

Summary of site visits in ORSC/ODADAS cooperative agreement programs

In 1997, funds were made available for the establishment of “cooperative agreement” programs using both ODADAS and ORSC services. The funding was made available by a federal cost-share arrangement specified in the federal Rehabilitation Act reauthorization and Ohio general revenue funds. In all, six programs were funded throughout Ohio to address one of two special populations: persons with disabilities who experience a substance use disorder, or women on public assistance who have a substance use disorder. Eligible consumers under either category should be eligible for state vocational rehabilitation services.

Purpose:

Following some difficulties with start up of programs, especially regarding the relatively low number of persons enrolled with a rehabilitation plan, there was some discussion among RSC and ODADAS staff about the likelihood that barriers to program implementation were shared across sites. The SARDI program at Wright State University, the initial grantee for the cooperative agreement funds, was contracted to interview program directors and partners in order to ascertain the degree to which cooperative agreement programs are encountering similar situations. The interviews were not intended to be program evaluations as much as interviews and surveys to identify commonalities in barriers to success, as well as an investigation of practices with particular promise for addressing these populations of consumers.

Method:

A single day meeting was scheduled with each site, but prior to the visit a site survey questionnaire was mailed to the individual project directors. The written survey served to introduce areas to be covered in the site visit, and it also gave initial indications of barriers/problems across sites. All site visits were attended by Dennis Moore, Ed.D., SARDI Director, and Jo Ann Ford, MRC, SARDI Assistant Director, or Diane Davis, B.A., Director of SARDI’s clinical program. The site visits were undertaken on the following days:

House of Hope, Columbus	12/10/98
The Work Resource Center, Cincinnati	12/11/98
Health Recovery Services, Athens	12/21/98
The Rehab Center, Mansfield	1/27/99
Family Recovery Center, Lisbon	2/5/99

Following the site visits, all notes, surveys, program data, and other sources of information were compiled into site-specific folders. A modified qualitative data analysis technique, the “method of constant comparison” (Glaser and Strauss, 1973), was utilized to compare and contrast information across sites. Information that could be considered to fall under the same topic area

was gleaned from each site, and the categories were adjusted according to all information that was collected. The major categories that emerged are contained in this report, with annotations based on discussions among the principal site visitors.

Results:

The following is a summary of the results of SARDI's site visit consultations with the five ORSC/ODADAS cooperative programs in Ohio. For purposes of clarity, content has been categorized into seven major areas: administrative issues, cooperating agency relationships, services, consumer profiles, outcomes, promising practices, and recommendations.

A. Administrative Issues

1. Four of five sites report key staff turnover and/or administrative instability. In some cases this means that the original conceptualizers of the grant proposals are no longer with the agency and that some of the foundational inter-agency relationship-building has been lost. There is a sense that the original vision of some of the projects has needed re-thinking. In one instance, there has been key player turnover in two of the three original partners, which has required that administrative staff not included in the grant budget be more involved, creating additional administrative hardship on that agency.
2. While the majority of host agencies demonstrated commitment to the cooperative agreement projects, budgetary resources for administration of the projects were repeatedly noted as inadequate. All agencies agreed that the administrative needs for their projects are greater than the budgetary support planned and allocated.
3. In at least two programs, the staff believe that the project is not sufficiently integrated into the overall agency functioning, and that agency administrators do not understand the issues and population to be addressed within the grant project. This has resulted in less support for the project and less assistance in developing a stronger relationship with the project partners and other referral sources within the community.
4. Administration and staffing of grant-funded positions has been difficult in at least three of the five projects. At the time of the SARDI site visit, one site had a vocational coordinator position which had not been filled after nearly six months of funding. In two other projects, the Program Directors reported internal difficulties with key agency administrators which make smooth operation of the project especially demanding. One situation involves a major change in agency administration, and another apparently involves a personality conflict. Such conflicts are not uncommon to community agencies, but these situations can be expected to adversely impact project performance especially during the first year of operation.
5. As mentioned previously, grant funding has been inadequate to increase the administrative time required by some agencies. One collateral issue to this increased cost situation comes from the ODADAS/ADAMH Board system: cooperative agreement programs report that in a number of situations ADAMH reimbursements for AOD services don't cover the actual costs of services needed by eligible consumers, thus creating funding gaps. In some cases, consumers require more intensive or longer lasting treatment than what is authorized or reimbursed.

6. In all projects, the start-up activities have taken longer than anticipated. Working out the differences in community VR, state VR, and AOD systems; developing program structure and materials; and identifying and cultivating referral sources have all contributed to a somewhat slower startup than anticipated. It was felt by most projects that one year is needed to lay the groundwork and that second- and third-year funding would result in higher productivity.

B. Cooperating Agency Relationships

1. All five site visits revealed that development of strong interagency relationships remains a challenge. Among other issues, VR and AOD staff members commented that the two systems lack an understanding of each other and this results in gaps in consumer services. Some specific issues identified include the following:
 - a. A gap in vision between participating agencies occurred when sites lost the staff who were critical in the original development of the projects.
 - b. Expectations for consumer progress are sometimes in conflict. For example, some ORSC counselors expect AOD consumers to have at least 90 days sobriety before beginning to work with them, while some AOD agencies see a need for consumers to begin vocational rehabilitation as soon as possible. The reasons AOD providers cited for the need for rapid involvement with the VR system include issues relating to self-esteem, increasing family stability, and encouraging consumers to consider career issues rather than taking the first available minimum wage position which often results in recidivism.
 - c. Paradoxically, AOD treatment providers traditionally have not included VR services or work goals in consumer treatment plans, believing that stable sobriety should come first.
 - d. Either through design or how client caseloads are assigned, apparently in the case of at least two sites a single VR counselor constituted the majority of contacts with the cooperative agreement program. Additional referrals of existing cases from VR local offices did not appear to be occurring.
 - e. State VR counselors historically have not needed to recruit consumers or work on retention of ambivalent consumers; however, consumers in the cooperative programs are more likely to be ambivalent or resistant, and they may not understand the value of attempting to access state VR services. A change in approach (shared commitment between AOD and VR to work on consumer retention) may be necessary for greater project success.
 - f. Some projects have ill-defined or inactive relationships with their partners, undermining project effectiveness. Regular meetings with partners are not always the norm, and at least one cooperative program reported no meetings with the partner agency for a number of months.
 - g. Projects reported that there are few referrals from ORSC to AOD treatment agencies, and that consumers in the ORSC system who have rehabilitation plans are not being referred for these cooperative agreement projects. In some cases consumers are placed on "interrupt status" by their VR counselor; therefore the connection with the VR counselor

becomes tenuous and may be lost altogether. In one instance, the cooperative agreement agency is actually making referrals to state VR, but the consumer is then being referred by the VR counselor to agencies outside the cooperative agreement, making it very difficult to coordinate services.

2. The multiple-system involvement of consumers creates a critical need for cross-training of agency staff. Some examples are as follows:
 - a. Drug courts were potentially excellent referral sources, but at least one program interpreted that the courts demand immediate work by all consumers, although this is not necessarily the case. Therefore, some eligible consumers were never channeled into the system.
 - b. The multiple agencies involved in consumers' lives do not always do a good job of documenting disability status, therefore consumers are not referred into appropriate programs and may not be successful. For example, there seems to be a gap in the identification of disabilities and functional limitations of women using public assistance, which impacts not only consumer outcomes, but also the active referral base of consumers available for cooperative agreement program treatment programs.
 - c. Agency staff don't understand the rules and regulations of their collaborating systems, e.g., return to work laws that pertain to FCFC's, Ohio Works First, TANF. Similarly, AOD providers don't understand the ORSC mission and guidelines regarding order of selection, being the payer of last resort, and the definitions of status codes within the VR system. (One site reports that VR counselors have volunteered to do training for the AOD treatment providers on the nature and focus of VR services in order to improve program understanding.)

C. Consumer Profiles

1. All projects are experiencing a much greater degree of disability/comorbidity among consumers. In the three years of the welfare-to-work push, consumers with some job skills and appropriate life management skills and mild or no disability have been successfully placed in employment through the efforts of community VR programs, state VR, AOD treatment providers, and other state programs. The consumers remaining in the public assistance "pool" are much needier and have fewer resources to draw on. The following specific comments were provided :
 - a. Many of the projects' consumers are enrolled in welfare-to-work programs, TANF funded efforts, and include both women and men on some form of public assistance.
 - b. Participants tend to be more transient than in past years, creating a high dropout rate and making retention and followup difficult, if not impossible.
 - c. At least three programs stated that consumers' functional limitations are much more severe than originally conceptualized for the grant. These limitations have often been

- undiagnosed or under reported by systems previously involved with the consumer. It is suspected that this leads to a lower referral rate, especially for women.
- d. All programs report a high rate of comorbidity with severe mental illness. Three of the five programs estimate that perhaps 50% of their consumers have or would qualify for 508 status in the community mental health system, meaning they are “chronically mentally ill”.
 - e. Three programs reported that fear and low self-esteem were seen as major barriers to consumers’ willingness to engage with projects and follow through, and this may be particularly relevant to women on public assistance.
2. Cultural issues were identified by three of five projects as significantly impacting the results of their work, far beyond what was anticipated at the time of proposal submissions.
 - a. In Appalachian culture there is a perception that an individual should take all “government benefits” possible, as this enables the individual to be “independent.” Any program which stresses true self-sufficiency (generating one’s own income and benefits) produces fear and resistance.
 - b. Deaf culture has its own norms, and traditional AOD treatment and VR programs have been less-than-effective in relating to deaf consumers, who continue to feel and operate outside the mainstream, but who are generally very comfortable with their peers.
 - c. Several programs reported that consumers feel a great deal of pressure to go to work immediately and take the first available job just to generate income. They have difficulty understanding the goals and value of a VR process and the time it takes. A vision of “career” or “life’s work” is foreign to consumer thinking. This makes recruitment and retention very difficult as it is typical for the treatment/VR process to span at least several months.

D. Services

1. In actual practice, some of the services described in the grant proposals are not being provided or are given low priority in the face of immediate consumer needs (two projects identified this as a problem). Consumer mental health issues, for example, often impact a provider’s ability to offer VR or job placement assistance. Some ORSC counselors indicate that AOD providers are not responsive to the population served and tend to have rigid rules which impact delivery of VR services.
2. Due to the difficult nature of the consumer population, staff are not always successful in portraying the advantages of VR services. As mentioned above, some consumers shy away from VR referrals because they lack a career vision for themselves or are driven by the need for immediate employment.
3. Two programs reported that it is critical that intake procedures be consumer-friendly and help with the recruitment process. Mass intakes and expectations that consumers fill out lengthy paperwork without assistance are examples of procedures to be examined. Also,

some programs begin their intake procedures by having consumers complete paperwork – even before hearing about the program and what it may be able to offer them.

4. A very basic barrier to the delivery of services concerns consumer worries about losing benefits. Consumers have difficulty risking the status quo for the possibility of fewer resources outside the public system. Cooperative agreement programs have not systematized a process for explaining benefits status to consumers. In site visits where TANF or social security professionals were present it was obvious that program staff did not fully understand the provisions currently available for addressing specific situations faced by consumers.
5. In many areas, especially the rural Appalachian ones, there are actually very few jobs available. Motivating consumers and helping them envision a meaningful work future is difficult when opportunities for employment are scarce.
6. Also in the rural areas, the lack of public transportation was cited as an issue. Agency staff try to fill this gap but have neither the time nor the funding to do so in a consistent manner.

E. Outcomes

In all five site visits the issue of outcomes generated a great deal of discussion. Some of the key points are described below:

1. The success of the programs is a function of perception, more than performance. This appears to hold true for all players, whether from the primary agency, VR counselors, or cooperating agency perspective. Although numbers may be low and progress to date may be less than proposed, most agencies believe that there have been significant gains made on behalf of consumers, and in the development of inter-agency relationships.
2. State VR counselors face large barriers in expectations for “26 closures” for the target population. As described earlier in this report, many consumers being served by the cooperative agreement programs have multiple and compound functional limitations, and consumers will require more support and a greater investment of time and resources in order to achieve “success.”
3. Most programs overestimated the number of consumers to be referred into the state VR system during the grant period, and underestimated the amount of time it takes a consumer to enter that system, move through the various treatment and VR components, and become employed. This impacts the numbers for the grant period, but should not be viewed as the only measure of success of the projects.
4. Traditional outcome measures may not be sufficiently sensitive to document consumer progress in areas such as alcohol and drug use, vocational adjustment and progress, community integration, or quality of life. Consumers likely will take longer than average to complete the process of AOD treatment and job acquisition.
5. By contrast, some consumers being recruited into the cooperative agreement programs are sufficiently functional to locate and secure minimum wage jobs on their own. Due to consumer perceptions of the need to find immediate employment or lose all benefits, they are reluctant to engage the VR process even if it could be of future assistance to them.

No instruments or measures are currently being employed which gages the need for addressing this issue early in the treatment planning process.

F. Promising Practices

Some notable programmatic strengths and promising practices emerged during the site visits, and cooperative agreement programs appear to be making an impact on consumer success. Some are described below:

1. Benefits analysis services increasingly are being provided for consumers as they participate in services or as referrals to state VR are made. This serves to lower anxiety, empower consumers with more information about what they stand to gain and lose by pursuing self-sufficiency, and increase retention in the program. VR counselors are reporting that a review of the benefits analysis with the potential consumer should be one of the first activities in the development of a rehabilitation plan.
2. Relatively intensive case management services are provided at two of the five projects, and staff at these two sites report that consumer retention is increased. Due to multiple comorbidity with mental illness, and other functional limitations (some of which arise from poverty, geographic location, lack of transportation or childcare), case management services may be necessary for many consumers of the cooperative agreement programs. Case management can be the link in providing interagency “seamless” services that occur with fewer gaps or delays in services. Definitions of “case management” vary, but in this case it refers to the provision of case coordination as well as components of “wrap around” services where the case manager can attend to a larger rehabilitation plan than may exist within a single agency.
3. At least one program has a staff member attend the first state VR appointment with consumers, resulting in lower consumer anxiety and much greater follow through on VR referrals.
4. It was reported by three of the programs that regular meetings are held with cooperative partners, including VR counselors, to discuss either specific consumer issues or larger programmatic concerns. It is suggested that this process could be strengthened even more by the inclusion of staff from the cooperating agencies mentioned in the grant proposals but not designated as the primary funding recipient. It is recognized that holding meetings that can be attended by AOD treatment staff is often difficult, due to time restrictions and productivity standards for staff. In some cases, this may require seeking an administrative release from the program director in order to ensure participation by the AOD provider if they are not directly reimbursed by the cooperative agreement grant.

G. Recommendations

Systems needs for additional services and supports were identified in the process of the site visits. Some of the consistently mentioned issues are as follows:

1. Emergency services, especially those providing some immediate cash assistance, are desperately needed. Consumers who are in crisis over unpaid utility bills, food shortages, or medical care, are much less likely to engage in a meaningful long range planning process. Cooperative arrangements with possible sources of such support should be included in these projects, such as local health boards or TANF
2. Measurements and definitions of success are not finite enough to describe accomplishments by current consumer populations. Consumers with multiple disabilities, limited life management skills, and cultural barriers to participation in the system, need additional methods for assessing rehabilitation needs and progress toward goals.
3. The local ADAS or ADAMH boards, or ODADAS service standards for productivity in the delivery of alcohol and drug treatment services is not congruent with the needs of this multiple-need population. In order to comply with existing productivity standards (e.g., number of persons in group counseling to qualify for units of service), agencies must try to serve too many consumers in too little time. This results in lower effectiveness and retention problems with consumers. Development of more realistic standards for “chronic” or “medically fragile” or “functionally limited” consumers should be developed as exceptions to service standards.
4. Cooperative agreement programs, VR counselors, and other partners in these endeavors must understand that many consumers qualifying for these services experience substantial and numerous barriers to full time, competitive employment. These barriers include in many cases multiple disabilities; an unsuccessful or non-existing prior work history; poor pre-vocational skills relative to independent living, self-care, interpersonal skills, or self-monitory behaviors; an over-reliance on what is perceived to be “all or nothing” social benefits; lack of meaningful transportation; unstable living situations; and, services delivery that is not properly sequenced or slow in provision of services. Considering these multiple factors, progress will be slow, and programs must continue to explore methods of service delivery over time. Consumers in these programs in many cases do not fit the older stereotype of an individual with a physical disability who utilizes VR to accommodate to the work place.
5. Additional training and networking of these programs could be very helpful. In many cases, the nature of consumer needs and the services delivery models being utilized are different than what has been experienced before. Time to share experiences could assist these programs, and this was spontaneously mentioned during three of the site visits. Training areas to consider include:
 - ORSC mission, “typical” case flow, and status codes
 - Promising new models of AOD treatment that include VR goals
 - How to assess “hidden” functional limitations for treatment planning
 - Public assistance alternatives and programs for bridging support for work
 - Establishing and measuring program and consumer outcomes
6. In most cases (at least three of five sites), the total grant project administration assigned did not appear to be sufficient to deal with all issues associated with start up and

maintenance of smooth operation. In at least two locations, key lead agency administrators were removed from the daily operations of the project to such a degree that there was minimal input or interaction with the grant project relative to the amount of time allocated to other agency components. For the projects that appear to have addressed this issue, they report that administrative time, beyond that funded by the cooperative agreement, is necessary in order to maintain project services. Two Project Directors mentioned this directly during the site visits. It is recommended that projects review administrative needs with their respective Project Officers in order to ascertain if adjustments in time and personnel are worth considering.

7. VR counselors from the same district or local offices as the cooperative agreement program should explore protocols for referring existing consumers of VR services to these programs. It seems that a number of current VR consumers could benefit from the cooperative agreement programs, but are not currently being referred.

Conclusion

The site visits were especially enlightening regarding a number of commonalities shared across sites. These include the revelation that many consumers qualifying for these cooperative services represent more complex and demanding cases than had been anticipated. Defining and elaborating cooperative working arrangements with multiple agencies, including state VR services has required much dialogue and planning, as well. The site visitors from SARDI have the strong impression that a number of very dedicated and competent professionals are involved with these projects, and a positive spinoff of these efforts will be the establishment of better and more integrated services for consumers in the future. It also seems clear that establishing these programs as viable service alternatives will take continued work, quite possibly beyond the time frames that were originally proposed. However, there have been a number of other positive outcomes even in the short period of time that the programs have been operational. These positive outcomes include the increased dialogue and planning between AOD and VR providers, a stronger focus on inter-agency case planning, and a recognition of the importance of features such as case management and benefits analysis when addressing the needs of persons with coexisting disabilities.