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Critical strategies for implementing supported employment

Deborah R. Becker[a,*], Stephen R. Baker[b], Linda Carlson[c], Laura Flint[d], Ruth Howell[e], Shannon Lindsay[f], Michael Moore[g], Steven Reeder[h] and Robert E. Drake[a]
[a]*Dartmouth Medical School. Dartmouth Psychiatric Research Center. Lebanon, NH, USA*
[b]*Department of Mental Health, 64 New York Ave. NE, 4th Floor, Washington, DC, 20002, USA*
[c]*University of Kansas, School of Social Welfare, Lawrence, KS, USA*
[d]*Vermont Department of Health, Division of Mental Health, Burlington, VT, USA*
[e]*CT Bureau of Rehabilitation Services, CT Department of Mental Health and Addiction Services, Hartford, CT, USA*
[f]*South Carolina Vocational Rehabilitation Department, West Columbia, SC, USA*
[g]*Oregon Department of Human Services, Addictions and Mental Health Division, Salem, OR, USA*
[h]*Maryland Department of Health and Mental Hygiene, Mental Hygiene Administration, Spring Grove Hospital Center, Catonsville, MD, USA*

Abstract. *Objective*: This paper provides a review of experiences by six states and the District of Columbia in disseminating an evidence-based practice, supported employment (SE). Each jurisdiction had unique strengths and barriers to overcome to effectively implement supported employment services for people with severe mental illness.
Methods: Using a case study approach seven jurisdictions report special aspects surrounding the implementation of evidence-based supported employment.
Results: Diverse strategies were used to augment implementation of supported employment services: a) Instituting state-level administrative procedures and reconfiguration of local staffing to enhance collaboration between mental health and vocational rehabilitation; b) Promoting SE services through the media, on-line training, and training by early adopters; c) Hiring benefits specialists; d) Teaching outcome-based supervision; and e) Building capacity for supported employment fidelity reviews.
Conclusions: Dissemination of evidenced-based supported employment was enhanced when six states and the District of Columbia addressed special aspects. Supported employment implementation included different pathways to good employment outcomes.

Keywords: Mental illness, supported employment, evidence-based practice, implementation

1. Introduction

Employment is an essential part of daily living for most non-elderly adults in the US. The majority of people with mental illness, however, remain unemployed [10]. Across all disability groups, people with psychiatric disabilities have been the fastest growing Social Security Administration beneficiary group [8].

Supported employment (SE) is widely recognized as the most effective approach to increase work opportunities for people with severe mental illness [3–5]. Yet access to SE services remains difficult if not impossible for most people with severe mental illness who want to work [1].

The Johnson & Johnson–Dartmouth Community Mental Health Program incorporates best practices in implementation of SE services. As part of the Johnson

*Address for correspondence: Deborah Becker, Dartmouth Psychiatric Research Center, 2 Whipple Place, Suite 202, Lebanon, NH 03766, USA. E-mail: Deborah.r.becker@dartmouth.edu.

& Johnson–Dartmouth Community Mental Health Program, participating states and the District of Columbia received small grants with the agreement to implement evidence-based SE through the partnership between public mental health and vocational rehabilitation statewide in a sustainable manner. The Dartmouth SE team provided training, site visits, and ongoing technical assistance. Each jurisdiction started with at least three sites. This program has been a highly successful private-public-academic collaboration since 2001 [6], which currently includes nine states and the District of Columbia.

In this article, project leaders from the original six states and the District of Columbia describe how they increased access to high-quality SE services in their areas. Each jurisdiction approached dissemination differently, but each also has achieved success. Throughout the article we refer to the state and local public mental health and vocational rehabilitation systems as Mental Health (MH) and Vocational Rehabilitation (VR) in order to reduce the possible confusion introduced by the many different names and acronyms that exist across the states and the District of Columbia. We use the terms Individual Placement and Support (IPS) and evidence-based supported employment interchangeably because they are the same.

2. System integration in Maryland

Maryland's systems collaboration for SE service delivery originated with a Memorandum of Understanding between MH and VR in 1987, which delineated the respective roles and responsibilities of both state agencies with respect to SE service delivery and established a precedent for an innovative blended financing structure. Since 2001 the Evidence-Based Practice in Supported Employment Initiative – a funded initiative sponsored by MH and VR – has crystallized both agencies' commitment to enhance the design and delivery of SE for individuals with severe mental illness and to improve competitive employment outcomes for shared clients. More recently, systems integration has been strengthened by administrative attention to MH and VR policies, regulations, and protocols related to SE, including a mandatory referral to VR for all individuals requesting SE services in the public mental health system (described below).

The effort to maximize funding for SE through leveraging funding streams and combining state and federal resources initially resulted in unintended bureaucratic complexities. SE providers, clients, and their family members and advocates had to negotiate three separate pathways to access to SE: VR, the local MH core service agency which serves as the gatekeeper and authorizing agent for SE, and the managed care entity, which authorizes adjunctive clinical services and supports according to medical necessity.

In 2005, MH and VR engaged national consultants and convened an interagency workgroup with joint stakeholders and constituencies to realign policy regulations and protocols related to SE consistent with evidence-based and recovery-oriented principles and practices. Recommendations from this workgroup led to an integrated web-based portal as a single point of entry for application, referral, and eligibility determination for clients and providers requesting SE services.

The managed care organization, under contract with MH, with funds appropriated by the Maryland Medicaid Infrastructure Grant, embedded critical ingredients of the VR referral and application into an existing web-based proprietary care management system. System prompts and data fields were revised and realigned to permit access by VR counselors to MH authorization requests and to client mental health treatment and psychiatric rehabilitation plans. Other policy changes allow VR counselors to presume eligible for VR services any individual who had been determined to be eligible for SE in MH.

The web-based system safeguards the confidentiality of information and grants limited access to VR counselor liaisons who, in turn, can verify online application, referral, and eligibility for SE services; access long-term funding; and review relevant MH rehabilitation and treatment records. The system reduces administrative burden and duplication of effort and expedites SE service delivery.

The SE Initiative in Maryland has enhanced the quality of SE services, honored the preferences of clients for competitive employment and for job diversity, increased competitive employment outcomes for SE clients, and increased case closure outcomes for VR counselors. VR outcome data for the most recently completed federal fiscal year demonstrate a nearly twofold advantage in closure outcomes for clients served by evidence-based SE programs versus those served by more traditional SE programs (65% vs. 35%),

3. Local service collaboration in South Carolina

In 2001, the South Carolina Departments of MH and VR entered into a partnership to create an IPS team lo-

cated at the Santee-Wateree Community Mental Health Center in Sumter, SC. This initial site served individuals who participate in the center's assertive community treatment program.

Because of the success of the pilot site, MH and VR provided funds along with other grant money to start additional IPS teams in other locations. South Carolina chose to use the term IPS to differentiate from traditional SE provided through VR. Initially, each IPS team in South Carolina added two employment specialist positions and a team leader position. MH funds paid for the team leader position and one of the employment specialist positions. VR funds paid for the other employment specialist position, which was designated to work 100% time with clients from the MH agency. The position title of the VR employment specialist subsequently was changed to employment coach to emphasize job duties specific to VR.

The employment coach from VR is part of the mental health treatment team and has hybrid duties. For example, some of the duties include opening cases with VR, facilitating the connection to VR, working specifically with the MH population, and conducting client-directed job searches, job development, skill building, job coaching, and guidance and counseling. In addition, the employment coach goes through the credentialing process to bill for MH services, e.g., helping clients manage symptoms on the job. Once someone has been stable on the job for at least 90 days and needs minimal intervention, the VR case is closed and the client can continue with IPS services from the MH agency. An extended service provider, who is often the IPS team leader or employment specialist, is identified to provide follow-up and monitoring.

The employment coach receives guidance and direction from the master's level VR counselor who is assigned to work with referrals from the MH agency. The VR counselor attends the weekly IPS team meeting and signs off on all functions of the employment coach. The employment coach, who is co-located at the MH agency with the IPS team, receives guidance from the IPS team leader.

The success of the IPS program led VR to adopt similar staffing patterns in its efforts to work with other disability populations that need intensive services (e.g., deaf and hard of hearing, brain injury, spinal cord injury, and youth transitioning from school to work). VR job coaches formerly provided SE to people with different disabilities, but they now have designated caseloads that are specific to a disability.

The state MH Director and VR Commissioner have modeled the flexibility, dedication, and commitment to the IPS program needed to sustain and expand the effort. Implementation of the IPS program required both agencies to alter their philosophies, approaches, and expectations. Staffing patterns were evaluated, new position descriptions were created, and the resources of both agencies were leveraged to allow the project to expand every year since 2001. IPS teams now exist in 10 of South Carolina's 17 community mental health centers. Seven of those sites have co-funded MH employment coaches/specialists. These IPS teams serve over 500 South Carolinians with serious mental illness every year and have seen a steady increase in the percentage of those individuals who have achieved successful competitive employment. In the 2006 state fiscal year (July 2005–June 2006), more than 50% of the individuals served in the IPS programs in South Carolina achieved competitive employment.

4. Shifting stepwise vocational services to SE in the District of Columbia

Prior to 2003, employment opportunities for individuals with mental illness in the District of Columbia were in the form of sheltered employment and set aside contracts. At the time, providers believed that there were limited job opportunities for individuals with limited job skills and high rates of co-occurring disorders living in an urban environment. Service providers attempted to create employment opportunities instead of assisting individuals in obtaining community-based employment. As a result in 2002, only 172 MH clients with mental illness in the District of Columbia were employed. The majority of placements did not meet the definition of competitive employment and MH had not partnered with VR in providing services.

In 2002, MH and VR agreed to collaborate in order to bring about enhanced employment opportunities for individuals with disabilities through a city-wide implementation of SE, which was determined to be the most efficient and measurable approach for providing employment services to individuals with mental illness based on their interests, preferences, and abilities. The Rehabilitation Research and Training Center for Workplace Supports at Virginia Commonwealth University assisted in the first phase of transformation from stepwise vocational services to SE. This first phase consisted of building consensus. Stakeholders from across the city attended a two-day conference and subsequent focus groups and community meetings. After these meetings, stakeholders completed a needs assessment.

The second phase of system reform, knowledge and skill development, began with state agency and service provider staff. Virginia Commonwealth University led the effort to develop a certificate-based on-line course on SE. State agency, service provider staff, and other stakeholders completed the course.

Phase three focused on financing and service delivery. MH selected three service providers through a request-for-proposals process to serve as demonstration sites to implement the IPS approach to SE. Extensive interagency collaboration between MH and VR on financing was implemented: (a) VR committed funds in a lump sum for the three providers, instead of the traditional fee-for-service payment process. These funds were blended with funds from MH and tied to outcome-based contracts. (b) Referral procedures between MH and VR were streamlined for quicker service delivery. (c) VR added counselors to their SE staff as part of their commitment to the initiative. (d) MH and VR began to share and compare outcome data. The process helps both agencies and service providers to identify and address service delivery issues and successes.

In 2004, three additional SE providers were added to the initiative, bringing the total number to six. Through the partnership between MH and VR, the number of clients receiving SE services has steadily increased. In 2004, 209 clients received services; in 2005, 367 received services; and for 2006, over 400 received services with an employment rate of 45 percent.

A foundation for providing SE services that meets the needs of individuals with mental illness has been established in the District of Columbia. Sustainability and capacity building, the final and most challenging aspects of systems change, remain as our final tasks. Currently MH is restructuring how it finances SE services to increase payments, which will allow providers to increase staff and thus increase their capacity to serve more clients. VR is also working with MH to further link VR funding to MH agencies to outcomes generated by SE providers. In addition, MH and VR are teaming up to increase outreach efforts to clients in the community who may not know about SE and how to access it and are planning to partner on grant submissions in order to develop SE services for transition-age youth.

The combination of building consensus, providing training and technical assistance, creating an interagency agreement, and realigning financing effected positive changes. The District of Columbia developed the interest and competence for shifting stepwise vocational services to SE through a demonstration that started with 3 pilot sites.

5. Media, SE training, employment outcomes in Oregon

Oregon's strong tradition of local control, reinforced by policies and structures of state and local government, makes it challenging to implement new interventions. Nevertheless, Oregon demonstrated that local and state partners can collaborate to implement evidence-based practices, such as supported employment. The Johnson & Johnson – Dartmouth Community Mental Health Program assisted MH and VR with three key components of SE implementation: media, training, and outcomes.

Oregon has a long tradition of open government and citizen participation, and the Oregon Department of Human Services has issued press releases that detail the impact of SE on clients' lives, in addition to new program development in partnership with the Johnson & Johnson–Dartmouth Community Mental Health Program. The news releases are sent to various media outlets, including Oregon radio stations and newspapers. State agencies have also provided interviews with public and private radio stations. The media attention has increased awareness among families, clients, and other providers in Oregon.

Options, a mental health provider and early adopter of SE in Oregon, assists the state with technical assistance and training. Through a state contract, Options provides training, facilitates local MH and VR partnerships, conducts fidelity visits, and collects outcomes. Options provides quarterly reports on local implementation and assists programs to improve fidelity and address funding issues.

MH collects quarterly data on employment for those enrolled in SE as part of the Johnson & Johnson – Dartmouth Community Mental Health Program. Quarterly reports are used to discuss local progress and implementation issues during statewide conference calls. The data also help the state meet outcome goals, such as those required for the federal Mental Health Block Grant. Oregon is now using data from the Department of Employment to examine statewide outcomes (employment rates, wages, and hours) for persons with serious mental illness on Medicaid. These data will help counties to recognize the problem of high unemployment for this critical population and the need for SE.

With the goal of disseminating SE services statewide, Oregon has used the media to educate local communities about the benefits of providing effective services that help people with mental illness return to

work. Tracking employment outcomes across all mental health providers and making them transparent has increased awareness and interest in SE. To increase the number of sites that implement SE, the state arranges training and technical assistance from an early SE adopter.

6. Benefits counseling in Vermont

Among several barriers to employment for individuals with mental illness, the most often cited is a fear of losing benefits, especially health care coverage [10, 15]. Individuals with mental illness who are beneficiaries of the Social Security Administration's disability programs frequently choose not to work or work under their potential because they have not received information about the new work incentives or have difficulty understanding the information [7]. In addition, the community mental health service providers who work with these individuals often do not have up-to-date information and typically feel just as confused about the disability programs and the new work incentives. To address this common barrier in Vermont, specialized benefits counselors and employment program staff collaborate to ensure that clients receive expert, individualized information and advice regarding their Social Security Administration benefits and the new work incentives. Comprehensive benefits counseling is an integral, supplemental service that enhances evidence-based SE services for individuals with a psychiatric disability in Vermont.

Vermont's Division of VR is responsible for the statewide implementation of specialized benefits counseling. These services began in 1999 with the receipt of a Social Security Administration grant, the Vermont Work Incentive Initiative. A trained benefits counselor in each of the state's VR offices provides benefits counseling to all individuals who receive benefits under the Social Security Disability Insurance program and/or the Supplemental Security Income program. The majority of clients who are referred to the benefits counselors are individuals with a mental illness [16]. The referrals are made by the community mental health center's employment specialists, VR Counselors, and MH case managers. As part of the implementation process, VR sponsors several statewide workshops in order to disseminate information regarding entitlements and new work incentives for clients, family members, and staff.

In the most successful employment programs in Vermont, the benefits specialist spends one or more days a week at the community mental health center. Such colocation allows for the best integration of this specialized service and helps to educate the other MH treatment staff regarding the new financial incentives connected to employment. Often the case manager joins the client during the initial benefits meeting, resulting in additional support for the client and accurate sharing of information for all stakeholders. In addition, the more successful employment programs in Vermont have coordinated all-staff training on benefits information and the new work incentives at their MH agency.

Yearly employment earnings for people with severe and persistent mental illness in Vermont have steadily risen over the last several years from approximately $5000 to $6000 per employed client between 2001 and 2006 [13]. Studies show that clients in Vermont have higher earnings after receiving benefits counseling [16, 17]. All 10 community mental health centers in Vermont provide SE services. These services have been enhanced with the comprehensive, supplemental service of individualized benefits counseling as shown by this increase. Some employment programs that successfully integrated benefits counseling with SE services found their employment outcomes almost doubled.

7. Outcome-based supervision in Kansas

Supervision is critical to the delivery of quality services in mental health. Kansas focuses on the role of supervisors using the client-centered management model of outcome-based supervision [14] as an organizational strategy for the implementation of evidence-based SE services. Kansas has had a long-standing relationship between the state's MH authority and the University of Kansas School of Social Welfare. The state contracts with the University to provide research, training, and consultation activities for community support programs. The partnership continued when the state began implementing evidence-based SE by providing the training and consultation for the project.

Outcome-based supervision places client outcomes as the centerpiece of the supervisor's purpose and performance [14]. Supervising by client outcomes involves measuring outcomes and using the measures to set goals to improve program performance. SE supervisors attend two days of training on this model of supervision. The training focuses on tools of outcome-based supervision such as using data, creating a rewards-based environment, field mentoring, giving feedback, and group supervision. Three of the client-outcome

supervision tools were particularly powerful in achieving high levels of SE fidelity and increasing client outcomes: information management, field mentoring, and group supervision.

Information management denotes the collection, measurement, and use of client outcome and implementation data. All of the Kansas sites use a simple data base to collect basic information on client outcomes. Outcomes include employment data such as place of employment, type of job, start and end dates. Outcome data are also collected nationally through the Johnson & Johnson–Dartmouth Community Mental Health Program, and the numbers and percentages of clients employed are reported quarterly. Data on the process of implementation such as the amount of time employment specialists spend in the community, number of job development contacts, and time between program entry and job search are also collected. This information is reviewed in leadership team meetings (the team created to oversee implementation efforts), employment team meetings, and state supervisors meetings. With this information, supervisors and implementation teams are able to set goals for employment outcomes, make decisions on areas to focus attention, and areas to reward and celebrate.

Field mentoring entails the supervisor accompanying his/her staff in the field for the purpose of improving skills by observing, modeling, and giving feedback on a particular skill. Field mentoring has been extremely successful in enhancing practitioner skills of job development. In one SE site, the supervisor spent at least 30 percent of her time in one month field mentoring on job development. During that time employment outcomes doubled.

Group supervision is a method of reviewing challenging client situations in order to develop new strategies or ideas. In contrast to team meetings that primarily discuss client situations for the purpose of sharing information or coordinating activities, group supervision specifies that the practitioner identify specifically what help they need from the team (e.g. ideas for engagement, strategies for job development, resources for transportation). Brainstorming enables the SE specialist to leave the meeting with a number of concrete ideas to try or share with the client.

To support the supervisors' role in the implementation of SE and use of outcome-based supervision, the Kansas University trainer/consultants hold quarterly supervisor forums. These meetings are centrally located in Kansas for the supervisors of the 12 programs involved in implementing SE. The forums are used to 1) share ideas on specific elements of the practice (e.g. what has been effective in improving job development skills), 2) reinforce the supervisor's role in successful implementation (e.g. using field mentoring to improve job development skills, setting expectations, and tracking fidelity elements), 3) review outcome and process data to set goals for improvement, and 4) celebrate successes and identify barriers to implementation.

Through an academic affiliated training team, SE supervisors are taught the skills of outcome-based supervision. In particular, information management, field mentoring, and group supervision have positively influenced SE implementation and employment outcomes in Kansas.

8. SE fidelity reviews in Connecticut

In 2002 the Connecticut Department of MH and Addiction Services began a statewide initiative to reframe recovery as the guiding principle and operational framework for the MH system of care. A set of recovery-oriented principles and practices were articulated to promote effective practices and clear outcome standards and to enable individuals to access and sustain meaningful roles in their communities. Evidence-based SE, which was identified as a key component of the initiative, offers persons with disabilities, their family members, and staff improved outcomes and tangible evidence of the positive impact of work on recovery.

The MH-operated mental health center that had served as a pilot site for the initial SE research [11], along with two additional mental health clinics, were selected for SE implementation through the Johnson & Johnson–Dartmouth grant. During the first years of the project these three centers received extensive training and technical assistance from the Dartmouth team. Conducting SE fidelity reviews using the Supported Employment Fidelity Scale [2] was part of the technical assistance from Dartmouth. As the three initial SE sites expanded to six, Connecticut recognized the need to build internal capacity to sustain the review process.

Connecticut therefore recruited the employment managers from the participating MH clinics, all of whom had received extensive training in SE, to form a statewide fidelity review team. Dartmouth trainers led the team in conducting joint fidelity reviews. With the local reviewers observing, they modeled effective ways to pose the questions and offered practical tips regarding the interview. At the end of each interview the team

debriefed with the trainers as a means of quality control, reviewing individual score sheets, discussing any major deviations, and reaching a consensus on the final scores. The local reviewers developed confidence that their scoring was consistent with the model. As a final step, the state MH employment coordinator wrote draft reports that incorporated the team's feedback, inviting the local and Dartmouth review team members to edit and/or add comments before the final version was sent to the agency. One side benefit of the team review process was that team members noted how much better they understood evidence-based SE services after observing other agencies up close and having the opportunity to engage in discussion on the nuances of evidence-based practice.

Connecticut's challenge is to continue to build the fidelity review team, incorporating new members as new mental health centers adopt SE. The goal is to maintain an interagency pool of trained and experienced staff who can conduct the reviews. The model offers our system flexibility and insures continuous expansion and quality control.

SE supervisors are a good resource for conducting the supported employment fidelity reviews. They understand the model and can learn the rating procedures for the scale. Furthermore, they benefit from seeing implementation nuances of other sites.

9. Discussion and conclusion

All states highlighted the benefit of being involved in the Johnson & Johnson–Dartmouth Community Mental Health Program, a national project to support statewide efforts to implement SE and of strengthening the partnership between MH and VR. Each state started implementing the evidence-based practice of SE in a small number of pilot sites and later was able to disseminate the practice more broadly. By December 2006, 58 sites across the 6 states and the District of Columbia were implementing SE. Some sites within these states implemented similar SE services earlier than the dissemination through the Johnson & Johnson – Dartmouth project and therefore are not included in these data.

In addition, individual states and the District of Columbia developed a range of innovative ways to promote SE. Maryland created administrative procedures to enhance the collaboration between MH and VR, and to increase access to services. South Carolina developed their own local staffing configuration in which VR assigned staff to the MH agency. The District of Columbia used an online training course to build staff skills to shift from a stepwise vocational approach to supported employment. Oregon expanded its training capacity by contracting with a MH agency and increased the demand for SE through education in the media and reporting employment outcomes statewide. Vermont addressed a huge barrier for people with psychiatric disabilities returning to work by co-locating VR benefits specialists in the MH agencies to improve access to comprehensive information about benefits and work incentives. Kansas used an academic affiliation to provide training on outcome-based supervision. Connecticut trained MH agency SE supervisors to develop a statewide capacity for conducting SE fidelity reviews.

The National Implementing Evidence-based Practices Project demonstrated that some practices are easier to implement than others [9] in press. In this national project, 53 community mental health centers in 8 states were selected to implement one of 5 evidence-based practices (supported employment, assertive community treatment, integrated dual diagnosis treatment, family psycho-education, and illness management and recovery) over a two-year period. Of these practices, SE was the easiest to implement, despite the lack of alignment with Medicaid and Social Security Administration regulations [1].

The growth in SE over the past 10 years reflects consonance with the recovery movement – both from the perspectives of clients who want to work and be independent and from the vantage of policy makers, MH professionals, and VR counselors who recognize that people with psychiatric disabilities have a much greater ability to work competitively than had been assumed [12]. Thus, the strategies described here can be seen as supplementing the natural drives toward recovery that motivate clients and organizations.

In summary, the initial 6 states and the District of Columbia in the Johnson & Johnson Community Mental Health Program implemented SE by following the critical components of the evidence-based practice. Implementation was buttressed by close coordination between mental health and vocational rehabilitation services. Across the jurisdictions different creative strategies were employed for effective dissemination: Improving administrative practices and staffing patterns between mental health and vocational rehabilitation services, promoting SE by using the media and different training technologies, improving access to benefits counseling, teaching outcome-based supervision, and building the capacity for SE fidelity reviews.

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