REPORT OF THE
DEPARTMENT OF REHABILITATIVE
SERVICES

Reevaluating of Policies Associated with Serving The Mentally Disabled

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

House Document No. 17

COMMONWEALTH OF VIRGINIA
RICHMOND
1987

COMMONWEALTH of VIRGINIA

ALTAMONT DICKERSON, JR.
COMMISSIONER

Department of Rehabilitative Services

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December 20, 1986

HOUSE JOINT RESOLUTION NUMBER 159

Requesting the Department of Rehabilitative Services to reevaluate policies associated with serving the mentally disabled under current programs.

To the Members of the General Assembly:

Seven months ago you asked us to examine and reevaluate existing policies and practices in order to reduce policy, funding and regulatory barriers associated with serving the mentally disabled under current programs and, thereby, increase the employability of the mentally disabled population and assist them in finding and keeping jobs.

I am pleased to forward for your examination the final report in response to House Joint Resolution No. 159. I am very qratified by the effective cooperation and group efforts among the Department of Mental Health and Mental Retardation, the Department of the Rights for the Disabled and my Department in dealing with the issues and opportunities surrounding this area of service delivery to the mentally disabled in the Commonwealth.

I am confident that the recommendations developed by the HJR 159 Study Group, if acted upon will facilitate improved vocational rehabilitation services and significantly increase the numbers of successful rehabilitations for this population.

Sincerely,

Altamont Dickerson, Jr.

Altamont Dickerson, Jr., Ed.D.
Commissioner

/hf

RESPONSE

TO

HOUSE JOINT RESOLUTION 159

Eva S. Teig
Secretary of Human Resources

Altamont Dickerson, Jr., Ed.D.
Commissioner
Department of Rehabilitative Services (DRS)

Study Group:

Department of Rehabilitative Services
C. Stephen Webster, Chairman
John E. Hayek
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Department of Mental Health/Mental Retardation
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Department for the Rights of the Disabled
Bryan K. Lacy

December 4, 1986

FINAL

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1986 SESSION

LD1998566

HOUSE JOINT RESOLUTION NO. 159

Offered January 21, 1986

Requesting the Department of Rehabilitative Services to reevaluate policies associated with serving the mentally disabled under current programs.

Patrons—Stambaugh, Marshall, and Slayton

Referred to Committee on Health, Welfare and Institutions

WHEREAS, the Joint Legislative Audit and Review Commission noted in its study on *State and Local Services for Mentally Ill, Mentally Retarded and Substance Abusing Citizens* that the current deinstitutionalization movement has served to reduce the census in state hospitals, but funds and services have not followed these clients to the communities; and

WHEREAS, a comprehensive community treatment and support system is essential for the delivery of appropriate services to mentally disabled clients; and

WHEREAS, it is estimated that for the 18,000 chronically mentally ill clients currently living in the community, an effective community support system must include psychosocial rehabilitation, transitional employment and case management/outreach capabilities in addition to adequate housing; and

WHEREAS, transitional employment involves ongoing professional support provided at the job site for disabled persons who could not gain paid unsubsidized employment or maintain this employment without assistance; and

WHEREAS, the Department of Rehabilitative Services has a mandate to provide employment-related services and has expressed a desire to coordinate efforts with the Department of Mental Health and Mental Retardation; and

WHEREAS, many chronically mentally ill persons currently living in the community are capable of holding part-time and full-time employment if assistance is offered; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That the Department of Rehabilitative Services is requested to examine and reevaluate existing policies and practices in order to reduce policy, funding and regulatory barriers associated with serving the mentally disabled under current programs and, thereby, increase the employability of the mentally disabled population and assist them in finding and keeping jobs.

The Department shall report its findings and provide recommendations for increasing the level of service to mentally disabled persons to the General Assembly prior to the 1987 Session; and, be it

RESOLVED FINALLY, That the Clerk of the House of Delegates prepare a copy of this resolution for presentation to the Director of the Department of Rehabilitative Services and the Secretary of Human Resources.

EXECUTIVE SUMMARY

House Joint Resolution 159 directed the Department of Rehabilitative Services to examine and reevaluate its existing policies and practices in order to reduce policy, funding and regulatory barriers associated with serving the mentally disabled under current programs and, thereby, increase the employability of the mentally disabled population and assist them in finding and keeping jobs. A study group was convened which included representatives from the Department of Mental Health and Mental Retardation (DMH/MR), the Department of the Rights for the Disabled (DRD) and the Department of Rehabilitative Services (DRS). In keeping with current public priorities, the focus has been on the Chronically Mentally Ill (CMI) population. The study group looked at the involved service delivery systems, cooperative efforts and initiatives. DRS policies, procedures and practices which might constitute barriers were examined. Input on perceived barriers was solicited from and provided by the local Community Service Boards as well as the Statewide Vocational Rehabilitation/Mental Health (VR/MH) Collaborative Task Force.

DISCUSSION AND FINDINGS

DRS serves 179 disability groups and administers the Vocational Rehabilitation (VR) program for vocationally handicapped citizens of Virginia under federal regulations and accountability measures. Several points in the VR process were examined at which the Chronically Mentally Ill (CMI) may be discouraged from accessing VR services. These are: 1) referral, 2) case acceptance, and 3) client program planning. The review of the above areas demonstrates that State and federal VR policies and practices are geared to provide services to CMI clients. Indeed, around 20 percent of DRS's currently open cases and successful closures are CMI clients. A "successful closure" occurs when the client is effectively placed for at least 60 days in a reasonably permanent, individually appropriate gainful vocational situation in which he or she receives a wage commensurate with that paid others for similar work.

In practice it is the counselor's ability to determine the client's vocational potential, and his/her knowledge of service options, and needs for non-traditional rehabilitation programs and outcomes that appear to hold the key to more effective VR services to the CMI population. To this end, the study group felt that inter/intragency training and communications and the development of local psychosocial/vocational rehabilitation programs, within existing CSBs, needed attention.

Mutual understanding among DRS, DMH/MR and the local Community Services Boards (CSBs) is at times compromised because of different agency structures, accountability systems and outcome expectations. The cooperating agencies are

struggling to fulfill client needs which were formerly met in state mental institutions. Further, resources allocated to the community have not kept pace with the needs of the increased numbers of clients following the de-institutionalization process. DRS staff have withdrawn from the State mental institutions and are now concentrating on serving CSB clients in the localities. Building new cooperative relationships and effective client service strategies challenges limited budget and staff resources necessary to alleviate individual and societal problems associated with the non-rehabilitated CMI population. The issues identified by this study stem from the manner in which each agency carries out its mission, communicates with each other and defines its roles and responsibilities.

RECOMMENDATIONS

A sustained commitment on the part of DRS to serve CMI clients, on the part of DMH/MR and CSBs to emphasize vocational rehabilitation and on the part of the General Assembly to fund appropriate services and positions will allow the CMI client the opportunity to maximize his/her potential and carry his/her own weight in society. To more effectively serve the mentally ill population and assist them in finding and keeping jobs, the following recommendations are set forth:

GENERAL ASSEMBLY

1. That the General Assembly consider additional funding and staff positions to increase the number of innovative vocational rehabilitation projects in CSB psychosocial rehabilitation programs.

2. That the General Assembly consider increased support to insure adequate CSB Core Services, and for the establishment and provision of DRS and CSB operated Transitional and Supported Employment Services for the CMI population.

3. That as a means of increasing employer participation, the General Assembly explore the enactment of legislation creating a State Targeted Jobs Tax Credit to provide employers an incentive for hiring job-ready chronically mentally ill individuals.

DEPARTMENT OF REHABILITATIVE SERVICES

1. That DRS develop and deliver curricula for its staff stressing effective service delivery processes and outcomes for the CMI population.

2. That DRS develop and disseminate guidelines to all CSB staff for the effective screening and referral of CMI clients to DRS.

3. That DRS clearly articulate and disseminate the definitions for successful VR closures to DRS and CSB staff.

4. That DRS disseminate information defining Transitional and Supported Employment Services and DRS's associated programmatic and fiscal responsibilities and capacities to cooperating agencies.

5. That DRS with the CSBs institute pre-referral conferences and subsequent interagency staffings to provide effective feedback on mutual clients.

6. That DRS with the CSBs form local, joint job marketing teams in order to assure an effective and coordinated approach to the employer community.

7. That DRS with the CSBs further explore the opportunities associated with potential DRS-CSB contractual relationships for providing appropriate employment services (e.g. Transitional and Supported Employment Services).

8. That DRS, DMH/MR and the CSBs define their respective long-term commitment to the vocational rehabilitation of the CMI population, and reflect this in appropriate planning and budget documents.

DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION

1. That DMH/MR encourage the CSBs to share confidential information (including third-party reports) to appropriate DRS staff on mutual clients. Statewide, uniform practices are needed.

2. That DMH/MR review practices regarding the CSBs billing DRS for services to mutual clients and issue guidance to the CSBs regarding standard and equitable practices. Statewide, uniform practices are needed.

3. That DMH/MR, with DRS, develop a glossary of relevant mental health and vocational rehabilitation terms to be distributed to all involved staff in each system.

COMMUNITY SERVICES BOARDS

1. That the CSBs, with DRS, negotiate and/or update written agreements that include specific, brief descriptions of locally available CSB and DRS services, a description of each agency's resources and responsibilities for each coordinated service, and a list of measurable objectives.

2. That the CSBs with DRS develop programs for interagency staff training specific to serving the CMI population, including definitions of agency's responsibilities and interagency interaction.

HJR 159 REPORT

I. Charge

House Joint Resolution 159 (HJR 159) of January 21, 1986 directed that the Department of Rehabilitative Services examine and reevaluate existing policies and practices in order to reduce policy, funding and regulatory barriers associated with serving the mentally disabled under current programs and, thereby, increase the employability of the mentally disabled population and assist them in finding and keeping jobs.

II. Focus of Study

In keeping with House Joint Resolution No. 159, and with legislative and administrative intent (see listing of documents below), this study focuses upon the Chronically Mentally Ill (CMI) population. This thrust by no means lessens the importance DRS places on services to the substance abuse and mental retardation populations.

* The Governor's Directive to the Commissioner of DRS dated April 30, 1986.
* Senate Document No. 22 - Commission on Deinstitutionization, 1986.
* JLARC Report - Improving Services For The Deinstitutionalized Mentally Disabled dated November 21, 1985.
* JLARC Report - State and Local Services For Mentally Ill, Mentally Retarded and Substance Abusing Citizens dated August 1, 1985.

III. Definitions of the Chronically Mentally Ill Population

In August 1985 the Joint Legislative Audit and Review Commission (JLARC) reported that more than 18,000 chronically mentally ill persons reside in Virginia's communities. CMI individuals are defined as those who have had one or more hospitalizations for mental illness and who have significant handicaps in independent living or vocational skills. The preponderance of these people are unemployed. Most require assistance and support to develop and maintain vocational skills, and to live effectively in the community.

While DRS's and DMH/MR's definitions of the Chronically Mentally Ill are similar, they are not identical. DRS's data systems capture information on this population via World Health Organization disability codes for psychotic disorders, neurotic disorders and character/personality behavioral disorders. Additionally, DRS definitions deal only with the working aged population. For purposes of this report the term Chronically Mentally Ill (CMI) shall be used in reference to DRS service delivery information and issues with the understanding that the definitional 'fit' is not perfect.

IV. Study Group Assignment and Objectives

Upon notification of HJR 159, DRS established a study group to respond to the resolution. Participating agencies in the study group include the Department of Rehabilitative Services (DRS), Department of Mental

Health/Mental Retardation (DMH/MR) and the Department of Rights for Disabled (DRD).

The objectives of the HJR 159 Study Group were:

1) To examine DRS policies, procedures, practices, and resource allocation and to identify barriers in service delivery to Virginia's CMI population; 2) to work with participating agencies and constituencies to develop a set of specific recommendations to reduce or eliminate barriers.

V. DRS State/Federal Partnership - Overview

DRS serves all disability groups at roughly 80 percent federal and 20 percent State funding, and operates under Federal Regulations and accountability measures. During FY 1986, federal participation came to $43,599,459. The Rehabilitation Services Administration (RSA) has developed and applied an effective system of financial and service delivery accountability (see Section V) which is reflected in The Rehabilitation Act of 1973 and subsequent Amendments. Within this federal/state structure, DRS is mandated to provide VR services to all eligible disabled individuals in Virginia as well as to provide determinations of disability for the Social Security Administration.

DRS's VR program directly provides services (such as counseling and guidance) within its staff's expertise, and purchases those services beyond DRS's abilities to provide directly.

DRS History:

A federal assistance program was established in 1920 to provide a limited range of services to physically disabled civilians to enable their return to employment. Until 1928 this program was administered through the Industrial Commission. From 1928 to 1964, the federal-state program was administered by the Department of Education. Initial operations were primarily confined to simple retraining and job placement of physically disabled adults. The long recognized need for physical restorative medical and surgical services as part of the rehabilitation process was authorized by federal amendments in 1943. At that time, the mentally disabled were also specified as part of the target population eligible to receive services, necessitating the provision of psychiatric and psychological restoration and treatment.

In 1964, state legislation established a state agency independent of the Department of Education. Federal amendments in 1965 increased appropriations by many millions of additional funds for innovating new practices in rehabilitation. This led to cooperative programs with a number of state agencies and local institutions and increased the department's outreach.

Since 1973, emphasis has been on providing a comprehensive range of services for the more severely disabled, with increasing attention on cost containment and efficiency/effectiveness. In 1985 state legislation, "the Virginians With Disabilities Act," further identified the scope and

authority of the department in areas of supported employment, environmental barriers and personal care assistance. Program expansion over the years has resulted from increasing knowledge of and efforts to provide the wide range of services needed by disabled individuals to reduce the need for hospitalization or institutionalization and to function in the competitive labor market, as well as in the family and community.

VI. Review of DRS System: Responsibilities, Services, Delivery System

DRS is designated by Title 51.01 of the Code of Virginia as the state agency for cooperating with the federal government in carrying out the Federal Rehabilitation Act in Virginia. The Vocational Rehabilitation program's goal is "to assist persons with mental, physical and emotional disabilities to achieve self-sufficiency and independence through the provision of comprehensive vocational rehabilitative services which result in the attainment of gainful employment."

DRS provides or coordinates an array of vocational rehabilitation services to vocationally handicapped persons through its statewide program. The scope of federally mandated vocational rehabilitation services arranged by DRS for all categories of disabled individuals is as follows:

1. Diagnostic and vocational evaluation
2. Vocational counseling and guidance
3. Physical and mental restoration
4. Vocational and other training services, including work adjustment
5. Maintenance (food, shelter, etc.)
6. Transportation
7. Services to members of the handicapped individual's family
8. Interpreter and note-taking services for the deaf
9. Telecommunications as well as other aids and devices
10. Recruitment and training services in the public service area
11. Job placement
12. Post-employment services
13. Occupational licenses
14. Other goods and services

Handicapped persons eligible for vocational rehabilitation are defined as the working aged disabled having a substantial handicap to employment who can reasonably be expected to benefit from services in terms of their employability. DRS serves persons with a full range of physical, mental or multiple disabilities.

General V.R. Client Process

The following is a brief description of the rehabilitation process.

1. Referral/Applicant Phase

   This includes the first face-to-face meeting of counselor and potential client, or the parent/guardian, if appropriate. The counselor obtains information on disability, income, vital statistics, education, work status, medical and social history.

2. Diagnostic Phase

During this phase the counselor gathers diagnostic information for the purpose of determining eligibility and program planning.

3. Eligibility Determination

With the information obtained in the referral and diagnostic processes, the counselor decides whether or not the applicant:

- Is disabled and suffers a vocational handicap; and

- May be employable after receiving DRS services.

If these conditions are met the applicant is eligible for DRS services. During 1986, 3,679 CMI clients were provided services following eligibility determination.

4. Individualized Written Rehabilitation Program (IWRP)

The individualized program is a key feature of the 1973 Rehabilitation Act. The client is involved in development of the program and has the opportunity to record his/her views regarding the planned services.

The IWRP also includes:

- Rehabilitation objectives;
- Specific services and scheduled dates;
- Schedule for review of progress;
- Responsibilities of the client, his/her cost participation and similar benefits available; and
- Basis for determining success.

5. Services

Up to this point all services will have been identified and planned. At this time the following services may be initiated and recorded in the client's Individual Written Rehabilitation Program (IWRP).

- Training services;
- Physical/Mental Restoration; or
- Counseling and Guidance; and
- Job Placement; and
- Follow-up.

For CMI clients whose cases were closed during 1986, $1,098,759 in purchased services were provided.

6. Case Closure and Follow-Up

When it has been determined that further services are not needed or will not contribute to the client's entering or maintaining employment, the case will be closed. When determined necessary, further VR services will be provided to the client by re-opening that client's case.

During 1986 a total of 732 CMI clients were vocationally rehabilitated. Following VR services, this group's aggregated net gain in earnings per week was $101,442.

VII. OVERVIEW OF VIRGINIA'S MENTAL HEALTH SYSTEM

The mission of the Department of Mental Health and Mental Retardation DMH/MR) is to provide for the mental health, mental retardation and substance abuse needs of the citizens of the Commonwealth. (DMH/MR) provides direct inpatient services for the mentally disabled through a network of State mental hospitals. Additionally it provides funding (between 50 and 90 percent), sets standards, and provides oversight to the 40 Community Services Boards (CSBs) which were established in 1968 by Chapter 10 of Title 37.1 of the Code of Virginia.

Chapter 10 of Title 37.1 charges the CSBs with the local provision of mental health, mental retardation and substance abuse services in the various jurisdictions throughout the Commonwealth. Though partially funded by DMH/MR, the CSBs are agents of local government.

In addition to coordinating client referral and discharge from the State mental hospitals, CSBs function as direct service providers, client advocates, community educators, organizers and planners, advisors to local government, and as the focal point for fiscal and programmatic accountability. The CSBs offer varying combinations of six core services: emergency (mandated), local inpatient, outpatient and case management, day support, residential, and prevention/early intervention services. Local availability of these services depends on financial resources, DMH/MR policies and the needs as perceived by the local governmental authority.

Community Services Boards retain responsibility for management of care to clients from their catchment area regardless of the actual locus of care. If a client has been placed in an inpatient facility, the CSB remains responsible for participating in treatment team meetings and in discharge planning. In crisis situations, where there is indication that hospital care may be needed, the CSB is responsible to perform a pre-admission screening, to determine the client's service needs, and to attempt to secure appropriate services in the community.

VIII. DRS-DMH/MR-CSB COOPERATIVE EFFORTS, INNOVATION AND EXPANSION

COOPERATIVE EFFORTS

RSA Training Issues

The Rehabilitation Services Administration (RSA) recognizes the need for interagency cooperation and innovation in serving the CMI population. There is mutual agreement among vocational rehabilitation (VR) and mental health (MH) professionals that the provision of VR services to the chronically mentally ill presents unique challenges. The unique challenges associated with serving the CMI population include: lack of self-confidence/esteem, strained relations with others, isolation, high

vulnerability to stress, inability to seek and sustain employment. Multiple contacts with the mental health service system, difficulties in coping with basic activities of daily living, episodic acting out inappropriately and inability to seek out and participate in productive activities.

In the fall of 1984, RSA awarded a series of long-term training grants specifically to provide for joint VR/MH training. Matrix Research Institute (under contract with RSA) in a summary draft report of Virginia VR/MH Administrator Seminars, July 15, 1986, cites the nature of the disability, the scarcity of appropriate programs, and the resistance of potential employers as contributing to difficulty in placing mentally ill persons into productive employment.

In Virginia, DMH/MR and DRS, capitalizing on this federal initiative, are receiving training for administrators, supervisors, and service delivery staff in effectively working with the CMI population. Out of this training has come a Statewide VR/MH Collaborative Task Force. The Task Force is designed to specifically improve cooperative efforts among DRS, DMH/MR central office staff, and CSBs through team building, the identification of barriers to effect mutual services, and the development of recommendations specific to each described barrier.

Transitional and Supported Employment Services

DRS has recently received a five-year grant from RSA to develop a system for making paid work opportunities in competitive industry available to persons with severe disabilities who have historically received services in CSB day support systems. This cooperative effort between DMH/MR and DRS has a goal of changing the predominant nature of day support services in Virginia toward the provision of supported employment opportunities.

Day support services are supervised daily activities which are not typically vocationally oriented. In contrast, transitional and supported employment services are competitively oriented and strictly vocational in their outcomes. Transitional and supported employment services utilize "job coaches" who guide and supervise each client and bring about his/her successful vocational adjustment. These services are similar to like services provided to the mentally retarded population. However, their application is in keeping with the characteristics of the CMI population. The clients are paid the going, competitive rate for their work and they work at a job site along with non-disabled co-workers. Transitional employment is the initial phase of Supported Employment and is a time-limited DRS purchased service involving intense interaction between the client and his/her job coach. Supported employment is a long-term, less intense, similar employment maintenance service provided by sources other than DRS. While sheltered employment services occur in a protected milieu, transitional and supported employment takes place in a competitive employment environment.

In order to make the transition from day support services toward supported employment services, DRS and DMH/MR will develop interagency approved program standards, funding criteria, and a system for monitoring and evaluating programs; will provide technical assistance and start-up grants to communities to initiate supported employment programs; and

will build awareness among parents, service recipients, and employers on competitively employment oriented services for persons with severe disabilities. While transitional and supported employment services have traditionally been focused on the mentally retarded population, state agencies are now adopting these services to the CMI population.

Joint Certification

DRS and DMH/MR have recently agreed to joint certification reviews of those sheltered workshops throughout the state that are commonly utilized and funded by the two agencies. Sheltered workshops are facilities engaged in production or service operations for the primary purpose of providing non-competitive employment for the vocationally handicapped. This cooperative effort will include the participation of CSB staff and local DRS staff as well as a team leader from either of the state offices of DRS or DMH/MR. As an aspect of this interagency facility review, the two agencies, along with consumers and providers of services, will be working to develop a compatible and comprehensive system of quality assurance that provides for regular and systematic review of programs. Additionally, DRS and DMH/MR are collaborating in the provision of technical assistance to address local workshop needs.

New Interventions in Private Rehabilitation Facilities

DRS has issued a Request for Proposals (RFP) to sheltered workshops which shall bring about the provision of innovative training to workshops for the benefit of DRS sponsored clients. This innovative training shall develop the vocational training methods required by the mentally disabled population. Workshop staff shall be trained in the most effective methods surrounding vocational behavior skills, transitioning from sheltered job experience to other employment options (e.g. competitive), and other appropriate prevocational development needs. Proposals submitted in response to this RFP will require workshops to coordinate with CSB and DRS staff in identifying mutual training and staff development needs. The curriculum development and training solicited in the RFP shall be provided by a third-party qualified in the field, agreed upon by DRS and recommended by a local CSB.

The number of sheltered workshop program in the Commonwealth developing services within a supported employment program design continues to expand. Workshop operated supported employment programs are a potential service resource for chronically mentally ill individuals. For example, the Colonial Workshop in Williamsburg provides work support services in the competitive labor market for persons who have a history of institutionalization for mental illness. Other facilities such as the Rappahannock Rehabilitation Facility in Fredericksburg are involved in planning efforts with local DRS and CSB representatives regarding the participation of the CMI population in supported employment programming.

INITIATIVES AND EXPANSION

The Virginia Beach CSB has had in place since the late 1970s a psychosocial rehabilitation program highlighting client vocational development. The program, known as Beach House, is designed after New York City's Fountain House, a nationally renown model in the provision of structured

community integration services to the chronically mentally ill. Such programs stress "wellness" and member accountability, and provide clients with developmental steps toward self-sufficiency in the community. The model is a combination "club" and, in a way, an extended family of mutually concerned members who provide each other with group support and attention. Critical to program success is the work ethic and client gain from employment. Since 1981, DRS has supported the model through providing a full-time counselor devoted to serving the vocational needs of Beach House clients. The VR counselor provides vocational counseling, preparation, employment contacts and job retention support. He/she also secures resources in the community and serves as the client's vocational advocate. Such programs are vocationally oriented and more structured than traditional Day Support programs. While the statewide percent of successful VR outcomes for the CMI population is 26 percent, that for the Beach House program is 66 percent.

DRS recently requested and received a $750,000 State special budget allocation from the General Assembly with which to replicate DRS involvement in 10 psychosocial programs at the following sites:

Richmond Community Services Board
Rappahannock Area Community Services Board
Hampton-Newport News Community Services Board
Harrisonburg-Rockingham Community Services Board
County of Loudoun Community Services Board
Cumberland Mountain Community Services
Chesapeake Community Services Board
Danville-Pittsylvania Mental Health Services
Colonial Services Board
Mental Health Services of the Roanoke Valley

Each site shall receive a VR counselor at $30,000, case service funds of $20,000 and a grant of $20,000 to provide ongoing employment support services.

Because the funds involved in these programs are not federal, DRS has a greater degree of latitude and flexibility in meeting the vocational needs of the CMI individuals who otherwise may have been considered ineligible or infeasible for VR services. This funding will allow existing psychosocial programs to expand their vocational orientation through the development of Transitional and Supported Employment Services. This expansion will increase the CMI populations' access to VR programming within these 10 localities. Collaboration of DRS and CSBs in these sites offers the opportunity to test and demonstrate services and strategies which may prove effective in rehabilitating CMI clients. A by-product of this will be increased local cooperative effectiveness. Additionally, the potential for statewide replication of innovative rehabilitation programming for the entire CMI population shall be demonstrated.

The success of DRS's participation in Beach House dramatically demonstrates the direction which the Department must follow to appreciably increase the number of successfully rehabilitated CMI clients. Presently approved manpower levels and budget constraints do not allow the Beach House program's replication beyond the 10 sites listed above. Therefore, DRS has requested from the General Assembly an additional

allocation of $1,478,200 for each of the next two years to provide adequate VR services to the 40 CSBs across the Commonwealth. This request, if allocated would provide minimal manpower and case service funds for the remaining 30 CSB operations. It is estimated that this program expansion would provide and increase VR services to approximately 3,850 CMI persons, and would rehabilitate some 870 additional CMI clients during the biennium.

IX. ISSUE IDENTIFICATION AND RECOMMENDATIONS

Up to this point, the material presented has described background and orientation of the agencies involved with the chronically mentally ill. Key to the provision of community-based mental health services is the local CSB. Likewise, the key provider of vocational rehabilitation services within the community to all disabled citizens including the CMI population is the DRS counselor. This is the point where the CSB and DRS professionals interact. To respond to the charge, the study group reviewed DRS policies and procedures, and solicited input from CSBs DMH/MR, DRD, DRS and the Statewide Collaborative VR/MH Task Force to identify barriers. It is the consensus of all contributing groups that communication and role clarity underlie the identified barriers.

A. DRS Eligibility and Success Issues:

The review of policy at the federal and state level related to case acceptance, eligibility determination and planning of services which lead to a successful VR outcome suggests that DRS policies and procedures are not discriminatory against the CMI population. The fact that about 20 percent of recent successful closures and currently open cases are CMI suggests that policy allows the mentally ill to receive VR services. In practice is it the ability of the counselor to view the CMI client as having VR potential, the understanding of client needs, the awareness of service options and the acceptance of non-traditional rehabilitation outcomes that appear to hold the greatest potential for more expansive and effective VR services to the CMI population. Implicit here is the need for staff training and the development of effective community resources for the CMI. In an earlier discussion of the VR process, service options and key decision points were described. The VR case status system and service options provide a framework within which individual cases may be managed, and client progress through the system documented. Within this federally mandated framework, there are three pivotal points which may constitute barriers to service to all clients.

1. Referral, Diagnosis and Case Acceptance

The first critical point occurs when a counselor decides whether a client will enter the VR service system. Regardless of the fact that any individual has the right to make application for VR services and subsequently have his/her eligibility for those services determined, a counselor's initial response to a potential applicant may influence the degree to which an individual is invited to exercise that right. Factors which come into play in considering a client's potential as a referral include: pressures for client vocational placements (successful closures); the anticipated degree of difficulty presented by the client's disability; the counselor's history of success or failure in

rehabilitating clients with similar needs and characteristics; awareness of and availability of services and employment opportunities appropriate to a client's needs; and the pool of potential clients competing for DRS services.

a. Pressure for Successful Closures

Of all public service programs, no other has such a clear measure of success as the state/federal VR program. It is this clarity of objective upon which VR accountability is based. This creates a pressure for success, as measured by the number of clients returned to employment, which is felt by DRS staff at all levels, particularly at the counselor level. "Success" occurs when the client is effectively placed for at least 60 days in a reasonably permanent, individually appropriate gainful vocational situation in which the client receives wages commensurate with that paid others for similar work.

DRS is federally mandated to work with the severely disabled. Significant success has been achieved in this area. Even with the complexities and demands on limited resources, DRS may not discard this program accountability standard--and the pressure inherent in that standard--which sets the VR program apart from maintenance and entitlement programs.

The discussion of pressure on counselors to produce successful client placements impacts services to the CMI population in that this pressure may cause counselors to restrict intake of CMI clients due to "apparent" negative likelihood of success. The tendency of DRS counselors to accept only a limited number of high risk clients is viewed by local CSBs as a VR imposed barrier to the CMI client.

The addition of State monies for these purposes alleviates many of these pressures.

b. Client Characteristics

What causes a potential CMI client to be viewed as a high risk? It must be kept in mind that the VR counselor operates within a context of employability. He/she essentially bases his/her acceptance of a client on a set of intangible predictors of the client's likelihood of success in employment.

These predictors include:

1. client appearance and self-presentation,
2. the discrepancy between the client's functional capacities and those typically ascribed to persons holding jobs,
3. the degree to which a client demonstrates his/her commitment to obtaining employment, and
4. any evidence furnished about the client such as:
   a. a poor work history,
   b. a history of non-compliance in a mental health treatment program,

c. present psychiatric symptomatology,
d. the client's clinical diagnosis and prognosis, or
e. lack of recent participation in productive activity.

Any of these predictors may have a tendency to discourage VR counselors from regarding CMIs as having employment potential.

However, findings of a comprehensive study of predictors of CMI vocational capacities* suggest that:

- a client's psychiatric symptomatology is not a valid indicator of his/her capacity to work.

- a client's functioning in a non-vocational setting is not a valid indicator of his/her capacity to work.

- a client's psychiatric symptomatology is not a valid indicator of his/her functional skills.

Similarly, this same research of the literature identified several predictors that are more appropriate for this client group. They include:

- the best clinical predictors of future work performance are ratings of a person's work adjustment skills made in a workshop setting or sheltered job site (including psychosocial programs).

- the best demographic predictor of future work performance is the person's prior employment history.

- a significant predictor of future work performance is a person's ability to "get along" or function socially with others.

- the best paper and pencil test predictors of future vocational performance are tests that measure a person's ego-strength or self-confidence in the role of worker.

It is possible that counselors may be erecting a barrier to case acceptance of the CMI client by employing some of the traditional, intuitive predictors of success. The implications here are that the DRS counselor needs to be less concerned with the client's symptomatology and functioning in a non-vocational setting and more concerned about his/her display of cooperation in work adjustment program, social program, prior work performance and self-image in the role of a worker.

The decision to accept a case, to view the client as potentially employable, includes the counselor's identification of

*Wm Anthony and Mary Jansen. Predicting the Vocational Capacity of the Chronically Mentally Ill. American Psychologist May, 1984.

the services a client may need to become employed. The probability of acceptance increases with the counselor's experience in serving persons with that disability and with his/her comfort in intervening directly to resolve those needs or his/her knowledge of services available in the community to address those needs. Closely related to the preliminary assessment of needs and services is the counselor's awareness of the array of employment opportunities potentially available. If the CMI applicant is viewed strictly from the perspective of his/her potential for full-time competitive employment, there is a chance that the client will be considered unemployable. Conversely, the counselor who is comfortable with and feels justified in considering such nontraditional options as part-time and supported employment may be more liberal in his evaluation of employability. The establishment of the innovative programs discussed under "Initiatives and Expansions" will widen the number of service and outcome options available to the counselor and client.

2. Eligibility for VR Services

A second critical decision point which can result in the denial of services to any applicant is the determination of eligibility. Federal regulations define eligibility as follows:

> "Eligible" or "eligibility", when used in relation to an individual's qualification for vocational rehabilitation services, refers to a certification that:
> (i) An individual has a physical or mental disability which for that individual constitutes or results in a substantial handicap to employment, and
> (ii) Vocational rehabilitation services may reasonably be expected to benefit the individual in terms of employability.

For the CMI client, it is usually quite easy to establish and document the presence of a mental disability which constitutes a handicap to employment. The difficulty arises in assessing how reasonable it may be to expect the individual to benefit from services in terms of employability. Employability refers to a determination that vocational rehabilitation services are likely to enable an individual to enter or retain employment consistent with his capacities and abilities in the competitive labor market; the practice of a profession; self-employment; homemaking; farm or family work; sheltered employment; homebound employment; or other gainful work. Recently part-time and supported employment has been sanctioned as a successful placement. It is the issue of feasibility that generally is viewed as a barrier to the CMI client.

The counselor purchases or collects information in order to determine that the client has a disability which constitutes a handicap to employment and whether VR services may reasonably be expected to benefit the client in terms of employability. Reports

of psychiatric or psychological examinations, often related to previous hospitalizations (obtained at no cost) are generally the documents upon which these determinations are based. In some cases, these reports are descriptive of the client at his lowest ebb. The client, often for reasons intrinsic to his illness, may view his vocational potential pessimistically or unrealistically, casting further doubt upon the reasonable expectation of employability. The VR counselor is oriented toward moving clients from referral to employment. When employment seems unlikely, a determination of ineligibility is the probable outcome.

Persons with all disabilities, some meeting the definition of chronic mental illness, are declared eligible, receive VR services, and are successfully rehabilitated. A review of 1986 closure patterns in Virginia shows that in comparison with all other disability groups served, persons with CMI stand a relatively better chance of being declared eligible and a somewhat lower

chance of being successfully closed. See chart below:

CMI and Non-CMI Clients
Declared Eligible and Successfully
Closed by Relative Percent
1986

	CMIs	Non-CMIs
Declared Eligible	54%	49%
Successfully Closed	26%	30%

Twenty-one percent of all cases closed during 1986 were CMI.

3. Program Planning

The third critical point for the CMI client occurs once eligibility is determined.

Following eligibility determination, there is a diagnostic study to determine the nature and scope of services needed by the individual. This study consists of a comprehensive evaluation of pertinent medical, psychological, vocational, social, educational and other factors relating to the individual's handicap and rehabilitation needs. This diagnostic study includes an appraisal of the individual's personality, intelligence level, educational achievement, work experience, personal, vocational and social adjustment, employment opportunities and other pertinent data helpful in determining the nature and scope of services needed. The study also examines the individual's patterns of work behavior, ability to acquire occupational skill and capacity for successful job performance.

Considerations of the nature and scope of services needed are based on service availability. It is in this exercise of matching needs to services that the Individual Written Rehabilitation Program (IWRP) has its roots. It is also here that experience of the VR counselor in working with CMI clients is most critical.

The VR counselor traditionally thinks of service as falling into one of three categories: counseling and guidance, physical restoration or training. The introduction of new services with varying definitions and guidelines, i.e., psychosocial rehabilitation, transitional employment and supported employment, at times transcend such categorization. VR staff need to be trained and otherwise helped to understand and appreciate the application of new service modalities appropriate to CMI clients.

RECOMMENDATIONS

1. That DRS develop and deliver curricula for its staff stressing effective service delivery processes and outcomes for the CMI population.

2. That DRS disseminate information defining Transitional and Supported Employment Services and DRS's associated programmatic and fiscal responsibilities and capacities to cooperating agencies.

3. That DRS clearly articulate and disseminate the definitions for successful VR closures to DRS and CSB staff.

4. That the General Assembly consider additional funding and staff positions to increase the number of innovative vocational rehabilitation projects in CSB psychosocial rehabilitation programs. For each of the next two years, 30 new VR positions and $1,478,200 are needed to establish additional local vocationally oriented programs for the CMI population.

5. That the General Assembly consider increased support to insure adequate CSB Core Services, and for the establishment and provision of DRS and CSB operated Transitional and Supported Employment Services for the CMI population.

6. That as a means of increasing employer participation, the General Assembly explore the enactment of legislation creating a State Targeted Jobs Tax Credit to provide employers an incentive for hiring job ready chronically mentally ill individuals.

B. DRS-DMH/MR-CSB Interface Issues

The centralized VR system and the decentralized MH system are not structured in the same way, nor are their values, accountability measures, and outcomes similar. Differing professional terminologies, procedural rules and client goals sometime make it difficult for the two systems to work in concert. Training and previous experience may not have equipped the VR counselor to effectively deal with the CMI population. CSB staff, and often clients, are impatient in the early phases of the VR system which appears to delay services while a counselor collects diagnostic information for what may be an obvious disability. Both service delivery systems are wrestling with client

needs that were formerly met in the institutions. Further, resources to the community have not kept pace with the needs of the increased numbers of clients following the advent of deinstitutionalization. Forging new cooperative relationships and designing innovative client service strategies places additional demands upon limited budgets and staff resources needed to maintain existing service levels.

The following is a discussion of the barriers that have been identified as existing in the manner in which the respective agencies carry out their mission, communicate with each other and define their roles and responsibilities.

1. **Commitment and Changing Priorities**

Concerns regarding agency commitment to serving the CMI population were identified by the Statewide Interagency Collaborative Task Force. MH and VR workers expressed interest in the clarification of each agencies' long-term plans to continue this thrust toward the vocational rehabilitation of the CMI population. DRS staff were concerned about the relative resource deployment for the growing number of priority disability populations (e.g., traumatically brain injured). Similarly, CSB staff voiced their concerns that vocational rehabilitation is but one of many issues to which they must commit scarce resources.

A strong commitment on the part of DRS to serve the CMI, on the part of DMH/MR and CSBs to emphasize vocational rehabilitation and on the part of the General Assembly to fund appropriate services and positions will allow the CMI client the opportunity to maximize his potential.

2. **Time Limited vs Lifetime Commitment**

An issue was raised in examining overlapping service obligations of CSBs and DRS to the CMI client population. The time limited focus of DRS intervention appears to be in conflict with the CSBs lifetime commitment. Effective DRS case management is evaluated in part by the length of time a client remains in certain statuses. The DRS emphasis on timeliness of decision making and service delivery is viewed by MH/MR and CSBs as inconsistent with the long-term, often cyclical needs of the chronically mentally ill. This issue is being addressed through DRS's provision of intense, time-limited Transitional Employment Services to be followed by the provision of longer termed, less intense Supported Employment services provided for or purchased by the CSBs for the same individual. Additionally, DRS can provide serial, short-term interventions for an individual for an extended period of time by re-opening the case.

3. **Information Exchange**

In certain instances, VR counselors have difficulty in receiving client information to determine eligibility from the CSBs in timely fashion. This is often related to the CSBs interpretation of confidentiality requirements, despite having received a signed

release of information authorization from DRS on behalf of the individual client. Some CSBs feel that they cannot release information which has been supplied by a third party such as a State hospital. A delay or inability to obtain diagnostic information can impede the delivery of VR service to CMI clients.

4. Interagency Payments

An important procedural issue identified was the varying practices of CSBs regarding charging DRS for certain mental health services (e.g., psychological evaluations) for mutual clients. It appears that in certain instances, charging DRS is a way to attempt to increase revenues. In other cases, CSBs charge DRS only if they did not have the requested information on file and were required to pay a third party to provide the service. Uncertainty in regard to what diagnostic information must or can be purchased and reluctance of DRS to purchase service from another public service agency discourages cooperation and may delay services to clients.

5. Availability of MH Support Services

Successful VR outcomes on the part of mutual CMI clients depend upon the degree to which CSB core services are effectively in place in each locality. The provision of supportive counseling, membership in a psychosocial rehabilitation program, residential services, medication monitoring and case management must be maintained for positive vocational rehabilitation results. CSB staff and programs must be readily accessible for case consultation with VR counselors, management of psychiatric emergencies, and to assure coordination of other programs and services. A barrier to successful VR outcome for some CMI clients is the lack of sufficient local support services including housing, transportation and CSB core services.

6. Certification of DRS Service Vendors

The availability of appropriate vocational rehabilitation services for the CMI population varies widely across the Commonwealth. In many areas, few programs are in place to help this population develop vocational survival skills. There may be no vendor on whom the VR counselor can count for vocational training and related services. Generally, the more rural the area, the fewer service options exist for the CMI. Examples of vendors would include providers of work adjustment and other vocational training services. Limited service options restrict the scope of VR planning and reduce the likelihood of VR success. As an example, there are currently only three certified vendors of transitional employment services geared toward the chronically mental ill in the whole state.

7. Job Development, Placement and Follow-up

The goal of all vocational rehabilitation services is to facilitate the client's entry into and retention of gainful employment. As DRS continues to expand its services to the severely disabled

population, including the CMIs, new and better job development, placement and follow-up methodologies are demanded to fit these clients' needs. Together, DRS and CSBs must develop and set in place Transitional Employment Programs (TEP) and Supported Employment (SE) opportunities for the CMI. Transitional Employment is a time-limited, specific job-learning and stabilization experience usually purchased by DRS, which is followed by a period of Supported Employment follow-up provided by CSB staff. These vocational services will usually represent a continuum for each client.

Although every effort must be made to increase competitive placement opportunities, some proportion of this population shall need a range of other less traditionally "competitive," long-term work opportunities. Whether in enclave placements, client-employing businesses operated by CSBs or other transitional/supported employment placements, programs are needed which provide long-term paid work options for clients who are currently not candidates for competitive jobs.

Although non-traditional employment alternatives increase the placement opportunities, there remain a host of barriers, real or perceived, to successful placement of CMI clients. These barriers include, but may not be limited to: employer prejudice; client behaviors; recurring needs for treatment; and the expectation of long-term follow-up. A State supported incentive such as a State tax credit would predispose employers to hire job ready CMI.

8. **Cooperative Agreements**

Common elements to many of the barriers described above are derived from communication and role clarification difficulties. This perception of communication and role difficulties is supported by the responses provided by the CSBs to Commissioner Dickerson's letter of 7/24/86 soliciting CSB input, and the Statewide Interagency VR/MH Collaborative Task Force.

Program effectiveness and the sharing of resources are facilitated when cooperative agreements clearly demonstrate administrative commitment, succinctly identify attainable goals and objectives and specify respective responsibilities and resource commitments. Currently DRS has 33 cooperative agreements with local CSBs. Existing agreements both on the state level with DRS and DMH/MR, and on the local level with DRS and CSBs were originally executed when the CSBs were just beginning. The absence of updated cooperative agreements reflecting current treatment modalities contributes to gaps in programs, potential for duplication of effort, unmet client needs, and expectations that surpass resources.

RECOMMENDATIONS

1. That the CSBs with DRS develop programs for interagency staff training specific to serving the CMI population, including definitions of agency's responsibilities and interagency interaction.

2. That DRS develop and disseminate guidelines to all CSB staff for the effective screening and referral of CMI clients to DRS.

3. That DMH/MR, with DRS, develop a glossary of relevant mental health and vocational rehabilitation terms to be distributed to all involved staff in each system.

4. That DRS, DMH/MR and the CSBs define their respective long-term commitment to the vocational rehabilitation of the CMI population, and reflect this in appropriate planning and budget documents.

5. That the CSBs, with DRS, negotiate and/or update written agreements that include specific, brief descriptions of locally available CSB and DRS services, a description of each agency's resources and responsibilities for each coordinated service, and a list of measurable objectives.

6. That DRS with the CSBs institute pre-referral conferences and subsequent interagency staffings to provide effective feedback on mutual clients.

7. That DMH/MR review practices regarding the CSBs billing DRS for services to mutual clients and issue guidance to the CSBs regarding standard and equitable practices. Statewide, uniform practices are needed.

8. That DMH/MR encourage the CSBs to share confidential information (including third-party reports) to appropriate DRS staff on mutual clients. Statewide, uniform practices are needed.

9. That DRS with the CSBs form local, joint job marketing teams in order to assure an effective and coordinated approach to the employer community.

10. That DRS with the CSBs further explore the opportunities associated with potential DRS-CSB contractual relationships for providing appropriate employment services (e.g. Transitional and Supported Employment Services).

APPENDICES

A. Community Services Board Services

B. Responses from CSBs Describing Barriers to CMIs Accessing VR Services

C. DRS Statistics: Services to the Chronically Mentally Ill

D. Definitions: Transitional and Supported Employment

E. Case Histories

APPENDIX A

COMMUNITY SERVICES BOARD SERVICES

A. Core Services Definitions: Categories and Subcategories

1. Emergency Services: Unscheduled mental health, mental retardation or substance abuse services, available 24 hours per day and seven days per week, which provide crisis intervention, stabilization, and referral assistance over the telephone or face-to-face, if indicated, to individuals seeking such services for themselves or others. These emergency services may include walk-ins, home visits, jail interventions, and pre-admission screenings and other activities for the prevention of institutionalization or associated with the judicial commitment process and the certification process for admission to mental retardation facilities.

2. Inpatient Services: Mental health, mental retardation, or substance abuse services which are delivered on a 24 hour per day basis in a hospital or training center setting.

   a. Medical/Surgical - Acute medical treatment and/or surgical services provided in state facilities. Such services may include medical detoxification, orthopedics, oral surgery, urology, care for pneumonias, post-operative care, ophthalmology, ear, nose and throat, and other intensive medical services.

   b. Skilled Nursing - Nursing services for mentally disabled individuals in state facilities who require nursing as well as other care. Skilled nursing services are most often required by acutely ill or severely/profoundly mentally retarded individuals and those geriatric mentally ill who suffer from chronic physical illnesses and loss of mobility. These services are provided by professional nurses, licensed practical nurses and qualified paramedical personnel under the general direction and supervision of a physician.

   c. Intermediate Care Facility/Mentally Retarded - Services provided in state training centers for mentally retarded individuals who require active habilitative and training services, including respite and emergency care, but not the degree of care and treatment provided in a hospital or skilled nursing home.

   d. Intermediate Care Facility/Geriatric - Services provided in State geriatric facilities which may include psychiatric treatment, therapeutic programs, medical and personal care. These services are provided by an interdisciplinary team to patients 65 years of age and older.

   e. Acute/Intensive Psychiatric or Substance Abuse Services - Intensive short term psychiatric or substance abuse services provided in state mental health facilities or in local hospitals which are supported by CSBs through contractual arrangements. These services may include intensive stabilization, evaluation, chemotherapy, hospital-based medical detoxification, psychiatric and psychological services and other supportive therapies provided in a highly structured and supervised setting.

f. Extended Rehabilitation - Intermediate or long term treatment provided in a state facility for individuals with severe psychiatric impairments and emotional disturbances, multiple handicaps and severe/profound mental retardation. These services may include rehabilitation training, skills building and behavioral management for those who are beyond the crisis stabilization and acute treatment stages.

3. Outpatient and Case Management Services: Scheduled outpatient mental health, mental retardation, or substance abuse services generally provided in sessions of less than three hours, on an individual, group, or family basis, and usually in a clinic, similar facility, or other location. These services may include diagnosis and evaluation, counseling, psychotherapy, behavior management, psychological testing, ambulatory detoxification, chemotherapy, and methadone maintenance. Case management services assure identification and outreach to potential clients and continuity of care for mentally ill, mentally retarded, and substance abusing clients by assessing, planning with, linking, monitoring and advocating for clients in response to their changing needs.

4. Day Support Services: A planned program of mental health, mental retardation, or substance abuse treatment or training services generally provided in sessions of three or more hours to groups of clients in a non-residential setting.

a. Day Treatment/Partial Hospitalization - A treatment program that includes the major diagnostic, medical, psychiatric, psychosocial, and prevocational and educational treatment modalities designed for patients with serious mental disorders or substance abuse problems who require coordinated, intensive, comprehensive, and multidisciplinary treatment of pathological conditions not provided in an outpatient clinic setting.

b. Psychosocial Rehabilitation - Programs for mentally ill or substance abusing clients that provide certain basic opportunities and services - socialization, evaluation, training, vocational and educational opportunities, and advocacy - in the context of a supportive, environment in the community focusing on normalization. Psychosocial rehabilitation programs emphasize strengthening client abilities to deal with everyday life instead of focusing on the treatment of pathological conditions.

c. Transitional Employment (MH, MR, SA) or Extended Sheltered Employment or Work Activity (MR) - Programs which provide remunerative employment for mentally ill, mentally retarded, and substance abusing clients as a step in the rehabilitation process for those who cannot be readily absorbed in the competitive labor market. These may include sheltered employment programs, work enclaves, specialized vocational training programs, and supported placements in competitive work settings.

d. Adult Developmental/Activity Center/Developmental Day Programs For Adults - Programs providing instruction and training for mentally retarded/developmentally disabled adults (age eighteen or older) in order that they may progress toward independent functioning.

e. Education/Recreation - Programs designed to provide education, recreation, enrichment, and leisure activities. Programs can consist of daily, weekly, monthly activities which are carried out during the summer or throughout the year.

f. Innovative Day Support Arrangements - Day support alternatives which assist clients in locating day support settings and may provide program staff, follow along, or assistance to the clients. The focus may be on assistance to the client to maintain the independent day support arrangement. An example would be supported placements in competitive work settings. For Performance Contract and reporting purposes, the unit of service for this subcategory is a client service hour. Units of service may be shown here or in the Outpatient and Case Management category, depending on how the service is delivered (i.e. either as a separate activity or as part of a case management function, respectively).

5. Residential Services: Overnight care in conjunction with an intensive treatment or training program in a setting other than a hospital or training center; or overnight care in conjunction with supervised living and other supportive services.

a. Intensive Treatment or Intermediate Care Programs: Mental Health Residential Treatment Centers, such as adolescent treatment programs; Intermediate Care Facilities for the Mentally Retarded (ICF/MR), which deliver active habilitative and training services in a community setting; and Medical/Social Detoxification Programs, which are non-hospital based and normally last from 3-7 days.

b. Primary Care - Substance abuse rehabilitation services which normally last no more than four months, with three to four weeks as the expected length of stay.

c. Therapeutic Community - A substance abuse psychosocial therapeutic milieu with an expected stay exceeding four months.

d. Group Homes/Halfway Houses - Facilities operated or contracted by CSBs which provide residence and 24 hour supervision for individuals who may require training and assistance in basic daily living functions such as meal preparation, personal hygiene, transportation, recreation, laundry, and budgeting.

e. Supervised Apartments - Programs operated or contracted by CSBs which provide residence for individuals who have achieved a limited capacity for independent living but who also require varying degrees of assistance, support, supervision, and staff intervention in order to function in the community.

f. Domiciliary Care - Provision of food, shelter, and assistance in routine daily living but not training; this is primarily a long-term setting but the expected stay can be brief. This is a less intensive program than a group

home or supervised apartment; an example would be a licensed home for adults funded by a community services board.

g. Residential Respite/Emergency Shelter - Programs which provide beds in a variety of settings reserved for short term stays, usually several days to no more than several weeks. Residential respite may be used for crisis stabilization, emergency shelter, or public inebriate shelter.

h. Sponsored Placements - Programs which place clients in residential settings and provide substantial amounts of financial, programmatic, or service support. Examples include specialized foster care, family sponsor homes, and residential services contracts for specified individuals. The focus is on individual client residential placements rather than on organizational entities with structured staff support and set numbers of beds described in preceding subcategories.

i. Supported Living Arrangements - Innovative residential alternatives which assist clients in locating residential settings and may provide program staff, follow along, or assistance to the clients. The focus may be on assistance to the client to maintain the independent residential arrangement. Examples include homemaker services, public-private partnerships and non-CSB subsidized apartments. For Performance Contract and reporting purposes, the unit of service for this subcategory is a client service hour. Units of service may be shown here or in the Outpatient and Case Management category, depending on how the service is delivered (i.e. either as a separate activity or as part of a case management function, respectively). This subcategory also includes respite care provided in a home setting or a setting other than that described in subcategory 5.g. These respite care units of service (client service hours) should be shown in this subcategory.

6. Prevention and Early Intervention Services - Activities which seek to prevent, or ameliorate the effects of, mental illness, mental retardation, and substance abuse.

a. Prevention - This is a proactive process which involves interacting with people, communities, and systems to promote the strengths and potentials of those individuals currently not in need of treatment and which is aimed at substantially reducing the occurrence of mental illness, mental retardation, and alcohol and other drug dependency and abuse. Examples of prevention services and activities may include: consultation and education, community network development, public information, training and education, and program consultation and development.

b. Early Intervention - These activities are intended to improve functioning in those people identified as beginning to experience problems or circumstances which are likely to result in mental illness, mental retardation, or substance abuse. Examples of early intervention services may include: client-based case consultations, education groups, and parent-infant education or infant stimulation programs.

APPENDIX B

Responses from CSBs Describing Barriers to CMIs Accessing VR Services

MATRIX OF CSB FEEDBACK ON BARRIERS
(Legend of CSBs follows)

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
A. DRS Counselor Training on CMI Population		X		X			X	X			X				
chronicity															X
need for support															
reinforcement															
early intervention												X			
CSB Training Prevocational Services.															
B. DRS involvement with CMI clients and CSB staff in client areas; more involvement by DRS in counseling with CMI client, staff, and early intervention.			X				X		X	X	X			X	
C. Increased Employment Opportunities					X						X				
Job Development															
Training															
OJT, TE, SE							X							X	
Placement														X	
Follow-along/up services.	X														X
D. Special needs of Southwest (rural area).							X				X				
E. Transportation.							X					X	X	X	
F. DRS/CSB communication and interaction;	X	X	X	X	X	X			X					X	
mutual understanding of respective processes;	X		X							X					
referral;															
eligibility criteria;			X		X			X	X					X	
accessibility;			X	X											
timeliness;	X			X					X	X				X	
functional assessment;															
local resources for services;											X				
feedback;															
waiting periods;				X					X						
time limited services;			X				X								
DRS caseload size;															
and diversity of caseload.								X							
G. Programming opportunities by DRS; DRS/CSB for MH/MR clients; and program agreement.	X			X	X			X		X		X	X	X	
H. Pressure for successful closures.						X									

COMMONWEALTH of VIRGINIA

ALTAMONT DICKERSON, JR.
COMMISSIONER

Department of Rehabilitative Services

4901 FITZHUGH AVENUE POST OFFICE BOX 11045
RICHMOND, VIRGINIA 23230-1045

TDD (804) 257-0315

July 24, 1986

Mr. Philip F. Estes
Director for Administration
Loudoun County Community Services Board
County of Loudoun
108 Edwards Ferry Road, N.E.
Leesburg, Virginia 22075

(SAME LETTER SENT TO EVERYONE ON ATTACHED LIST

Dear Mr. Estes:

House Joint Resolution No. 159 requires the Department of Rehabilitative Services (DRS) to conduct a study to determine how its services to the Chronically Mentally Ill (CMI) might be improved. The Department is conducting this study in cooperation with the Department of Mental Health and Mental Retardation.

It has been determined that it would be useful to learn from the Community Services Boards' (CSB) staff what they perceive as barriers, issues and problems which are affecting DRS services to this population. More specifically, what can DRS do to help CMI persons access the vocational rehabilitation service system and receive more appropriate and timely services. An opportunity has been provided in the training program which was conducted by Matrix Research Institute for DRS and CSB staff to identify barriers to serve this population, however, you may have additional suggestions or ideas which would be useful.

Therefore, if you and your staff would give some thought to this issue and write to me by August 7, 1986, it would be greatly appreciated. I will assure you your input will be given careful consideration and, to the extent possible, utilized to improve our cooperative efforts.

If you have any questions, please contact Stephen Webster who is responsible for coordinating this study. He may be reached at (804) 257-0268.

Sincerely,

Altamont Dickerson, Jr.

Altamont Dickerson, Jr., Ed.D.

cc: Howard Cullum, Commissioner, MHMR
Stephen Webster, Management Analyst

COMMUNITY SERVICES BOARD RESPONSES

Legend

1. Arlington County, Virginia
   Community Services Board
   1801 North George Mason Drive
   Arlington, Virginia 22207

2. Central Virginia Community Services
   2235 Landover Place
   Lynchburg, Virginia 24501

3. Chesapeake Community Services Board
   1417 N. Battlefield Boulevard
   Suite 350
   Chesapeake, Virginia 23320

4. Chesterfield Community Services Board
   POB 92
   Chesterfield, Virginia 23832

5. Community Mental Health and
   Mental Retardation Services Board
   206 N. Washington Street, Suite #1
   Alexandria, Virginia 22314

6. County of Prince William
   9208 Centreville Road
   Manassas, Virginia

7. Eastern Shore Mental Health and
   Mental Retardation Services Board
   POB 453
   Nassawadox, Virginia 23413

8. Henrico Area Mental Health and
   Retardation Services Board
   10299 Woodman Road
   Glen Allen, Virginia 23060

9. Mental Health Services of the
   Roanoke Valley
   920 S. Jefferson Street, Suite 410
   Roanoke, Virginia 24016

10. Mt. Vernon Mental Health Center
    8119 Holland Road
    Alexandria, Virginia 22306

11. Planning District One
    Community Services Board
    Cloverleaf Square
    Big Stone Gap, Virginia 24219

12. Rappahannock Area Community
    Services Board
    601 Caroline Street
    Fredericksburg, Virginia 22401

13. Rockbridge Area Community
    Services Board
    315 Myers Street
    Lexington, Virginia 24450

14. Western Tidewater Community
    Services Board
    131 North Saratoga Street
    Suffolk, Virginia 23434

15. Rappahannock Rapidan Community
    Services Center
    401 South Main Street
    Culpeper, Virginia 22701

16. Northwestern Community Services
    POB 356
    200 N. Royal Avenue
    Front Royal, Virginia 22630

17. City of Virginia Beach
    Pembroke Six, Suite 218
    Virginia Beach, Virginia 23462-289

APPENDIX C

DRS Statistics: Services to the Chronically Mentally Ill

PROPORTION OF TOTAL BUDGET SPENT ON MENTALLY DISABLED DIRECT SERVICE COSTS

Of the entire population of open and closed cases processed during 1985, 45% of all cases were mentally disabled. There were an additional 3,000 carrying a secondary mental disability. Frequencies, percents and costs given below represent only clients with a primary mental disability.

Current Annual Direct Services Costs for this population were $7,465,977. This is equivalent to 50% of the total $15,001,238 tracked on all clients processed during this time.

Disability:	% Of Total Cases Served:	Direct Services Costs:	% Of Direct Costs:
Psychotic	9%	$1,371,109	9%
Neurotic	7%	1,425,993	10%
Alcohol Abuse	4%	539,628	4%
Drug Abuse	1%	169,351	1%
Other Mental	5%	950,570	6%
Learning Disabilities	3%	410,173	3%
Autism	0% (M.I.=30%)	2,222	0% (M.I.=3
Mental Retardation Mild	9%	1,279,375	9%
Mental Retardation Moderate	5%	1,082,612	7%
Mental Retardation Severe	1% (M.R.=15%)	234,943	2% (M.R.=18%)
	(45%)	($7,465,977)	(50%)

During the fiscal year ending June 30, 1985, $1,423,639, or 74% of the $1,926,257 spent for all clients served in rehabilitation facilities, were spent on the mentally disabled population.

Mentally Ill	663	34%	$564,456
Mentally Retarded	779	40%	859,183
	(1,442)	(74%)	($1,423,639)

In the whole VR program $73,296 was paid on the mentally disabled from the Trust Fund. This represents 11% of total TF expenditures of $646,890.

DEPARTMENT OF REHABILITATIVE SERVICES

CLOSURES TAKEN DURING FFY 1985

Disability	No. Closures/%Total	Success Rate	Previously Closed %	M Case Cost	M Time Opene
All Disabilities	12,591/100%	31%	17%	$552	10 mo.
Mentally Disabled	5,656/45%	34%	20%	463	10 mo.
Mentally Ill	2,714/22%	30%	22%	465	9 mo.
Mentally Retarded	1,813/14%	45%	18%	571	13 mo.
Substance Abuse	776/6%	24%	18%	261	7 mo.

During this period 45 percent of all DRS closures were mentally disabled, 49 percent of successful closures were from this population. Thirty-eight percent of recorded case service expenditures ($2,617,269) went to the mentally disabled.

30

As of March 31, 1986 there were open cases as such:

Mentally Ill	3,106
Mentally Retarded	2,531
Substance Abusers	812

Therefore, there were 6,449 open cases (41% of total DRS open cases) with mental disabilities.

CSW
June 9, 1986

PSYCHOTIC, NEUROTIC AND CHARACTER/PERSONALITY/BEHAVIOR DISORDERS CLOSED BY DRS BETWEEN OCT. 1, 1985 AND MARCH 31, 1986.

HJR 159 WORK GROUP

PSYCHOTIC:

Number closed = 600. 24% were successful closures. Of the cases receiving major VR services, 58% were Training cases, 30% were Counseling & Guidance, and 13% were Physical/Mental Restoration cases. Cases diagnosed as psychotic averaged 8.2 months case duration.

PSYCHONEUROTIC:

Number closed = 407. 25% were successful closures. Of all cases who received major VR services (status 14, 16 & 18), 61% were Training cases, 23% were given Counseloing & Guidance and 16% were Physical/ Mental Restoration cases. Cases in this category were involved with DRS an average of 8.3 months.

CHARACTER, PERSONALITY & BEHAVIOR DISORDERS:

Number closed = 334. 34% were successful closures. 50% of all closures were Training cases, 39% were Counseling & Guidance and 11% were Physical/Mental Restoration cases. Average case longevity was 7.6 months.

These cases represent 22% of total cases served/closed during this period.

ALL MENTALLY DISABLED:

Number closed = 2,733. 34% successful closures. 71% were Training cases, 21% were Counseling & Guidance and 16% were Physical/Mental Restoration. Average time of DRS intervention was 8.5 months.

ALL DISABILITY GROUPS SERVED:

Number closed= 6,128. 29% of all closures were successful. 63% were Training cases, 21% were Physical/Mental Restoration and 16% were Counseling & Guidance cases. Average case longevity was 8.5 months.

Between October, 1985 and June, 1986 DRS served 5,209 CMI clients. This represents 21 percent of all cases dealt with during that period. The CMIs experienced a 28 percent success rate. The success rate for all clients was 30 percent.

APPENDIX D

DEFINITIONS: TRANSITIONAL AND SUPPORTED EMPLOYMENT

RELATIONSHIP OF TRANSITIONAL EMPLOYMENT SERVICES TO SUPPORTED EMPLOYMENT

Virginia has experienced significant growth in recent years in the development of services designed to assist disabled workers enter and remain in the competitive labor market. Many local service programs have developed within the framework established by demonstration efforts of the Virginia Commonwealth University Rehabilitation Research and Training Center and Project Employability, which was initiated by VCU with DRS funding in 1978. There are now numerous local examples across the state of effective programs providing training and support services to disabled workers in competitive industry. The cooperative participation of Community Service Board, rehabilitation facilities, DRS and DMH/MR, and others has contributed substantially to the success achieved to date in making competitively oriented employment services available. The interest in expanding the availability of these services continues to grow, and these guidelines provide a basis for effective movement from localized demonstration efforts to a more statewide program.

The relationship between transitional employment services and supported employment builds on Virginia's successful experience with demonstration efforts. The relationship is based also on Virginia being one of ten states funded for five year projects by the Federal Rehabilitation Services Administration to develop a state system of supported employment. DRS' efforts to develop vendors of transitional employment services is a part of a systematic state effort to provide persons with severe disabilities the opportunity (a) to perform paid work in job sites where non-disabled persons are present as co-workers and (b) to receive support from trained staff at the job site. DRS' efforts in the areas of transitional employment services and a state system of supported employment are closely related and are built on the following definitions of terms:

> Transitional Employment Services: An intensive training and support service of a time limited nature provided at a regular, integrated job site by qualified support staff for the purpose of assisting severely disabled workers to obtain paid work and to stabilize in such employment. Service can involve job placement and job development assistance. It is primarily characterized by one-to-one post placement job site training and also an emphasis on developing a job environment supportive of integrating the disabled worker into the regular work force. For those clients who require long term job site assistance to maintain employment, the period of transitional support sponsored by DRS is followed by ongoing support sponsored by an agency other than DRS.
>
> Supported Employment: Paid work in a variety of integrated settings, particularly regular work sites, especially designed for severely handicapped individuals, irrespective of age or vocational potential (1) for whom competitive employment at or above minimum wage has not traditionally occurred and (2) who, because of the disability, need intensive ongoing post employment support to perform in a work setting (Federal Register, 6/15/85).

These definitions describe supported employment as an outcome and transitional employment services as a subset of the full range of services required for some clients to achieve and maintain supported employment. It

is possible that some clients sponsored by DRS for transitional employment services will not require ongoing support on the job site and will be independent in employment after a period of job site assistance. However, DRS will place a priority on developing and utilizing vendors of transitional employment services who have the staffing capability to provide ongoing support within a program of supported employment.

The Federal definition of supported employment referenced above has four key components which are: employment, integration, ongoing support, and severe disability. The components of the definition are summarized as follows:

1. Employment: Supported employment is paid employment that provides an individual regular opportunity to work, especially in competitive industry. The work schedule must offer the opportunity for the individual to be engaged in paid work at least 20 hours per week. A Federal Standard for a minimum wage or production level for supported employment does not exist.

2. Integration: Work is integrated when it provides the disabled worker with frequent daily social interactions among people without disabilities. The Federal standard for integration requires that an individual work in a place (a) where no more than eight people with disabilities work together and which is not immediately adjacent to a program serving persons with disabilities, and (b) where co-workers without disabilities are present in the work setting or immediate vicinity.

3. Ongoing Support: Supported employment exists only when ongoing support is provided. An individual should be considered to be receiving ongoing support when publicly funded services providing interventions directly related to sustaining employment are available to the disabled worker.

4. Severe Disability: Supported employment exists when the persons served require, because of their disability, intensive ongoing support to perform in a work setting. The Federal supported employment initiative is designed to serve persons who are or may be funded for ongoing services in day programs.

CONTENT OF TRANSITIONAL EMPLOYMENT SERVICES

Transitional employment services usually involve the use of a trained employment specialist, frequently called a job coach, to provide job site training and follow-along services to clients. The service is usually characterized by an intensive initial period of trainer/client and trainer/employer contact designed to develop client work and production behaviors acceptable to the employer while simultaneously creating a job environment supportive of integrating the disabled worker into the regular work force. Gradual reductions of assistance by the trainer take place as the client becomes more competent and stabilizes on the job. For those clients in supported employment, the DRS sponsored transitional employment service ends at the time when the client has demonstrated a competence acceptable to the employer (given a stable level of ongoing support). The amount of time sponsored by DRS will be based on individual client need. From that

point of job stabilization, job site follow-along is provided on an ongoing basis at the level required to maintain the disabled worker's employment.

The potential exists to provide transitional employment services within a variety of integrated community settings. These options include placement of individual workers in competitive jobs, group placements in regular work settings utilizing enclaves in industry or work crews, or establishing small specialized work settings which include integrating opportunities.

DRS will provide time-limited funding to make available job site support within a variety of supported employment options. As examples, a job coach could be assigned to an individual client who is entering employment in a competitive job; a job coach might also be assigned to a client entering an enclave or joining a mobile crew. In each example, the role of the job coach, within the transitional employment service purchased by DRS, is to assist the disabled worker to develop skills and behaviors which enable that individual to function acceptably within supported employment with a consistent level of ongoing support being provided after DRS case closure. Within an enclave or mobile crew, that ongoing support would be provided by the enclave or crew supervisor. Within a supported competitive jobs program, the support is provided on a periodic basis by a job coach coming to the job site (with increased support during crisis situations). The DRS role, therefore, is to assist persons with severe disabilities enter and stabilize in supported employment with the agreement that ongoing support will follow DRS case closure.

APPENDIX E

Case Histories

CASE HISTORIES

Fred is a 26 year old man who has been a member of Blue Ridge House since 1978.

Fred's psychiatric problems began at age 16 when he had a psychotic episode while attending a Job Corps Training Program. Since then he has had multiple hospitalizations with four admissions to the University of Virginia Hospital, and five admissions to Western State Hospital. These hospitalizations ranged from two weeks to several months. He has been diagnosed as having schizophrenia and has been taking psychotrophic medication since his first episode.

When Fred started attending Blue Ridge House, he had never worked. Although he was interested in working, he had a great deal of difficulty attending to tasks for more than a few minutes at a time. He started helping out on the maintenance unit and eventually was placed on a DRS sponsored Transitional Employment Placement as a dishwasher working 20 hours per week. After completing his second Transitional Employment Placement (TEP) he was placed in competitive employment as a dishwasher.

Fred has been working competitively in the same job for the last three years. He lives independently in a clubhouse apartment and still receives a number of supportive services from Blue Ridge House. These services include the Saturday recreation program, evening employment dinners and assistance with money management. Blue Ridge House staff have maintained an open line of communication with his employer and at times have had to arrange for Fred to take some time off when he has experienced a recurrence of symptoms.

Paul is a 43 year old man who moved to Charlottesville from New England in 1983.

Prior to moving, Paul had a ten year history of manic depressive illness which had resulted in six hospitalizations. He had been unemployed since 1982 following his last hospitalization. When he arrived in Charlottesville Paul was severely depressed even though he was receiving an adequate level four medication. He spent much of his time withdrawn in his room and had given up hope of employment.

Early in 1984, Paul was referred to Blue Ridge House by his out patient therapist. At first he was reluctant to start the program, but within a month he was actively participating in the clerical unit and had done some work for the Club House business. After about four months at Blue Ridge House Paul was referred to DRS for sponsorship on the Transitional Employment Program. He successfully completed a six month placement as a dishwasher at a local restaurant. Following the completion of the placement he was hired into a light dishwashing position at the same restaurant. He worked this job for about a year and then moved on to a job as a janitor at a conference center where he is currently working about 33 hours a week and earns $4.50 per hour.

Marty carries a diagnosis of paranoid schizophrina and experiences auditory hallucinations and suicidal ideations.

He currently is 21 years old and has been attending Beach House since approximately 17 years of age. Marty has been hospitalized many times since 17 years of age for symptoms and overdoses. He has a substance abuse problem and has been in several foster homes. While in E.S.H., he became familiar with Beach House and was encouraged to attend on weekly visits from the hospital. On several occasions he had to be awakened and prodded to make these visits. He was discharged as a ward of the state and experienced problems attending Beach House due to sleeping problems and lack of motivation. After several years at Beach House, Marty finally became motivated and worked a TEP at Things Unlimited. His transportation was funded by DRS and he maintained this job for approximately four months, until the contract ended. He then started a janitorial TEP at Domino's Pizza, again being funded with transportation by DRS. He held onto this position for five months and was very successful. He has recently left this job to work full time with McDonalds. This position is an OJT through DRS called "McJobs." DRS will be funding this OJT for approximately eight weeks and again will help provide transportation funds. Marty has purchased his own car during this period and is in the process of trying to graduate from Transitional Living Program to independent housing through Beach House. Marty has come a long way and provides a good role model for other members.

Elizabeth is a 28 year old woman that carries the diagnosis of manic depressive illness.

She also has a substance abuse problem and is seen in counseling. She has been a member of Beach House since February, 1982, and had very sporadic history of employment and attendance to Beach House. She requested training as a receptionist and was told by a DRS counselor that she would need to attend Beach House and volunteer in the clerical unit. After successfully doing this, she was granted an OJT through DRS as a credit clerk at Grand Furniture. Transportation was also funded. After three months Elizabeth quit this job, complaining of boredom. One year later she approached me wanting training. Again she was not participating in the clubhouse. A verbal agreement was made between us in that she attend and work in Beach House for approximately four months. Again, this motivated Elizabeth and she began secretarial administration training at Commonwealth College. DRS funded training and transportation. She attended this school for approximately one year. During this period she requested dental work for an injury to her mouth resulting from a gunshot wound. DRS funded complete restoration involving partial dentures, x-rays, cleaning, fillings, etc.

Elizabeth graduated with honors and was on the dean's list and honor rolls. She since has worked as a clerical assistant since November, 1985, until August 29, 1986. She will work for the month of September at Beach House as a clerical assistant through C.A.I. Again, Elizabeth has proven to be a successful DRS case.