

TANF
Providing Mental Health Services for TANF and
Other Low Income Participants Webinar
June 15, 2016
TANF 614 Task 2.3

Ms. Gillissen: Welcome to “Providing Mental Health Services for TANF and Other Low-Income Participants” webinar. My name is Jennifer Gillissen and I am from Kauffman and Associates and I will be your moderator today along with Carol Mizoguchi. I would like to start with explaining a little bit about the webinar interface. You should all see the first slide of the PowerPoint presentation in the Q&A box to the right. We’ll be answering questions at the end of the webinar; so you can enter a question at any time. If you need technical assistance during the webinar please use your Q&A box. Please note that this webinar is being recorded. I will now turn it over to Carol Mizoguchi.

Ms. Mizoguchi: Good afternoon and thank you for joining today’s webinar, “Providing Mental Health Services for TANF Participants.” We are excited to have a panel of expert presenters to discuss this critical topic with you today. My name is Carol Mizoguchi. I’m from the Office of Family Assistance and I’m going to be one of the facilitators today. So, many of you attended the “Office of Family Assistance Gateway to Opportunity Improving Parental Employment and Family Well-Being Outcomes” convening in Washington, D.C. last fall. During that national meeting we held a workshop on “Integrating Mental Health Services for TANF Participants” through ACA collaboration. This topic remains a critical and timely component of a responsive TANF program and OFA wanted to take this opportunity to continue the conversation. This webinar offers us an opportunity to share the latest policy and program ideas around the provision of mental health services to TANF Participants. We know that individuals with mental health conditions are more likely to be poor and unemployed and that an estimated one fourth to

one third of TANF participants have a mental health condition that can become a major barrier to consistent employment. Since the passage of welfare reform in 1996, jurisdiction has had to rethink their approaches to providing mental health services to TANF participants in order to comply with work requirements; however, mental health service...mental health issues are nuanced and complex and need to be addressed with a holistic understanding of their pathways of *** (*unclear* - 2:39) on families. For example, having a depressed parent puts children at high risk for behavioral problems and mental health illness themselves. Peer TA has seen many questions over the years of strategies for coordinating mental health services for TANF participants and a number of states have taken steps towards conducting mental health screening and assessment, developing support services, connecting recipients to SSI benefits, allowing recipients to access state-funded programs and linking recipients to skilled mental health professionals. Our conversation today will focus on understanding what has worked to help caseloads with mental health needs. Should the focus be on mental health first or concurrently with employment services? And how can TANF agencies work more effectively with outside partners to coordinate services and approaches? Our learning objectives today include understanding the challenges TANF programs face in providing mental health service, progress made in states since welfare reform in 1996, and newer implications and opportunities for collaboration in the context of policy changes such as the Affordable Care Act and the Workforce Innovation and Opportunity Act. We'll also hear about experiences and lessons learned from programs that have taken different approaches to addressing the mental health needs of TANF participants. And finally, considering your own TANF program population and whether or not there are any insights you can take home to improve or better streamline your jurisdictions connections to mental health services. So as I mentioned before, we're fortunate to

have a wonderful slate of expert speakers and we're going to hear from Dr. Mary Spooner. Dr. Spooner is a senior manager with ICF International. She is a senior manager... I'm sorry - kind of a repeat. Um, she is... She leads several mental-health-related projects; her experience and evaluations of system transformation initiatives in health, education, and the criminal justice sector. She currently leads multi-site evaluations as system-wide interventions that serve children exposed to violence and children with serious emotional disorders. Dr. Spooner will provide an overview of the implications of addressing mental health needs among TANF participants and offer insight into the structural and perceived barriers to mental health services access in a TANF setting based on her own work with TANF families and other low-income populations. Dr. Spooner also holds the Adjunct Assistant Professor position at the Northwestern University's School of Medicine where she teaches a graduate course in U.S. Mental Health Policy and there she speaks to change and new opportunities and state practices across mental health systems in the context of overreaching federal policy changes such as the Affordable Care Act. And then we'll hear from Timothy Cantrell who is the Assistant Deputy Commissioner for the New York City Human Resources Administration Office of Rehabilitation Services and also the Director of WeCARE Operations. WeCARE or the Wellness Comprehensive Assessment Rehabilitation and Employment initiative provides clients with a comprehensive biopsychosocial assessment conducted by a licensed social worker and reviewed by a physician, as well as a full vocational evaluation that identifies each client's strengths, skills, and aptitude. New York City partners with a number of vendors to serve TANF participants with behavioral health conditions and offers a range of services to help participants achieve their employment goals. WeCARE was...has presented with OFA before and we're excited to have them back today. And finally, we'll hear from Miranda Gray who is the administrator for the Reach Up program under the

Vermont Department of, um, Department for Children and Families Economic Services Division and Reach Up is Vermont's TANF program and it technically makes the approach to mental health service provision; including substance use services through direct partnership with *** (unclear - 8:07) Agency. Ms. Gray has worked for the state of Vermont for eight and a half years. She's a graduate of St. Michael's College with a Bachelor of Arts degree in Psychology and she began her career providing direct services to TANF clients at the Orange County Parent Child Center. In 2007 she began her career with the Agency of Human Services as a Reach Up case manager. She has worked since 2010 in Reach Up's central office and serves families in providing guidance to law and staff, and more recently she has had the opportunity to oversee Vermont's Reach Up Substance Abuse and Mental Health Program which was established in late 2013, among other grants and contracts that support Vermont's TANF program and the clients they all serve. So, as you can tell we have folks with a lot of experience and so we're excited. So before we begin the presentations, we have a poll question and so I will just ask the audience to respond and then we'll look at...just kind of get...look at the responses and then we'll go ahead and have Mary do her presentation. And I think I'm supposed to move these slides and I haven't... There's a slide of the presenters. And here's the first poll question. "Do you..." Oops. "Do you or another member of your team, um, or did you or another member of your team attend the "Providing Mental Health Services for TANF Participants workshop at OFA's Gateway to Opportunity National meeting?" (Pause.) And I guess a large majority did not attend. So, some of this will be new information. (Pause.) And most of it... Okay, so we'll go ahead and Mary can go ahead with your presentation. Thank you.

Dr. Spooner: Thank you, Carol for the introduction. I am happy to be able to participate in this webinar today and I hope we have a good discussion about mental health and really the

challenges and we'll probably give some supports that are in place to help TANF and low-income families. If my voice drops, just let me know. As the title of this slide indicates, I'll be talking about the implications of providing mental health services for TANF and low-income families; but first I want to give you an idea of what you can expect during this presentation. First I'm going to talk a little bit about the definition of mental health, mental illness, and mental disorders; look at the prevalence of mental health and substance abuse issues; talk a little bit about mental health and the well-being of TANF recipients; the challenges in providing mental health services for these populations; and a few of the mental health focused policies and initiatives that are out there and some policy recommendations. Generally when I make presentations of this nature I like to focus attention on what we mean by mental health and mental illness and those differences. Unfortunately, because of the images of the media and so forth, mental health gets really very negatively, too besieged with a sense of violence and so forth. But when we talk about mental health we're really talking about a state of well-being in which the individual relies on his or her own abilities and cope with normal stresses of life and work productively and truthfully and is able to make a contribution to his or her community. So when we talk about mental health, we're talking about overall well-being and not just the absence of being a mental disorder. When we talk about mental illness we're talking about the collective diagnosable mental disorders and when we talk about those disorders, actually, we're talking about the health conditions characterized by alterations in thinking and moving, behaviors, et cetera, through these...the stress of day-to-day (*?unclear - 13:16*) functioning. The truth is that mental health and substance abuse appears all around us every day. So let's look at this slide that shows the population of adults and children impacted by mental health and substance use and I'm beginning on SAMSHA's 2014 report of past year, substance use

disorders and mental illness amongst the adult population here, and what those data tell us is that 43.6 million adults had any type of mental illness in the past year. 9.8 million had a serious mental illness. 20.2 million had a substance use disorder. And when we dissect those populations we can see based on this graphic how this falls out. So in the big blue circle we have 35.6 million persons with mental illness with no substance abuse disorder. On the side list we have 12.3 million persons with substance use disorders with no mental illness. And then we have a co-occurring group in that green shaded area that represents persons with substance use disorders and mental illness. That is a huge population of persons and if we are thinking in practical terms, this represents the population of a state such as, um, Washington. So what is the prevalence of serious emotion disorders among children? Just over 21 percent of children 13 to 18 years currently or at some point during their life had a serious debilitating emotional disorder. I want you to bear this in mind because it has bearing on our later conversation. Roughly 10 percent of them form (*?unclear - 15:29*) a serious disorder that causes such things as impairment in functioning at home, at school, and in the community. And using data from one of the evaluations that I manage, we found that 6 percent of the children 0 to 21 were served by systems of care - which I'll talk about a little bit later on - um, were from families that receive TANF services. So what's the prevalence of mental illness amongst TANF recipients? 34 percent of all recipients reported at least one typical or mental impairment based on the U.S. General Accounting Offices report in 2001, and 36 percent reported either very poor mental health or that health limits work. Looking at the prevalence of substance use, about 20 percent of TANF recipients reported that they had used an illicit drug at least once in the past year. Approximately 5 percent reported illicit substance use or dependence and 6.5 percent reported alcohol abuse or dependence. I want to talk a little bit about adverse childhood experiences, because this has some

implications of the mental health and well-being of the population. Looking at the pyramid on the right and looking at that arrow next to it we see that families may be exposed to adverse childhood experiences that set very early in life. They're going to *** (*unclear - 17:22*) all the way up until death, and as we deal with those adverse childhood experiences and their families, who tend to experience disruptive new development, social, emotional, and permanent impairment, adoption of upheld with complex behaviors, disease, disability, social province and dysfunction leads to early death. Almost two-thirds of the study participants reported at least one each, and it is an adverse childhood experience which could be anything such as child abuse, neglect, physical, sexual abuse. All those behaviors or childhood traumas describe as adverse childhood experiences. Lots of researchers of this kinds of population found is that as the number of instances increase, so does the list of the events in that pyramid. And this is extremely concerning as it leads to mental health, particularly as we find that Kessler and his team uncovered the fact that 50 percent of all diagnosed mental health concerns were found in adults had started by the age of 14 and 75 percent by age 24. So these conditions present very early in life. Moving to the next slide, so what does this have to do with the TANF population and the experiences? The truth is that poverty, as I represent here with four pillars in this matrix, in many ways it determines the actions and behaviors of low-income populations. As the cornerstone of the life experiences of low-income families, that it is complicated and at the same time it complicates the lives of families. So when you look at a matrix like this, there's a relationship between all of these factors and all of them are influenced by poverty in one way or another. These links are sometimes obvious as indicated by the firm lines and not so obvious as indicated by the broken lines. Families caught in this property maze may find it difficult to get out of poverty and to seek any type of help, mental health, work, any of the...almost any of the other

results that can be out there, unless they have the required support. So for example, a deficient income affects family's ability to provide for basic needs such as housing, food, health. Access to housing, we know that generally the type of neighborhoods in which families have lived and there's fewer accessing communities that *** (*unclear - 21:05*) to the challenges for raising children. The absence of cars (*?unclear - 21:08*) and open spaces. For example children are less likely to thrive and experience good all-around health. Access to housing determines where children go to school and the quality of education they receive and the potential for employment that may lift them out of poverty. Poor neighborhoods are also the places where families often encounter experiences of the trauma of community violence. Lack of resources in many instances may be associated with experiences of domestic violence. So physical health, in fact mental health and vice-versa, and for many, employment is not possible if there's a child with a physical or mental disability and we saw the numbers just now. In these circumstances they cannot be possible if the *** (*unclear - 22:07*) in the neighborhood falls; um, and they can't afford to pay for daycare. So what we know is that having mental health conditions in childhood is a significant predictor of mental health disorders later in life. *** (*unclear - 22:27*) who are not working who are TANF-sanctioned were experiencing housing and stability are more likely than others to report substance abuse. Substance use is also associated with increased (*unclear*) and cycling on and off TANF and substance use together with mental health issues creates serious problems. So what does all of this have to do with accessing mental health services? The fact is that there are many barriers to families with human services even if they want to go there and access those services and that has to do with the stigma around mental health, also about the denial that many persons that may be *** (*unclear - 23:21*) about the mental needs. This is particularly true in the case of young persons who often are difficult to convince about their need

for mental health services. Sometimes systems are difficult to navigate. You have to go from one service to the other, to the other in order to get services and then sometimes transitioning from one system to another is difficult, especially when you're talking about young people moving from a child system into an adult system. The financial cost of mental health services are also a deterrent to seeking health. The ACA has helped some but there are still challenges particularly (in) states where Medicaid has not been expanded. In terms of unemployment, you know many families in this country receive services because...receive mental health coverage because they are employed. And then there's always that *** (*unclear - 24:17*) of lack of trust of systems and providers. So what are some of the head mental health focus initiatives that are out there?

There's the Screening, Brief Interventions and Referral to Treatment initiative and this allows for screening with such severity of substance use and referring persons to treatment. There's also Systems of Care for children with serious emotional disorders and I think every state in the country has Systems of Care in some form, either because they have been recipients or because they are now expansion grantees and those are coordinated networks of community-based services that support children with serious emotional disorders and their families. There's Mental Health First Aid, and this is how you get to adults as well as to young adults, and Mental Health First Aid provides screening for persons in the community to identify persons in mental distress and provide support and referral and this has its first responders, teachers, and all the persons of that nature in the community. There's a Safe Schools/Healthy Students state program which provides mental health services in school so that children and youth have access to services, but also to ensure that schools are safe and they're conducive to learning. States also (have) the "Now is the Time Plan" which is the President's plan that was introduced some time ago with the *** (*unclear - 25:56*) on violence with provisions for providing mental health services with a

focus on that transient age population 16 to 25 years that have mental illness. Those that come with Mental Health First Aid treatment of teachers provide schools with occupants (*?unclear - 26:11*) and other safety features. An emerging initiative is the Evidence-Based Treatments for First Episode Psychosis. Components of Coordinated Specialty Care, and this is an initiative coming out of NIH research, and it's really a collaborative recovery-oriented approach through involvement in compliance, um, treating members and relatives as appropriate as active participants in the care of persons with first episode psychosis. Then there is the community behavioral health clinic, and I think Miranda is going to talk a little bit about that Section 223 of the Protecting Access to Medicare Act, and this helps states to establish certified community behavioral health clinics and they provide programs to integrate behavioral health with typical health and increase consistent use of evidence-based practices to improve quality of care. There are also private initiatives and foundations such as Annie Casey and they have initiatives that try to address children with mental health and disconnected youth and so forth. So in thinking about mental health and engaging these populations in mental health services, recommendations would focus on things like researching the group's frame of reference and mental health in terms of that definition I presented before and it's about the coping and it's about helping people to be productive. On this level the approach of poverty, understanding where people are, that they have to be met where they are and then planning the challenges related to the status they have and why they are in that particular situation. Using a strength-based approach which helps people with the positive aspects of their lives and where they can go next. Building trust: many people for whatever reasons are skeptical of systems that may be able to support them. They don't trust those systems and it's about gaining that trust. The other recommendation is about providing integrated care. This has become more and more popular. Previously, I'm sure many of this

audience will know that you couldn't provide mental health services with substance use services together and we couldn't use those words in the same sentence and that's changing. People are talking about integrating care and qualitative staff and staff in physical care services. Also, providing the types of clinical assessments that you help to identify persons in need of services and the *** (*unclear - 29:18*) of that treatment and making those services culturally appropriate; because in many instances services are not culturally appropriate and when they are culturally appropriate - I'm not talking about translating forms into Spanish or translating forms into something - many people would say, "Well, it's culturally appropriate, because we have everything in Spanish." No, it goes beyond that. It's about understanding people and views that are related to both the economic status, to the race, ethnicity, um, to communities. Understanding what works for populations and then the other thing, it's about wrapping services around the families. The truth is that working with these populations you have to take them as a whole package, because services have got to be wrapped around. Many of the children who have serious emotional disorders, the parents have some sort of mental health disorder. And parents that have mental health disorders, the children have some, um, deal with emotional disorders. Think about wrapping the services around the family and knowing that together they make a family unit and everything affects everybody in the unit. And then the other thing is promoting in the agency collaboration. Some of my work, um, is about understanding collaboration between agencies and some of my work continually shows is the intention and collaboration between agencies and who's at the table and who's not at the table and why this agency is not at the table. It's about now thinking about how agencies can work collaboratively for the benefit of families. And particularly given the challenges that are associated with these populations, if they're going to be able to access mental health services, it's going to have to be a team effort between all of

the sectors that serve these families. So that's my presentation. I do want to leave with you this... There's a mantra from SAMHSA which I like very much. It says, "Behavioral health is essential to health. Prevention works. Treatment is effective and people recover." And so I am going to turn the presentation over to the next person. Thank you very much.

Ms. Mizoguchi: Mary, thank you so much for that presentation. That was great. So now we have... Before we have our next presenter we'll have our audience poll and they've already moved ahead and *** (*unclear - 32:15.*) Real quick, the majority of the folks with large...uh, mental health is significant as long as there are participants, so, with their TANF population, 88.8 percent. Okay, thanks to the audience for participating in that. So next we are going to hear from Timothy Cantrell. I will turn it over to him.

Mr. Cantrell: Good day everyone. I'm very happy to be part of the panel this afternoon and I'll be discussing what I hope will be a useful practical example of working with mental health conditions while in TANF programming, but specifically I'll be primarily speaking about the WeCARE program in New York City. So early in the 2000s, around about 2006, New York City Human Resources Administration recognized the fact that we needed a specific way to address those people who have either medical or mental health barriers, clinical barriers to finding employment as part of welfare reform. Each year the WeCARE program in New York City serves over 50,000 people and those basically include anyone who is declared, anyone who is not exempt from work program activities, anyone who's declared that they have medical or mental health issues that could prevent them from going back to employment. So we have developed an integrated model service which by potential rehabilitation, wellness services, disability application services, and other wraparound services to help those people, not disengage from trying to find employment, but ultimately under...change their condition or learn to work with

their condition so that they can get back into the workforce. One key thing to realize about the WeCARE program in New York City is that we don't provide any direct medical services. We focus on assessment and we focus on referring to other care providers or making those connections for those that are necessary. The WeCARE program itself is operated under a contract to the agency and it is a performance-based contract. It is 55 percent performance-based where the contract is only paid if they achieve certain milestones such as successful SSI applications, successful completion of the wellness plans, or post *** (*unclear - 34:58*) with retention and I'll get into each of those types of services in just a moment. Um, the program itself, as I said, serves over 50,000 people a year. There's over 500 staff under contract to us with the vendors who provide the services. The staff themselves are a very interesting mixture of case managers and qualified health professionals such as licensed master social workers, LPNs, RNs, and MDs. So the model that I put up on the screen for you at this time is the overall view of how WeCARE itself works. So even a client, again, who has said that they have a medical or mental health condition which precludes them re-engagement of workforce receives what's called a biopsychosocial. So there's a number of different components of this. The first is a psychosocial assessment by a social worker which goes through whatever barriers they may have in their lives, their activities of daily living, their education, their home life, of work experience, any of those social factors which may be impacting their ability to re-engage with the workforce. Following that, they receive a full medical examination by a licensed physician that lasts anywhere between 20 and 40 minutes where the client's health concerns are reviewed plus the physician looks for anything else that they might be unaware of or hasn't or simply hasn't mentioned. In conjunction with that medical exam, standard *** (*unclear - 36:42*) are performed. So we do blood work and things like that as well. Um, again also brought into consideration is any documentation that the

client brings in. We encourage them to bring in anything that they have from any previous physicians or any programs that they may be in. We can review that in addition to our own examination. Based on the result of this initial assessment that we go through - which takes place in one day and can take up to about 3 to 4 hours depending on the amount of time that the customer needs or the client needs - we may or may not need an interview to do an additional assessment on the customer and those additional assessments can include psychiatric. They can include orthopedic. Those are bipolar or *** (*unclear* - 37:33) problem. Every now and again we'll see people who need a follow-up cardiology, (*unclear*), something like that. So if the initial physician is unable to really come up with a clear assessment we do refer to a specialist or we get a clearer picture of the person. The complete time for the assessment to review all documentation and come up with a determination of whether a person does fit in our program, it takes up to 10 days, but most commonly all documentation and results are used within about three or four days resulting in something called a functional capacity outcome and that's the...which is basically, "What is going to be the best service track for this individual?" In addition to the medical assessment and a psychosocial assessment, if necessary, we do have Cases ACT <substance abuse specialists> at each service site, at each medical assessment site I should say, where it gives a history of substance use within the past 12 months or if the individual indicates they are currently using substances, we will throw them to a Cases ACT to see if that is something that needs to be taken into account in their service plan. And one other piece of analysis that's done coming up with an appropriate FCO is something called sequential evaluation. The sequential evaluation is a multistep process used by SSA to determine whether someone is appropriately or would best be served by SSI or if they are eligible for SSI. In the sequential evaluation, the physician takes all of the information that I've just gone through and first of all compares against

what are called blue book listings to see whether the client meets the specific criteria to be eligible for SSI under...because of a specific heart condition or because of a specific orthopedic condition or specific psychological condition. If they don't meet the specific criteria for a listing, then the sequential evaluation goes on to look at what are called the grid rules where the combination of the clients age, work experience, educational background, exertional and non-exertional mix (*?unclear - 39:48*) and whether they will be able to continue to keep work that they've done in the past are all taken into account to see whether, again, if we're not meeting a specific condition whether this person - we call it a combination of these things - is someone who could not really be expected to engage in the workforce for at least the next year and in which case, SSI would make the determination for them. The SCOs that can come out of this process - one of which as I just mentioned was federal disability - that we will report them down the SSI track and help them in their SSI application. When they've got people who may have medical conditions that are not permanently disabling or disabling for up to a year, but are temporarily disabling; for example, someone might have a broken leg or someone might have a psychiatric condition that they are just starting to see the psychiatrist and take medication. In which case, they may not be able to re-engage with the workforce for 30, 90, 180 days; in which case we will issue what's called a Realms Plan for them. So this is to help someone who is unstable in whatever their current medical or mental condition is and is expected to improve over time such that we can at that point we engage them in trying to find work. We also have a combination of those two tracks called Wellness Plus which is basically someone who is eligible for SSI potentially according to the sequential evaluation, but also has a temporary condition that requires a wellness plan so that they can address it. Otherwise, we have two other options for someone who comes through the assessment process. One is vocational rehabilitation. This is

where the client is deemed to be employable, but with specific limitations. So for example, it might be someone who has an orthopedic condition where they cannot work in a warehouse anymore, but they do have skills that are transferable that can help them find other work. Lastly, we do have people who come through the assessment process who are deemed fully employable without limitations. In which case they are not engaged in the WeCARE program, but rather sent to one of our counterpart programs within the agency, the Back-to-Work program which works with people who are fully employable. Before I go into each of the specific tracks on how we work with them, I should mention that we also have something called a clinical review team. People's conditions are not static. They change over time. They get better or worse as people go through the program. So we always have the ability within the program to review someone to a clinical review team which again is our consistent *** (*?unclear - 42:31*) by health professionals to see what the change has been for them and whether we need to reassess functional capacity to *** (*unclear - 42:40*) them aside. So as I mentioned, one of the simplest SCOs is the fully employable FCO. This is a case where the physicians would need all information in case the *** (*unclear - 42:56*) cannot participate in the regular HRA employment programs and they are referred outside of WeCARE. The wellness track is where the client needs medical treatment to stabilize their condition. So they come in after receiving their FCO designation and they meet with the case manager who specializes in enrollment plans and this person will perform a number of functions to help them come to the point where they can engage with their job search. First of all, they'll link the customer or the client and collaborate with an appropriate treatment provider. So if someone comes in, they don't have the current treating or primary care physician, we will make referrals for them or to specialists so that they can find someone who can help them with their living situation. We provide health education information that may be relevant to

specific conditions. We monitor and facilitate compliance with and progress in medical treatment. In some of our wellness plan, we check in with them minimally of every 30 days, if not more often, to make sure they are making their appointments, that they're progressing their treatment and to see where we need to adjust anything in their specific treatment plan and that's all part of the ongoing case management process, um, reminding them about appointments and making sure, again, that they've got all the providers and resources that they need. At the end of the wellness plan their status is reevaluated, because it's only done by the physician who first assigned them their FCO. They take a look at any new medical documentation that has been collected and submitted as part of the wellness plan and they also look at a key document, the treating physician wellness form, which comes back from whomever their primary care physician or physicians are, with that physician's recommendation to whether this person is ready to go back to the workforce or whether some other track is going to be more appropriate to them. At the end of the wellness plan, which again can generally last no more than 180 days, they're deemed either fully employable or sent to more rehabilitation or deemed they need to go into disability at this point. Vocational rehabilitation track is going to be a track where someone is going to be involved for all of the participation hours they're going to need in their job search and training. Whether employable with limitations and the first step in this process is that they come in and they go through a diagnostic vocational evaluation. This generally takes a day. It can take a little bit longer depending on the specific situation of the individual and it's a full assessment of their skills and their interests and basically, taking a look at what's going to be the most appropriate type of employment for this person given the current medical and mental health conditions. If necessary, during the DVE process we may perform a sequential evaluation again. We see given everything that we discovered as a part of the skill assessment whether this person

is going to be able to continue to do the same sort of work that they were doing in the past. And if not, then we will consider changing their FCO through SSI or federal disability so that they can make that application. The DVEs are conducted by certified rehabilitation counselors who at the end of the process take into account all of the person's background, education, physical assessment, and come up with an individual plan for employment. At that point the person enters the full vocational rehabilitation track. It consists of case management, job readiness training when needed. In certain circumstances if an individual is ready to go to employment we will fast-track them to job developers. It's an interesting area in that they are actually supported by two case managers, if you will, or they have a regular case manager and they're working with a job developer as well. So there's a little bit more in terms of support for this particular track. The goals for this are to place them in permanent employment and under the performance-based piece of the contract we pay the contractor for retention at 30, 90, and 180 days once a person has found employment. The program overall between all of the regions in New York places about 350 people a month on average. While they're in the vocational rehabilitation track they also take part in what's called currently the work experience program. This is actually a community service option where for part of the participation hours then they work with non-profits or non-governmental organizations in the area as a way of building resume and skills. Um, when they leave the *** (*unclear* - 47:53) as a part of placement they also receive transitional benefits or they receive Metro cards or transit costs for up to 90 days and then also, as a part of the contract, the vendor provides them with incentive awards when they hit their 30, 90, and 180-day mile steps. Otherwise, a customer could be assigned to the federal disability track. Again, in this case we've gone through the sequential evaluation and either by virtue of meeting a condition or by meeting goodwill qualifications referring that this person is very likely

eligible for SSI. In which case they have, generally speaking, one meeting with the case manager where they bring in their documentation and the case manager works with them to build a case and to submit their evaluation or SSI application through SSI or SSA or SSI or SSDI. If it happens to be the case that the customer already has an application pending, then we will supplement that application with whatever documentation that has been added new to the case or whatever they got through our own assessment process. We help them gather documents if necessary and if they are unsuccessful in their initial application in getting SSI then we also have a process by which the agency helps them to appeal their SSI decision. So that's an overview of the program overall, uh, how WeCARE works and how it works following the people with medical or mental health conditions as well and substance use issues. Speaking about specifically mental health, what we found looking at data over the past 12 months is that 38 percent of our new WeCARE enrollees each year had at least one mental health diagnosis and I think that is more or less in line with the earlier statistics that we were seeing for TANF population. We have 16 percent of our new enrollees who had two or more mental health diagnoses and 10 percent of our WeCARE enrollees require a secondary psychiatric evaluation. So when they came through their assessment they were deemed such that they needed to see a psychiatrist separately so that we could get that evaluation before making a decision as far as a functional capacity outcome. And one clarification that I would offer on these stats is these are clients who were specifically diagnosed as part of the assessment process with these conditions rather than the clients stating that they had a condition. So their medical input, if you will, on these statistics. We also took a look at the mental health diagnoses that we have seen most commonly. So we tend to see most often episodic mood disorders or neurotic disorders. To a lesser degree we see adjustment reactions. We see a core substance use of non-dependent abuse of drugs is at 6 percent, for

dependence is at 4 percent. Alcohol dependence in each of our steps it was only at 1 percent and then we have smaller numbers of personality disorders, attention deficit, hyperactivity, and developmental delays. And these numbers also are...reflect co-morbidity. So a client with multiple diagnoses would be in multiple of these categories. Looking at our actual FCO distribution, there is something of an interesting difficulty between clients without mental health diagnoses and those with mental health diagnoses. Generally speaking, we'll see that the numbers are very similar. We have about 40 plus percent of people with wellness plans. We have about seven - oh, sorry - 4 to 5 percent in our Wellness Plus program. We have 2 percent that have no functional limitations, but where we do see a little bit of a difference is between VRS, our Vocational Rehabilitation Services, and those on SSI and there's a shift of about seven percentage points where we have a smaller number of people who are able to work with limitations with that mental health diagnoses and a larger number of people going in to that "unable to work" category. The outcomes specific to those with mental health diagnoses, of those who were assigned an FCO of "unable to work" during this period, 10 percent were ultimately awarded SSI benefits and of those with mental health diagnoses and we assign an FCO of vocational rehabilitation, 11 percent of those were placed into employment. So clearly working with this population of individuals with mental health barriers to employment, we do have to have specific strategies in place, um, to help them in their job search or their other work such as wellness plans and SSI. We coordinate treatment services with outside providers including substance use. I haven't really covered it in this presentation, but HRA has an extensive line also of substance use specific programming where we offer intensive case management and work assessment in coordination with outpatient and residential (?unclear - 53:40) and harm reduction providers. That's not WeCARE specifically. We provide that

throughout the agency. We also reduce required participation hours based on the condition and we utilize excuse hours for appointments and treatments. So if someone comes in and presents with intensive substance use concerns or mental health condition, for example, where they require regular therapy, then we adjust their hours so that they can take part in those activities. We offer specialized job search to anyone with a medical or mental health condition, rather, the job search with the case manager and job developer is always tailored to what the specific condition is, what their functional capacities are, and what their functional capacities aren't. And again, as I mentioned earlier, we have ongoing case management in addition to working with the job developer in their VRS consulting program. And that concludes my presentation or overview of the WeCARE program and I look forward to your questions at the end of the webinar.

Ms. Mizoguchi: All right. Thank you. So now we will hear from Miranda Gray.

Ms. Gray: Thank you, Carol. Good afternoon and thank you for this opportunity to talk to you about Vermont's Reach Up Substance Abuse and Mental Health program. I've been working in <a> best practice model adding substance abuse, mental health case managers, and clinicians to Reach Up teaming model. To give you some background on why Vermont decided to start this program, about one in five TANF recipients abuse drugs or alcohol. Approximately one third of welfare recipients have a mental health condition that may interfere with employment and then nationally approximately 50 percent of people with a substance abuse condition have a co-occurring mental health condition. So our purpose is to provide integrated substance abuse and mental health services for people in Reach Up. This is done by increasing access to community and case management through our designated agency systems. In many states it is known as the community mental health centers. When we were looking to what we would like to do here in Vermont, we reached out to our federal partners ACF and to ask, "What are other states doing?"

We were connected with the mom's program out of New Haven, Connecticut and then Utah who had clinicians already embedded in their TANF program. To give you some background, this is an Agency of Human Services Interdepartmental program. The departments involved directly with this grant in Vermont include the Department for Children and Family Economic Services Division—this is where our TANF program is housed—the Department of Mental Health and Vermont Department of Health, Alcohol, and Drug Abuse programs. The program was implemented in two phases. In November of 2013 we launched this program in four of our 12 districts throughout the state and then with the governor's help in the legislature we were able to bring up the program in our remaining eight districts in July 2014. We work with 11 agencies across the state to provide services to our Reach Up participants. With few exceptions, all of the agencies provide substance abuse and mental health services and like *** (*unclear - 57:27*) we were given this opportunity to try this program really more so under the guise of substance abuse that we were seeing so prevalent here in Vermont. So our initial model: um, I'm sure what would be provided that service for our participants we decided to place one substance abuse mental health case manager and one clinician in each of our district offices. Due to the nature of who could provide primary mental health services versus primary substance abuse services, the model looked a little bit different in each of our regions. We had to have memorandums of understanding created in certain areas so that it is very clearly outlined how we were going to collaborate together to provide the best support for our participants. Now our initial model: each district manager and clinician were expected to be working with 35 participants and substance abuse and mental health case managers were often doing all of the original case management. In addition to engaging a therapeutic relationship, we were also asking them to create what we call here in Vermont, Family Development Plans of "What do you need to do in order to obtain your

goal of employment?” They were also implementing the fiscal penalties that are a part of TANF law that if you’re not compliant and you’re not engaging, will reduce your grant. Services provided had to be billable under the Medicaid fee schedule. Participants that were not willing to engage could not remain with these case managers and clinicians indefinitely because there has to be billable hours in order to sustain the program here in Vermont. And some of the services provided by case managers under this program included specialized screenings and referral to interagency resources for assessments for substance abuse, mental health, and trauma. The facilities, along with other treatment plans, facilitate and coordinate treatment team meetings. They coordinate closely with our Hub and Spoke department and in Vermont our Hub and Spoke programs are mostly tied to our methadone clinics or are our methadone clinics in some areas. And then also we provide integrated service planning and coordination and specialized community support that is outlined in the state of Vermont fee-for-service Medicaid manual. Medical services provided under this program included access to evidence-based programs such as Seeking Safety which is focused on obtaining safety from trauma and/or substance abuse and our *** (*unclear - 1:00:13*) course and that is a program for parenting mothers who are questioning their own use of alcohol or drugs or who are experiencing the effect of another substance abuse behavior. Diagnosis and evaluation, emergency services, individual therapy, group therapy, as well as case reviews for each case manager and then case consultation toward their teams *** (*unclear - 1:00:34*) basis. We wanted our internal case managers to have the opportunity to present cases anonymously to protect the *** (*unclear - 1:00:44*) you would think that we should possibly engage that participants, because there seems as though there was something going on and help to maybe get them into that...into this program. The *** (*unclear - 1:00:58.*) We the case managers screen all of our new persons *** (*unclear - 1:01:04.*) Positive

results yield a referral for a substance abuse and mental health case manager and/or clinician. Best practice is to hold three-way meetings, introduce the person to the substance abuse and mental health case manager and we are able to do this through having the substance abuse and mental health staff sit in our offices routinely. So currently in our agreement with the designated agencies and preferred providers we have stated that they need to be present in our offices at least one day a week, but what we've found is that often times they are present more, because that is what we found is working to engage participants. Some of our challenges: one of our greater challenges is knowing the physician. This is a really hard job and the compensation isn't that great for these substance abuse *** (*unclear - 1:01:58*) and mental health case managers and clinicians. We're trying to navigate two separate systems of care. If the preferred provider here in Vermont through ADAD <Alcohol and Drug Abuse Division> which can administer the substance abuse services versus our designated agencies through the Department of Mental Health who administers our mental health services. As we know, clearly people have co-occurring and if they're... We're working with some of our agencies that cannot provide both. Determining what the connections to the hub should look like and how to begin a process. One of the things that we did not realize when we were implementing this program was how many of our participants are connected to the methadone clinic. We hadn't taken that into account. So as we've been working through this, the past couple of years we've had to look at "How do our case managers and outside clinicians connect to methadone clinicians? What does that relationship look like? How do we make sure we have coordinated treatment plans and not treatment plans that would be pulling the people apart?" And also, some of the challenges of funding: um, the grantees receive a very small amount of general funds to account for a population that tends to have more no-shows, than others. So they really are needing to focus on

being able to get Medicaid billings to have billable hours and that has been a challenge. Another challenge is *** (*unclear - 1:03:35*) meeting participants and both the case manager and clinician. We found that when the participant had *** (*unclear - 1:03:42*) it's very daunting for them to have to tell somebody else and if they are a person dealing with their case manager and felt a good rapport with them, we ultimately need to get this participant to engage with the clinician and we need to be able to get a diagnosis, create a treatment plan of which a case manager can then provide services and have those billable. We've often struggled with retaining staff. Um, I think since we began this program in November 2013 we still have only three staff that initially started with us still onboard today. This is, you know, a difficult program at times to have people in *** (*unclear - 1:04:24.*) So that is something that we have seen. You know and they're dealing with a lot of people. It's a lot of challenge in their background that is most defined. So that takes a toll for the case managers and clinicians as well. Another challenge here is gathering the data. We three departments, although in the same agency, have no common database. So it's really hard to be able to get information without having the manual process and matching them up. And then also determining what is the effect. Everybody wants to know, "How do you... How many *** (*unclear - 1:04:59*) successful?" And if it is defined as, um, for TANF that we've got some into treatment and now they're off working full-time, they're no longer on assistance or the success that we finally got someone to engage in treatment and they're no longer actively using. The last one *** (*unclear - 1:05:20*) that we found and needed to address is that it was really challenging for our case managers to build a therapeutic relationship when often administering the TANF rules, but it's hard to get someone to open up to you when...if they're not engaging in the Reach Up program, then are part of them receiving a fiscal sanction. That brings us to our present day models. The changes that we made based upon

challenges that we saw. The six agencies are still working with the case manager and clinician model. So, there are still two people who are placed, but we *** (*unclear - 1:05:58*) where it is working really well. Meanwhile, five agencies indeed that has moved to having a clinical case manager model. This is where participants have to tell their story to one less person. They're getting... Participants are getting assessed sooner and not allowed to be able to bill Medicaid, but they're going to have less time, the expense to clients that isn't Medicaid billable. We also, as of July of last year, decided to not have the sub-state and mental health case managers opt to administer the region program. So now they are paired with an internal regional case manager and they work together cohesively of what makes the most sense, um, in terms of treatment, what can we really be doing in the treatment and outside is what can we be asking them to engage, engage in a community service placement at this time and believe that they can really do or do we need to focus on getting them stabilized and then working on some...obtaining support skills? In the Vermont central office, this program of one of my primary rules is I coordinate face-to-face community practices. Essentially what this is, is I bring center all of our providers, our supervisors, our staff that are doing this work, the clinicians, and some state mental health case managers together to talk about what's going well; what are some challenges that we're facing; what training do they need? We've identified that we have a population that has event (*?unclear - 1:07:45*) trauma that we had a significant amount of domestic violence. This is something that our case managers and clinicians felt they needed more support around. So we brought in trainers to be able to give them state resources so that they felt more comfortable and capable of going out and working with our participants. I also coordinate national team meetings in every district. So I pull together all of the supervisors and workers as needed to really go down, "What's doing well in their area?" and if there are folks think that are really *** (*unclear*

- 1:08:19) challenging, how do we overcome those together? And then I've also been working to find ways to collaborate with our Family Services Division, because we have seen a significant amount of caseload overlap just between our TANF and our Child Protective payments. The data that we're currently tracking includes the number of screens. Of the number of screens, the numbers being positive for substance abuse and mental health and then we're *** (unclear - 1:08:49.) Of the number of effects from the new treatment and the number referred treatments, the number of initiating treatment and *** (unclear - 1:08:58) and the number of *** (unclear - 1:09:00) services. Here are our ADAD measures that we decided to *** (unclear - 1:09:04) and moving into our grant cycle this next fiscal year, we're working at how to treat these, because what we found is our model *** (unclear - 1:09:12) functioning and behavior. So we're looking at how many were best enrolled or offered an appointment within three days. So what we found is we have some people that aren't ready; although we've identified they're staying positive, they weren't ready at that moment to engage in treatment. And so it might not be the three days out that they seek the appointment. It might be two weeks. It might be a month and we rely (unclear - 1:09:40) on people and our partners for this. So attached is a graph that we shared with our legislature this year. It shows that 54 percent of participants became engaged with treatment after being screened by our contracted staff. We felt that this was significant, but we are identifying those that need treatment and we're able to get about 64 percent of those that we've identified. That concludes my presentation. If you have any further questions I would be more than happy to talk about our program further. Thank you.

Ms. Mizoguchi: Thank you, very much Miranda. So at this time we're going to ask our final polling question, the third and final question. "Does your program currently have a formal effort in place for addressing mental health services or mental health issues among program

participants?” (Pause.) Hmm. Okay. I’m not sure what’s going on with the *** (unclear - 1:11:04.) Okay. So I just want to say thanks to our wonderful presenters who provided a wealth of information that we can all use as we work with TANF families and now we’re going to open up the session for questions from those of you on the phone lines on the webinar. There’s one question I see. Marcia Bigley had a question for you Tim and her question is, “How many SSI appeals will reach your staff to assist with before they determine that the client might need a different plan?”

Mr. Cantrell: We work in tune to work with them and even throughout the appeal process and post process, uh, to apply for SSI it needs to fulfill a clinical basis, the fact is the most appropriate track for that person. So when you apply for SSI it’s all about how well the case is constructed and documented. So you go through the process of the initial decision and then you can have...if that’s denied, you can do an appeal and the results are on an administrative level will appeal after that. If the client continues to be denied in that process and they come back and they come back for us, to us for assessment at that point, if the assessment comes back as an SSI, we will continue to keep them in that track. I hope that answered the question.

Ms. Mizoguchi: Thank you, Tim. Okay, so we’ll just give a few seconds here and see if there are any more questions. There’s a question. “So if a client is receiving SSI for her child, can she still apply for TANF?” And I think Miranda or Tim can tackle that one.

Mr. Cantrell: She should still be able to apply for SSI, but of course our TANF application is all about family income and SSI does tend to be higher level of benefit than the regular TANF benefits. So depending on family circumstances, at the end of the day the application might not be approved, but it’s all really going to be case driven.

Ms. Gray: And for Vermont, we've got a mom with a child *<unclear>* would be eligible. We say that that child still makes them eligible and we don't look at SSI income for children in Vermont.

Ms. Mizoguchi: Wonderful and here's... There's a question for Vermont. "How does clinical case manager's deal with the inherent dual relationship, i.e., the clinic case managers monitor participation?" So...

Ms. Gray: Yeah, um... I'm sorry, go ahead.

(Silence.)

Ms. Gray: So how do clinical case managers deal with inherent dual relationships? Um, I think what we have found... You know it's that kind of detailing that we've found with our participants is the not having to engage with in a relationship with two people and a lot of it...and maybe it's a bit unique to Vermont, but my feeling is a lot of clinicians are doing case management work anyway, helping clients navigate other areas of their life if it is that they have... They don't know how they're going to pay their rent, you know, this month, then they're kind of stepping in that role anyway and this just allows for that to happen more naturally. You know that not being a clinical case manager myself, I'm not exactly sure how, you know, to be able to speak further, but that's my understanding is that, you know, where we have this model it seems to be working. Um, but it's in terms of one less person for our client to have to talk about their story with.

Ms. Mizoguchi: Great. Thank you. Okay, so we're going to see if we can get some more questions. Oh, here's a question now. "When a client is denied for SSI where would they get the information to appeal? Is it online?" Tim or Miranda.

Ms. Gray: I'm not sure here in Vermont, because we don't... We contract out for those services. So I'm not sure. So I would defer to Tim if he has an answer.

Mr. Cantrell: I don't have the information. I don't know specifically whether it is online. I would suspect it is on the SSA website, but I can't answer that tentatively. For us from a programmatic perspective we actually have a unit that helps them with that appeal so long as they have not elected to have separately what's called a "****" (*unclear - 1:17:50*) to...which is like a vendor or someone like that who may be taking the case with them. We have a specific unit, so we help them with that actual appeals process, but from a public perspective just "Joe on the street," I would have to think it's on SSA, but I can't say for sure.

Ms. Mizoguchi: And there's a comment from Indiana saying that they actually give a paper application. It says it's very simple. And I know in Washington state we have tearing off **** (*unclear - 1:18:25*) and contracting out with attorneys, but it sounds like it varies from jurisdiction to jurisdiction. Someone else has commented that you can appeal the decision online through the Social Security website. Okay, so I have a final question, I guess, or if there are any more from the audience. So I just want to ask the panelists if they just want to offer a piece of advice for TANF programs interested in better providing mental health services to TANF or low-income participants. So in addition to all of the wonderful very rich information that you've already provided, if there's just like a, you know, a take away that you want the participants on this webinar to leave with, um, that would be great. And so I'm going to start with Dr. Spinner since she led us off and we'll just let her answer first.

Dr. Spinner: Yeah. In terms of advice for TANF programs, I suggest that in the light of what I've presented today it's important to think about families and TANF recipients as persons who are willing and able to seek mental health services, but require as much support as they can get and also to think about how agencies can build in a strength-based approach to services, making services culturally appropriate, and just ensuring that the services are beneficial to the whole

family and you know with all the services there are stipulations and guidelines and it's important to understand how those can be applied and might be applied. I think in terms of mental health services it's not only the problem areas. Like I explained, the need for mental health services are not necessarily connected to violence or particular behaviors and it's about doing that screening and helping recipients and families to think about how they plan around, again, to finding and using the services they need. So that would be my take away.

Ms. Mizoguchi: Thank you. Tim?

Mr. Cantrell: I think the one thing that I would offer as an observation as a piece of advice is it really is not an either/or decision in terms of balancing, you know, health petitions or any medical condition, an inclusion in a workforce development program into get the client back to work. In fact, I think the integration or the collaboration, if you will, between the two is really instructed to any client who has such a condition and how they're going to be able to balance their life going forward, because you know in many cases a mental health condition is not necessarily going to resolve itself and even if they do or when they find employment it's something that is going to have to be balanced against the other demands in their lives. So I should think, you know, my recommendation or my hope or my observation would be that we find ways to make sure that we have a fully integrated model that ensures that people are getting these mental health services while at the same time - to the extent that their condition allows, obviously, - that we keep them moving in the direction of employment ultimately and that's what's going to serve them best.

Ms. Mizoguchi: Wow. Thank you. Okay, Miranda.

Ms. Gray: Tim's a hard one to follow.

(Chuckle.)

Ms. Gray: So I guess my last piece of advice is if there's a way for you to find a way to bend (?) some of these mental health services into your program, I encourage you to do so because I think it is important to help people by getting these barriers addressed. It's going to help them to find ways to employment or maybe a point to identify that the Social Security route is the one that we need to be pursuing assistance. It opens up other opportunities for our participants to be able to move forward and become more self-sufficient and that hopefully then one day not need our services in the same capacity that they do today.

Ms. Mizoguchi: Great. Wow, well this is very, very enlightening. I think mental health, when we hear that its very intimidating and how all these different thoughts go through our head and we think about the material and sometimes it's presented in a real dry manner and so...but this, you all, the presenters, I just want to say, thank you, because you guys definitely exceeded our expectations here at OFA. It was very informative and I think from the questions it was also engaging and the folks that participated in the webinar, I want to thank you again and as far as the audience, thank you for calling in. And I just want everybody to just remember that to provide your feedback on this webinar using the survey that will appear in a separate pop-up window when the webinar ends and also a transcript and audio recording of this webinar will be available shortly on the Peer TA Network website which is at peerta—and that's one word—<https://peerta.acf.hhs.gov/>. >We would like to just hear from you as far as any future webinar topics that you have thoughts or ideas of things that you would like for us to research and present that would be great. And you can send your ideas by email to peerta - again, that's one word - [@icfi.com](mailto:peerta@icfi.com)<<mailto:peerta@icfi.com>> And then, as always, we've mentioned this before, but we are very... We're looking to expand our network and reach a greater number of people and so we would appreciate if you would just direct your colleagues from your local

and state networks and agencies to our website and again, that website is <https://peerta.acf.hhs.gov/> . And we look forward to your participation on future webinars, and again, just I would like to thank all of the participants and definitely I would like to thank all our expert presenters.

(End of webinar - 1:26:56.)