

STEPPING UP: Innovations in career development for California Mental Health consumers

A Report on the Supported Employment and Supported Education Summit
Funded by the California Department of Mental Health
Convened and facilitated by the California Institute for Mental Health
Hosted by the California Department of Rehabilitation
Sacramento, California
May 2, 2010



California Department
of Mental Health



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PART I: SUMMARY AND STRATEGIES

As California counties and their providers work to implement the Mental Health Services Act (MHSA) vision of recovery-oriented services for individuals living with mental illness, employment of persons with mental disabilities has remained a challenge. Employment remains an important goal because work is a normalizing role for adults in our society and the source of much identity and self-esteem. Accordingly, many consumers¹ view employment as an essential part of their recovery. But while most consumers (71%) want to work, few (15%)² do as a result of significant existing employment barriers.

Work is a rewarding experience for mental health consumers and an important element of their recovery program. Beyond that, counties increasingly see employees with lived experience as valuable members of a diverse and culturally competent staff required to meet the needs of people with mental health disabilities.

Counties have identified educational attainment as a significant barrier in recruitment, retention, and advancement of people with lived experience in the behavioral health workforce. Nationwide, 86% of persons with psychiatric disabilities withdraw from college prior to obtaining degrees³. Only 9,000 persons with psychological disabilities are enrolled in California postsecondary schools, among 650,000 public mental health consumers (34% of whom have at least a high school education)⁴. In 2007, only 6 social work

students of 833 undergraduates with a psychological disability earned a degree, and 12 of 1,200 earned a master's degree in social work⁵.

Supported employment and supported education offer more mental health consumers the important opportunity to advance their recovery by participating in the mental health workforce and to broaden the diversity of experience among California's mental health professionals. As a result of participating in supported education programs, students experience improvements in work readiness, social skills, and self-esteem. Yet there is widespread recognition that supported education programs are not available to the extent necessary to bring significant numbers of consumers into the workforce, and continued budget challenges threaten existing programs.

Against this backdrop, the California Institute for Mental Health (CiMH), with funding provided by the California Department of Mental Health (DMH), organized an advisory committee of statewide leaders (see Appendix 1) in order to plan a one-day summit on supported education and supported employment.

Summary

On May 3, 2010, CiMH convened a summit of experts in supported employment and supported education with a broad array of local and statewide mental health leaders. The summit, hosted by the California Department of Rehabilitation (DOR), was focused on the topics of supported education and supported employment for consumers of county mental health services. The purpose of the meeting was to present supported education and supported employment models; to review the research on the outcomes of each; to identify challenges to widespread implementation of these practices in the California mental health system; and to explore potential linkages and collaborations between these practices.

- 1 At the state level, there is some variation in the terms used to describe individuals receiving mental health services, but California's Mental Health Services Act, in its Code of Regulations, presents a legal definition of consumer: an individual of any age who is receiving or has received mental health services.
- 2 Kessler, R. C., Foster, C. L., Saunders, W. B., & Stang, P. E. (1995). Social consequences of psychiatric disorders, I: Educational attainment. *The American Journal of Psychiatry*, 152(7), 1026–32.
- 3 Kessler, R. C., Foster, C. L., Saunders, W. B., & Stang, P. E. (1995). Social consequences of psychiatric disorders, I: Educational attainment. *The American Journal of Psychiatry*, 152(7), 1026–32.
- 4 This statement combines two data sources. The source of the 9,000 figure is the California Postsecondary Education Commission website: <http://www.cpec.ca.gov/On-LineData/OnLineData.asp>. The 650,000 figure was cited in the California Department of Mental Health Clients

and Service Information (CSI) data system in a report called *Client and Service Information (CSI) System*.

- 5 From California Postsecondary Education Commission website (interactive data): <http://www.cpec.ca.gov/On-LineData/OnLineData.asp>

Following introductions and an overview of the goals of the meeting, subject matter experts Tim Stringari, Rick DeGette and Dan Chandler gave in-depth presentations on practices of supported education and supported employment (particularly on Individual Placement and Support (IPS)), and summarized the research supporting their successful outcomes. An example of real-world implementation was presented by CAMINAR, a nonprofit organization that operates an innovative program conceived and funded by San Mateo County, combining both supported education and supported employment services together to achieve the maximum benefit for consumers.

The presentations summarized three key themes:

- 1) Successful and research-validated supported education models were developed 20 years ago, but they have not been widely implemented.
- 2) IPS is a specific approach to supported employment that has demonstrated very successful outcomes — on average, more than 60% of participants work. In controlled trials IPS is far more successful than other approaches in helping consumers find and keep jobs. However, it is not well-known in California and has not been widely implemented in the state.
- 3) San Mateo County's integration of supported education and supported employment through CAMINAR effectively substantiates how the approaches can be combined in a career pathway for people with disabilities.

Taken together, the presentations demonstrated strong evidence of the value of these models. Participants noted that despite their recognized potential for the California mental health system, they are not widely utilized. While the poor economic climate and resulting reduction of services makes the initiation of new programs problematic even with the Mental Health Services Act, the mission of education and employment for people with mental health disabilities has become an even more pressing mandate.

One participant noted, “The whole supported employment ground has changed under our feet, and we are not keeping pace with the most effective practices.” Another stated, “Now that we know what works, why

are we spending money on what doesn't work?” (Please see resource links in Appendix 3.)

With agreement about the value of the work and education and the goal of promoting them within county mental health systems, the group developed recommendations to advance the use of supported education, the IPS model of supported employment, and the integration of both as a career path for people with mental health disabilities. Participants identified a number of immediate next steps and strategies, and made recommendations to advance implementation. Many also made specific commitments to assist in the effort.

Strategies

A facilitated discussion followed the presentations on the programmatic models, their implementation, and the outcomes of supported education and supported employment. Participants agreed on the value of both models, particularly in the context of promoting recovery. The group discussed strategies and recommendations to move toward wider implementation of the models.

Recommendation: Develop a leadership group

Participants felt that the benefits and effectiveness of supported education and IPS supported employment are strongly supported by research. A statewide plan is needed to respond to and surmount the barriers that impede wider adoption. The plan must be multifaceted and requires a focal point for its effective implementation.

The major recommendation is the initiation of *a statewide leadership group that will develop and implement a plan to increase knowledge of supported education and employment practices as essential components of mental health services (or recovery services), and will identify solutions to the barriers to more extensive implementation of these programs. To be effective, this group should have ongoing staff support, a specified time frame, and requirements to report on its accomplishments.*

A funding source would need to be identified to support such a statewide group to enable it to organize a comprehensive drive toward expanding the availability of supported education and IPS supported employment throughout California.

This group will need to develop its own action plan, but the concerns, issues, and suggestions of summit participants, described below, can inform the process.

CONCERN 1: Knowledge about supported education and the IPS model of supported employment is insufficient.

STRATEGY: Spread the word.

Summit participants stated that one reason why supported education and the IPS model of supported employment haven't been more widely adopted is that public mental health leaders, policymakers, and systems are not well aware of the strong research support for these models. Another potential barrier to wider adoption is the lack of knowledge about the practical realities of the models, and resulting concerns and fears about the models.

The group identified a critical need to develop and disseminate information about the practices and their outcomes in order to increase knowledge of these practices among key leaders and policymakers, and to attain the "buy-in" of key agencies and organizations, including DMH, DOR, the California Mental Health Directors Association, the California Mental Health Planning Council, mental health advisory boards and commissions, consumers, family members, advocates, one-stop centers, workforce investment boards, employers, chambers of commerce, and other key stakeholders and partners.

ACTION STEPS for the leadership group to consider once funding sources and staffing resources are identified:

- Develop a short cohesive presentation on supported education and IPS supported employment.
- Make presentations to key organizations and leaders who have the power to implement these programs.
- Meet with consumer groups to share information about the practices, and solicit their opinions about

the relevancy of the practices in supporting career development for consumers. Concerns and issues that participants raised at the summit included:

- a) The role of peer support groups in both IPS supported employment and supported education
 - b) Pathologizing, confidentiality of personal mental health information, and loss of the distinction of the role of "student" or "employee" and instead experiencing the extension of the role of "patient"
 - c) The blurring of boundaries that occurs when a therapist is part of the IPS team
- Consider engaging consumers, family members, and advocates in a "speakers bureau" to present and advocate for these system changes.
 - Explore the possibility of joining the Dartmouth IPS Supported Employment Center, supported by Johnson & Johnson. At the least bring speakers from the project to address key stakeholders.
 - Consider the possibility of convening a smaller group in San Mateo County for a follow-up discussion to consider the value of pursuing participation in the Dartmouth Project.

CONCERN 2: Department of Rehabilitation (DOR) definition of supported employment differs from IPS model.

STRATEGY: Collaborate with the California DOR.

Participants observed slight differences between the state-regulated DOR definition of supported employment requirements and the IPS model. Collaborating with DOR to coordinate the IPS model with existing DOR services to meet the needs of people with mental health disabilities is an important next step. The current DOR-DMH Cooperative Program training offers a module on supported education that is available to individual counties upon request. The Dartmouth initiative has influenced modification of DOR policies in several states.

ACTION STEP for the leadership group to consider:

- Meet with DOR to explore integrating IPS with existing DOR programs.

CONCERN 3: More community college resources are needed for supportive education.

STRATEGY: Strengthen collaborations with community colleges.

Many mental health leaders indicated a need for curricula in community colleges to more effectively respond to the needs of people with psychiatric disabilities, including expansion of supported education programs like that under way at the College of San Mateo. Cancellation of required courses and threats of more cuts caused frustration, and participants noted that including people with psychiatric disabilities in a dialogue over course offerings and potential cuts is imperative. In particular, cuts to Disabled Students Programs and Services (DSPS) in the community college system were identified as a significant barrier. The California Foundation for Independent Living Center's (CFILC) 504 Campaign Take Action for Accommodations was mentioned as a potential advocacy resource.

ACTION STEPS for the leadership group to consider:

- Develop collaborative relationships with community colleges.
- Group leaders could meet with the California Community Colleges Chancellor's Office (CCCCO) about the supported education needs of people with psychiatric disabilities, building DMH's existing partnership with the CCCCCO.
- Consider how to find common ground with community college staff members on components of the Mental Health Services Act (MHSA) Regional Workforce, Education, and Training Collaboratives to better address the needs of people with psychiatric disabilities within the California Community Colleges.

- Collaborate with DOR in conceiving and enacting ways to support the needs of students with disabilities within the California Community College system.
- Create linkages and respond to the needs of students with psychiatric disabilities in the California State University and University of California systems.
- Develop relationships with leaders — both mental health and non-mental health folks who can contribute to provision of services to Transitional Age Youth (TAY); participants can include advocacy groups and professionals working with this population, to promote supported education as a key mental health service for TAY.

CONCERN 4: Financial resources are insufficient to fund IPS supported employment and supported education.

STRATEGY: Highlight overall cost effectiveness and develop strategies to transition funding.

Although supported education and supported employment are cost-effective practices, no dedicated funding streams have been established for them. As a result of the lack of funding allocations, these supported employment and supported education services compete with other services for existing funds. More information about the actual costs of implementing these services would be useful, as would information about how existing IPS supported employment and supported education programs could undergo a transition to these more effective models.

ACTION STEPS for the leadership group to consider:

- Develop more detailed cost and benefit information based on research and existing programs in California and other states.
- Clarify all the activities that can be billed under Medi-Cal rehabilitation services.
- Develop alternative ways in which a mental health system can convert existing programs and/or dollars to use for supported employment. Create strategies to enable the transition to the IPS model.

- Track changes to Medi-Cal waivers and State Plan amendments to ensure that supported education and the evidence-based model of IPS supported employment are included to the extent possible.
- Identify funding for a study of costs in a California high-fidelity IPS supported employment program.
- Develop an inventory of existing supported education and supported employment county and program activities.
- Develop strategies for managing the transition to the IPS model.

CONCERN 5: The potential benefit of integrated supported employment and supported education into one program has yet to be fully explored.

STRATEGY: Create a special focus on combined programs or collaborations as a more comprehensive and coordinated employment service.

Although combining supported education and supported employment holds great promise, it is rarely done.

ACTION STEPS for the leadership group to consider:

- Gather more information on programs doing both — e.g., UCLA.
- Develop better relationships with generic disability groups that share interests in education and vocational issues.
- County mental health agencies are developing a number of collaborations to meet the goals of the MHSA, affording opportunities for these entities to support a pilot program that combines supported education and supported employment programs. The California Mental Health Services Authority (CalMHSA), regional partnerships, and cross-systems including DMH, DOR and higher education institutions are some examples of relationships to explore.
- Research what potential funding might be available for supported education/supported employment programs through SAMHSA.

PART II: THE PRESENTATIONS

SUPPORTED EDUCATION: BASED ON KEY PRINCIPLES

Presented by Tim Stringari, MFT, education consultant, and Dan Chandler, PhD, research and evaluation consultant

Presenter Tim Stringari began by defining supported education as supports and services to assist people with psychiatric disabilities in gaining access to and succeeding in a postsecondary college or technical school. Initiated through community partnerships that pool resources and maximize opportunities, supported education (although classified in this report as a “model” for purposes of description) does not refer to just one fixed model, but to a range of configurations unique to local communities and their resources. The common denominator of these successful supported education partnerships, however, is the combination of key principles grounded in psychiatric rehabilitation and recovery:

- Normalization that cultivates a student identity equivalent to that of all other college students
- Self-determination
- Support, skills, and resources
- Hope and recovery
- System change that supports these principles

These common principles guide development of supported education programs and lead to individualized and programmatic supports and services that are over and above existing educational resources. Services and supports may be provided by a mental health agency, self-help or wellness group, clubhouse, mobile staff, or on-campus program. Eligibility usually requires acceptance of illness, enrollment in treatment, and a targeted mental health diagnosis.

The need for supported education was presented in both a social and statistical context: 86% of people with psychiatric disability withdraw from college prior to receiving a degree. Only 9,000 California postsecondary

students identify as having a mental health disability, in contrast to the 650,000 public mental health clients (34% of whom have at least a high school education). In the field of social work, a key mental health career, only 6 of 833 undergraduates and 12 of 1,200 master’s degree students who identified as having a mental health disability received degrees in 2007. Stigma and prejudice, fluctuation of student needs, lack of service coordination, the psychosocial effects of mental illness, and inadequate funding of Disabled Student Programs and Services were identified as key factors contributing to the low college participation rate of persons with mental health disabilities.

Successful supported education programs to improve these outcomes focus on three domains of intervention:

- **Access** — This component involves outreach and recruitment, orientation and “walk-through” visits, connection with an identified contact person, and assistance with registration and financial aid applications.
- **Retention** — This domain involves on-site support staff, transitional classes, faculty training, peer support, study labs, book funds, tutoring, crisis intervention, developing a support network through social activities, and a safe place to meet.
- **Outcomes** — Desirable results are achieved through services and plan coordination, career planning, assistance with degree application paperwork and transfer applications, and liaison with transfer sites or employers.

Research and evaluation consultant Dan Chandler followed with a discussion about the research and evidence basis for supported education programs. Chandler noted some limitations in the academic research, including the small number of studies (19) and methodologies that did not compare across different sites. Nevertheless, virtually all of the studies of supported education report positive results, and offer evidence that supported education is an “effective practice.”

Some key research findings are:

- 1) Supported education students tend to be older than other college students and have diagnoses

and histories typical of serious psychiatric disability; they are more likely to have some college experience or work experience.

- 2) Student retention and achievement in academics usually is comparable to that of other students. In a good study done in California, participants had a 3.1 grade point average
- 3) Students often work at the same time they go to school (up to 49% of students), and many studies have shown that two-thirds or more work after leaving school.
- 4) Success is not predicted by diagnosis. The factors found to predict success include having a partner, having a car, and involvement in productive activities at baseline.

Finally, experience of those administering and providing supported education programs in California leads to conclusions on outcomes that have been validated by formal research:

- 1) Accommodations and services required by students with psychiatric disabilities are similar or identical to those provided to students with other disabilities.
- 2) Students with psychiatric disabilities are neither prone to crisis nor disruptive to the campus environment.

Three additional findings, observed in practice but not yet validated by formal research, are:

- 3) As a result of participating in a supported education program, students experience

improvements in work readiness, social skills, and self-esteem.

- 4) The development of personal supportive relationships with peers and other students is a key factor in the success of students with psychiatric disabilities.
- 5) Most problems that arise are related to the stigma of mental illness or due to role confusion on the part of college staff.

Emphasized throughout the presentation on supported education was the value of the normalizing experience of developing a student identity:

“There are many positive outcomes for providing supported education services to people with psychiatric disabilities. A major one is that mental health consumers become college students. The role of the college student in our society is highly valued. The role of the mental health consumer is very devalued. With this change of role and identity, students realize they are not their illness, but a functioning, productive member of the community.”

— Karen Unger

“Schools, particularly community colleges, are hope-infused environments. Everybody there is in recovery from something.”

— Tim Stringari

SUPPORTED EMPLOYMENT AS AN EVIDENCE-BASED PRACTICE: THE IPS MODEL

Presented by Rick DeGette, MA, MFT, education consultant, and Dan Chandler, PhD, research and evaluation consultant

Presenter Rick DeGette began with a focus on the role and value of competitive employment in people’s lives, noting that work is the typical role for adults in our society as well as a primary source of identity and self-esteem. Attaining employment is viewed by many consumers as an essential hallmark of recovery — 71% of consumers of the public mental health system want to work, but only 15% of them do.

Competitive employment provides a sense of meaning and structure, helps to mitigate psychiatric symptoms, provides for better finances and quality of life, enhances social contacts and relationships, and significantly reduces treatment costs. Research on the Individual Placement and Support (IPS) model shows that working does not translate into higher rates of hospitalization or other functional problems. “If you think work is stressful, try unemployment.” Overall, working is helpful to psychiatric recovery as well as to people’s lives.

Supported employment was developed to respond to the need and desire of people with psychiatric disabili-

ties to join the workforce. Characterized by mainstream jobs in the community (as opposed to sheltered workshops or other “protected” employment), supported employment typically pays at least minimum wage, involves work settings that include non-disabled employees, provides a service agency for ongoing support, and was designed to serve people with the most serious disabilities.

The Individual Placement and Support (IPS) model is a next-generation approach to supported employment. It is based on principles of consumer choice, integration with treatment, competitive employment as the goal, personalized benefits planning, rapid start of work after the consumer expresses interest in working, continuous follow-along supports, and honoring consumer preferences.

Principles of IPS have been the subject of extensive research that has validated the model as an “evidence-based practice.”

DeGette outlined the characteristics of the IPS model, including a 25-point fidelity scale, a 20:1 caseload ratio for employment specialists, and a 30-day operating standard within which to link a client with an employment specialist. He also noted the primary differences between the IPS model and employment programs that are typically operating in the California public mental health system today.

Those differences are identified in the following table:

CURRENT PRACTICES IN CALIFORNIA	IPS MODEL
Emphasis on job “readiness”	Minimum focus on readiness in favor of quick entry to employment (employed in about 4 months)
Treatment and recovery preconditions	No preconditions, including substance abuse (although tailoring is necessary)
Jobs “owned” by agency or other protected setting	Competitive employment
Referral to separate agency for treatment	Integration with treatment team
Job coaching important	Job coaching less important, job development very important
“Choose, get and keep” approach with extensive pre-vocational career planning	Quick engagement of consumer’s interest, rapid entry, responsive to query “Do you want to work?”

The IPS model is affordable — costs average \$1,361 per person (with a caseload of 18:1 per employment specialist). In addition, a 2008 study found that per capita expenditures for the broad category of “supported employment” in the state-federal vocation rehabilitation system is less for clients with psychiatric disabilities.

Chandler followed with an overview of the research outcomes of studies of IPS. In the past 15 years the IPS model has been compared to many other vocational approaches, and is consistently superior to them.

Key findings:

1. There are 13 randomized controlled trials of supported employment. Results from nine recent studies show that IPS results in a range of successful employment from 25% to 80% (average 62%), with *outcomes 37% higher on average than the other employment models to which IPS was compared.*
2. One recent study at Thresholds in Chicago found that 75% of IPS participants achieved competitive work, compared to 37% in the vocational program that uses methods often considered best practices in California.
3. Long-term results in two studies found that between 47% and 71% of participants were working 10 years later.
4. Although Chandler expressed the need for more research on long-term savings in treatment costs, one study found that treatment of people who received IPS services over 10 years cost \$166,000 less in outpatient stays and institutional services over a 10-year period than treatment for clients who worked under other vocational approaches.
5. In the recent National Evidence-Based Practices Project, IPS also was found to be easier and quicker to implement to high fidelity than the other SAMHSA evidence-based practices being studied. High fidelity can be achieved within six months.
6. A Transition Age Youth IPS program at UCLA that also provided supported education helped 93% of participants either to return to college or to find work (31% of those participants worked, 36% went back to school, and 33% did both).

Chandler stated that IPS is not a panacea and that areas within it need further development. For example, job

tenure for IPS averages just 22 weeks for the first job, and only 43% of participants worked 20 or more hours per week. Employment also is limited by ubiquitous external conditions, including stigma and discrimination, low wages, SSI disincentives, and difficulties in qualification for housing and health insurance based on employment status. These system issues, however, affect employment pursuits for all people with mental health disabilities, and IPS produces the most effective outcomes of all models despite these barriers.

In conclusion, DeGette outlined the core elements of successful implementation of IPS programs at the program, county, and state levels:

- **Training** — Coaching should be intensive, ongoing and hands-on.
- **Leadership Commitment** — Administrative guidance is necessary at the program, agency, county, and state levels.
- **Attitudes** — Success cannot be achieved without staff members who believe in competitive employment and hold high opinions of the abilities, talents, and spirit of people with psychiatric disabilities.
- **Funding** — Examination of funding for current supportive employment activities is necessary in light of implementation of IPS model.
- **Independent Measurement of Fidelity** — Low-fidelity programs (for example, the Veterans Administration program) have been tried and are not effective. County and state agencies can assess fidelity.

SAMHSA has designated the IPS model of supported employment one of five evidence-based practices. An extensive research project, the National Evidence Based Practices Study, looked at implementations of the model in multiple states (excluding California). Follow-up implementation efforts are being led by Dartmouth Psychiatric Institute, where the IPS model was developed, with the support of Johnson & Johnson. Twelve states, including Oregon, already are participating in this new initiative. California is not yet involved formally with the national project, although Alameda County is informally collaborating with Dartmouth and Johnson & Johnson and is hoping to be formally included sometime in the near future.

SAN MATEO COUNTY'S CAMINAR BLENDED MODEL: JOBS + EDUCATION

***Presented by Michael Schocket, CPRP,
director, CAMINAR Jobs Plus, and Chris
Robinson, MA, director, CAMINAR
Supported Education***

CAMINAR program directors Michael Schocket and Chris Robinson gave the final presentation on their blended model that integrates supported employment and supported education to create a true career pathway. Throughout the past 40 years, CAMINAR has been serving people of all disabilities in San Mateo, California. CAMINAR's unique approach combining jobs and education grew out of the San Mateo County Department of Behavioral Health and Recovery Services' commitment to developing new approaches to serve its population and striving to maintain these innovative services even as funding pressures mount. The nonprofit CAMINAR provides intensive case management, 24-hour crisis and post-crisis residential homes, specialized youth services, and Wellness Recovery Action Plan (WRAP). Their philosophy is that jobs and education are essential and empowering mental health services.

"Jobs Plus" is the CAMINAR employment program, described as providing both supported employment and employment with supports. Established in 1993 with a grant from the California Department of Rehabilitation (DOR), Jobs Plus joined the DOR Co-Op in 2001. It is accredited by the Commission on Accreditation of Rehabilitation Facilities and recognized by DOR as one of California's "Best Practices for Supported Employment."

Jobs Plus provides vocational counseling, testing, assessment in a real-work setting, competitive employment referrals, supported education referrals, Social Security benefits counseling, job-seeking skills, job development and placement, job coaching, and promotion of natural supports. Clients are not screened out on the basis of job readiness, low functioning, substance use or other arbitrary criteria.

The program has found that the desire to work is the best predictor of employment outcomes. The program

is run with a person-centered approach and a seamless delivery system that provides supports for as long as a person is employed.

The Jobs Plus program developed over time, based on real-world experience. Many of the program's approaches echo IPS; in an independent comparison to the IPS Model Fidelity Scale, Jobs Plus scored 12 out of a possible 15. The key finding from the program's experience has been that diagnosis is not relevant to employment outcomes; 41% of successful participants had a diagnosis of schizophrenia or schizoaffective disorder.

The program's outcomes have yielded consistent success. Between 2006 and 2009, 63% of clients achieved job retention milestones. Average wages were \$9.23 per hour, and the average hours worked per week was 25.

CAMINAR stresses the importance of partnerships and collaborations in achieving success. Jobs Plus has essential partnerships with county Behavioral Health and Recovery Services, the Department of Rehabilitation Cooperative Program, clinicians, psychiatrists and case managers, and local employers.

CAMINAR's supported education program, called "Transition to College," pre-dates their Jobs Plus program and is equally grounded in collaboration with both the community and the local community college, the College of San Mateo. Transition to College operates on the philosophy of providing safe beginning or re-entry to college, individualized supports, belief in and acknowledgement of success, and enhancing quality of life.

Significantly, the program is embedded within the Disabled Students Program Services (DSPS) at the College of San Mateo to help ensure access to an equal education as required under Title II of the Americans with Disabilities Act, Section 504 of the Rehabilitation Act of 1973, and Section 11135 of the California Government Code. Transition to College program staff attend DSPS staff meetings, conduct joint student orientations and events, and by 2011 will share program space with DSPS on the campus.

In terms of best practices, the Transition to College program scored 256 out of 270 on the University of Kansas Supported Education Fidelity Scale. Key program elements include displaying materials throughout locations; orienting new staff to supported education;

ongoing attention in program staffing; developing educational assessments and plans for each student; providing one-on-one assistance for enrollment, financial aid and other student resources; and tracking and sharing outcomes every three months.

Program results for the 2007–2009 period show that staff members devoted 431 service hours performing services for 129 students. The program conducted 30 specialized classes and regular social activities; coordinates with San Mateo mental health programs; and administers a contract to furnish supported education services to transition-age youth. Statistical analysis showed that 51% of program graduates are employed after graduation — 69% of whom work in the mental health system.

The integration of CAMINAR's supported education and supported employment programs was based on

an early model for developing a true career pathway (Egnews, 1993). Program integration began with a strategic planning process in 2007, and has resulted in shared goals, improved service delivery, joint community presentations, staff cross-training and greater access to job readiness information and training. Next steps for the integrated programs include creating a vocational-educational case manager, developing social enterprise, and creating critical linkages with the California State University and University of California systems.

Program integration of supported education and supported employment programs, as CAMINAR has achieved, can be successful based on high compatibility of principles and approaches:

SUPPORTED EDUCATION	SUPPORTED EMPLOYMENT
Focus on mainstream education	Focus on competitive employment
Readiness based on consumer choice	Eligibility based on consumer choice
Rapid enrollment into classes	Rapid job search
Integration of mental health and supported education services	Integration of mental health and employment services
Attention to consumer preference in course and degree choice	Attention to consumer preference in the job search
Individualized education supports	Individualized job supports
Personalized academic counseling	Personalized benefits counseling
Implementation to a fidelity scale	Implementation to a fidelity scale

APPENDICES

Appendix 1: Supported Employment and Supported Education Advisory Committee Roster

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Appendix 2: Supported Employment and Supported Education Summit

May 3, 2010

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Debra Brasher	Inspired at Work
Daniel Chandler	Consultant
Chris Coppola	San Mateo County Behavioral Health and Recovery Services
Betty Dalquist	California Association of Social Rehabilitation Agencies
Rick DeGette	Alameda County Behavioral Health Services
Lucinda Dei Rossi	Inspired at Work
Kristin Dempsey	San Mateo County Behavioral Health and Recovery Services
Kathleen Derby	National Alliance on Mental Illness, California
Rita Downs	Calaveras County Behavioral Health
Lana Fraser	California Department of Rehabilitation
Cheryl Grimm	California Department of Rehabilitation, Mental Health Cooperative Programs
Lisa Harris	California Department of Rehabilitation, Mental Health Cooperative Programs
Brian Keefer	California Mental Health Planning Council
Sharon Kuehn	California Network of Mental Health Clients
Harriet Markell	California Council of Community Mental Health Agencies
Danny Marquez	Crossroads Employment Services
Joan Meisel	Consultant
Laurel Mildred	Consultant
Peg Morris	CAMINAR
Mason O'Neil	World Institute on Disability
Maria Ostheimer	California Network of Mental Health Clients
Chris Robinson	CAMINAR
Michael Schocket	CAMINAR
Adrienne Shilton	California Institute for Mental Health
Vicki Smith	California Institute for Mental Health
Tim Stringari	Educational Consultant
Narkesia Swanigan	California Mental Health Planning Council
Christa Thompson	Calaveras County Behavioral Health
Zoey Todd	Department of Mental Health
Toni Tullys	Alameda County Behavioral Health Care Services
Tina Wooten	Santa Barbara County Mental Health Department

Appendix 3: Links to Supported Education and Supported Employment Resources

CiMH has established a website that lists numerous resources related to each model. You'll find the list at: <http://www.cimh.org/Services/MHSA/Workforce-Education-Training/Past-Conference-Calls-and-Meetings.aspx>

The resources are listed under May 3, 2010, and include links to the following documents:

1. Meeting Agenda
2. Supported Education (Microsoft PowerPoint file)
3. Supported Employment as an Evidence Based Practice (PowerPoint file)
4. CAMINAR Program Overview (PowerPoint file)
5. Johnson & Johnson-Dartmouth Community Mental Health Program (Summary)
6. Guide to Dartmouth Website (Summary)
7. Coordination of IPS Supported Employment With State Rehabilitation Agencies (Summary)
8. Dartmouth IPS Supported Employment Fidelity Scale
9. Speaker Biographies
10. San Mateo County's Transition to College Supported Education Program (Tim Stringari, Report)
11. Supported Education Fidelity Scale (University of Kansas Scale)
12. Supported Education for Persons with Psychiatric Disabilities (Dan Chandler, Report)
13. Developing Supported Education Programs at California Universities: A Toolkit of Possibilities (Tim Stringari, Rick DeGette, Dan Chandler, Report)
14. Individual Placement and Support for Individuals with Recent-Onset Schizophrenia: Integrating Supported Education and Supported Employment (Psychiatric Rehabilitation Journal Article)
15. Implementing SAMHSA Evidence-Based Practice Toolkits — The Individual Placement and Support Model of Supported Employment (Dan Chandler, Report)

The California Institute for Mental Health is a non-profit public interest corporation established for the purpose of promoting excellence in mental health. CiMH is dedicated to a vision of “a community and mental health service system which provides recovery and full social integration for persons with psychiatric disabilities; sustains and supports families and children; and promotes mental health wellness.”

Based in Sacramento, CiMH has launched numerous public policy projects to inform and provide policy research and options to both policy makers and providers. CiMH also provides technical assistance, training services, and the Cathie Wright Technical Assistance Center under contract to the California State Department of Mental Health.



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