All Change Is Difficult, No Matter How Long You Put It Off

Making Mental Health Systems of Care "High Performers" in Employment Outcomes

JOE MARRONE, MARIANNE FARKAS, AND LARRY ABRAMSON

ABSTRACT

This article reviews the state-employment-system design work resulting in the creation of the High Performing States model of analysis. We apply this analysis to the work needed to improve mental health systems' ability to create structures, funding, and policies to promote employment. We derive recommendations from this analysis on how best to ensure these policies and improve funding mechanisms to obtain better employment outcomes for people experiencing serious mental illnesses. Policy changes cannot stand the test of time without concomitant leadership, training, advocacy, enthusiasm, and high expectations from all parties involved.

KEYWORDS

employment, policy, organizational change, funding, system sustainability

Although most people with serious psychiatric disabilities do not work, between 55 and 75% indicate a desire to do so (Drebing et al., 2004; Frounfelker, Wilkniss, Bond, Devitt, & Drake, 2011). The recognized vision of Recovery includes work as one important domain in which to develop a sense of purpose (e.g., Farkas 2007; Hogan, 2003). Effective interventions that support Recovery by facilitating employment of people with significant psychiatric disabilities have been identified over the past two decades. The most globally researched model is Individual Placement and Support (IPS), which repeatedly demonstrated outcomes in the range of 50 and 60% (Drake & Bond, 2014). Despite the existence of these

advances, the national employment rate of individuals with psychiatric disabilities declined from 23% in 2003 to 21.7% in 2015 (Substance Abuse and Mental Health Services Administration [SAMHSA], 2015). The number of people with serious psychiatric disabilities who attempt or get access to evidence-based supported employment through public mental health (MH) programs (2%) or are in the labor force, even if unemployed (45.1%), remains low (SAMHSA, 2015). There is general consensus that this SAMHSA National Outcome Measures data is flawed and inaccurate, yet it is the only statewide measure of employment across MH systems of care that exists. This fact, in and of itself, points to a major systemic issue, a lack of policy attention to employment that this article seeks to confront.

The widespread implementation of supported employment, and IPS in particular, has clearly encountered obstacles (i.e., lack of provider knowledge and skills, negative beliefs and attitudes among providers toward employment of individuals with psychiatric disabilities, and general population and system challenges; Mueser & McGurk, 2014). Federal or state policy sets the overall framework for implementation efforts and providing access to effective employment interventions for individuals with serious psychiatric disabilities. As Rapp et al (2005) noted:

> The bedrock of policy makers' efforts is the establishment and codification of [positive] client outcomes. They are the ends for which the service system is designed and for which consumers, providers and others work. Creating positive client outcomes' requires, at least in part, access to effective services and interventions. (p. 351)

Implementing any innovation within a complex entity is an involved process that must attend to a multiplicity of variables (e.g., Baker, Harris, & Battersby, 2014; Fixsen, Naoom, Blase, Friedman, & Wallace, 2005). One public policy challenge is to foster individual and institutional behavior and attitudes that support governmental priorities. The priority for people with psychiatric disabilities is enhanced access to employment interventions and ultimately to employment itself.

Three Broad Issues Impede Access and Development of Federal, State Policies

The Institute for Community Inclusion at the University of Massachusetts Boston has examined system change in the employment arena for

people with intellectual disabilities for many years (Hall, Butterworth, Winsor, Gilmore, & Metzel, 2007). This analytic guide for outlining key components of system change was developed through observational field work and technical assistance to multiple states in their efforts to improve employment outcomes for people with disabilities. There are many differences between serving this population and serving those with psychiatric disabilities; nevertheless, this process provides a framework for understanding critical elements that distinguished states that performed well in implementing employment services versus those that did not (Table 1). This framework highlights important general barriers to implementing employment interventions that impede access to effective employment services.

Policy considerations should be congruent with factors that enhance system performance at the administrative level, just as evidence-based supported employment has been validated to improve programmatic outcomes. The disparity between the knowledge base and successful implementation of and access to employment for people with psychiatric disabilities is related to the elements of this High Performing States Model (HPS) and the applications of the three broad critical issues: (a) a culture of systems that devalues the importance of employment; (b) an organizational climate that affects both provider and service recipient attitudes to employment; and (c) a lack of coherent structure, funding, and evaluation of services to effect employment outcomes.

Buttressing this ICI framework specific to the MH arena, the Rehabilitation Research and Training Center at Boston University's Center for Psychiatric Rehabilitation convened a State of the Science Meeting of researchers, individuals with psychiatric disabilities, service providers, administrators, and representatives of federal agencies to discuss the policy and the difficulties in accessing effective employment interventions (Boston University Center for Psychiatric Rehabilitation, 2013). These same three overarching issues were identified as major obstacles to access to employment interventions.

Lack of Focus on Employment as an Organizational or System Outcome

Druss (2014) suggests that the mounting evidence of positive employment outcomes when using IPS challenges society to rethink the purpose

Table 1. Elements of High Performing States (HPS)

Element	*Description*
Leadership	Local and state-level administrators are clearly identifiable as "champions" for employment.
Strategic goals and operating policy	State mission, goals, and operating policies emphasize employment as a preferred outcome.
Financing and contracting methods	Funding mechanisms and contracts with providers emphasize employment as the preferred outcome.
Training and technical assistance	There is a sustained and significant investment in employment-related training and technical assistance.
Interagency collaboration and partnership	Through interagency agreements and relationships, provider collaboration, and outreach to stakeholders, employment is shared as a common goal.
Services and service innovation	State agency works to create opportunities for providers, individuals, and families to make optimum use of resources available for employment; includes disseminating information related to creative strategies to support people in employment.
Performance measurement and data management	Comprehensive data systems are used as a strategic planning tool to further the state's goals of increasing employment.

of and payment for MH treatment for individuals with serious psychiatric disabilities. Traditionally, medical insurers have been reluctant to fund anything beyond services deemed "medically necessary." Thus, employment outcomes have only very recently been seen as within the mandate of mental health. Employment outcome data had not been recognized as an important variable in reporting the status of MH services. Federal agencies focusing on services for individuals with psychiatric disabilities (e.g., SAMHSA) did not, until very recently, include employment in their strategic initiatives.

Many states have endorsed the "Employment First" paradigm, which led to enacting policies and programs to support the employment of people with disabilities (Stewart, Shanbacker, Wills, Waits, & Simon,

2013). However, there is a lack of state policies that explicitly note that employment is an expected outcome of the state *mental health* system of care. As a result, most state MH policies neither incentivize employment as an outcome nor sanction entities within the system that do not achieve employment goals. The emphasis within MH on "person centeredness" and Recovery as a personal journey for individuals makes policy makers hesitant about how appropriate it is to expect employment services when consumers do not actively state an interest in such interventions. Most state policies do not identify long-term unemployment as a clinical health risk factor to be addressed within MH systems. This continues despite the substantial evidence showing an association between long-term unemployment and poor physical and mental health outcomes even in the absence of preexisting conditions. Such data exist from 1938 (Eisenberg & Lazarsfeld) through 2016 (Frasquilho et al.; Stam, Sieben, Verbakel, & de Graaf, 2016; Vaalavuo, 2016) with numerous epidemiological studies in the intervening years (Gathergood, 2013; Milner, LaMontagne, Aiken, Bentley, & Kavanagh, 2014; Montgomery, Cook, Bartley, & Wadsworth, 1999; Warr & Banks, 1987). MH systems of care have not treated long-term unemployment as a significant clinical risk factor requiring robust intervention. In terms of the HPS, these elements indicate a lack of *state leadership* willing to create *strategic goals* and *operating policies,* including using *data* and *financing mechanisms* to focus on achieving improved employment outcomes.

Attitudes to Employment

Culture influences the behavior of individuals within any system (Parmelli et al., 2011). The culture throughout the MH system of undervaluing employment outcomes has filtered down to the climate of individual organizations in which few providers, individuals in Recovery, or their family members' request employment services. Even while it is clear that many consumers would value employment help if offered, many still express fear and ambivalence. When the MH system does not support employment, providers contribute to the fear of going to work by focusing on deficits and chronicity, and using professional coercion (Rapp et al., 2005). Many MH professionals believe work to be too stressful (Marwaha, Balacvhandra, & Xie, 2008; Rinaldi et al., 2008) despite extensive evidence to the contrary (Kukla, Bond, & Xie, 2012). These factors undermine

individuals' hopes and dreams that work and recovery are possible, discouraging people from pursuing employment. Negative attitudes about work among family members, related to concerns about stress or the loss of benefits, also have similar deleterious effects (McFarlane, 2002; Mueser, 2006). Federal policies such as those of the Social Security Administration (SSA) were designed to serve workers with disabilities at the end of their working careers, rather than workers who need support to succeed in employment. A lack of awareness about possible programs (e.g., SSA work incentives and benefits planning) and the fear of losing benefits continues to be a strong deterrent to workforce participation (Livermore, Mamun, Schimmel, & Prenovitz, 2013) and therefore to participation in supported employment services.

Social and employment discrimination, and ambivalence about employment on the part of many providers, clinical staff, families, and individuals in Recovery themselves, all stem from negative attitudes toward employment as a viable and realistic goal (Rueda et al., 2012; Ucok, Gorwood, & Karadayi). State system culture lends weight to attitudes that create barriers to implementing innovations (Parmelli et al., 2011). When states fail to identify employment as a strategic outcome goal, this omission leaves many providers feeling that unemployment is not a health policy concern and that employment itself might be seen as a clinical stressor to be avoided. There is a lack of human resource development within state systems on specific skill sets needed by staff in order to get people employed, even when evidence-based supported employment is initiated. Program administrators are aware that most community MH systems are underfunded overall. Allocating more money to employment will take money away from other needed services. State fiscal policies are especially concerning if costs are capitated in a managed care environment. As the HPS suggests, inadequate *contracting* and *finance* policies can be an impediment to implementation of employment services because they limit resources and shape negative attitudes toward implementation.

Finally, there is little consumer and family grassroots advocacy within most states for policies focusing on employment. New York State is one exception through its We Can Work campaign (http://www.nyaprs.org/community-economic-development/toolkit/). In terms of the HPS framework, states whose *strategic goals, training and technical assistance, collaboration, and partnerships* coalesce around effective employment services

are more likely to hire and retain staff and to support stakeholder groups who believe in employment as a critical element of Recovery; thereby promoting access to supported employment services.

Lack of Coherent Organization, Funding, and Evaluation of Services Designed to Deliver Employment

Funding directives by the Centers for Medicare & Medicaid Services and the Rehabilitation Services Administration, as well as state-level MH funding decisions directly affect availability of employment services (Levit et al., 2013). While federal programs such as the Workforce Innovation and Opportunity Act of 2014 (P.L. 113–128) try to coordinate employment services for individuals across disabilities, their implementation has been problematic at the state level (Cook & Mueser, 2013). Another example of attempts to correct deficiencies in appropriate agency collaboration is reflected in the 2014 passage of the Protecting Access to Medicare Act (P.L. 113–93), one of whose provisions includes the Excellence in Mental Health Act. Within the latter there are mandated collaborators for Care Coordination, with the option of including a plethora of suggested "other community or regional services, supports and providers" (https://www.thenationalcouncil.org/topics/excellence-in-mental-health-act/). Yet neither vocational rehabilitation (VR) nor any Department of Labor entity appears on the list.

There is general consensus that overall employment outcomes for people with mental illness still remain unacceptably low compared to the general populace (Lowe, 2013; Marrone, Burns, & Taylor, 2014; Marrone, Smith, & Foley, 2008), but the evaluation of services has been hampered by lack of a clear definition of employment outcome. There is no common definition of employment (more precisely, "successful employment") used in many studies beyond the general "paid work in competitive integrated settings." No clear objective data exist to provide an overarching measure of employment outcomes. The various systems measuring employment for people with psychiatric disabilities do not use directly comparable data. Consequently, comparing implementation and general program efforts is problematic. There is no solid national information about the rate of employment achieved to provide benchmarks against which to measure progress in including individuals with psychiatric disabilities in the workforce.

Organizations with different mandates and cultures are often thrown together in the effort to develop supported employment services. For example, interagency collaboration between state MH and VR agencies is key to improving employment outcomes for people with psychiatric disabilities (Haines et al., 2012). While work is acknowledged as a key to Recovery within the MH community, the culture of VR has sometimes not been seen as welcoming. VR agencies' pace of eligibility and service provision is often seen as unduly delayed, especially for a population where quick job search is seen as one key to successful employment. Without the availability of MH system support to either bridge the time lapse or develop new methods of administration to counter this VR agency tendency, the issue of timing can impinge both on client motivation and the ability of the service provider to deliver fidelity-based employment interventions. Another issue that creates obstacles to interagency collaboration has to do with the fact that different states and different public systems within those states (e.g., VR and MH) measure the characteristics of the clients served very differently. Some MH agencies are only open for service to people with serious and persistent mental illness; others assist people with other diagnosable mental illnesses. VR agencies use functional criteria, not diagnostic labels; many restrict services to those with the most significant disabilities.

Latimer, Bush, Becker, Drake, and Bond (2004) estimated that service costs for providing evidence-based supported employment services for an individual in the first year of service is approximately $4,000 (2004) or approximately $5,400 in 2018 dollars. Salkever, in a 2010 report reviewing various cost studies of IPS, found most in a range of $4,000 to $5,000. Most saliently, he concluded that the extent to which these costs were additive to budgets depended on whether they replaced other traditional day services. A major barrier to the implementation of effective supported employment services is funding, since there is no single stream of funding available. Concerns abound about whether any Medicaid options can and/or should support employment as an outcome. Funding options that exist, like the 1915(i) Rehabilitation State Plan Option or 1115 Waiver, require complex financial decisions within state Medicaid parameters, including whether to use them to support employment. A state's willingness to use Medicaid options involves administrative decisions around revenue

neutrality, the statewide reach of such services, appropriate target groups, and whether waiting lists are allowed. These are often reflected in state policies about financing and contracting.

Mental health systems of care can overly rely on VR funding for employment. Even with good collaboration, the scale of VR resources is dwarfed by the numbers of people needing employment within those systems. In addition, providers struggle with the need to "hand off" a client with whom they have established a trusting but fragile relationship.

Some of the policy areas involving funding models, policy changes, Social Security incentives, and Medicaid issues that would make the ability to access employment services easier are extremely complex and require incremental changes to be brought about by coalitions of like-minded disability advocates with a long-term change emphasis. To illustrate how these broad policy and system design components identified in the preceding pages can work at "ground level," we present two state case studies. Both are heavily invested in creating a broad-based array of evidence-based supported employment services as encompassed in the IPS model, and both have been longstanding members of the Dartmouth–Johnson & Johnson collaborative. This collaborative was a learning community of states interested in IPS development. Although the Johnson & Johnson sponsorship has since ended, the learning community continues under the auspices of Westat, where the IPS research has moved from Dartmouth. In addition, each of these states models excellent VR-MH system collaboration and joint policy development as well as focusing on key areas enumerated in Table 1. One difference in these partnership activities is that in Maryland, the VR agency supported an initial MH system effort, whereas in Oregon the VR agency was instrumental in encouraging the MH agency to begin delivering evidence-based supported employment as a system policy priority.

The two state case studies are presented as exemplars of the creation of many policy and system changes focusing primarily on IPS implementation. We sought to include them as both models and cautionary tales. The caution is that while recognizing efforts the programs made that did have impact, these did not create "breakthrough" outcomes at the state level as SAMHSA and other system data indicate. Thus, the Oregon and Maryland programs have made progress at the site-programmatic level, which has of-

ten been the focus as states begin to emphasize evidence-based employment. This somewhat limited focus in the field has improved results for some affected programs. Nonetheless, it has not led to the breakthrough systemic improvements the authors recommend because they do not go far enough in addressing employment overall through some of the macro policy elements noted, not just IPS program development.

Case Study 1: Maryland's System Change and Its Impact on Cornerstone Montgomery

The Maryland Health and Mental Hygiene Administration (MHA) has a stated goal of increasing the number of clients receiving evidence-based supported employment by 10% each year. Maryland systematically improved regulations, funding, administrative efficiencies, and interagency partnerships, thus creating additional incentives for service providers to expand capacity. Initial piloting and impetus for many of these changes emanated from Cornerstone Montgomery (formerly St. Luke's House), which is a community mental health provider offering a variety of community-based MH services for adults and youth. Over a 10-year period, Cornerstone grew its employment program from 100 to 600 clients per year by doing the following:

- A single point of entry to supported employment was established across MHA and VR.
- Mental health SE providers received automatic approval as VR vendors.
- Eligibility of MHA system clients for VR was presumed at referral with guest access to MHA data. This change allowed for easy access for clients and elimination of lengthy VR assessments.
- Braided funding streams were created with MHA and VR.
- Shared definitions, service documentation, data, incentives for fidelity, and outcomes were created within both systems.
- VR/MHA generated a Supported Employment cost study and adjusted rates based on that analysis. MHA established a statewide Employment Network for receiving SSA Ticket to Work payments with the assistance of the Institute for Community Inclusion.

Cornerstone Montgomery can serve as a prime example for state and federal policy makers invested in improving employment success for consumers within public mental health. In FY 2014 Cornerstone Montgomery served 1,005 clients in its psychiatric rehabilitation programs; 604 of those received IPS employment services. Of these, 65% worked during the year.

The high penetration rate of Cornerstone impacts service delivery at multiple levels:

1. Hiring and training practices for all staff include IPS fidelity measures.
2. Program consumers see peers working and believe they can work.
3. Program staff believes that consumers can work in competitive jobs.
4. Employers look to the agency as a source for qualified job applicants.
5. The Recovery process is enhanced by workplace integration.
6. Department-wide employment goals are in place for even nonvocational programs.

System changes that occurred in Maryland were critical to the growth and the quality of EB SE. Consistent leadership with a shared vision was just as important. Consumer groups generally put employment at the top of their list of what they wanted.

Case Study 2: The Oregon Experience

Statewide implementation of IPS is the outcome of decades of collaboration between community MH providers and local Oregon VR branch offices; the ability to access funding outside traditional financing methods; and the belief that individuals experiencing psychiatric illness, including youth, can work. Oregon's passage of a bill requiring 75% of state general funds invested in MH be expended on evidence-based services over a several-year period also stimulated this work. Evidence-based supported employment (specifically IPS) was introduced in Oregon at a statewide MH conference in the early 2000s. Then, two separate programs (one urban, one rural) each secured Community Action grants to explore IPS implementation. One of these sites combined with a related federal grant to build consensus, plan, train, and eventually leverage funding from the state

MH authority. A Dartmouth–Johnson & Johnson grant followed and supported three sites statewide. The number of sites had grown to seven prior to the award of a Medicaid Infrastructure Grant (MIG) in 2005. Increasing the availability of supported employment for individuals with mental illness as well as intellectual and developmental disabilities was identified as a priority under the state MIG. There are now IPS-supported employment sites all across the state.

Collaboration was critical to the successful implementation of IPS. It grew from decades of work at the community level between local MH programs and VR branch offices. Joint training in the early 1980s for the implementation of supported employment training set the foundation for the partnership. A key element was a discussion of the cultural differences between the two programs. This event also created the space where the partners could plan how they would work together. A second important facet of the systemic shifts that occurred was funding from the community action grants and Dartmouth–Johnson & Johnson. Investments by VR, using the "services to groups" modality under VR funding regulations, aided in building the capacity in local community MH programs to provide employment services. The third facet was a shared belief that the target population could work. Also, Oregon was fortunate in that the tenure of the state and local partners' key administrative personnel has been stable. Perhaps the most important outcome of this partnership has been the creation of the Oregon Center for Excellence for Supported Employment, which provides technical assistance, training, quality assurance, and research to VR and MH programs. Funding for the Center came initially from the VR-managed state MIG and subsequently directly from the state mental health entity.

Finally, another policy innovation that has recently sprung from this aggressive approach to EB SE implementation is with the development of the Coordinated Care Organizations (CCOs) in Oregon as part of the inauguration of the Patient Protection and Affordable Care Act (ACA) within the state. Oregon has a strong emphasis on integrated physical and behavioral health care throughout its medical care system, which was reinforced as part of the preparations for the ACA. So supported employment for people with psychiatric disabilities is now considered one of the core interventions within the CCO panoply of services.

Discussion and Implications for Practice

Extant policy and regulatory formulations and funding mechanisms must be improved to expand access to evidence-based supported employment for people experiencing serious mental illnesses and ultimately to obtain better employment outcomes. Policy changes cannot stand the test of time without concomitant leadership, training, advocacy, enthusiasm, and high expectations from all parties involved—staff, clients, advocates, and governmental entities. Success also depends on providers who understand the importance of listening to the person and attending to them in a respectful and facilitative way.

Some strategies have not proven as effective as intuitively seemed. Funding, for example, has been increased for employment in some areas (Marrone, Burns, & Taylor, 2014) without measurably improving the overall employment rate for clients of MH systems in the state. Extensive training and knowledge dissemination has occurred (Becker et al., 2011; Drake, Becker, Goldman, & Martinez, 2006) without necessarily resulting in increased overall employment.

Some ways to move toward more robust employment outcomes for clients of public MH systems should include the following:

1. Prioritizing employment outcomes concurrently with housing within Recovery-oriented MH systems of care both by federal focus (e.g., in block grant funding) and at state levels (e.g., by mandating employment services as part of a comprehensive MH service program).
2. State policies should identify the treatment of long-term unemployment as a significant clinical risk factor requiring robust intervention by MH agencies.
3. Evidence-based supported employment for individuals with psychiatric disabilities should be included in state Medicaid plans (e.g., through the 1915[i] State Plan option or the 1115 Waiver) and in Medicaid plans offered to the Medicaid expansion population.
4. State fiscal and regulatory policies should experiment with incentivizing schemes for client outcomes rather than service activity alone.

5. VR should maximize its use of its existing regulations to incorporate policies that promote greater access to supported employment services. These might include: more common use of immediate presumptive eligibility for people on SSI or SSDI, allowing clients to develop an employment plan with their employment provider in the MH system and submit for approval rather than creating with the VR counselor, eliminating lengthy mandatory assessments prior to service approval, setting no minimum time standards for abstinence from substance use in lieu of examining commitment to sobriety and readiness to change indicators, and providing a flexible method of measuring the 90-day competitive employment minimum to focus on continued engagement and employment in the labor market rather than just job stability, per se.

Further research and exploration is needed to address questions in key policy and system design areas, more definitive answers to which could support the sort of overall employment impact for people with mental illness that has so far proven elusive:

1. Does good statewide evidence-based program development or emphasis on Recovery have an impact on overall employment outcomes and economic engagement for VR or MH systems of care? If not, why not?
2. Is improving employment services program by program the best way to change systems to produce better employment outcomes, assuming a modeling approach for an overall system of care impact? If not, what strategies might work better?
3. Are there clients within public MH systems nationwide who could or should be supported in different ways from those researched currently to reach employment success? While access to evidence-based supported employment is critical, it may well be that the numbers of people in need of employment services dwarf even the potential availability of the IPS model plus the possibility of enhanced funding through Medicaid or service expansion. Ongoing research to identify and evaluate a range of policy approaches could lead to enhancement of overall national employment outcomes.

4. Why have various change efforts and policy developments not produced better overall outcomes in the systems they are trying to affect the most—public VR and state/local MH authorities?
5. What are feasible tools for progress monitoring that are cost effective, accurate, and have some legitimacy? Is there a better way to use administrative data?
6. If we are looking to improve system outcomes through evidence-based practice, can we use tools already in place, or do we need to create tools to monitor system change? Is the system prepared to apply evidence-based measures for all innovations?

Discovering better answers to these questions will improve our ability to assist people more potently and consistently in employment, career, and life success in the future. Moving Recovery-oriented MH systems of care much closer to "high performance" than currently exists remains a goal both crucial and remarkably difficult to reach and sustain.

JOE MARRONE, MEd, Senior Manager for Public Policy, Institute for Community Inclusion, UMASS Boston

MARIANNE FARKAS, ScD, Director of Training, Dissemination and Technical Assistance, Center for Psychiatric Rehabilitation, Boston University

LARRY ABRAMSON, BS, Abramson Consulting, Silver Spring, MD

COMPLIANCE WITH ETHICAL STANDARDS

Each of the authors declares that he or she has no conflict of interest in regard to this submission.

ETHICAL APPROVAL

This article does not contain any studies with human participants performed by any of the authors.

REFERENCES

Baker, W., Harris, M., & Battersby, M. (2014). Health workers' views of a program to facilitate physical health care in mental health settings: Implications for implementation and training. *Australasian Psychiatry, 22*(6), 560–563; doi:10.1177/1039856214546675

Becker, D. R., Drake, R. E., Bond, G., Nawaz, S., Hazlett, W., & Martinez, R. (2011). Best practices: A national mental health learning collaborative on supported employment. *Psychiatric Services, 62*(7), 704–706. doi:10.1176/ps.62.7.pss6207_0704

Boston University Center for Psychiatric Rehabilitation. (2013, September 25–26). *Proceedings of the State of the Science Meeting on Policy and Employment for Individuals With Psychiatric Disabilities.* Boston, MA: Boston University.

Cook, J. A., & Mueser, K. T. (2013). Economic security: An essential component of recovery. *Psychiatric Rehabilitation Journal, 36*(1), 1–3. doi:10.1037/h0094739

Drake, R. E., Becker, D. R., Goldman, H., & Martinez, R. (2006). Best practices: The Johnson & Johnson–Dartmouth Community Mental Health Program: Disseminating evidence-based practice. *Psychiatric Services, 57*(3), 302–305. doi:10.1176/appi.ps.57.3.302

Drake, R. E., & Bond, G. R. (2014). Introduction to the Special Issue on Individual Placement and Support. *Psychiatric Rehabilitation Journal, 37*(2), 76–78. doi:10.1037/prj0000083

Drebing, C. E., Van Ormer, E. A., Schutt, R. K., Krebs, C., Losardo, M., Boyd, C., . . . Rosenheck, R. (2004). Client goals for participating in VHA vocational rehabilitation: Distribution and relationship to outcome. *Rehabilitation Counseling Bulletin, 47*(3), 162–172. doi:10.1177/0034

Druss, B. G. (2014). Supported employment over the long term: From effectiveness to sustainability. *American Journal of Psychiatry, 171*(11), 1142–1144. doi.org/10.1176/appi.ajp.2014.14070900

Eisenberg, P., & Lazersfeld, P. (1938). The psychological effects of unemployment. *Psychological Bulletin, 35,* 358–390. doi:10.1037/h0063426

Farkas, M. (2007). The vision of recovery today: What it is and what it means for services. *World Psychiatry, 6*(2), 68–74.

Fixsen, D. L., Naoom, S. F., Blase, K. A., Friedman, R. M., & Wallace, F. (2005). *Implementation research: A synthesis of the literature* (FMHI Publication #231). Tampa, FL: University of South Florida, Louis de la Parte Florida Mental Health Institute, National Implementation Research Network.

Frasquilho, D., de Matos, M., Santos, T., Gaspar, T., & Caldas de Almeida, J. (2016) Unemployment as a source of mental distress to individuals and their family: Unemployed parents' perceptions during the economic recession. *International Journal of Social Psychiatry, 62*(5), 477–486. doi:10.1177/0020764016650469

Frounfelker, R. L., Wilkniss, S., Bond, G. R., Devitt, T. S., & Drake, R. E. (2011). Enrollment in supported employment services for clients with a co-occurring disorder. *Psychiatric Services, 62,* 545–547. doi:10.1176/ps.62.5.pss6205_0545

Gathergood, J. (2013). An instrumental variable approach to unemployment, psychological health and social norm effects. *Health Economics, 22*(6), 643–654. doi:10.1002/hec.2831

Haines, K., Marrone, J., Halliday, J., Tashjian, M., Klemm, M., Stoddard, S., & Foley, S. (2012). *Description of supported employment practices, cross-system partnerships, and*

funding models of four types of state agencies and community rehabilitation providers. Boston, MA: Institute for Community Inclusion.

Hall, A. C., Butterworth, J., Winsor, J., Gilmore, D. S., & Metzel, D. (2007). Pushing the employment agenda: Case study research of high performing states in integrated employment. *Intellectual and Developmental Disabilities, 45*(3), 182–198. doi:10.1352/1934-9556(2007)45[182:PTEACS]2.0.CO;2

Hogan, M. F. (2003). New Freedom Commission Report: The President's New Freedom Commission: Recommendations to transform mental health care in America. *Psychiatric Services 54*(11), 1467–1474.

Kukla, M., Bond, G. R., Xie, H. (2012). A prospective investigation of work and nonvocational outcomes in adults with severe mental illness. *Journal of Nervous and Mental Disease, 200*(3), 214–222. doi:10.1097/NMD.0b013e318247cb29

Latimer, E., Bush, P., Becker, D., Drake, R., & Bond, G. (2004) How much does supported employment for the severely mentally ill cost? An exploratory survey of high fidelity programs. *Psychiatric Services, 55,* 401–406.

Levit, K. R., Stranges, E., Coffey, R. M., Kassed, C., Mark, T. L., Buck, J. A., & Vandivort-Warren, R. (2013). Current and future funding sources for specialty mental health and substance abuse treatment providers. *Psychiatric Services, 64*(6), 512–519. doi:10.1176/appi.ps.201200298

Livermore, G., Mamun, A., Schimmel, J., & Prenovitz, S. (2013). *Executive summary of the Seventh Ticket to Work Evaluation Report* (Final Report, July 30, 2013). Princeton, NJ: Center for Studying Disability Policy. Retrieved from https://www.disabilitypolicyresearch.org/our-publications-and-findings/publications/executive-summary-of-the-seventh-ticket-to-work-evaluation-report

Lowe, S. D. (2013). *How can research inform us about challenges and possible strategies needed, related to disability policy for people with psychiatric disabilities early in their working careers.* Briefing paper prepared for the Boston University Center on Psychiatric Rehabilitation, State of the Science Meeting on Policy and Employment for Individuals with Psychiatric Disabilities, September 25–26, 2013, Washington, DC.

Marrone, J., Burns, R., & Taylor, S. (2014). Vocational rehabilitation and mental health employment services: True love or marriage of convenience? *Journal of Vocational Rehabilitation, 40*(2), 149–154. doi:10.3233/JVR-140672

Marrone, J., Smith, F. A., & Foley, S. (2008, December) Comparison of VR outcomes for clients with mental illness across system indicators. *Research to Practice* (No. 47). Boston, MA: Institute for Community Inclusion. Retrieved from https://www.communityinclusion.org/article.php?article_id=265&staff_id=27 (figures updated through FY 2010)

Marwaha, S., Balacvhandra, S., & Xie, H. (2009). Clinicians' attitudes to the employment of people with psychosis. *Social Psychiatry and Psychiatric Epidemiology, 44*(5), 349–360. doi 10.1007/s00127-008-0447-5

McFarlane, W. R. (2002). *Multifamily groups in the treatment of severe psychiatric disorders.* New York: Guilford.

Milner A., LaMontagne A. D., Aitken, Z., Bentley, R., & Kavanagh, A. M. (2014). Employment status and mental health among persons with and without a disability: Evidence from an Australian cohort study. *Journal of Epidemiology and Community Health, 68*(11), 1064–1071. doi:10.1136/jech-2014-204147

Montgomery, S., Cook, D., Bartley, M., & Wadsworth, M. (1999). Unemployment predates symptoms of depression and anxiety resulting in medical consultation in young men. *International Journal of Epidemiology, 28*(1), 95–100. doi:10.1093/ije/28.1.95

Mueser, K. T. (2006). Making cognitive-behavioral therapy work: Clinical process for new practitioners. *Psychiatric Rehabilitation Journal, 30*(2), 155–157. doi:10.2975/30.2006.155.159.

Mueser, K. T., & McGurk, S. R. (2014). Supported employment for persons with serious mental illness: Current status and future directions. *L'Encéphale, 40*(Suppl. 2), S45–S56. doi:10.1016/j.encep.2014.04.008

Parmelli, E., Flodgren, G., Beyer, F., Baillie, N., Schaafsma, M., & Eccles, M. (2011). The effectiveness of strategies to change organisational culture to improve healthcare performance: A systematic review. *Implementation Science, 6*(33). Retrieved from https://implementationscience.biomedcentral.com/articles/10.1186/1748-5908-6-33

Rapp, C., Bond, G., Becker, D., Carpinello, S., Nikkel, R., & Gintoli, G. (2005). The role of state mental health authorities in promoting improved client outcomes through evidence-based practice. *Community Mental Health Journal, 41*, 347–363. doi:10.1007/s10597-005-5008-8

Rinaldi, M., Perkins, R., Glynn, E., Montibeller, T., Clenaghan, M., & Rutherford, J. (2008). Individual placement and support: From research to practice. *Advances in Psychiatric Treatment, 14*(1), 50–60. doi:10.1192/apt.bp.107.003509

Rueda, S., Chambers, L., Wilson, M., Mustard, C., Rourke, S. B., Bayoumi, A., . . . Lavis, J. (2012). Association of returning to work with better health in working-aged adults: a systematic review. *American Journal of Public Health, 102*, 541–556. doi: 10.2105/AJPH.2011.300401

Salkever, D. (2010). *Toward a social cost-effectiveness analysis of programs to expand supported employment services: An interpretive review of the literature.* Rockville, MD: Westat.

Stam, K., Sieben, I., Verbakel, E., & de Graaf, P. (2016). Employment status and subjective well-being: The role of the social norm to work. *Work, Employment & Society, 30*(2), 309–333. doi:10.1177/0950017014564602

Stewart, L., Shanbacker, E., Wills, M., Waits, M. J., & Simon, M. (2013). *A better bottom line: Employing people with disabilities. Blueprint for governors.* Retrieved from https://classic.nga.org/files/live/sites/NGA/files/pdf/CI1213BETTERBOTTOMLINE.PDF

Substance Abuse and Mental Health Services Administration. (2015). CMHS Uniform Reporting System outputs. Retrieved from https://www.samhsa.gov/data/report/2015-cmhs-uniform-reporting-system-output-tables

Ucok, A., Gorwood, P., & Karadayi, G. (2012) Employment and its relationship with functionality and quality of life in patients with schizophrenia: EGOFORS Study. *European Psychiatry, 27*, 422–425. doi:10.1016/j.eurpsy.2011.01.014

Vaalavuo, M. (2016). Deterioration in health: What is the role of unemployment and poverty? *Scandinavian Journal of Public Health, 44*(4), 347–353. doi:10.1177/1403494815623654

Warr, P., & Banks, B. (1987). *Work, unemployment, and mental health*. Oxford, United Kingdom: Oxford University Press.