

# Chapter 11: Employment

The purpose of this chapter is to describe employment services for people with serious mental illness and/or substance abuse problems, including existing resources, particular strengths of current programs, and needs. The chapter includes narrative information gathered through focus groups and personal interviews, as well as available data from ODMHSAS and other sources.

## A. Existing Resources

Existing employment resources for people with mental health diagnoses include pre-vocational activities within Psycho-Social Rehabilitation (PSR) Programs, as well as Transitional Employment programs at the State's two certified clubhouse programs. In FY2005, only 70 adults received employment services funded by ODMHSAS. This is among a total of 9,746 adults, 18 or older, who were unemployed or not in the labor force at admission to ODMHSAS-funded mental health outpatient services, with at least 30 days between admission and discharge. One CMHC, Green Country, has a contract with the Department of Rehabilitation Services to provide supported employment. Tribal employment programs are also available to ODMHSAS clients who are tribal members.

Mental health consumers are eligible for services directly from DRS and its contractors. Through its Division of Vocational Rehabilitation (VR), DRS provides employment services that help individuals with disabilities find and keep employment in careers of their choice. The primary vocational rehabilitation services are counseling and guidance with job placement. Other services may be provided as needed to compensate for, correct or prevent disability-based barriers to employment. These services can include, but are not limited to vocational, college or other training ; assistive technology evaluations, equipment and training; personal assistance services while receiving VR services; self-employment assistance; and transitional school-to-work services for youth with disabilities. DRS also contracts with community-based services providers to provide supported employment, transitional employment, and employment and retention services.

ODMHSAS serves adults with income less than 200 percent of the federal poverty level. As shown in Exhibit 11.1., adults who receive ODMHSAS-funded mental health services have low income and the majority have no more than a high school education. To evaluate the median income of clients who received ODMHSAS-funded mental health services, client records were matched with data from the Oklahoma Employment Security Commission. The following table indicates that the median income for clients has remained around \$7,000 from fiscal years 2001 to 2005.

Exhibit 11.1.  
 Median Income of Individuals, Age 18 – 64,  
 who received ODMHSAS-funded  
 Mental Health Services

Fiscal Year	Income
2001	\$7,044.84
2002	\$6,928.00
2003	\$7,375.71
2004	\$6,697.60
2005	\$7,004.84

As part of the intake process, ODMHSAS collects data on individuals' level of education. As shown in Exhibit 11.2., one-third of mental health clients have less than a high school education, and only 20 percent have had any education beyond high school.

Exhibit 11.2. Education Level of Adults  
 Admitted to OMDHSAS-funded Mental Health Services

Fiscal Year	Less than High School Diploma		High School Diploma or GED		Some College or College Graduate		Total
	#	%	#	%	#	%	
2001	5,776	33%	8,168	47%	3,586	20%	17,530
2002	7,400	33%	10,435	46%	4,787	21%	22,622
2003	6,502	31%	10,065	48%	4,291	21%	20,858
2004	4,888	31%	7,901	50%	2,967	19%	15,756
2005	6,190	33%	8,958	47%	3,726	20%	18,874

To evaluate employment among ODMHSAS mental health service recipients, discharge data from ODMHSAS were analyzed to determine the number of clients who were unemployed and not in the labor force. As shown in Exhibit 11.3., over two-thirds of adults receiving ODMHSAS-funded mental health services were either unemployed or not in the labor force at the time of discharge from a community mental health center (CMHC). The rate of adult clients age 18-64, not in the labor force appears to be declining slightly (from 45 percent in 2001 to 41 percent in 2005), but it does not appear that these clients are more likely to become employed, since the rate of full- or part-time employed is also declining over time. The largest change in employment status was a 5 percent increase in the percent unemployed from 2001 to 2005.

Exhibit 11.3. Employment Status at Discharge for Adults, age 18-64,  
who received OMDHSAS-funded Mental Health Services

Fiscal Year	Full-time Employment		Part-time Employment		Unemployed		Not in Labor Force		Total
	#	%	#	%	#	%	#	%	
2001	1,746	20%	785	9%	2,347	26%	4,028	45%	8,906
2002	2,376	17%	1,174	9%	3,801	28%	6,313	46%	13,664
2003	2,150	18%	1,036	8%	4,038	33%	5,010	41%	12,234
2004	971	13%	577	7%	2,785	36%	3,392	44%	7,725
2005	1,267	12%	755	7%	3,998	39%	4,168	41%	10,188

\* The sample only includes Mental Health Clients served at a CMHC with at least 90 days between their admission and discharge. Clients under the custody of DOC and those whose services were limited to Residential Care are removed from the sample.

Additional evaluation of the 2,022 mental health service recipients employed either full- or part-time at discharge revealed that the majority (84%) were employed in a competitive setting, followed by 15 percent in supported employment settings, with the remainder either in volunteer, transitional employment, or sheltered workshop settings, as shown in Exhibit 11.4.

Exhibit 11.4. Employment Setting for People, age 18 to 64,  
who Received ODMHSAS-funded Mental Health Services  
and Discharged from a CMHC in FY 2005

Full- or Part Time Employment Setting	Count	Percent
Competitive	1,698	84.0
Supported	300	14.8
Volunteer	13	0.6
Transitional	9	0.4
Sheltered Workshop	2	0.1

Education and employment data for substance abuse clients is very similar to that for mental health service recipients. As shown in Exhibit 11.5. and 11.6., individual income for substance abuse clients has remained close to \$7,000 for the past five years, and one-third of the clients have less than a high school education.

Exhibit 11.5.  
Median Income of Individuals, Age 18 – 64,  
who received ODMHSAS-funded  
Substance Abuse Treatment

Fiscal Year	Income
2001	\$7,174.89
2002	\$7,231.69
2003	\$6,716.58
2004	\$6,588.26
2005	\$7,441.33

Exhibit 11.6. Education Level of Adults  
Admitted to OMDHSAS-funded Substance Abuse Treatment

Fiscal Year	Less than High School Diploma		High School Diploma or GED		Some College or College Graduate		Total
	#	%	#	%	#	%	
2001	4,077	33%	5,790	47%	2,370	19%	12,237
2002	4,612	33%	6,467	46%	2,837	20%	13,916
2003	4,374	33%	6,400	49%	2,374	18%	13,148
2004	4,511	34%	6,552	49%	2,372	18%	13,435
2005	4,755	32%	7,203	49%	2,731	19%	14,689

ODMHSAS discharge data for substance abuse treatment clients were analyzed to determine the number of clients who were unemployed or not in the labor force. In comparison to mental health clients, a much larger percentage of substance abuse treatment clients (39% in FY2005) were employed either full-time or part-time. As seen in Exhibit 11.7., from 2002-2005, the percent of clients with full-time employment at discharge decreased by 22 percent, while the percent of clients unemployed at discharge increased from 37 percent to 44 percent. The percent of clients with part-time employment or not in the labor force has remained relatively consistent over the five year period.

Exhibit 11.7. Employment Status at Discharge for Substance Abuse Treatment Clients age 18 - 64\*

Fiscal Year	Full-time Employment		Part-time Employment		Unemployed		Not in Labor Force		Total
	#	%	#	%	#	%	#	%	
2001	2,489	40%	509	8%	2,346	37%	951	15%	6,295
2002	2,868	35%	718	9%	3,182	39%	1,449	18%	8,217
2003	2,370	33%	564	8%	3,216	44%	1,116	15%	7,266
2004	2,423	32%	630	8%	3,456	45%	1,159	15%	7,668
2005	2,544	31%	701	8%	3,614	44%	1,399	17%	8,258

\* Includes substance abuse treatment clients with at least 30 days between admission and discharge. Does not include clients under the custody of DOC, clients who received only detox services and dependents of substance abuse treatment clients.

Among the 3,245 adults age 18 – 64 who received OMDHSAS-funded substance abuse treatment and were employed either full- or part-time in FY2005, 89 percent were employed in a competitive environment, followed by 10 percent in a supported environment. The remaining one percent were in a volunteer or transitional employment setting.

## **B. Strengths**

### Strengths – Innovative Initiatives

A collaborative project between ODMHSAS and the Department of Rehabilitation Services (DRS) to implement the Supported Employment evidence-based toolkit from the federal Substance Abuse and Mental Health Services Administration (SAMHSA) is in development, and model programs at seven CMHCs are projected to be implemented in October 2006. DRS is working to arrange for start-up funds to help develop capacity before the new programs are ready to bill through the existing “milestone” reimbursement system. The University of Oklahoma will develop training curricula for staff in these model programs. ODMHSAS and DRS leaders said that the two state agencies have built an exceptionally strong working relationship, which is credited for the success of this initiative to date. Their collaborative efforts have included working with peer agencies in five other states to hold a regional conference on Supported Employment in Albuquerque in 2005.

### **C. Needs and Existing Barriers**

#### **Policies**

Focus group participants identified a need for a comprehensive ODMHSAS policy and action plan to develop Supported Employment, Supported Education, and other opportunities for clients to succeed in the workplace. Several groups stressed that employment is an essential part of recovery for many people, and that a strong policy stance promoting and funding a range of employment and educational services is needed if the department wants to build a recovery-oriented system. Many participants noted that consumers need strong support services to successfully re-integrate into the workplace..

A need to develop additional types of employment approaches beyond those available through the Department of Rehabilitation Services (DRS) was noted, including a suggestion to seek start-up funds from the private sector to encourage the growth of consumer-run businesses. Expanding the number of consumers employed within the mental health system and the types of jobs available to them were also identified as ways to expand employment opportunities and to provide role models for consumers to encourage them to pursue employment.

Systemic barriers to employment were noted in focus groups from all parts of the state. On both the state and federal levels, the structure of public benefits programs creates disincentives to employment. For instance, public housing and food stamps can be issues when clients return to work; their rent goes up and their food stamps go down. Because keeping stable housing is key to people’s recovery, many worry about their ability to keep their housing if they try to transition to employment. The possible loss of Medicare and/or Medicaid is a particularly strong disincentive to employment, as most entry-level jobs do not provide health insurance, and people can find themselves unable to pay for their medications and other health care needs; this in turn can interfere with their ability to hold a job. People receiving Social Security benefits face a complex formula that requires them to monitor the number of hours worked every month so they don't lose all their benefits.

Other systemic barriers have to do with policy issues in other systems. The lack of public transportation in both urban and rural areas was cited as a major barrier to employment, along with a shortage of stable, permanent housing and the lack of access to vocational training and higher education.

**Practices/Services**

As noted earlier, employment is an essential part of recovery for many people. One important outcome of mental health treatment included in the federal National Outcome Measurement System is the change of employment status from admission to discharge. ODMHSAS collects employment information at admission to and discharge from a treatment episode. Exhibit 11.8. indicates that the majority of clients do not change their employment status from admission to discharge. The largest change is that 15 percent of clients who were employed part-time at admission are employed full-time at discharge. Small percentages of clients who are not employed or not in the labor force at admission become employed either full- or part-time, while others go from employment at admission to being unemployed when they leave treatment.

Exhibit 11.8. Change in Employment among Adult Recipients, Age 18 – 64, of ODMHSAS-funded Mental Health Services, Discharged in FY 2005\*

Employment Status at Admission	Total	Employment Status at Discharge							
		Employed Full-time		Employed Part-time		Unemployed		Not in Labor Force	
		#	%	#	%	#	%	#	%
Employed Full-time	1,106	854	77%	64	6%	116	10%	72	7%
Employed Part-time	815	120	15%	509	62%	91	11%	95	12%
Unemployed	4,547	210	5%	118	3%	3,266	72%	953	21%
Not in Labor Force	3,717	83	2%	64	2%	525	14%	3,045	82%
<b>Total</b>	<b>10,185</b>	<b>1,267</b>	<b>12%</b>	<b>755</b>	<b>7%</b>	<b>3,998</b>	<b>39%</b>	<b>4,165</b>	<b>41%</b>

\* Includes clients who received ODMHSAS-funded mental health services at a CMHC with at least 90 days between admission and discharge. Clients under the custody of DOC and whose services were limited to residential care were removed.

Change in employment is also an outcome for substance abuse treatment. As shown in Exhibit 11.9., the majority of clients remained in the same employment status from admission to discharge. Among those unemployed at admission, 15 percent became employed either full-time or part-time, and among those not in the labor force, 6 percent became employed. Nineteen percent of those employed part-time at admission are employed full-time at discharge. These gains are not offset by the much smaller percentages becoming unemployed at discharge; thus, the direction of movement is more positive for substance abuse than mental health clients, although there are still significant problems with a lack of employment.

Exhibit 11.9. Change in Employment among Adult Recipients, Age 18 – 64, of ODMHSAS-funded Substance Abuse Treatment, Discharged in FY 2005\*

Employment Status at Admission	Total	Employment Status at Discharge							
		Employed Full-time		Employed Part-time		Unemployed		Not in Labor Force	
		#	%	#	%	#	%	#	%

Employed Full-time	2,092	1,890	90%	52	2%	110	5%	40	2%
Employed Part-time	704	136	19%	469	67%	67	10%	32	5%
Unemployed	4,231	471	11%	160	4%	3,298	78%	302	7%
Not in Labor Force	1,231	47	4%	20	2%	139	11%	1,025	83%
Total	8,258	2,544	31%	701	8%	3,614	44%	1,399	17%
* Includes substance abuse treatment clients with at least 30 days between admission and discharge. Does not include clients under the custody of DOC, clients who received only detox services and dependents of substance abuse treatment clients.									

Consistent with the data reported above, clients and service providers agreed that there is a lack of focus on employment within most mental health and substance abuse programs, and that few staff have expertise on this issue. While Psycho-Social Rehabilitation programs (PSRs) offer volunteer in-house work activities and some pre-vocational activities, many clients noted that there was little capacity within the program to help them move forward into the job market. Many mental health consumers expressed an interest in preparing for GED exams, but did not have access to GED classes or even the funds needed to take the exam. Staff and consumers also talked about the need for Supported Education programs as an important adjunct to Supported Employment, so that clients can prepare for careers, not just entry-level jobs. Most people who raised employment issues said that they were aware of few if any services available in their communities.

People from several areas of the state noted that employer prejudice against people with mental health diagnoses was a barrier to employment. One staff group said that if people presented well, their chances of finding a job were better than people who exhibited symptoms. Another group mentioned that people with developmental disabilities, whom they believed employers preferred over mental health clients, held most of the low-wage jobs in their area. Consumers from all areas stated that “employers do not want to hire us.”

Differences in the cultures of the mental health system and the DRS system, and a lack of understanding of each system’s role by staff of the other system, were mentioned frequently as barriers to successful employment outcomes for mental health consumers. These differences and misunderstandings were also made clear by staff comments. Local DRS staff often complained that mental health agencies and homeless shelters seemed to assume that DRS is an employment agency, rather than a rehabilitation services agency, and refer large numbers of clients who are not ready to work. They felt that the mental health system’s priorities were out of order – that people needed housing, food and treatment before they were ready for a job. “There is such a lack of mental health services that people who are referred to us are unable to get the help they need to become ready to work,” was a typical comment.

DRS staff said that they would not accept referrals of mental health consumers who were not on medication or were not treatment compliant, a stance that is not compatible with a recovery-oriented philosophy. Similarly, some DRS staff felt that they should be able to talk with a client’s mental health worker because “the therapist knows better than the client what’s best for them.” Many DRS staff stated that they did not understand how local mental health systems worked and did not know how to help their

clients access mental health services. Similarly, staff in many local mental health agencies seemed only vaguely aware of the scope of DRS services, how to help their clients gain access to these services, or whether the services were successful. Others stated that the DRS process was tedious and time-consuming, and was not welcoming to people who may need to make several attempts before succeeding at a job. Statements made by both DRS staff and mental health staff indicated that many of them did not believe that people with psychiatric disabilities are capable of holding a steady job for any length of time or of building a career.

### **Workforce Development Issues**

DRS staff and mental health consumers who use DRS services agreed that training is needed for consumers on how to successfully use services, and for DRS counselors to familiarize them with mental health issues, to ensure that staff understand how best to support people with mental health problems. DRS staff noted that some of the barriers they face in working with people with psychiatric disabilities are that this issue was not addressed in their rehabilitation master's program and that caseloads are too large: a typical caseload is 150 -200 people. Counselors feel that they aren't able to give each client the time they deserve. Both mental health staff and DRS staff expressed a need for cross-training and co-training.

### **Organization/Collaboration**

While there is a good collaborative working relationship between ODMHSAS and DRS on the state level, many focus group participants noted that this is not necessarily true on the local level, and that better organizational linkages need to be forged in communities to better serve people with psychiatric disabilities. DRS counselors felt that they should be paired with mental health staff, so they can work together as a team and learn to trust each other. Participants said that this team approach would give workers in each agency a better appreciation of what each other was responsible for, and allow them to use a more holistic approach to meet clients' needs. Local DRS staff also spoke of a need to work more closely with criminal justice agencies, but felt that such overtures had not been responded to.

### **Data**

DRS staff stated that barriers to sharing assessment and treatment information between agencies interfere with their ability to serve clients efficiently and effectively.

### **Financing Issues**

Inconsistent DRS funding levels from year to year results in variations in the number of people who can be served. DRS has three priority groups based on level of disability; sometimes they have funds only to serve the most disabled. Under the current funding system, known as "milestone" reimbursement, there are barriers to establishing new employment programs, since the largest payments to a program aren't made until the client has a six-month job retention. It was felt that this puts programs in a bind because they do not have a steady cash flow. A number of CMHCs stated that they had formerly operated on-site Supported Employment programs, but that the funding structure forced them to discontinue the programs.

A barrier identified on the mental health side is the lack of new funding to develop additional capacity for employment programs. There was a call to re-direct some existing ODMHSAS funds into employment and education services.