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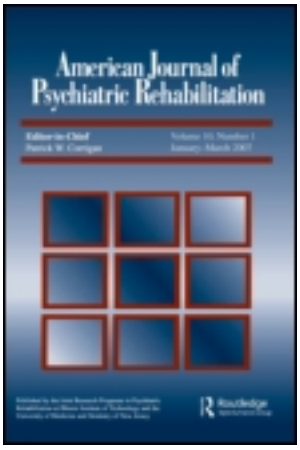

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The first Queensland trial of integrated services at West Moreton was supported by a Rotary Health Evaluation Grant in 2006 and 2007. In 2008–2009 the ESI-12 project was supported by the Mental Health, Alcohol and Other Drugs Directorate (MHAODD) of Queensland Health and the Queensland Centre for Mental Health Research (QCMHR). This support is continuing through 2010 and 2011. We thank Aaron Groves, Elizabeth Powell, Renee Ryan, and Renate Woodward of MHAODD; Geoff Lau of the Princess Alexandra Hospital Mental Health Service; Nikki de Jonge and Liza Scriven of Steps Employment; Cathy O'Toole of Advance Employment; David O'Halloran of CRS Australia at Bellerive; Francis Gilfedder of the Queensland Centre for Mental Health Research; and Meredith Harris of the University of Queensland.

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To argue that public-funded mental health services can provide better value for the community by becoming more recovery and social inclusion oriented. One way to achieve this is to implement evidence-based practices in supported employment by integrating employment services with community-based treatment and care. One of the necessary changes that this approach involves is close integration between continuing mental health treatment and care and supported employment services. The implementation of 12 formal partnerships was observed qualitatively over a 3-year period. Research and service delivery staff at all 12 sites contributed information about the supporting factors and challenges encountered in establishing formal partnerships between existing supported employment services and local community mental health teams. A range of supporting factors and implementation challenges were identified during the establishment of 12 such formal partnerships. These results suggest that formal partnerships could be established more rapidly and more sustainably if these potential issues are anticipated and addressed. Formal partnerships between community mental health service teams and supported employment providers can be successfully established in Australia. Although they may be more challenging to implement than the alternative direct employment method, successful formal partnerships promise to improve the value to the wider community of public-funded mental health services.

Keywords: *Evidence-based practices; Mental health; Recovery; Supported employment*

THE RATIONALE FOR INTEGRATING MENTAL HEALTH AND DISABILITY EMPLOYMENT SERVICES

Internationally, the usual approach to providing community mental health services is in isolation from vocational rehabilitation and supported employment services. However, this segregation is now also known to produce fewer competitive employment outcomes for clients. The best example of improved integrated approaches to supported employment is individual placement and support (IPS), which was designed specifically for people with severe and persistent mental illness (SPMI) who typically receive treatment and care from a public-funded community mental health team. When IPS is delivered as intended with high fidelity to the core principles and practices, the results are promising (Bond, 2004; Bond, Draker, & Becker, 2008). In addition, several studies specifically support the principle of the IPS model that close integration between vocational and mental health services promotes better employment outcomes (Bond; Cook et al., 2005; Gowdy, Carlson, & Rapp, 2004; Rapp et al., 2010).

In a recent review of 11 higher fidelity randomized controlled trials (Bond et al., 2008) 62% of clients commenced competitive employment over periods of 6 to 24 months. This compared with 25% when other traditional and segregated forms of employment assistance were provided. (Bond, 2004; Bond et al.; Burns et al., 2007; Cook et al., 2005; Killackey, Jackson, & McGorry, 2008; Latimer et al., 2006; Twamley, Jester, & Lehman, 2003). More IPS clients than control service clients worked 20 or more hours per week (66% vs. 14.2%). Among those who obtained a competitive job, the time to first job averaged 144 days for IPS participants vs. 214 days for controls, a difference of 10 weeks (Bond et al.).

In Australia, a randomized controlled trial involving 41 young people with first episode psychosis (Killackey et al., 2008) found similar benefits. Better outcomes compared with treatment as usual (no enhancement to usual case management) were obtained for employment commencements (13 vs. 2, $p < 0.001$), hours worked per week (median 38 vs. 22.5, $p = 0.006$), and total new jobs acquired (23 vs. 3). Although these Australian and international studies did not specifically investigate the extent of integration, they provide indirect evidence that when integration is included in a set with six other supported employment service principles, the integrated

services consistently outperformed the alternative vocational services, which were typically segregated services.

Establishing formal partnerships aligns closely with the first priority of Australia's Fourth National Mental Health Plan, namely, to develop better mental health service structures to improve social inclusion and recovery outcomes for clients with SPMI (Australian Government, 2009a). The second action listed in this plan (p. iv) is to ''coordinate the health, education and employment sectors to expand supported education, employment and vocational programs which are linked to mental health programs.'' In addition, the new National Mental Health and Disability Employment Strategy (Australian Government, 2009b) makes direct reference to the National Mental Health Plan, and it became demand driven from March 2010, meaning that all eligible referrals to contracted disability employment services can attract outcome-based recurrent funding.

The need for strong intersectorial links to mental health services in Australia was first recognized as critical at the outset of the first National Mental Health Strategy (Whiteford, 1994), but it has never been successfully implemented nationally (Whiteford & Buckingham, 2005; Whiteford, Buckingham, & Manderscheid, 2002). Strong intersectorial links are needed because population studies show that 80% to 84% of people with SPMI have become excluded from the labor force (Waghorn, Chant, Lloyd, & Harris 2009) compared with 23% to 26% among healthy adults. Approximately 28% of current disability support pension recipients have psychiatric or psychological conditions as their primary source of disability (Australian Government, 2009b). In our experience, segregated services as usual equals disability and social exclusion as usual, in which clients may get basic mental health care but little is done to support individual vocational goals, even though there may be a requirement for these to be considered within individual recovery plans (Lloyd, Deaner, Tse, & Waghorn, 2009; Lloyd & Waghorn, 2008). This is particularly unfortunate for clients because real vocational progress can drive recovery and increase clinical engagement while providing new opportunities for increasing social inclusion in the wider community.

The relationship between vocational progress and clinical engagement may be dynamic. For instance, we found through anecdotal reports in previous studies that the new opportunity to directly access employment services can strengthen initial clinical

engagement (Porteous & Waghorn, 2007, 2009), particularly among young people with first-episode psychosis when employment assistance is the client's most preferred form of assistance. On the other hand, there is evidence that vocational progress may diminish clinical engagement in the medium term as clinical care becomes less necessary or as people become established in employment—and tend to use fewer mental health services (Bush, Drake, Xie, McHugo, & Hoslet, 2009; Perkins, Born, Raines, & Galka, 2005; Schneider et al., 2009; Strickler, Whitley, Becker, & Drake, 2009).

THE AUSTRALIAN SERVICE DELIVERY CONTEXT

Australia has a national network of community-based mental health services linked to public hospitals for the provision of outpatient care, and inpatient care when needed. The mental health system is funded by state-federal funding agreements, while services are managed by six state and two territory governments. Mental health treatment and care is provided at no cost to Australian residents with severe and persistent forms of mental illness, provided services are available and accessible in the local area. Otherwise, community residents can access mental health treatment through private medical practitioners, psychologists, or psychiatrists at wholly or partly subsidized rates through Medicare, the national health scheme.

The funding and delivery of mental health treatment services in Australia and New Zealand, as in most developed countries, is typically segregated from the provision of employment services (King et al., 2006; Browne, Stephenson, Wright, & Waghorn, 2009; Killackey & Waghorn, 2008; Waghorn, Collister, Killackey, & Sherring, 2007). In Australia, employment services are the responsibility of the federal government and are administered by the Department of Education, Employment, and Workplace Relations (DEEWR) as the sole purchaser of contracted services. Three main types of publicly funded employment services are available. Services are typically provided by nongovernment organizations (for-profit and not-for-profit), consisting of (1) mainstream services for unemployed persons and sole parents (known as Job Services Australia) with four levels of service intensity, depending on the needs of job seekers; and (2) Disability Employment Services, which are further divided into two distinct programs. Disability Management Services are for job seekers with disability, injury, or health conditions who require the assistance of

a disability employment service but who are not expected to need long-term support in the workplace. The second Disability Employment Service program is an Employment Support Service for job seekers with permanent disability and with an assessed need for more long-term and more regular support in the workplace. In addition, for those who are injured at work or in motor vehicle accidents, both public (state and territory governments) and private insurers provide vocational rehabilitation as part of an insurance contract.

A BRIEF HISTORY OF INTEGRATED SERVICES IN AUSTRALIA

In 2007, Queensland Health supported a 3-year trial of eight integrated employment specialists in six health districts using a mix of state and federal government funding. These arrangements also enabled additional sites to participate in the trial in 2008 and allowed similar partnerships to be established independently of the research trial. By October 2010, eight Queensland health districts had established formal partnerships with disability employment services that colocated 16 full-time employment specialists into community mental health teams. Another five partnerships are currently being planned. These partnerships build on the success of a 2006 partnership established in the West Moreton Mental Health Service District in the western suburbs of Brisbane. A 3-year trial of 12 of these integrated employment specialists—11 in Queensland and 1 in Tasmania—is known as the Employment Specialists Initiative (ESI-12). This study is due for completion in 2010 and final reporting in 2011. The implementation experiences at these 12 sites, where employment services and mental health services were intended to be closely integrated, provide the basis for this report. Characteristics of the 12 trial sites are shown in Table 1.

Other Australian Pioneers

Three other Australian organizations have made advances in this direction. In 2006, a youth mental health service in Melbourne commenced an integrated service by directly engaging an employment specialist as a member of an early psychosis treatment team (Killackey et al., 2008; Killackey & Waghorn, 2008). Here, the employment consultant is employed directly by the mental health service outside the federal government's disability employment

TABLE 1. Partnerships established under the Queensland Employment Specialists Initiative (ESI-12)

Locations	Mental Health Service	Disability Employment Service	Number of Co-located Employment Specialists	Initial Seed Funding	Expansion Plans
Cairns	Cairns and Hinterland Health Service District	Worklink	1	Yes	No
Kirwan, Townsville	Townsville Health Service District	Advance Employment	2	Yes (for one site)	Expanded in 2009 to a second colocation at North Ward.
Nambour	Sunshine Coast Health Service District	STEPS Disability Employment	1	No	Expanded in 2010 to 8 new colocations at Maroochydore (4), Bundaberg (2), Hervey Bay (1), Maryborough (1). Further colocations planned in 2011 for Mackay (1) and Bowen (1).
Chermside, Pine Rivers, and Prince Charles Hospital	Metro North Health Service District	Comepass Employment, Help Industries, Red Cross Employment	2	Yes (for both sites)	Expanded in 2010 to 3 new colocations at Nundah, Caboolture, and Redcliffe.
Windsor, Royal Brisbane Hospital, and Fortitude Valley	Metro North Health Service District	Breakthru	1	No	No. Expansion limited by unsuitable physical facilities.
Macgregor, Brisbane	Metro South Health Service District	Breakthru	1	Yes	No

(*Continued*)

Table 1. Continued

Locations	Mental Health Service	Disability Employment Service	Number of Co-located Employment Specialists	Initial Seed Funding	Expansion Plans
Wacol, Goodna, and Ipswich	Darling Downs-West Moreton Health Service District	Connect2 (Previously Workline)	2	No	Expanded to a third colocation at Redlands Hospital in 2010. One further colocation being considered.
Ashmore	Gold Coast Health Service District	Centacare Employment Group	1	Yes	Yes, Ashmore colocation ceased in 2009. New colocation planned for 2010.
Bellerive, Hobart, and Tasmania	Tasmanian Department of Health & Human Services	CRS Australia, Bellerive	1	No	Planning 2 further colocations in southern Hobart.

service contracting system (DEEWR, 2007; King et al., 2006). Although funding from another source remains available, this site does not need to establish a formal partnership with a disability employment service.

By October 2010, 13 further partnerships had been established with Victorian community mental health teams. The first Australian integrated service using a formal partnership method commenced in regional Victoria in 2006 (Waghorn et al., 2007), and it has recently expanded to a second regional partnership in Victoria. In New South Wales, the Hunter New England Mental Health Service successfully established an enhanced intersectorial links method (King et al., 2006; Sherring, Robson, Morris, Frost, & Tirupati, 2010) for facilitating and monitoring referrals from mental health teams to several disability employment services in the local region. This team is currently planning three formal partnerships to provide colocated services in New South Wales.

Successes and Failures in Establishing Formal Partnerships

Since 2006, approximately 30 formal partnerships have been successfully established throughout Australia and another 21 in New Zealand. In Queensland, 7 of 16 health service districts are now involved in this program. Although new partnerships are planned in Queensland, New South Wales, Victoria, and Tasmania, to our knowledge the four remaining states and territories are not currently experimenting with this approach. There have also been three notable partnership failures. In Queensland, one partnership failed for multiple reasons despite being involved in the ESI-12 trial. One of the major reasons for failure was that the employment service did not adopt evidence-based practices sufficiently thoroughly to succeed and inspire confidence among the clinical team. A second major reason for failure was that the clinical team sometimes did not take responsibility for managing the development of an integrated service. This is explained by one senior mental health team leader, who noted that ''the nature of public mental health services is very focused on clinical crisis management and symptom reduction and less focused on the rehabilitation needs of the clients. This ultimately impacts on where limited resources (space, time people) are directed and where the priorities are for case managers.''

In northern Tasmania, a planned partnership failed at a late stage due to the mental health team's not providing a nominated coordinator and the physical resources needed for joint-service delivery. In an urban location in Western Australia, an established partnership failed after 2 years of part-time operation, most probably because the employment specialist operated as a visiting officer two mornings per week and never achieved a sufficient profile with the mental health team. The main problem with part-time partnerships or visiting services (Waghorn, 2009) is that some mental health team members also work part-time and may not attend case review meetings; therefore, the employment specialist may not get to know all staff directly and may not elicit referrals from each team member, and hence may not develop shared care arrangements with clients of each staff member. This in turn limits the prospects for the development of integrated services wherein client vocational goals are routinely addressed in all individual treatment and recovery plans.

Although the fidelity scale indicates that employment specialists can be linked to up to two clinical teams (Bond et al., 2001) in a partnership model, employment specialists also have a home employment service with which they must meet weekly to stay in touch with their employer, their peers, and the employment program requirements. The most successful sites in our ESI-12 involved a simple one-to-one arrangement in which a full-time, colocated employment specialist operating from one clinical team and sourcing clients only from that clinical team. This seemed particularly important when clinical teams were large—200 or more active clients— because demand often grew quickly to generate a full employment specialist caseload within 3 months. We also found that personal contact with individual team members was more important than attending meetings in the early stages until there were enough clients employed and clearly making progress, to warrant discussion at case review meetings.

Another barrier to partnership formation has been the lack of suitable facilities within the mental health service building. Due to the varying suitability of office accommodation, some willing services have not been able to accommodate an employment specialist on a full-time basis alongside other mental health team members. In other cases, whereas a desk, telephone, and car park were available, sufficient access to interview rooms was not. Sometimes this was solved by developing more efficient management of shared interview facilities.

One important lesson from these early failures is that colocation is more likely to lead to service integration if it is established as a full-time endeavor with ongoing joint service management and onsite leadership by the mental health team (Waghorn, Lockett, Bacon, Gorman, & Dorie, 2009). The rapid growth of partnerships in some Australian states is promising, but unless we learn from these early experiences about how best to establish a formal partnership, there are risks of failure that could prevail even if the joint service attains the expected client employment outcomes. Despite these difficulties, the growth of formal partnerships is accelerating, inspired by some successful partnerships. These affiliations use informal networks of practitioners and researchers who recognize the feasibility of this approach. The key issue now is how best to establish and sustain partnerships that enhance the value to the community of both public mental health services and disability employment services.

INTERNATIONAL STRATEGIES FOR INTEGRATING SERVICES

The most common strategy for adopting these practices in the U.S. and U.K. has been by direct employment of an employment specialist as a new member of the community mental health team. In the U.S., the employment specialist is also sometimes employed by another branch of government, namely the state-federal vocational rehabilitation system. However, these approaches to service integration are not practical in Australia because of duplication with an existing national network of disability employment services funded on a per-capita, employment-outcome basis. A more feasible approach involves establishing formal partnerships so that an employment specialist employed by an established disability employment service can be colocated into a mental health team to build a full caseload of shared clients. This method is also found in New Zealand where Workwise Employment recently established 21 formal colocation partnerships with public-funded mental health teams from Auckland to Wellington. Another seven locations in Rotorua and Taranaki regions are using a less optimal attachment method until full-time colocations can be formally established.

ESTABLISHING NEW PARTNERSHIPS

Each site in the Queensland ESI-12 trial was implemented according to a common, yet flexible, basic plan. The first six sites enrolled

received seed funding from Queensland Health Mental Health Alcohol and Other Drug Directorate of $AU75,000 per site in the first year and $AU50,000 in the second year to reimburse the initial costs of joint service delivery. The next six sites that volunteered to join this trial did so on the basis that seed funding was not available and that they must contribute to the cost of participation in the research trial. Partnerships that received seed funding do not seem to have become any better established than those that have been self-funded, as there have been successes and failures within each group. The implementation plan for each site consisted of the following steps: (1) providing assistance to the mental health team to identify disability employment services in the local area; (2) sending information to those employment services to invite them to a joint presentation on evidence-based practices; (3) a presentation to staff of both services on evidence-based practices, the roles of all staff involved, and a discussion of implementation issues previously encountered; (4) distribution to interested services of resources needed to establish formal partnerships, such as sample service level agreements, sample minutes for steering group meetings, DVDs from Dartmouth Psychiatric Rehabilitation Center about implementing the IPS Supported Employment model, and copies of PowerPoint presentations and other relevant Australian publications. In 2009, a comprehensive information resource, ''Building a Career of Your Choice,'' written for clients, clinicians, and family members, was distributed to all sites (Harris, Cleary, King, & Waghorn, 2009; King, Cleary, Harris, Lloyd, & Waghorn, 2011).

In the early stage of implementation, each ESI-12 site received an initial 3 hours' training in evidence-based practices in supported employment designed for employment service and mental health staff. However, training was not a requirement for partnership implementation, and not all members of mental health teams attended this training. Most employment services stated that training for their employment specialist was not necessary because they considered that they were already using evidence-based practices and already had contracted to demanding, outcome-based funding targets. Partner employment services typically assigned employment specialists experienced in their employer's usual practices. Most disability employment services involved considered that the only likely change to their existing practices would be delivering the service as a joint program from within a community mental health team.

To encourage the development of IPS practices, each employment specialist was provided with a copy of the IPS Fidelity Scale and manual (initially the 15-item version [SAMHSA, 2009], replaced in 2010 by the 25-item version, unpublished) and asked to make self-assessments for detailed item-level discussions by telephone with one member of the investigating team. The research component of the trial was coordinated separately. Research officers were appointed to interview all clients of the joint service and control clients at each site and were trained in data collection for this study. Ongoing support for the research component was provided by regular telephone conferences and by one-to-one supervision. Research officer salaries were provided from the research budget with the exception of officers from two sites that contributed this resource. A common monthly snapshot reporting system for employment outcomes was designed for use by all sites. This was used to monitor the caseload and employment outcomes attained and the implementation of several IPS practices. A statewide steering group was established from representatives of each site to support the Queensland sites in particular, meeting quarterly to keep all stakeholders, including the Queensland Mental Health Alcohol and Other Drugs Directorate, informed about progress toward the goal of establishing an employment specialist on every Queensland mental health team.

IMPLEMENTATION EXPERIENCES

Information about implementation experiences at each site was collected using several methods. The investigation team was in regular contact with sites to provide ongoing support. Investigation team members attended steering group meetings in person or by telephone conference as requested by site coordinators. Troubleshooting visits and onsite training were provided as required, although these were rarely requested. Minutes of steering groups were also examined for salient issues, and site coordinators and employment specialists were invited to submit comments on relevant issues each year. Employment specialists were encouraged to submit copies of their monthly snapshot reports each quarter to the investigation team just prior to meetings of the statewide steering group. To supplement these methods, a survey of all 12 sites targeting mental health team members in particular was

Table 2. Factors supporting the establishment of formal partnerships

Factor	Brief Description	How this Supports Successful Partnerships
National and state mental health policies	Increased support from the National Mental Health Plan, Queensland Mental Health Plan, and Queensland Health.	These plans provide a policy framework to support this initiative in principle. The Queensland Directorate of Mental Health is actively encouraging every mental health team in Queensland to establish a similar formal partnership.
Recurrent funding	The National Mental Health and Disability Employment Strategy provides recurrent funding.	This national strategy provides demand-driven client outcome-based funding that enables partner disability employment services to benefit from new referrals from mental health services.
Joint service governance	A standard Queensland service-level agreement has been developed for partnership governance.	This standard agreement addresses the legal, insurance. and shared resource issues that can be barriers to establishing joint service delivery.
Knowledge of evidence-based practices	An IPS fidelity scale is available that provides operational definitions of 25 foundation practices.	This scale can be used to monitor the quality of service integration and the implementation of evidence-based practices by each individual employment specialist. Sites that use this scale regularly form stronger partnerships.
Tools to monitor joint service effectiveness	A monthly snapshot report is used to monitor the progress of the employment specialist's case list.	Discussion of the monthly snapshot report at each steering group meeting provides the basis for ongoing evaluation and problem solving. Referrals can be reconciled against current cases, and monthly outcomes provide a check on the implementation of evidence-based practices.
Tools to monitor joint service effectiveness	International performance benchmarks.	Information about employment outcomes attained by international efficacy trials, effectiveness studies, and Australian disability employment services, is available to all participating disability employment services.

Increasing client demand for employment services	Client demand for employment services typically increases with the effectiveness of the joint service.	Increased client demand validates the effectiveness of the partnership. Increased demand can be met by brokered referral to other local segregated services and by the steering group actively seeking new employment service partners. Waiting lists for employment services are not recommended due to risks to client motivation.
Mental health leadership	One or more senior mental health staff have designated roles to support the partnership.	Sites with designated coordinators seemed to have stronger partnerships than sites with no clear on-site leadership arrangements.
Employment service staffing	Stability of employment specialists.	Sites with low turnover of employment specialists seem to have stronger partnerships and better integration than sites where turnover of employment specialists is more frequent.
Attitudes of clinical teams	Increasing expectations among clinical team members that clients can be successfully employed.	The success of clients in employment raises the hopes and expectations of other members of the clinical team. This can create more enthusiasm for the joint service and ensure continuing referrals. There is a need for ongoing shared responsibility and decision making involving regular communication, rather than just referral to the program.
Role of steering group	The steering group meets regularly to manage and develop joint services.	Sites with proactive steering groups seem to be more effective than partnerships with no steering group or a group that meets infrequently. Districts that have multiple colocated employment specialists may need additional meetings with key parties to monitor daily operational issues.
Activities of steering group	The steering group develops new policies and procedures to support joint services.	The joint service requires new referral procedures to prevent client exclusion. Risk management plans may be needed to ensure safety of all parties. More detailed health professional reports may be needed for any mandatory external assessments of clients' employment assistance needs.

conducted in 2010. This survey covered satisfaction with referrals, participation of the employment specialist, and client employment outcomes; communication with the employment specialist; barriers to referring clients; and finally, suggestions for program improvement. Factors reported via these methods that supported the establishment of strong and stable partnerships are shown in Table 2.

The overall positive nature of the experiences reported by most formal partnerships can be seen in the natural expansion of this program to date. Initially, six sites received seed funding to establish partnerships, then another six sites joined the ESI-12 trial by 2007 on the basis that they did not need funding to establish a partnership. By December 2010, 23 formal partnerships had been established (either full time or in transition to full time colocations), and only one site had ceased operating as a colocation (see Table 1). In addition, another six sites are either planned for commencement in 2011 or had begun preestablishment discussions. This represents a fivefold natural expansion in approximately 3 years.

THE CHALLENGES OF JOINT SERVICE DELIVERY

At each site, a range of site-specific and common joint service delivery issues emerged that, if not attended to promptly, could erode partnership strength, joint service effectiveness, or at worst promote a return to segregated services. Examples of the major issues encountered and possible solutions are shown in Table 3.

Formal partnerships of this type necessarily involve bringing together two different organizational cultures. This has subsequent implications for joint service delivery that require good leadership and management at several levels (Waghorn, Lockett, et al., 2009), particularly if both organizations do not mutually value the professional input of the other. We found that differences in organizational culture need to be considered carefully during the initial selection of candidate partners. This can include ensuring that at partnership commencement the disability employment service is willing to change practices in the direction of more intensive and individualized services for clients with more complex needs than they may be currently fulfilling. Differences in organizational culture are expected to become less problematic as each organization increases its understanding of these differences and values the partner's contribution to joint service delivery. Once the partnership is

TABLE 3. Examples of challenges encountered when implementing formal partnerships

Challenge	Description	Possible Solutions
The time taken to establish new partnerships	The time required to establish new partnerships has ranged from 3 to 12 months.	1. Allocate state or national resources to coordinate and support the establishment of new partnerships. 2. Encourage networking to share resources to support the timely establishment of new partnerships. 3. Develop a formal and transparent process to rapidly establish new partnerships when circumstances are favorable.
Physical facilities	Not all mental health service premises are suitable for colocation.	1. Increase investment in buildings and physical facilities for community mental health teams. 2. Improve management of physical facilities such as interview rooms to ensure employment specialist has equal access.
Fidelity to evidence-based supported employment practices	High-fidelity practices may not be sufficiently developed or may drift back to less effective usual practices. The disability employment service may resist adopting evidence-based practices.	1. Use regular fidelity assessments for service development. 2. Provide regular training in evidence-based practices in supported employment. 3. Provide training in how to accommodate evidence-based practices within existing service contracts. 4. Specify in the joint service agreement a requirement for the employment service to adopt and develop evidence-based practices.
Referrals	Client referrals to the employment specialist may not always be appropriate. Clients currently working or are linked to another employment service provider cannot proceed immediately. Clients wanting assistance may not be referred by their case manager.	1. Provide training to clinical teams in referring all interested clients to discourage the selective referral of only high-functioning clients. 2. Establish a client self-referral process. 3. Conduct referrals in person and ensure relevant clinical and risk management information is provided. 4. In new sites, ensure 20 suitable referrals are made in the first 3 months. Allow employment specialists to transition to a caseload of 100% shared clients.

(*Continued*)

TABLE 3. Continued

Challenge	Description	Possible Solutions
Role of clinical teams	More involvement by mental health team members in joint service delivery and in ongoing evaluation of the joint service.	1. Designate clear roles for team leaders to coordinate and support the partnership with responsibilities for regular joint training and partnership development. 2. Other interested staff can be encouraged to attend meetings and forums about the joint service. 3. Summaries of fidelity assessments and snapshot reports can be provided to all mental health team members. 4. Team members can be involved in regular program outcome reports at conferences and in peer-reviewed journals.
Role of clinical teams	Maintain enthusiasm of clinical team for the project and to continue clinical support when needed.	1. Develop an ongoing training and support plan for clinical teams and ensure new team members receive timely training in the joint service. 2. Provide regular feedback to clinical teams via fidelity assessments, snapshot reports, program outcome reports, client feedback forums, and management meetings.
Developing integrated services	Joint services can become less integrated over time while appearing to be functioning well.	1. Encourage the steering group to adopt a joint service development approach so that constructive in-depth feedback on the quality of the joint service is sought from all stakeholders at least once per year. 2. Review existing policies and procedures to ensure compatibility with joint service delivery.

Client difficulties obtaining and keeping employment	Keeping clients engaged and helping workers maintain employment are the major challenges.	1. Reasons for individual clients dropping out (attrition) and for ceasing employment can be routinely discussed at regular steering group meetings. 2. The employment specialist can regularly discuss clients' work performance with the treatment team so that the treatment plan can be refined to improve work performance. 3. The quality and frequency of referrals can be monitored to ensure that all clients interested in employment are referred promptly and not discouraged from participating.
Excess demand for employment services	An effective partnership will generate excess demand for employment services from clients who see their peers succeeding in competitive employment.	1. To accommodate increasing referrals, the clinical team can either expand the program with new partnerships or negotiate referrals to other disability employment services in the region. 2. Clients can be given a choice of being on a waiting list for the integrated employment service or being referred to a segregated disability employment service in the region.

established, the continuing willingness of the integrated employment service to develop and support high fidelity practices is essential to develop service integration and prevent drift away from high-fidelity practices. This is important because evidence-based practices can often seem in conflict with existing employment service provider contracts and historical practices. Joint service practices can be monitored using staff trained in fidelity assessment with the new 25-item fidelity scale developed for this purpose.

From the mental health team perspective, strong commitment to the integration of employment and mental health services as a basic recovery strategy is needed, along with the recognition that this is a more intensive collaboration than is typically required with other community service organizations. This is because the treatment plan often needs to be revised as soon as the person commences employment, in order to optimize his or her work performance. This is a level of service integration not required by housing services or disability support services. Not understanding this requirement can lead mental health services to see an employment service as no different than any other community service such as disability support, advocacy, or housing. Yet this important difference in level of service integration needed means that other community services can be engaged by the mental health team either independently as needed or as wraparound services to help individual clients maintain their vocational activity. Subsequently, collaboration with nongovernmental organizations do not need to be as strong as that with the employment service, and they can be maintained by the usual methods consisting of interagency meetings, site visiting services, joint training, and brokered referral of clients (King et al., 2006; Waghorn et al., 2007). We found that formal partnerships between mental health and disability employment services were readily formalized around a commitment to joint delivery of evidence-based practices in supported employment (Bond, 2004; Bond et al., 2008; Sherring et al., 2010), and supported education when this was feasible (Mowbray et al., 2005; Robson, Waghorn, Sherring, & Morris, 2010).

LESSONS LEARNED

The major lesson learned is that formal partnerships designed to deliver evidence-based practices in supported employment can be

established in Australia. However, once established, these partnerships require continuing joint management, and they are at risk of deterioration if it is assumed that they are self-perpetuating. There is an ongoing need for regular joint service management, routine reporting of practice fidelity, and client employment outcomes, along with feedback from key partnership stakeholders. Even if an effective employment service is established, it is likely to decline in effectiveness over time if mental health team members lose interest in supporting clients' vocational goals or if employment service provider practices drift away from the evidence base. On the other hand, we found that strong partnerships can be established at little or no cost to either service due to the favorable environment, namely, supportive mental health policies and a demand-driven disability employment funding system. Our strong partnerships demonstrated that service integration can be developed over time, increasing the employment prospects for clients more than is possible by the usual forms of interservice collaboration. Although one site managed only a weak partnership more like a loose collaboration, no associated clinicians or employment staff wanted to revert back to segregated service delivery. The remaining 11 sites established stronger partnerships which, to varying degrees, seemed to enhance both the mental health service and the disability employment service, in accord with the extent of service integration developed.

LIMITATIONS

The main limitation of this report is that the supporting factors and issues identified were gathered eclectically from several sources, rather than by using a single qualitative design. However, a compensating strength is that the information about establishing formal partnerships was obtained from 12 sites with different employment service providers in varied labor markets and health service environments, using multiple methods for collecting data over a 3-year period. The involvement of the investigation team in having regular conversations at each site, steering group meetings, delivering training in evidence-based practices, developing outcome reporting systems, assessing practice fidelity, and general problem solving has provided extensive firsthand exposure to the range of supporting factors and issues reported. Hence, we are confident that

the major implementation and joint service delivery challenges have been identified.

CONCLUSIONS

Formal partnerships between community mental health service teams and supported employment providers can be successfully established in Australia, although they seem more challenging to implement than the direct employment method of delivering evidence-based supported employment. A partnership strategy is viable in Australia, New Zealand, and the U.K., where extensive networks of disability employment services may already be well established. The major implication is that, compared with the direct employment method, formal partnerships may need more ongoing joint service management to progressively develop integrated services over time. Unless successful joint service systems can be established in Australia, it is unlikely that high-fidelity, evidence-based supported employment will gain traction because of an existing national network of segregated disability employment services. There are now sufficient partnerships in Australia to warrant the establishment of a national governance and resource center to support existing partnerships and to encourage new, high-quality partnerships.

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