ROAD TO RECOVERY:
BEST PRACTICES AND FINANCING STRATEGIES FOR SUPPORTED EMPLOYMENT

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IPS Supported Employment for People with Mental Illness

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2014
Individual Placement and Support (IPS)

- IPS Supported Employment
- 25 years of refinement
- Serious mental illnesses
- Highly individualized
- Client choice at every step
Current Status of IPS

- IPS model is simple and direct
- IPS is effective
- Other benefits accrue with consistent work
- Work outcomes improve over time
- IPS is relatively easy to implement
IPS Supported Employment

- Competitive employment
- Team approach
- Integrated mental health and vocational services
- Job development
- Client choice regarding timing
- Benefits counseling
- Rapid job search
- Job matching based on client preferences
- On-going supports
  - Becker (IPS Fidelity Scale, 2010)
21 Randomized Controlled Trials of Individual Placement and Support (IPS)

- Best evidence available on effectiveness
- RCTs are gold standard in medical research

Bond, Drake, & Becker (2012)
Competitive Employment Rates in 20 Randomized Controlled Trials of IPS
Non-Employment Outcomes

- Self-esteem
- Quality of life
- Symptom Control
- *No changes with sustained sheltered employment* (Bond et al., 2001)
Long-Term Outcomes

- 4 studies with 10-year follow-ups
  (Test, 1989; Salyers, 2004; Becker, 2006; Bush, 2009)
- Work outcomes improve over time
- Costs decrease dramatically for consistent workers
  (Bush et al., 2009)
Johnson & Johnson-Dartmouth Project

- Mental health-vocational rehabilitation collaboration
- Implement evidence-based supported employment - IPS
- Local programs selected by states
- Dartmouth provides training, consultation, evaluation
- National Learning Collaborative
- States: Alameda Co., CA, CT, DC, IL, KS, KY, MD, MN, MO, NC, OH, OR, SC, VT, WI
- International: Italy, Netherlands, Spain

(Becker et al., 2011)
Clients Served & Working in the IPS Supported Employment Learning Community in the USA

Data points represent annual averages for four quarterly reporting periods. Current year data represent an average of reporting periods that have occurred to date.

Number of Clients Served

- Served
- Working
- Percent Working

Percent of Clients Working

0% 20% 40% 60% 80% 100%

10000 9000 8000 7000 6000 5000 4000 3000 2000 1000 0

IPS International

- Many countries adopting IPS: Australia, Canada, Germany, Holland, Hong Kong, Italy, Japan, New Zealand, Norway, Spain, Sweden, Switzerland, United Kingdom

- Italy and Netherlands: first international J&J-Dartmouth collaborators
New IPS Populations

- Posttraumatic Stress Disorder
- Substance Use Disorder
- Traumatic Brain Injury
- Spinal Cord Injury
IPS and Unemployment

- Evidence from the U.S.
- Evidence from Europe
Financial Support

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- Sarah Swanson
- Sarah Lord
- Howard Goldman
- Sandy Reese
- Kikuko Campbell
- Will Haslett
- Saira Nawaz
- Crystal Glover
Information: books, videos, research articles

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- http://sites.dartmouth.edu/ips
Thresholds Youth Programs

- 16-26 y/o
- Residential, Transitional Living, Parenting, School, Team Outreach
- Community Based
- Founded in TIP Principles
- Bridge to Adulthood
Individual Placement & Support (IPS)

TIP Informed Youth & Emerging Adult Programs

TAY choice

Place & Train

Community-based

Coaching

Futures focus

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IPS Adaptation Feasibility Study

- Supported education
- Peer mentors
- Career development focus
Adapted IPS Principles

Same
- Attention to consumer preferences
- Time unlimited supports
- Rapid search
- Integration with mental health treatment
- Systematic job development

Modified
- Zero exclusion is the goal
- Competitive employment, paid internships, and mainstream educational activities are the goal
- Benefits and financial aid planning is important
- Systematic education development

Added
- Exposure to the worlds of work, career and education
- Youth voice and advocacy
Vocational Peer Mentoring

Qualifications:
• Self-identified as having a SMHC
• Experience in YAP or other service systems
• HS grad with employment or post-secondary enrollment

40 hours of training:
• Increase knowledge of IPS model
• Learn how to share story
• Build active-listening skills

• 1-6 mentees per mentor
• Weekly meetings in the community
Peer Mentoring Role

• Work closely with education and employment specialists

• Provide emotional support & validation

• Engage young people in vocational services

• Support young people in exploring worlds of work & school

• Teach, role-model, and coach professionalism, maintaining hygiene, and having appropriate boundaries
Team
Structure

Team Leader

Vocational Team

Employment Specialist

Education Specialist

Peer Mentor

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Important Lessons For Adapting IPS

• Pros/Cons of Supported Education Specialist
• Clinical Team Connection
• Engagement Strategies
• Role Clarification
• In Vivo Teaching
• Soft Skills Training
Important Lessons For Vocational Peer Mentoring

- Clinical Support
- Boundaries
- Role Clarification
- Support out-of-program meetings
- Purposeful integration with vocational staff
Thresholds Veterans’ Program

Started 3 years ago with a private foundation grant recognized the need for a focused program for veterans with mental illness. 50% of staff are veterans – acknowledge the need for peer supports.
Thresholds Veterans’ Program

- Components of the program
  - Housing first model
  - Benefits assistance
  - Mental health services
  - Trauma informed services
  - Supported employment
  - Supported education
Supported Employment

• Follows all the core principles of IPS

• Benefits are an issue not only from the SSI side but from veterans’ side if based on disability and not combat related
Additional issues with employers

• Concerns about PTSD and traumatic brain injury – great resource: http://www.americasheroesatwork.gov

• National pushes to hire veterans

• Federal contractor requirements
Additional issues for veterans

• Transition to civilian life – sense of isolation and hesitancy to ask for help

• Cultural competency issues of community service providers
  http://www.mentalhealth.va.gov/communityproviders/

• Difficulty in articulating skills learned in the military
Resources for military skill translation

• [http://www.onetonline.org/crosswalk/MOC/detailed](http://www.onetonline.org/crosswalk/MOC/detailed) tells you what the civilian equivalent jobs are

• [http://www.military.com/veteran-jobs/skills-translator/](http://www.military.com/veteran-jobs/skills-translator/) gives you step by step instructions on how to de-militarize your work experience
Supported Education

• Principles of Supported Education are followed:
  – Interest and skill exploration
  – Tours of potential academic/vocational programs
  – Discussion of disclosure pros and cons
  – Review of supports needed to link to and to maintain in training and/or school
  – Resource: [http://cpr.bu.edu](http://cpr.bu.edu) – Supported Education Toolkit
SEDU Additions for Veterans

• Integral component of Supported Education:
  – Educational benefits review – once in a lifetime opportunity – essential that we link the veterans to representatives at the VA who know the ins and outs of the financial benefits
  – Linkage to the Office of Veterans that most campuses have – can help with accommodations as well
  – Some states have legislation around licensing/certifications for military experience. Need to research those in your state
Contact Information

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Medicaid and Behavioral Health – New Directions

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July 10, 2014
Role of Medicaid with Behavioral Health

• Major Drivers
  – More people will have Medicaid coverage
  – A significant number of those individuals will have behavioral health issues
  – Medicaid will play a bigger role in MH and SUD than ever before
  – Focus on primary care and coordination with specialty care
  – Major emphasis on home and community based services and less reliance on institutional care
  – Early identification, preventing chronic diseases and promoting wellness is essential
What’s on Our Radar Screen?

- Ensure that people understand and have the opportunity to enroll in the Medicaid program
- How to best encourage benefit designs that promote or test evidenced based practice
- How to address provider capacity issues to promote access to services
- Ensuring that approaches look at the whole person—primary care, behavioral health and long term services and supports
Preventing and treating mental illness and substance use is integral to overall health.

Services and programs should support health, recovery and resilience for individuals and their families who experience mental or substance use disorders.

Individuals and families should have choice and control over all aspects of their life, including their mental health and substance use disorder services.

Services should be of high quality and consistent with clinical guidelines, evidence-based practices or consensus from the clinical and client communities.

Services should maximize community integration
Goal Four: Better availability of Evidenced Based Practices to enhance recovery and resiliency and reduce barriers to social inclusion. Areas of Focus:

- Supported Employment
- Housing Supports
- Screening and Early Identification of MH/SUD condition
- Trauma and Children and Youth
- Supports for Children and Youth with MH or SUD
CMS Approach to Supported Employment (SE)

- Understand that work is an important to recovery
- People with serious mental illness are unemployed at extraordinarily high rates
- Medicaid funds a significant amount of day treatment and psychosocial rehabilitation services
- Understand that SE is most effective intervention in terms of positive employment outcomes:
  - Significant improvement in mental health status;
  - Reductions in the number of admissions and lengths of stays for inpatient hospital use, both medical and psychiatric;
  - Decreased number of psychiatric crisis visits;
  - Increased attendance at regularly scheduled mental health visits; and
  - Significant improvement in quality of life.
Supported Employment

- Suggested Benefit Design:
  - Assessment
  - Supportive Counseling
  - Financial planning and benefits assistance
  - Job development
  - Job supports
Section 1915(a)

- Section 1915(a) of the Social Security Act (SSA)
  - Cover some, but not all components of SE
  - Activities that we have allowed states to cover
  - Activities that are not likely reimbursable under 1905(a)
State option to amend the state plan to offer HCBS as a state plan benefit; does not require institutional LOC

Modified under the Affordable Care Act effective October 1, 2010 to allow comparability waivers, add “other services”

States cannot waive statewideness or cap enrollment

State: Iowa
Section 1915(c)

- Home and Community Based Services Waiver
- Must meet institutional level of care (NF, ICF-IDD, Hospital)
- Cost neutrality between HCBS and institutional services
- Connecticut and Montana
Research and Demonstration Waivers
Additional flexibilities to design and improve coverage
More innovation with MH and SUD services more recently
Vermont, Arizona and Hawaii
Voluntary or mandatory enrollment into managed care

Restrict the number or types of providers that can deliver a service

Permits states (in some instances) to use savings from managed care program and reinvest in other services

Michigan, Iowa and North Carolina
Balancing Incentive Program

- Enhanced FMAP to increase diversions and access to HCBS, effective October 1, 2011
  - 2% if less than 50% LTSS spending in non-institutional settings
  - 5% if less than 25% LTSS spending in non-institutional settings

- SMD letter and application published September 12, 2011

- User Manual released October 14, 2011
**Money Follows the Person**

- Affordable Care Act extends and expands through 2016
- Offers States substantial resources and additional program flexibilities to remove barriers
- 43 States plus District of Columbia participate
- More than 20,000 transitioned from institutional settings to home and community based settings
- Enhanced match used to build HCBS capacity and create infrastructure necessary to help sustain rebalancing long-term care systems
Section 1915(k)

- Community First Choice
- Pays for attendant care related to ADLs and IADLs as well as health related tasks
- Can be provided at home or a community based setting
- Can help people get to work
- Assist individuals in the workplace
- Must meet institutional level of care
Final regulations 1915(k) - Community First Choice


Final Regulations 1915 (i) and 1915(c), including proposed characteristics for Home and Community Based Services settings

Road to Recovery:
Employment and Mental Illness