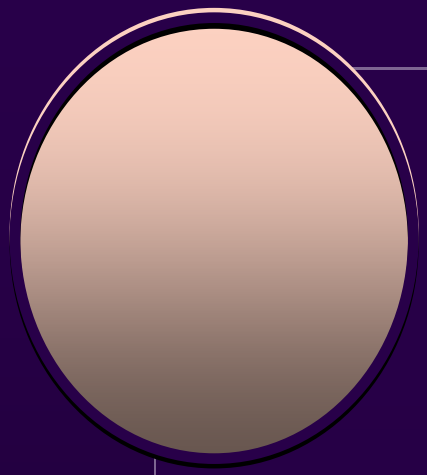
IF YOU THINK
WORK IS BAD FOR
PEOPLE WITH MENTAL ILLNESS,

THEN WHAT ABOUT
POVERTY,
UNEMPLOYMENT,
AND
SOCIAL ISOLATION?

# LILY TOMLIN

**“No matter how cynical you become, it's never enough to keep up.”**



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**NOTE: Most material in PPT I originally developed but some reflects collaboration I have done in past with Virginia Selleck, Ph.D., Paul Barry, and developed some through work with the Boston University RRTCs On-Line TA Project**

# WILL TOUCH ON:

- Employment as a Social Determinant of Health
- Clinical implications of long-term unemployment
- Connection between Psychiatric/ Behavioral Health Recovery and Employment
- Evidence-based practice for supported employment for people with serious mental illness
- Best practices in collaboration between VR and Behavioral Health Systems of Care
- Importance of rapid engagement for effective VR service delivery
- Importance of clinical staff positivity towards employment for clients with legitimate ambivalence towards working (creating a Motivationally Enhancing Environment not just using a Motivational Interviewing strategy)
- Using a “Quadrant Model” of targeting employment interventions to the specific needs of people with psychiatric disabilities.

# *VISION OF RECOVERY*

## JOE MARRONE

**IS WORK THE MOST IMPORTANT PART OF LIFE FOR EVERYONE?**

**NO. BUT IT IS THE MOST IMPORTANT PART OF LIFE THAT WE IN HUMAN SERVICES ARE LEAST SUCCESSFUL AT HELPING OUR CONSTITUENCY ACHIEVE.**

# THOMAS EDISON

" RESULTS!

WHY, I'VE GOTTEN A LOT OF RESULTS.

I KNOW SEVERAL THOUSAND THINGS THAT WON'T WORK. "

# MH SYSTEMS /EMPLOYMENT FIGURES 2020 (SAMHSA)

## US ADULT MH

OVERALL = 23.6%/ CAL = 10.6%

IN LABOR FORCE (LOOKING FOR WORK OR EMPLOYED) = 47.1%/

CAL = 47.6%

ACCESS TO EBP SE = 1.9 %, CAL = 0.1%

# MARRONE'S RULE # 1

**SOMETIMES YOU CAN**

**ONLY DO**

**THE BEST YOU CAN DO,**

***NOT*** **THE BEST THAT CAN BE DONE.**

**BUT, ALWAYS**

**KNOW AND STATE THE DIFFERENCE.**

*“ ALL CHANGE IS DIFFICULT – NO MATTER HOW LONG YOU PUT IT OFF. “*

*------ JOE MARRONE*

John P. Kotter (1998).

Leading change: why transformation efforts fail.

In: Harvard Business Review on Change. Cambridge: Harvard Business School Press.

1. Not establishing a great enough sense of urgency
2. Not creating a powerful enough guiding coalition
3. Lacking a vision
4. Undercommunicating vision by a factor of ten
5. Not removing obstacles to new vision
6. Not systematically planning for and creating short-term wins
7. Declaring victory too soon
8. Not anchoring changes in the organization's culture

# 5 SIGNS TO RECOGNIZE SYSTEM CHANGE:

**Grieff, D., Proscio, T., & Wilkins, C. (2003).** Laying a new foundation: Changing the systems that create and sustain supportive housing. Oakland, CA: Corporation for Supportive Housing

# 5 SIGNS TO RECOGNIZE SYSTEM CHANGE:

- **CHANGE IN POWER:** Designated positions—people with formal authority—responsible for the new activity (not just individuals who care about it).

# 5 SIGNS TO RECOGNIZE SYSTEM CHANGE:

- **CHANGE IN MONEY:**

  **Routine funding is earmarked for the new activity in a new [new money, shift in existing funding, or new priorities & criteria for accessing money].**

# 5 SIGNS TO RECOGNIZE SYSTEM CHANGE:

- **CHANGE IN HABITS:**

  **Participants in a system interact with each other to carry out the new activity as part of their normal routine not just respond to special initiatives, demonstrations, or projects.**

# 5 SIGNS TO RECOGNIZE SYSTEM CHANGE:

- **CHANGE IN TECHNOLOGY OR SKILLS:**

**Growing cadre of skilled practitioners at most levels in the delivery chain, practicing methods not previously common or considered desirable. Practitioners are now expert in skills that new system demands & have set a standard for effective delivery of results. (e.g.., http://www.acreducators.org/)**

# 5 SIGNS TO RECOGNIZE SYSTEM CHANGE:

## CHANGE IN IDEAS OR VALUES:

**New definition of performance or success, & often a new understanding of the people to be served & the problem to be solved [i.e., new goals]. The new definition & understanding are commonly held among most actors in the system, & are no longer in great dispute**

# *VISION OF RECOVERY*

**SHOULD WORK,**

**NOT JUST**

**“MEANINGFUL” OR “PRODUCTIVE” ACTIVITY**

**BE AN ESSENTIAL PART OF RECOVERY VISION?**

# Changing Our *Belief System* about work for people w. serious mental illness

## (Virginia Selleck)

**From: Work is too stressful. People can only hope for "maintenance" and "stabilization." Only a small portion of this population can work.**

**To: Work is both a recovery intervention and a path to better physical health. The majority of people with SMI want to and can work.**

# “LIFE LIVED WITHIN THE CONFINES OF THE HUMAN SERVICE & REHABILITATION LANDSCAPE IS A LIFE IN WHICH THE FREEDOM TO BECOME & MAKE YOUR OWN FUTURE IS DIMINISHED”

PATRICIA DEEGAN

20th World Congress Rehab International: Oslo, Norway – JUNE 2004

# *TERRY PRATCHETT*

**"I'll be more enthusiastic about encouraging thinking outside the box when there's evidence of any thinking going on inside it. “**

IF PEOPLE

*CAN* WORK

PEOPLE

*SHOULD* WORK

**“ I CAN’T UNDERSTAND WHY PEOPLE ARE FRIGHTENED OF NEW IDEAS; I’M FRIGHTENED OF THE OLD ONES.”**

***JOHN CAGE, COMPOSER***

# REASONS WHY PEOPLE WITH MENTAL ILLNESS DO NOT WORK ???

CHAT BOX

# REASONS WHY THEY SHOULD ???

CHAT BOX

# MARRONE EASY QUESTION

IS IT BETTER TO WORK 2-3 HOURS A WEEK AT SOMETHING A PERSON LIKES THAN 15-20 HOURS WEEK (OR MORE) JUST TO MAKE A LIVING?

**SIMPLE ANSWER:** NO

HOW DO YOU ANSWER THIS QUESTION FOR YOURSELF OR YOUR LOVED ONES?

**A ship in harbor is safe -- but that is not what ships are built for.**

**John A. Shedd**

***Salt from My Attic, 1928***

# *WHY PEOPLE SHOULD WORK*

## *Marrone & Golowka, 2000*

- **Unemployment is <u>much</u>, <u>much</u> worse for your mental health than the stresses of employment**
- **Responsibility of citizenship -- "Part of the deal”**
- **Work is not enough, but it’s a better start on the "American Dream" than unending unemployment & poverty**

# *WHY PEOPLE SHOULD WORK*

## *Marrone & Golowka, 2000*

- **More likely to lead to a career than just planning**
- **It doesn't get easier later on**
- **Employment is a more dependable & less stressful way of life than SSI, SSDI, TANF**
- **Way to meet people & expand networks**

# *WHY PEOPLE SHOULD WORK*

## *Marrone & Golowka, 2000*

- **Gives people more status than "consumer"**
- **Way to help people develop possibilities for intimacy, love, & sex**

# *WHY PEOPLE SHOULD WORK*

*Marrone & Golowka, 2000*

- **Only way to help people find their way out of poverty**
- **Much more interesting day to day + gives leisure more meaning**

**REMAINING UNEMPLOYED IS WORSE FOR YOU THAN BEING EMPLOYED IS GOOD FOR YOU**
**( SOME JOBS ARE PAID FOR YOU).**

**AVOIDING LONG TERM UNEMPLOYMENT IS A BETTER OPTION THAN WAITING FOR AN IDEAL OR PERFECT JOB MATCH.**

# UNEMPLOYMENT IS BAD FOR YOU !!!

Marrone files = approx. 100 epidemiological studies (1938-2021) w. correlation between long term unemployment & physical/ mental health sequelae

HAPPY TO SHARE UPON REQUEST

# This 1987 book offers a nice summary of all these studies:

## SIDE EFFECTS OF UNEMPLOYMENT IN THE GENERAL POPULATION

- Increased substance abuse
- Increased physical problems
- Increased psychiatric disorders
- Reduced self-esteem
- Loss of social contacts
- Alienation and apathy

Warr, P.B. (1987), *Work, Unemployment and Mental Health*
Clarendon Press, Oxford

Marrone, J. & Swarbrick, M. (2021).

The Detrimental Health Impact of Unemployment.
Behavioral Health News. 8[3]. Available at:
*https://behavioralhealthnews.org/the-detrimental-health-impact-of-unemployment/.*

- Epidemiological studies - strong correlation between long-term unemployment and poor physical and mental health, even for people without pre-morbid conditions.
- Long term unemployment consistently ignored as significant health risk factor - more emphasis responding to client's expressed wish to seek employment than need for clinical staff to assertively assist the client to recognize and address risks attendant to long-term unemployment.

## Specific policies and support practices that urgently address long-term unemployment:

- Clinical staff to address long-term unemployment on all service plans
- Create more opportunities for EBSE/ IPS + employment overall (? Specific youth needs)
- Efforts between mental health systems of care and strictly employment focused systems (e.g., workforce - Employ BR, etc.)
- Always include employment *STATUS* and *OUTCOMEs* as 1 set of metrics for CMHC/LGE providers
- Reporting publicly available information on employment status and employment goals achieved for all the adult clients they serve
- When people NOT interested in employment, create strategies to address impediments

# “IT IS NEARLY IMPOSSIBLE TO MAKE YOUR OWN FUTURE WHEN YOU ARE NOT PART OF THE ECONOMIC FABRIC OF THE CULTURE YOU LIVE IN”

**PATRICIA DEEGAN**

**20th World Congress Rehab International: Oslo, Norway – JUNE 2004**

" WHAT DRIVES ME UP THE WALL IS THE INTENTIONAL TEACHING OF FEAR OF HAVING ANY KIND OF MEANINGFUL LIFE BECAUSE 'YOU WILL DECOMPENSATE' OR ' YOU ARE STRESS SENSITIVE'. THE MOST STRESSFUL THING IN THE WORLD IS BEING A COUCH POTATO WITH NOTHING TO DO, NO WHERE TO GO, AND NO ONE TO TALK TO. "

ED KNIGHT, PH.D.

# WHAT DO WE KNOW ABOUT EVIDENCE BASED PRACTICE AND EMPLOYMENT FOR PEOPLE WITH PSYCHIATRIC DISABILITIES

## (AND THE BEHAVIORAL HEALTH SYSTEM'S ROLE IN SUPPORTING IT OTHER THAN JUST FUNDING MORE OF IT)

# RITA MAE BROWN

IF THE WORLD WERE A LOGICAL PLACE, MEN WOULD RIDE SIDESADDLE

**For people with disabilities, the real issue is really workforce participation, not unemployment**

# RESEARCH BASED PRINCIPLES OF IPS MODEL


ROBERT DRAKE, MD

&

GARY BOND, PH.D.

(WESTAT – BOTH PREVIOUSLY AT DARTMOUTH MEDICAL SCHOOL


https://ipsworks.org/

- *COMP. EMPLOYMENT = GOAL*
- *RAPID JOB SEARCH*
- *MH & REHAB INTEGRATED*
- *TIME UNLIMITED SUPPORT*
- *ATTENTION TO PREFERENCES*
- *CONTINUOUS ASSESSMENT*
- *BENEFITS COUNSELING*

*MORE RECENTLY ATTENTION TO INCLUSION OF PEERS ON IPS TEAMS*

# W. EDWARDS DEMING

" BEWARE THE CONTINUOUS IMPROVEMENT OF THINGS NOT WORTH IMPROVING "

# Thom Hartman
## "ADD, An Alternate View"

**"I am not inattentive, you are just boring."**

**BREAK?**

# PRACTICES DIFFERENTIATING HIGH VS LOW PERFORMING SE PROGRAMS IN MH

GOWDY, CARLSON, & RAPP
PSYCH REHAB JOURNAL
VOL 26, #3, WINTER 2003

(DESCRIBES KANSAS PROGRAMS)

# HELPING PEOPLE DECIDE TO WORK

1. *CASE MGRS/ THERAPISTS PROMOTE WORK, NOT JUST MENTION IT*
2. *CASE MGRS (SOMETIMES TXS) INITIATE WORK TALK*
3. *CONSUMERS < TALK FEARS ABOUT BENEFITS AND MORE ABOUT DOING THE JOB WELL*

# HELPING PEOPLE GET A JOB

1. *< PRE-VOC PROGRAMMING*
2. *RAPID VOC ASSESSMENT*
3. *DVR APPROVAL HAPPENS RAPIDLY DUE TO HI QUALITY RELATIONSHIP DVR/ SE STAFF*
4. *MORE COMFORTABLE WITH DISCLOSURE DISCUSSION*
5. *MORE KNOWLEDGE OF ACCOMMODATION*
6. *MORE DIRECT EMPLOYER CONTACT FROM STAFF*

# HELPING PEOPLE KEEP A JOB

1. *MORE FREQUENT CONTACT W. EMPLOYERS AFTER WORK START*
2. *HIGH DEGREE OF SUPPORT FOR PROBLEMS ON JOB*
3. *CONSUMERS SAW WORK SITE AS HELPFUL AND FLEXIBLE*
4. *CONSUMERS HAD GREATER DEGREE OF JOB SATISFACTION*

# IF EVERYONE'S ALREADY DOING IT,

# HOW COME IT NEVER GETS DONE ???

# AMBROSE BIERCE

**BORE, n. --**

**“ A PERSON WHO TALKS WHEN YOU WISH HIM TO LISTEN. “**

# SO WHAT SHOULD SYSTEM/ PROGRAM ADMINISTRATORS DO ???:

- EMPLOYMENT FOCUS AN ADMINSTRATIVE NOT CLINICAL PEROGATIVE

- Simply focusing on quantitative results without qualitative measures is unethical; producing high-quality outcomes without affecting significant numbers of people is self-indulgence. Enduring system change involves both quality and quantity.

POLL

# SO WHAT SHOULD SYSTEM/ PROGRAM ADMINISTRATORS DO ???:

- LINK WITH EMPLOYMENT AT TIME OF ENTRY INTO MH SERVICES (PART OF INTAKE AND INITIAL APPT)
- DELINK CLINICAL APPROVAL FROM EMPLOYMENT
- ACTIVELY ENCOURAGE EMPLOYMENT AT MGMT/ CLINICAL LEVELS IN TERMS OF HOW ADMINSITRATORS INTEGRATE IT INTO TOTAL SYSTEM OF CARE
- CONSUMERS ACTIVELY SOUGHT FOR JOBS AT ALL LEVELS NOT JUST PEER ROLES (MODELING FOR BUSINESS)
- EMPLOYMENT ON ALL SERVICE PLANS IF PERSON UNEMPLOYED AT LEAST 3 MONTHS
- ALL STAFF RECEIVE ORIENTATION AND SOME TRAINING NOT JUST ON RECOVERY/ EMPLOYMENT BUT ALSO DANGERS OF UNEMPLOYMENT
- FOCUS ON EMPLOYMENT NOT JOB RETENTION

# SO WHAT SHOULD ADMINISTRATORS DO ???:

- EMPLOYMENT OUTCOMES IDENTIFIED FOR SYSTEM OF CARE NOT JUST FOR EMPLOYMENT PROGRAMS
- OUTCOMES TRACKED AND DISSEMINATED TO BOTH THE MH PROGRAM AND COMMUNITY AT LARGE
- RESULTS GET COMPARED TO PEOPLE WITHOUT DISABILITIES IN TERMS OF WAGES, UNEMPLOYMENT RATE, POVERTY
- TRACK WAGES IN TERMS OF WEEKLY WAGES NOT HOURS X HOURLY WAGE
- OUTCOME BASED FUNDING/ MILESTONES BUT START UP FUNDING AVAILABLE
- SYSTEM CREATES INCENTIVES FOR EMPLOYMENT AND DISINCENTIVES FOR NOT ADDRESSING UNEMPLOYMENT
- PEOPLE SHOULD BE ENCOURAGED TO THINK OF GETTING OFF SSA OR TANF AS A SUCCESS, NOT A DISINCENTIVE
- BE CLEAR THAT MOTIVATION IS STAFF'S JOB

# SPECIFIC ISSUES FOR YOUTH (16-25)

- BETTER LINKAGE WITH TRANSITION TYPE SERVICES
- BETTER INTEGRATION OF YOUTH AND ADULT MH SERVICES IN TERMS OF PHILSOPHY OF RECOVERY AND TRANSITION TO WORK
- YOUTH NEED MORE DIRECTION
- PLANNING LESS IMPORTANT THAN ACTION- IMMEDIACY
- JOBS THAT WE SHY AWAY FROM FOR ADULTS MORE AND MORE (FOOD, FILTH, FLOWERS ETC ETC) ARE MORE ATTRACTIVE & APPROPRIATE FOR YOUTH
- DON'T TRY TO GET YOUTH TO ACT LIKE ADULTS IN TERMS OF JOB/ EMPLOYMENT STABILITY

| *MOTIVATIONAL INTERVIEWING (MI)* | *MOTIVATIONALLY ENHANCING ENVIRONMENTS* |
|---|---|
| **FOCUSED ON THE CLIENT** | FOCUSED ON THE ORGANIZATION |
| **WHAT THE CLIENT NEEDS TO CHANGE** | WHAT THE ORGANIZATION NEEDS TO CHANGE |
| **FOCUSED ON TALK LEADING TO BEHAVIOR** | FOCUSED ON ORGAN BEHAVIOR AS PRECURSOR TO TALK |
| **ASSUMPTION THAT CLIENT WILL CONTROL SUBSEQUENT EVENTS** | ASSUMPTION THAT THE WAY THE ORGANIZATION IS STRUCTURED AFFECTS CLIENT SUCCESS |
| **WHAT CLIENT DOES CONSISTENTLY** | WHAT STAFF DO CONSISTENTLY |
| **CLIENT TRACKS OWN GOALS- INDIVIDUAL** | ORGANIZATION SETS, TRACKS, & PUBLICIZES EMPLOYMENT GOALS FOR ALL CLIENTS |
| **HELP CLIENT NAVIGATE COMPLEX SYSTEMS** | MAKE SYSTEM LESS COMPLEX- EASIER TO ACCESS |
| **HELP CLIENT EXPRESS NEEDS CLEARLY** | ALL STAFF IN ORGANIZATION UNDERSTAND THE IMPORTANCE OF RESPONDING TO CLIENT EXPRESSED NEEDS |
| **HELP CLIENT ASK FOR HELP** | SUPPORT SI GIVING PEOPLE WHAT THEY WANT; HELP IS GIVING PEOPLE WHAT YOU FEEL THEY NEED |
| **OVERCOME BARRIERS TO ACCESS SUPPORTS** | ELIMINATE BARRIERS (“EASY ACCESS”) TO GET SUPPORT |

## Self- Examination for Agencies Contemplating Employment Services
## AKA: If we really cared about employment, what would we do differently?
## Questions From Virginia Selleck
## Here is a list of activities, in no particular order:

*What message do you give staff and persons served about the importance of employment in recovery?

*Does your board of directors think employment is one of your goals, and do they support it?

*Is employment a goal on every treatment plan? (Not everyone wants to work *now,* but it should be touched on and supported at every review.

*Does your agency intake delve into employment history as well as the person's ideal job? Does it ask the person what barriers they feel about employment? Does it test for literacy?

*Does the agency leadership support providing training about employment in various domains (employment as SDOH; how to refer for services; etc)

*Does your agency encourage work across system (silo) boundaries? (VR, Workforce, CRP's, etc)

*Does your agency measure employment outcomes as an expected outcome of treatment (along with reduction of unnecessary hospitalization and homelessness, etc)?

*Does your agency provide or link persons served with benefits planning/financial literacy helpers?

*Do your leadership/supervisors help staff develop and identify core competencies that support employment work such as tenacity, flexibility, acting with a sense of urgency, working across boundaries, advocacy, detail orientation, etc?

*Does your agency provide clear guidance about policies, rules, practice guidelines about the appropriate use of your funding services in the delivery of employment and employment support related services?

## Self- Examination for Agencies Contemplating Employment Services
## AKA: If we really cared about employment, what would we do differently?
## Questions From Virginia Selleck
## Here is a list of activities, in no particular order:

*Does your agency guard against the "tyranny of low expectations" around functional assessment ratings that do not rate productivity in the same way we do for non -clients, i.e. it is not productive to just hang around the house and do laundry, shopping, etc- If an adult in this culture is not a caregiver, productivity is typically measured by employment or school.

*Does your agency provide training on IPS/Evidence Based Practice to staff who are not directly providing the service?

*Does your agency provide incentives for employment services? DISINCENTIVES?

*Do you know what your staff (at all levels) really think about employment as a goal for the majority of persons served? (How about an anonymous survey?)

*Does your agency take special care with young people when considering application for SS? Remember the very small percentage of people who leave the roles once they are on, thus, young people need special guidance to see SS as a temporary stop in their employment/career life.

*Does your agency provide clear guidance about policies, rules, practice guidelines about the appropriate use of your funding services in the delivery of employment and employment support related services?

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# DIRECT SERVICE CLINICIANS/CASE MANAGERS

*MATERIAL DEVELOPED BY PAUL BARRY, FORMER DIRECTOR OF THE VILLAGE, LONG BEACH, CA*

- Encourage employment goals when creating a treatment plan.
- Move away from encouraging pre-vocational activities and support any effort to work in a real job - part-time, temporary, full time, etc. *(Research out of Boston University has shown that participation in pre-vocational activities do little to prepare consumers for working. Other research shows that the best preparation for a job … is a job).*
- Help consumers, unsure that they have any marketable qualities, identify concrete experiences, strengths, personal characteristics, skills or interests that could make them appealing to employers.
- Encourage consumers to talk about what a "recovered" life might look like in their life *("recovery" meaning that an individual has created a life not defined by their illness).*
- Encourage consumers to simply practice describing themselves to you in "non-disabled" ways (moving away from diagnosis, symptoms and hospitalizations to interests, strengths and past work experiences – volunteer or otherwise).
- Know where consumers fall regarding employment on the "Need for Change Survey". Follow up with individuals who are "Interested but Not Ready", ascertaining if they are:
    - retired; fear benefit loss; fear failure; are uncomfortable with the unknown; do not think they are capable enough; other?
- Use "Motivational Interviewing" techniques to address employment reluctance.
- Talk about your own past job experiences – especially early jobs at which where you failed or struggled but that eventually added to your own employment path.
- Move quickly to create an *Action Plan* when an individual shows interest in employment.
- Have the individual visit employment sites and just observe people working.
- Help consumers realize that the illness is seldom a reason why individuals with mental illness lose jobs
    - Identify the potential impact of "Vocational Immaturity" related to behaviors that often cause people to lose a job *(Sample included)*

## DIRECT SERVICE CLINICIANS – *CONT.*

*MATERIAL DEVELOPED BY PAUL BARRY, FORMER DIRECTOR OF THE VILLAGE, LONG BEACH, CA*

- Provide support for someone considering or starting a job by:
  - Visiting the job site with the individual before starting or applying for the job
  - Driving the individual to the job the first day or two.
- When addressing the financial benefits of working encourage the consumer to identify something concrete they would like to save for with the additional income.
- Use the packet "How Earned Income Effects SSI/SSDI" so to alleviate fear that working (and earned income) will jeopardize eligibility for benefits. *(Sample included)*
- Accompany the new worker on their way to the job for the first day or two.
- Provide help with problems related to transportation to the job that include ride sharing, bus coaching, assistance from friends or family and car ownership.
- Address the "response to failure" by staff to a consumer's loss of a job
  - *When a consumer goes on a date that doesn't go well most competent, caring clinicians would ask what went wrong, what a person would do differently next time if anything and encourage them to try again. There should be a similar response to a job effort that doesn't go well.*
- Invest as much time in someone who has started a potentially life changing job as you would for someone who is having a life changing crisis.

# LEADERS

*MATERIAL DEVELOPED BY PAUL BARRY, FORMER DIRECTOR OF THE VILLAGE, LONG BEACH, CA*

- During an initial intake of a consumer have staff ask:
  - "What job would you like to have?" rather than "Would you like to work?" (or not ask at all)
  - What employment experience does the person have (even if it was a volunteer or part time job)?
  - In your experience are there obstacles to going work? What are they?
  - Are there benefits to working? What are they?
- Create an *Employment Action Group* rather than a *Vocational Group* that:
  - Helps create a functional resume
  - Visits potential employment sites
  - Invites working consumers and guest employers to share job-getting and job-keeping experiences
  - Review behaviors that compromise success on the job (*Vocational Immaturity List included*)
  - Create an "Individualized Support Plan" (where will each individual find support once working?)
  - Understand the impact of earned income on SSI/SSDI
- Help staff conceptualize a menu of employment options (not specific jobs) that can include:
  - Part time employment
  - Temporary or seasonal employment
  - Group placements
  - Day labor options
  - Full time employment
  - Volunteer (as long as the volunteer work supervisor requires basic performance criteria is met)
- Integrate employment outcomes into the performance assessment of individual clinical/case management staff.

# LEADERS – CONT.

*MATERIAL DEVELOPED BY PAUL BARRY, FORMER DIRECTOR OF THE VILLAGE*, LONG BEACH, CA

- Identify a "champion" of employment from the clinical staff on each team or department in the organization or agency.
- Integrate the ***Employment Specialist*** (if one is available) into the clinical team planning process.
- To counter the impression that bosses expect perfection in an employee, invite an employer to address consumers about what it takes to be successful on the job (especially an entry-level job). Bosses will generally talk about very practical behaviors such as:
  - Showing up on time
  - Doing what they are asked to do
  - Getting along with others
  - Willing to learn new things

  (These are behaviors that are generally based in attitude and do not require substantial experience, education or expertise)
- Clarify where service providers can get concrete job development services to which they can refer.
- Assess and provide feedback on each case manager's performance with regards to promoting and supporting employment outcomes.
- Help staff recognize the "Pygmalion Effect" – that *our higher expectations as professionals can make things happen that otherwise wouldn't.*
- Understand and communicate what researcher, Courtenay Harding has called " Clinician's Illusion":
  - *Ms. Harding has found that it is common for direct service providers to feel that a very few of their consumers actually recover a "normal life" because the service providers so often seem to serve the same people with the same problems over and over again. But that appears to be an emotional observation rather than an accurate one. In fact, from her extensive research, many consumers who recover a non-disability based life fall off the radar of service providers without fan fair or, often, many thanks. This factor often denies providers with an insight into how successful they have actually been.*
- Create an agency "Wall of Fame" with pictures of consumers who have been employed (with their permission). This effect can often reduce an assumed norm that "people like me can't work".
- When interviewing a candidate for a direct service staff position assess the level of "buy-in" to the importance and feasibility of employment for consumers served.

# ADMINISTRATORS

*MATERIAL DEVELOPED BY PAUL BARRY, FORMER DIRECTOR OF THE VILLAGE, LONG BEACH, CA*

- Find ways to deliver the message to staff and persons served that employment contributes to mental health and recovery in profound ways. In short, it has been shown to lead to
  - Reduced symptomatology and reduced hospitalizations
  - Increased medication compliance
  - Improved quality of life
  - Improved integration into community
  - Increased self-esteem and self-efficiency
- Assess and provide feedback to each leader on their efforts to promote and support employment to their case management team.
- Establish an expectation that it is part of each can manager's responsibilities to ask about, encourage and support employment. Include the responsibility on direct service evaluations.
- Identify and measure various employment outcomes along with other outcomes and publish such data on agency reports that are both incremental and annual.
- Offer families of consumers served instruction or training on the benefits of employment as well as the "Effects of Earned Income on SSI/SSDI".
- In addition to training on the "Impact of earned income on SSI/SSDI", create a simple written document or packet that both a consumer and provider can refer to at the moment the concern arises (*Sample included*).
- Feature employment services on website brochures and annual reports.
- Identify credible clinical experts that can present to staff in person or in writing about the positive impact employment has been shown to have on clinical outcomes.
- Provide guidelines on how a psychiatrist or nurse prescriber can support employment outcomes for the consumers with whom they work *(Sample included).*

## ADMINISTRATORS – CONT.

*MATERIAL DEVELOPED BY PAUL BARRY, FORMER DIRECTOR OF THE VILLAGE, LONG BEACH, CA*

- Help staff learn how to document (and bill) for employment services so as to be in compliance with existing guidelines rather than to not bill for such services or not provide them at all.
- Identify practices that need to be *stopped* because they inadvertently discourage or inhibit movement towards actual employment. *Initiate* practices that contribute to a culture that encourage employment.
  - Example: Replace long term passive vocational groups with active job development services.
- If Continuing Education Requirements are needed, have training in employment oriented services offered as a qualifying option.
- Advocate that your Board of Directors make Employment Rates for Consumers one of your agency's measurable goals.
- Actively challenge staff members, leaders and board members to move past the "Soft Bigotry of Low Expectations" so often seen in the field.

## HOW A PSYCHIATRIST OR OTHER PRESCRIBER CAN SUPPORT EMPLOYMENT

*MATERIAL DEVELOPED BY PAUL BARRY, FORMER DIRECTOR OF THE VILLAGE, LONG BEACH, CA*

- Provide a vision of a life defined by a consumer's potential not their problems.
- Believe in and communicate the value of work.
- Encourage others on the treatment team to consider employment a positive strategy to address symptomatology, medication compliance and avoidance of hospitalization.
- Talk with consumers about the functional rather than the pathological:
  - Encourage consumers to replace an agenda of pathologies with one of hopes, plans, challenges, ideas or even obstacles to address
- Encourage consumers to cope with challenge rather than protect them from stress.
- Reflect the "dating" view of failure:
  - When a consumer goes on a date that doesn't go so well most caring clinicians would ask "what happened?" or "what would you do differently next time if anything?" and encourage them to just try again…because that's just how dating is. There can be a similar response to a job effort that didn't go well.
- Persevere.

## Almost 10 Things Non-Employment Staff Can Do to Support Work

("cheat Sheet" developed by Virginia Selleck)

**1. Do no harm.**

- Don't discourage people from working - Encourage them
- Have humility about your ability to predict the future
- Balance concerns about stress - unemployment is stressful, too

**2. Learn about vocational resources.**

- Network with people/programs that help people find jobs
- Learn how other systems work & collaborate

**3. Learn about benefits or find somebody who specializes in this**

- SSI/SSDI
- PASS Plans
- IRWEs

**4. Change your program/service to accommodate worker schedules**

- Are psychiatrists available after 5 p.m.?
- Are support groups and counseling sessions flexible?

**5. Be sensitive to a person's discouragement**

- All jobs are not equal - available choices are often not the best fit
- A person can be serious about wanting to work and still reject a particular job

**6. Know the prerequisites (if any) people must complete prior to working**

- People are motivated differently

- 7. Cultivate a Recovery/Rehabilitation mentality and culture
- If "getting a job" is a person's treatment plan goal; it's everyone's job to help them; not just the employment staff
- 8. Learn about the Americans with Disabilities Act
- Be creative and brainstorm reasonable accommodations
- 9. Keep your eyes open for potential jobs and feed leads to job developers and other team members
- Talk to people who are working and have them share their stories to others - staff and others receiving services
- 10. What's your best idea?-

_____
_____
_____
_____
_____
_____

**Informational survey about providing employment services**

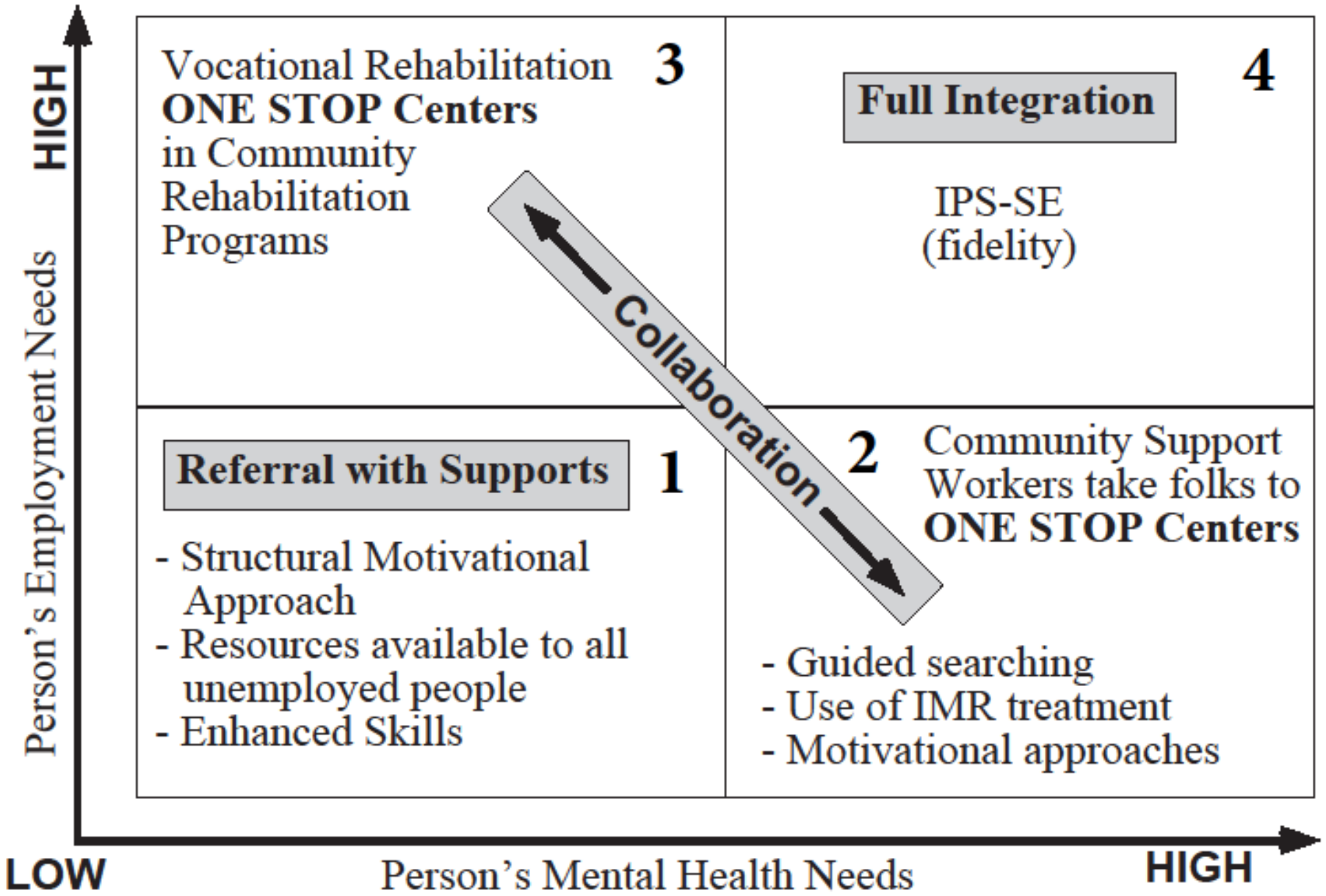
(Developed by Virginia Selleck)

1. What percentage of people with serious mental illness can work (with appropriate supports)?
   15% 25% 45% 65% 85%
   What percentage of people with ID/DD can work (with appropriate supports)?
   15% 25% 45% 65% 85%
   What percentage of people with serious co-occurring disabilities or substance abuse issues can work (with appropriate supports)?
   15% 25% 45% 65% 85%
2. In your day to day work with the people you serve, what have emerged as the barriers to finding community- based employment? **Please Rank the following from highest to lowest:**

| | |
|---|---|
| **External barriers** (i.e. stigma, not enough jobs, lack of transportation) | **Characteristics of the disability** (cyclical nature of symptoms, medication issues, treatment issues) |
| **Social security and benefits concerns** | **Parental reticence or safety fears** |
| **Lack of Employer Incentives** | **Behaviors of the person served** (person will not follow plan, person impedes progress) |
| **Other:**_____ | **Lack of job developer skills or resources** |

3. I believe helping persons served to get and keep jobs is one of the most important parts of habilitation/rehabilitation. Rate from 1(strongly agree) to 5 ( strongly disagree)
   1 2 3 4 5
4. I have had disagreements with colleagues in my agency on the "work readiness" of persons served. Rate from 1 (strongly agree) to 5 (strongly disagree).
   1 2 3 4 5
5. I find it difficult to understand the rules and policies about how to pay for employment supports and services. Rate from 1 (strongly agree) to 5 (strongly disagree)
   1 2 3 4 5
6. I feel confused about how to actually provide employment services to the people I serve. Rate from 1 (strongly agree) to 5 (strongly disagree).
   1 2 3 4 5
7. I believe that employers do not want to hire individuals with disabilities. Rate from 1 (strongly agree) to 5 (strongly disagree)
   1 2 3 4 5
8. I believe that people with disabilities can obtain and maintain employment through the use of assistive technologies. Rate from 1 (strongly agree) to 5 (strongly disagree)
   1 2 3 4 5
9. I believe persons with disabilities can maintain employment with the use of natural supports. Rate from 1 (strongly agree) to 5 (strongly disagree)
   1 2 3 4 5
10. Please add any comments you may have that have not been addressed above concerning this topic:

# Employment Strategy Quadrants



# 3] Hi Employ, Low MH Support: VR, One Stop/Workforce Ctrs/ CRPs

## ASSESSMENT:

- Work History with gaps and poor job tenure (for type of employer)
- Unclear vocational goals
- Poor interview skills
- Stated interest in job finding
- May or may not need specific job skill training
- Self Assessment of readiness for employment low
- MH issue stable and has not affected employment recently
- Not engaged or interested in clinical assistance currently

# 3] Hi Employ, Low MH Support: VR, One Stop/Workforce Ctrs/ CRPs

## POSSIBLE INTERVENTION/ ASSISTANCE

- Benefits Discussion
- Employer intermediary
- Job search skills group (short term)
- MH medication mgmt, counseling, probably not intensive case mgmt (latter not precluded)
- Short term work experience
- Job Skill Training
- Vocational Counseling or testing
- Peer Support
- Coordination with VR or others

# 4] HI Employ, Hi MH Support: EBSE/IPS ASSESSMENT

- Work History with gaps and poor job tenure (for type of employer)
- Unclear vocational goals
- Poor interview skills
- Even “lukewarm” interest in job finding
- Low Self Assessment employment readiness
- MH issue may or may not be stable and has affected employment negatively consistently
- Possible co-occurring issues (MH-SA)

# 4] HI Employ, Hi MH Support: IPS

## POSSIBLE INTERVENTION/ ASSISTANCE

- Fidelity Components of IPS
- Continuing support from clinical team as well as IPS staff
- Intensified clinical/med support sometimes
- Motivational interventions
- Co-occurring EBP re MH/SA

# 2] Low Employ, Hi MH Support: One Stop/ Workforce Ctrs/CRPs

## ASSESSMENT

- Good Work History with few gaps and good job tenure (for type of employer)
- Clear vocational goal
- May or may not need specific job skill training
- Good job interviewing skills
- High interest in job finding
- Self Assessment of readiness for employment is high
- MH issue may not be stable but has not affected employment negatively consistently
- Possible co-occurring issues (MH-SA)

# 2] Low Employ, Hi MH Support: One Stop/ Workforce Ctrs/CRPs

## POSSIBLE INTERVENTION/ ASSISTANCE

- Intensified clinical/med support sometimes
- IMR
- Peer Support
- Medication management that does not interfere with job issues
- Co-occurring EBP- MH/SA

# 1] Low Employ, Low MH Support: General Employment Services/ One Stops/ Agencies

## ASSESSMENT

- Good Work History with few gaps and good job tenure (for type of employer)
- Clear vocational goal
- May or may not need specific job skill training
- Good job interviewing skills
- High interest in job finding
- Self Assessment of readiness for employment is high
- MH issue may not be stable but has not affected employment negatively consistently
- Not engaged or interested in clinical assistance now

# 1] Low Employ, Low MH Support: General Employment Services/ One Stops/ Agencies

## POSSIBLE INTERVENTION/ ASSISTANCE

- Job Skill Training
- Coordination with non MH agencies (per client approval)
- Peer support (perhaps with other workers)

**VIRGINIA SELLECK**

**ADDED SOME SPECIFIC INFO RELEVANT TO BEHAVIORAL HEALTH**

**CLINICAL**

**OR**

**CASE MANAGEMENT STAFF:**

- **Quadrant #1 (lower left) Characteristics : People who have previous good work history with few gaps and reasonable job tenure, having a clear vocational goal. They have a high interest in working and do not need intensive mental health services that would interfere with job attendance. They possess adequate interviewing skills.**

- **Actions of Care Manager: Referral with Supports Refer to resources that are available to all job seekers; engage in motivational approaches with client to help clarify objective; assist with providing information about location and availability of employment resources and "debrief" client for stress level and follow-thru. Provide linkage to benefits counseling if necessary. Coordinate with non-mental health agency per client approval if needed.**

- **Quadrant #2 (lower right) Characteristics: As above, person my have a good work history and desire to work, including a clear vocational goal. They may or may not need specific job skill training. Mental health issues are present and somewhat unstable and may be complicated by poorly managed substance use issues.**

- **Actions of Care Manager: Collaboration and Cooperation: Determine needs for intensified clinical and/or medication support. Possibly anti craving medications. Arrange clinical services around employment hours; provide Illness Management and Recovery treatment; potentially co-occurring substance use treatment ; link to peer supports. Collaboration and Cooperation between care manager and other entities.**

- **Quadrant #3 (upper left) Characteristics: Work history with gaps and poor tenure, unclear vocational goals, poor interview skills; low self assessment of employment readiness, but interested in job finding. May need specific skills training depending on vocational interests. May have recently gotten better control of mental health symptoms, or has only recently thought about working. Not engaged in time consuming day treatment or other mental health care that would interfere with work.**

- **Actions of Care Manager: Collaboration and Cooperation: Benefits planning linkage; potential referral to Community Rehabilitation agency specializing in employment (vender of Vocational Rehabilitation); referral to VR for services, possibly vocational counseling to clarify interests and training needs; coordination and collaboration with other vocational entities; monitor psychiatric symptoms and treatment needs as employment search proceeds and job starts occur; encourage peer support;**

- **Quadrant #4 (upper right) Characteristics: Poor work history with gaps / poor job tenure; unclear vocational goals yet at least "lukewarm" interest in job finding. Low self assessment of ability or very unrealistic self assessment. Mental health issues likely negatively affected previous working attempts or thoughts of working. Possible co occurring substance use disorder.**

- **Actions of Care Manager: Full Clinical Integration Fidelity components of Individual Placement and Support if possible; intensified clinical support and integration between clinical services staff and employment staff; use of motivational interventions; possible need for integrated dual disorder treatment**

# John Galbraith

**“Given a choice between changing and proving that it is not necessary, most people get busy with the proof.”**

# *GREEK PROVERB*

***" BEFORE PRACTICING VIRTUE, FIRST SECURE AN INDEPENDENT INCOME. "***

# STIGMA REDUCTION: ABILITY TO CHANGE BEHAVIOR THROUGH EDUCATION IN THIS AREA IS NEGLIGIBLE

Corrigan, P. W., L. P. River, et al. (2001). "Three Strategies for Changing Attributions about Severe Mental Illness." Schizophrenia Bulletin 27(2): 187-195.

# ROLE/ LIMITS OF TRAINING?

**“You can teach a turkey to climb a tree, but it’s easier to hire a squirrel.”**

FROM

Spencer M. Lyle Jr., McClelland C. David, Spencer M. Signe (1994) Competency Assessment Methods. History and state of the art. Paper first presented at the American Psychological Association Annual Conference, Boston, MA  P. 8

***YOU CAN HAVE***
***A JOB***
***WITHOUT A CAREER***
***BUT***
***YOU CAN'T HAVE***
***A CAREER WITHOUT***
***A JOB!***

***(YOU CAN'T DISCOVER***
***WHAT ISN'T THERE)***

- **Casper, E. S. and C. Carloni (2006). "Increasing the Utilization of Supported Employment Services With the Need for Change Scale." Psychiatric Services 57(10): 1430.**
  - **-- Of 49 people with high NFC ratings (high felt need for employment), 45 were accepted into supported employment services. Only ten of these consumers would have been referred by their practitioners. The NFC increased referrals to supported employment by 24 percent in this sample.**

# NFC Self-Rating Scale (Edward S. Casper)

| | | | | |
|---|---|---|---|---|
| First, read each of the 5 statements below. Then, consider which one best describes how you now feel about your Job. Finish by placing an X in the box to the Left of the statement that best describes how you now feel about your Job. | | | First, read each of the 5 statements below. Then, consider which one best describes how you now feel about being unemployed. Finish by placing an X in the box to the Left of the statement that best describes how you now feel about being unemployed. | |
| | I am Very Dissatisfied with my Job, and feel an URGENT NEED to change it. | | | I am Very Dissatisfied with being unemployed, and feel an URGENT NEED to change. |
| | I am Dissatisfied with my Job, and feel a STRONG NEED to change it. | | | I am Dissatisfied with being unemployed, and feel a STRONG NEED to change. |
| | I am Not So Sure how I feel about my Job, and NOT SURE if I want to change it. | | | I am Not So Sure how I feel about being unemployed, and NOT SURE if I want to change. |
| | I am Satisfied with my Job, and DON'T WANT to change it now, but maybe in the future I would. | | | I am Satisfied with being unemployed, and DON'T WANT a change now, but maybe in the future I would. |
| | I am Very Satisfied with my Job, and DEFINITELY DON'T WANT to change it. | | | I am Very Satisfied with being unemployed,and DEFINITELY DON'T WANT to change now. |

# *GILEAD* by Marilyn Robinson

**I've probably been boring a lot of people for a long time. Strange to find comfort in that idea. There have always been things I felt I must tell them, even if no one listened or understood."**

***John Ames, P.144***

# MARRONE'S RULE # 2

NEVER GET MAD AT SOMEONE FOR NOT DOING SOMETHING YOU HAVEN'T ASKED THEM TO DO.

HOPE,

HELP,

*AND*

HASSLING

# COLLABORATORS, TEAMMATES, OR SPARRING PARTNERS?

## *BEHAVIORAL HEALTH/ LGE AND LRS/ EMPLOYMENT PROVIDER INTERACTION*

**“ YOU NEED A LITTLE LOVE IN YOUR LIFE & FOOD IN YOUR STOMACH BEFORE YOU CAN HOLD STILL FOR SOME DAMN FOOL’S LECTURE ABOUT HOW TO BEHAVE.”**

***BILLIE HOLIDAY***

# CLINICAL- EMPLOYMENT COORDINATION TEAM –

## WHAT GETS IN THE WAY?
## CHAT BOX

## WHAT STRATEGIES HAVE YOU USED TO OVERCOME BARRIERS?
## CHAT BOX

# WHAT DO WE KNOW ABOUT VR- BH BEST PRACTICE –

## *PEOPLE WITH PSYCHIATRIC DISABILITIES (IN ADDITION TO EBSE- IPS)*

**PROVIDERS TO OFFER:**

**Referral summarizes of why referral is being made:**

- **What does the individual want from DVR and how do they feel about engaging in the DVR process?**
- **What strengths the individual brings to the process of searching for and getting a job?**
- **What clinical, legal, social, or other issues might interfere with the individual's job search or eventual employment?**
- **What employment services or support is the individual already engaged in with the Mental Health Provider? What support will be provided while he individual engages in DVR services?**
- **Is the Mental Health Provider's clinical staff supportive of the individual's referral to DVR and why?**
- **If so, what clinical services/support will they provide while the individual engages in DVR services?**

✓ **Provider and DVR should have some sort of *formal* LT support plan in place**

# WHAT DO WE KNOW ABOUT VR- BH BEST PRACTICE

## *PEOPLE WITH PSYCHIATRIC DISABILITIES (IN ADDITION TO EBSE- IPS)*

**VRs AGREEING TO:**

- ✓ All individuals receiving SSI or SSDI will be "presumed eligible" by DVR
- ✓ Once eligible, DVR will begin working with the individual to identify an employment goal and develop an IPE. Information and material provided at time of referral used to make this process go faster in most cases.
- ✓ DVR, the Customer, and MH Provider will determine jointly what MH services will be needed and provided to enable the individual to succeed in employment. This will include identification of the mental health services/support provided while the individual is preparing for and seeking employment, as well as the mental health services/support the individual will need after they get a job.
- ✓ If an individual will require long term, sustained mental health and is served as a DVR "supported employment" case, supported employment procedures will be followed - planning for what sort of LT support needed once they get a job and DVR services phase out.
- ✓ Provider and DVR should have some sort of *formal* LT support plan in place

“HELP” IS GIVING PEOPLE WHAT THEY NEED;

“SUPPORT” IS GIVING PEOPLE WHAT THEY WANT

IDEALLY, WE DO BOTH!

OVERSIMPLIFIED
BUT HELPFUL MODEL
TO UNDERSTAND
THE WAY
WE PERCEIVE
CLIENT
PROBLEM SOLVING

# Engagement

**Factors that enhance engagement**

- First contact is critical lasting impression
- Relationship and engagement need to be ongoing
- Take time to develop rapport
- Demonstrate respect and cultural competence
- Good and clear communication
- Shared decision making
- Expertise
- Reflective practice

# Ask:

- My level of investment in person making change?
- How able am I to let the person make own choices (even when I think the choice is less than wise)?
- What kind of challenging behaviors or signs of discord do I react to?
- What am I doing to influence the discord?
- What is the discord telling me about myself and about the other person?

# JERRY GARCIA

" SOMEONE HAS TO DO SOMETHING AND IT'S PRETTY PATHETIC IT'S GOT TO BE ONE OF US "

# COLLABORATION

- DON'T ASK BEFORE YOU GIVE SOMETHING FIRST
- ALWAYS SAY YES TO FIRST
- LEVELS OF CHANGE:
  - YOURSELF
  - YOUR ORGANIZATION
  - OTHER SYSTEMS

# DAVID KAHNEMANN
## Psychologist – Economist

"I am not very optimistic about people's ability to change the way they think, BUT

I am fairly optimistic about their ability to detect the mistakes of others."

# EDWARD ABBEY

One man alone can be pretty dumb sometimes, but for real bona fide stupidity, there ain't nothin' can beat teamwork.

# OLD YIDDISH PROVERB

If 1 person calls you a jackass, ignore him;

If a second person calls you a jackass, think about it;

If a third person calls you a jackass- get a saddle.

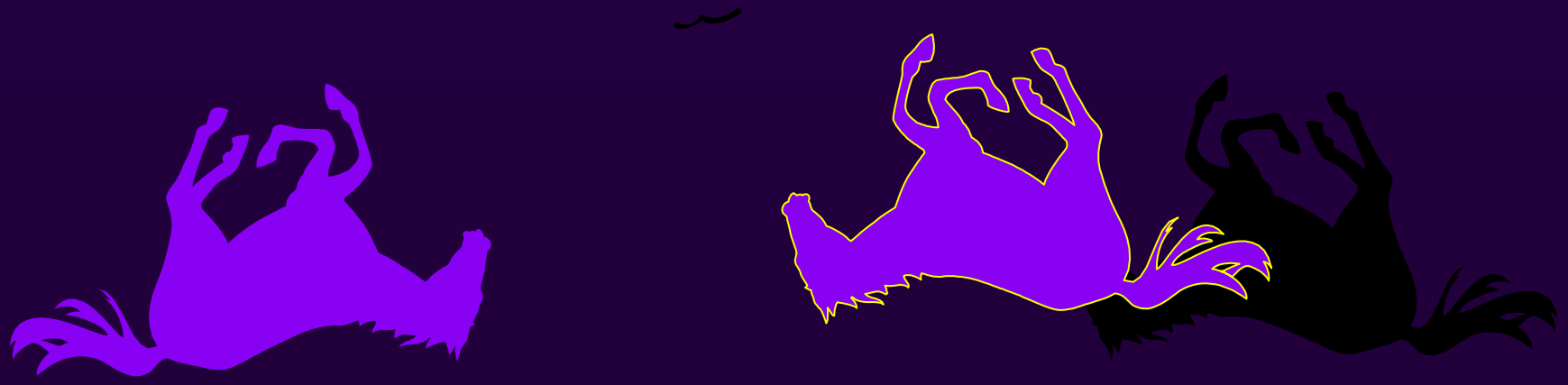
“Some cause happiness
wherever they go;
others,
whenever they go.”

OSCAR WILDE

# So why have Recovery/ Employment not moved more fully into community practice?

# ANY DEAD HORSES IN YOUR ORGANIZATION?

*(TAKEN FROM MATERIAL FROM ARTHUR EVANS, PH.D., FORMER DEPUTY COMMR, CT DMHAS), NOW MH DIRECTOR, PHILA MH*



Dakota tribal wisdom says that when you discover you are riding a dead horse, the best strategy is to dismount. However, in human services, we often try other strategies with dead horses, including the following:

* Saying things like “This is the way we have always ridden this horse.”

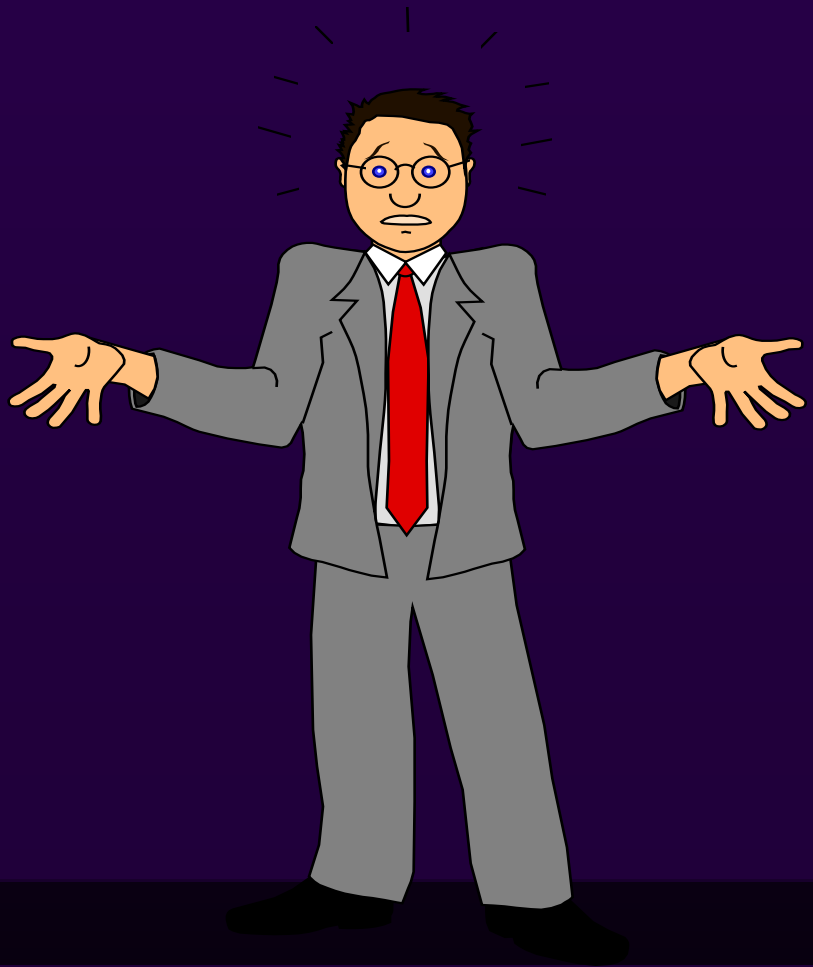
or from a Native American Tribal Saying:

"If we don't turn around now, we just may get where we're going."

* Appointing a committee to study the horse.
* Harnessing several dead horses together for greater performance
* Providing additional funding to increase the horse's performance
* Arranging to visit other sites to see how they ride dead horses

* Increasing the standards to ride dead horses
* Creating a training session to increase our riding ability
* Changing the requirements; declaring “this horse is not dead.”
* Declaring the horse is “better, faster and cheaper” dead
* Promoting the dead horse to a supervisory position

# Finding a consultant knowledgeable about dead horses.



" There is nothing you can say in answer to a compliment. I have been
complimented myself a great many times, and they always embarrass me

-- I always feel they have not said enough. "

Mark Twain