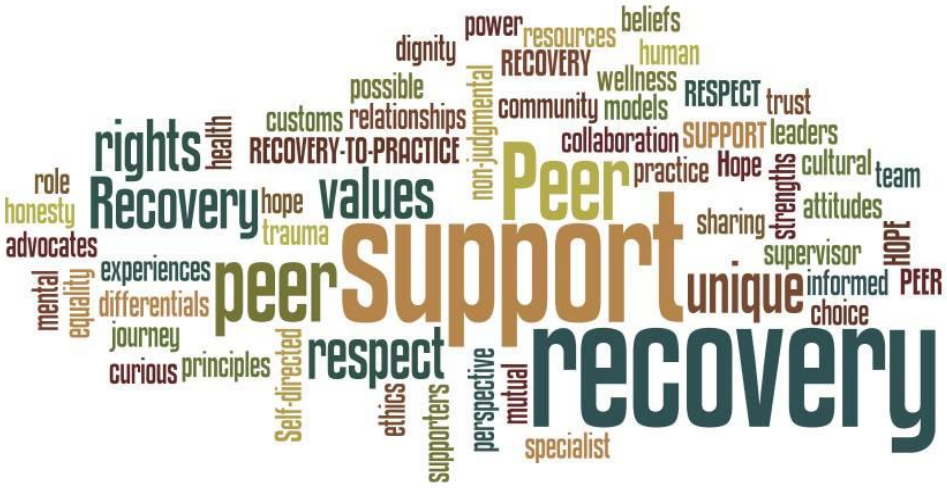
TCLI AMH Services Toolkit



NC DHHS DMHDDSAS

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Transitions to Community Living: Services

DOJ Background

In August 23, 2012, the State of North Carolina signed a Settlement Agreement with the United States Department of Justice concerning community integration of individuals with severe mental illness (SMI) and severe and persistent mental illness (SPMI) in or at risk of entry into adult care homes. As outlined in the Department of Justice (DOJ) Settlement Agreement, the State has agreed to 1) develop and implement effective measures to prevent inappropriate institutionalization; and 2) provide adequate and appropriate public services and supports identified through person-centered planning in the most integrated setting appropriate to meet the needs of individuals with SMI or SPMI.

The State is responsible for providing evidence-based and recovery oriented supports for individuals transitioning to the community. As part of the community-based adult mental health (AMH) service continuum for individuals with SMI/SPMI, the Agreement emphasizes fidelity Assertive Community Treatment (ACT) and Supported Employment (SE). As such, the Department of Health and Human Services (Department) has enhanced these policies and implemented fidelity evaluations to ensure quality and positive outcomes.

> Services and supports shall: be evidence-based, recovery-focused and community-based

The **Transitions to Community Living Initiative (TCLI)** [1] is the implementation of the activities set forth in the Agreement. Through this initiative, the Department must ensure that by July 2019:

- **5,000 individuals are receiving services from at least 50 ACT teams meeting fidelity**
- **2,500 individuals are receiving Supported Employment to fidelity.**

[1] http://www.ncdhhs.gov/mhddsas/providers/dojsettlement/index.htm

Adult Mental Health Services

When referring to TCLI service and supports, the focus is on supporting adults with primary mental health needs and co-occurring substance use challenges to achieve their goals and move towards their own recovery pathway. As such, services touch upon the entire adult mental health (AMH) service continuum that the State and the LME-MCOs offer individuals in the community. As the State enhances its AMH services, the goal is that all AMH services and supports reflect the latest research in community-based recovery supports that are guided by shared decision making and person-centered planning, and utilize assistive technology to advance recovery.

The Foundation

TCLI focuses on the goal of recovery and community inclusion, supported through the mental health consumer movement's advocacy on the roles of self-determination and peer supports to enhance quality of life. Olmstead's motto of ***"Community Integration for Everyone"*** is the guiding principle in the development of the AMH community-based services. As referenced in research, the State is *"ensuring that each individual has every opportunity to participate in community life and to be valued for his or her uniqueness and abilities, like everyone else"*[2].

"We all have value despite where we are on our journey and what challenges we are facing. [A job and an apartment] is worth struggling for and worth the risk"

AMH Services are also supported through research on **Recovery-Oriented Systems of Care (ROSC)**. Although this concept started in the substance use community, it has been extended to mental health recovery within research for a number of years. A ROSC *"offers a comprehensive menu of services and supports that can be combined and readily adjusted to meet the individual's needs and chosen pathway to recovery. ROSCs encompass and coordinate the operations of multiple systems, providing responsive, outcomes-driven approaches to care. ROSCs require an ongoing process of systems improvement that incorporates the experiences of those in recovery and their family members."*[3]

[2] http://tucollaborative.org/comm_inclusion/community_integ_intro.html
[3] http://store.samhsa.gov/shin/content/SMA08-4315/SMA08-4315.pdf

North Carolina aims to join the community of recovery-oriented states[4] employing practices and policies that use psychiatric rehabilitation and recovery as a framework to guide the development of all behavioral health related policies, processes and practices and ensure that people receiving services in North Carolina have access to the type and amount of service that they need. **People with SPMI/SMI can and do recover.** Recovery is not rigidly defined as a cure, removal of symptoms, nor achieving and maintaining stabilization; rather it is about living a life of purpose, meaning, and wellness. It is about "getting a life" that one wants to live.

Recovery is "no longer viewing oneself primarily as a mental patient and reclaiming a positive sense of self"

States and LME-MCOs shall use standardized measures to assess quality, access, and recovery using ***Recovery Outcome Measures***. There are new instruments to measure recovery and advance Mental Health System Transformation, such as the **Recovery Oriented System Indicators (ROSI)**[5,6] which is a 42-item consumer self-report survey and administrative profile that looks at what helps and hinders mental health recovery. A compendium (2005) titled "Measuring the Promise: A Compendium of Recovery Instruments, Volume II[7]" and another resource from the UK[8] (2010) on over 30 current measures can be useful for LME-MCOs and providers in self-assessment.

Furthermore, LME-MCOs should have provisions for and/or facilitate access to services and trainings for service providers that include but are not limited to:

- Evidence based, promising and emerging practices in mental health
- Recovery oriented organizational cultures
- Integration of peers as providers such as consumer-operated services
- Employment as a path to recovery
- Community living and Supportive Housing
- Psychiatric Advanced Directives
- Wellness Planning and wellness-self management
- Asset development and financial wellness
- Trauma-Informed Care for adults
- Dignity of Risk[9]

[4] http://www.pmhca.org/recovery/seventeen.html
[5] http://www.nasmhpd.org/docs/publications/docs/2006/Phase_II_Mental_Health_Recovery.pdf
[6] http://www.power2u.org/downloads/ROSI-Recovery%20Oriented%20Systems%20Indicators.pdf
[7] http://www.power2u.org/downloads/pn-55.pdf
[8] http://www.recoverydevon.co.uk/download/Review_of_Recovery_Measures.pdf
[9] http://tucollaborative.org/pdfs/Toolkits_Monographs_Guidebooks/community_inclusion/Managing_Risk_in_CI.pdf

The Approach

The service approach for AMH is based upon **Psychiatric Rehabilitation (PsyR)** that is designed around ***"Helping People with Psychiatric Disabilities Lead Fulfilling Lives"***. Psychiatric Rehabilitation, also known as psychosocial rehabilitation, and sometimes simplified to *Psych Rehab*, is the process of restoration of community functioning and well-being of an individual diagnosed with a mental disorder and who may be considered to have a psychiatric disability. According to *"A Primer on the Psychiatric Rehabilitation Process*[10]*"*, Psych Rehab interventions assist people to be successful and satisfied in the living, working, learning, and social environments of their choice[11]. These approaches help people determine the roles they wish to achieve (goals), help identify what they need to do and can do well (skills), and what they have or need to have (supports).

Widely recognized evidence-based practices with which Psych Rehab for adult with mental illnesses is a foundation include:

- Assertive Community Treatment
- Family Psychoeducation
- Wellness (Illness) Management and Recovery
- Integrated Dual Disorders Treatment
- Supported Employment
- Permanent Supportive Housing
- Consumer-Operated Services (Peer Supports)

It is the position of DHHS that all staff providing AMH services should have a basic understanding and training on Psych Rehab and Recovery, in addition to other evidence-based approaches such as Motivational Interviewing, Wellness Self-Management, Housing, Employment, and Whole Health.

Educational Resources

North Carolinians for Recovery Oriented Care (NCROCs): https://sites.google.com/site/nc4recovery/project-definition

Psychiatric Rehabilitation Association: http://www.uspra.org/

Boston University's Center on Psychiatric Rehabilitation: http://cpr.bu.edu/

[10] http://www.bu.edu/cpr/products/books/titles/prprimer.pdf
[11] http://www.bu.edu/cpr/products/books/titles/prprimer.pdf

Center for Practice Innovation:

http://practiceinnovations.org/AboutCPI/WhatareEvidenceBasedPractices/tabid/194/Default.aspx

SAMHSA Recovery to Practice: http://www.samhsa.gov/recoverytopractice/

New York Association of Psychiatric Rehabilitation: http://www.nyaprs.org/

TCLI Responsibilities and Requirements

This section describes each section of the DOJ Settlement Agreement and expands on the roles and responsibilities for the State and the LME-MCOs in policy and fidelity implementation, accessibility and development of services, and annual goals described in the Agreement.

BREAKDOWN OF DOJ SETTLEMENT AGREEMENT

Section & Page	Description	DHHS's Role	LME-MCO's Role
III.B.7.b. Page 6	Housing Slots will be provided for individuals to live in settings that meet the following criteria: They include **tenancy support services** that enable residents to attain and maintain, integrated, affordable housing.	Ensure ACT teams provide Tenancy Support Services Ensure Tenancy Support is provided to individuals not in ACT. Support Training for Tenancy Support Specialists on Housing First and Supportive Housing	Ensure every person transitioning is connected with Tenancy Support Services if they so choose. Ensure Tenancy Support Services are provided at an adequate frequency and intensity upon transition whether provided by ACT or other provider.
III.C. 1 & 2 Page 8	**Community-Based Mental Health Services** The state shall provide access to the array and intensity of services and supports necessary to enable individuals with SMI in or at risk of entry in an Adult care home to successfully transition to and live in community based settings. The State shall provide each individual receiving a housing slot with access to services for which that individual is eligible. The state shall also provide individuals with SMI in or at risk of entry to adult care homes who do not receive a housing slot under this agreement with access to services for which that individual is eligible.	Ensure individuals in the DOJ priority population are receiving services and supports across all residential and housing settings. .	Ensure individuals are linked with services PRIOR to or UPON transitioning; this means they are already approved for services, linked to the provider, an integrated PCP is completed with the provider, and UM authorizations at the appropriate frequency and intensity have been approved for services to start DAY 1 of transition.

			Ensure there is an adequate provider network based on local needs and gaps. For each person in the DOJ priority population, service type and provider (including address) must be entered into every TransITions data entry. If not receiving services, describe why.
III.C.3 **Page 8**	The services and supports referenced above shall: (a) Be evidence-based, recovery-focused, and community-based (b) Be flexible and individualized to meet the needs of each individual (c) Help individuals to increase their ability to recognize and deal with situations that may otherwise result in crises; and (d) Increase and strengthen individual's networks of community and natural supports, as well as their use of these supports for crisis prevention and intervention	Ensure all AMH service definitions and policies support evidence-based practices and recovery; revise definitions as necessary. Promote expansion of peer and community supports.	Ensure individuals are referred to evidence-based services. Ensure mobile crisis and other interventions are available in the catchment area. Connect individuals with peer and natural supports, including peer crisis respite and other options to deescalate and avoid crisis.
III.C.4 **Page 8-9**	The State will rely on the following community MH services to satisfy the requirements of this Agreement: ACT, CST, Case Management, Peer Support Services, PSR, and any other services in III.C.1 and 2.	Ensure service definitions and policies support evidence-based practices and recovery; revise definitions as necessary.	Ensure access to services that support maximum independence and are recommended in the Comprehensive Clinical Assessment (CCA). Ensure adequate provider network and robust community-

			based service supports
III.C.5 **Page 9**	All ACT teams shall operate to fidelity to either the Dartmouth Assertive Community Treatment (DACTS) model or the Tool for Measurement of Assertive Community Treatment (TMACT) = *{TMACT is selected tool per policy}*	Ensure fidelity through evaluations and certification status (provisional, full, exceptional) per policy.	Support fidelity **Note.** Totals are cumulative. Current total includes 53 individuals who have been discharged since beginning In-Reach in a State psychiatric hospital. **Note.** Totals are cumulative. Current total includes 53 individuals who have been discharged since beginning In-Reach in a State psychiatric hospital. through training, policy, contracts, and funding supports.
III.C.6 **Page 9**	A person center service plan shall be developed for each individual, which will be implemented by a qualified person who is clinically responsible for ensuring that all elements and components of the plan are arranged for the recipient in a coordinated manner. Individual service plans will include psychiatric advance directives and/or crisis plans so that such measures can be incorporated into the response to any behavioral health crisis.	Ensure PCPs are psychiatric rehabilitation centered, recovery-focused and integrated with the full array of supports the individual is receiving (reviewed during transitions for Housing Slot participants and reviewed during Fidelity evaluations for service recipients).	Transition Coordinators support development of the PCP by including all supports the person is receiving into one integrated plan. The Individual and their selected participants and providers are included in the treatment planning meeting.

III.C.7 **Page 9**	The state is in the process of implementing capitated prepaid inpatient health plans for Medicaid reimbursable mental health services. The state will monitor services and service gaps through contracts with the LME-MCO, will ensure that the number and quality of community mental health service providers is sufficient to allow for successful transition of individuals with SMI, who are in or at risk of entry to an adult care home, to supported housing, and for their long term stability and success as tenants in Supportive Housing.	Review gaps and needs analyses from LME-MCOs to support service array. DHHS will hold the LME-MCOs accountable for providing access to community-based mental health services in accordance to 42 CFR.	Ensure adequate provider network and robust community-based service supports.
III.C.8 **Page 9**	Each LME-MCO will provide publicity, materials, and training about the crisis hotline, services, and the availability of information for individuals with Limited English Proficiency, to every beneficiary consistent with federal requirements as well as to all behavioral health providers, including hospitals and community providers, police departments, homeless shelters, and department of correctional facilities.	Request information on training availability and samples of marketing materials from LME-MCOs.	Ensure available information to community partners and stakeholders, businesses, family members and advocacy groups about TCLI and other services/supports in the catchment area.
III.C.9 **Page 10**	By July 1, 2013, all individuals receiving ACT services will receive services from employment specialists on their ACT teams.	Ensure ACT vocational specialists have training and tools to provide SE within ACT. Review number of clients in ACT receiving vocational supports through Fidelity Evaluation data.	Ensure ACT teams have full-time Vocational Specialists on the team, who are dedicated to SE, as per policy through regular provider monitoring.
III.C.9.a-g **Page 10**	By July 2013, all ACT teams in the State will operate in accordance with a nationally recognized fidelity model and the State will increase the number of individuals served by ACT teams to 33 teams serving 3225 individuals. These numbers increase each year of the agreement. At the end of the agreement	Ensure annual goals are met through client data rosters from Fidelity Evaluations	Ensure ACT teams have the supports, staffing, and training needed to meet fidelity through provider monitoring of adherence to service definitions.

	in 2019, the State will have 50 ACT teams serving 5000 individuals.		
III.D.1 **Page 11**	The State will develop and implement measures to provide Supported Employment services to individuals with SMI, who are in or at risk of entry to an adult care home that meet their individualized needs. SE services are defined as services that will assist individuals in preparing for, identifying, and maintaining integrated, paid, competitive employment. Services offered may include job coaching, transportation, assistive technology assistance, specialized job training, and individually tailored supervision.	Ensure SE services are available for individuals with SMI and that they include all resources necessary for successful community jobs. Collaborate with DVRS local offices to ensure coordination and continuity of services.	Ensure provider contracts, funding, and policies are aligned to serve individuals with SMI. Ensure adequate provider network and robust community-based service supports
III.D.2 **Page 11**	Supported employment services will be provided with fidelity to an evidence based supported employment model for supporting people in their pursuit and maintenance of integrated, paid, competitive work opportunities.	Ensure service definitions and policy support evidence-based practices; revise definitions as necessary.	Ensure adequate behavioral health network to support IPS-SE teams with mental health integration.
	Supported Employment Services will be assessed by an established Fidelity Scale such as the scale included in the Substance Abuse and Mental Health Services Administration SE toolkit.	Ensure fidelity to IPS-SE or other fidelity models through evaluations and certification status (fair, good and exemplary fidelity) per policy.	Support fidelity to IPS-SE or other fidelity models through training, policy, contracts, and funding supports.
III.D.3 **Page 11**	By July 1, 2013, the State will provide supported employment services to a total of 100 individuals. The requirements increase each year such that by July 1, 2019, the State will provide supported employment to a total of 2,500 individuals.	Ensure annual goals are met through client data rosters from Fidelity Evaluations. Support in partnership between LME-MCOs, providers and VR local offices in partnership in the IPS model.	Ensure supported employment providers have the supports, staffing, and training needed to meet fidelity through provider monitoring of adherence to service definitions.

Community Based Mental Health Services

Assertive Community Treatment (ACT)

What is ACT?

ACT is an evidence-based practice that is comprehensive and includes a multi-disciplinary clinical team that utilizes the expertise of medical, therapeutic, social work, vocational, substance abuse, and peer support professionals to assist individuals diagnosed with severe and persistent mental illness to achieve and sustain recovery in the community of their choice. ACT services are holistic, frequent, intensive, and provided directly in the community to enhance the overall quality of life through building self-confidence and proficiency across all domains of life functioning.

ACT is often known as the "***hospital without walls"*** bringing comprehensive psychiatric rehabilitation supports to individuals where they live. ACT has undergone a significant evolution from where it started in the 1970's in Madison, Wisconsin. Core elements remain the same, with a more focused adoption of contemporary evidence-based psychosocial practices that focus on growth-oriented outcomes reflecting community integration, transition, and recovery.

AS OF OCTOBER 2014, NC HAS 81 ACT TEAMS THAT MEET FIDELITY

Who can get ACT?

ACT is most effective when serving the intended population, as evidenced from years of research in adult mental health; this includes individuals who experience severe and persistent mental illnesses and co-occurring challenges. Priority diagnostic groups include schizophrenia, schizoaffective disorder, and bipolar disorder because these illnesses more often cause long-term psychiatric disability. Individuals with other psychiatric illnesses may be served depending on their level of the long-term disability. Individuals with a primary diagnosis of a substance use disorder or intellectual/developmental disabilities are not the intended client group. To read about eligibility and the full clinical coverage policy for ACT, follow this link and see page 68:
http://www.ncdhhs.gov/dma/mp/8a.pdf

How do you access ACT services?

ACT providers are available across North Carolina. LME-MCOs maintain access to providers (i.e., referrals may come through the MCO and/or ACT teams receiving referrals directly will screen and submit requests to LME-MCOs) and are responsible to determine a person's access to this service through Care Coordination, Care Management, and Utilization Management. To find services in your area, see the LME-MCO locator: http://www.ncdhhs.gov/mhddsas/lmeonblue.htm

Fidelity to the Model

North Carolina has implemented various methods to promote and ensure high-fidelity ACT practice for individuals served. Evidence based practices often have tools to measure adherence to the model. For ACT, we use the have used the DACTs and the TMACT, or Tool for Measurement of ACT, which is a comprehensive and valid measure of evidence-based ACT.

In FY2012, the state utilized the DACTs fidelity scale interviews and initial fidelity surveys were conducted to complete a baseline fidelity score for each team in the state. These scores were used to provide feedback to ACT teams and as part of QM during the implementation of the TMACT service definition.

Compared to other measures of ACT fidelity, the TMACT evaluates the presence and quality of person-centered, recovery-oriented practices, and a wide variety of psychosocial practices to be offered through ACT, can better discriminate between low and high fidelity ACT teams, and is sensitive to change over time as a team enhances its practices.

"Today, I went to visit him in his one bedroom apartment. It was the happiest I had ever seen him. He had his furniture, his dog, and that was all he needed. He told me that life was GREAT! On my way home, I just kept thinking, ONE GUY was significantly helped today and it's a good thing. ONE PERSON didn't fall through the cracks today." - ACT Team Peer Specialist

The TMACT evaluation serves dual purposes: (1) ensuring that teams are operating at some basic level of fidelity (final rating of 3.0+ on the TMACT, which is measured across a 5-point scale [1 (low fidelity) to 5 (high fidelity)], and (2) providing pointed and individualized quality improvement guidance and support to teams. TMACT evaluators, who include DHHS/TAC staff and Provider Peer Evaluators (i.e., ACT providers in leadership roles), are highly trained, experienced staff in community mental health services and/or

evaluation. Evaluations occur over a two day period and include data from observation, documentation, and interviews.

In addition to selecting in skilled professionals to be trained as TMACT evaluators, all TMACT reports are supervised by Dr. Lorna Moser, Director of the ACT TA Center and Co-Developer of the TMACT, ensuring the reliability and accuracy of ratings and guiding quality improvement recommendations, before being submitted to ACT teams.

Training and Technical Assistance

The *ACT Technical Assistance Center* developed through the UNC Center for Excellence in Community Mental Health helps lead fidelity evaluation, training and technical assistance. Lorna Moser, PhD, is the Director and also one of the co-developers of the TMACT tool; Stacy L. Smith, LPC is a consultant also working on supporting fidelity evaluation and providing consultation and training. Through UNC, the State is strengthened with a research base and guidance around best practices in community mental health services, as well as source for assistance in performance monitoring and outcome data tracking.

The UNC ACT TA Center also provides and coordinates the following in partnership with DHHS:

- **"Introduction to High-Fidelity ACT Trainings"**: developed to meet policy requirements; 3-day face to face trainings are held every other month in various parts of NC.
- **Monthly ACT webinars**: partnering with DHHS to address specialty areas of ACT, policy implementation and other updates
- **ACT-related Evidence Based Practice (EBP) trainings**: developed to support high-fidelity ACT; these include Integrated Dual Disorders Treatment, CBT for Psychosis, Wellness Management and Recovery, and Psychiatric Rehabilitation
- **NC ACT Coalition:** 19 agencies operating ACT teams are members of the NC ACT Coalition, which is a grassroots provider group starting in 2006, and coordinated by Dr. Moser since 2009. The Coalition is a central resource for provider-peer support, advocacy, mentorship, and guidance. The Coalition meets every other month.

UNC ACT Technical Assistance Center: http://www.med.unc.edu/psych/cecmh/community/unc-assertive-community-act-team-training-center

NAMI- ACT Information: http://www.nami.org/Template.cfm?Section=ACT-TA_Center

Assertive Community Treatment (ACT) Evidence-Based Practices (EBP) SAMHSA KIT: http://store.samhsa.gov/product/Assertive-Community-Treatment-ACT-Evidence-Based-Practices-EBP-KIT/SMA08-4345

The TMACT: a new tool for measuring fidelity to assertive community treatment: http://www.ncbi.nlm.nih.gov/pubmed/21659289

There is a national 85% unemployment rate for individuals with mental illnesses

Supported Employment (SE)

What is Supported Employment?

The Individual Placement and Support (IPS) model of Supported Employment helps people with severe mental illness work at regular jobs of their choosing. Although variations of supported employment exist, IPS refers to the evidence-based practice of supported employment. Some of the characteristics of IPS Supported Employment include: practitioner focus on client strengths, work as a pathway to recovery and wellness, and a multidisciplinary team approach. An IPS approach changes the way employment services are delivered, as "employment readiness" is replaced by a "place then train" approach in which the only requirement to seek employment is a desire to work. Furthermore, an Employment First approach is supported and promoted by practitioners so that work is the expectation for individuals receiving mental health services.

IPS-SE was developed by the Dartmouth Psychiatric Research Center in 1996 and was later endorsed by SAMHSA and included in the SE Evidence-Based Practices (EBP) KIT. IPS-SE is well researched in 20 randomized controlled studies showing that it is 3 times more effective than other types of supported employment. Furthermore, research from 2012 shows that competitive employment rates in IPS sites are as high as 61% compared to 24% for controls[12].

The primary outcome of IPS-SE is ***Competitive Employment*** which is defined as a job that pays at least minimum wage, for which anyone can apply and is not set aside for persons with disabilities.

IPS-SE HAS 8 PRACTICE PRINCIPLES THAT INCLUDE:

1) Focus on competitive employment
2) Eligibility based on client choice (zero-exclusion) and not excluded on the basis of readiness.
3) Integration with mental health services and vocational rehabilitation: teams work side by side.
4) Attention to client preferences rather than providers' judgments, subjectivity, or convenient employer connections.
5) Personalized benefits counseling
6) Rapid job search rather than providing lengthy pre-employment assessment or training
7) Systematic job development: employer network based on clients' interest
8) On-going and individualized support for as long as the client wants and needs it.

NC Implementation

Feedback from community meetings and trainings tell us that the "employment" focus and Employment First philosophy is a major paradigm shift for North Carolina's system of care. There is a clear need for hands-on systematic training and mentorship to understand the model and shift agency practices. There is also need for stronger focus on removing barriers such as "readiness thinking" through continuing education and research dissemination and on improving benefits counseling with individuals and their families, as well as improving job development using the dual customer approach with employers.

Furthermore, DMHDDSAS has been working very closely with the **Division of Vocational Rehabilitation Services (DVRS)** in this initiative. With the support of DVRS Program Specialist for

[12] http://www.ncbi.nlm.nih.gov/pubmed/22295007

Mental Health and Substance Use, Gina Price, MS, LPC, LCAS, CCS, CRC, the State was able to obtain a grant from Dartmouth for technical assistance and implementation.

NAMI NC has also partnered with this initiative to develop the Family Advocacy for IPS Supported Employment Project. This program is also supported by Dartmouth and was established to engage family members and family advocacy groups in our collective efforts to promote employment for individuals with mental illness. Local NAMI affiliates will be paired with their respective local providers and LME-MCOs to enhance access and advocacy for IPS-SE.

AS OF NOVEMBER 2014, NC HAS 8 IPS-SE TEAMS THAT MEET FIDELITY.

Who can get SE?

The IPS-SE model of supported employment supports individuals in any phase of their recovery and aims to help individuals find and keep a job through support from Employment Support Professionals and Employment Peer Mentors. As evidenced through years of research in AMH, this model has been found most effective when serving its target population, inclusive of individuals who experience severe and persistent mental illnesses and co-occurring challenges. Eligibility to services may vary based on entrance criteria from various programs. To learn more visit the following sites:

- DMHDDSAS state-funded policy http://www.ncdhhs.gov/mhddsas/services/employment/index.htm
- DMA waiver services (1915 B3) policy – page 24: http://www.ncdhhs.gov/dma/lme/1915_Final_MHWaiver_Renewal_2.pdf

DVR eligibility http://www.ncdhhs.gov/dvrs/pwd/employment.htm

Priority for TCLI: At Risk Definition

The settlement mandates that we serve individuals "**in or at risk for entry into an adult care home**:" For the purposes of the settlement, the term "at-risk for entry into and adult care home" is an individualized determination. It should be based upon documentation of factors which would indicate that an individual with a SMI/SPMI is living in an unstable or tenuous environment, and may seek adult care home placement without the intervention of MH services and supports.

Individuals Must Meet Criterion of :

1. Have a verified diagnosis of SMI/SPMI

AND

2. Living in an ACH

Or

At Risk of living in an ACH (This should be documented based on the factor that they are in Unstable Or Tenuous living environments)

Broad examples or categories of individuals who may be considered "at risk" include but are not limited to:

- Persons being discharged from state hospital who are homeless or has unstable housing
- Persons with PASRR screening indicating presence of SMI/SPMI
- Persons who have had multiple community hospital or Emergency Room Visits for psychiatric reasons
- Persons paying 50 percent of income in rent, as that situation is not sustainable
- A single person on SSI is paying on average 68% of his/her income on rent (priced out, 2012).

How do you access IPS Supported Employment?

Supported Employment providers are available across North Carolina. DHHS maintains a list of current IPS model providers through the LME-MCO system, many of whom also have vendor contracts through Vocational Rehabilitation:

1) LME-MCOs maintain access to providers and are responsible to determine a person's access to this service through Care Coordination, Care Management, and Utilization Management. To find services in your area, see the LME-MCO locator: http://www.ncdhhs.gov/mhddsas/lmeonblue.htm.
2) SE is also available for those eligible for services through DVRS. One may self-refer, have a friend or family member refer, or a provider refer to DVRS for SE services. DVRS maintains a pool of supported employment providers. Locations of the VR offices can be found on this website: http://www.ncdhhs.gov/dvrs/vroffices.htm

Fidelity to the Model

North Carolina has developed a new infrastructure to provide IPS Supported Employment. Since the inception of the new IPS-SE service definition in May 2013, DHHS and LME-MCOs have worked together to identify providers through network enrollment and start-up necessary to meet fidelity. As of July 1, 2013, North Carolina began fidelity evaluations for new providers using the IPS-SE Fidelity Scale[13], developed by the Dartmouth Psychiatric Research Center and located in the SAMHSA toolkit. The IPS Supported Employment Fidelity Scale also serves a roadmap or a compass that can help practitioners obtain better outcomes.

> *"Most important is getting my Career back, which I took great pride in and loved very much and doing it drug free. Without the Employment Peer Mentor, I feel I would become depressed again and could relapse back into substance abuse."* -K.

The IPS-SE evaluation serves dual purposes: (1) ensuring that teams are operating at some basic level of fidelity (Final rating of 74+ on the SE scale), and (2) providing pointed and individualized quality improvement guidance and support to teams. IPS-SE evaluators, who include DHHS/TAC staff, are highly trained, experienced staff in employment services and evaluation to assure high reliability and validity in ratings and technical assistance reports. Evaluations occur over a two day period and include data from observation, documentation, and interviews.

After completing a fidelity visit, the fidelity evaluators provide feedback to the agency by sending a completed IPS Supported Employment Fidelity Scale form and a written report that includes observations, assessments, and recommendations for program improvement. All reports are supervised by Stacy Smith, LPC-S, CS-I, LCAS, NCC with DMHDDSAS, in consultation with Dartmouth, ensuring reliability and accuracy of ratings and guiding quality improvement recommendations, before being submitted to IPS-SE teams.

Training and Technical Assistance

The state has also developed supports to train providers through the *NC Employment First Technical Assistance Center*[14] which provides statewide technical assistance. The training is provided

[13] http://www.dartmouthips.org/resources/programs/program-implementation-and-fidelity/
[14] http://www.nceftac.org/

through Promise Resource Network, Inc. located in Charlotte, NC. The team brings years of experience in recovery and employment that will support providers identify with a new approach in reaching competitive employment outcomes.

Significant support has been provided by the model developers, Debbie Becker and Dr. Bob Drake, with the ***Dartmouth Psychiatric Research Center***. North Carolina is part of the J&J Community Mental Health Project and international learning collaborative through a 4 year grant with Dartmouth that began in July 2013 that will help develop a sustainable infrastructure for this model in partnership with DVRS. The Divisions jointly selected 4 sites (out of the total number of providers) as "Dartmouth Research Sites" that will be required to send their outcomes to the model developers for international research. Dartmouth national trainer, Sarah Swanson, has been an integral support for our implementation process.

The NC Employment First Technical Assistance Center (NC|EF|TAC) also provides and coordinates the following in partnership with DHHS:

- ***"Foundations of SE and Recovery":*** developed to meet policy requirements; 2-day face to face trainings are held as needed in various parts of NC.
- ***Learning Communities***: webinar sessions held monthly on various topics such as Job Development, Working with Criminal Backgrounds; and Understanding Supplemental Security Income and Social Security Disability benefits, and Assistive Technology.
- ***Employment Peer Mentor Training***: developed by PRN to meet policy requirements and new specialty area of Peer Support; 2-day face to face trainings are held as needed.
- ***Benefits Counseling for Recovery Training***: 1-day face to face training to support practice improvement and workforce development, facilitated by TAC consultant
- ***VR Training***: Together with DVRS, provides onsite technical assistance to local VR offices.

Credentialing of Employment Support Professionals

As part of workforce development around Supported Employment, North Carolina now has 62 CESPs with a total pass rate is 82%. The CESP[15] is the new ***Certified Employment Support***

[15] http://www.apse.org/certification/

Professional national certification program through APSE. This program supports the IPS-SE model and helps enhance professionalization among employment staff in the field through the requirement of continuing education in best practices. Testing began in April 2013 with co-sponsorship from DMHDDSAS. Eleven states are participating so far; the following data describes North Carolina's position with the number of CESPs:

Educational Resources

NC Employment First Technical Assistance Center: http://www.nceftac.org/

Promise Resource Network, Inc. http://www.promiseresourcenetwork.com

Dartmouth IPS Supported Employment Center: http://www.dartmouthips.org/

Center for Practice Innovations: http://practiceinnovations.org

Employment Resource Book, 2014:
http://practiceinnovations.org/Portals/0/Instructions/IPS/workbook_final_online_03-30-14.pdf

Ohio Supported Employment Coordinating Center of Excellence: www.ohioseccoe.case.edu/

U.S Department of Labor's Office of Disability Employment Policy: http://www.dol.gov/odep/

Association of People Supporting EmploymentFirst (APSE): http://www.apse.org

Other Services Referenced in TCLI

LME-MCOs offer a customized array of services in their catchment areas based on local needs. To find out about all the services in your area, which may include additional services not mentioned in this manual, please contact your local LME-MCO.

Peer Support Services (PSS)

Peer Support is a newly evidence-based practice under SAMHSA's Consumer-Operated Services Evidence-Based Practices Toolkit. "Peer support is a system of giving and receiving help founded on key principles of respect, shared responsibility, and mutual agreement of what is helpful. Peer support is not based on psychiatric models and diagnostic criteria. It is about understanding another's situation empathically through the shared experience of emotional and psychological pain. When people find affiliation with others they feel are 'like' them, they feel a connection. This connection, or affiliation, is a deep, holistic understanding based on mutual experience where people are able to 'be' with each other without the constraints of traditional (expert/patient) relationships." (Mead, 2001)

NC Certified Peer Support Specialists (NC CPSS) are people in recovery from mental health and/or substance use challenges who provide support to others whom can benefit from their lived experiences. Peer Support Specialists *"introduce and advance communities' understanding of recovery and community integration as the catalyst for transforming individual lives"*[16]. As mentioned in the Settlement Agreement and in efforts to support an inclusive systems change initiative supporting recovery and evidence-based practice integration, it is a priority to expand and enhance Peer Supports that align with best practices. To support TCLI, DHHS has included peers in the following roles/capacities:

> *"I have seen more progress in both Supported Employment and Independent Living initiatives since the Department of Justice Settlement with North Carolina that are a direct result of the inclusion of Peer Support than has been seen in the preceding decade."* -Peer Specialist in Western NC

- **In-Reach Specialists** – must be NC CPSS
- **ACT** – all teams must have a NC CPSS
- **IPS-Supported Employment** – adds "Employment Peer Mentors" (NC CPSS specialty) as a new staff role
- **Peer Support Service** – standalone services which eligible individuals can have access to their own peer support staff

[16] http://www.mhrecovery.org/

Workforce Development Training

NC offers a Peer Support Certification program supported through its contractor, the UNC School of Social Work's Behavioral Health Resource Program[17]. The North Carolina Certified Peer Support Specialist Program provides acknowledgment that the peer has met a set of requirements necessary to provide support to individuals with mental health or substance use issues. The State has been working to improve the training and workforce development of individuals seeking CPSS certification and working in the field.

SUPERVISING PEER SUPPORT SPECIALISTS: a free, three hour web based course, Supervising NC Certified Peer Support Specialists, on the virtual learning portal. This self-paced course has been developed in collaboration with NC Peer Support Specialists. This course is designed to assist managers and supervisors wishing to enhance their skills supervising NC Certified Peer Support Specialists. Anyone interested in creating and or improving their organizational culture, understanding the role of the North Carolina Certified Peer Support Specialist, and learning more about the role of the supervisor working with Peers is encouraged to sign up. The training can be found here: http://bhrp.sowo.unc.edu/supervising-nc-certified-pss

AS OF OCTOBER 2014 THERE ARE 1,399 CERTIFIED PEER SUPPORT SPECIALISTS IN NC

Educational Resources

NC Mental Health Consumers Organization: http://www.ncmhco.org/

North Carolina Consumer Advocacy, Networking, and Support Organization: http://nccanso.org/

Promise Resource Network, Inc. http://www.promiseresourcenetwork.com

National Empowerment Center: http://www.power2u.org/

International Association of Peer Supporters (iNAPS): http://www.naops.org/

Pillars of Peer Support Initiative & National Reports: http://www.pillarsofpeersupport.org/

Peers for Progress: http://peersforprogress.org/

Community Support Team (CST) and other MH Services

Community Support Team (CST) is one of the services available to help support individuals transitioning to the community. This service has been available in North Carolina for some time but,

[17] http://pss-sowo.unc.edu/pss

as we learned through stakeholder feedback, there are gaps and time-limits in the current model structure. To address these shortcomings, DHHS convened a workgroup in 2013 to review and revise the CST service definition to ensure that it is recovery-oriented, evidence-based and community-based. The workgroup, which included LME-MCOs, providers, consultants, and peer specialists, proposed enhancing CST to include a focus on evidence-based practices. Discussions about policy improvements are in process.

Research tells us that individuals with SMI/SPMI often need long-term and flexible support options to address issues as they arise. These services centered on Psych Rehab should be continuous and holistic in nature. DHHS and the LME-MCOs are currently considering service opportunities to address gaps in the AMH continuum that include evidence-based practices such as recovery education centers, consumer-run organizations, crisis peer respite, integrated dual disorders treatment, wellness management and recovery, and focus on integrated treatment, family psychoeducation, *Critical Time Intervention*[18] (CTI) and other EBPs.

Educational Resources

Personalized Recovery Oriented Services (PROS): http://pros.nyaprs.org/pros-services/

Ohio Center for Evidence-Based Practices: http://www.centerforebp.case.edu/practices

Dartmouth Psychiatric Research Center Projects: http://prc.dartmouth.edu/projects/

NC Practice Improvement Collaborative: http://www.ncpic.net/

Tenancy Support Services (TSS)

Tenancy Supports services are being provided to individuals transitioning to their own homes. Training for Tenancy Support staff is critical to ensure providers are equipped with tools around Psychiatric Rehabilitation to assist individuals to learn skills to live and thrive in the community.

Beginning July 2013, DMHDDSAS began seeking high quality resources for training founded on the philosophy of best practices such as SAMHSA's Permanent Supportive Housing Evidence-Based

[18] http://www.criticaltime.org/

Practices Toolkit and Housing First. DMHDDSAS began work with the **Center for Social Innovation's T3**[19] Training consultants. SAMHSA and other states have contracted with this center for evidence-based practice training such as Motivational Interviewing and Critical Time Intervention. T3 had the right combination of subject matter experts with national experience in housing first practices and supports for our target population. The center had readily available training on this model and was able to quickly tailor around our need and overlay principles of other evidence-based practices around motivational interviewing, engagement, retention, and recovery.

Trainings were developed by T3 and four 2-day trainings were scheduled for February and March 2014 in Raleigh, Wilmington, Greensboro, and Asheville (aiming to educate over 225 staff). These trainings will be followed by 3 web-based communities of practice. The trainers are Ken Kraybill, Housing and MINT trainer from the Center for Social Innovation, and Linda Kauffman of the 100,000 homes campaign in DC. The target audience has includes LME-MCO TCL staff, housing specialists, care coordinators, peer support specialists, ACT teams, and housing staff.

The training is titled ***"Best Practices in Tenancy Support"*** *and* cover the Permanent Supportive Housing and Housing First models, Motivational Interviewing, working with landlords, doing home visits, responding to crisis, and the overall basics of a person-centered, housing-focused, trauma-informed, recovery-oriented, and peer-integrated approach to tenancy support.

Educational Resources

100,000 Homes Campaign: http://100khomes.org/

Center for Supportive Housing: http://www.csh.org/

Permanent Supportive Housing Evidence-Based Practices (EBP) SAMHSA KIT: http://store.samhsa.gov/product/Permanent-Supportive-Housing-Evidence-Based-Practices-EBP-KIT/SMA10-4510

Homelessness Resource Center: http://homeless.samhsa.gov/Default.aspx

Pathways to Housing (Housing First): http://pathwaystohousing.org/

Temple University Collaborative on Community Inclusion of Individuals with Psychiatric Disabilities: http://tucollaborative.org/

[19] http://www.center4si.com/training/

About this Toolkit

This was developed for the TCLI initiative by the NC DHHS Division of Mental Health Developmental Disabilities and Substance Abuse Services (DMHDDSAS) Community Mental Health Section in conjunction with the other Divisions of DHHS that provide AMH services which include the Division of Vocational Rehabilitation Services (DVRS), Division of Medical Assistance (DMA), as well as the two TCLI Technical Assistance Centers to support implementation and expansion of community-based adult mental health services. This document will be updated regularly to align with practice improvement and initiative progress.

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