West Virginia University – Center for Excellence in Disabilities (WVU-CED)
Perceptions and Practices of Mental Health Professionals Regarding Employment of Individuals with Serious Mental Illness
Tuesday, November 28, 2017
2:00 p.m. – 3:00 p.m.

Remote CART Captioning

>> If you want to go ahead and share your screen, when you're ready. I'm just pulling up your boy for the next --

>> So are you seeing me or the PowerPoint?

>> We see thanks for using WebEx on your desktop.

>> Okay.

>> Who is it that's trying to get on?

>> I have join from a video system or application, which we don't have that ability. I guess. We have a computer. And then it says to join by phone. Which is what I did.

>> Okay. --

>> Go back and try the video for the first option. Not the phone. First option.

>> Okay.

>> Because you can be connected in both ways. The phone and the video system.

>> Okay. So, if I dial the video system, it is -- just put the number and then WVU-CED and then --

>> Let me see. We need to send you a link so that you can go into your web browser, put that link in, and it'll take you to the screen.

>> Who is speaking? And I'll send it to them.

>> It is Barbara.

>> Do you have her email, Les?

>> [giving email]

>> okay. I'll send it to you right now.

>> Okay. Thank you.

>> Lesley, while we're getting set up, can you see the PowerPoint?

>> No. I think -- go ahead. Do you have shared screen options, again, under "Quick."? Like quick start?

>> Hello.

>> And then the share screen.

>> Hello?

>> There you go.

>> Hello. Hello. My name is Albert.

>> Just getting set up.

>> That's fine. I tried to join by computer, but it wouldn't install the thing to do it.

>> Oh, okay.

>> I didn't realize it was going to want to install something. State computers won't allow that.

>> We'll need to get your information because sometimes ahead of time if there's a block on there and they just don't know it's there, you know, with DHHR that --

>> Right.

>> That there's been a block. But that WebEx has been used successfully there. So, we could troubleshoot. Dr. Fleming, do you care if I send your slides to people who can't join?

>> No, that's fine.

>> Okay. That way you can see her slides too.

>> And this is Barbara, I was waiting for the email, but I have not received it.

>> I was having some difficulty getting it. And I'm sending it right now.

>> Okay. Thank you.

>> For the people having trouble accessing it, I have learned from experience if you don't have authorization to download WebEx, you can choose to

run the application instead and then it will let you. I work for DHHR, and I couldn't download it, but you can run the application and it can work.

>> I can try it. Let me click join meeting and see what happens here.

>> Okay, Barb, it should be coming to you right now. It might say, "Have trouble connecting, click here." And then on the next screen, click on" Run application" instead of trying to download it.

>> Mine gives me more options --

>> Yeah, click on "More option."

>> It's asking for an install.

>> Does it show "Run application" when it shows for options?

>> It doesn't.

>> Okay.

>> I'm to the getting a "Run application."

>> It really doesn't want you to join.

>> That's right. And if you'll send --

>> All I'm getting is an install. It just says "Install," no other options.

>> What is your email and we'll send the slides?

>> [giving email]

>> Okay.

>> Right. And I --

>> Okay. I'll send you those. We're going to go ahead and get started. And you will have something to look at. Okay. That sounds good. Well, and thank you all -- I think we have several.

We have -- we had 56 plus individuals registered for today's ground rounds, and many of them were new people attending our grand rounds. So, it's pretty exciting and we appreciate you joining us. And we'll continue to make she's accessible wherever you are. We have these on a monthly basis and we want you to be able to see them. Thank you for joining us.

Okay. So, with that -- let me go ahead, if you don't mind muting your phones, muting your computers while Dr. Fleming is going to present. About the last 15, 10 minutes of the hour we'll open it up to questions and answers. Sounds good? Okay.

So, Dr. Fleming, thankfully, joined us. She also gave up some of her early Thanksgiving week time to practice this WebEx with me. And -- but there's always something that comes up. So, thank you for that time, Dr. Fleming. And with that, just real quickly, I wanted to introduce and describe Dr. Fleming's work

to everyone.

So really short. So, Dr. Fleming earned her Ph.D. in rehab from Auburn University, and MS in rehabilitation counseling from Boston University. She worked as a rehab counselor for over 15 years in the private sector and the Georgia vocational rehabilitation agency. She moved to Auburn in 2013 to be the executive director of the Center for disability research and policy studies at Auburn University. She's a clinical assistant professor with the special ed rehabilitation and counseling department. So, again, we're very honored to have you here with us, Dr Fleming. And with that, I will turn it over you. We can see your slides and we can hear you. And, again, just a reminder to everyone to mute behind you. Thank you.

>> All right. Now, you all can hear me?

>> Yes.

>> Leslie -- you can see the slides and you can hear me, hopefully it won't sound like I'm -- at you. It's hard to do this without being able to see anybody. But when Lesley asked me to participate in this, I was trying to think what folks want to hear, and I was working with a health agency in Alabama -- let me turn my volume down because I can hear myself.

Echoing in the background.

the work we're doing here with the mental health agency in Alabama. That's what I'm going to talk to you guys about. So hopefully most of you have already heard about the model of Individual Placement and Support. It's a model of support and employment. It's an evidence half based practice that leads to competitive, integrated employment. I'll talk a little bit about the funding from SAMHSA that we received in Alabama, and talking about the limitations on the availability of IPS. So, the research shows that it works. Yes, it is not available in many states. Those states implementing it are having great outcomes, but it's still not readily available. And we kind of did a survey before we implemented the project here in Alabama to get a sense of what the practitioners thought about it. So, we'll talk a little bit about that. And then kind of wanted to hit the highlights of the benefit of integrating of the teams with the employment teams.

So, I have moved the slide. And most of you know this statistic on the employment of folks with disabilities is abysmal. We're trying to improve the options. So, I wanted to make sense for folks with disabilities to go to work, a lot of it -- so people with

disabilities have less resources and live in poverty, primarily to their need for the insurance which necessitates them to have limited income. And, Lesley, give me a note if I'm talking too fast. I have the tendency to talk too quickly, especially on a topic which I know, which I do. Let me know if I'm talking too fast.

>> Okay. I will.

>> Hold on, I have a question.

>> Dr. Fleming: I heard I have a question.

>> I'm looking on the state, if you hit speaker and turn the mic off. I think there are other people that might need to do it.

>> Can you hear it?

>> Dr. Fleming: If I turn the speaker off --

>> I'm talking everybody on the phone to you. If they have a speaker on their phone, and the mic lights up, if they turn the mic off, maybe we won't have so much feedback, maybe. All right? I'm doing that now.

>> Dr. Fleming: Shall I begin again?

>> Okay.

>> Dr. Fleming: I still hear background noise on the phone. Okay. All right. So, in if 2009 Smart wrote a wonderful book on disability. Is she talks about the

biggest obstacle people with disabilities is the stigma attached to it. And so, part of the discussion that I looked at was the social rule of work that they did way back when talking about the need to move people from devalued social roles into valued social roles. And one of those valued social roles is employment. I can still hear an echo, are you guys okay? I'll let you guys continue to work on that. Sorry about that.

So, work is part of the recovery process. Trying to get some of the changing of the mind-sets regarding employment. Some people refer to the stress involved in going to work as a deter rent to go to work, but truly when folks go to work, they have improved self-esteem, better quality of life. One of the gentlemen that assisted with a project here in Alabama, he talked about the fact that he was now able to have ice cream in his freezer like everybody else does because he's going to work and now has the income to purchase that.

So, it was a great story to kind of share because it really talks about the importance of going to work. Some of the research shows that there's less dependence on the disability systems, less use of mental health services as well as hospitalizations. But our project, we have not gotten the information on

the cost for medical services, but a lot of the other outcomes that test results have shown. It says I have been muted by the host. Can you all still hear me?

>> Yes, we can hear you.

>> Dr. Fleming: Okay. Just making sure. Let's see. So, employment first has been a buzzword that's been out there for a while trying to get states to start looking at employment as a viable option for folks. So -- but, a lot of states don't have IPS employment services as part of that model. And so, we're trying to figure out a way to change those within the system in order to make employment an option for folks. Most people with significant psychiatric disabilities are able to secure employment with the necessary support. They're also able to live independently and be actively involved with their family and friends.

Another lady that we helped was homeless and had not seen her children for probably ten years. And when she went to work for the first time in a long time, she was able to secure housing and then she was able to visit her daughter and establish that relationship again. So, employment really did have a huge impact for a lot of folks.

All right. So, what do we know about employment? So, research shows that most people

want to go to work, and they're wanting to go to work really is the primary indicator of success. So, it's not about being without -- using drugs, with having transportation, it really is that desire to go to work that shows they have the best employment outcomes partnership for patients however, 60% of individuals diagnosed with SMI indicated that they wanted to go to work. But less than 15% nationwide have access to supported employment services. And less than 2% have access to IPS.

So, 85% of people with serious mental illness are unemployed. So, if they're unemployed, and they're dependent upon the disability system, they can expect a life of poverty. And actually, receiving SSI or SSDI check really lends itself to living below the poverty line. So truly, the only way to turn that around and to escape a life of poverty is to increase their income through employment.

So, let's look at what is IPS? I don't know how many people that are participating today know what IPS is. But its purpose is to identify the individual strengths of that person. Not focusing on what they can't do, but really trying to focus on what they can do. And then, through the assistance of an employment specialist, they're obtaining personalized

work at competitive age in a graded setting. It is an evidence-based practice that leads to successful employment outcomes, but, again, as I said a few minutes ago, it's limited in availability.

So, for those who don't know what IPS -- there's eight principles of IPS. So, as we look at those, there's a focus on competitive integrated employment. Which basically means real work for real wages at a job that anybody can get in the community. And they're working in businesses where a variety of people work. People with and without disabilities.

Eligibility is based on consumer choice. The model is "Zero Exclusion." If the person indicates they want to go to work, they are referred to support in support and employment. And a requirement of job wording is, or sobriety is not there. That may be part of the outcome because they may, in their desire to go to work, stop using drugs in order to secure employment. But it's not an eligibility criteria to prevent them from participating. A third principle is rapid job search That doesn't necessarily mean rapid job placement. Part of that is getting them informational interviews so that they're hearing from people where they want to work that they need to stop

abusing drugs in order to gain employment. And part of that process of working with employers and talking to people has really changed those behaviors that need to change in order to secure that type of work.

The fourth principle, which I personally think is one of the biggest changes in support employment is the integration of the mental health team with the employment team. And so, it's really having clinicians meet regularly with the people out there looking for employment to kind of work together and strategize what types of jobs make sense for each person.

So, the fifth principle is the consumer preference is honored. So, it's not about working with an employment specialist who has maybe ten jobs that are held for someone with a disability, but really trying to identify those jobs that the person wants and only seeking out those employment opportunities based on a what that person wants.

Number six is individualized job supports. For supported employment, most folks know that the job coach is present is there's ongoing support as needed. With IPS some of the folks that are being assisted may not want the employment specialist to be with them at the work place, but then those job supports are provided after hours or before work or

when it's needed to kind of negotiate the situation.

Another big thing is the personalized benefits counseling. For our project, because we had a grant come through, we were able to hire dedicated benefits specialists that could work with participants throughout the process to help them understand how going to work would impact their benefits. But most states have available benefits counseling so that folks can talk to someone about how going to work with affect their benefits. Because it is a big concern, a big fear for a lot of folks that have never worked.

And then the eighth principle is the developing relationships with employers through multiple in-person visits to understand their business needs. So that it's really taking the time to get to know the employer way before you start negotiating and talking to them about employment for someone in particular. But really trying to take the time to understand their business so that the person that is referred ultimately to the employer is able to really meet the needs of that business.

So, this slide just hits the highlights. There's lots of research that's been done about the effectiveness of IPS. So, the research shows that IPS leads to improved employment outcomes. Now, a lot

of their comparison control groups were only going, mental health services, existing services that the agencies had available. Comparing it to an employment program. But further research is being done comparing an IPS model to other support employment models to see if it's still -- it's highly -- with better outcomes.

So, the majority of IPS participants obtain competitive employment. So, that's what prompted us to want to bring IPS to Alabama. So, before we implemented the model in Alabama, I did a research study trying to get a sense of what the current clinicians, what their perceptions were about employment for their consumers. Did they value competitive integrated employment? And what do they currently do around the people that they work with in helping them go to work. And trying to figure out what was stopping them from considering employment for their consumers.

So, with did the two pilot sites. One was in Central Alabama, and one was in Southern Alabama. And we used the health professionals' perceptions of employment survey developed by Gladman in Australia. And so, we modified the instrument a little bit But administered it to all the clinicians that were

able to participate with the IPS projects.

So, a lot of them valued competitive employment, but didn't think the people they worked with could go to work. They felt they were not interested in going to work because they had a fear of losing disability benefits. They were not certain about work. They also felt that they really wouldn't follow-up -- they weren't following up with their plans and, so they weren't really ready for employment. However, for those folks who did refer to the employment specialists, they did have employment outcomes that were successful.

So -- but -- most of the clinicians didn't really talk to their clients about going to work, nor did they think that their clients could work full-time. Or didn't think they could work part-time. So, work wasn't really being considered. And so, they weren't really referring people to employment. And so therefore, because they didn't believe their clients could go to work, they really weren't referring them to employment. So, their perceptions greatly impacted their practices.

So, without believing in the employment -- they believed that employment was a good thing, but they didn't think their consumers could go to work. So,

trying to change that philosophy, we were hoping once we provided the training around IPS and started implementing IPS so that more people were born to work, we were hoping that we would change those thoughts and those practices.

Because the research from previous efforts showed that it led to positive employment outcomes. So, what we found -- so, then we implemented the -- we got a grant to assist in at least 450 people to go to work over the next five years. We're actually starting year four at this point. So, we used peer support. We integrated the mental health with the employment team and provided lots of training and tried to build up the infrastructure.

So, in integrating the employment team -- and one of the sites really resisted this because their clinicians weren't meeting regularly, and they didn't see the need to change that practice of not meeting to discuss cases because they were just too big. So, through much -- they finally agreed to do it. And so -- so, truly -- and research showed, and it also showed in reality, that integration leads to lower drop-out rates for the consumers. And improved the communications between the clinicians as well as the consumers. One of the things that was interesting

was having people go to work allowed the opportunity for the clinicians to really have those positive exchanges of information. And instead of just talking about symptoms, because the person was making changes in their life and was going to work, they were really able to bring back real examples to the clinicians to help them work through.

Clinician became more involved, which led to better treatment. And then the clinical information is incorporated in the employment plan. So, when the employment specialist would meet with the consumers to kind of talk about work, they were able to bring some of those real things to the clinician. The clinician was able to come and say, well, yes, that job may be an opportunity, but it may not be a good fit given the nature of their disability. So, they were really able to kind of talk through some of the strategies for positive outcomes.

So, just to kind of give you a sense, the integrated treatment team, what it can look like and what if does look like for our two sites is really you have the employment specialists, you have the VR counselor. But then you also have a peer specialist, a benefits specialist, housing support, the psychiatrist is involved, the case managers are involved, the day

treatment manager is involved. So, you have a lot of people around this person to be able to provide the supports that are needed. So, depending upon what the issue is, if it's a work place issue, the employment specialist may be able to intervene. If it's a medication issue, then the psychiatrist is able to adjust the medications in order for the person to be able to go to work at a certain time.

So, the other integration that VR and now health now meet monthly and VR as assigned a dedicated counselor to the project so that they meet monthly, but they pretty much talk weekly if not daily depending upon what's going on. So, it really allows that integrated approach to ensure that all aspects can be addressed and that nothing really -- the ball doesn't get dropped because everybody is involved. And it really has been kind of one of those critical pieces for our success on the project.

So, for my involvement and the Center's involvement, we have been going in for the past three years conducting focus groups with the leadership teams of the two pilot sites, with the leadership with the VR and mental health agencies. And to kind of really figure out what system we have, what is the critical issue for systems change. We have

conducted to consumer focus groups trying to get their input about what's working, what's not working.

And how they feel about going to work and the efforts. I feel like I'm going really fast through this. I hope you guys are okay. So, we have also done fidelity reviews. A big piece of the IPS model is adherence to the fidelity of the model is important. So, we go in -- in the beginning we went in over six months to conduct the fidelity reviews until the site reaches good fidelity, and then we go annually to continually assess how it's going and what needs to get tweaked and what needs to change in order to meet fidelity. So, in the beginning some of that had to do with the integration of the treatment teams, trying to get leadership support so that -- as part of -- and so that employment is part of overall goals of the Centers.

So, in the past, if someone said they wanted to go to work, they just referred them to VR and they really weren't involved in that process and now that's totally changed how they operate. Another big stumbling block that we're still facing is strategies for sustainability. We're still trying to figure out how we're going to fund the IPS service once the grant period ends.

And working with other states, trying to get input. Because the SAMHSA grant was awarded to seven other states. And I'm not sure why my video is getting fuzzy. I'm sitting perfectly still, but my camera is not working. Hopefully you are not looking at my video anyway. Just focus on the PowerPoint. So, we're working with serve other states. All seven states are funding it in different ways. And working with states that have been implementing IPS for a while. Every state's funding system is so different, pretty much if you figure out one state's funding system, you've pretty much only figured out one state's funding system because it doesn't transfer to other states because of the way the insurance is set up, access to Medicaid and Medicare for funding options is totally different in every state.

And then the other piece that we're evaluating is the employment outcomes and really looking to make sure that the positions that are -- the positions that are secure ready individualized and that they're really achieving competitive integrated employment.

So now looking at how people -- so the focus groups we did this year, which was for year three, trying to get a sense of -- do people still have those same perceptions and practices regarding

employment now that they've been implementing IPS for the past couple of years?

So, what we have found is that most of the clinicians in leadership now feel that employment is part of recovery. That -- that the option of referring people to work really makes sense. People that have not worked in a long time, if ever, are now going to work. And so that those work outcomes are huge and that the positive impact on the person and their families is well worth the effort that it takes in order to get somebody a job.

A lot of the clinicians shared with us that the work really gives people hope again and they really didn't have that beforehand. But people do need supports in the work place to be successful so that those job supports are a critical component of that. We had some confusion there for a while with the pilot sites because, when they were talking about job coaching, they were comparing it to what is typically provided with -- whoops -- with -- with the DD population. And so, it's not that one-on-one hand holding and doing the job with somebody, but really looking at doing job coaching differently. So, some of the supports that people needed weren't being provided from that idea that they weren't supposed to

be doing is. But truly trying to make sure that the job supports that are needed in order for that person to be successful needed to be in place.

So, they've had to kind of revisit that job coaching/job support role to make sure that they are available Because the one site was really spending all the time up front to find out what the person wanted, finding them a job. But then, because they weren't providing support, they did not have a good retention rate. They're really trying to revisit that. So, when the person says they don't want anybody to know that they are receiving mental health services, that also meant the job coach couldn't talk to their employer on their behalf to understand what was going on. So, trying to revisit that with each individual to discover what level of disclosure was needed in order for that person to be successful.

So, acknowledging that there was a mental health issue. Maybe not disclosing the diagnosis, but more looking at what supports were needed in the work place in order for them to be successful. The other big piece has been integration of the employment team and the treatment teams. The impact has just been huge. And so, we were able to participate in two -- two of the focus groups at each of

the pilot sites were the integrated team itself. We had clinicians and employment specialists together. There were probably 15 people in the room. Just talking about the wonderful experience that they've had with IPS, the impact that it's had on the people that they work with. The people that they didn't think would ever go to work. It just totally transformed their lives.

But the big concern that we have has to do with the sustainability and finding funding. So, I think those were the -- these were the highlights of the focus groups we did this year. Hopefully as we continue to work on it this year, trying to find out how to use the funding. Our big obstacle is trying to find mental health dollars that are available to pay for employment support and to pay for practitioners' time to build relationships with individuals with disabilities as well as with the businesses.

Some states have found that money by closing down their community -- community-based -- day treatment programs, excuse me. In order to fund employment programs. But a lot of advocates and consumers are really nervous about that because that is how they spend their day is going to the day program. So, trying to find that balance of shutting things down and focusing on employment, but also

ensuring that people's needs are met. So, for me, of course, I wish that we could increase funding, so we could maintain both systems of the day programs as well as the employment programs so that they would have options. But I'm not sure that an increase of funding is going to be available.

But hopefully we can come so some advocacy with our legislators. The states that did the expanded Medicaid option, we did not in Alabama. And so, the states that expanded Medicaid have -- were able to provide the supports in the work place such that it's had a significant impact on people being able to go to work because they were able to get the supports that we needed. So, I know there's some discussion with the health care of eliminating those options, but the expansion of Medicaid really allowed more people to go to work than previously were able to be employed.

All right. So, this is my Albert Einstein quote. If you remember nothing from my presentation today, remember this quote. We can't solve problem business using the same kind of thinking we used when we created them. I think that's true for a lot of the disability service organizations that are out there, whether it's VR, DD, mental health, really trying to look at how the system operates in order to support

people to reach their goals of employment and living as independently as possible.

And that really does require some changing of how we do things. But that we've got here, because of the systems that we have in place. And so really trying to make that systems change and that culture change within those adult agencies can really lead to more people having the opportunity to go to work and getting out of the life of poverty. I think I've ended faster than I thought. So, I probably skimmed through too many things in the beginning quickly trying to get covered all of my slides.

So, we could open the floor for Q and A. And I can revisit areas that I went too quickly in the beginning. Are we still there?

>> Yes.

>> Dr. Fleming: I don't know -- Lesley, you want to do the questions through the chat room or over the telephone? What's the easiest way to do that?

>> Lesley Cottrell: Can you hear me?

>> Dr. Fleming: Yes.

>> Lesley Cottrell: I feel like the guy on the phone. I muted everyone. Seems like when I do that, I mute my own. So -- yep. We have unmuted

everyone's phone. At this point, be aware of that. No one put us on hold or anything. And does anyone have any questions?

>> I don't have any questions.

>> Lesley, this is Jennifer. Dr. Fleming, when you did that survey for the practitioners, did you get a good response rate? Or were they willing to fill out that survey for you?

>> Dr. Fleming: Well, they were. But I think that the -- the advantage I had with what they were about to undertake implementing the IPS project. I gave them a choice not to participate, but I'm not sure their supervisors gave them a choice not to participate.

>> I understand that. I'm the employment specialist here the at center. And also, the work incentives program manager here. We do the benefits counseling for the state. Unfortunately, we find that a lot of -- we're not -- we don't have a lot of clients right now with serious mental illness. And just watching your presentation today put a lot of questions in my mind how we can, you know, increase employment options for that population here in West Virginia.

>> Dr. Fleming: It really required extensive

training in the very beginning trying to get the idea of zero exclusion so that if a person wants to go to work that they get referred. But, of course, somebody has to start the conversation about work in order for them to say, yes, I want to go to work.

>> Right.

>> Dr. Fleming: And so, we had -- the mental health agency changed the application process so that there were multiple prompts to discuss work as an option for folks. So, it really took champions at the local areas to kind of make those changes. Policy changes as well as practice changes at the two mental health sites, soon to be three, to really make sure that employment was part of the conversation. And then it wasn't just one conversation, it was multiple conversations. The other thing that we started doing is if someone just said an inkling of work, they referred them to the benefits specialist to really delve deep into that conversation about work and what it would mean to their benefits. They really knew what they were getting themselves into to say, yes, I want to go to work.

>> We have been working with VR here in West Virginia. I have been working for many, many years on getting them to start benefits and counseling

first. So that they could have successful outcomes with their work with folks who are coming through their system. Because we're finding that a lot of folks will go through the VR system. And then at the end with benefits counseling, and then at the end find out they're not going to work.

>> Dr. Fleming: Yes.

>> Thank you very much.

>> Dr. Fleming: You're welcome. Thank you for listening.

>> Lesley Cottrell: Any other questions?

>> This is Kim Brown. I had a question. Did I hear that if a client was not completely abstaining from drugs or alcohol, they could still work if they were able to?

>> Dr. Fleming: Yes. Yes, well, to be referred to IPS they could still be using. Then, depending upon what the job was, they still had to follow all the rules of the employer. But if you think about people that you all know, does anybody use alcohol and drugs and have a job? And for the most part, yes. So, we were kind of -- the disability agencies -- were really setting a higher standard for our consumers. Now, illegal substance and using drugs in the work place is still the law of the land. I'm not talking about

that.

But really that it's not a criteria not to be participatory. But oftentimes what happens is once they start participating in IPS and really start thinking about employment, oftentimes people are able to make that change to stop using in order to go to work. They have a reason not to use the alcohol or the drugs. And they have hope again. So, it does -- it does tend to happen that they're not using drugs when they go to work. But it's not a criterion for participation.

>> Perfect. Okay. Thanks.

>> Lesley Cottrell: Any other questions? This is -- it was a large piece, and you have this multi-disciplinary group. Without having to relive all of that, that seems to be a logistical nightmare. Are you guys physically close to one another? What were some of the things that made that easy? What were some of the things that made it difficult if someone is trying to build that?

>> Dr. Fleming: Well, definitely having the grant helped. Because trying to -- still the focus groups, you could just tell. They loved the IPS model. Thing it would be such a disservice to people with serious mental illness to take it away, but they have no idea

how we're going fund it. And I don't mean we -- me -- I mean, the state of Alabama. So -- yes. The grant was a huge factor in our ability to do this.

The two pilot sites, one was near -- if anybody knows Alabama -- one of the pilot sites was kind of north-central Alabama near Birmingham, and one was in Mobile. So, they're kind of on opposite ends of the state, but Montgomery and Auburn are kind of in the middle of the state. So, it's like an hour and a half to Birmingham and three hours to Mobile. So not too bad of a logistical nightmare because it's just two sites. The third site that we're adding this year is in Montgomery. So, you kind of have a southern, middle and northern part of the state kind of. But I think the logistical nightmare is trying to expand it to more sites so that more people have access to the service.

And that's going to take us several years to kind of figure out. I think the -- trying to get the -- the two agencies, mental health and VR, really having to take a leadership role to figure out how to do it. And a big part is the funding of it. So that for mental health, employment really hasn't been anything they've paid for, funded, in the state of Alabama. So that really is shifting priorities and shifting the money in order to make it doable. But during the focus groups and the

reviews, because you weren't doing it monthly, it did make it feasible. And it wasn't just me by myself.

I had an evaluation team that did this with for the two pilot sites. And then part of the funding allowed the mental health agency to hire a dedicated IPS coordinator. And that person was able to weekly go to the two sites and provide the technical assistance and training that was needed. And then the professionals who started this IPS model at Dartmouth and really taken the lead in the research have provided technical assistance and have established this large learning community that has representation from many states in the U.S. as well as other countries internationally.

And so, it's large learning community that's constantly providing technical assistance and support. I think -- I don't think I included their website into the PowerPoint. I can send it to you, Lesley, maybe you can share it with everybody else. If you Google IPS Center, they're now affiliated with West End D.C. Even if you don't have -- there's a wonderful -- there's forms, protocol, the fidelity review manual is there. There's a wealth of information at their website to kind of bring these models to life.

>> Lesley Cottrell: That would be good. Yeah.

I would be happy to share that.

>> Dr. Fleming: Okay.

>> Lesley Cottrell: And kind of related to that, my last question was, you know, I know that at some point it may still be going on that our Governors over time have had this standing workforce development group. And perhaps their agenda items have slightly changed, but, you know, we have had that focus on employment and increasing our employment. Whether it's because we have been hit by, you know, Kim kind of referenced the drug use issue and our workforce is declining. Or we have an aging population. We have a lot of things toward that.

Is that helpful? Is there -- you mentioned sustainability being the issue in the forefront of you all's mind at this point, and that makes sense because of the grant period. But do you all have the infrastructure that can be tapped into? Is that something that can be tapped into for this, but maybe increase awareness about your model and capture cost effectiveness data?

>> Dr. Fleming: We're hoping to be able to capture cost-benefit information. We are starting year four, and we don't have access to the Medicaid data to look at the hospitalization costs. I think if we could

show our legislators that by going to work and participating in IPS, led to reduced hospitalizations, I think that might help sway the legislators to increase the funding or to make funding available for the mental health agency.

And I don't know about West Virginia, but in Alabama, our legislators don't care that there's research and documentation from other states having effectiveness with IPS. They really want to see how it's impacted Alabama. So, we've got great personal anecdotal stories, but we just don't have that data story to show that this is -- that the cost to implement -- to bring in and develop an IPS program and then implement it and then provide those services to folks leads to cost savings down the road.

So, we've got great quality of life stories, but I don't know that that'll get us increased funding until we have the -- we can show. Other states have shown us -- nationally the research is out there showing the cost-benefit is well worth the investment. The initial cost is high, but over time, because the person's going to work, there's a cost savings at the other end.

>> Lesley Cottrell: Successful -- yes.

>> Dr. Fleming: Say that again.

>> Lesley Cottrell: The stories are successful in their own right.

>> Dr. Fleming: Yes, hopefully so. We're hoping to get both in the next couple years.

>> Lesley Cottrell: Right. Right. Well, are there any other questions for Dr. Fleming? Okay. Well, Dr. Fleming, thank you for joining us. And we really appreciate your presentation. I thought it was really informative and, you know, it's always nice to have a model of what others are doing and learn from that experience. So, I think you've given us that.

>> Dr. Fleming: Well, thank you.

>> Lesley Cottrell: Thank you. And with that we'll go ahead and close out. And Dr. Fleming, I'll follow-up with you individually. Okay.

>> Dr. Fleming: Okay. Sounds great. Thank you all for joining.

>> Lesley Cottrell: Thank you very much.

>> Dr. Fleming: Bye, bye.