Integrating the Individual Placement and Support (IPS) Model of Supported Employment for Transition-Age Youth in the Texas Community Mental Health System

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Why integrate IPS in mental health services for TAY in Texas?
1. TAY do not typically engage in the mental health service system
2. Rates of employment are low among young adults with a SED identified in HS\(^1\)

Employment Rates at 4 & 8 Years Post-HS Completion

<table>
<thead>
<tr>
<th></th>
<th>Ever Employed</th>
<th>Currently Employed</th>
</tr>
</thead>
<tbody>
<tr>
<td>4 Years</td>
<td>63%</td>
<td>42%</td>
</tr>
<tr>
<td>8 Years</td>
<td>91%</td>
<td>50%</td>
</tr>
</tbody>
</table>

\(^1\)Newman et al., 2009 – NLTS-2
3. Integration of developmentally-appropriate approaches is necessary.
4. IPS makes sense because vocational development is key part of the transition to adulthood.
5. IPS principles are a good fit for TAY.

- Zero exclusion
- Integration of IPS into clinical services
- Job preferences drive services
- Competitive employment
- Job development
- Rapid job search
- Benefits counseling
- Follow-along supports
6. IPS has been & is being adapted &/or implemented with system-involved TAY.
Texas TAY-IPS Project Description

- Role of Texas System of Care
- Provider Recruitment
- Training – Dartmouth & Thresholds
- Monthly Consultation Calls with Experts
- One-on-One Site Coaching by UT-Champion
- Evaluation
Research Questions

(1) What challenges do providers face in engaging TAY?

(2) How did providers plan to implement IPS in their context?

(3) What made the IPS implementation process successful?

(4) What barriers did providers experience during IPS implementation?
Data Sources & Analysis

a) Focus groups & interviews with providers
b) Monthly peer learning collaborative meeting notes
c) Monthly client tracking forms
d) Data reviewed by research team using open-coding & thematic analysis
Sites

Site 1 – IPS program
  – Expand services into child and adolescent services and engage more young adults.
  – Population to serve: TAY ages 16-26

Site 2 – Adult Employment Program
  – Focus on Juvenile Justice involved youth
  – Population to serve: TAY ages 15-21 seeking supported employment services

Site 3 - Child and Adolescent Program
  – Target youth about to leave high need child services
  – Population to serve: TAY ages 16-21
Year 1 Findings: Organization Level

- Child and Adult teams lack collaboration
- Organizations have “buy-in”
- Lack of ownership over TAY as a unique population
- Integration into current programs is challenging, but resources do not typically exist to develop new programs
- Marketing and outreach look different for this age group
Year 1 Findings: Provider Level

• Engagement of this age group is challenging
  – Need for culture/philosophical adjustment
  – Need for skills training (e.g., motivational interviewing)
  – Policy barriers to texting

• Adult providers focus on getting employment

• Child providers focus on traditional case management

• Focus on educational and employment goals appears to be too much
Year 1 Findings: Client Level

- Challenges related to parent/family involvement
- In general, developmentally appropriate challenges (e.g., quitting jobs)
- Consistently show desire to work and go to school
  - Trend in goal setting: begin with education & employment goals; switch to only employment
Next Steps…

- Individual level data collection
- Developing a transition-age youth service program within a LMHA
- Working with state to create full service array for this age group
  – TAY LOC
Thanks y’all!
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• Ferguson KM, Xie B, Glynn S. Adapting the individual placement and support model with homeless young adults. *Child and Youth Care Forum* 2012;41:277-294.


Challenges in Integrating Near-Age Transition-Age Youth Peer Support in Substance Use Recovery Treatment

Deborah Cohen, Ph.D., MSW
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Perceptions

Transition Age Youth (struggling to find substance use recovery)

Adult Provider Professional (well-intentioned & trained to treat substance abuse)

http://www.noetic.org/education/worldview/curriculum
BENEFIT OF PEER SUPPORT

“By sharing their experiences, peers bring hope to people in recovery and promote a sense of belonging within the community.”

http://www.samhsa.gov/recovery/peer-support-social-inclusion
Peers important for engagement

- “Peers” are recognized as essential in engaging challenging to engage populations
- In psychiatric rehabilitation, peers are especially effective at increasing engagement early in the treatment process
- No research that directly addresses the impact of peer support for youth or young adults with SMHC (Radigan et al., 2014)
  - Our discussant, Dr. Klodnick is leading the way to document near-age peer support success.
- “Near-age” peer mentoring programs are popular for at-risk youth (e.g., Big Brothers/Big Sisters of America; Rhodes, 2008) where younger mentees are paired with slightly older mentors in school programs
State sponsored program

- 8 grants provided to community-based substance abuse providers.
- Contract provided outlining program and training.
- Monthly check-in calls.
- State-wide gathering to share experiences.
Goal of the project

- Tasked to speak to each site and learn about their implementation.
- Provide recommendations for further program development and expansion.
Formative Evaluation Questions

• What challenges do providers face in identifying peers;
• How did providers train and supervise the peers;
• What made the implementation process successful; and
• What barriers did providers experience during implementation?
Youth Recovery Coaches

• Each agency was instructed to hire up to two, full-time, 18-24 year old peer recovery leaders.

• Young adults had to have at least 6 months recovery.

• Peers were expected to lead: recovery support groups, structured activities such as a “game night”, and coordinate community service projects.
Program Structure

• Serve youth and young adults between the age of 13-21.
• Beyond YPC, program was required to connect the youth and young adults to traditional behavioral health services, in addition to vocational and educational services.
Site was to provide YPC training in:

- goal setting and developing strategies
- strategic planning
- conducting and participating in effective meetings
- managing and resolving conflicts
- conducting focus groups
- consensus building
- group facilitation skills
- valuing and respecting different viewpoints
Interviews

- Six of the eight pilot agencies participated.
- Sample
  - 6 program administrators
  - 5 direct line supervisors
  - 8 peer providers
Coding

• Themes were categorized using the Coordinated Framework for Implementation Research (CFIR).

  – Intervention Characteristics
    • planned intervention to be implemented
  – Outer Setting
    • ecosystem in which the program exists
  – Inner Setting
    • culture, structure, age, maturity, and size of an organization
  – Characteristics of Individuals
    • knowledge and belief of the individuals who are implementing the program
  – Process
    • informal and formal processes that are in place to implement a program
Intervention Characteristics

- Intervention was based on a contract not a manual
  - Sites were expected to develop their own training.
  - Sites expressed need for greater model guidance.
- Sites struggled to hire
  - Age restriction was a barrier to hiring.
  - Young adults within that age range either were not interested in a full-time position, had not been sober for over 6 months, or did not feel ready to provide peer support to others.
- All peer providers indicated challenge completing the paperwork requirements.
Outing setting

• Sites with a pre-existing community network were more successful recruiting staff and clients.
  – However the criminal justice oriented networks in some cases were not helpful.
• Every supervisor noted struggles to provide effective support the young adult peers.
• Public transportation was a barrier at every site.
Inner Setting

• Integration is very important
  – Greater number of referrals, and better client retention.
  – Those peers felt more supported by agency and supervisor.
Characteristics of Individuals

• Every site was very committed to making the program work.  
  – The differences lied in their personal knowledge for how to be successful.

• Culture bumping  
  – At some sites the new recovery oriented model struggled to exist with a traditional model.
Process

• Uncertainty in regard to planning and execution within all agencies.
• Sites appeared a bit stymied where to begin and how to move forward.
• Sites noted a need to obtain more step-by-step guidance and attain more prescribed information.
Recommendations

- Supervisor Training
- Consistent Training for all peers
- Greater model specification
- Flexible funds to cover transportation
- Monthly calls should be restructured
- Provider hiring flexibility
  - Such as part-time and extending the age to 30.
References


An Examination of Factors Related to the Use of Mental Health Services Among Transition-Age Homeless Youth at LifeWorks in Austin, TX

Liz Schoenfeld, Ph.D. | Director of Research & Evaluation
LifeWorks | Austin, TX
LifeWorks’ priority population is transitional youth & young adults particularly young parents, runaway/homeless youth, & youth aging out of foster care.
# LifeWorks Services

## Housing
- Street Outreach
- Emergency Shelter
- Transitional Living
- Young Parents Program
- Supportive Housing & Rapid Rehousing
- Permanent Supportive Housing

## Education & Workforce
- GED
- Workforce
- Life Skills
- After Care
- Transitional Services
- Teen Parent Services
- Substance Abuse & Violence Prevention

## Counseling
- Shared Psychiatric Services
- Resolution Counseling
- Youth & Adult Counseling
- Community-Based Counseling

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*Empowering Self-Sufficiency*
we know that youth who are homeless or unstably housed often report a range of mental health issues.
but do a greater proportion of homeless youth report mental health issues relative to other vulnerable youth receiving services?
Sample:

- 805 youth aged 16–26, who initiated and enrolled in services during a one-year period
  - Age: $M = 20.06$, $SD = 2.89$
  - Gender: 51.87% male, 47.26% female, .87% transgender
  - Race: 38.06% Hispanic White; 27.50% African American; 24.80% Caucasian
  - Education: 5.22% <HS; 48.11% some HS, 31.16% HS/GED graduate, 7.43% some college; 8.08% other

- 49.07% self-identified as homeless or unstably housed ($n = 395$)

- 20.12% Street Outreach; 17.27% Youth & Adult Counseling; 13.42% After Care Transitional Services
<table>
<thead>
<tr>
<th></th>
<th>Homeless Youth</th>
<th>Stably Housed Youth</th>
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</thead>
<tbody>
<tr>
<td>History of depression</td>
<td>58.04%</td>
<td>44.81%</td>
</tr>
<tr>
<td>Currently depressed</td>
<td>19.25%</td>
<td>20.13%</td>
</tr>
<tr>
<td>History of suicidal ideation</td>
<td>35.94%</td>
<td>26.44%</td>
</tr>
<tr>
<td>Recent suicidal ideation</td>
<td>14.55%</td>
<td>11.05%</td>
</tr>
<tr>
<td>Attempted suicide</td>
<td>22.33%</td>
<td>11.58%</td>
</tr>
<tr>
<td>Diagnosed MH disability</td>
<td>9.04%</td>
<td>3.09%</td>
</tr>
<tr>
<td>History of MH hospitalizations</td>
<td>28.71%</td>
<td>14.38%</td>
</tr>
</tbody>
</table>

generally speaking, a greater proportion of homeless & unstably housed youth reported a history of mental health issues relative to other vulnerable youth.
does this apparent need for mental health services translate into program enrollment?
youth & adult counseling

• one of the largest providers of free & low-cost counseling services in Central Texas

• brief, solution-focused therapy model

• provides prevention & early intervention services to at-risk youth through the Department of Family & Protective Services
Analytic Strategy:

- Logistic regressions were conducted using SAS Proc Logistic.
- Controlled for gender, age, income, and history of abuse/trauma.

\[
\log_e \left[ \frac{\pi}{1-\pi} \right] = \alpha + \beta_1 \text{(Housing Instability)} + \beta_2 \text{(Gender)} + \beta_3 \text{(Age)} + \beta_4 \text{(Income)} + \beta_5 \text{(Abuse/Trauma)}
\]
<table>
<thead>
<tr>
<th>Predictor</th>
<th>$\beta (SE)$</th>
<th>Odds Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intercept</td>
<td>-1.13 (.12)***</td>
<td>—</td>
</tr>
<tr>
<td>Housing Instability</td>
<td>-.38 (.11)***</td>
<td>54% less likely</td>
</tr>
<tr>
<td>Gender</td>
<td>.25 (.10)*</td>
<td>64% more likely</td>
</tr>
<tr>
<td>Age</td>
<td>-.07 (.04)*</td>
<td>7% less likely (with each year increase in age)</td>
</tr>
<tr>
<td>Income</td>
<td>.00 (.00)***</td>
<td>42% more likely (with each $5,000 increase)</td>
</tr>
<tr>
<td>History of Abuse/Trauma</td>
<td>.24 (.12)*</td>
<td>61% more likely</td>
</tr>
</tbody>
</table>
what about the number of sessions attended among those who enroll in counseling services?
Sample:

- 188 youth aged 16–26, who initiated and enrolled in counseling services during the same one-year period; of these, 141 provided information about their housing stability
  - Age: $M = 20.06, SD = 3.15$
  - Gender: 42.55% male, 57.45% female
  - Race: 53.19% Hispanic White; 23.40% African American; 20.57% Caucasian
  - Education: 3.76% <HS; 49.62% some HS, 32.33% HS/GED graduate, 9.02% some college; 5.27% other

- 29.79% self-identified as homeless or unstably housed ($n = 42$)
Analytic Strategy:

- multiple regressions were conducted using SAS Proc Reg
- controlled for gender
- \( Y = a + b_1(\text{Housing Instability}) + b_2(\text{Gender}) \)
<table>
<thead>
<tr>
<th>Predictor</th>
<th>$b$ (SE)</th>
<th>Interpretation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intercept</td>
<td>5.24 (.57)***</td>
<td></td>
</tr>
<tr>
<td>Housing Instability</td>
<td>-2.56 (.76)***</td>
<td>Youth who were unstably housed attended significantly fewer sessions</td>
</tr>
<tr>
<td>Gender</td>
<td>1.54 (.70)*</td>
<td>Females attended significantly more sessions</td>
</tr>
</tbody>
</table>
do youth’s mental health outcomes at program exit differ as a function of housing stability?
On a scale of 1 to 10, I consider my life to be a...
Analytic Strategy:

- multiple regressions were conducted using SAS Proc Reg
- controlled for baseline perceptions, number of counseling sessions attended, and gender
- \( Y = a + b_1(\text{Housing Instability}) + b_2(\text{Baseline Mental Health}) + b_3(\text{Sessions}) + b_4(\text{Gender}) \)
<table>
<thead>
<tr>
<th>Predictor</th>
<th>$b$ (SE)</th>
<th>Interpretation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intercept</td>
<td>5.33 (.45)***</td>
<td></td>
</tr>
<tr>
<td>Housing Instability</td>
<td>.76 (.40), $p = .06$</td>
<td>Those who were homeless/unstably housed had marginally better outcomes</td>
</tr>
<tr>
<td>Baseline Mental Health</td>
<td>.38 (.04)***</td>
<td>Higher baseline scores were tied to more positive scores at exit</td>
</tr>
<tr>
<td>Number of Sessions</td>
<td>.13 (.04)**</td>
<td>Attending a greater number of sessions was tied to better outcomes</td>
</tr>
<tr>
<td>Gender</td>
<td>-.59 (.36), $p = .10$</td>
<td>Females had marginally poorer outcomes</td>
</tr>
</tbody>
</table>
implications

- reduction of barriers
- engagement is essential
- trauma-informed screening tools
- community advocacy
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