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UMMS- Supporting Youth Vocational Goals with Mental Health and Vocational Rehabilitation Collaboration: Implications for the Present

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Live Captioner standing by...

>> MODERATOR: Hi, everyone. We are going to give people a minute or so to join. Thank you.

Good afternoon, everyone. My name is Deirdre Logan, knowledge transition coordinator for the transitions for adulthood. Before we get started with our webinar today, I'm just going to go over a few housekeeping slides and then turn it over to the presenters.

so just so you know, the webinar is being recorded and will be available on the transitions to adulthood Center for Research's website. If you need live captions, they're available here. I can put that in the chat box. Please note that participants are automatically muted when they join and it's good if you can enter the unique audio pin if you're calling in over the phone. If you do have audio problems, you can check the settings and go to webinar's audio tab. And after the presentation, we'll have a Q&A session as well as a discussion. Please raise your hand to be unmuted or type your question into the question box to participate in either the Q&A or discussion. If you have any technical difficulties, you can email me, the organizer, at Deirdre.logan [Away from mic] or send a message through the questions tab. With that, I'm going to turn it over to Dr. Maryann Davis.

>> Thank you, Dee. We are very excited to be providing this webinar today. It's always nice to have a visual image of your presenters. I'm Maryann Davis, professor in the Department of Psychiatry at UMass medical school. Anwyn Gatesey-Davis is a recent college graduate. She will also be presenting. As will Nancy Koroloff, who is professor emerita from Portland State University and their pathways center.

We are your presenters today. We're very thrilled to see with the registrations we have a very diverse audience in terms of it includes both people who work in the mental health system as well as people who work in the vocational rehabilitation system, which we think is so exciting to have both communities together here today because this is such an important conversation. As well as others, other investigators, researchers and students. With no further ado, we'll get started. I want to start off by saying that the work that we present here today and the research that it is based on was funded through a rehabilitation research and training center grant from the national Institute on disability,

independent living and rehabilitation research as well as the substance abuse and mental health services administration. The contents of this presentation don't necessarily represent the policy of these agencies or health and human services that they are a part of and you shouldn't assume an endorsement by the Federal Government. I also wanted to thank numerous people who have been helpful in conducting this research who aren't part of the presentation today. In particular, I wanted to shout out a thanks to -- Marcella Hayes, Martha Castro, GinWhite, Diane [Away from mic] and John Connelly, all of whom without whose work and help on this project we would not have been able to complete this. Thank you to all of you. So the purpose of this webinar today is to explore and discuss the collaboration between public mental health systems and state vocational rehabilitation systems to address the vocational goals of transition age youth with mental health disabilities. And we think these systems are particularly important for several reasons, one, state mental health facilities provide mental health services to individuals who have the most serious mental health conditions, so they are the primary provider of mental health services in state systems. State vocational rehabilitation services provide vocational supports for training education and working to all individuals with disabilities. So another very important player. When you think about the vocational goals of transition age youth with serious mental health conditions. We were focusing and we will focus here on these two systems and we won't be focusing on school systems for this particular reason. A lot of work has looked at the connections between state vocational rehabilitation services and special education or schools because a lot of the transition from school to work when it involves the vocational system occurs through the special education system and through transition planning. However, less than 10% of students who have a serious mental health condition are served in special education. So that particular bridge between schools and vocational rehabilitation is not a strong one for these youth. Whereas many of them are served in state mental health authorities, and that is partly why, and a large factor as to why we wanted to examine the question between these services. So our main goal is to identify factors that facilitate or impede the mental health and vocational rehabilitation collaboration, and in particular to address the mindful meditation we see today in this day and time for trying to continue to help these youth to obtain their vocational goals.

one of the most important reasons we want to connect youth with mental health conditions and mental health disabilities to state vocational rehabilitation services is because of this workforce innovation and opportunity act. This is a national law that was passed in 2014 and the final rules for implementing it were passed in 2016. Part of it is designed to provide high quality, continuous and seamlessly delivered services for youth and it defines them as being 14 to 24 years old. Within this law, vocational rehabilitation systems are responsible for the delivery of services for individuals with disabilities. And specifically, vocational rehabilitation has specific requirements for services for youth and for students with disabilities.

So this law defines a youth with a disability as a 14 to 24 year old with a disability as defined by section 504 of the Rehabilitation Act of 1973. If you're interested in how that defines disability, this is the link to their website.

There are specific services for students with disabilities that state vocational rehabilitation agencies must provide. A student with a disability is an individual who's enrolled in secondary or post-secondary education who meets the age requirement for the provision of transition services in the state. That's usually somewhere between the ages of 16 and 21 years. As an individual with a disability as defined by

section 504 of the rehab act or is receiving special education and related services under the Individuals with Disabilities Education Act?

So a student in school who meets disability criteria under either of these conditions and meets the requirement for the ages for providing transition services is eligible as a student with a disability.

This is particularly important for the mental health populations since so many of them are not served under the Individuals with Disabilities Education Act.

So the services that vocational rehabilitation is mandated to provide include these. For youth with disabilities, vocational rehabilitation is required to spend 50% of their allotted funding for supported employment goes to the provision of supported employment to youth with the most significant disabilities. That's a substantial commitment to youth with disabilities.

VR must also provide services for students with disabilities. These are called the pre-employment transition services. Or some folks will call it -- these services include job exploration counselling, work-based learning experiences like internships, counselling on opportunities for enrollment in comprehensive transition services or post-secondary education programs, workplace readiness training to develop social skills and independent living and instruction in self-advocacy. This may include peer mentoring. These are all very important services for young people at the beginning of their work lives and students with disabilities can access them through their vocational rehabilitation service.

So you can see that state vocational rehabilitation agencies offer very important supports for youth with disabilities, but why should we focus on the question of collaboration between mental health and vocational rehabilitation systems?

Well, there are several benefits that research has found for collaboration. For individuals, while it doesn't always necessarily directly improve their outcomes, it does increase their service utilization. So for when systems collaborate better, we see client utilization of those services increase. And that is important. For the organizations that are collaborating there have been been several areas in which they have benefited. It builds organizational capacity, it allows them to leverage existing resources better, and when you think about a couple of collaborating programs, they get to acquire a pool of new resources and skills through that collaboration. That also helps with solving of complex problems. There are many benefits of collaboration.

So the studies that we are going to present to you today used three different methods to examine this question of vocational rehabilitation and mental health collaboration. The first is a qualitative study of stakeholder perspectives. The second is a web survey that measured collaboration level and possible associated factors in local vocational rehabilitation and mental health programs. And the third is a secondary analysis that examined the characteristics of youth accessing state vocational rehabilitation services in the national database of vocational rehabilitation services.

It's worth noting that the first two studies were conducted in the communities that had received now is the time healthy transitions grants from the substance abuse and mental health services administration. These communities all had composed and completed activities to improve services for transition age youth with or at risk of a serious mental health condition. You can see on the map on the right where those communities were located. Grants went to 17 states including the district of

Colombia. And for each of the states, they had to have multiple sites. So these grants reached a significant number of communities and these grants were funded between 2014 and 2019.

I'm now going to turn this over to Anwyn Gatesey-Davis who will present on the first study.

>> Hi, everybody!

My name is Anwyn and I'm going to do talk about the qualitative study titled perspectives of mental health and vocational rehabilitation agency leadership on collaboration.

So this study focuses on three key stakeholders. I am skipping slides. So the participants for the study as was just mentioned is based on the now is the time healthy transitions grant locations and our participants were the local leaders of vocational rehabilitation systems and mental health systems where those grantees were located.

And so the study is focusing on three key stakeholders. Vocational rehabilitation, adult mental health, and child mental health. And those were the three points on our quote unquote triangle. The study is looking at collaboration, which we defined as actively working together to achieve shared goals for the vocational outcomes of 16 to 26 year olds with psychiatric disabilities. And for this study we were asking three main questions. Is collaboration happening across the triangle?

So across those agencies. What facilitates that collaboration?

And what are the challenges for the collaboration?

Our methods included semi-structured qualitative phone interviews on the phone. those coders had an intercoder reliability of 78 so they were in strong agreement. Once the codes were applied, we looked at the transcripts and looked at the excerpts that had been selected and identified the big picture themes, which is what we'll be talking about here, the most important things. The first question is collaboration happening, there are a range of responses but many participants indicated that collaboration wasn't happening between stakeholders for a variety of reasons. So here are a few key quotes from the different agencies. From VR, we have so here's part of the problem. There is no coordination between the state mental health and the VR agency as it relates to transition youth. From adult mental health we see but when I talk to people about VR most of our staff don't relate to that because they are not really working with them. And from child mental health, yeah, I think what happens is they're in school. They're on an IEP. The schools will sometimes refer kids to VR. The schools do those referrals. So child mental health is relying on the schools to make those connections. There was a smaller group of participants who reported that there was a level of collaboration between their agency and another. They could provide concrete examples but they were definitely the exception to the rule. We wanted to find out what facilitates this collaboration so it can be improved and we can see what's working.

There were three emerging themes. Firstly, structured opportunities to get to know each other and get to know the work that both agencies are doing helps to foster that collaboration. Secondly, that training together or training each other's staff is another way to get to know each other and the services that are provided by the agencies. And lastly, that opportunities to work together towards shared goals such as referrals or planning for something like WIOA is another way to facilitate collaboration.

So what works?

What are these things that facilitate?

One of the main things is attending meetings with staff from other agencies. You get to know each other and learn about the services that are provided. So one participant said knowing key people, that's where it's helped with our regional interagency councils. Everybody there knows some -- another person said we have VR staff designated to work with our providers. They go on site with our providers to give them an understanding of who they are, what they are, what they do, what their strengths and weaknesses are and then they meet regularly with our staff to review where we are and we address issues proactively. So they're getting to know each other through meetings and working together.

We also see that cross training or shared training is another good way for staff to learn about each other's work and get to know each other. This is something that was mentioned primarily by participants from the mental health agencies but also was throughout. So they said yes, we're working with VR very aggressively to try to get a lot of our providers trained in employment services so they understand how to work with and intervene and also understand what services are available to the individual who is impaired.

And then working towards a shared goal, that's another thing that very clearly was helpful. For this one example is working towards planning for WIOA or the usage of WIOA. We worked with them, being VR, around the type of technical assistance we need from WIOA and we were able to select our provider. So we have been at the table. We are at the table helping to craft the initiative and to implement the initiative. We're equal partners. On the other side we see some of the challenges, some of the things that aren't working and makes it a little bit difficult. One of those things is that different agencies don't necessarily have the same perspective on how they should work with young people in this population.

Someone from VR said, you know, we've always provided services to youth but this is an emphasis on providing services to a much larger percentage of youth. And our counselors are sort of going help, we --

[Reading.] from child mental health you see I've met personally with the local workforce investment boards, which is a vocational rehabilitation locally, and said we have kids that don't want to do this. They politely say, well, you know you're the mental health case manager so that's really your job to do that end of it. And our job is to do the work end of it. They have different perspectives on who is playing what role and who is in charge of what. Another challenge is having just on the logistical end a different pace of case flow. They work on different time frames. So we saw on the mental health end, saying we work very quickly but vocational rehabilitation they have got a much slower process. So adult mental health said we use motivational interviewing and once they're in the action phase, we have about a five day window. And VR is on a five month window time frame. Very different. Child mental health says we do work with VR but I find for this population it's too full and too cumbersome. There are too many hoops to jump through. Too much paperwork and red tape. They're getting caught up in logistical differences.

So from those got a few take-aways. One really looking at different agencies and where they're struggling and where they're succeeding. For children's willing mental health, the providers are generally uninformed about VR and WIOA because those are just not things that they see as their role and get involved with. And how these services could support their youth and young adults.

Adult mental health, on the other hand, is more used to working with VR, but they are much more used to working with older adults and don't necessarily consider the unique needs of young adults or the younger range of those that they provide services for.

And vocational rehabilitation provides a general service to all individuals with disabilities but they don't necessarily recognize the special needs of young adults with mental health conditions or of young adults who are not in high school or are not going through the school system. So we're seeing those gaps there.

I'm going to hand it back to Maryann for the next study.

>> Thank you, Anwyn. So this next study is -- shared web surveys with the local programs in the sites that have received now is the time [Away from mic] transition grants. And this work was done in collaboration with rav-- as we mentioned before, there are some we wanted to examine factors that would potentially be associated with collaboration with the idea that if they are malleable, that is if you can change them, then these may be things that when programs or systems want to enhance collaboration they could focus on these to help with future collaboration.

So in previous research literature, largely from the human services literature and from industry, these four seemed like good possibilities to investigate. So the first one is being knowledgeable about each other. The second is when important program stakeholders promote collaboration. So like system leaders in some ways promoting better collaboration. The third is a trusting and positive relationship among the organizational leaders that are potentially collaborating.

And the fourth is organizational complementterity. That is when two programs, goals or services are complementary, have a shared vision, their competition with one another is low.

So this study was designed to investigate in a quantitative way the relationship between those malleable factors and observed or reported collaboration. So the participants again came from the now is the time healthy transition communities. We sought out community consultants from the lead programs in these grants from each of the communities and talked with them of what is known in -- this expert helped us identify programs that served transition age youth who were either in the mental health system and they served this age group, not exclusively this age group, any part of this age group, or they were in the vocational rehabilitation system and could also serve this age group.

So we ended up having 22 consultants that identified 223 programs in 24 of the communities. These programs represented child mental health, adult mental health, and vocational rehabilitation, but we also discovered there was what we call the transition age youth mental health. And those were programs that served only those who were in the transition age, whereas child mental health served children up to age 18, adult mental health served young adults and adults ages 18 and older. And VR essentially served individuals who were 14 and older.

So within the programs we identified a potential key informant who is someone who knows the organization and their relationship with other organizations so they were in a good position to answer the questions. We then sent both through regular mail and email an invitation, a fact sheet and a link to the web survey. And then we sent many, many many reminders to encourage as much participation as possible. Any participant received a 20-dollar gift card. And we were able to recruit -- we got 223

programs that were named. We found that 198 of them met our criteria for what we were looking for in a program. We sent invitations to individuals there and got a 51% response rate.

The web survey that we sent had four sections. There was a section on getting basic program information. And then we implemented a measure of collaboration. This collaboration measure was adapted from the social network analysis questionnaire that Joe morcy and colleagues had used repeatedly in the 1990s and early 2000s. And the questions were adapted so that an individual was reporting on their program's collaboration with a group of other programs in traditional social network analysis, an individual would report on their programs with how frequently they made referrals to another specific program in their community, but because we didn't have large networks to ask this of, instead of saying how often do staff from your program meet with staff in this other program for client planning purposes, we asked how often do staff in your program meet with staff from child mental health programs for client management purposes.

So it was an adaptation of that measure.

We then had a section that had questions about the malleable correlates of the collaboration. There were three items on the perceptions of key stakeholders or systems leadership goals and rewards for collaboration, seven items on complementterity, two items on relationship quality, and four items about the depth of knowledge about the other programs, and finally a short section on respondent characteristics. We ended up having 100 programs and 100 respondents that we felt was a fairly robust response rate given the distance and the type of study that this is.

You can see from these characteristics of the person who was answering on behalf of their study that most of them were White, most were female. They had job responsibilities that typically included administrative duties and supervision of front line staff as well as a variety of other responsibilities. They were quite experienced and most of them had been in their position for quite a while so we felt they were very appropriate key respondents.

The programs that they were reporting on also very much captured the nature of the programs that we were trying to recruit. So you can see that 30 of the programs were from child mental health programs, 26 were transition age youth mental health programs, 26 were adult mental health programs, and 18 were vocational rehabilitation programs.

Across the 100 programs, programs typically served a client population that was comprised of about half males. About half reported serving transgender individuals and they served moderate populations on average. The vast majority were private nonprofit businesses, they provided mental health services followed by vocational rehabilitation services and then a variety of other services. And they were most commonly funded by Medicaid and then state mental health systems because so many of them were mental health programs, many of them received private insurance, private foundation funding. Almost a quarter of them received vocational rehabilitation system funding. Client fees helped support the work as well as Medicaid, substance abuse system also chipped in and you can see a few other types of funding sources. And on average, the ages of the programs were 24 years. They primarily were not brand new programs, although there was wide variability in the years that they had been in existence.

So our first question was about what is the level of collaboration between vocational rehabilitation and mental health programs. And we looked at this by the type of mental health program. And by that I

mean what age do they serve. So you can see the type of reporting program is on the bottom and the collaboration score is on the Y axis.

The bar represents the mean collaboration score that each type of program reported about the other type of program. So in this first group on the left, VR programs reported a mean collaboration score with adult mental health programs, that's the darker blue column, of about close to 13. With transition age youth mental health programs of about 12 on their score of collaboration. And with child mental health programs of almost 10.

The green bars represent the collaboration score that the mental health programs reported with VR programs. You can see that VR programs reported a lower level of collaboration with child mental health than with either transition age youth or adult mental health programs. Those pair wise comparisons were significant. If you look all the way to the right with the child mental health programs being reported program, they reported a lower collaboration with vocational rehabilitation than with transition age youth mental health programs although there was no difference with adult mental health. You can see in the next grouping to the left the transition age youth mental health programs also reported a lower level of collaboration with vocational rehabilitation programs than with either adult or child mental health programs. And in general adult mental health did not report differences in their collaborations. These were not significantly different and were generally relatively low.

Then if we look at the malleable factors that could be associated with collaboration level, we conducted a general linear model univaried analysis to examine the contribution of each type of malleable factor to the reported collaboration level.

So for example, where we see perceptions of collaboration reward, this would have been for a child mental health agency, their perception of collaboration reward for collaborating with the vocational rehabilitation programs. And the score of collaboration would have been what they reported as their score of collaborating with vocational rehabilitation programs.

You can see in this table that the only variable that was significant was the depth of knowledge. No other malleable factor was significant, including the not a malleable factor but including the type of mental health program. In other words, it was more important in contributing to the level of collaboration, depth of knowledge was the most important factor and the mental health program type, although we saw a lot of variability in their level of collaboration, it could essentially be explained primarily by their depth of knowledge.

An important aspect of this particular analysis was that the model accounted for 42% of the variance in collaboration score. That's a very robust model for explaining any given variable. so we had chosen appropriate variables to take a look at. If we look at that depth of knowledge in a little bit more detail, you can see that the depth of knowledge score increased the collaboration score also increased. So the depth of knowledge is across the bottom and the collaboration score with VR is along the Y axis. Specifically, as we observed a one point increase in the depth of knowledge, that resulted in an increase in collaboration of .73, which is close to a 1:1 relationship. So it was very, in many ways, tightly associated with an increase. We have to reiterate that this is a correlation. This is not predictive. We didn't manipulate anything and we didn't observe this over time, but it's a strong indication that the degree to which you get to know one another would facilitate your level of collaboration.

So our conclusions from the web survey study is the collaboration between child mental health and vocational rehabilitation programs is generally less than the collaboration between vocational rehabilitation and the other two types of mental health programs. That this lack of collaboration or lower level of collaboration might be due to a lack of knowledge about each other. And that perhaps by increasing activities that enhance better knowledge of each other, we may be able to increase collaboration between these two sets of systems.

Our final study is a secondary analysis of the national vocational rehabilitation database. This work was done in collaboration with Susan Foley, Joe maroni and Nye Quan from the Institute of community conclusion and with Nancy Koroloff who is our discuss ant for this presentation. This national database is what's called the RSA911 database. It collects the case closure data for all state vocational rehabilitation agencies. It collects the case closure data for any exit of a client in a given fiscal year. It provides the individual characteristics at the time the client applied for VR services. It provides their disability information. The services that they were provided and their employment outcome for those who received services.

RSA911 has been analyzed and reported in a lot of different research papers. One of the most to the point previous investigations was conducted by Todd Honeycutt and his colleagues where they examined youth who are 14 to 24 years old. Again, looking at the age group that the workforce innovation opportunity act defined as youth. And they looked at those who applied for VR services in 2004 to 2007 and their cases were closed by 2013. They looked at a variety of factors in understanding the experience of those youth in the VR system. And two of the things they reported about youth with mental health disabilities was they had a lower likelihood of receiving services. And of those who received services, they were less likely to close with a successful employment outcome than other disability groups. We were interested in understanding that in a little bit more detail. Our current analysis that we're in the middle of, we haven't completed it, but we have done some analyses that informs our conversation today. We examined the RSA911 database, again looking at youth with disabilities ages 14 to 24 and looked at fiscal years 2015 to 2017 in the 50 states and Washington, DC. This is during the time that WIOA was enacted and the rules were specified. We were interested in examining the similarities and differences between youth with mental health disabilities and youth with other disabilities to see if some of the characteristics might explain the poorer outcomes that Honeycutt and colleagues found and also whether we found similar lower use of VR services and poorer employment outcomes at closure.

For those who are familiar with that database, we developed a scheme for categorizing youth in different categories. So our group that we are most interested in is the green group, the primary mental health impairment. The source of impairment is a variety of mental health conditions. If what was listed as a source of impairment was ADHD, autism, intellectual disability or traumatic brain injury, they were not included as their primary mental health impairment being mental health. The second group were those who had a cognitive-based impairment and it was those disabilities such as specific learning disabilities, ADHD, autism, intellectual, you can see the list here, that primarily contribute a cognitive-based impairment. And individuals who had a primary mental health impairment were excluded from this category. So these two are mutually exclusive. The third categories are those youth with physical sensory or communicative impairments. And you can see in the third column the list of types of impairments that youth in this category had. We also found there was a remaining group of youth that fit into this other mental health impairment category, which was that they were reported to have a

cognitive psychosocial or other mental health impairment but didn't fit into either the primary mental health or cognitive-based group. Finally, there was less than 2% of the sample group of youth that had a substance abuse or impairment. We excluded the youth with substance abuse and [Away from mic] impairment and youth who had an unknown impairment from the analysis.

So if we look at the client demographics by their disability group, first of all, you can see the sample is huge. It's 485,159 youth.

And the green column represents those with a primary mental health disability. You can see they comprise 16% of the sample. You can also see those were the cognitive-based disability comprise a huge portion of youth who are served by state VR services. That's almost 63% of the sample had this kind of disability. The other mental health group was a small portion of about 5%. And those with the physical sensory or communicative impairment was about 15% of the sample.

The mental health population, we are going to focus on that group, so the primary mental health group, was more evenly male and female where you see a larger proportion of males in the cognitive-based disabilities. And you could say that the mental health disability group was a little bit more a larger proportion were White than other disability groups, but generally these were not markedly different distributions of race or ethnicity. What was markedly different was the age at which they applied for services. This graph shows the age at which each youth applied for VR services. You can see along the bottom they're 14 to 17, 18 to 21 or 22 to 24 years old. Throughout the remaining slides youth with the mental health disability are represented with the green bar and those with other disabilities are represented with blue bars. A very important finding here is that many more youth with mental health disabilities apply for VR services at ages 22 to 24 than in any other disability group, almost a third of youth with mental health disabilities doesn't apply to VR services until 22 to 24 years old. This is well past high school. It's even typically past if an individual is going to pursue college. This represents probably after they have started or completed college, for the most part. We think that this finding reflects the disconnect between child mental health programs and VR programs as well as the under representation of youth with mental health disabilities and special education. Looking again at the green bars, at the time that youth with mental health disabilities apply, so this is educational attainment at application, probably reflecting their older age group to a certain extent, they tend to have attained a high school education or some post-secondary education compared to other groups. You can see a slightly elevated bar on post-secondary and lower bar on less than a high school education. Probably more telling is that when they apply, youth with mental health disabilities are more likely than others to be not employed, so a very high bar in the second group from the left. And they are much likely than youth and other disabilities to not be employed at the time of application because they're a student or in training at the time.

So they are primarily applying when they are seeking employment and they don't have a job.

What we find is that more youth with a primary mental health disability who are eligible, they are eligible, but they don't have an individual plan for employment. So one of the major mechanisms that vocational rehabilitation services offer for planning the services that you will receive is to develop an individual plan of employment. And you can see in the mental health group that while the red bar is of comparable size to youth and other disabilities, the dark blue bar is higher. That is that they are eligible but they do not end up having an individual plan of employment.

Unsurprisingly then they are a little less likely to receive services, much as Honeycutt and colleagues found. Among the more common services that are received, you can see that in the green bars that the mental health population is less likely to receive other training, they're less likely to serve job search or placement services, and they're less likely to receive the more customized short-term employment supports. These are important services that this population is less likely to receive. If we look at the outcomes at the point that they are closed or their case is closed with vocational rehabilitation services, we start all the way to the right, which is the most positive outcomes that is after they have received services that they are discharged and they have an employment outcome at the time they are discharged. The mental health population is far less likely than youth in other disability groups to be exiting with an employment outcome. On the other hand, you can see in the red circled group to the left, they are much more likely than youth and other disability groups to have their cases closed after they have been determined eligible but before they received an individual plan for employment.

So as Honeycutt and colleagues found, this population remains up through 2017 to have less likely -- to be less likely to have a positive employment outcome at the time of closure. So those are the findings from our three studies. I did want to check to see, Nancy, do you want to go through the synthesis at this time?

>> I'm here. We have a couple of questions that I'm just looking at. I'm going to have you respond to -- if I can find it here. There's a question about the relationship between outcomes and the level of collaboration. Can you comment on whether or not this would be with the web survey, can you comment on whether there's any information in any of our data about that?

How does the degree of collaboration correlate to the outcomes such as employing youth training programs completed, et cetera.

>> This study, the collaboration study, it was based on the web survey, did not assess youth outcomes. And unfortunately, the RSA911 database cannot assess collaboration. So within these three studies, we can't examine the question about whether collaboration contributes to better outcomes directly. What we do know is from the research literature that on an individual basis, better collaboration -- so let's say if mental health programs that serve transition age youth had better collaboration with VR in the future, we might expect that youth from the mental health system would utilize VR services more, which we would consider to be a very positive step.

>> And here's a second comment. If the person from Michigan would like to raise their hand and add to this, please do that and Dee will unmute you. I'm going to read the comment. Special education in Michigan goes up to age 26. Some student families don't apply for VR or mental health services until they're transitioning out of that secondary education system. It's often a last minute scramble. Pre-apps have assisted us in making a more seamless transition with ISDs. Do we have that commenter on the line?

>> Yes, I'm here.

>> Do you want to say anything more about that?

>> No, I just wanted to chime in from the results that were provided in regards to the late age that some of those students may be applying for services. We have seen that as well here in Michigan. I am online from the Bureau of Services for blind persons and consumers age 14 and up and we have been

doing that before WIOA. But we have seen a lot of consumers with multiple disabilities, especially with those cognitive impairments or intellectual impairments, they are receiving special education services through a transition center. They're called different things, but they pretty much age out at age 26 and they receive their certificate of completion. And usually around that last IEP is when the family is really kicking into gear to apply for those VR or mental health services during that handoff from the ISD to the adult system.

>> Thank you. I also just want to -- you reminded me that the information that we have been talking about here is also going to be very useful, I think, to family members and to family organizations given that we're seeing that these young people often aren't in school, often don't have an IEP. It may, as often is the case, it may well fall to the family members or adult allies to help young people access pre-apps and also think about applying to VR. This is another -- is anybody from a family organization on the call, be interested in your comments about how you might be able to use some of this information. Do we have any other raised hands?

Okay. Please either write your questions in at the question box or raise your hand. I'm trying very hard to make sure I don't miss anybody's question.

So let's go to the questions that are in the slides. Do we have that slide, Maryann?

One of the things I would really like to hear from people about is given the pandemic and given the environment of COVID and also given some of the demonstrations and some of the racial tension we're all experiencing, how do you see what we are talking about in terms of building stronger ties between mental health and VR, how do you see that changing in this climate?

Anybody want to comment on that or have any thoughts on that?

I'm going to wait just a little while to see whether anybody raises their hands. Dee, you're watching for raised hands.

>> MODERATOR: Yes, I am.

>> Okay. Cynthia Barrow has her hand raised.

>> Go ahead, Cynthia.

>> Am I unmuted?

I'm from Boston and work for the Department of Mental health both adults and young adult. And I'm an occupational therapist but I'm usually the only person on the team that even thinks about VR and will facilitate referrals working with the young adults and completing a simple application and getting them connected. But I think right now in terms of COVID, the emphasis has really been on therapy and psycho pharm and I'm not sure where rehabilitation fits into all this. There's no in-person visits, the clubhouses that do employment are closed. So that's just a thought I have on the subject.

>> Any other thoughts?

>> MODERATOR: I'm unmuting Debra pick enwho also has a comment in the question box.

>> Can you hear me?

>> Yes, please go ahead.

>> I'm actually a parent educator with the exception of children assistance center in North Carolina so I work with parents who have children with special needs and I'm also a parent of a son that's totally blind with progressive hearing loss. And in North Carolina we can -- I actually started the process with my son, him inviting the VR counselor to his IEP meetings at the age of 14. I'm not sure about the other states, but I know that schools can't invite the VR counselor. He had to start advocating for himself and invite the VR counselor which was very helpful in him getting summer jobs working towards what his vision is.

And I guess my question is, when I'm looking at these numbers, why are we waiting until -- he actually just graduated from a four-year college. He's still working with his voc rehab counselor. I feel like once they get to that point, it's not too late, it's never too late, but we need to find a way to start earlier to help professionals in the school system collaborate with families to include the VR counselors. And he is actually getting weekly therapy sessions, mental health. I had to bring that in with COVID-19, which is helping him, but at the end of the day, our children with disabilities, they want to be able to add value to society. They want a job. Yes, that's great to have the SSI, but they want to get out there and they want to show that they have abilities and not go home and watch TV.

>> Thank you very much. I see another hand raised.

>> Nancy, can I comment on that really quickly?

This is Maryann. I just want to say how much I agree, Debra, that young people want to contribute to society, that their preference is to be engaged in work that gives back to society. And I'm so happy for you and your child who just finished college. It's wonderful that you have found the supports to help get him or her to that point. What I'm also hearing is that your connection to VR was through the schools. I would encourage any family members who are on the webinar today to perhaps think about how to, if your child is not in special education, how to connect with vocational rehabilitation perhaps through, if they're getting children's mental health services or transition age youth mental health services or even if they're young adults in adult mental health services, that that, we're hoping, will become a more common venue for getting young people connected to the really amazing services that vocational rehabilitation can offer.

>> Thanks. Shall we go to Andrew?

Andrew, are you on the line?

>> Yeah, can you hear me?

>> Yes.

>> I'm a pre-employment transition specialist in Montana. We created a separate bureau for pre-apps because we recognized we needed an entirely separate bureau to handle work with the schools and making sure we're getting referrals. I started as VR counselor, just transitioned in the pre-app specialist role a few months ago. One thing that we do that's unique in Montana is using our pre-apps funds we actually provide funding to the schools and a lot of high schools are in contract with us to provide pre-apps in-house. We start referrals at 14. That's what Montana's decided to do. Usually the transition from 8 grade to freshman year -- signing them up for high school about pre-apps and they're

getting the form signed to start working with us. Me as the pre-apps specialist I help coordinate the meetings with schools. Then we also work closely with the mental health agencies that are inside the schools. Most of our schools contract with outside mental health services. So I will go in and give inservices to those programs to ensure that the students with mental health are getting referred. An area that we still continue to find trouble with is getting 504 students referred just because the 504 coordinators are usually the school counselors or principals so they're less involved with voc rehab. That's an area we Australian Sign Language with. For the most part we found success starting at 14, giving inservices to IEP managers and special ed departments, talking to school counselors and principles. And attending any requests. A small rural school I'll be going out in August from 6 to 8 in the afternoon where teachers invite parents and students to learn about the school and different programs. I'll be out there with some information on our program. That's what we found worked here is making ourselves as available as as many different conferences as we can, being in the schools regularly and trying to get in touch with mental health providers as early as we can and educating them on what's available. It seems to be working very well.

>> Can I just ask quickly here, can parents or family members also refer themselves and their young people directly to you?

>> Yeah, absolutely. It's one of those things where I don't know how voc rehab as a whole is kind of a well kept secret even though it shouldn't be. It's been around for 100 years. A lot of people don't hear about it unless they had a friend or family member refer them and they say I have been working with Andrew through whatever high school. You guys should get in touch. I do get those from time to time. Otherwise our schools do a really good job if the student has an IEP they get the referral process started early. We do get referrals from parents and even therapists and mental health providers, we encourage them to send referrals as often as possible too, even if just a quick email or phone call that connects me to the parent or student. We can then start services that way. We take referrals really from anybody who's willing or able to contact us and to get the process started.

>> Thank you. We have one more comment that I want to draw your attention to. It's not a question. For many of you, if you haven't heard of the IPS or individual placement and support program which is an evidence-based model of supported employment and is often very commonly offered through adult mental health, you may want to go to the website that's mentioned here and just make sure that you know about it. The evidence for the model strongly encourages collaboration with VR, and we have made great strides in Tennessee to create a partnership between the Department of Mental health and VR. This model also has significantly -- I just jumped ... significantly higher successful outcomes in VR. We have HT, healthy transition program, in Tennessee as well as first episode psychosis and are making progress with the young adult population. Any other raised hands here?

I see Aubrey. Aubrey, would you like to make a comment?

>> Hi, good afternoon, everyone.

>> Afternoon.

>> We can hear you.

>> Can you guys hear me?

>> Yes.

>> Perfect. I work with VR down here in the state of Texas. I'm actually the navigator. I'm not sure, [Away from mic] really raised my hand to expand on and just give a little bit more insight to something that was stated earlier by the parent and also the mom that works in the disability realm as well is that reaching out, you have to continuously reach out, because that is a valid point. We don't want to see a kiddo turn 18 or 21 before we're putting them in pre-ette services because that goes down to the age of 14. If you have a kiddo that is 14, 15, 16, even if 13, about to be on the cusp of 14, I say reach out to VR then, reach out immediately. That's why we have these programs because we realize kids age out and we don't want them to go so far without having those services when they are available now. I do know that for counselors, that has been a huge change because mostly our counselors -- stated earlier in the presentation, used to working with adults. Now we're putting them in this position to work with youth. We're putting them in the position to work with adolescents. But that's part of the initiative that the states have seen. Those kids need help too and sooner than later. I would firmly recommend reach outreach outreach out. If you have a navigator reach out to them. If you reached out at a local level and haven't gotten the answers you feel you need, reach out to the state level. Go to state offices and say I think my child qualifies for services. Who exactly should I contact?

Because the service is out there and available. And I know for our schools here, our counselors actually do reach out as far as the school counselors, they do reach out to our VR counselors and say I have a student, we're doing an IEP, can you come. The VR counselor may not always make it, but they do reach out and ask because it is important to have them in there if they are available to do so because they have a lot on their plates as well but they are there for the kiddos. We don't want to see them graduate to the couch. We want to help them out as much as we can as early as we can. I just wanted to add that piece in there just to piggyback on what that mom was saying earlier.

>> Thank you. We have a request for Andrew in Montana, someone would like to know your contact information. Dee, how do we handle that?

Do they just put it in the chat box?

>> MODERATOR: If he's comfortable with it, he could -- it looks like I can copy it and send it out via the chat box right now along with his phone number. Give me one sec. I know I'm going to be the bad guy, but we're actually after time, so I don't know -- .

>> We'll wrap it up.

>> MODERATOR: Yeah, I'm sorry.

>> That's okay. Yes, if Andrew is okay with that, it sounds like a really interesting program in Montana and I'm sure other people will want to know more about it. If that's okay with Andrew, we will put that in the -- Dee will provide that. Otherwise we want to thank you all. Thank you Maryann and Anwyn. Any last comments?

>> No, just to say it's been a wonderful conversation and we appreciate everybody's time. And we're very impressed with the extent to which we have people from across the country and from different kinds of agencies and you shared your knowledge and experience and families as well. We're very appreciative of your time today.

>> My apologies to those people whose comments or questions we didn't get to. If we can, if it's a question we can answer, we'll do that online. Thanks, everybody.

>> MODERATOR: I can send you the questions. We have them recorded. And I can also post the comments, if folks are comfortable with that, that came in on our website as well so that folks can see what other states may be doing or comments folks put in that may be helpful such as the IPS works website. Thank you, everyone, so much. The video recording and the slides will be made available on our website. I would look for it next week just with the short week with the holiday for us. And be on the look out for future webinars. Thank you so much, everyone.