

Making Sense of Employment Research - “Developing a Peer Workforce for Provision of IPS. What can Research Tell Us?” With Dr. Judith Cook, Ph.D.

This call is being recorded.

Alexa Trolley-Hanson:

This is Alexa Hansen, and I am a doctoral student at the Center for Psychiatric Rehabilitation at Boston University. And the moderator today is making sense of Employment research Webinar. The webinar is funded by the National Institute on Disability Independent Living Rehabilitation Research. This webinar content does not represent the views of the policies of the funding agency. We should not assume endorsement by the federal government. I'd also like to acknowledge that the territory on which EU stands is that of the OG in Massachusetts people, and we honor and respect the history in current efforts of native indigenous communities. This webinar is being recorded, recorded, and closed. Captioning is on, and you can do it by clicking the button on your screen. We are going to have a question and a answer session at the end of the presentation. If you have a question during the presentation, you can post your question in the q and a box, and I'll pose them in order at the end. If you have a technical difficulty or technical question, you can please chat me directly using the chat feature on the bottom of your screen. Also, we really appreciate your feedback about this webinar, so I'll be posting a survey in the chat at the end of the session. I'd like to welcome Dr. Judith Cook, who's presenting developing peer workforce with the provision of IPS. What can you research tell us? This work is based on findings from her recent project that trained peer support workers to deliver IPS along workforce of and wellness services. Dr. Cook is an internationally recognized authority on mental health services research with a focus on clinical and rehabilitation outcomes of children and adults receiving community-based care. She directs the federally funded research center along with numerous grants. In contrast, studying intervention science, psychiatric epidemiology, and outcomes research. She consults with federal agencies, including the National Institutes of Health, social Security Administration, department of Labor, government Accountability Office, substance Abuse and Mental Health Services Administration in education. I would like to welcome Dr. Cook, and I'm excited to hear <inaudible>. Thank you.

Dr. Judith Cook:

Thank you everyone. Okay, that's not quite where I wanted to start my presentation, so let me take that down and go fix that up. There we go. All right let's try this again. Well again, wonderful. Come. Okay. So, thank you Alexa, and thank you everyone for your patience. Um, I'd like to acknowledge the funding that we received from the federal agencies, LER, and SAMHSA for the work I'll be reporting on today. The contents of my presentation don't represent the policies of any federal agency, and I have no conflicts of interest to disclose regarding today's presentation. Today's agenda includes a brief review of the evidence base for IPSS supported employment. I'll also discuss research confirming the importance of health promotion and wellness support for people in mental health recovery. Next, I'll discuss ways to support people's work goals, while also educating them about how their health influences their ability to get and keep a job. I'll discuss a project done at my center evaluating a new approach that combined peer provided IPSs supported employment and peer led health support for working. Finally, I'll describe freely available tools and resources that you can use to help you learn more about these new practices and adopt them in your own work. So, let's start with a polling question to find out more about each other, please tell us why you're interested in today's webinar by checking one or more of the following alternatives.

Tell us if you're joining because you deliver IPS or some other model of vocational services if you provide peer support, and you can check more than one if you want to learn more about peer delivered IPS if you are a researcher interested in studying peer-LED services or related topics. So, I'm going to give another half minute to all of you, um, to click on all the responses that apply to you. This is one of those ones where you can check all that apply, and we'll see what we learn about each other. And I give a few more seconds to folks. Thank you so much for being willing to take the poll. I appreciate it. All right, I think we've got all the responses we're going to get. So, I'm going to end the poll and I am going to share the results with you. And it looks like most of you want to learn more about IPS delivered by peers, um, 58%, but a good proportion of you deliver IPS or another model of vocational services. Welcome. I'm glad that you've joined. Um, some folks are providing peer support. It's nice to have 13% of my audience be, uh, peer providers. Uh, and 26% of you are researchers welcome. cause I am going to talk about research, um, and, uh, it's nice to have colleagues that, um, would join in in, in doing this work and studying I peer provided IPS. So, I am going to stop sharing this and x out of it and move on. Let's see if I can successfully slides taking a little while to allow me to move this slide forward. There we go. So, I appreciate you, uh, sharing some information about yourself through that poll. Uh, I'd like to now move on to reviewing the practice of IPS and the principles that underlie it. First, people are helped to find competitive employment, which is a job that anyone can hold, not set aside for people with disabilities that pays a living wage, um, and, uh, is not, uh, segregated in any way. Second, they're helped to find a job that meets their individual preferences. So, this isn't a cookie cutter job placement approach where you can only choose from a limited number of jobs. Instead, you're helped to decide on and find the job that you feel is right for you. IPS follows a zero-exclusion policy, meaning that you don't have to be at a certain level of mental health recovery to get IPS services, and you can even be unsure whether you want to work. IPS also emphasizes rapid job placement. So, the goal is for people to begin working as soon as they feel ready and they're able to get a job. Um, people receive support for as long as they need it, so there are no arbitrary time limits to this service. IPS services are also integrated with the rest of the person's services that they might be receiving by having regular meetings and ongoing coordination with other service providers. And finally, the service services and IPS include benefits and entitlements counseling so people can understand how work might affect their disability income and other benefits they might get. They might get housing vouchers or, um, uh, utility support. There's also acceptance of the fact that many people want to work while continuing to receive S S S I or S S S D IPSS is an evidence-based practice supported by over 26 randomized control trials, and that's the, uh, research design that's the most rigorous. And these were conducted both within and outside the United States. These studies followed people over a considerable amount of time. Two thirds of them followed people for 18 months or more and contrasted the outcomes of IPS recipients with people that got services as usual. In 25 of the 26 studies, people who received IPS did better across all the studies. The competitive employment rate was 55% for people receiving IPS services, but less than a quarter, 23%, um, of control participants were able to achieve competitive employment. IPS is the only model of employment services that has been definitively shown to work for people with psychiatric disabilities. Here's a graphic look at these studies results with the black bars representing IPS and the red ones representing control participants. The height of the bars represents the proportion of people who were working competitively in each study, and almost all the bars, as you can see that are black, are longer than the red ones, meaning that a higher percentage of IPS participants achieved competitive employment. IPSS has, uh, been around for a while, and you might think that with such a strong evidence base, IPS would be widely available, but unfortunately this is not the case. There are challenges in implementing IPS due in large part to the need to blend funding streams to pay for the different kinds of services involved in IPS. Typically, this means blending state vocational rehabilitation dollars, Medicaid funding, state general revenue, which is a fancy term for your state tax dollars and other sources

of service funding. So, because of this and other challenges, IPS isn't widely available to people with psychiatric disabilities. While 41 out of 50 states and the District of Columbia have one or more IPS programs numbering over 850 programs nationally, this service reaches less than 50,000 people per year with a very low penetration rate. In a recent national survey of state administrators, IPS workforce issues, um, was one of the top four implementation challenges. And another survey of programs in rural areas found that lack of IPS providers was especially problematic in rural regions of the United States. IPS has had numerous adaptations, um, and, uh, no model can do everything, but every many people in the field agree that more attention needs to be paid to integrating peer support into IPS service delivery. This has been done in several ways. One is by hiring and training certified peer specialists to deliver IPS as employment specialists. That's the name of the staff that deliver IPS. They work directly with participants to identify what kind of job they want, assist them with their job search, and then support them once they're working. Another way peers are used in IPS programs is to engage people in, uh, employment services. Since some people may be hesitant to consider getting a job for several different reasons. Once the person begins IPS services, uh, peer support may be provided during the initial assessment period after people enter IPS, and peer support has been, seemed to be helpful in the creation of the person's vocational profile, and that's a document that guides there, uh, job search. So, it's an important document. Another way of involving peers in IPS is to include them on teams that assess IPS. Fidelity. Fidelity means that a team is following the specific principles and practices of the IPS model, which is related to better outcomes for the people that receive IPS services. So, we really want IPS fidelity to be high. And finally, some programs use peers to train IPS staff about recovery and the role of peer support in keeping a job. My center at U I C has developed a toolkit featuring different ways IPSS programs have integrated peer support with examples of actual programs. Many of them run by, um, peers, uh, around the us and the link to that tool is provided in this slide. So, I, I encourage you to look. Another missing ingredient is directing specific attention to physical health, um, uh, issues that impact employment. We know that in the general population, health is a major determinant of whether people can work, including how much work they do, for example, whether they work full-time or part-time, and how long they stay in the workforce when they decide to retire or, um, stop working. While this is true for everyone, we also know that many people with psychiatric disabilities have especially poor physical health, and many of those who are working must manage, um, several chronic conditions including diabetes, cardiovascular disease, and arthritis. So, it makes sense that part of supporting people's ability to get and keep a job includes helping them be healthy enough to do both. Let's do another polling question. I'd like to know what you think is the most important health issue for people in mental health recovery who are working or engaged in a job search. Please choose the one you consider to be primary. Is it accessing medical care, creating health routines that support working or job searching psychiatric medications that interfere with working, or people's lack of awareness about how their health and work affect each other? So, let's take another 30 seconds for you to choose what you think is the most important, um, health implication, uh, for people that are trying to work competitively. And we'll see what the group thinks. Uh, I'm sure you might endorse all of these, but what do you think is the most critical to address and it give people another minute or not another minute, but another few seconds? All right, I'm going to show you the results. So interestingly, they're somewhat, um, equally divided. Um, about a third of people think that creating health routines that support working or a job is, uh, the most important health issue. And about another third, think that, uh, people's lack of awareness about health, uh, affects their ability to work and working, uh, affects their health. Um, and that's great because, uh, those things are both major issues. And what I'm going to talk about next, um, about a quarter of you though, um, feel that not getting good medical care, um, is a major issue and 14%, um, feel that psychiatric medications that interfere with working are a major issue, um, which they certainly are. So, thank you very, very much for sharing these results. I really

appreciate it. It's always interesting to see what people think about some of these issues. All the factors I've discussed so far set the stage for our project, which focused on the provision of IPS and health promotion services by certified peer support specialists. Several factors led us to propose this. First, all states now have behavioral health peer specialist certification programs, so it's possible to get certified in all states. In fact, this is one of the few areas of workforce expansion in the behavioral health field. The, the growth of, uh, peer support. Um, we have a shortage of most types of behavioral health providers like case managers and psychiatrists. Moreover, the latest data we have shown us that a quarter of all mental health facilities in the United States offer peer support. So, this workplace is in place, um, and available to be able to provide these services in peer run programs. Employment services are also a very popular offering, much more so than in traditional programs, many of which don't, uh, provide specific services to help people work. In addition, many states 41 at last count allow Medicaid billing for peer support services, and Medicaid dollars are one of the major, um, types of funding that gets combined in the provision of IPS. So, it's very important that Medicaid, um, funds peer support. While many peer run programs provide vocational services, as I mentioned, their effectiveness is pretty much unknown. And this creates a need for, um, models that are evidence-based that, um, we've been able, we've shown are possible to deliver at peer run programs. And one final argument for our project is the fact that historically a major focus of peer delivered recovery support has been the promotion of health and wellness. So, the emphasis on health plus the popularity of employment services in peer operated programs lend support to what we were trying to accomplish in our project. We partnered with a large peer run program in New York City called Baltic Street, and I'd like to tell you more about our partners and the organization they run. Baltic Street has been operating since 1977 and they're now, um, the largest peer led organization in the state. They offer several services including supported employment, housing, advocacy, supported education services that bridge the transition from hospital to community and self-help and peer support. Baltic Street follows the eight dimensions of wellness model, which describes how wellness consists of feeling good about different life areas that all are seen to influence each other, including a person's emotional, financial, spiritual, social, occupational, physical, environmental, and intellectual situation. Our center approached the Baltic Street leadership with the idea of adopting IPSs in its existing vocational program and training its IPS employment staff to deliver physical wellness for work, along with peer support, and then to evaluate the success of these efforts. And luckily, they, uh, said yes and were willing to join us in this program. So, what is physical wellness for work that I just mentioned? Uh, some of you may be familiar with the work of Dr. Pre Swarbrick of Rutgers University and the peer run statewide agency named Collaborative Support programs of New Jersey or C S P N J for short. Dr. Swarbrick has developed models of peer health and wellness coaching, which focus on the eight dimensions of wellness I just described, and this includes work as one of the eight in the occupational sphere for our project. She and her colleagues created a model of peer health education and wellness support called Physical Wellness for Work. This model involved a structured set of activities that occurred during meetings between participants and their employment specialists. At these meetings, job seekers learn about linkages between work and five topics, including getting adequate sleep and rest being physically active, making time for stress management and relaxation, healthy eating, and getting good medical care and preventive medical care. People learn how to establish health routines that support and promote employment. The specific employment they hope to get with routines comprised of individual health habits. So, for example, someone who's in the job search process and going out on job interviews might develop a routine where they were sure to get enough sleep the night before a job interview, um, then having a nutritious snack prior to going into the interview and then taking a walk after the interview to relieve stress. The manual for delivering Physical wellness for work is available for free from my center at the link on this slide, here's a look at the page from the manual introducing the notion that physical health and work are interconnected. People start by

rating their physical health, what they feel it's like right now, and then describe what they do in a typical day in the morning, the afternoon, in the evening. And then they answer questions about how many hours a day they'd like to work, as well as how many hours a week they'd like to work. Next, they think about their current health habits and how they go together to create wellness routines. And this is a new way of thinking, a, uh, about it. For some folks, they think about how their current routines support their work goals. Um, again, focusing on what they already do. Well, that's an important part of physical wellness for work. In addition to what health habits, they might like to add to their lifestyles to create new routines, each topic includes a try This suggestion, which on this page is in the orange box. In this case, it's to listen to a podcast about how starting a new job provides opportunities to start new healthy practices like bringing a nutritious lunch or taking the stairs instead of using the elevator. And that podcast, uh, is recorded by yours truly, I'm happy to share each of the five topics is covered in a similar format in the manual. The format begins by providing some background about each area and how it affects a person's overall health and specific connections to working. Here's the section on physical activity. It starts by describing how physical activity builds stamina, which is required in most jobs, and how physical activity helps reduce work-related stress and can improve concentration, which are also required by both. Most jobs. People then characterize how active they are now on a typical day and what kinds of physical activity they enjoy, such as walking or running or shopping. Then people think about what level of physical activity is required by their current job or if their job searching by their desired job and whether they now have the stamina that's needed to do that job. Next, they're presented with some suggestions for increasing their physical activity if they want to, and how those might relate specifically to work. Uh, it's not suggested that they adopt these suggestions, they're just talked about to, um, get people thinking about what good suggestions for them might be. There are ideas for exercising at your desk, for example, putting activity into your work commute and how to build variety and physical activity to avoid boredom. The try this suggestion for this topic in pink is to check out a dance video produced at my center by peers and occupational therapy graduate students to put some fun in their workout, and that's available for free after learning about the other topic. Stressful sleep, stress management, healthy eating, for example, people can decide whether they want to start a new habit or routine to support their work goals, and they fill out a worksheet at the end of the manual to plan for that. Let's do another polling question. Which of the topics covered in physical wellness for work do you think contributes most to your work performance? Would you say it's healthy sleep and risk? Physical activity, relaxation, and stress management, eating well or getting needed medical care and keeping up with health screenings to prevent poor health? Think a little about these. I they're all important, but think about the one that's the most important, um, to your work performance. And I can tell you right away minus relaxation and stress management, I'm going to give you 30 more seconds to think about this and weigh in on what works for you. It's very interesting. We only have responses, oh, there's one for the fourth area, but we don't have people, um, responding to all five areas. So that's, that's interesting. I'm going to give it another few seconds. Oh, now we do. Now we have folks, and this is really a personal thing, and I think it changes over time. Um, relaxation and stress management. It, um, was not, um, the major contributor to my work performance, uh, when I first began my job, for example. All right, I think everyone has weighed in, so I'm going to share the results. Um, almost 50% say it's healthy sleep and rest, 48%, but a considerable amount like me. And think the most important, uh, aspect is relaxation and stress management. Um, smaller numbers think that it's physical activity, eating well or getting medical care and health screenings. Um, so that's interesting to know about your perceptions of your work performance. Alright, let's move on. Let's turn to the research we did to evaluate the outcomes of peer IPSs and physical wellness for work. We designed our project knowing that Baltic Street had two vocational teams providing supported employment services in the adjoining boroughs of Brooklyn and the Bronx. The teams were very similar. They had an identical staffing

pattern consisting of a team leader and two to three full-time equivalent staff members. Uh, they had the same supervision format. They served about the same number of people, and while they were located at separate offices in different areas of the city, which was good in this case, given our research design, these areas did have similar geographic and job market features, which was also good. Um, because it could have affected our work outcomes if one area had lots of jobs and the other area didn't have lots of jobs. Um, staff on each team were completely non-overlapping because we didn't have the resources to conduct a randomized study. We trained the staff and team leader of Team one to provide IPS services while the other team, team two continued to offer supported employment services as usual. The training we gave to team one included assigned readings and completing the IPS practitioner skills course. Um, that is offered by, um, the IPS uh, training institute that I'll say more about in a moment. And then, uh, people received weekly telephone supervision and twice monthly in-person visits with the IPS expert who had trained them. Um, and we, uh, uh, uh, hired this person, uh, from the IPS Employment Center. Um, so we knew they had a good background on, on evidence based IPSs. This training was repeated whenever new staff were hired. Staff also had performance goals using benchmarks, which I'll describe a little later. And there was ongoing IPSS Fidelity assessment using the scale developed by the IPS Employment Centrum, and again, the IPS Employment Center is the international IPS training and Education organization. Um, so it was important, um, that we adhered to their standards and used an expert from their center. The staff training for physical wellness for work was like the IPS training and was done by, in this case, uh, a peer health promotion expert, Dr. Swarbrick and her colleagues from C S P and J. It included didactic instruction about the linkages between health and work, how to do wellness goal setting with people, and how to model your own, uh, wellness activities in relationship to your work. So that vocational staff were modeling the use of wellness tools from physical wellness for work for participants. So, they weren't just teaching it to them, they were showing them how it worked in the peer employment specialist lives. The same kind of ongoing technical assistance and feedback was provided at monthly visits to the program and twice monthly telephone supervision was provided. And finally, the C Ss p and j trainers worked with the vocational program managers to create a logging system that would capture the wellness services that were delivered and a notation system for documenting these health promotion services and documenting each person's progress in the participant's file. So that was important because there was no paperwork tracking that as there already was. Um, for IPS, the study period lasted for two years from July 2015 through July 2017. And the outcomes on which we compared the two teams included individual client outcomes as well as team outcomes. So, an example of a client level outcome is whether a person ever got a competitive job. And an example of a team outcome is the team's monthly percentage of people they served who were working in competitive employment. We also looked at people's average hourly wage. Their average number of hours worked per week, um, their job tenure or several days that they held a job, uh, and monthly number of jobs starts. So, the, the number of jobs that, uh, people got in a, in a particular month, that that was a team level outcome for the analysis. For those of you who are, um, statisticians, we used a random effects logistic regression model that adjusted for factors known to influence employment outcomes, um, like, uh, uh, age, gender, race, ethnicity, education, and the number of months they stayed in the program because we didn't randomly assign people, we needed to control for those things statistically. And here's what we found. We compared the rates of competitive employment over two years among 184 IPS participants and 164, um, supported employment as usual participants. The competitive employment rate for the IPS team, which is the dotted line, was lower than the, um, uh, supported employment as usual team at the start of the study. But by about month five, the IPS team's rate began to exceed the rate of the supported employment as usual team. And it continued to rise throughout the end of the study in July 2017. And the rate for team two plateaued until May 2017 when it declined sharply through July 17 at the study end. So clearly

there was an advantage in competitive employment for the team that adopted IPS and health promotion. Over the entire study period of two years, 43% of IPS participants achieved competitive employment compared with only 21% of, uh, team Twos participants. On average, 38% of IPS participants were in competitive employment each month compared with only 18% of generic supported employment participants. The IPS group had significantly more job starts per month and a significantly longer mean job tenure. They worked, uh, in their jobs a longer period than in the control team. However, the teams did not divert in, um, uh, average hourly wage or in average number of hours worked per week. So that's kind of interesting. We'll talk more about that in a minute. Recall that Fidelity is the extent to which a team follows the principles and practices of the IPS model of service delivery. And that teams with higher fidelity, um, get better outcomes for the people they work with. So, to determine Fidelity, IPS experts visit a program and gather different types of information and then complete a fidelity scale by assigning scores to different indicators in our project. Fidelity assessment was conducted by an external expert from the IPS Employment Center, um, and a trained partner. They made in-person visits to the program during which they interviewed the Baltic streets, uh, c e o, the vocational program director team, one's IPS, team Leader, IPSS Employment Specialists, a sample of IPS service recipients. And they also audited 10 randomly selected client files and reviewed vocational outcome data that were kept by the program. This information was then used to complete fidelity scale items that were divided into three sections. Um, one assessed, um, staffing, um, one assessed, uh, the services that they were provided and how they were provided, and the other assessed the organization of the team at the projects beginning the IPS team received a score of 71, which meant that the services did not meet the minimum standards for IPS, which is what we expected. Um, halfway through the study at the study midpoint, um, the fidelity rating was 99, so it had risen to showing fair fidelity to IPSs. Um, and then by the end of the study, um, the Fidelity assessment visit showed that the score was at 110, which indicates good fidelity to IPS teams are delivering acceptable IPS services at the fair to good level. Um, in an earlier study, the only one that I'm familiar with that trained peers to provide IPS the highest fidelity level that they were able to achieve was fair. So, our study is the first to show that a good fidelity level can be achieved with ongoing supervision and training. So, let's do our final polling question. Now. I'd like to know, as a researcher, which of our evaluation findings did you find most interesting? Was it our finding that people who received IPSS and health promotion had higher rates of competitive employment, that those receiving the new intervention held their jobs longer, that the IPS teams had a higher monthly, uh, number of jobs starts, or that there was no difference between the two teams in the hourly wage people earned? So, um, this is purely, um, an opinion question. Which of these did, did you think is, is the most interesting to you personally? I'll give you, um, a few more seconds to think about this as the study pi. I considered them all interesting, of course, but, um, I'm hoping that you can elevate one, um, and check that and we can see what people think I right. I think everybody that's going to weigh in as well, there's a couple more people. All right, let me share the results here. And here we see that 50% find that it's interesting that people who got, um, peer delivered IPS, um, and, and health and wellness support held their jobs longer. And I do agree that's a, a very interesting finding. Uh, about a third of you are, uh, happy to see that, um, the competitive employment rate was, was higher. Um, and a few of you, um, thought it was interesting that those, um, receiving peer IPS didn't have a higher wage. Um, and that, uh, the IPS team had a higher number of jobs starts that kind of goes along with, um, having competitive employment. So, thanks for sharing that as a researcher. Um, I really appreciate that. It's nice to know what people out there think of our findings. To me, the most interesting part of the study was observing the ways in which, um, Baltic Street encountered both challenges and advantages when implementing IPS. And I want to share some of those. Um, and I'm going to start with the challenges, uh, which again, we overcame. Um, one obstacle was the need to shift the relationship between service providers and recipients. While recipients take, um, uh, the lead in, uh, setting goals and acting in traditional

peer support, not the peer supporter that recipients really drive that process. In IPSs, the employment specialist guides the job seeker through a predetermined sequence of service delivery steps. They don't force them through. Um, but there is a structure to IPS, um, and the, uh, employment specialist guides that process. The Peer Employment specialists in our study needed some additional training and support to feel comfortable assuming this leadership role, while they continued to honor peer support principles of mutuality choice and relationship building. Um, so they really needed, um, uh, permission and, and needed to feel comfortable taking a little more of a leadership role, uh, but not violating any of the peer principles of, of peer support. Another obstacle, uh, which everybody always thinks is going to be the big one, um, is the absence of a larger service provider team with a psychiatrist and case managers and counselors with whom to directly coordinate IPS services. Bureau run programs don't typically provide those kinds of, uh, or employ those kinds of staff. Um, so this led to the need for employment specialists to coordinate with offsite treatment providers. Again, if the participant gave their permission. So, they did this through emails and phone calls, um, to discuss issues such as, uh, problems with medication regimens, for example, um, service coordination and other kinds of issues. So, while it was a bit of an obstacle, it was surmountable. Another challenge was the use of benchmarks to evaluate the job performance of employment specialists. Benchmarks are, if you're not familiar with the term, they're a standard by which a person's performance on a job can be measured or judged, and they're used in IPS to monitor things like how many new employer relationships are being established or how many new jobs are started. Um, those are key aspects of IPS, and specific attention is paid to those. Um, the peer specialists in our project were not used to having benchmarks in their vocational service delivery, and they were concerned that having performance standards, um, like uh, what they were asked to meet were unrealistic. Um, one, one benchmark involved reaching out to new employers and interesting them in hiring people into open positions in their organizations. This is called cold calling, and it's one of the most challenging parts, I think, of employment specialists' roles because it involves persuading people to hire someone you're working with and risking rejection from the employer, and, uh, the benchmark for employment specialists, uh, at Baltic Street was making 16 new employer contacts per month. And initially they were like, we can't do that. That's for a week. Um, and they also, uh, were asked to follow the benchmark of five new job starts each month. But given the attention that was paid to those benchmarks, the fact that they were used as guides, people weren't punished if they couldn't meet them, but having them exist and the desire to see if you could reach them, um, led the employment specialist to find that they could meet and exceed these targets. Um, and more importantly, they saw that if they were able to achieve the benchmarks, um, the people they worked with had better work outcomes and that the team's competitive employment rate went up. Uh, a final challenge, uh, in this project, um, in this conversion to IPS was the high rate of vocational staff turnover. And interestingly, this same problem exists in non-peer run programs. So, this doesn't, um, must do just with peer run, uh, programs. It's due at least in part, to the low pay scale of employment service providers compared to clinical positions and other types of positions in our project. It may have been magnified by the fact that peer specialists tend to make lower salaries to begin with. So, some of the employment specialists were motivated to leave Baltic Street, um, and work in, uh, let's say, say an IPS program for another agency. Um, fortunately, Baltic Street was able to raise the pay scale for vocational program staff soon after the program ended. Uh, there's no real way around this. Um, the program needs to adequately compensate IPS employment specialists, so they're just going to turn over. Um, and that hurts the team's performance. Now, in addition to the challenges I described, there were several ways that Baltic Street's peer run philosophy and peer staff made adopting IPS and health promotion much, much easier. First, Baltic Street was already doing supported employment, so they're already invested in many features of IPS, such as helping people get competitive jobs, not workshop jobs or not, uh, short-term temporary jobs. Um, they were also invested in not having service time

limits, um, and consumer choice guiding job development. That was not a hard sell at all At Baltic Street. The integration of the new health component into the work of the agency's employment specialists was aided by the fact that all Baltic Street staff, um, not just in the vocational program, but throughout the whole agency, were comfortable in the role of health educator, um, and understood how important, uh, physical health and wellness were to people's recovery process. Another facilitator was that service recipient trust was higher in a peer run program, which made engagement into IPS employment services much easier. People trusted that, um, the folks they worked with were going to pay employment or pay attention to whether, um, they were, uh, going to reach limits to their S s I or S s d I, for example. Um, a final advantage was the ability of the peer vocational staff to demonstrate how health routines positively impacted their own work, their own professional work at Baltic Street. So that was another advantage that you wouldn't necessarily get at a traditional agency. If you are thinking about adopting some of what you've learned in today's webinar, here's some resources you can take advantage of. Uh, first SAMHSA offers a free supported Intu employment toolkit that describes the IPS model, the research that supports it, how to adopt it, and train your staff to deliver it, and ways to evaluate your success. It's a little dated, but it's worth looking at. And it's available from SAMHSA at the web link on this slide. Second, there's a free comprehensive web portal hosted by my center with webinars and podcasts on different features of IPSS delivery. These include how to engage people into IPS services, how to assess IPS, fidelity Cultural Competency and IPS delivery, um, uh, getting jobs for veterans and people that have been involved in the criminal justice system, working with job seekers who have H I V and other chronic conditions, and providing a specialized kind of vocational peer support that, um, was developed at, uh, Boston University. This web portal also has a separate section for employers and another section for tools, uh, for families and other supporters of people who are working or looking for work. And everything on that web portal is free. So, um, I, uh, encourage you to check it out. Third, the peer coach, uh, peer health coach model that was used in my project is available at the, in the manual I described earlier called Physical Wellness for Work. Um, and there's the link to that. And fourth, the toolkit I mentioned on different ways to involve peers in IPS is available online with descriptions and examples from different programs across the us. And finally, the definitive source of all things IPS is the IPS supported or the IPS Employment Center. Their website includes a wealth of courses, research studies, uh, supported employment policy developments and updates on the national IPS learning community that they have run for decades now. So, I want to encourage you to access and explore these resources no matter what your interests are in this area. This slide contains references for the research that I cited in my presentation today. I know it's in mosquito font. Um, so no one's going to be able to read it online, but, um, the slides will be available, um, from BU after the presentation, so you can check out, um, the research that I mentioned, and here's my contact information if anyone wants to follow up with me. Um, thank you so much for your attention, and I'll turn it back to Alexa for questions and discussion.

Alexa Trolley-Hanson:

Thank you so much. Um, Dr. Cook for this great presentation. Um, we do have about 10 minutes before, um, we need to end today. We do have a few questions in the question-and-answer section. The first is, um, a question about, um, noticing that the counties in the US were closed between IPS and non IPS. I think this is from the beginning of the presentation. Do you have any thoughts as to why?

Dr. Judith Cook:

Uh, so I didn't hear the first part of the question.

Alexa Trolley-Hanson:

The question says, I noticed, um, that the, it's a kind of poorly worded question, and it was pushed by an anonymous attendee, so I can't ask that person to share, but it's a question about I think the, um, the relationship between IPS and non IPS providers within the US and how they're close. Um, and I think that was answered. I think this goes to the reason why people don't adopt IPS models.

Dr. Judith Cook:

Okay. Um, so I, I think one, um, issue with adopting IPS is, as I mentioned, the need to blend the blend, the different funding sources. Um, if an agency isn't willing to do that, and that involves a lot of administrative record keeping, um, uh, Medicaid won't pay, for example, for specific job development, but it will pay for people, um, to get some help working on, uh, symptoms, for example, that might, uh, interfere with their ability to work. It will pay in most states. Now remember, Medicaid is different in each state. Each state has its own Medicaid plan, but in most, uh, instances, Medicaid will pay for services that are health related. Um, and so, uh, it's very difficult to, you know, keep one set of records for Medicaid, another, um, for state general revenue, um, another for other funding sources. So that can be a big obstacle. Um, and another obstacle is the fact that not all states have the interest in employment for people in mental health recovery, um, to undertake a more demanding but effective, uh, model of service delivery. So, I would say, in my opinion, those are two major issues that, um, states continue to deliver non IPS supported employment.

Alexa Trolley-Hanson:

Um, we also have two questions from Leon Mark, can I allow you to talk? And, and, um, please, if you'd like to ask your questions, you can unmute yourself and, uh, ask your question.

Dr. Judith Cook:

Hi, Leon.

Leon Mark:

Dr. Cook, thank you for taking my question. My question is, um, one is if the peer model isn't really about the same thing as the deployment model, how do you fuse those two models together, even the peers to the, to the peer model fidelity, and, like you said, be more, more prescriptive in their interactions with the, uh, recipients,

Dr. Judith Cook:

Right? So, I wouldn't use the word prescriptive, I would use the word more structured. Um, and so, uh, you know, in a model, in, in a typical peer model, um, if, uh, the person you are working with never says, I want to go on a job interview, um, you just never go there as their peer supporter, um, as an IPS staff person. Um, you explain that, uh, part of the IPSs process involves helping people feel comfortable knowing what kind of job they'd like, um, and getting them ready to go on job interviews. Um, and then if the person, uh, expresses, um, you know, concerns about that, then those concerns are addressed. So, nobody's forced to do anything, but there is an idea that there's a process of steps, um, that the employment specialist guides them through. That isn't necessarily true of peer support in general, which just tends to be participant led.

Leon Mark:

Right? That's, that's what I'm saying. It's, uh, it's more directed by the staff interest rather than the recipient's interest in the beginning, at least.

Dr. Judith Cook:

Yeah, I think I would say that it's directed, um, by the recipient's interests, but using a structure, um, that is like the model structure. Um, so if you want IPS, um, you know, it's explained to you what this involves. Um, and you, uh, must have some desire to go through the steps, but you also have every right to say, I'm not ready for this step. Um, so I think that's, I think that's what the difference is. Great question. By the way,

Leon Mark:

Another question also, Dr. Cook. Uh, the peer work for wellness, it seems to like a step back from the, uh, in intentional p uh, in IPS deployment model, because it's not, it's not rapid, uh, placement, it's not, it would be for the rapid placement of the IPS model.

Dr. Judith Cook:

So, it's meant to go along with rapid placement.

Leon Mark:

Oh, it, oh,

Dr. Judith Cook:

So, it's not something that gets done, uh, before IPS starts. It gets done, um, with, uh, the person wherever they are in the IPS process. So, if they're job searching, then um, people, you know, think about, uh, what kind of health routines will help them in job searching. If they're already working, um, then the emphasis is on, you know, what do I need to do to hold this job?

Leon Mark:

Like, more skills to keep you working rather than just the, uh, benefits counseling or the, uh, work with your supervisor and coworkers more, more tools get to work on,

Dr. Judith Cook:

Right. It's a supplement to, uh, evidence based IPS.

Leon Mark:

Thank you. Thank you, Alexa.

Alexa Trolley-Hanson:

Thank you. Um, we also have a question from Fabricio. Um, I'm going to let you unmute yourself and ask your question.

Dr. Judith Cook:

Hi, Fabricio.

Fabricio:

Hi, how are you? Good to see you. Great presentation. I was just curious about your opinion regarding vocational rehabilitation here in the state of Illinois and the degree of, of their support for IPS.

Dr. Judith Cook:

That's a great question. Thanks for asking. Illinois has been a leader, um, in adopting IPS and has been a part of the IPS learning community, um, for a couple decades now. Decades. Um, it has a strong alliance between its division of mental health and its Department of Rehabilitation services. Um, you know, there's still lots of obstacles that, uh, they must confront, but I think in terms of supported employment for people with psychiatric disabilities, um, it, it's a model state. It's one of the leaders, um, other states are Maryland and Iowa. Um, and, uh, some of those are, are covered in the, um, peer, um, IPSS toolkit that I mentioned earlier. But at, that's a good question. Thanks for asking. How about some more questions?

Alexa Trolley-Hanson:

And raise your hand or you can, um, post it on the question I ask answer bots. All right, Katie, I'm going to, um, let you.

Dr. Judith Cook:

Hi, Katie

Alexa Trolley-Hanson:

<inaudible>, sorry, go ahead.

Katie:

Oh, hi. Can you hear me, okay?

Dr. Judith Cook:

I can.

Katie:

Okay. Uh, hi. I'm wondering, um, so, so in New York, after you guys, um, found these results, did any other agencies that already use IPS decide to hire people working as peers? Um, or has that been a barrier to kind of like getting more people who work as peers involved in providing IPS, like at agencies that already do it?

Dr. Judith Cook:

That's such a good question. Um, you know, it, it hasn't happened yet. We just published our results, um, last year. And in my experience, when you're trying to do something really, hard, um, and when you're trying to show that peers can make things happen, it helps to have some, uh, evidence to advocate. Um, I, I can tell you that in programs around the country, um, more and more IPSs, uh, programs are adopting, uh, peer support. And I believe the same thing is true in New York, but I can't point to any specific examples.

Katie:

Okay. I was just wondering. Thank, um, thank you so much, <laugh>.

Dr. Judith Cook:

You're welcome. Thanks for attending and asking a question.

Alexa Trolley-Hanson:

All right, well we are at the end of our presentation for this afternoon. Um, I just would like to remind everyone that we will be sharing this presentation, um, on the Center for Psychiatric Locations, <inaudible> and that, so you'll be able to access it again. And that would include, um, Dr. Cook's contact information so you can reach out to her via, um, email if you have any questions in the future. I also posted in the chat a survey about this presentation that is helpful to us, um, in, um, getting your feedback about where our webinar is going in the future. We do have a webinar that has been scheduled for November. Watch the website and your email because we'll be sending out information about that very soon. Thank you so much to Dr. Cook and thank you so much to all of you for taking time your afternoon. Join us for this conversation.

Dr. Judith Cook:

Thank you everyone.