Community Inclusion for Persons with Serious Mental Illness in North Carolina
February 20, 2018
Breakout Groups

Transition Age Youth

• What is not working:
  o Homeless youth: The HUD definition of homelessness and housing: youth who do not meet the definition.
  o Funding.
  o Young people are a transient population.
  o Lack of public awareness and success stories.

• What is working:
  o TCLI:
    ▪ Initial and monthly stipend ($2000 for apartment and items the first month).
    ▪ Identification at the LME/MCO.
  o Rapid job search
  o Community practice → systems theory

• What is not working:
  o Sometimes services exclude each other.
  o Transition from child to adult (diagnosis and medical necessity).
  o EBPs and bringing them to fidelity and scale.
  o More ongoing research.
  o Fragmented system.
  o Need for timely response.
  o More prevention needed.

• Long-term Needs (Trauma – Isolation – Abandonment):
  o Support (family and peer)
  o Advice
  o Wraparound services/case management
  o Daily living skills
  o Knowledge of community resources
  o LGBTQ
  o Education and skills for job
  o Training for advocacy and rights
  o Housing
  o Collaboration
  o NC START for I/DD/MH (crisis service case manager)
  o Critical Time Intervention (CTI)
  o Community Collaborative System of Care
  o SAYSO/Youth Villages Lifeset - YVNetwork
  o College including housing
  o Early psychosis identification (Center for Excellence)
  o Youth Move
Family Partners
- Identification of foster youth (food insecurity, housing support)
- First in Families

Problems to be Solved:
- Empowerment
- Engage in services
- Catch earlier/develop plan
- Environment → social determinants
- Self-determination → choice
- Navigate system

Peer Support – Person with Lived Experience
- Mutual – Equal – Connected – Shared
- What is working:
  - Empowering
  - Educating/shared experience
  - Instilling hope, sharing stories
  - Encouragement
  - More opportunities to use peers
  - Culture shift
  - Less scripted roles
  - Being used in more services (IPS)
- Barriers – Challenges:
  - Eligibility requirements
  - Coordination
  - Transportation
  - Uneducated public – stigma
  - Inappropriate expectation of peers
  - Expectations of funding sources
  - Payees’ misunderstanding
  - CE of peer support
  - Inadequate compensation/no career ladder
- Implementation – What will I do tomorrow?
  - Internal training for clinical staff
  - More outreach: advocate and educate
  - Not being a Medicaid billable service
  - Develop a community resource guide
  - Local collaborative for peer support
  - Ask → Listen

Employment
- What is working:
  - People are feeling accomplished.
  - Employment is increasing socialization opportunities.
  - People are pleasantly surprised at what they can do and how much.
• Starting to coordinate across stakeholders regarding employment, especially as it relates to behavioral health.
  • Zero Exclusion + Rapid Job Search are becoming part of the culture.
  • Focus on competitive and individualized jobs.
  • Having a job has improved symptoms and symptom management.
  • Employing peer mentors—going well—we need to continue to build on this.
  • See yourself in the other person’s dreams through employment.
• Help:
  • Disconnect from ability to work.
  • How to bring vision back to people who have lost their vision.
  • Clear message across all levels and stakeholders.
  • What are the supports that help people go to work successfully (child care, transportation, medication)?
  • DVC-VOC assessment says they can’t work and need training.
  • Employment before moving out so in place and community is being established to support the move.
  • Awareness of community resources that support employment.
  • Focus on employment.
  • IPS provider is making clients in ACH go to their office for intake (17-mile minimum), which is a barrier to services.
  • Rightsizing number of teams per mileage covered/problems with coverage.
  • Try not to be “gatekeepers” for the service.
  • Policies around benefit retention when working need to change to support people going back to work.
  • Access to educational opportunities to improve employment situation.
  • Access to well-trained benefits specialists, especially for ACT (even more limited).
  • Still battling the misconception that work will make things worse coming from mental health professionals.
  • Silos across multiple public systems—they’re breaking but not BROKEN.
  • Funding resources are threatened at multiple levels.
  • Advocacy at local and state levels for funding and support from people regarding IPS.
  • Continued training/education on the IPS model.
  • Increased understanding of how employment outcomes impact funding to divisions (DVR paid back for services if employed for 9+ months).
  • Employment First legislation.
  • Exception around SE AND Education in policy.
  • Readiness conversations with stakeholders = not resistant to zero readiness.
  • Open to talk regarding employment = treatment.
  • IPS has a wraparound component.
  • Opportunity to bridge jobs talks to jobs for people with disabilities (Governor is big on jobs).
  • CPSS program \(\rightarrow\) avenue for meaningful employment.
  • Volunteering as a path to employment for people that want this option.
  • People are motivated to work, need to get past previous negative experiences.
- Talking about benefits and liking to trained benefits counselors.
- People with criminal records can now find employment.
- ABH staff from top to bottom have embraced this model, increasing the number of people in service.
- Providers serve as experts to talk about services.

**Needs:**
- System set up (benefits) to cut off when employed = no safety net.
- WIPA ➔ only for people currently employed.
- Sometimes people have been told for a long time to not work.
- Worries about medication and sustained employment.
- How does/should volunteering fit in to this?
- Multiple goals—education and employment not approved for authorization by MCOs.
- Need to focus on engaging people living in ACHs.
- We need employment to ALWAYS be part of recovery conversations (State agencies, MCOs, providers).
- How to inspire hope and build confidence in an especially daunting place and daunting task.
- High Level Champions of Employment (Governor, Secretary, General Assembly)!!
- More organized IPS success stories.
- Consideration for young adults in college to reflect the unique needs of individuals.
- The State needs to model the change they want to see (hiring policies, supporting education).
- How are different divisions coordinating across “the Silos”?
- DVR/ACT regarding joining to focus on employment and education.

**Top three activities to improve employment access and outcomes for people with disabilities:**
- **Group 1:**
  - Advocacy- especially from/by people receiving services
  - Employment First legislation coming from a State level
  - Leadership support
- **Group 2:**
  - Access to benefits counseling
  - Fully understanding Employment First and the dignity of risk (patience when changing dialogue)
  - Continuum of options and informed choice

**Recreation**
- What’s working:
  - Housing: people have the opportunity to move into the community and select neighborhood.
  - Using technology: teach how to use phone, Facebook messenger, meet up application
    - Connecting with friends/family.
• Meetup application
  • Eventbrite
  o Linking to community stakeholders and developing partnerships
    • Community college: offer classes to person with mental illness.
    • YMCA
    • Psychosocial Rehab center: partner with officers to decrease fear of clients.
    • State hospitals: bring community in (ACHs – Hospital Liaison).
  • Co-production/Natural supports
    o Person-centered planning: encouragement of support groups (NAMI, Resbit, NCStar)
    o Peer support: local/creative touch
    o Relationship/people mapping: visual, differential professional/personal support
    o Transition to Community Living (TCL) initiative
• Needs/interests around recreation:
  o Actually ask peers “as experts” and value their input.
  o VOICE: opportunity to explore recreational interests, rather select limited options.
  o Incorporate business to donate/volunteer.
  o Community outreach: stop isolating as a population.
  o Include people that are not included in Medicaid.
  o Individual drive.
  o Tools: identify and support recreational interests.
  o Transportation.
  o Incorporate other community resources.
  o TEACH: social/interpersonal/self-advocate/empowerment skills.
• Barriers:
  o “Rescuing doesn’t facilitate motivation.
• Recommendations:
  o Develop training/strategies for peers to support recreation.
  o Highlight successful programs/strategies.
  o Expand transportation availability.
  o Advocate/educate consumers and mainstream organizations.
    • Reduce negative attitudes in the community by supporting community programs to “pull”/welcome individuals with lived experience.
    • Identify key leaders in mainstream communities who also have lived experience.
    • Invite mainstream providers in to discuss SMI issues/concerns.
    • Hold recovery rallies, inviting mainstream providers.
    • Be present in mainstream communities (join boards, be at the table).
    • Establish community partners.
  o Hold community fairs to showcase recreation opportunities.
  o Work with NAMI to focus on leisure/recreation.
  o For consumers:
    • Establish the individual within the community.
    • Support individuals to make decisions in the mainstream environment.
Help individuals find their own motivation by drawing on their past interests, expanding on their current interests, and exploring potential interests.

- Action plan:
  - Create statewide resource website.
  - Every county should offer recreation opportunities free to all community members.
  - Transition plan: introduce to police, EMS, YMCA, etc.

- Questions:
  - Rural communities
  - How do we define/expand “medically necessary” transportation?
  - How do we tap into community resources?
  - How do we identify interests and support motivation?
  - How do we support mainstream community to “pull” people in?
  - How do we reduce prejudice/discrimination in mainstream settings?