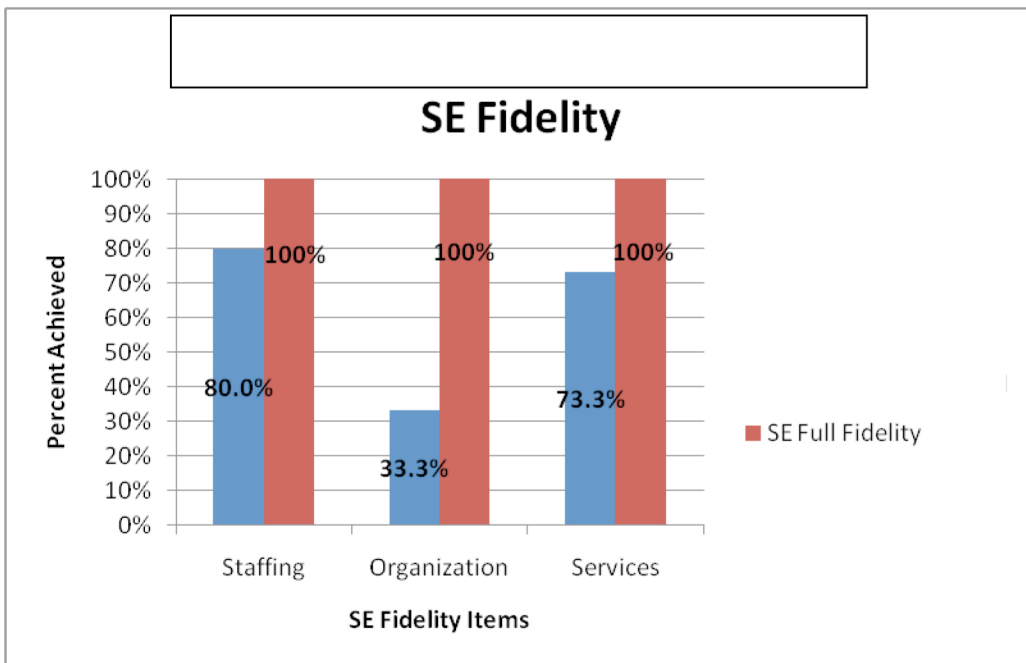
Goodwill notes that it is very interested in developing a deeper understanding and more complete implementation of an evidence-based Supported Employment Program. Goodwill has engaged in several conversations with the Dartmouth J&J project staff and also attempted, earlier in this year, to participate in a funding proposal to SAMHSA to strengthen employment services. Goodwill looks forward to future dialogue and guidance.

V. A Word of Thanks

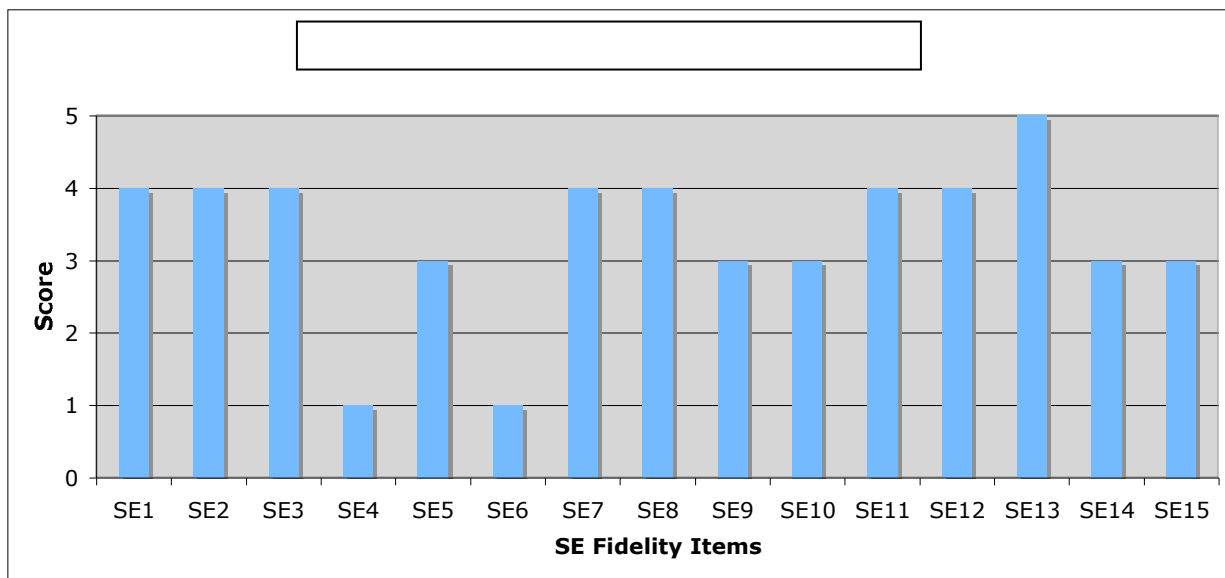
Goodwill staff were extremely hospitable during the site visit. Individual program staff were especially helpful in assisting with organization and scheduling of the site visit. Thank you for the quality services that you provide to persons with SMI.

VI. Appendix

**APPENDIX G.
Individual Site-Visit Report: Program C (continued)**



APPENDIX G.
Individual Site-Visit Report: Program C (continued)



APPENDIX H. Individual Site-Visit Report: Program D

Program D Employment Program: A Fidelity, Structure and Process Analysis

Date of site visit:
May 26, 2010

Date of report:
September 27, 2010

Report prepared by:
Nancy H. Liu, M.A.

Program Evaluation Tools:

--Supported Employment Fidelity Scale (SE Fidelity Scale)
--Comprehensive Instrument of Mental Health & Recovery and Rehabilitation Services (CIMHRRS)

Program Evaluation conducted by:
Nancy H. Liu, M.A.
Paul Nabity, B.S.

Supervision provided by:
Jim Harvey, MSW
William D. Spaulding, Ph.D.

For further information on the SE Fidelity Scale, please consult:
Substance Abuse and Mental Health Services (SAMHSA) Community Mental Health Tool-Kit Evaluating Supported Employment Programs:
http://download.ncadi.samhsa.gov/ken/pdf/toolkits/employment/SE_Evaluating_Your_Program.pdf

For further information on the CIMHRRS, please contact:
Robert W. Johnson, Ph.D.
rwjohnson01@gmail.com

APPENDIX H.

Individual Site-Visit Report: Program D

Executive Summary:

This report describes an analysis of the program fidelity, structure and organization of the Program D Employment Program, which is aimed at helping individuals with mental illness achieve and maintain competitive employment.

The purpose of this analysis is two-fold. First, this analysis is aimed at determining the fidelity of the Program D Employment Program to the Individual Placement and Support (IPS) model of Supported Employment (SE), an evidence-based practice (EBP), which is aimed at helping persons with severe mental illness (SMI) achieve and maintain competitive employment. A second, and no less important, goal is to determine whether the Program D Employment Program conforms, in structure and operation, to the particular treatment model on which it is based. The Comprehensive Inventory of Mental Health Rehabilitation and Recovery Services (CIMHRRS) examines the recovery and rehabilitation focus of programs, with a particular emphasis on structural and process components of a program's day-to-day functioning. As specific treatment models are associated with specific outcomes, it is expected that the outcome of any treatment can be achieved only when the treatment is delivered with high fidelity. In turn, the expected outcome of a treatment program must be consistent with the mission of that program. The CIMHRRS is used to examine the organizational structure and approach of service providers to facilitate recommendations outlined in the 2003 President's New Freedom Commission Report. Specifically, this report mandates the transformation of the mental health services system for people with SMI to a rehabilitation focused, recovery-oriented and consumer and family driven system at the national, state, and local levels.

I. Description of the evaluation and instruments

The Supported Employment Fidelity Scale, previously named the IPS Fidelity Scale (Bond, Becker, Drake, et al., 1997) is based on the SE implementation and evaluation measures from the SAMHSA community toolkit (SAMHSA, 2007; Becker and Bond, 2002). The SE Fidelity Scale has been used to assess various SE programs and consistently demonstrates that better employment outcomes are associated with adherence to the SE model (McGrew and Griss, 2005).

The Comprehensive Inventory of Mental Health and Recovery and Rehabilitation (CIMHRRS) is a 52-item instrument designed to assess the fidelity of various programs to particular service models for persons with severe mental illness (SMI). It is used to both quantitatively and qualitatively characterize programmatic differences in service settings for people with SMI. Through a structured site review, evaluators assess the relative strengths and liabilities of service programs.

The on-site evaluation was conducted on May 26, 2010 at the Program D Employment Program, located in Nebraska. The evaluation schedule lasted from 9:00 am to 5:00 pm and included interviews with Employment Specialists, Consumers and Employers. In addition, the evaluators observed a treatment team meeting, reviewed

APPENDIX H.
Individual Site-Visit Report: Program D (continued)

charts and conducted a thorough review of the program's Policies and Procedures Manual. Two independent evaluators conducted all ratings. All discrepancies in ratings were reconciled by consensus.

II. Program Description

The Program D Employment Services reports in its Policies and Procedures Manual that its primary goal is to help persons with disabilities obtain and maintain employment. Employment services are advertised as free to employers, with the provision of additional benefits, including recruitment assistance; job retention and services support; job development; ongoing support and consultation; and tax credits. For program participants, an emphasis is placed on special Goodwill training and supervision and offer participants skill and vocation strength assessments; job skills training, including job coaching, communication and time management; retention support through Employment Specialists, person-centered planning; and employer contacts. Goodwill only accept those who are also working with Vocational Rehabilitation Services. Once a person is referred to Vocational Rehabilitation, the participant and counselor will complete a written individual plan for employment by doing vocational/career exploration, an assessment of work readiness skills, determination of an appropriate job goal, and definition of the services necessary to reach that job goal. Eligibility for the Goodwill Employment Program is explicitly stated as determined by the Vocational Rehabilitation counselor and must include a DSM Axis I or Axis II diagnosis of mental health or substance abuse. Once eligibility has been determined, there is no waiting list for services. Goodwill Employment Specialists assist participants with job placement, specifically: job leads, completing applications, resume development, job search activities, employer contacts and interview skills. Once placed, Employment Specialists can provide assistance with communicating with employers, problem solving, and conflict resolution. Employment Specialists utilize community resources for everyday living situations or problems that may inhibit the participant's employment opportunity. Employment Specialists will assist with various participant needs, such as transportation, daycare, and housing. Specifically, Behavioral Health Employment Services are aimed at the following goals: preparing individuals for competitive employment; providing support both on and off the job; increasing employment retention; enhancing an individual's ability to functioning in community settings; decreasing the need for more intensive levels of behavioral health services; providing transitional employment opportunities through Goodwill retail stores and funding is provided through a contract with Vocational Rehabilitation services.

APPENDIX H.
Individual Site-Visit Report: Program D (continued)

III. Overview of Results

Supported Employment Fidelity

Supported Employment Fidelity was measured using a standardized and validated tool (see below). Fidelity scores can fall into one of three possible categories: 1) Good Implementation, 2) Fair Implementation and 3) Not Supported Employment.

As noted in Figure 1, the results of this analysis indicate that the Program D Employment Program achieved a score that fell within the *Not Supported Employment* category, considering a number of factors. It is noted that the SE fidelity score for the Program D Employment Program falls within the upper bounds of this category, suggesting that SE Fidelity could be improved to better approximate fair implementation of the SE program. Specific domain scores are found in Figure 1 and specific item scores are found in Figure 3.

Strengths of the program that are in keeping with the SE model include the following:

1. *Rapid search for competitive jobs.* First contact with an employer about a competitive job is typically within 1 month after program entry.
2. *Jobs as transitions.* Employment specialists at Program D Employment Program were able to help consumers end jobs when appropriate and offer to help them all find another job, recognizing that all jobs are viewed as positive experiences on the path of vocational growth and development.
3. *Follow-along supports.* Most consumers are provided flexible, individualized follow-along supports that are individualized and ongoing. This includes crisis intervention, job coaching, job counseling, job support groups, transportation, treatment changes and supportive networks.

APPENDIX H.
Individual Site-Visit Report: Program D (continued)

Needs of the program to improve adherence to the SE model include the following:

1. *Integration of rehabilitation with mental health treatment.* Employment specialists should be attached to 1 or more case management treatment teams. To improve fidelity, this would include weekly treatment team meetings with shared decision-making and 3 consumer-related case manager contacts per week. It is noted that at Goodwill, as a provider of community based behavioral health services, does not have the structure or resources of a licensed mental health center. Goodwill requests guidance from the Division of Behavioral Health to develop an effective method for achieving a higher fidelity rating on this criterion.
2. *Zero exclusion criteria.* All consumers should be encouraged to participate and should not be screened out or referred out of the program based on requirements such as job readiness, lack of substance abuse, no history of violent behavior, minimal intellectual functioning and/or mild symptoms. It is possible that the lack of integration of employment services with mental health treatment may be contributing towards the inability of the Program D Employment Program to be able to serve all consumers. It is noted that Goodwill's understanding of Nebraska's current service structure has been (1) that Vocational Rehabilitation funding is for the purpose of serving consumers from the point of referral through successful employment closure, and (2) the funding from Behavioral Health Regions 2 and 3 is for the purpose of providing long-term support. Based on this understanding, Goodwill directs BHEP program referrals from all sources to Vocational Rehabilitation for eligibility determination. Goodwill has very strong and consistently applied practice of referring all consumers to Voc Rehab immediately at the point upon which the consumer expresses an interest in work. Goodwill's BHEP serves all individuals referred to the program from Vocational Rehabilitation.

It is also noted that the Nebraska's current SE service definition states that individuals with a mental health diagnosis or substance abuse will be admitted; however, SE as a service was primarily developed for persons with severe mental illness (SMI).

3. *Vocational generalists.* Each employment specialist should carry out all phases of vocational service including engagement, assessment, job development, job placement, job coaching, and follow-along supports. Although employment specialists at the Program D Employment Program did provide a number of these supports to consumers, several of these items were not, including vocational assessment and job development.

APPENDIX H.
Individual Site-Visit Report: Program D (continued)

Recovery and Rehabilitation of Services

The goal of the CIMHRRS is to determine how well the Program D Employment Program conforms, in structure and operation, to the particular treatment model on which it is based. This is important because specific treatment models are associated with specific outcomes and these outcomes are achieved when the treatment is delivered with high fidelity. In turn, the expected outcome of a treatment program must be consistent with the mission of that program.

As noted in Figure 2, the results of this analysis indicates that the Program D Employment Program has reached minimal integration in the five domains of the CIMHRRS: 1) Program Mission; 2) Organizational Boundaries; 3) Treatment Team Structure & Process; 4) Assessment Process; and 5) Treatment Planning.

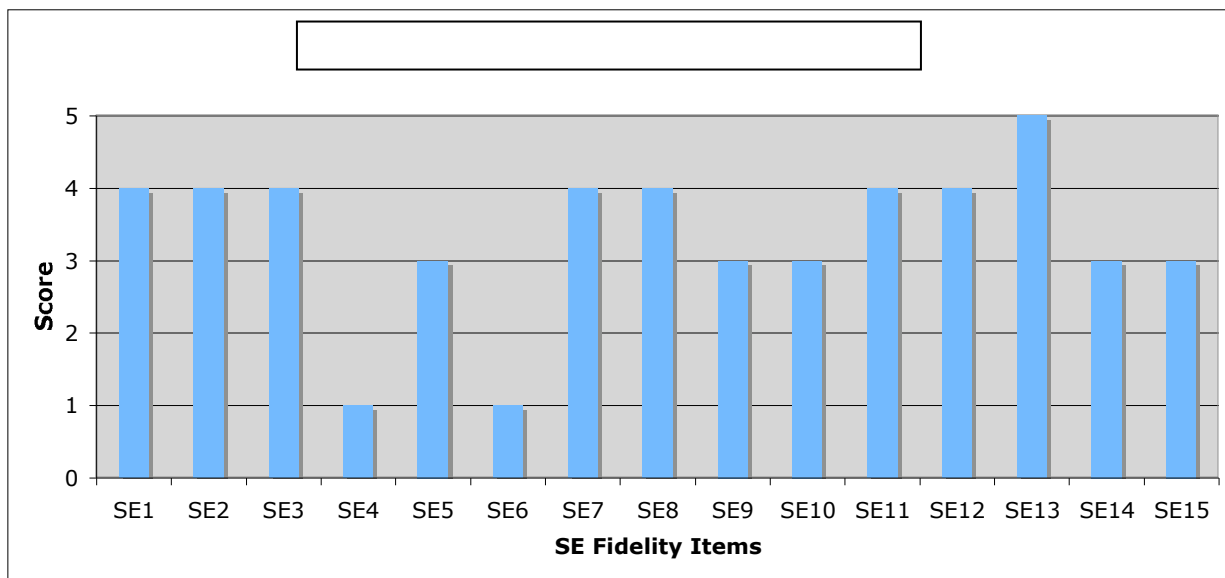
Assets of the program which contribute to the successful realization of its mission include:

1. *Identifiable Program Mission Statement.* The mission of the Program D Employment Program is clear and operationalized, focusing on helping individuals with disabilities, and in particular, those with SMI, obtain and maintain competitive employment.
2. *Explicit Admission Criteria for the Appropriate Delineation of Organizational Boundaries.* Admission criteria are well-defined and contribute towards appropriate organizational boundaries.
3. *Role of Consumer in Service Provision.* Consumers were employed full-time by the Goodwill Program and function as a full member of the team in addressing client treatment issues.

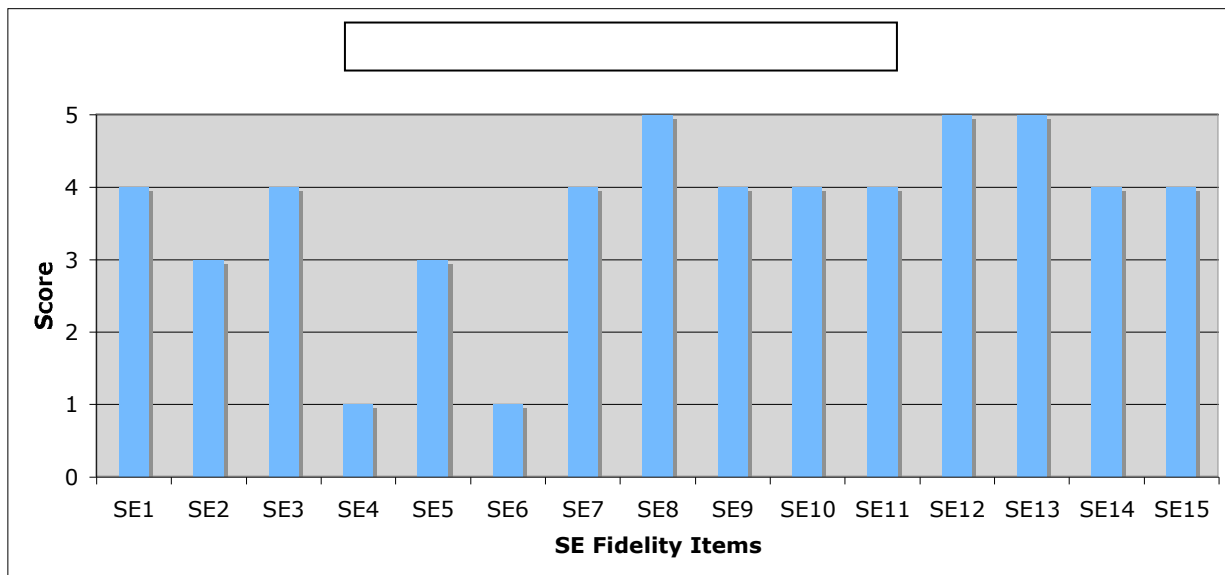
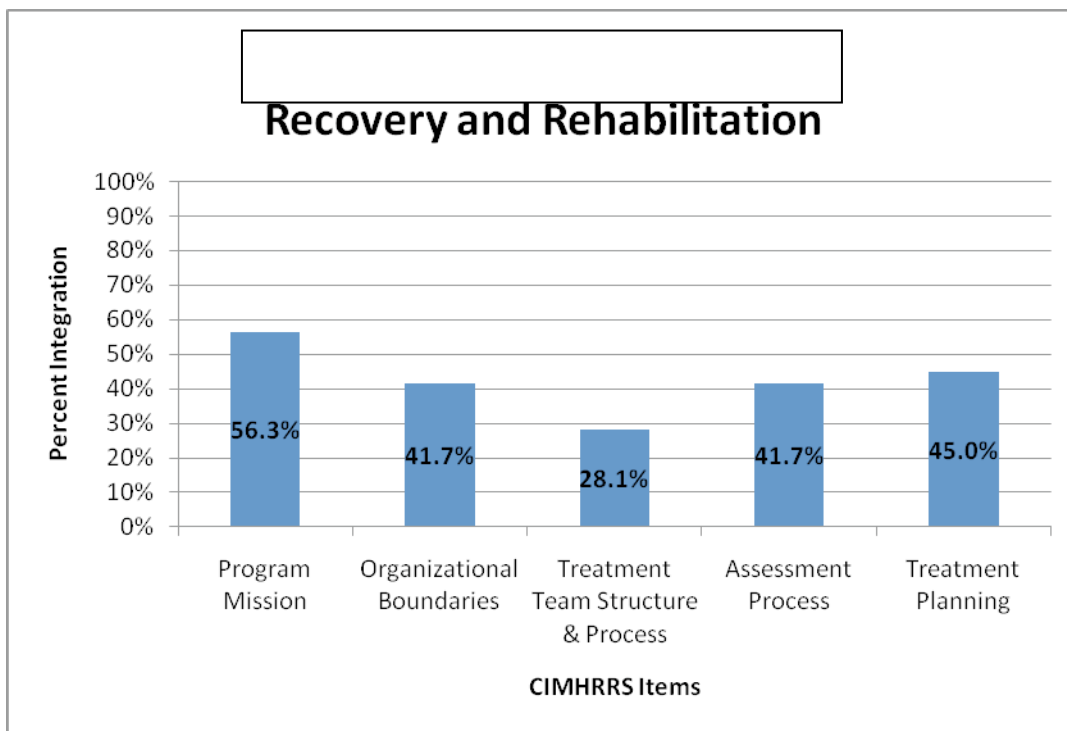
Characteristics deemed most crucial to successful realization of its mission include:

1. *Thorough training of all staff in the program model and approach.* Although the Program D Employment Program has a clearly defined and operationalized mission, there is less specificity regarding the particular model and approach the program applies in order to successfully realize this goal. Moreover, it appears that staff are not able to articulate the specific model from which the Program D Employment Program works. An articulated program theory or model will assist in this area and should by regulatory standards, adhere to the specific SE Fidelity program model to ensure the delivery of Supported Employment services. Staff

APPENDIX G.
Individual Site-Visit Report: Program C (continued)



**APPENDIX H.
Individual Site-Visit Report: Program D (continued)**



APPENDIX I.
Individual Site-Visit Report: Program E

Program E Employment Program:
A Fidelity, Structure and Process Analysis

Date of site visit:
May 25, 2010

Date of report:
September 27, 2010

Report prepared by:
Nancy H. Liu, M.A.

Program Evaluation Tools:
--Supported Employment Fidelity Scale (SE Fidelity Scale)
--Comprehensive Instrument of Mental Health & Recovery and Rehabilitation Services (CIMHRRS)

Program Evaluation conducted by:
Nancy H. Liu, M.A.
Paul Nabity, B.S.

Supervision provided by:
Jim Harvey, MSW
William D. Spaulding, Ph.D.

For further information on the SE Fidelity Scale, please consult:
Substance Abuse and Mental Health Services (SAMHSA) Community Mental Health Tool-Kit Evaluating Supported Employment Programs:
http://download.ncadi.samhsa.gov/ken/pdf/toolkits/employment/SE_Evaluating_Your_Program.pdf

For further information on the CIMHRRS, please contact:
Robert W. Johnson, Ph.D.
rwjohnson01@gmail.com

APPENDIX I.

Individual Site-Visit Report: Program E

Executive Summary:

This report describes an analysis of the program fidelity, structure and organization of the Program E Employment Program, which is aimed at helping individuals with mental illness achieve and maintain competitive employment.

The purpose of this analysis is two-fold. First, this analysis is aimed at determining the fidelity of the Program E Employment Program to the Individual Placement and Support (IPS) model of Supported Employment (SE), an evidence-based practice (EBP), which is aimed at helping persons with severe mental illness (SMI) achieve and maintain competitive employment. A second, and no less important, goal is to determine whether the Program E Employment Program conforms, in structure and operation, to the particular treatment model on which it is based. The Comprehensive Inventory of Mental Health Rehabilitation and Recovery Services (CIMHRRS) examines the recovery and rehabilitation focus of programs, with a particular emphasis on structural and process components of a program's day-to-day functioning. As specific treatment models are associated with specific outcomes, it is expected that the outcome of any treatment can be achieved only when the treatment is delivered with high fidelity. In turn, the expected outcome of a treatment program must be consistent with the mission of that program. The CIMHRRS is used to examine the organizational structure and approach of service providers to facilitate recommendations outlined in the 2003 President's New Freedom Commission Report. Specifically, this report mandates the transformation of the mental health services system for people with SMI to a rehabilitation focused, recovery-oriented and consumer and family driven system at the national, state, and local levels.

I. Description of the evaluation and instruments

The Supported Employment Fidelity Scale, previously named the IPS Fidelity Scale (Bond, Becker, Drake, et al., 1997) is based on the SE implementation and evaluation measures from the SAMHSA community toolkit (SAMHSA, 2007; Becker and Bond, 2002). The SE Fidelity Scale has been used to assess various SE programs and consistently demonstrates that better employment outcomes are associated with adherence to the SE model (McGrew and Griss, 2005).

The Comprehensive Inventory of Mental Health and Recovery and Rehabilitation (CIMHRRS) is a 52-item instrument designed to assess the fidelity of various programs to particular service models for persons with severe mental illness (SMI). It is used to both quantitatively and qualitatively characterize programmatic differences in service settings for people with SMI. Through a structured site review, evaluators assess the relative strengths and liabilities of service programs.

The on-site evaluation was conducted on May 25, 2010 at the Program E Employment Program, located in Nebraska. The evaluation schedule lasted from 9:00 am to 5:00 pm and included interviews with the Employment Specialists, Consumers and Employers. In addition, the evaluators observed a treatment team meeting, reviewed

APPENDIX I.

Individual Site-Visit Report: Program E

charts and conducted a thorough review of the program's Policies and Procedures Manual. Two independent evaluators conducted all ratings. All discrepancies in ratings were reconciled by consensus.

II. Program Description

The Program E Employment Services reports in its Policies and Procedures Manual that its primary goal is to help persons with disabilities obtain and maintain employment. Employment services are advertised as free to employers, with the provision of additional benefits, including recruitment assistance; job retention and services support; job development; ongoing support and consultation; and tax credits. For program participants, an emphasis is placed on special Goodwill training and supervision and offer participants skill and vocation strength assessments; job skills training, including job coaching, communication and time management; retention support through Employment Specialists, person-centered planning; and employer contacts. Goodwill only accepts those who are also working with Vocational Rehabilitation Services. Once a person is referred to Vocational Rehabilitation, the participant and counselor will complete a written individual plan for employment by doing vocational/career exploration, an assessment of work readiness skills, determination of an appropriate job goal, and definition of the services necessary to reach that job goal. Eligibility for the Goodwill Employment Program is explicitly stated as determined by the Vocational Rehabilitation counselor and must include a DSM Axis I or Axis II diagnosis of mental health or substance abuse. Once eligibility has been determined, there is no waiting list for services. Goodwill Employment Specialists assist participants with job placement, specifically: job leads, completing applications, resume development, job search activities, employer contacts and interview skills. Once placed, Employment Specialists can provide assistance with communicating with employers, problem solving, and conflict resolution. Employment Specialists utilize community resources for everyday living situations or problems that may inhibit the participant's employment opportunity. Employment Specialists assist with various participant needs, such as transportation, daycare, and housing. Specifically, Behavioral Health Employment Services are aimed at the following goals: preparing individuals for competitive employment; providing support both on and off the job; increasing employment retention; enhancing an individual's ability to functioning in community settings; decreasing the need for more intensive levels of behavioral health services; providing transitional employment opportunities through Goodwill retail stores and funding is provided through a contract with Vocational Rehabilitation services.

APPENDIX I. Individual Site-Visit Report: Program E

III. Overview of Results

Supported Employment Fidelity

Supported Employment Fidelity was measured using a standardized and validated tool (see below). Fidelity scores can fall into one of three possible categories: 1) Good Implementation, 2) Fair Implementation and 3) Not Supported Employment.

As noted in Figure 1, the results of this analysis indicate that the Program E Employment Program achieved a score that fell within the *Not Supported Employment* category, considering a number of factors. It is noted that the SE fidelity score for the Program E Employment Program falls within the upper bounds of this category, suggesting that SE Fidelity could be improved to better approximate fair implementation of the SE program. Specific domain scores are found in Figure 1 and specific item scores are found in Figure 3.

Strengths of the program that are in keeping with the SE model include the following:

1. *Caseload.* Employment specialists manage caseloads of up to 25 consumers per employment specialists.
2. *Ongoing, work-based vocational assessment.* Vocational assessment at the Program E Employment Program is an ongoing process based on work experiences in competitive jobs occurring in community settings. These assessments are aimed at problem solving using environmental assessments and considering reasonable accommodations.
3. *Rapid search for competitive jobs.* First contact with an employer about a competitive job is typically within 1 month after program entry.
4. *Follow-along supports.* Most consumers are provided flexible, individualized follow-along supports that are individualized and ongoing. This includes crisis intervention, job coaching, job counseling, job support groups, transportation, treatment changes and supportive networks.

Needs of the program to improve adherence to the SE model include the following:

1. *Integration of rehabilitation with mental health treatment.* Employment specialists should be attached to 1 or more case management treatment teams. To improve fidelity, this would include weekly treatment team meetings with shared decision-making and 3 consumer-related case manager contacts per week. It is

APPENDIX I.
Individual Site-Visit Report: Program E

2. noted that Goodwill, as a provider of community based behavioral health services, does not have the structure or resources of a licensed mental health center. Goodwill requests guidance from the Division of Behavioral Health to develop an effective method for achieving a higher fidelity rating on this criterion.

3. *Zero exclusion criteria.* All consumers should be encouraged to participate and should not be screened out or referred out of the program based on requirements such as job readiness, lack of substance abuse, no history of violent behavior, minimal intellectual functioning and/or mild symptoms. It is possible that the lack of integration of employment services with mental health treatment may be contributing towards the inability of the Program E Employment Program to be able to serve all consumers. It is noted that Goodwill's understanding of Nebraska's current service structure has been (1) that Vocational Rehabilitation funding is for the purpose of serving consumers from the point of referral through successful employment closure, and (2) the funding from Behavioral Health Regions 2 and 3 is for the purpose of providing long-term support. Based on this understanding, Goodwill directs BHEP program referrals from all sources to Vocational Rehabilitation for eligibility determination. Goodwill has very strong and consistently applied practice of referring all consumers to Voc Rehab immediately at the point upon which the consumer expresses an interest in work. Goodwill's BHEP serves all individuals referred to the program from Vocational Rehabilitation.

It is also noted that the Nebraska's current SE service definition states that individuals with a mental health diagnosis or substance abuse will be admitted; however, SE as a service was primarily developed for persons with severe mental illness (SMI).

Recovery and Rehabilitation of Services

The goal of the CIMHRRS is to determine how well the Program E Employment Program conforms, in structure and operation, to the particular treatment model on which it is based. This is important because specific treatment models are associated with specific outcomes and these outcomes are achieved when the treatment is delivered with high fidelity. In turn, the expected outcome of a treatment program must be consistent with the mission of that program.

As noted in Figure 2, the results of this analysis indicates that the Program E Employment Program has reached minimal integration in the five domains of the CIMHRRS: 1) Program Mission;

APPENDIX I.
Individual Site-Visit Report: Program E

2) Organizational Boundaries; 3) Treatment Team Structure & Process; 4) Assessment Process; and 5) Treatment Planning.

Assets of the program which contribute to the successful realization of its mission include:

1. *Identifiable Program Mission Statement.* The mission of the Program E Employment Program is clear and operationalized, focusing on helping individuals with disabilities, and in particular, those with SMI, obtain and maintain competitive employment.
2. *Explicit Admission Criteria for the Appropriate Delineation of Organizational Boundaries.* Admission criteria are well-defined by the Program E Employment Program and contribute towards appropriate organizational boundaries.
3. *Role of Consumer in Service Provision.* A consumer was employed full-time with the Region III Goodwill Program and functions as a full member of the team in addressing client treatment issues, which is consistent with the goals of recovery and rehabilitation services.

Characteristics deemed most crucial to successful realization of its mission include:

1. *Thorough training of all staff in the program model and approach.* Although the Program E Employment Program has a clearly defined and operationalized mission, there is less specificity regarding the particular model and approach the program applies in order to successfully realize this goal. Moreover, it appears that staff are not able to articulate the specific model from which the Program E Employment Program works. An articulated program theory or model will assist in this area and should by regulatory standards, adhere to the specific SE Fidelity program model to ensure the delivery of Supported Employment services. Staff training in the specific SE program model will likely improve achieved employment outcomes.
2. *Systematic program process monitoring and evaluation.* The continuing monitoring of fidelity and outcomes will improve the program's ability to address program drift from its mission goals and model. As noted above, this can be conducted using SE Fidelity materials found on the SAMHSA website.
3. *Integration of treatment in both the treatment plan and provision of services.* The Program E Employment Program can improve its ability to effectively address clients' multiple service needs (e.g., dual disorders, independent functioning) that

APPENDIX I.

Individual Site-Visit Report: Program E

may be challenging for one employment specialist alone to handle. This can be completed through regular (i.e., on a weekly basis) interactions with case managers and mental health providers and shared decision-making on mental health treatment team meetings.

4. *Staff development in the areas of recovery, recovery-oriented services, Psychiatric Rehabilitation and personalization of treatment and individualized treatment planning.* The Program E Employment Program can improve the individualization of treatment geared towards recovery. Evidence-based practice, recovery and psychiatric or psychosocial rehabilitation are major movements in current mental health treatments, of which Supported Employment is one. Staff should be trained specifically in these models of treatment to more effectively deliver SE services. It is noted that staff at the Program E Employment Program were actively advocating for consumers, suggesting significant potential of this program to delivery high-quality, effective recovery and rehabilitation services.

5. *Development of comprehensive assessment and treatment technologies relevant to the impairments, disabilities, and goals of its identified population.* Although the Program E Employment Program completes a variety of assessments, the utilization of these assessments on a more regular basis will inform the best provision of services and subsequently, outcomes achieved. The assessments could also be more comprehensive to include interpersonal skills, basic independent living skills, cognitive functioning and symptom assessment will provide a more comprehensive understanding of the consumer's functioning and, combined with integrated service provision, will improve the overall employment outcomes achieved by the program.

IV. Conclusions

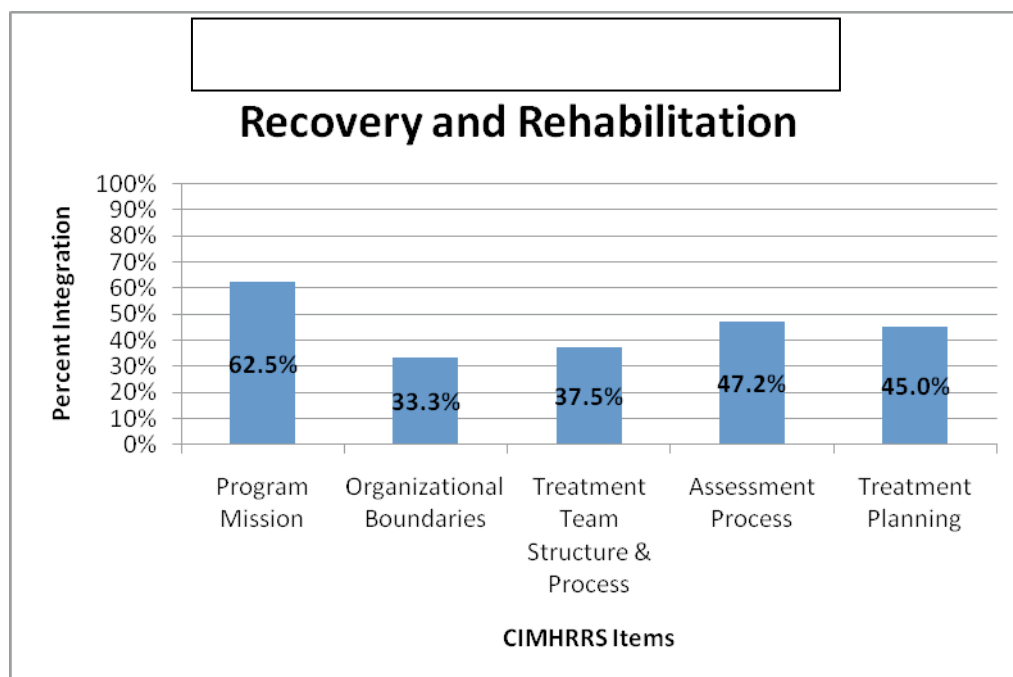
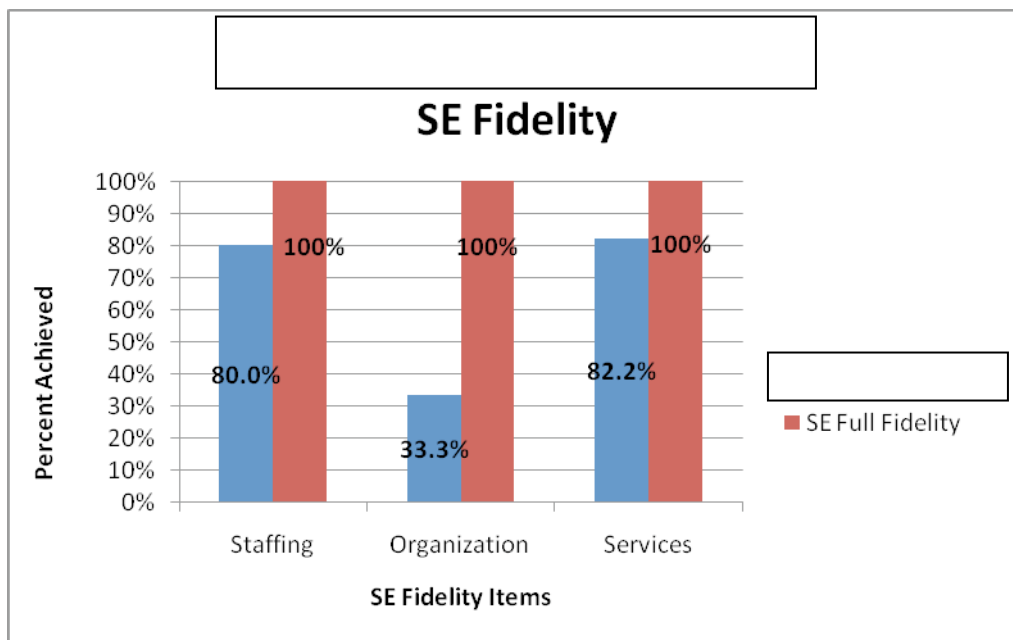
Goodwill notes that it is very interested in developing a deeper understanding and more complete implementation of an evidence-based Supported Employment Program. Goodwill has engaged in several conversations with the Dartmouth J&J project staff and also attempted, earlier in this year, to participate in a funding proposal to SAMHSA to strengthen employment services. Goodwill looks forward to future dialogue and guidance.

V. A Word of Thanks

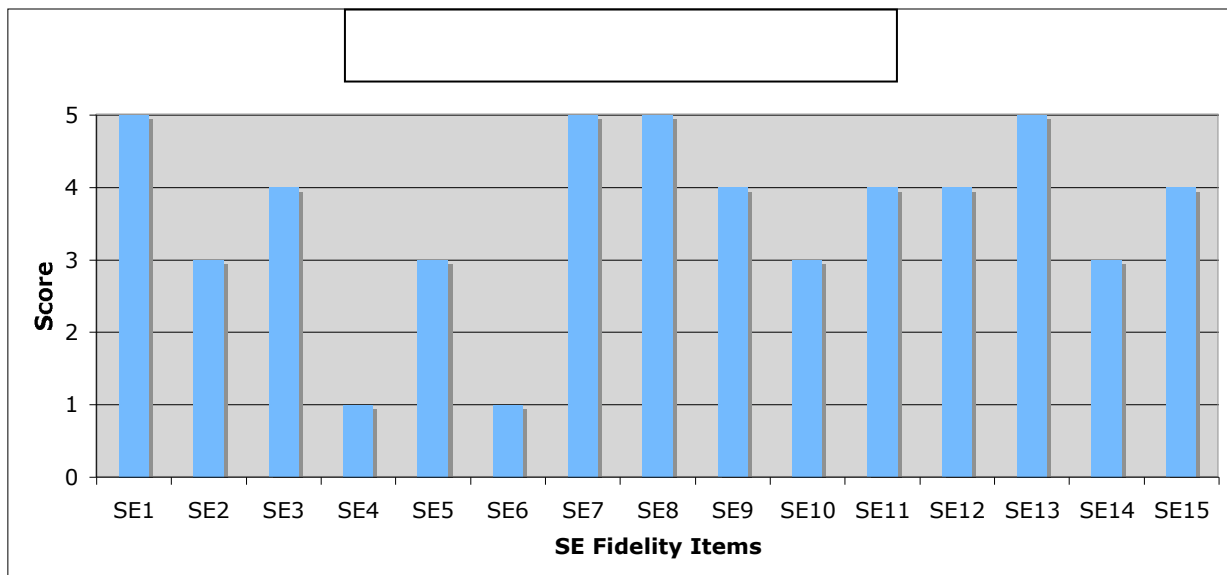
Goodwill staff were extremely hospitable during the site visit. Individual Program staff members were especially helpful in assisting with organization and scheduling of the site visit. Thank you for the quality services that you provide to persons with SMI.

**APPENDIX I.
Individual Site-Visit Report: Program E**

VI. Appendix



APPENDIX I.
Individual Site-Visit Report: Program E



APPENDIX J. Individual Site-Visit Report: Program F**Program F Employment Program:
A Fidelity, Structure and Process Analysis**

Date of site visit:

June 22, 2010

Date of report:

August 30, 2010

Report prepared by:

Nancy H. Liu, M.A.

Program Evaluation Tools:

--Supported Employment Fidelity Scale (SE Fidelity Scale)

--Comprehensive Instrument of Mental Health & Recovery and Rehabilitation Services (CIMHRRS)

Program Evaluation conducted by:

Nancy H. Liu, M.A.

Paul Nabity, B.S.

Supervision provided by:

Jim Harvey, MSW

William D. Spaulding, Ph.D.

For further information on the SE Fidelity Scale, please consult:

Substance Abuse and Mental Health Services (SAMHSA) Community Mental Health Tool-Kit Evaluating Supported Employment Programs:

http://download.ncadi.samhsa.gov/ken/pdf/toolkits/employment/SE_Evaluating_Your_Program.pdf

For further information on the CIMHRRS, please contact:

Robert W. Johnson, Ph.D.

rwjohnson01@gmail.com

APPENDIX J.

Individual Site-Visit Report: Program F (continued)

Executive Summary:

This report describes an analysis of the program fidelity, structure and organization of the Employment Program at Program F, which is aimed at helping individuals with severe mental illness (SMI) achieve and maintain competitive employment.

The purpose of this analysis is two-fold. First, this analysis is aimed at determining the fidelity of the Employment Program at Program F to the Individual Placement and Support (IPS) model of Supported Employment (SE), an evidence-based practice (EBP), which is aimed at helping persons with SMI achieve and maintain competitive employment. A second, and no less important, goal is to determine whether the Employment Program at Program F conforms, in structure and operation, to the particular treatment model on which it is based. The Comprehensive Inventory of Mental Health Rehabilitation and Recovery Services (CIMHRRS) examines the recovery and rehabilitation focus of programs, with a particular emphasis on structural and process components of a program's day-to-day functioning. As specific treatment models are associated with specific outcomes, it is expected that the outcome of any treatment can be achieved only when the treatment is delivered with high fidelity. In turn, the expected outcome of a treatment program must be consistent with the mission of that program. The CIMHRRS is used to examine the organizational structure and approach of service providers to facilitate recommendations outlined in the 2003 President's New Freedom Commission Report. Specifically, this report mandates the transformation of the mental health services system for people with SMI to a rehabilitation focused, recovery-oriented and consumer and family driven system at the national, state, and local levels.

I. Description of the evaluation and instruments

The Supported Employment Fidelity Scale, previously named the IPS Fidelity Scale (Bond, Becker, Drake, et al., 1997) is based on the SE implementation and evaluation measures from the SAMHSA community toolkit (SAMHSA, 2007; Becker and Bond, 2002). The SE Fidelity Scale has been used to assess various SE programs and consistently demonstrates that better employment outcomes are associated with adherence to the SE model (McGrew and Griss, 2005).

The Comprehensive Inventory of Mental Health and Recovery and Rehabilitation (CIMHRRS) is a 52-item instrument designed to assess the fidelity of various programs to particular service models for persons with severe mental illness (SMI). It is used to both quantitatively and qualitatively characterize programmatic differences in service settings for people with SMI. Through a structured site review, evaluators assess the relative strengths and liabilities of service programs.

APPENDIX J. Individual Site-Visit Report: Program F (continued)

The on-site evaluation was conducted on June 22, 2010 at Employment Program at Program F, located in Nebraska. The evaluation schedule lasted from 9:00 am to 5:00 pm and included interviews with the Program Director, Employment Specialist and Consumers. In addition, the evaluators observed a treatment team meeting, reviewed charts and conducted a thorough review of the program's Policies and Procedures Manual. Two independent evaluators conducted all ratings. All discrepancies in ratings were reconciled by consensus.

II. Program Description

Program F is a private, non-profit corporation located in Nebraska. It serves adults over the age of nineteen, diagnosed with severe and persistent illness. Program F offers consumers a variety of disciplines designed to fit the needs of the individual and believes that all consumers make a worthwhile contribution to society. The Supported Employment Program at Program F has been operating since 1993 and through a cooperative agreement with Vocational Rehabilitation, the Program F Employment Program helps with job placement and job coaching. It is noted that the Program F Employment Program serves mostly individuals with *severe and persistent mental illness*, which is the population for which the IPS model of SE was developed.

III. Overview of Results

Supported Employment Fidelity

Supported Employment Fidelity was measured using a standardized and validated tool (see below). Fidelity scores can fall into one of three possible categories: 1) Good Implementation, 2) Fair Implementation and 3) Not Supported Employment.

As noted in Figure 1, the results of this analysis indicate that the Employment Program at Program F achieved *Not Supported Employment* of the SE program. It is noted that the program scores within the upper bound of the *Not Supported Employment* category, considering a number of factors. Specific domain scores are found in Figure 1. Specific item scores are found in Figure 3.

Strengths of the program that are in keeping with the SE model include the following:

1. *Caseload.* Consistent with high SE fidelity, the Program F employment specialists manage caseloads of up to 25 consumers.
2. *Follow-along supports.* Consistent with high SE fidelity, most consumers at the Program F Employment Program are provided flexible, follow-along supports that are individualized and ongoing. This includes crisis intervention, job coaching,

APPENDIX J.
Individual Site-Visit Report: Program F (continued)

job counseling, job support groups, transportation, treatment changes and supportive networks.

Needs of the program to improve adherence to the SE model include the following:

1. *Integration of rehabilitation with mental health treatment.* The Program F Employment Program serves a difficult to treatment population. As such, high SE fidelity requires that Employment specialists should be attached to 1 or more case management treatment teams. To improve fidelity, this would include weekly treatment team meetings with shared decision-making and 3 consumer-related case manager contacts per week.
2. *Zero-exclusion criteria.* High SE fidelity requires that there are no eligibility requirements (such as job readiness, lack of substance abuse, no history of violent behavior, minimal intellectual functioning and mild symptoms) for the SE program. The Program F should ensure that all consumers are encouraged to participate regardless of these other factors, to stay in keeping with SE fidelity.
3. *Permanence of jobs developed.* The diversity of jobs can be improved so that employment specialists provide options for either the same types of jobs, e.g., janitorial, or jobs at the same work settings, less than 10% of the time.

Recovery and Rehabilitation of Services

The goal of the CIMHRRS is to determine how well the Employment Program at Program F conforms, in structure and operation, to the particular treatment model on which it is based. This is important because specific treatment models are associated with specific outcomes and these outcomes are achieved when the treatment is delivered with high fidelity. In turn, the expected outcome of a treatment program must be consistent with the mission of that program.

As noted in Figure 2, the results of this analysis indicates that the Employment Program at Program F has reached minimal integration in the five domains of the CIMHRRS: 1) Program Mission; 2) Organizational Boundaries; 3) Treatment Team Structure & Process; 4) Assessment Process; and 5) Treatment Planning.

Assets of the program which contribute to the successful realization of its mission include:

1. *Program Mission.* The mission of the Employment Program at Program F is clear and operationalized, focusing on helping individuals with SMI obtain and maintain competitive employment.

APPENDIX J.
Individual Site-Visit Report: Program F (continued)

2. *Explicit Admission Criteria.* Admission criteria are well-defined and contribute towards appropriate organizational boundaries.
3. *Support and Integration of Off-Site Training.* The Program F Program supports off-site training and attempts to integrate these trainings into the current program. Treatment provision is clear and focused on providing SE services.
4. *Recovery Orientation.* The program demonstrates a strong understanding of recovery in SMI. The program assists in developing activities outside of the mental health service system (i.e., career development, community integration, or development of leisure activities).
5. *Psychosocial (or Psychiatric) Rehabilitation.* The program demonstrates a strong understanding of psychosocial or psychiatric rehabilitation. The services provided by the Program F Program promote the acquisition of new skills or coping abilities that support independent functioning in the community.
6. *Assessment of Goals.* The Program F Program strongly acknowledges consumers' goals and preferences and this is integrated into the treatment plan.

Characteristics deemed most crucial to successful realization of its mission include:

1. *Thorough training of all staff in the program model and approach.* Although the Program F Employment Program endorses a strong mission statement, there is no clear articulation of the principles and practices that underlie Supported Employment. An articulated program model, specifically a high fidelity SE model will improve the realization of the mission of the Program F's Employment Program. This model would describe the specific approach detailing how day-to-day services are directly related to achievement of the mission and would likely adhere specifically to the components of SE Fidelity. Staff training in the specific SE model will also improve achieved employment outcomes.
2. *Systematic program process monitoring and evaluation.* This will improve the program's ability to address program drift from its mission goals and model. This could be conducted using SE Fidelity materials found on the SAMHSA website.
3. *Integration of treatment in both the treatment plan and provision of services.* This will improve the ability of Program F's Employment Program staff to

APPENDIX J.
Individual Site-Visit Report: Program F (continued)

effectively address clients' multiple service needs (e.g., dual disorders, independent functioning) that may be challenging for one employment specialist alone to handle. This can be completed through regular interactions with case managers and mental health providers.

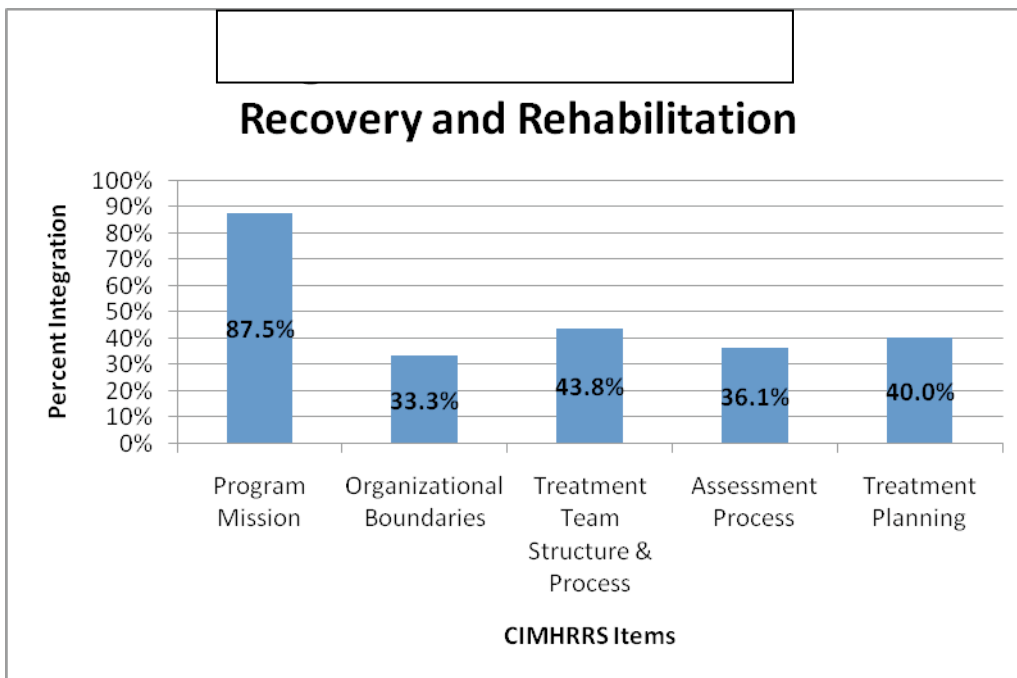
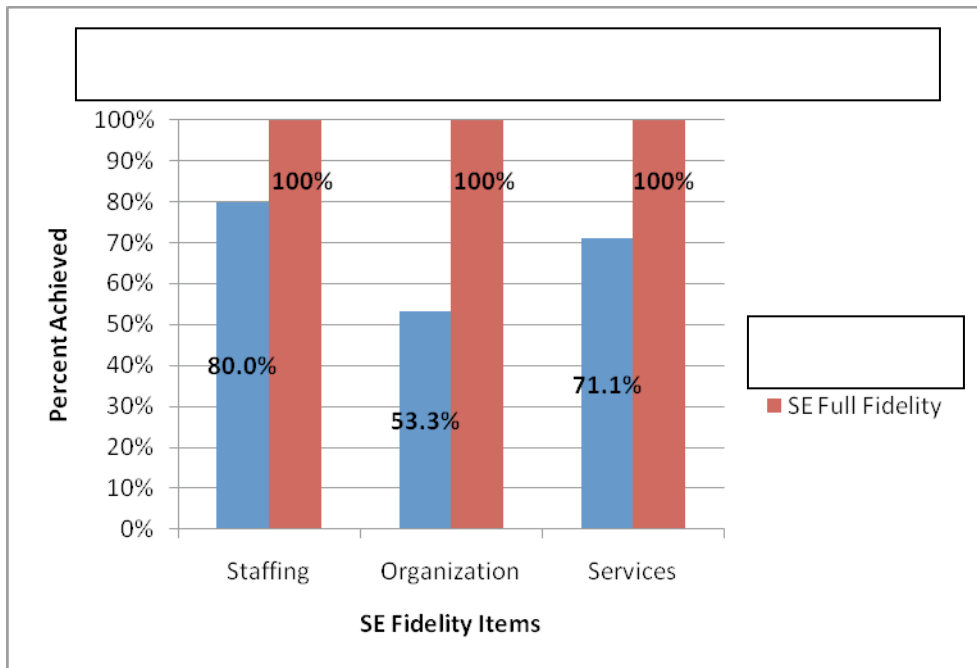
4. *Development of comprehensive assessment and treatment technologies relevant to the impairments, disabilities, and goals of its identified population.* Although the Employment Program at Program F a variety of assessments, the utilization of these assessments on a more regular basis will inform the best provision of services and subsequently, outcomes achieved. The assessments could also be more comprehensive to include interpersonal skills, basic independent living skills, cognitive functioning and symptom assessment will provide a more comprehensive understanding of the consumer's functioning and, combined with integrated service provision, will improve the overall employment outcomes achieved by the program.

IV. A Word of Thanks

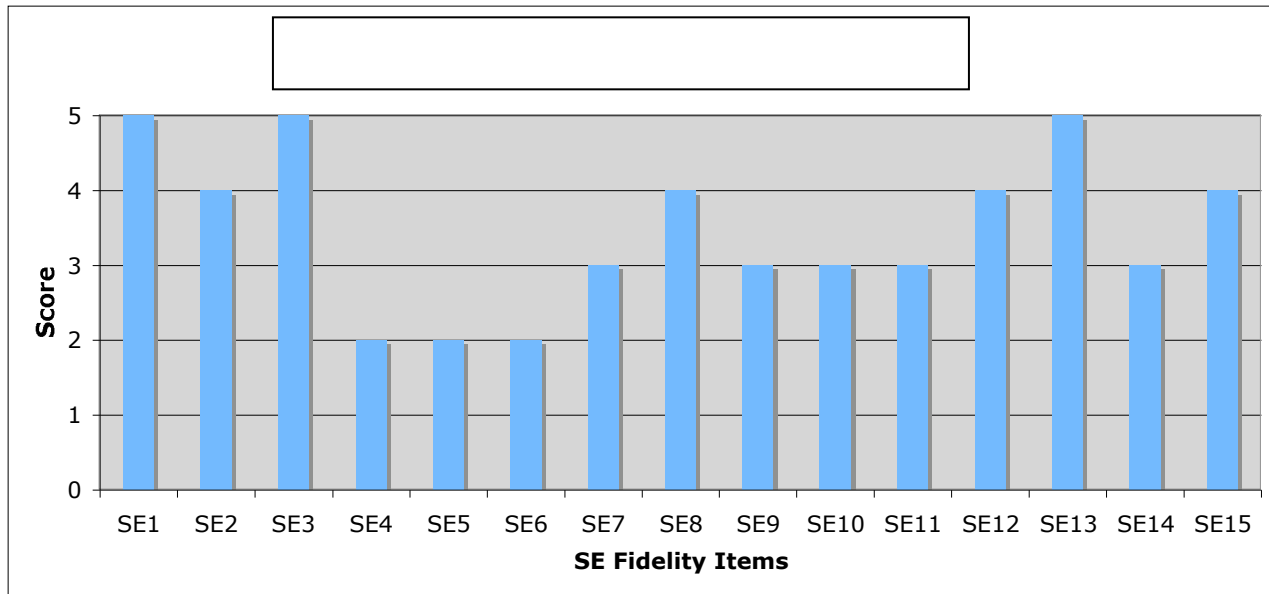
Program F staff and consumers were extremely hospitable during the site visit. Individual program staff were especially helpful in assisting with organization and scheduling of the site visit. Thank you for the quality services that you provide to persons with SMI.

V. Appendix

**APPENDIX J.
Individual Site-Visit Report: Program F (continued)**



APPENDIX J.
Individual Site-Visit Report: Program F (continued)



APPENDIX K.
Individual Site-Visit Report: Program G

Program G Employment Program:
A Fidelity, Structure and Process Analysis

Date of site visit:
June 23, 2010

Date of report:
September 27, 2010

Report prepared by:
Nancy H. Liu, M.A.

Program Evaluation Tools:
--Supported Employment Fidelity Scale (SE Fidelity Scale)
--Comprehensive Instrument of Mental Health & Recovery and Rehabilitation Services (CIMHRRS)

Program Evaluation conducted by:
Nancy H. Liu, M.A.
Paul Nabity, B.S.

Supervision provided by:
Jim Harvey, MSW
William D. Spaulding, Ph.D.

For further information on the SE Fidelity Scale, please consult:
Substance Abuse and Mental Health Services (SAMHSA) Community Mental Health Tool-Kit
Evaluating Supported Employment Programs:
http://download.ncadi.samhsa.gov/ken/pdf/toolkits/employment/SE_Evaluating_Your_Program.pdf

For further information on the CIMHRRS, please contact:
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APPENDIX K.

Individual Site-Visit Report: Program G

Executive Summary:

This report describes an analysis of the program fidelity, structure and organization of the Employment Program at Program G, which is aimed at helping individuals with severe mental illness (SMI) achieve and maintain competitive employment.

The purpose of this analysis is two-fold. First, this analysis is aimed at determining the fidelity of Employment Program at Program G to the Individual Placement and Support (IPS) model of Supported Employment (SE), an evidence-based practice (EBP), which is aimed at helping persons with SMI achieve and maintain competitive employment. A second, and no less important, goal is to determine whether the Employment Program at Program G conforms, in structure and operation, to the particular treatment model on which it is based. The Comprehensive Inventory of Mental Health Rehabilitation and Recovery Services (CIMHRRS) examines the recovery and rehabilitation focus of programs, with a particular emphasis on structural and process components of a program's day-to-day functioning. As specific treatment models are associated with specific outcomes, it is expected that the outcome of any treatment can be achieved only when the treatment is delivered with high fidelity. In turn, the expected outcome of a treatment program must be consistent with the mission of that program. The CIMHRRS is used to examine the organizational structure and approach of service providers to facilitate recommendations outlined in the 2003 President's New Freedom Commission Report. Specifically, this report mandates the transformation of the mental health services system for people with SMI to a rehabilitation focused, recovery-oriented and consumer and family driven system at the national, state, and local levels.

I. Description of the evaluation and instruments

The Supported Employment Fidelity Scale, previously named the IPS Fidelity Scale (Bond, Becker, Drake, et al., 1997) is based on the SE implementation and evaluation measures from the SAMHSA community tool-kit (SAMHSA, 2007; Becker and Bond, 2002). The SE Fidelity Scale has been used to assess various SE programs and consistently demonstrates that better employment outcomes are associated with high adherence to the SE model (McGrew and Griss, 2005).

The Comprehensive Inventory of Mental Health and Recovery and Rehabilitation (CIMHRRS) is a 52-item instrument designed to assess the fidelity of various programs to particular service models for persons with severe mental illness (SMI). It is used to both quantitatively and qualitatively characterize programmatic differences in service settings for people with SMI. Through a structured site review, evaluators assess the relative strengths and liabilities of service programs.

The on-site evaluation was conducted on June 23, 2010 at Program G, located in Nebraska. The evaluation schedule lasted from 9:00 am to 5:00 pm and included interviews with Program Directors, Employment Specialists, Consumers and a family member of a Consumer. In addition, the evaluators observed treatment team meetings,

APPENDIX K.

Individual Site-Visit Report: Program G

reviewed charts and conducted a thorough review of the program's Policies and Procedures Manual. Two independent evaluators conducted all ratings. All discrepancies in ratings were reconciled by consensus.

II. Program Description

In an effort to adhere to the ICCD guidelines, all services including employment are rendered in accordance with those guidelines.

The Employment Program at Program G is a Clubhouse model program and reports in its Policies and Procedures Manual that its goal is to help people recover from mental illness and become contributing members of society (p.3, Employment Handbook, 2009). To realize this goal, Program G encourages individuals to obtain pre-vocational work skills by either attending and working in the Program G or by finding community volunteer jobs to assist them in developing a work history. Program G has three levels of employment: Transitional Employment, Supported Employment, and Independent Employment. In order to ensure that Program G provides these employment services, participants should 1) express a desire to work; 2) sign-up with a Vocational Rehabilitation Counselor; and 3) be assessed to determine which employment services would benefit the individual. Transitional employment positions (TEs) are part-time, temporary paid positions that are contracted by Program G with an employer. TEs are typically held for 6-9 months in duration and individuals usually work 15-20 hours per week. Upon completing a TE, individuals either move onto another TE or to a different type of employment. Supported employment positions (SEs) differ in that they are owned by the individual who is employed. They are permanent, full-time or part-time positions that the individual maintains with support of the Program G staff. The goal of SE is to assist the individual in becoming as independent as possible and employment staff help with the initial training of the individual and helps the individual on the job as needed. Independent employment positions (IEs) are positions for which persons have applied, interviewed, and trained without any direct involvement with employment staff. Employment specialists provide a variety of services including helping individuals arrange transportation to and from work, as well as to doctor appointments to ensure medication compliance; provide education and assistance to employers on a regular basis; provide support to members off the work site (i.e., shopping for necessary clothing, talking to members about employment concerns, ensuring all other needs are met, such as housing and social); provide on the job training to individuals; assist individuals in reporting earnings to appropriate authorities (Social Security, DHHS, HUD); and to provide education and assistance to employers on a regular basis (Program G Employment Handbook, 2009).

APPENDIX K.
Individual Site-Visit Report: Program G

III. Overview of Results

Supported Employment Fidelity

Supported Employment Fidelity was measured using a standardized and validated tool (see below). Fidelity scores can fall into one of three possible categories: 1) Good Implementation, 2) Fair Implementation and 3) Not Supported Employment.

As noted in Figure 1, the results of this analysis indicate that the Employment Program at Program G achieved a fidelity score within the range of *Not Supported Employment* of the SE program. It is noted that the program scores within the upper bound of the *Not Supported Employment* category, considering a number of factors. Specific domain scores are found in Figure 1.

Strengths of the program that are in keeping with the SE model include the following:

1. Employment specialists manage caseloads of up to 25 consumers.
2. First contact with an employer about a competitive job is typically within 1 month after program entry.
3. Employment specialists help consumers end jobs when appropriate and offer to help them all find another job.
4. Most consumers are provided flexible, follow-along supports that are individualized and ongoing. This includes crisis intervention, job coaching, job counseling, job support groups, transportation, treatment changes and supportive networks.
5. All consumers are encouraged to participate and include a variety of sources that solicit referrals, including self-referrals, family members, self-help groups.

Needs of the program to improve adherence to the SE model include the following:

1. *Integration of rehabilitation with mental health treatment.* Employment specialists should be attached to 1 or more case management treatment teams. To improve fidelity, this would include weekly treatment team meetings with shared decision-making and 3 consumer-related case manager contacts per week.

Program G notes that the Employment Specialist will develop a more formalized documentation process of the input and role of the consumer's case advisors and other community providers on the treatment team.

2. *Ongoing, work-based vocational assessment.* Vocational assessment should be ongoing and occur in community jobs. Minimal testing may occur but not as a prerequisite to the job search. This assessment aims at problem-solving using environmental assessments and considers reasonable accommodations. Assessments that do not match SE fidelity are those that require participation in a prevocational assessment at the program site.

Program G notes that information from a more comprehensive assessment done by the consumer's case advisor or community providers is currently used in addition to Program G's Employment Assessment to help identify all known barriers to successful employment. Program G notes that the Employment Specialist will research additional assessments that may enhance the assessment process.

3. *Permanence of jobs developed.* Virtually all competitive jobs offered by employment specialists should be permanent, in order to ensure high SE Fidelity. Jobs that DO NOT count as supported employment under the SE definition endorsed by SAMHSA include temporary or time-limited status jobs. Program G notes that it has a strong Transitional Employment Program, which is recognized as a vital and valued component of the Clubhouse Model. Program G is committed to offering both traditional supported employment and transitional supported employment. They note that providing both options has enabled and encouraged consumers that were intimidated by permanent employment to at least try employment. More often than not after experiencing employment, most went on to permanent employment. An additional benefit of the Transitional Employment Program is the direct educational opportunities to co-workers and employers about what mental illness is and most importantly, what mental illness is not. The relationships that have been cultivated by this program have resulted in strong community awareness and support for individuals with mental illness.

4. *Community-based services.* Employment specialists should spend 70% or more of their time in the community, in order to be in keeping with high SE Fidelity.

Recovery and Rehabilitation of Services

The goal of the CIMHRRS is to determine how well the Employment Program at Program G conforms, in structure and operation, to the particular treatment model on which it is based. This is important because specific treatment models are associated with specific outcomes and these outcomes are achieved when the treatment is delivered with high fidelity. In turn, the expected outcome of a treatment program must be consistent with the mission of that program.

APPENDIX K. Individual Site-Visit Report: Program G

As noted in Figure 2, the results of this analysis indicate that the Employment Program at Liberty Centre Services, Inc. has reached minimal integration in the five domains of the CIMHRRS: 1) Program Mission; 2) Organizational Boundaries; 3) Treatment Team Structure & Process; 4) Assessment Process; and 5) Treatment Planning.

Assets of the program which contribute to the successful realization of its mission include:

1. *Identifiable Program Mission Statement.* The mission of the Employment Program at Program G is clear and operationalized, focusing on helping individuals with SMI obtain and maintain employment in the community.
2. *Identifiable Program Model and Theory.* Moreover, the Employment Program at Program G has a clearly defined and operationalized model and approach, which is likely due to its maintenance of ICCD accreditation. This improves the realization of the mission at the Employment Program at Program G, as a specific model and approach detailing how day-to-day services are directly related to the could be improved; however an articulated program model that more closely adheres to the nationally-recognized components of SE. Fidelity will likely improve staff effectiveness and achieved employment outcomes.
3. *Explicit Admission Criteria.* Admission criteria are well-defined and contribute towards appropriate organizational boundaries.
4. *Organizational Boundaries.* Treatment provision is clear and focused on providing employment services.
5. *Training.* The organization strongly supports the off-site training for staff and this training directly facilitates the program's mission as a Clubhouse program; moreover, the program attempts to integrate these trainings into the current program.
6. *Recovery Orientation.* The Employment Program strongly supports a recovery orientation to empower persons with SMI to be able to function more independently in the community.

Program G specifically notes that the expectation of recovery is the main component of the program's culture. Recovery-focused services are evidenced by the following:

- Many consumers drive and have their own vehicles, but for those who do not have access to available and affordable transportation, it becomes a barrier to employment. Program G has developed an agreement with the

APPENDIX K.
Individual Site-Visit Report: Program G

- local cab company to offer transportation at a reduced cost to consumers. In addition, Program G provides transportation to doctor, therapy or pharmacy appointments at no cost to the consumer. Rides to and from work are provided at an affordable rate and consumers are able to access all community resources.
- In an effort to make services easily accessible staff is available on call 24 hours a day, 7 days a week.
- The Clubhouse environment is built on peer relationships and support. This support occurs both naturally and formally. Consumers prepare and lead educational presentations and provide job mentoring. Program G employs six consumers in various jobs within the organization.
- Consumers develop their own goals and review them monthly with their advisor and placement manager. All Program G notes are available to consumers to make their own notations and review the staff's notations.
- Relationships between the consumer and staff are one of mutual respect. It is the consumer's choice which staff they would like to work with and how involved they would like to be in the clubhouse and other programs.
- Quality and affordable housing is recognized as a priority by staff in all programs. Staff will assist consumers in locating housing that fits their needs and help locate financial assistance when needed, along with landlord communications.
- Community education opportunities are held with local high schools, colleges and service clubs, as well as in-house presentations. Consumers prepare and present these presentations with the hope of opening a dialogue between the community and themselves and eliminating the myths that are associated with mental illness.
- Program G believes strongly in the power of competitive employment for consumers and will continue to cultivate those opportunities for consumers.

Characteristics deemed most crucial to successful realization of its mission include:

1. *Systematic program process monitoring and evaluation.* This will improve the program's ability to address program drift from its mission goals and model, specifically as the program seeks to more closely adhere to the Supported Employment Program. This could be conducted using SE Fidelity materials found on the SAMHSA website.

It is noted that Program G's Quality Review Team (QRT) meets monthly to review all services, including employment. All aspects of services are reviewed in an effort to identify barriers to our consumers in accessing services. Data integrity and billing integrity are regularly reviewed. In addition to the QRT

APPENDIX K.

Individual Site-Visit Report: Program G

activity, each program develops annual goals that will enhance the program and monitor its effectiveness. These goals are reported on quarterly, and reviewed by the QRT and Board of Directors. Bi-monthly employment meetings are attended by consumers and placement managers and are led by the Employment Specialist. This meeting is used as a vehicle to identify consumer needs, employer needs, brainstorm solutions and celebrate employment. In the process, the expectation of employment is created and permeates the entire clubhouse.

2. Integration of treatment in both the treatment plan and provision of services. This will improve the Program G 's ability to effectively address clients' multiple service needs (e.g., dual disorders, independent functioning) that may be challenging for one employment specialist alone to handle. This can be completed through regular interactions with case managers and mental health providers.

3. Development of comprehensive assessment and treatment technologies relevant to the impairments, disabilities, and goals of its identified population. Although the Employment Program completes a variety of assessments for persons in the program, the utilization of more comprehensive assessments used on a more regular basis will inform the best provision of services and subsequently, outcomes achieved. The assessments might include interpersonal skills, basic independent living skills, cognitive functioning and symptom assessment. A more comprehensive understanding of the consumer's functioning that is combined with integrated service provision so that multiple needs are addressed, will improve the overall employment outcomes achieved by the Employment Program at Program G.

IV. Conclusions

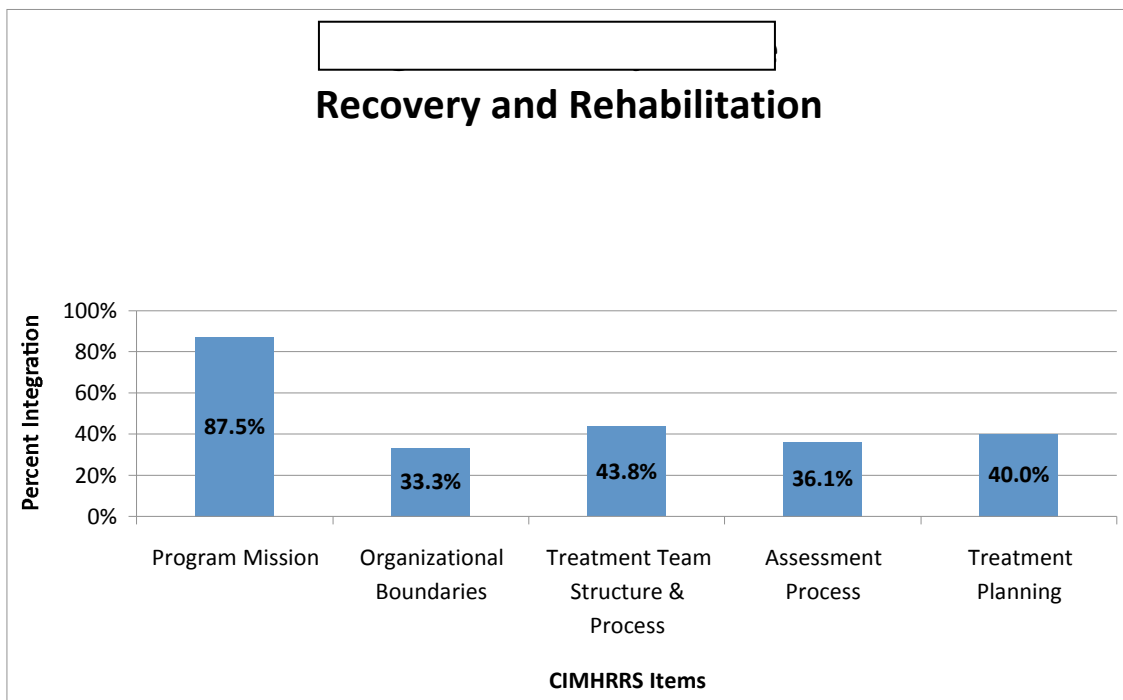
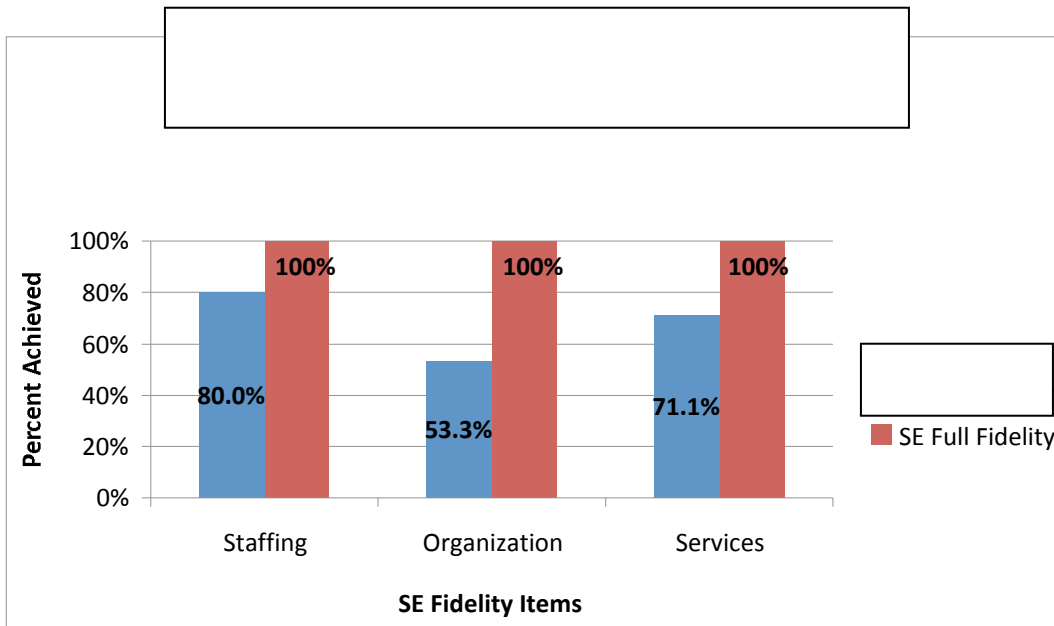
It is noted that prior to the implementation of SE in the State of Nebraska in Fiscal Year 2008, the SE Program at Program G had been providing employment services for over 25 years, using the guidelines required by the International Center for Clubhouse Development (ICCD). Program G recognizes the importance of complying with the State's service definition while also adhering to ICCD standards. Program G notes that it is passionate about providing the quality of services that are instrumental in assisting individuals advance in their journey of recovery.

V. A Word of Thanks

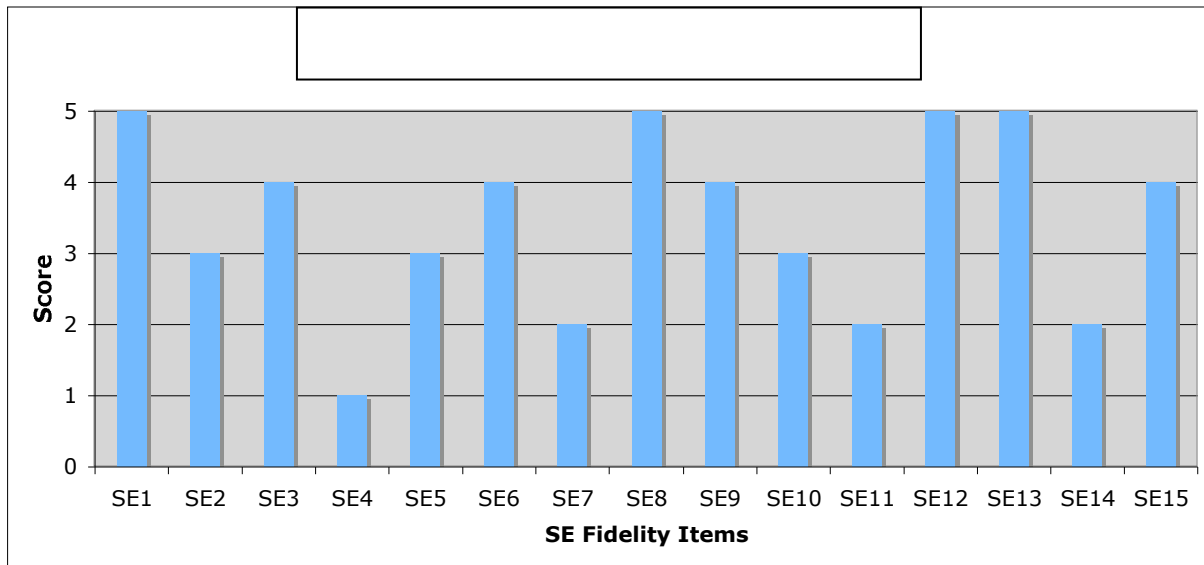
Staff at Program G were extremely hospitable during the site visit. Individual program staff were especially helpful in assisting with organization and scheduling of our site visit. Thank you for the services you provide to persons with SMI.

**APPENDIX K.
Individual Site-Visit Report: Program G**

VI. Appendix



APPENDIX K.
Individual Site-Visit Report: Program G



APPENDIX L.
Individual Site-Visit Report: Program H

Program H Program:
A Fidelity, Structure and Process Analysis

Date of site visit:
April 30, 2010

Date of report:
August 30, 2010

Report prepared by:
Nancy H. Liu, M.A.

Program Evaluation Tools:
--Supported Employment Fidelity Scale (SE Fidelity Scale)
--Comprehensive Instrument of Mental Health & Recovery and Rehabilitation Services (CIMHRRS)

Program Evaluation conducted by:
Nancy H. Liu, M.A.
Paul Nabity, B.S.

Supervision provided by:
Jim Harvey, MSW
William D. Spaulding, Ph.D.

For further information on the SE Fidelity Scale, please consult:
Substance Abuse and Mental Health Services (SAMHSA) Community Mental Health Tool-Kit Evaluating Supported Employment Programs:
http://download.ncadi.samhsa.gov/ken/pdf/toolkits/employment/SE_Evaluating_Your_Program.pdf

For further information on the CIMHRRS, please contact:
Robert W. Johnson, Ph.D.
rwjohnson01@gmail.com

APPENDIX L.

Individual Site-Visit Report: Program H (continued)

Executive Summary:

This report describes an analysis of the program fidelity, structure and organization of the Program H Program, which is aimed at helping individuals with severe mental illness (SMI) achieve and maintain competitive employment.

The purpose of this analysis is two-fold. First, this analysis is aimed at determining the fidelity of the Program H Program to the Individual Placement and Support (IPS) model of Supported Employment (SE), an evidence-based practice (EBP), which is aimed at helping persons with SMI achieve and maintain competitive employment. A second, and no less important, goal is to determine whether the Program H Program conforms, in structure and operation, to the particular treatment model on which it is based. The Comprehensive Inventory of Mental Health Rehabilitation and Recovery Services (CIMHRRS) examines the recovery and rehabilitation focus of programs, with a particular emphasis on structural and process components of a program's day-to-day functioning. As specific treatment models are associated with specific outcomes, it is expected that the outcome of any treatment can be achieved only when the treatment is delivered with high fidelity. In turn, the expected outcome of a treatment program must be consistent with the mission of that program. The CIMHRRS is used to examine the organizational structure and approach of service providers to facilitate recommendations outlined in the 2003 President's New Freedom Commission Report. Specifically, this report mandates the transformation of the mental health services system for people with SMI to a rehabilitation focused, recovery-oriented and consumer and family driven system at the national, state, and local levels.

I. Description of the evaluation and instruments

The Supported Employment Fidelity Scale, previously named the IPS Fidelity Scale (Bond, Becker, Drake, et al., 1997) is based on the SE implementation and evaluation measures from the SAMHSA community toolkit (SAMHSA, 2007; Becker and Bond, 2002). The SE Fidelity Scale has been used to assess various SE programs and consistently demonstrates that better employment outcomes are associated with adherence to the SE model (McGrew and Griss, 2005).

The Comprehensive Inventory of Mental Health and Recovery and Rehabilitation (CIMHRRS) is a 52-item instrument designed to assess the fidelity of various programs to particular service models for persons with severe mental illness (SMI). It is used to both quantitatively and qualitatively characterize programmatic differences in service settings for people with SMI. Through a structured site review, evaluators assess the relative strengths and liabilities of service programs.

The on-site evaluation was conducted on April 30, 2010 at the Program H Program, located in Nebraska. The evaluation schedule lasted from 9:00 am to 5:00 pm and included interviews with Program Director, Employment Specialists and Consumers.

APPENDIX L. Individual Site-Visit Report: Program H (continued)

In addition, the evaluators observed a treatment team meeting, reviewed charts and conducted a thorough review of the program's Policies and Procedures Manual. Two independent evaluators conducted all ratings. All discrepancies in ratings were reconciled by consensus.

II. Program Description

The Program H reports that it is a consumer-run, voluntary not-for-profit statewide association that brings together service recipients, families, professionals, advocates and concerned citizens to address all aspects of mental health and mental illness. Program H was recently awarded 3-year accreditation by CARF International. Program H reports that it provides Supported Employment services and focus on helping individuals find competitive jobs that are based on the person's preferences and abilities. In its mission and procedures, the Program H acknowledges the six principles of SE: 1) Eligibility is based on consumer choice. No one is excluded who wants to participate; 2) SE is integrated with treatment; 3) Competitive employment is the goal; 4) Job search starts soon after a consumer expresses an interest in working; 5) Follow-along supports are continuous; and 6) Consumer preferences are important. The Program H Employment Specialists develop an individualized employment plan with interested consumers that meet the interest and desires that are consistent with their goals and assist individuals seeking competitive and permanent employment in the community. The program currently has 2 employment specialists and 1 benefits counselor.

III. Overview of Results

Supported Employment Fidelity

Supported Employment Fidelity was measured using a standardized and validated tool (see below). Fidelity scores can fall into one of three possible categories: 1) Good Implementation, 2) Fair Implementation and 3) Not Supported Employment.

As noted in Figure 1, the results of this analysis indicate that the Program H achieved *Fair Implementation* of the SE program, considering a number of factors. Specific domain scores are found in Figure 1. Specific item scores are provided in Figure 3.

Strengths of the program that are in keeping with the SE model include the following:

1. *Caseload.* Consistent with high SE fidelity, Program H employment specialists manage caseloads of up to 25 consumers.
2. *Vocational services staff.* Consistent with high SE fidelity, Program H employment specialists provide only vocational services and do not provide non-vocational services such as case management.

APPENDIX L.
Individual Site-Visit Report: Program H (continued)

3. *Vocational unit.* Consistent with high SE fidelity, Program H employment specialists form a vocational unit with group supervision at least weekly and provide support for each other's cases and backup and support for each other.
4. *Ongoing work-based assessment.* Consistent with high SE fidelity, vocational assessment is an ongoing process based on work experiences in competitive jobs.
5. *Rapid search for competitive jobs.* Consistent with high SE fidelity, the first contact with an employer about a competitive job is typically within 1 month after program entry.
6. *Individualized job search.* Consistent with high SE fidelity, most employer contacts are based on job choices, which reflect consumers' preferences and needs rather than the job market. Moreover, it is noted that Program H employment specialists were especially sensitive to client preferences and worked diligently to prioritize employer contacts that were related to what consumers enjoyed and their personal goals and needs rather than the job market.
7. *Diversity of jobs developed.* Consistent with high SE fidelity, employment specialists provide options for either the same types of jobs (e.g., janitorial, or jobs at the same work settings) less than 10% of the time.
8. *Permanence of jobs developed.* Consistent with high SE fidelity, virtually all competitive jobs offered by Program H employment specialists are permanent.
9. *Jobs as transitions.* Consistent with high SE fidelity, employment specialists help consumers end jobs when appropriate and offer to help them all find another job.
10. *Follow-along supports.* Consistent with high SE fidelity, most consumers are provided flexible, follow-along supports that are individualized and ongoing. This includes crisis intervention, job coaching, job counseling, job support groups, transportation, treatment changes and supportive networks.

Needs of the program to improve adherence to the SE model include the following:

1. *Integration of rehabilitation with mental health treatment.* Employment specialists should be attached to 1 or more case management treatment teams. To improve fidelity, the Program H should aim towards weekly treatment team meetings with shared decision-making and 3 consumer-related case manager contacts per week.

APPENDIX L.
Individual Site-Visit Report: Program H (continued)

2. *Community-based services.* Program H employment specialists should spend 70% or more of their time in the community to ensure that vocational services such as engagement, job finding, and follow-along supports are provided in community settings.

Recovery and Rehabilitation of Services

The goal of the CIMHRRS is to determine how well the Program H conforms, in structure and operation, to the particular treatment model on which it is based. This is important because specific treatment models are associated with specific outcomes and these outcomes are achieved when the treatment is delivered with high fidelity. In turn, the expected outcome of a treatment program must be consistent with the mission of that program.

As noted in Figure 2, the results of this analysis indicates that the Program H has reached moderate integration in the five domains of the CIMHRRS: 1) Program Mission; 2) Organizational Boundaries; 3) Treatment Team Structure & Process; 4) Assessment Process; and 5) Treatment Planning.

Assets of the program which contribute to the successful realization of its mission include:

1. *Program Mission.* The mission of the Program H is clear and operationalized, focusing on helping individuals with SMI obtain and maintain competitive employment.
2. *Articulated Program Theory/Model.* The Program H demonstrates an acknowledgement of the standardization of Supported Employment and strives to adhere to the major principles and practices that are consistent with high SE fidelity.
3. *Explicit Admission Criteria.* Admission criteria are well-defined and contribute towards appropriate organizational boundaries.
4. *Support and Integration of Off-Site Training for Staff.* The program strongly supports and attempts to integrate off-site training in the SE model for Program H employment specialists.
5. *Recovery Orientation.* The program demonstrates a strong understanding of recovery, its definition and attempts to integrate this into day-to-day program practice.

APPENDIX L.
Individual Site-Visit Report: Program H (continued)

6. *Vertical Team Approach.* The Program H demonstrates strong vertical agreement in endorsement of the program model. There is consistent agreement across levels of leadership supporting the model. Most staff are trained and are providing services that all in line with this model.
7. *Role of Consumer in Service Provision.* Consumers are employed full-time by the program and function as full members of the team in addressing client treatment issues.
8. *Client role in treatment plan development.* Treatment plan at the Program H is client driven.

Characteristics deemed most crucial to successful realization of its mission include:

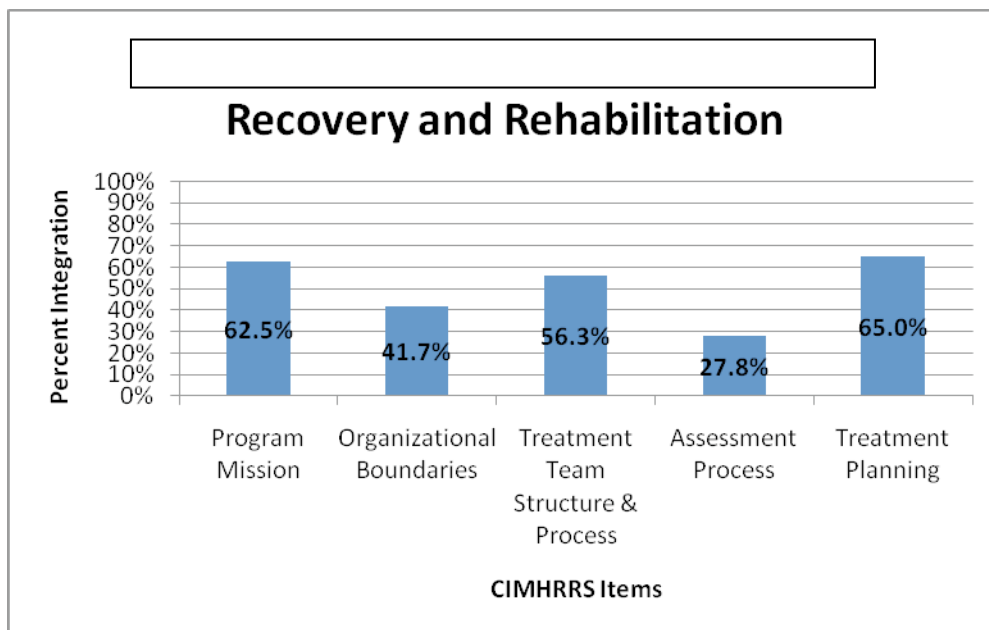
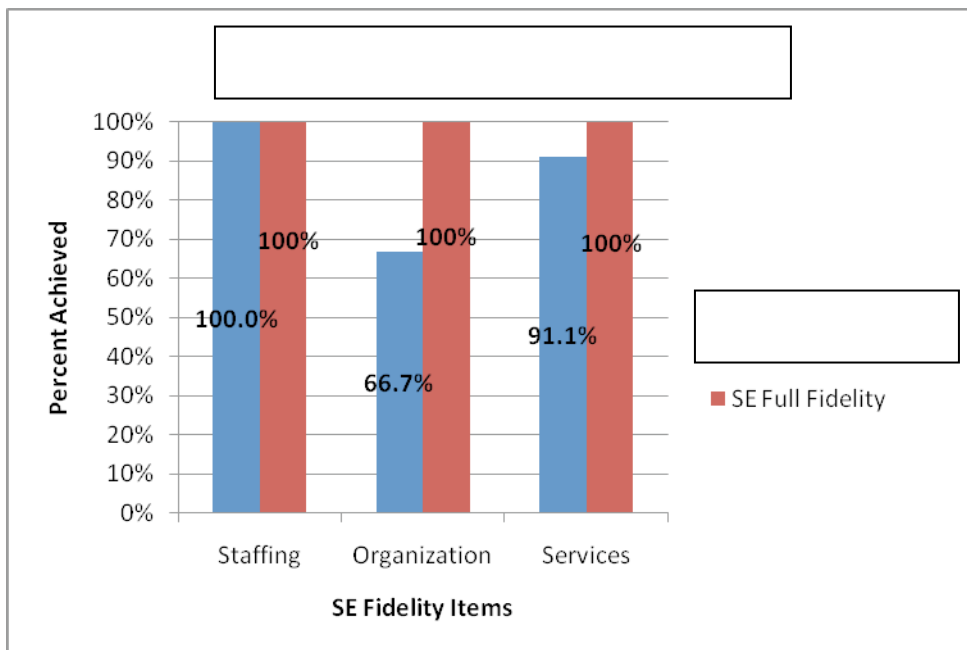
1. *Systematic program process monitoring and evaluation.* The Program H should strive to monitor its fidelity to the SE program. This will improve the program's ability to address program drift from its mission goals and model. This could be conducted using SE Fidelity materials found on the SAMHSA website.
2. *Integration of treatment in provision of services.* The adequate integration of mental health treatment in the provision of services will improve the Program H Program's ability to effectively address clients' multiple service needs (e.g., dual disorders, independent functioning) that may be challenging for one employment specialist alone to handle. This can be completed through regular interactions with case managers and mental health providers.
3. *Development of comprehensive assessment and treatment technologies relevant to the impairments, disabilities, and goals of its identified population.* Although the Program H completes a variety of assessments, the utilization of these assessments on a more regular basis will inform the best provision of services and subsequently, outcomes achieved. The assessments could also include interpersonal skills, basic independent living skills, cognitive functioning and symptom assessment, which will provide a more comprehensive understanding of the consumer's functioning. When combined with integrated service provision, this will improve the overall employment outcomes achieved by the Program H.

IV. A Word of Thanks

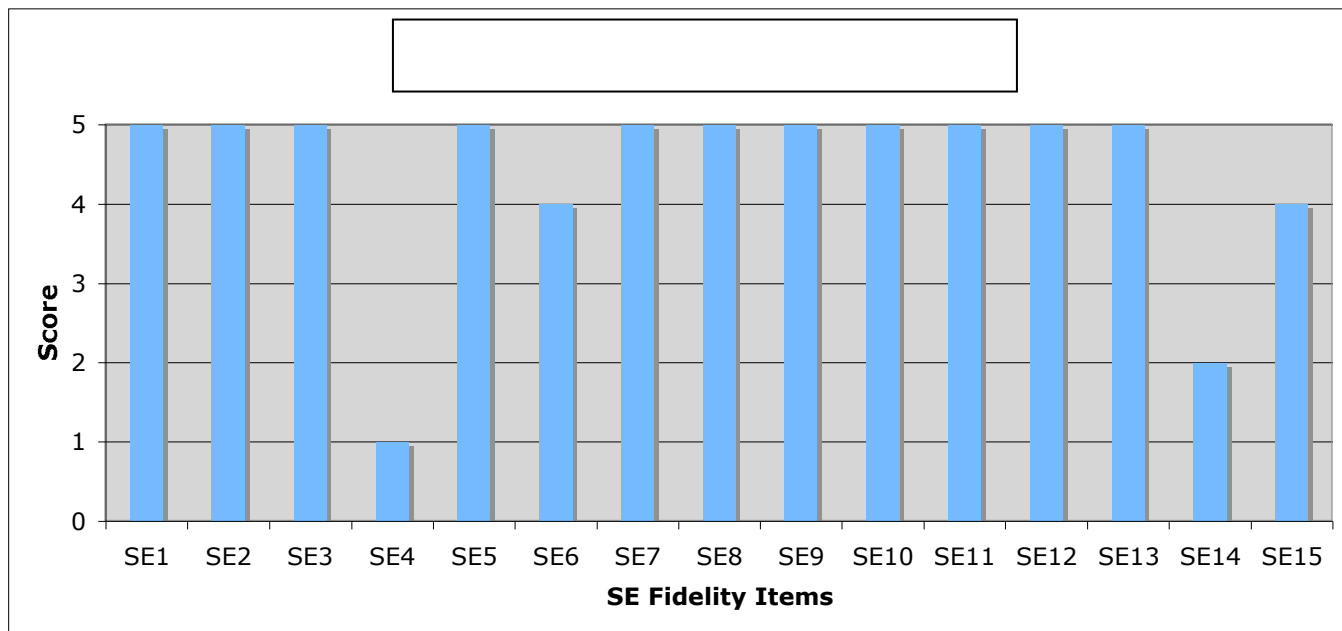
Program H staff were extremely hospitable during the site visit. Individual program staff was especially helpful in assisting with organization and scheduling of our site visit. Thank you for the quality services that you provide to persons with SMI.

**APPENDIX L.
Individual Site-Visit Report: Program H (continued)**

V. Appendix



APPENDIX L.
Individual Site-Visit Report: Program H (continued)



APPENDIX M.
Individual Site-Visit Report: Program I

Program I:
A Fidelity, Structure and Process Analysis

Date of site visit:
April 9, 2010

Date of report:
September 28, 2010

Report prepared by:
Nancy H. Liu, M.A.

Program Evaluation Tools:
--Supported Employment Fidelity Scale (SE Fidelity Scale)
--Comprehensive Instrument of Mental Health & Recovery and Rehabilitation Services (CIMHRRS)

Program Evaluation conducted by:
Nancy H. Liu, M.A.
Paul Nabity, B.S.

Supervision provided by:
Jim Harvey, MSW
William D. Spaulding, Ph.D.

For further information on the SE Fidelity Scale, please consult:
Substance Abuse and Mental Health Services (SAMHSA) Community Mental Health Tool-Kit Evaluating Supported Employment Programs:
http://download.ncadi.samhsa.gov/ken/pdf/toolkits/employment/SE_Evaluating_Your_Program.pdf

For further information on the CIMHRRS, please contact:
Robert W. Johnson, Ph.D.
rwjohnson01@gmail.com

APPENDIX M.

Individual Site-Visit Report: Program I

Executive Summary:

This report describes an analysis of the program fidelity, structure and organization of the Program I Vocational Program that is aimed at helping individuals with severe mental illness (SMI) achieve and maintain competitive employment.

The purpose of this analysis is two-fold. First, this analysis is aimed at determining the fidelity of the Program I to the Individual Placement and Support (IPS) model of Supported Employment (SE), an evidence-based practice (EBP), which is aimed at helping persons with SMI achieve and maintain competitive employment. A second, and no less important, goal is to determine whether the Program I conforms, in structure and operation, to the particular treatment model on which it is based. The Comprehensive Inventory of Mental Health Rehabilitation and Recovery Services (CIMHRRS) examines the recovery and rehabilitation focus of programs, with a particular emphasis on structural and process components of a program's day-to-day functioning. As specific treatment models are associated with specific outcomes, it is expected that the outcome of any treatment can be achieved only when the treatment is delivered with high fidelity. In turn, the expected outcome of a treatment program must be consistent with the mission of that program. The CIMHRRS is used to examine the organizational structure and approach of service providers to facilitate recommendations outlined in the 2003 President's New Freedom Commission Report. Specifically, this report mandates the transformation of the mental health services system for people with SMI to a rehabilitation focused, recovery-oriented and consumer and family driven system at the national, state, and local levels.

I. Description of the evaluation and instruments

The Supported Employment Fidelity Scale, previously named the IPS Fidelity Scale (Bond, Becker, Drake, et al., 1997) is based on the SE implementation and evaluation measures from the SAMHSA community toolkit (SAMHSA, 2007; Becker and Bond, 2002). The SE Fidelity Scale has been used to assess various SE programs and consistently demonstrates that better employment outcomes are associated with adherence to the SE model (McGrew and Griss, 2005).

The Comprehensive Inventory of Mental Health and Recovery and Rehabilitation (CIMHRRS) is a 52-item instrument designed to assess the fidelity of various programs to particular service models for persons with severe mental illness (SMI). It is used to both quantitatively and qualitatively characterize programmatic differences in service settings for people with SMI. Through a structured site review, evaluators assess the relative strengths and liabilities of service programs.

The on-site evaluation was conducted on April 9, 2010 at Program I, located in Nebraska. The evaluation schedule lasted from 9:00 am to 5:00 pm and included interviews with Program Directors, Employment Specialists and two Consumers, one who was recently hired as a Peer Specialist. In addition, the evaluators observed a My

APPENDIX M. Individual Site-Visit Report: Program I

Action Plan (MAP) treatment team meeting, reviewed charts and conducted a thorough review of the program's Policies and Procedures Manual. Two independent evaluators conducted all ratings. All discrepancies in ratings were reconciled by consensus.

II. Program Description

Program I reports in its Policies and Procedures Manual that its philosophy is “based upon the organization philosophy of Program I that all citizens, including those with a psychiatric disability, have the right to be treated with dignity and respect, and the right to fully participate within the community in accordance with one's own individual abilities. Recognizing the value that individuals and the community as a whole place on work.

Program I believes that vocational opportunities must be included as an integral part of its network of services designed to promote maximum community participation and integration. Guided by this philosophy and belief, Program I's Vocational services has, as its goal, the provision of supported employment following the principles found with the evidence-based best practiced model. The services are provided both on and off the job and assist individuals with a mental illness in choosing, obtaining, and retaining meaningful employment.”

III. Overview of Results

Supported Employment Fidelity

Supported Employment Fidelity was measured using a standardized and validated tool (see below). Fidelity scores can fall into one of three possible categories: 1) Good Implementation, 2) Fair Implementation and 3) Not Supported Employment.

As noted in Figure 1, the results of this analysis indicate that Program I achieved *Fair Implementation* of the SE program. It is noted that the program scores within the lower bound of the *Fair Implementation* category, considering a number of factors. Specific domain scores are found in Figure 1. Specific item scores are provided in Figure 3.

Strengths of the program that are in keeping with the SE model include the following:

1. *Caseload*. Employment specialists manage caseloads of up to 25 consumers.
2. *Vocational unit*. Employment specialists form a vocational unit with group supervision at least weekly and provide support for each other's cases and backup and support for each other.

APPENDIX M.
Individual Site-Visit Report: Program I

3. *Ongoing work-based assessment.* Most consumers are provided flexible, follow-along supports that are individualized and ongoing. This includes crisis intervention, job coaching, job counseling, job support groups, transportation, treatment changes and supportive networks.

Needs of the program to improve adherence to the SE model include the following:

1. *Integration of rehabilitation with mental health treatment.* Employment specialists should be attached to 1 or more case management treatment teams. To improve fidelity, this would include weekly treatment team meetings with shared decision-making and 3 consumer-related case manager contacts per week.
2. *Individualized job search.* Employer contacts should be based on job choices, which reflect consumers' preferences and needs rather than the job market. It is noted that Program I has done an excellent job fostering relationships with community-based employers; however, it appeared that a match between consumer preferences and job contacts could be improved to match most, if not all, consumer preferences.
3. *Diversity of jobs developed.* An improvement in the diversity of jobs can be improved so that employment specialists provide options for either the same types of jobs, e.g., janitorial, or jobs at the same work settings, less than 10% of the time.

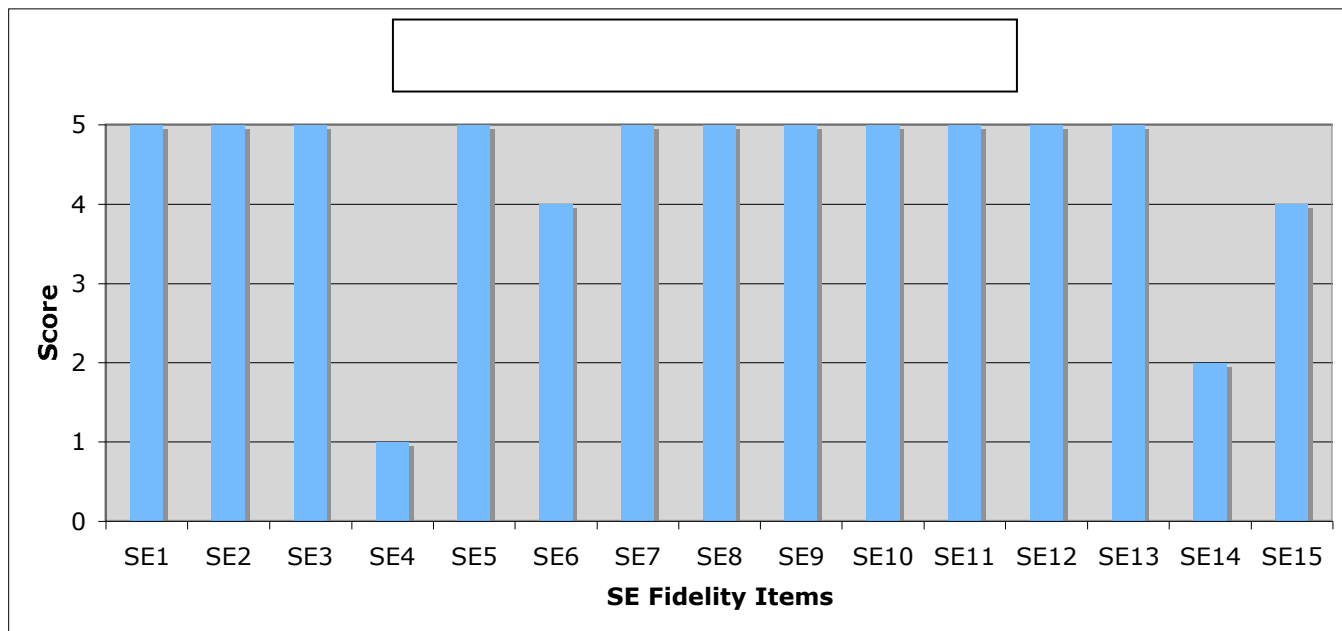
Program I notes that data are collected on the actual diversity of jobs and employers obtained by individuals served in the program. Records indicate that approximately 25% of persons served by the Program I were employed with Retail, which is consistent with the SE Fidelity rating on the item regarding diversity of jobs attained, namely that employment specialists assist clients obtain different types of jobs about 70-84% of the time.

Recovery and Rehabilitation of Services

The goal of the CIMHRRS is to determine how well the Program I conforms, in structure and operation, to the particular treatment model on which it is based. This is important because specific treatment models are associated with specific outcomes and these outcomes are achieved when the treatment is delivered with high fidelity. In turn, the expected outcome of a treatment program must be consistent with the mission of that program.

As noted in Figure 2, the results of this analysis indicates that the Program I has reached minimal integration in the five domains of the CIMHRRS: 1) Program

APPENDIX L.
Individual Site-Visit Report: Program H (continued)



APPENDIX M.
Individual Site-Visit Report: Program I (continued)

2. *Systematic program process monitoring and evaluation.* This will improve the program's ability to address program drift from its mission goals and model. This could be conducted using SE Fidelity materials found on the SAMHSA website.
3. *Integration of treatment in both the treatment plan and provision of services.* This will improve the Program I's ability to effectively address clients' multiple service needs (e.g., dual disorders, independent functioning) that may be challenging for one employment specialist alone to handle. This can be completed through regular interactions with case managers and mental health providers.
4. *Staff development in the areas of recovery, recovery-oriented services, Psychiatric Rehabilitation and personalization of treatment and individualized treatment planning.* Program I states as a major goal of the program, the individualization of treatment geared towards recovery; however the off-site training of staff may assist in providing more services that are comprehensive and recovery-based. Program I places a strong emphasis on the training of their staff; however these practices do not appear to be consistently implemented in practice.
5. *Development of comprehensive assessment and treatment technologies relevant to the impairments, disabilities, and goals of its identified population.* Although the Program I completes a variety of assessments, the utilization of these assessments on a more regular basis will inform the best provision of services and subsequently, outcomes achieved. The assessments could also be more comprehensive to include interpersonal skills, basic independent living skills, cognitive functioning and symptom assessment will provide a more comprehensive understanding of the consumer's functioning and, combined with integrated service provision, will improve the overall employment outcomes achieved by the program.

Program I notes that it conducts a number of assessment tools that are utilized on an ongoing basis; however the program may benefit from the integration of assessment information to guide treatment planning and achievement of goals.

IV. Conclusions

The Program I program has a strong recognition of the principles of recovery and rehabilitation and especially the Supported Employment model. Overall, Program I

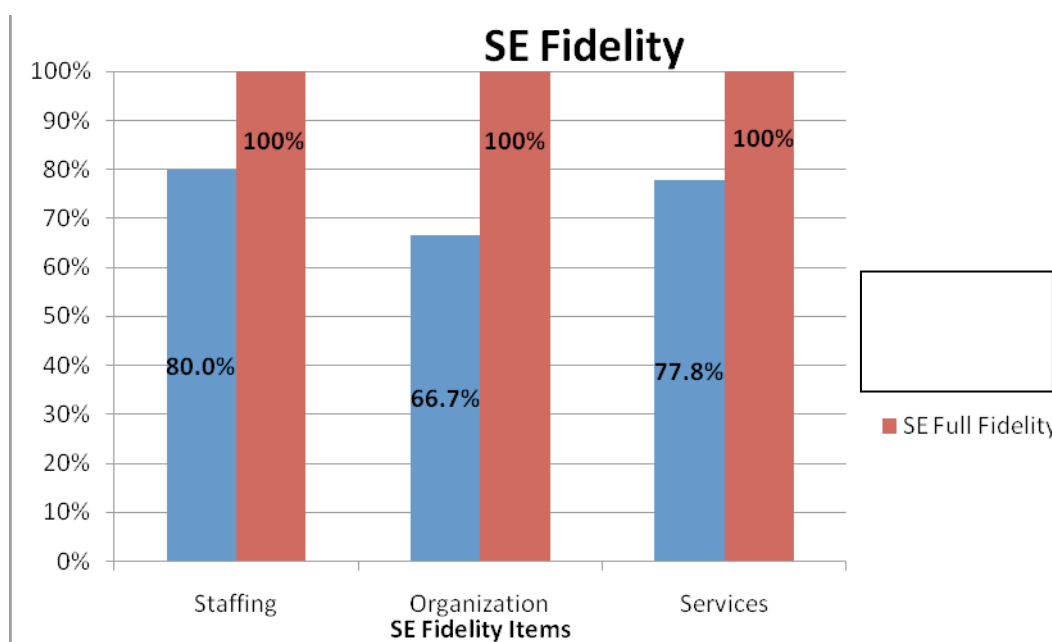
APPENDIX M.
Individual Site-Visit Report: Program I (continued)

functions at the *Fair Implementation* of the SE model and would benefit from increased integration of training and assessment into daily practice to achieve improved outcomes and service provision.

V. A Word of Thanks

Program I staff were extremely hospitable during the site visit. Individual program staff has been especially helpful in assisting with organization and scheduling of our site visit. Thank you for the quality services that you provide to persons with SMI.

VI. Appendix



**APPENDIX M.
Individual Site-Visit Report: Program I (continued)**

