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Determining Appropriate Outcome Measures in a Psychosocial Rehabilitation Model for the Mentally Ill: a Knowledgeable Citizen's Perspective

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DETERMINING APPROPRIATE OUTCOME MEASURES IN A PSYCHOSOCIAL REHABILITATION MODEL FOR THE MENTALLY ILL: A KNOWLEDGEABLE CITIZENS' PERSPECTIVE

By

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This dissertation research focused on the determination of appropriate outcome measures for community-based psychosocial rehabilitation programs for the mentally ill from the perspective of knowledgeable citizens. Specifically, this research identified a conflict between the Mississippi Department of Mental Health, as the certifying agency, and the Mississippi Division of Medicaid, as the funding agency, with regard to the transitional employment component of the psychosocial rehabilitation program.

In order to ascertain whether transitional employment should be retained in the psychosocial rehabilitation program, survey questionnaires and in-depth interviews were completed with one hundred and sixty-eight consumers and twenty-three staff in six psychosocial rehabilitation Clubhouse programs in north central Mississippi. The survey questionnaires and interviews focused primarily on the effects of demographics, diagnosis, and barriers to employment on the willingness of consumers with mental illness to participate in transitional employment.

Eleven independent variables were identified including age, living arrangements, years of attendance in the psychosocial rehabilitation program, diagnosis, stigma/attitudes, external influence, symptoms of mental illness, training/experience/education deficits, social/cognitive/behavior deficits, financial barriers, and total barriers to employment. Mixed methodology found convergence between quantitative and qualitative findings with regard to seven independent variables and differences with regard to four. Mixed methods found age, living arrangements, and years of attendance in the psychosocial rehabilitation program were not predictive of willingness to participate in transitional employment. Mixed methods found that stigma/attitudes, external influence, symptoms of mental illness, and total barriers to employment were predictive of willingness to participate in transitional employment. Symptoms of mental illness were found to have the greatest impact.

Mixed methods also differed in the findings with regard to four variables. While no statistical significance was found to support diagnosis, training/experience/education deficits, social/cognitive/behavior deficits, or financial barriers as predictors of willingness to participate in transitional employment, substantively these variables are important. Based on the findings, the study recommends adjustments and considerations by the Mississippi Department of Mental Health, the Mississippi Division of Medicaid, and the psychosocial rehabilitation programs that will reconcile the differences and lead to the development and implementation of appropriate outcome measures.

DEDICATION

This work is dedicated to Joseph Baker, my husband of thirty-seven years, and my partner in every endeavor. No one has been more patient and supportive of my effort and the sacrifices necessary to balance work, family, and academic pursuits. This work is also dedicated to my children, Angela, Andrew, and Ashley. My children share the belief of their parents in the value of a college education and the pursuit of a career. As we attended classes at Mississippi State University, often at the same time but in our respective fields of interest, we challenged each other to set high goals and push for attainment even when it felt impossible. Their encouragement has been a sustaining force.

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CHAPTER I

INTRODUCTION

Outcome measures are becoming the financial lifeline for publicly administered mental health programs. Comparing and contrasting the New Public Management framework with the beginning of a shift toward Public Value Theory governance in public administration, the author investigates the determinants of efficient and effective outcome measures in a community-based psychosocial rehabilitation program for adults with mental illness. The author further examines social justice theory, active citizenship, and the theory of intrinsic work motivation to evaluate the integration of a transitional employment component into the psychosocial rehabilitation process.

This study examines the Mississippi Department of Mental Health Operational Standards for Mental Health, Intellectual/Developmental Disabilities, and Substance Abuse Community Service Providers (DMH, 2010; DMH, 2011), the Mississippi Division of Medicaid definition of psychosocial rehabilitation and criteria for reimbursement (DOM, 2011), and barriers to currently defined successful outcomes in the psychosocial rehabilitation program.

Utilizing a qualitative approach which includes a case study, structured interviews, and document and record analysis, triangulated with a quantitative approach utilizing a multivariate regression model of defined independent and dependent variables, the author explores the determinants of efficient and effective outcome measures in the

community mental health center- based psychosocial rehabilitation programs in six counties in Mississippi.

Statement of the Problem

The mental health system in Mississippi serves clients in the both the public and private sector. The Mississippi Department of Mental Health, based in Jackson, has oversight and certification responsibilities for mental health, intellectually/developmentally disabled, and alcohol and substance services in the public sector, with some entrance into the private sector when public money is reimbursed for private services. Authority for this oversight and certification was provided by the Mississippi Code of 1972 as follows:

Statutory Authority

The Mississippi Department of Mental Health (hereafter referred to as "DMH") is the state agency charged with administering the public system of mental health, intellectual/developmental disabilities, substance abuse, and Alzheimer's Disease and Other Dementia Services. The agency was created in 1974 by an Act of the Mississippi Legislature, Regular Session. The creation, organization and duties of the DMH are defined under Section 41-4-1 through 41-4-27.

The State of Mississippi vested standard-setting authority in the DMH through Section 41-4-7 of the *Mississippi Code, 1972, Annotated,* which authorizes the Department to:

- supervise, coordinate, and establish standards for all operations and activities of the state, related to mental health and providing mental health services (Section 41-4-7 (c));

- certify, coordinate and establish minimum standards and establish minimum required services for regional mental health and intellectual disability commissions and other community service providers for community or regional programs and services in mental health, intellectual disability, alcoholism, drug misuse, developmental disabilities, compulsive gambling, addictive disorders and related programs throughout the state (Section 41-4-7 (f)); and,

- establish and promulgate reasonable minimum standards for the construction and operation of state and all DMH certified facilities, including reasonable minimum standards for the admission, diagnosis, care, treatment, transfer of patients and their records, and also including reasonable minimum standards for providing day care, outpatient care, emergency care, inpatient care and follow-up care, when such care is provided for persons with mental or emotional illness, intellectual disability, alcoholism, drug misuse and developmental disabilities (See Section 41-4-7(g)) (DMH, 2011).

The primary service providers at the local level for mental health, intellectually/developmentally disabled, and alcohol and drug services and programs are the fifteen Regional Mental Health Centers. "The community mental health centers in Mississippi were formed as a result of the Federal Community Mental Health Centers Act of 1963, mandating community access to mental health care. The Mississippi State Legislature passed the Regional Commission Act of 1972 to organize its own community mental health centers. The state is divided into 15 mental health regions according to population" (CMHC, 2011).

These agencies were further established as public nonprofit political subdivisions of the counties in which they operate. There are differences among the Community Mental Health Centers in the number of counties represented, ranging from one county to ten; the number of clients served; annual budgets; and the number and variety of programs and services offered. In contrast, each Center is required to offer a specific array of core services; to conform to the Operational Standards for Mental Health, Intellectual/Developmental Disabilities, and Substance Abuse Community Service Providers developed by the Department of Mental Health; and to have programs and

services certified by the Department based on compliance with these same Standards. The most recent Operational Standards became effective January 1, 2011 (DMH, 2011), and include language introducing evidence-based outcome measures for the first time. Funding for services provided by the Community Mental Health Centers varies but a majority of the Regions report receiving more than 75% of their annual operational revenue from Medicaid fee-for-service reimbursement (DMH, 2010).

As the federal government has introduced more accountability measures in the form of evidence-based outcome measures, the state is struggling to identify and require implementation by the Community Mental Health Centers. Input from the Community Mental Health Centers on appropriate measurement instruments has been limited. Prior to this initiative, the Community Mental Health Centers were required to submit Annual Program Plans and Evaluations which were a precursor to evidence-based outcomes, mostly consisting of utilization numbers and limited attempts to address how effectively a program had met some pre-identified, mostly subjective, service goals. Although credit must be given for the attempts made to evaluate programs internally, there was no standardization of goals among the Community Mental Health Centers and no ability to generalize any level of effectiveness across similar programs across the state. The implementation of evidence-based outcome measures holds promise at least in the area of generalizable evaluation data.

Despite the planned improvement in data collection, the effectiveness and efficiency of individual programs offered by both the Department of Mental Health and the Regional Mental Health Centers continues to be an area of concern. The rising cost of healthcare in the United States and the expected additional impact of Healthcare Reform will undoubtedly force all levels of government to seek avenues to reduce costs.

Healthcare currently demands 35 % of the state of Mississippi's annual budget (Chantrill, 2011). On a federal level, the Medicare/Medicaid/CHIP entitlement program commands a whopping 21% of the federal annual budget and continues to grow (Center on Budget and Policy Priorities, 2010).

As Medicaid is a federal-state match program, Mississippi is positioned better than most with lowest state-required match in the country. Having been in the 23% range for a number of years, federal stimulus money resulting from the American Recovery and Reinvestment Act of 2009, reduced the match for Mississippi to 15.4% (Kegley, 2010). As the drop was temporary, the match rate has begun to climb back to the pre-American Recovery and Reinvestment Act of 2009 level, expecting to be at 24.9% by July 1, 2011. At the current time, the state of Mississippi appropriates general fund money for the purpose of Medicaid match for all Medicaid services except services provided by the Community Mental Health Centers. For an extended period of time, the Community Mental Health Centers have paid their own Medicaid match, creating a significant financial burden and endangering the ability of some Community Mental Health Centers to continue to provide services. In the spring of 2010, a memo of understanding was negotiated between the Department of Mental Health and the Community Mental Health Centers, with approvals by the Governor's Office and the Division of Medicaid, to require the Department of Mental Health to pay 50% of the federal match obligation for the Community Mental Health Centers from the Department's operating budget. Neither the Department nor the Community Mental Health Centers have the ability to sustain long term payments of the match and legislative relief is being pursued although full funding is doubtful. The implication of this action is that the state of Mississippi, in its FY2012 budget, is being asked for approximately $43 million for match for current

Community Mental Health Center service levels even before the impact of the tremendous increase in Medicaid expenditures anticipated as a result of healthcare reform (Kegley, 2011). It seems reasonable to speculate that the array and amount of Medicaid services across the nation will be substantially altered or reduced over the next few years as both the state and federal government are unable to support the funding requirements.

Given the cost constraints, programs and services must compete for viability. With outcome measures and cost being the likely policy drivers in the political arena, administrators and practitioners, as citizens with relevant knowledge, have a primary role in establishing the outcome measures that will drive the policies. Unfortunately, as the tenants of New Public Management have been embraced in the public sector, outcomes are often secondary to costs in the efficiency/effectiveness battle.

Background

The Clubhouse Model

According to the National Alliance on Mental Illness, "one out of every five families in Mississippi has a member who suffers from a serious mental illness" (NAMI, 2011). The array of mental health services available to an individual in a Community Mental Health Center in Mississippi is based on the client's level of need. General services include individual, group, and family therapy, psychiatric evaluation, medication monitoring, case management, and psychosocial rehabilitation. In some regions of the state, group homes, supervised housing units, or transitional housing units are available. This study will focus on the six psychosocial rehabilitation programs operated by one of the larger Community Mental Health Centers in Mississippi.

Demographically, the consumers range in age from eighteen to fifty-five, with the highest percentage from age thirty to forty. Approximately 60% are female; 40% are male. 80% are Afro-American; while 20% are Caucasian. All are low income; most draw social security or social security disability income. In two of the counties, 50% of consumers in the psychosocial rehabilitation program reside in supervised apartments, independent of family and caretakers. (BTI, 2011).The Department of Mental Health subscribes to the Clubhouse Model of psychosocial rehabilitation developed by Fountain House.

> " The origins of Fountain House lie in the idea which inspired a small group of people back in the 1940's - the belief that people with mental illness are capable of helping each other. In a little more than sixty years, that vision has yielded a supportive community that annually helps some 1300 people in New York City and is the inspiration for 55,000 people in Fountain House model programs around the world" (Fountain House, 2010).

The Clubhouse Model utilizes a work-ordered day to mimic social situations in the workplace. The goal is to foster the work habits of daily attendance, task completion of meaningful work assignments, and development of the essential social skills necessary to transition to the community workforce. Clubhouse participants meet the Diagnostic and Statistical Manual (DSM IV) criteria for an Axis I mental illness diagnosis. A significant number of the consumers suffer from schizophrenia, bipolar disorder, or major depression and almost all are prescribed psychotropic medications to manage their disease symptoms.

Under the Clubhouse Model, the program consists of two major components: the task-oriented work units within the Clubhouse facility and transitional employment opportunities for consumers. The work units within the Clubhouse are designed to mimic

potential employment positions in the community. Units vary among Clubhouses but some of the more common work units include the kitchen unit, snack bar unit, clerical unit, library unit, thrift store unit, maintenance unit, and gardening unit.

The kitchen unit is responsible for the planning, preparing, serving, and clean-up of the noon meal. The snack bar unit stocks and sells snacks throughout the day including short order breakfast items. The clerical unit maintains time and attendance and documentation for each of the other work units and develops and prints a Clubhouse newsletter. The library unit categorizes books and videos, checks items for loan in and out, and facilitates consumer access to computers. The thrift store unit accepts donations, launders clothing, sorts and prices items for sale, and sells donated items to consumers at very discounted prices. The maintenance unit performs custodial and janitorial tasks. Finally, the gardening unit performs yard maintenance and prepares, plants, maintains, and harvests a vegetable garden for consumer consumption. Some of the Clubhouses have developed units for the clean-up and preventive maintenance of program vehicles, security, and videotaping and producing an internal newscast. Each consumer is aware that participation in a work unit within the Clubhouse is an expectation and most participate without a high level of prompting.

It is important to understand the management concept of the Clubhouse Model. Based on the New York City Fountain House Model, the Clubhouse belongs to the consumers and is run by the consumers. Staff provide support, encouragement, and assistance when needed. In the programs discussed in this study, the staff also provide transportation and serve as drivers. Consumers are free to provide their own transportation if they choose but less than 3% are able to do so. In some Clubhouses across the state, the agencies provide vans but consumers serve as drivers. Based on the

work units described, it can be demonstrated that individuals develop a wide variety of job skills which can be translated into the skills and experience necessary to perform a vast number of entry level job tasks in the community that are far beyond the limited janitorial duties often associated with the mentally ill.

Transitional Employment

The second component of the Clubhouse Model is the transitional employment program. Historically, each Clubhouse had a target goal of 25% of Clubhouse members employed in transitional employment positions, with an allowance that 10% of placements could be in positions within the Community Mental Health Center. The new Operational Standards are much more lenient in the number of placements required but continue to address employment opportunities as a key aspect of Clubhouse activity. According to the Mississippi Department of Mental Health Operational Standards:

> X.A.6. Transitional, supported and independent, employment opportunities must be an integral part of Psychosocial Rehabilitation/Clubhouse Services and must be available to at least 10% of the number of participants the program is certified to serve.
>
> X.A.7. A minimum of one (1) transitional employment placement must be available in a competitive employment setting in the community in which individuals without disabilities are also employed and that is not operated by the provider program. Transitional employment placements must be part-time and time-limited, generally fifteen (15) to twenty (20) hours per week and six (6) to nine (9) months in duration.

The Clubhouse transitional employment placement is an interesting concept. Instead of an employer hiring an individual, the job belongs to the Clubhouse. A Clubhouse staff member is responsible for training the consumer in the elements of the job, providing supervision, providing support and coaching, and providing retraining, when needed. The most unique feature of the transitional employment placement is that, in the event the consumer is absent for any reason, the Clubhouse staff members agree to work the job so that the needs of the host company are met. Consumers are paid by the host company for their work, usually minimum wage, and consumers are limited to working 15 to 20 hours per week. A consumer must rotate from a transitional employment placement every six to nine months but the consumer can move to another transitional employment placement if one is available.

From concept to practice, the transitional employment placement program has met with varying success. Frequently, employment opportunities involve shift or weekend work and Clubhouse employees are reluctant to give up family time to work in place of consumers that are developing reliability skills. Conversely, employers are reluctant to allow individuals not formally employed to work in their businesses for liability reasons. Despite these obstacles, Clubhouse staff have been successful in finding employment opportunities for consumers in the communities. Consumers, ironically, have become the greatest obstacles to program success. Despite a willingness to participate in internal work units, consumers have demonstrated a reluctance to participate in the transitional employment placement program.

Ten years ago, a survey was conducted with the participants in these same psychosocial rehabilitation programs. 40% of current consumers were attending the Clubhouses at that time. The survey findings indicated that 98% of consumers at that

time (n=165) did not wish to pursue temporary or permanent employment outside the agency (CMHC, 2001). At that time, there were adequate transitional employment placement opportunities in all but one of the counties with Clubhouses. Despite recruitment attempts, Clubhouse staff continue to report a high level of reluctance by consumers to participate in the transitional employment placement program. The contrast in motivation for internal versus external work is an important area of research. Based on the Clubhouse Model, the primary program goal is to build social skills and appropriate work habits with the end goal of transitioning a mentally challenged but stable consumer back into the work force.

Expectations of the Certification and Funding Agencies

According to the Department of Mental Health (2011), 5158 individuals were served in 64 clubhouses across the state of Mississippi in 2010. The psychosocial rehabilitation clubhouse model utilized in the community mental health centers today looks substantially different from its inception in 1988. At that time, the Mississippi Department of Mental Health and the community mental health centers engaged in a collaborative effort with the Mississippi Department of Rehabilitation Services to establish the Mississippi Systems Integration Program (DMH, 2011). This effort was specifically intended to expand vocational rehabilitation services to the mentally ill. Initially implemented as a five-center pilot project, the Mississippi Systems Integration Program project was expanded statewide in 1992. “Vocational Rehabilitation made federal money available to allow Clubhouse programs to hire job development staff to help expand the service to strategic Mental Health Regions. These transitional

employment specialist positions are funded jointly by monies from both" (MSIP, 1993, p.1).

According to the Mississippi Systems Integration Program's transitional employment philosophy:

> "work and the capacity for independent living have a positive effect on the self-concept/self-worth, and are vehicles for continued learning and growth by people with long-term mental illness.
>
> A. The opportunity to work is fundamental for the well-being of people with mental illness.
> B. Staff and members are committed to increased and improved employment opportunities for people with serious mental disabilities who have been traditionally underserved.
> C. With appropriate training and support, people with severe mental illness can be valuable employees.
> D. As with the psychosocial rehabilitation model, transitional employment placement also identifies and builds on members' strengths and skills rather than emphasizing alleviation of deficits or symptoms" (MSIP, 1993, p. 7).

The philosophy of transitional employment within the psychosocial rehabilitation programs has not changed over the years. However, by the late 1990's, funding for the collaborative positions ended and the psychosocial rehabilitation programs were expected to absorb the cost of providing transitional employment from program revenue derived from fee-for-service primarily from Medicaid. Through the years, the unfunded specific-duty positions of transitional employment specialists have been diminished to the point where transitional employment is often now a component responsibility within the job duties of the psychosocial rehabilitation program manager.

The *FY2011 Mississippi State Plan for Community Mental Health Services* addresses the "Areas on Which Attention Was Focused in FY2010 for Adults with Serious Mental Illness" (DMH State Plan, 2011, p. 8). These include: "Improving the quality of clubhouse psychosocial rehabilitation services throughout all services throughout all service regions of the state and expanding the number of International

Center for Clubhouse Development-certified clubhouses to a minimum of one in each community mental health region in the state" (DMH State Plan, 2011, p. 8).

Further, the plan identifies the following strength in community-based adult services: "Implementation of the comprehensive service system for adults with serious mental illness reflects the Department of Mental Health's long-term commitment to providing services, as well as supports, that are accessible on a statewide basis. The Department of Mental Health has continued efforts to improve the clubhouse programs by providing technical assistance on the International Center for Clubhouse Development program model; International Center for Clubhouse Development-certified programs have been developed that can serve as more cost-effective in-state training sites. The Department of Mental Health Division of Community Services plans to expand the International Center for Clubhouse Development-certified clubhouses to each region in the state" (DMH State Plan, 2011, p. 23).

An important component of the clubhouse model is transitional employment. The expectation in the model is that 25% of consumers in an International Center for Clubhouse Development-certified program will be actively engaged in transitional employment (Fountain House, 2010). The current Operational Standards for Mental Health, Intellectual/Developmental Disabilities, and Substance Abuse Community Service Providers, Part X, Psychosocial Programs state:

> X.A.6. "Transitional, supported and independent, employment opportunities must be an integral part of Psychosocial Rehabilitation/Clubhouse Services and must be available to at least 10% of the number of participants the program is certified to serve.
>
> X.A.7 A minimum of one (1) transitional employment placement must be available in a competitive employment setting in the community in which individuals without disabilities are also employed and that is not operated by the provider program. Transitional employment placements must be part-time and

> time-limited, generally fifteen (15) to twenty (20) hours per week and six (6) to nine (9) months in duration" (DMH Operational Standards, 2011, p. 104).

The minimum requirements for transitional employment participation by consumers have been attributed to the outgrowth of the economic recession, job loss and the high unemployment rate in Mississippi. While there is little doubt that these are contributing factors, the absent role of the Department of Rehabilitation Services should be considered as a factor in terms of loss of funding, support, and vocational intervention expertise. Further, this study will focus on the citizen perspective to determine how those with first-hand knowledge of the psychosocial rehabilitation and transitional employment programs view and evaluate prospective program outcomes. It is expected that the findings of this study will demonstrate a disconnect between the expectations of the Department of Mental Health and the ability of the psychosocial rehabilitation programs to effect the desired outcomes related to transitional employment.

In addition to the issues raised by the expectations of the Department of Mental Health, the role of the Mississippi Division of Medicaid exerts a major influence on the activities of psychosocial rehabilitation related to transitional employment as the primary source of funding for the psychosocial rehabilitation programs in community mental health centers in Mississippi. Psychosocial rehabilitation is reimbursed on a fee-for-service basis. A service consists of a fifteen minute increment of time in which services are provided that are certified by the Mississippi Department of Mental Health. A maximum of twenty units (fifteen minute increments) per day and a maximum of five days per week are eligible for reimbursement (DMH, 2011). In addition, each individual for whom reimbursement is requested must qualify for Medicaid services under the *Medicaid Eligibility Guide* of the Division of Medicaid.

The Division of Medicaid defines psychosocial rehabilitation as follows:

> "Psychosocial Rehabilitation is a program of structured activities designed to support and enhance the role functioning of beneficiaries with serious and persistent mental illnesses who are able to live in their communities through the provision of regular, frequent environmental support. Program activities aim to improve beneficiaries' reality orientation, social adaptation, physical coordination, daily living skills, time and resource management, and task completion as well as to alleviate such psychiatric symptoms as confusion, anxiety, disorientation, distraction, preoccupation, isolation, withdrawal and feelings of low self-worth. The program must operate with a minimum of five (5) beneficiaries per day for a minimum of two (2) hours per day for two (2) days per week. Psychosocial Rehabilitation may be provided to adults with SPMI" (DOM Provider Policy Manual, 2001, 15.05).

The Division of Medicaid's definition of psychosocial rehabilitation does not include reference to transitional employment by intent. According to the *Mississippi Division of Medicaid 5-Year Strategic Plan FY 2010-2014,* one of the strategic goals of the Division of Medicaid is to "maximize revenue by containing costs, eliminating duplication, and using all sources of funds" (DOM Strategic Plan, 2010, p. 2). The elimination of duplication is particularly relevant to the role of the Division of Medicaid in funding psychosocial rehabilitation.

The Division of Medicaid does not fund services that are intended to be funded by an alternative source, such as another state agency. Consequently, the Division of Medicaid does not fund vocational or educational services with the understanding that such services should be funded by the Department of Rehabilitation Services and the Department of Education respectively. Since neither the Department of Rehabilitation Services nor the Department of Education fund psychosocial rehabilitation in the community mental health centers, services such as General Equivalent Diploma instruction, vocational training, and job coaching are unfunded despite their relevance to vocational intervention. Even if a funding source could be identified, Medicaid prohibits

such activities from occurring during the five hours per day that Medicaid is reimbursing the program.

In summary, the Department of Mental Health requires transitional employment as a component of psychosocial rehabilitation; the literature heavily demonstrates the value of employment in areas of self-esteem and quality of life issues for the mentally ill; but the funding mechanism prohibits primary program time from being used to provide the educational and vocational supports necessary to effect successful transitional employment outcomes. The fact that the Division of Medicaid neither funds the supports necessary for transitional employment within the psychosocial rehabilitation program nor includes transitional employment within its definition of psychosocial rehabilitation suggests a conflict between the expectations of the certifying agency and the expectations of the primary funding agency. This research is intended to suggest policy considerations in the resolution of this conflict from a citizens' perspective.

The Purpose of the Study

The purpose of this dissertation is to explore the outcome expectation differences between the Department of Mental Health, as the program certification agency; the Division of Medicaid as the primary program reimbursement agency; and the barriers to expected outcomes from the perspective of citizens in their dual roles as citizens and consumers, and citizens and professionals, respectively. With New Public Management tenants having established a foothold in Mississippi public agency management and a developing dialogue on the benefits of adopting a Public Value Theory component, this research will focus on two primary research questions:

Research Question 1

How are the differences in outcome expectancies between the Department of Mental Health and the Division of Medicaid best reconciled?

- What are the barriers to reconciliation?

Research Question 2

Based on Public Value Theory, Social Justice implications, and the claims of Active Citizenship, what outcomes are deemed appropriate to the psychosocial rehabilitation program by citizens with a dual role as consumers or professionals?

- How are the suggested outcomes reconciled with the New Public Management tenants embraced by the Department of Mental Health and the Division of Medicaid?
- What are the barriers to adopting the proposed outcomes?
- What does the psychosocial rehabilitation program look like after the reconciliation?

The determinants of the answer to the first question are derived from an analysis of the current and historical development of the certification standards implemented by the Department of Mental Health and the reimbursement guidelines adopted by the Division of Medicaid. The analysis of the Department of Mental Health certification standards will develop an understanding of how psychosocial rehabilitation theory and stages of change theory have defined the model of psychosocial rehabilitation embraced by the certifying agency. The analysis of Division of Medicaid reimbursement methods and defining of psychosocial rehabilitation will develop an understanding of how the application of the New Public Management tenant of efficiency has been applied to create barriers to effective management and a resulting conflict with the outcome expectancies of the Department of Mental Health.

The determinants of the answer to the second question are derived from a case study of six psychosocial rehabilitation clubhouses in Mississippi under the same professional and business management, similarly certified for program operation by the Department of Mental Health, and primarily reimbursed on a fee-for-service basis by the Division of Medicaid. Concurrently with the case study, the research will incorporate the citizen participation aspect of the public value theory to define the consumers and professions participating in the programs as having a dual role as citizens. In this capacity, a structured interview questionnaire will be administered to identify goals and outcomes for the programs based on the participant's role as a citizen and those goals and outcomes for the program attributed to the participant's role as either a consumer or a professional. Since the focus of this research is primarily on the transitional employment aspect of psychosocial rehabilitation in the Clubhouse Model, the questionnaire will address issues related to income, age, ethnicity, education, diagnoses, symptomology, medication, living arrangements, family support, and previous work history. The questionnaire will apply work motivation theory to determine readiness for work, interest level, and motivation to participate in the transitional employment program while attempting to identify the institutional, programmatic, and internal barriers to participation and successful outcomes currently defined. A quantitative multivariate analysis of the data utilizing the Statistical Package for the Social Sciences (SPSS) will be performed in order to triangulate findings with the qualitative analysis to further support the research conclusions.

CHAPTER II

PUBLIC ADMINISTRATION PROCESS: A LITERATURE REVIEW AND THEORETICAL PERSPECTIVE

Public administration theory has evolved substantially over the past one hundred years. At the present time public agencies in Mississippi are rooted heavily in the paradigm of New Public Management, eagerly adapting outcome measures, implementing expense management practices, and mirroring the practices of private sector businesses. Participants in psychosocial rehabilitation programs are referred to as "consumers" and the expectations of efficiency in low-cost program operation and effectiveness in achieving goals of program attendance, improved socialization skills, and workplace re-entry are openly communicated. Despite this, New Public Management is not adequate to determine evidence-based practices and appropriate outcome measures. New Public Management fails to consider the role of the participant and the citizen in the design of programs or in the determination of the criteria for outcome measurement. On a macro level, Public Value Theory, Social Justice Theory, and Active Citizenship Theory offer an explanation of the appropriate role and value of the knowledgeable citizens' perspective. In addition, Intrinsic Work Motivation Theory offers an understanding of the compatibility or conflict between the activities within the psychosocial rehabilitation program and the intent of the program activities as defined by the certifying and funding agencies. A further discussion of the theories outlined in this framework is necessary.

New Public Management

The evolution of public management theory continues, although the tenants of New Public Management have gained a firm foothold in public administration. Developing from politically appealing demands in the 1980's to downsize government, reduce waste and spending, and develop accountability measures, New Public Management challenged demands for the privatization of governmental functions by adapting private sector business practices to governmental agencies.

Much of the New Public Management literature utilizes case studies to demonstrate New Public Management applications for analysis and critique. Donald Kettl describes the advent of the Government Performance and Results Act of 1993 as resulting in one of the most significant examples of public management reform in the United States (Kettl, 1995). "The Clinton administration capitalized on popular support for downsizing by linking NPR to a dramatic cut in the civilian federal workforce, claiming a budget savings of $100 million" (Barzelay, 2001, p. 33). This theme: that downsizing equals efficiency, has not been without its critics. With regard to New Public Management in particular, Kettl claims that support from Congress for proposals that promised savings were very forthcoming but as members of Congress faced the direct impact of these savings on their constituency, the support just as quickly faded (Kettl, 1995).

New Public Management includes many concepts foreign to our long running, traditional governmental bureaucracy, a bureaucracy that has grown exponentially in size and scope since its inception by our Founding Fathers. Osborne and Gaebler (1992) attribute the doctrines of adapting and changing organizational culture, reengineering, the concept of the "customer" both externally and internally as a service focus, and the

principles of total quality management as the key aspects of improvement in the New Public Management.

Table 1 presents comparisons that broadly identify the management focus shift from traditional bureaucratic management to governance under New Public Management (Ewalt, 2001). An analysis of Ewalt's (2001) assessment of the shift from traditional bureaucratic governance to management mirroring the private sector under New Public Management demonstrates the authority and interest differences between the two models. Under the model of traditional bureaucratic governance, the primary focus is rule implementation, cost-control, and a procedural focus, with the interests of the government dictating the services provided to the citizens. In this model, efficiency takes clear precedence over Table 1 effectiveness.

Table 1 Comparison of Bureaucratic and Governance/New Public Management Implementation

Bureaucratic Implementation	Governance/New Public Management	Implementation Relevance
Public Interest	Results Citizens Value	Normative frame replaced by pragmatism
Efficiency, equity	Quality and value	Citizens' expectations must be met; target population; treatment not necessarily uniform
Administration	Production	Oversight functions; market competition
Control	Winning Adherence to norms	Culture change; communication demands
Specify functions, Authority structures	Identify mission, culture, customers, outcomes	Incentives, sanctions
Justify costs	Deliver value	Function uncertain; linked to performance
Enforce responsibility	Build accountability	Level of competition impacts control; options
Follow rules, procedures	Identify, solve problems, continuously improve process	Self-regulating partnerships
Operate administrative systems	Separate service from control	Hierarchy/decentralization levels
	Expand customer choice	Level of competition; flexibility
	Provide Incentives	Potential for unintended consequences
	Measure, analyze results	Outcomes vs. process
	Enrich feedback	Network complexity

(Ewalt, 2001)

New Public Management, based on Ewalt's (2001) assessment, demonstrates a shift to considerations of effectiveness and, to some degree, equity and effectiveness balanced with efficiency. The primary differences involve the introduction of citizen

considerations in terms of values, interests, and results. New Public Management, in this analysis (Ewalt, 2001), shifts from the government as a service provider indifferent to the marketplace to the government as a service provider in a competitive environment in which the adaptation of private sector business practices are pragmatic. The model shift from traditional governance to New Public Management requires a redefinition of service from control to interactive communication with the citizens; a shift from the government determining the needs and preferences of the citizens to the citizens allowing the government to respond to the needs and preferences put forth by the citizens (Ewalt, 2001).

Early criticisms of New Public Management include the unbalanced focus on "outputs" versus "outcomes" resulting in the implementation of numerous programs as well as privatization efforts that lacked the outcome measures to determine whether they were either efficient or effective (Schick, 1990). Schick acknowledges that the incorporation of strategic planning into the public management process in the 1990's brought effectiveness into the policy implementation process while continuing the focus on efficiency (Schick, 1990).

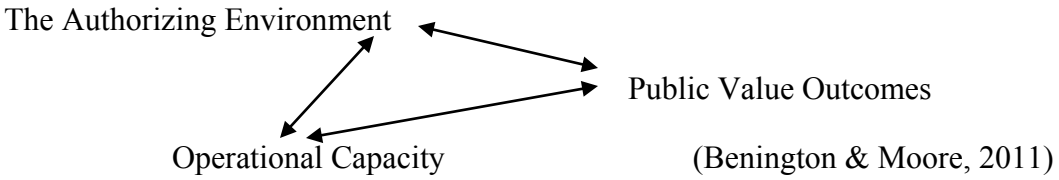
New Public Management undoubtedly has brought about a paradigm shift in public administration theory and practices. In Mississippi, evidence-based practices are becoming the new language of public monitoring and funding agencies. This is especially true in publicly funded health care and mental health care as the competition with other agencies for public dollars becomes increasingly competitive and demanding. Earlier arguments, such as those offered by Schick, continue to prevail. With the United States continuing in a major economic recession, it would seem that efficiency is far more easily defined than effectiveness. Despite this, a complexity exists between the interaction of

efficiency and effectiveness. For each measure of cost reduction, a measure of effectiveness may be lost. To minimize this effect, defined effectiveness goals with appropriate outcome measures are essential to the efficiency/effectiveness balance. This research will accept New Public Management as the current overarching public management paradigm in Mississippi, while looking to other theories to explain how "efficiency" and "effectiveness" can best be reconciled.

Public Value Theory

According to Mark Moore, "What makes political management necessary is that public managers share responsibility with other officials, and with citizens, for deciding what would be valuable to produce with public resources and for actually producing what they agreed would be valuable to produce (Moore, 1995, p. 189). The assumption for management in the public sector has long been that managers should strive to fulfill their legislative mandates in the most efficient and effective ways possible (Moore, 1995). Public Value Theory does not challenge the belief that efficiency and effectiveness are critical to success in the end game. It does, however, suggest that the political arena from which legislative mandates originate may not be the appropriate source for the determination of public value (Moore, 1995). "It is not enough to say that public managers create results that are valued; they must be able to show that the results obtained are worth the cost of private consumption and unrestrained liberty foregone in producing the desirable results" (Moore, 1995, p. 29). This is the litmus test of public value creation and suggests that equity is a primary consideration in Public Value Theory beyond considerations of efficiency and effectiveness.

At the heart of Moore's theory of public value is the "strategic triangle" illustrated below:



(Benington & Moore, 2011)

Figure 1 The Strategic Triangle

Based on the assumptions of the interactive and interdependent elements of the framework, John Benington and Mark Moore (2011) claim that all three dimensions must be in a defined alignment in order for public value to be created. Benington and Moore (2011) further define the elements of the framework as follows:

- "Defining public value – clarifying and specifying the strategic goals and public value outcomes which are aimed for in a given situation"

  "Authorization – creating the 'authorizing environment' necessary to achieve the desired public value outcomes – building and sustaining a coalition of stakeholders from the public, private and third sectors (including but not restricted to elected politicians and appointed overseers) whose support is required to sustain the necessary strategic action"

  "Building operational capacity – harnessing and mobilizing the operational resources (finance, staff, skills, technology), both inside and outside the organization, which are necessary to achieve the desired public value outcomes"

  (Benington & Moore, 2011, p. 4)

In Public Value Theory, Moore places the burden of realignment of the authorizing environment, the operational capacity, and public value outcomes on the

shoulders of the public administrator, charged with the responsibility of altering resources and outcomes to meet changing political demands; altering outcomes to meet the realities of limited resources; and assuming the negotiation role to ensure that the political support and resource allocations remain adequate to meet the desired strategic outcomes (Benington & Moore, 2011). Public Value Theory goes beyond the role of the public manager to address the key role of the citizen. The results created by public managers are valued by the citizens from whom preferences in how resources are allocated are determined. An ongoing dialogue between citizens and public managers is essential to the determination of public value. Public Value Theory suggests that citizens, through the democratic process, form the authorizing environment and that public managers have an obligation to inform the citizens when resource allocation conflicts occur so that equitable distribution of resources can be determined. Public Value Theory places a strong emphasis on accountability derived through outcome measures. Here again, the citizens provide goal-setting input, against which outcomes can be measured. The role of the citizen, as well as the public manager, is essential to the alignment of each component of Moore's Strategic Triangle.

Public Value Theory offers a prescriptive framework for public administration that includes consideration of equity, efficiency, and effectiveness consistent with New Public Management. However, the two theories part company when discussing the role of the citizen. As New Public Management views citizens as consumers, Public Value Theory recognizes that the enforcement and compliance mandates of government often place citizens in the coerced roles of paying fines and paying taxes, significantly different from the role of a voluntary consumer of goods and services. In this role, the citizen has both rights and obligations. This aspect of public administration clearly differentiates the

complexity of the role of the citizen in the public sector from that in the private sector. In addition, "the argument in *Creating Public Value; Strategic Management in Government* included the idea that citizens could debate the role of government in society, and contribute to deciding which individual circumstances and social conditions they wanted to treat as a collective public responsibility to be managed by government, and which they wanted to treat as a private responsibility to be managed by individuals through market relationships" (Benington & Moore, 2011). Such actions and debates are illustrated by the political roles of the American Association of Retired Persons, the National Association for the Advancement of Colored People, and the modern day Tea Party, among others. The following table illustrates some of the key differences that Public Value Theory identifies between the private and public sectors.

Table 2 Comparison of Key Issues of Public Value Theory

Issue	*Sector*	*Focus*
Management	Private	Create private value; profit/loss
Management	Public	Create public value
Use of Resources	Private	Private consumption
Use of Resources	Public	Public goals
Value	Private	Purchase price exceeds cost to produce
Value	Public	Choices made of representative govt.
Decision Influence	Private	The marketplace; supply and demand
Decision Influence	Public	The political marketplace; legislative
Accountability	Private	The Individual
Accountability	Public	The Collective "We"

(Moore, 1995)

Public Value Theory recognizes that much can be learned from the private sector, especially in terms of efficiency and effectiveness. At the same time, Public Value Theory suggests that public value is determined by the collective society of citizens and

not by a group of consumers as defined by New Public Management (Benington & Moore, 2011). In the private sector, consumers' choices are influenced by market forces to ultimately purchase a good or service. Ability to pay and willingness to pay are the primary drivers of consumer actions in private markets. As consumers in the private sector, refusal to buy a good or service will ultimately determine the viability of a product. As such, the marketing aim of the private sector is to be competitive and manipulative. "Public sector markets want to inform and educate, not to manipulate" (Wensley & Moore, 2011, p. 141). Public sector markets provide public goods and services. The cost of these services is frequently allocated through public taxation and licensing fees. If a citizen refuses to pay a tax or a licensing fee, the outcome may be a hefty fine for the transgression but the tax or the licensing fee does not go away because the majority of citizens choose to be compliant with the tax or fee thus not being subjected to the fine. Willingness to pay does not affect the product or the service stability in the public sector due to the nature of public goods and services and their roots in legislative actions. The public value lies in adherence to the law and the resulting beneficial effects and not in the payment of fines. In the same way, citizens may choose to be compliant with the rules and regulations of public programs because they fear exclusion from eligibility. "In practice, creating public value relies upon taking a pragmatic and non-ideological approach to the delivery of public services, giving real effect to the principle 'what matters is what works' viewed through the lens of the principles of equity and accessibility" (Coats & Passmore, 2008, p. 5).

Public Value Theory is not without its critics. When synthesized, the primary arguments seem to center on the elevated role of the public administrators and managers in the architectural design and control of public outcomes (Rhodes & Wanna, 2009).

Despite this argument, which may indeed be a shortcoming of the theory presented, Public Value Theory recognizes the complexities of public administration in dealing with issues unique to the public sector. Further, the theory addresses the implementation responsibilities of the public manager while recognizing the influence of collective citizens as the source of value determination in the outcomes. In this light, it is the citizens that both define the strategic goals of public programs and ultimately control the resources to achieve these goals. Public Value Theory offers an expanded way of thinking beyond New Public Management, drawing on its strengths while acknowledging its shortfalls especially in New Public Management's limited view of the role of the citizen in public administration.

Social Justice Theory

Social Justice Theory allows us to understand and apply principles of fairness and equity in the broader aspect of social relationships beyond individual interests. David Miller (1999) proposes a theory of social justice based on three basic levels of human relationships which he identifies as solardistic community, instrumental association, and citizenship. The solardistic community can be described as the most basic of relationships, with a need for belonging and self-worth sustained by a sense of brotherhood. Miller (1999) includes relationships in this community based on loyalty, obligation, security, love and affection, and personal belief systems. The instrumental association expands the relationship criteria to associations based on a common purpose or desired outcome. Miller (1999) classifies governmental bureaucracies and charitable organizations in this group but the relationship criteria could just as easily include a hospital, a business, or an organized fund drive. The most relevant aspect of Miller's

relationship discussion is the relevance of social justice in relationship to citizenship. For Miller, and others including John Rawls, goods and services, as well as rights and obligations, are to be equally allocated to all members of a society based solely on the attribute of citizen status.

Miller (1999) uses the relationship model to distinguish the forms of justice which determine the allocation of resources within them. Solardistic community and instrumental association relationships allocate resources based on their own rules for distribution. While need and negotiation are factors in determining one's allocation or entitlement, hierarchy in the organization or family, role, and influence are also determinants. Additionally, as roles and needs change over time in these relationships, allocations of resources change as well. Solardistic community and instrumental association relationships do not describe the fundamental characteristics that serve as the basis for social justice theory. Citizenship serves as the relationship basis for social justice, regardless of beliefs, values, common purpose, or other identifying aspect. Based on social justice theory, citizenship entitles members of society to equal access to resources, rights, and obligations. A description of Miller's human relationships is outlined in Table 3 below. This description outlines the applicable form of justice, the underlying principle, the basis for the relationship, and examples of each for purposes of comparing the relationships developed in Miller's theory.

Table 3 Miller's Theory of Social Relationships

Relationship	*Form of Justice*	*Underlying principle*	*Basis*	*Examples*	
Solardistic community	Distributive	Common Identity; community ties	Need	Families, clubs, religious groups; professional associations	
Instrumental association	Distributive				
Citizenship	Distributive and Social	Common social and political status; equality		Rights and obligations	All citizens

(Miller, 1999)

The concept of citizenship is a key aspect in the claim of social justice theory to have relevant application in public administration. According to Miller, "the status of citizen is an equal status: each person enjoys the same set of liberties and rights, rights to personal protection, political participation, and the various services that the political community provides for its members" (Miller, 1999, p. 30). Miller further states, "although equality is the primary principle of justice governing relationships among citizens, sometimes citizenship may ground claims of justice based on need or desert. Citizens who lack the resources necessary to play their part as full members of the community have a just claim to have those resources provided. Thus medical aid, housing, and income support may for some people be regarded as needs from the prospective of citizenship" (Miller, 1999, p. 31). Miller argues social justice from the basic needs aspect of welfare in terms of income, health care, and housing but an argument can be made that entitlement has gone too far with public resources being allocated to individuals above the poverty level and including such things as higher education and cell phones which might be considered to exceed basic human needs.

Extending the principle of equality under the concept of citizenship acknowledges that each citizen has a right to obtain employment that will provide an income adequate to provide for basic needs (Miller, 1999). Under the Theory of Social Justice then, it could be reasonably argued that the mentally ill, as well as other disabled sectors of our society, have a right as citizens to obtain the necessary treatment and vocational training to enable them to reenter the employment market.

The foundations of Social Justice Theory are generally attributed to the writings of John Rawls. The theory of social justice put forth by Rawls has provided a basis from which both support and arguments have derived. The key elements of Rawl's theory suggest "that valid principles of justice must be publicly justifiable; the people who are going to use them must be able to justify them to one another using only commonly accepted modes of reasoning" (Miller, 1999, p. 53). Rawls postulates the notion of "concerned judgments" in which individuals determine the justice of an act or institution after reasoning without the effects of self-interest. In order to identify these appropriate judgments, Rawl's theory asks the individual to consider their judgments in relation to those held by others. If similar judgments are made by many others and self-interest is not determined to be an overriding motivating factor, then these collective judgments define social justice (Miller, 1999).

When considering Rawl's theory, it is also imperative to understand how Rawls views public justification. Rawls maintains that decisions related to justice are made by rational choice but tempered by a concept of "reasonableness" which considers the beliefs that will be held by others having full knowledge and adhering to "conceptions of the good" (Miller, 1999, p. 57). Some difficulty is raised when defining "conceptions of the good" (Miller, 1999) since differences of opinion on what is "good" vary widely.

Often "good" is based on personal beliefs and often such beliefs are rooted in religious foundations. Issues of abortion, gun control, capital punishment, and support for entitlement programs are often linked inextricably with religious or political views. Such differences render both "reasonableness" and "good" as arguably subjective terms.

Consideration of social justice as a normative theory is important to the discussion of outcomes in public service programs. Collectively, such theories, including Rawls', acknowledge that internal beliefs and self-interest play a role in influencing the individual's view of justice. Concurrently, the fairness, equity, and equality of the administration of public programs requires that social justice should be based on impartial and collectively held beliefs predicated on the principle of the greater good of the collective public and resulting in an equitable distribution of the resources and responsibilities. The application of social justice theory requires an establishment of outcomes that balance meeting the needs of the greatest number of people with assisting the greatest number of people in need, given the resources available and an agreement on these outcomes by all relevant stakeholders.

Active Citizenship Theory

Attempts to redefine and enlighten public administration have largely been the outgrowth of criticisms of the public bureaucracy. Efforts to shift government functions to the private sector are based on the assumption that public management is wasteful, inefficient, and somehow substandard to management in private companies and organizations. Such criticisms fail to acknowledge public management's responsibility to consider fairness and equity; concepts usually foreign to private industry. In *Refounding*

Public Administration, Gary L. Wamsley sets out to dispel this myth. Wamsley (1990) presents as fact the following items presented in Table 4 for consideration:

Table 4 Public/Private Comparison

Most clients of bureaucracy are not dissatisfied; in fact, the vast majority of them are very pleased with the services and treatment received.
The rate of productivity increase in the public sector is not clearly lower than the private sector; it is probably higher overall.
The federal government has not grown in the number of employees since the early 1950's. (This may be challenged in light of the ARRA of 2009)
The bureaucracy is not a monolith, it is composed of many small and diverse bureaus and offices.
Public agencies stimulate and implement change; resistance to change is no more endemic to the organizations in the public sector than to the private.
Studies have shown that the private sector is more top-heavy with administrative personnel than the public sector.
Waste and inefficiency are no more prevalent in the public sector than in the private but in the former it is seen as waste of the taxpayer's money, while in the latter we fail to see that it is passed on to us in the prices we pay as consumers.

(Walmsley, 1990)

Having acknowledged the negative image of public administration, Wamsley advocates the concept of the "public interest" be reinserted into the dialogue as the basis for public governance. The public interest concept allows for a more global consideration of issues: consideration of multiple issues, a focus on the long range rather than short term results, and a consideration of multiple, often competing views of the citizens affected, while bringing together a wealth of information from which to make decisions (Wamsley, 1990). "The key to the legitimacy of any criterion, including the public interest , is not whether it is subjective but whether all those who have a stake in the matter at hand have had the opportunity in defining it" (Wamsley, 1990, p.40).

Wamsley clearly articulates that the role of public administration should not be abdicated to the private sector. This researcher agrees with this position and further believes that the private sector is incapable of adequate consideration of the public interest and issues requiring equity and fairness in the provision of public goods and services. The private sector is also incapable of considering the active citizen as the primary stakeholder in public policy decisions. As problematic as the definition of public interest might be, a role for stakeholders , including citizens, in the decision process of public management is congruent with the democratic principles on which this country was founded.

To further this discussion and lay additional theoretical foundation for this dissertation research, the concept of "active citizenship" as defined by Camilla Stivers, offers the most promising approach to inserting "public interest" into a lead role in public administration. According to Stivers, "administrative legitimacy requires active accountability to citizens, from whom the ends of government derive" (Stivers, 1990, p.247). Public administration theory recognizes the role of citizens as consumers possessing valuable information and support for public programs, as the source of the value placed on specific outcomes, and as co-producers of public services (Stivers, 1990).

Despite this recognition of the roles citizens have played in public administration, Stivers argues that the roles of citizens as advocates, lobbyists, and consumers with opinions have been perceived in a less than favorable light, approaching definition as the unpleasant cost of doing business in the public sector (Stivers, 1990). For Stivers, the role of the citizen in government has been evolutionary. Historically, since the inception of our Constitution and electoral process, the role of the citizen has been passive, deferring public administration governance to officials serving on behalf of the citizens. The result

has been an ever-increasing reduction in the quality of citizenship, as the administration and citizenry move farther apart in terms of values and interests (Stivers, 1990). Quality of citizenship is reflected in the positive correlation between government actions and public opinion. Recent bank and industry bailouts, stimulus funding, and health care reform illustrate government actions largely independent of citizen support.

Rooted in Aristotelian philosophy, active citizenship in the ideal allows the citizen to take an active role in governance, acting in the public interest and not driven by self-interest. Such idealism presents a field day for critics consumed by the notion that the human species is, for the most part, incapable of any action absent self-interest. For Stivers (1990) the tensions are rooted in conflicts between individual and group needs; individual liberties and social equity; and between the trampling of the individual freedoms of some to preserve only a portion of the individual freedoms of the population affected as a whole. Examples include wiretaps based on suspicion only and the extensive use of cameras and monitoring devices throughout the country. Stivers (1990) also contends that the neutrality role of the public administrator directly conflicts with active citizenship as it sets the professional apart from his role as a citizen, assigning special qualifications that are, in fact, within the capability of every citizen. Stivers prefers to view public servants as described by Terry Cooper: "citizen-administrators . . . employed as one of us, to work for us and bearing the responsibility for encouraging participation by other citizens" (Cooper, 1984). Finally, Stivers (1990, p.252) claims that "shared meaning between the citizens and the bureaucrats is what makes true accountability possible."

The following table outlines the key tenants of Stivers' theory of active citizenship:

Table 5 The Primary Tenants of Active Citizenship Theory

Tenant	Result
Equality of Individuals (Rights and Needs)	Bonds the group
Knowledge community (Open to members and not silenced by the bureaucrats	Leads to trust
All citizens have knowledge; knowledge about unacknowledged conditions and unintended consequences of actions must be applied	Produces change
Open dialogue with citizens concerning costs/benefits and shared actions with citizens	Accountability

(Stivers, 1990)

Stivers (1990, p.265) concludes that "a substantive public decision-making role for citizens is important as a mechanism for constructing a shared understanding of the public interest." Stivers' theory of active citizenship serves as a fundamental justification for the research and methodology in this dissertation study. Accepting that the program staff and consumers in the CMHC psychosocial rehabilitation programs serve a dual role as citizens, that collectively they are members of a unique knowledge community, and that all citizens (including the mentally ill) have the capacity to act in the public interest, this study hopes to gain valuable insight into the development of appropriate program outcome measures as well as their meaningful rationale.

Intrinsic Work Motivation Theory

A large volume of literature has been written about theories of work motivation. The majority of the research has focused on extrinsic motivational factors including those financially-based rewards that are considered within the control of managers within the workplace. Some of the many items categorized as extrinsic rewards include hourly pay, salaries, titles, benefits, perks, and special training opportunities. Theorists, including Frederick Herzberg, theorized that salary and basic benefits were essential to job

satisfaction but not motivational to work performance (Herzberg, 1959). As early as 1943, Dr. Abraham Maslow theorized that motivation was hierarchical in nature and need-based. As basic needs were met, individuals were no longer motivated by the same factors. Basic needs, therefore, of food and shelter could be satisfied by wages. Once satisfied, wages were no longer a motivating factor as individuals moved on to the satisfaction of other needs such as self-esteem and, ultimately, self-actualization (Maslow, 1998). Maslow's Hierarchy of Needs theory of motivation suggests a continuum of motivational factors moving from extrinsic to the intrinsic.

Thomas (2000) suggests that changes in the structure of the workforce in recent decades have necessitated a change in the application of motivation theory from an extrinsic focus to an intrinsic focus. Such changes include a significant downsizing in middle management positions resulting in flatter organizational structures and more complexity and decision-making at the line level. Thomas refers to this role shift in line employees as a shift from compliance with the direction of the manager to partnership with the work team. No longer is task completion the only desired goal for management to obtain from employees; the new focus is to obtain commitment to the product result and ultimately, to the business and employer. With the days of job security and guaranteed pensions long gone, commitment requires a focus on intrinsic rewards to keep good workers (Thomas, 2000). Thomas challenges rational models of work behavior claiming that they are future-oriented and goal driven, lacking a focus on what is happening for the worker here and now. Thomas prefers reinforcement theory to explain worker behavior. According to Thomas, "In a reinforcement model, then, feeling energized by one's work is simply the experience of getting rewards directly from the work" (Thomas, 2000, p. 12)

The core concept in Thomas' theory of work motivation is a sense of purpose. "Without a clear notion of purpose, workers cannot make intelligent choices about work activities, and they are deprived of a sense of the meaningfulness of their work" (Thomas, 2000, p. 18). The intrinsic motivation model of purposeful work is relatively simple: work is made up of a group of tasks; tasks are made up of a group of activities; whether or not the activities that are chosen will accomplish the task is uncertain; and as a result of the uncertainty, the accomplishment of tasks is intrinsically rewarding (Thomas, 2000).

Psychosocial rehabilitation programs for the mentally ill in Mississippi, also known as Clubhouses, are structured to provide a workday-mirroring experience for consumers. Participants are assigned to work units to collectively complete tasks necessary for the running of the Clubhouse including such things as meal preparation, record keeping, gardening, thrift store management and other purposeful activities. The Thomas model of intrinsic motivation has profound implications in the design of an effective psychosocial rehabilitation program. Motivating the mentally ill is especially difficult given the barriers to employment generally perceived for this population. Consequently, the Clubhouse work-ordered day should be configured to allow as much personal control by consumers over activities as possible. The role of program staff is to guide the consumers in identifying their work interests and to provide feedback as to whether chosen activities are accomplishing tasks efficiently and effectively. The lack of intrinsic rewards as a motivational factor should be considered in light of the very low participation of current consumers in both transitional and competitive employment.

CHAPTER III

PSYCHOSOCIAL REHABILITATION AND VOCATIONAL INTERVENTION: A LITERATURE REVIEW

Attitudes Toward Employing the Mentally Ill

Stigma has long been associated with the willingness of individuals to seek treatment for mental illness. Jagdeo, et. al. (2009) analyzed data found in the U. S. Nation Comorbidity Study and the Ontario Health Survey with a total respondent population of 12,779 aged 15 to 54 years of age. According to findings of the study, 15 to 20% of the population would likely not seek psychiatric treatment for emotional problems due to the perceived associated stigma and as many as 50% said they would be embarrassed if their friends knew that they had sought treatment. Those most likely to resist treatment included younger, socio-disadvantaged males and those with co-occurring substance abuse problems (Jagdeo, et.al., 2009).

Research by Jagneo, et. al. (2009) further confirms the general stereotype of the individual with mental illness as being perceived as weak, unpredictable, unlike other people, and potentially violent. According to Erik Erikson's theory of the stages of human development, the young males identified in this research as most likely to be resistant to seeking mental health treatment would be those working through self-identity and a need for belonging. Viewing themselves in the stereotypical concept, especially as weak or different from their peer group, would be congruent with a lack of willingness to seek treatment for mental health issues and would further support the very high response

rate indicating these individuals would be embarrassed by their friends' knowledge of their having sought treatment.

Throughout the literature, there is a suggestion that employers, clinicians, and caregivers influence the perceptions of the mentally ill regarding their ability to work. Marwaha, Balachandra, and Johnson (2008) explored clinical attitudes regarding the ability of individuals with psychosis to return to employment utilizing a questionnaire survey. One hundred thirty-eight clinicians from nine community mental health teams in North London, UK, were surveyed with a response rate of 66%. Although a good response rate, the sample size was less than one percent of the population, limiting the scope of the study significantly and therefore, its generalizability. According to the research, clinicians believed a greater number of clients on their caseloads could return to work than researchers expected. This number, however, was consistently well below half the average caseload. The research further indicated that 70% of the clinicians surveyed expressed confidence in assessing a mental health client's capacity for work, although 84% of those responding had not had formal training in this type of assessment (Marwaha, Balachandra, and Johnson, 2008).

The information gathered did not assess the level of symptoms present or the stability level of any individual clients. The findings also support the tendency for clinicians to believe that employment presents a high risk for the exacerbation of the symptoms of mental illness largely owing to stigma and stress in the workplace. Possibly owing to this fear, the researchers suggest that clinicians "more often judge them [clients] to be capable of doing jobs that are perceived to involve a low level of technical skills and interpersonal interactions" (Marwaha, Balachandra, and Johnson, 2008, p. 356). This aspect is consistent with findings by Goldberg, et. al. (2001) that suggests that vocational

rehabilitation staff also tend to place the mentally ill in underutilized positions despite previous work history out of a fear of stress-related exacerbation of the mental illness.

Finally, the Marwaha, Balachandra, and Johnson (2008) study found that only 10% of clinicians believed that getting people back into paid work was a high priority suggesting that clinicians lacked confidence in the ability of patients to handle the stress of employment or the risk of benefit loss. In addition, the findings indicated that clinicians did not view work activities as a clinically integrated function but as one to be relegated to programs external to the mental health centers.

Social stigma has long been recognized a barrier to recovery for the mentally ill. Van't Veer, et.al. (2006) looked at public attitudes toward the mentally ill based on the variables of social distance, beliefs about stereotypical characteristics, causal attributions, and background variables. Social distance was defined as "the extent to which people wish to avoid social interaction with people with a psychiatric background" (van't Veer, et. al., 2006). For purposes of that study, stereotypical characteristics included intelligence, trustworthiness, tendency to aggression, employability, causing disturbance to other people, and criminal tendencies. Causal attributions ranged from genetic transmission to victimization by sexual abuse to substance abuse. Finally, background variables included the socio-demographic variables of age, gender, level of education, employment status, and personal experience with mental illness. Race and ethnicity were not addressed. The researchers administered a questionnaire to assess how the larger community feels about the mentally ill via mail to two subgroups: one group of randomly selected addresses and one group with addresses in close proximity to mental institutions. A 33% response rate was obtained (n=812), and the researchers chose to combine the

subgroup responses when no substantial differences were noted (van't Veer, et. al., 2006).

The study found that the majority of people indicated "a willingness to interact with a mental patient" (van't Veer, et .al., 2006). Of particular interest was the response range to the question, "would you mind having this person to work with you as a colleague?" Researchers found 58% "willing" or "definitely willing"; 36.1% "maybe"; and 5.6% "unwilling" or "definitely unwilling." Respondents in this study were far more willing to work with someone with a mental illness (58.3%) than to be willing to become friends with someone with mental illness (46.5%). Thirty-seven and two-tenths percent believed individuals with mental illness are unable to maintain a regular job and Seventy-four and seven-tenths percent believed the mentally ill to be aggressive (van't Veer, et. al., 2006). While the van't Veer, et. al. (2006) research has limitations in its response rate, sample size, and admission that most of the respondents were older and highly educated, it does reinforce the stereotypical opinions which individuals with mental illness report experiencing in the community and in the workplace. Further, it builds on other research with similar findings of the pervasive social stigma attached to people with mental illness (Wolff, et. al., 1996; Corrigan, et. al., 2001).

Fleury, Grenier, and Lesage (2006) performed a comparative analysis to determine the similarities and differences in defining client needs by staff members and clients with serious mental illness. The study paired 165 users and staff members in six treatment settings in Montreal, Quebec. Although a broad range of user participants were identified, the majority profile consisted of the following characteristics: average age 45 years; male; single; childless; unemployed; high school education; apartment-living; and diagnosed with schizophrenia (Fleury, Grenier, & Lesage, 2006). The staff were

composed of nurses, psychiatrists, social workers, and educators, with the professional qualification majority varying by area (Fleury, Grenier, & Lesage, 2006).

The research found agreement between staff and users in identifying the most common problems experienced by the mentally ill including "psychotic symptoms, company, food, daytime activities, and money" (Fleury, Grenier, & Lesage, 2006, p. 283). Further, the study found that discrepancies existed between staff and users related to self-care (27.9% of staff reported problems, compared with 8.5% of users), benefits, including access to low income subsidies and disability entitlements, (16.9% of users, compared with 2.4% of staff), and information about mental illness, treatment options, prognoses, and access to benefits (38.8% of users, compared with 24.2% of staff) (Fleury, Grenier, & Lesage, 2006).

The most important aspect of the findings in that study is not the elements of divergent opinions but rather the areas of agreement. The researchers found programs, interventions, and services were most frequent and appropriate when there was user-staff agreement on the problem (Fleury, Grenier, & Lesage, 2006). This suggests that staff are unlikely to implement services that are not defined as necessary by the clients. Conversely, it also suggests that staff are unlikely to provide specific services for clients when the staff are not in agreement that the problem is significant or a high priority for treatment. Fleury, Grenier, and Lesage (2006) conclude that more attention should be paid to secondary problems encountered by the mentally ill including socialization, daily activities, food, finances, and hygiene, not addressed in the traditional care models of programs, intervention, and services. Further research in this area is clearly indicated.

Diksa and Rogers (1996) studied the attitudes of employers toward hiring individuals with psychiatric disabilities. The research attempts to identify disability-

friendly work sectors while identifying specific barriers to employability for the seriously mentally ill. Data was obtained from telephone surveys conducted with 373 participants from businesses in the Boston area (Diksa and Rogers, 1996). The study indicated that the most supportive work environment for individuals with psychiatric disabilities is the social service sector, while the least supportive is transportation, communication, and utilities. The researchers attribute this finding to a greater exposure and familiarity with mental illness in the social service sector (Diksa and Rogers, 1996).

This research is short-sighted in its conclusions that employment efforts for the mentally ill should be targeted toward user-friendly work environments. A match between existing or trainable skills, client interests, and employment opportunities should be the driver in vocational rehabilitation, based on current philosophical vocational intervention models. Diksa and Rogers (1996) did, however, recognize the importance of employer attitudes in outcome success. Such attitudes require targeted education and positive outcome experiences to change negative attitudes toward employment the mentally ill.

Effects of Diagnosis on Employability

Patten, et. al. (2009) a group of clinically-credentialed researchers, completed a longitudinal study of individuals experiencing major depressive episodes and their co-existing occupational status. Although limited by a response rate of less than five percent (305 respondents of a sample population of 6,570 mentally challenged individuals) and further limited by lack of knowledge regarding the symptom severity of the participants, the study concluded that individuals experiencing major depressive episodes were significantly more likely to have left the workforce within two years of experiencing a

major depressive episode. The study further found that "people aged 26 to 45 years with major depressive episodes have more than double the risk of this transition" (Patten, et. al., 2009, p. 841). That research is important to acknowledging the impact of mental illness on the ability of the individual to remain in the workplace after they are first employed. While the research establishes a correlation, it should not be assumed as a causal relationship since severity of symptoms, job-related issues, lack of appropriate mental health treatment, co-occurring disorders, and a variety of other factors may have influenced the termination of employment.

The International Classification of Diseases (ICD) was developed in the 1850's and became the responsibility of the World Health Organization " in 1948 when the Sixth Revision, which included causes of morbidity for the first time, was published. The World Health Assembly adopted in 1967 the World Health Organization Nomenclature Regulations that stipulate use of the International Classification of Diseases in its most current revision for mortality and morbidity statistics by all Member States. The International Classification of Diseases is the international standard diagnostic classification for all general epidemiological, many health management purposes and clinical use" (World Health Organization, 2011). The International Classification of Diseases is currently in its tenth revision. Most Member States, particularly in Europe, have implemented use of the ICD-10. The United States lags behind, however, and is scheduled for transition from the ICD-9 to the ICD-10 in January of 2012.

Waghorn, et. al. (2005) studied individuals with ICD-10 anxiety disorders related to disability, employment and work performance. Utilizing a survey questionnaire of identified households and residential situations with an individual previously identified with an anxiety disorder, researchers obtained a very high response rate of 93-94.4%. In

identifying the sample population, “2.9% of working age Australians were found to have a primary ICD-10 classified anxiety disorder of at least 6 months duration” (Waghorn, et. al., 2005, p. 61).

The Waghorn, et.al. (2005) research identified individuals diagnosed with anxiety disorders as being less likely to be employed and, if employed, less likely to be employed full time than the general population, as well as more likely to be receiving disability income. While acknowledging the limitations of not having a clinical understanding of the illness category, this research suggests that a multi-dimensional approach including mental health treatment, vocational training, and educational training could positively affect the ability of this population to increase participation in the workforce and simultaneously reduce the burden of disability payments on the taxpayer.

Waghorn, Chant, and Jaeger (2007) compared employment functioning and disability among individuals diagnosed with bipolar disorder and individuals diagnosed with schizophrenia. The research methodology utilized secondary data analysis and included 156 individuals diagnosed with bipolar disorder and 385 individuals diagnosed with schizophrenia (Waghorn, Chant, and Jaeger, 2007). Generally accepted as an episodic illness, that research confirms both vocational and social dysfunction continuing to occur during episodic intervals even during periods when the individual may be asymptomatic of the illness. Further, that finding indicates that functional recovery may not correlate directly with syndromal recovery (Waghorn, Chant, and Jaeger, 2007). That finding therefore, suggests that individuals with diagnosed bipolar disorder or schizophrenia with symptoms either controlled by medicine or in remission may continue to experience episodes of social or vocational dysfunction. Conversely, individuals experiencing little or no social or vocational impairment may simultaneously experience

some symptoms associated with mental illness that do not result in functional impairment. The Waghorn et. al. (2005) research found no predictive measures between the presence of symptoms of mental illness and the level of social and vocational functioning.

That study found that the vocational training needs and issues for individuals with bipolar disorder were different from those necessary for individuals with schizophrenia on many dimensions. Of particular interest is the recognition that bipolar disordered individuals are found to be more likely to be perceived as needing less vocational intervention based on the way they present to vocational professionals during asymptomatic periods (Waghorn, Chant, and Jaeger, 2007).

Marwaha and Johnson (2004) conducted a literature-based research study investigating schizophrenia and employment. The researchers found difficulty in citing the employment rate among schizophrenics as a result primarily of the labeling and classification of data in the research reviewed, but concluded that the generally agreed European employment rate for schizophrenics of ten to twenty percent was substantially below the generally agreed European employment rate for the general population of seventy-five to eighty percent (Marwaha and Johnson, 2004). The researchers cite the reasons for a further deterioration in the employment of schizophrenics in recent years as "likely due to an interplay between the social and economic factors, labor market conditions, the barriers that people face, provision of services, individual choices, and incentives for people with schizophrenia to work" (Marwaha and Johnson, 2004, p. 347). That research is important because it collectively identifies the many complexities to be considered when addressing the social and vocational functioning needs of the schizophrenic population. The study also points out the lack of direct clinical research to

aid in understanding the influence of clinicians and caregivers on the ability of the schizophrenic to seek employment as well as the lack of a fact-based understanding of the financial and social barriers which inhibit vocational motivation.

Barriers to Employment

Akabas, Oran-Sabia, and Gates (2006) studied the effects of an integrated model of supported employment in helping the mentally ill obtain competitive jobs in the community. According to the researchers, "often mental health services are provided independently of vocational services, with little communication between the clinician and employment specialist" (Akabas, Oran-Sabia, & Gates, 2006, p. 20). In conjunction with identifying a need for integrated clinical and vocational services, that research also identifies additional considerations for an effective program model. According to the researchers, "consumers typically experience a range of issues (for example, unstable housing, involvement in the criminal justice system, domestic violence, lack of transportation, and physical health problems, among others) that could pose barriers to work and, therefore, need attention as they move into employment" (Akabas, Oran-Sabia, & Gates, 2006, p. 20).

Contrary to the work-ordered day model of psychosocial rehabilitation, this study cites previous research that finds that long term work-readiness activities are negatively correlated with a willingness to move to competitive employment (Bond, 1998; Gowdy, Carlson, & Rapp, 2003). That study further supports practices including comprehensive assessments, on-going support, consumer involvement, and building a job market in the community allowing potential employment opportunities for a variety of consumer interests (Akabas, Oran-Sabia, & Gates, 2006). That research concludes that a specialty

program incorporating the practices outlined above is the most effective vocational intervention model for the mentally ill. While this program model appears to have merit, it is not fundamentally different from other supported employment programs with clinical integration.

Koletsi, et. al. (2009) studied experiences with Individual Placement and Support, vocational rehabilitation and employment from the client perspective through semi-structured interviews of 48 individuals with mental illness. That study reaffirms perceived barriers to employment for the mentally ill, including symptoms of mental illness, lack of previous work history, age, stigma, lack of personal motivation, high local unemployment rates, difficulty finding jobs of interest, fear of failure or interpersonal difficulties, and difficulty filling out requisite paperwork. Of particular interest is the determination that the perceived barriers to employment were the same regardless of the method of vocational intervention (Koletsi, et. al., 2009).

Henry, Hippel, and Shapiro (2010) conducted an experimental research study to examine social skills impairment in individuals diagnosed with schizophrenia. The study evaluated differences in social skill impairment during an interview process when it was perceived by the subject that one interviewer had knowledge of the subject's mental illness and the other interviewer did not. In actuality, neither interviewer had knowledge of the subject's mental illness (Henry, Hippel, & Shapiro, 2010). The researchers found that social skills were diminished in three of the six test areas for individuals that perceived that the interviewer had knowledge of their mental illness (Henry, Hippel, & Shapiro, 2010). Several limitations should be noted in the study including the small sample size (n=30), the lack of social skills assessment and evaluation prior to the research experiment, and the relatively high level of grade-equivalent education (13.4

years). The education factor suggests a more highly developed social skill set prior to the onset of schizophrenia.

Despite these limitations, the research can be cautiously considered as validating that perceptions of stereotyping and discrimination by members of the public against the mentally ill are as influential as actual behaviors. The effect is equivalent to reverse stereotyping. While the stigma of mental health extends to schizophrenics in the belief that they are socially incompetent, this research suggests that schizophrenics assume they will be stereotyped and discriminated against by anyone in a non-clinical setting with a knowledge of their mental illness. In fact, the subjects in this study may have been ill-at-ease by the belief that one interviewer had knowledge of their mental illness but failed to address the issue. Since the subject expected that one interviewer had knowledge of the subject's mental illness, the subject may have been suspicious that mental illness was not brought up in the interview, even in a subtle way. It may have proven beneficial to the study to have one interviewer actually aware that the subject had been diagnosed with a mental illness so that stigma perceptions by both the subject and the interviewer could have been measured. The lack of knowledge that the subject was mentally ill by both interviewers leaves questions as to what perceptions were actually measured.

Marwaha and Johnson (2004) identify barriers to employment for people diagnosed with schizophrenia. These "barriers to getting employment include stigma, discrimination, fear of loss of (public) benefits and a lack of appropriate professional help" (Marwaha and Johnson, 2004, p. 337). Stigma is often cited as one of the greatest barriers to employment faced by schizophrenics (Schulze and Angermeyer, 2003; Rinaldi and Hill, 2000; Marwaha and Johnson, 2004). The fear of losing benefits under entitlement programs has long been put forth as a major barrier to employment for people

with mental illness. Research is lacking, however, in determining whether this fear is grounded in actual experience. Despite this, Warner (2001) did find a higher instance of employment in people with schizophrenia in Italy, a country where individuals are permitted to receive greater earnings before benefit reduction.

Factors that Influence Employment Outcomes

MacDonald-Wilson, Rogers, and Massaro (2003) explored the functional limitations of individuals with serious mental illness in the workplace. This study deviated from the most commonly found dysfunctions in the workplace that generally include poor social interactions and interpersonal problems. According to the researchers, their study "confirms recent literature suggesting that people with severe psychiatric disabilities have limitations in cognitive functioning that affect work performance (i.e., learning, memory, attention, executive functioning)" (MacDonald, Rogers, & Massaro, 2003, p. 22). The researchers also found that cognitive deficits were most often associated with increased job accommodation in terms of coworker assistance and supervisor oversight (MacDonald, Rogers, & Massaro, 2003). That research is particularly relevant in introducing an overlooked but extremely important characteristic of the mentally ill: the level of cognitive functioning. The study indicates the importance of assessing cognitive functioning prior to employment to determine the level of support needed, as well as determining appropriate placements in terms of safety and ability, in order to foster positive employment outcomes for the participant and the employer.

Majors, et. al., (2010) studied the effects of supported employment following first episode psychosis. Although based on the findings of a very small sample population (n=114), this study produced preliminary conclusions that contradict current practice

methods in mental health treatment. Traditional mental health treatment models focus on a continuum of care generally outlined in Figure 2 below:

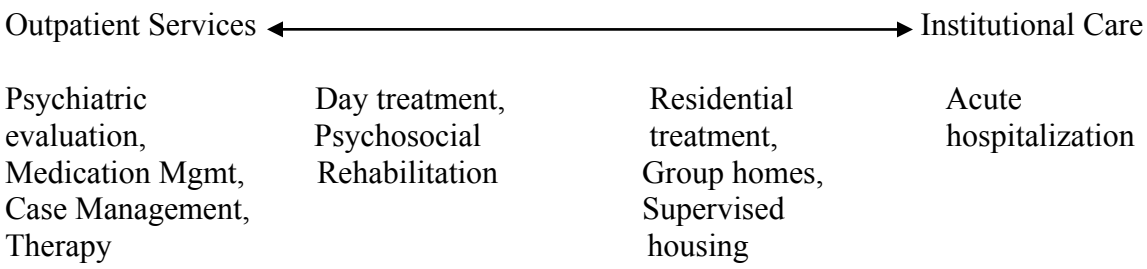


Figure 2 Mental Health Continuum of Care

Based on the continuum of care, psychosocial rehabilitation is an option for the treatment of the seriously and persistently mentally ill who have not responded to less intensive treatment methods. For clarification, it should be noted that the continuum is multidirectional with a number of individuals entering the treatment range at the acute hospitalization level and moving into less restrictive treatment modalities as stabilization occurs. General consensus in the treatment of mental illness requires individuals to be treated in the least restrictive environment dictated by the individual's needs, safety, and current level of functioning. Majors, et. al. (2010) found a statistically significant predictor of vocational recovery for individuals that participated in a vocational intervention program, such as transitional employment, within the twelve months following a first psychotic episode. While the study does not clearly articulate the determinants of the psychoses and prognoses for recovery, the study does present an important area of future study by suggesting that vocational intervention should be considered as an early intervention component of recovery from mental illness.

King, et. al., (2006) studied evidence-based practices in employment for the mentally ill relative to the policy environment in Australia. The researchers observed that

the employment rate for the mentally ill in Australia in 1998 was four times less than the general population's employment rate. According to the researchers, "increasing opportunities for people with mental illness to rejoin their leisure, friendship and work communities are expected to substantially improve social quality" (King, et. al., 2006, p. 472). That research reaffirms earlier research by Rutman, (1994) and Waghorn, (2005) suggesting that the primary barriers to employment for the mentally ill include the effects of mental illness on the person, the availability of jobs and the required vocational support, stigma, and low expectations by clinical service providers. In addition, King, et. al., (2006) suggest that the policy environment in Australia is not conducive to providing adequate funding and support for vocational services for the mentally ill while also failing to encourage access to vocational services via the mental health system.

After a critique of Australian policy, the researchers suggest that "there is an opportunity to improve employment outcomes for Australians with severe mental illness through enhancing integration of mental health care and vocational assistance" (King, et. al., 2006, p. 475). The researchers further suggests that a fully integrated mental health and vocational services system facilitates an understanding of which employment services are more or less successful for persons with mental illness (King, et. al., 2006). A key aspect of the research by King, et. al. (2006) is the affirmation of seven evidence-based service components necessary for an effective vocational program for the mentally ill. Supported by research by Bond, (1998, 2002) and Waghorn, (2005) each claims a varying level of empirical support and include:

- "The goal is competitive employment in the open labour market"
- "Consumer choice as the only entry criterion"
- "Rapid commencement of job search activity within 4 weeks of commencement"

- "Integration of mental health care with vocational services"
- "Assistance components are determined by consumer preferences"
- "Support is not time-limited"
- "Benefits counseling to minimize disincentives through the impact on health benefits, income support payments and fringe benefits"

(King, et. al., 2006, p. 474)

The significance of that research is its claims to provide evidence-based elements of an employment program for the mentally ill that are consumer-driven and foster consumer participation in the decision process. The empirical support for these factors suggests that program outcomes may be appropriately derived from their inclusion in a psychosocial rehabilitation model.

Sanderson and Andrews, (2006) conducted a study of the literature to obtain an understanding of mental disorders in broader community settings apart from programs that focused directly on the treatment and training of the mentally ill. After reviewing previously peer-reviewed literature from seven studies with relatively large sample populations (average 6264), the researchers found evidence to support "a strong association between aspects of low job quality and incident depression and anxiety" (Sanderson and Andrews, 2006, p. 63). That research further found that the workplace environment may contribute to depression and anxiety in workers through an effort/reward imbalance or a lack a fairness in workplace procedures. The researchers further suggest that "workers exposed to adverse psychosocial work environments have increased risk for developing significant psychiatric symptoms" (Sanderson and Andrews, 2006, p. 71). It follows then, that individuals with pre-existing mental illness would be more likely to experience an exacerbation of symptoms in such a work

environment. That research indicates the need for additional study of placements for individuals with mental illness in the work environment. While much of the literature focuses on the treatment, support, and training of the mentally ill to adjust to the workplace environment, there is little research to identify work environments that are incompatible with recovery and unsupportive to workforce reintegration.

Michon, et. al., (2004) analyzed outcome data for participants in eight studies on vocational rehabilitation programs to determine person-related predictors of employment outcomes. Researchers in that study utilized multivariate analysis to determine the relative contribution of variables, choosing employment outcome as the dependent variable. The research focused on four dimensions: demographic factors, psychiatric illness factors, functioning in other areas including social functioning, and current work performance. The study found current work performance and social functioning to be the most predictive indicators of a positive employment outcome "outweighing the influence of work history and severity of symptoms" (Michon, et. al., 2004, p. 413). In contrast to other studies reflected in the literature, this research found that diagnosis and psychiatric history did not impact a favorable employment outcome and the psychiatric symptoms of mental illness had less influence than psychiatric vocational rehabilitation work performance (Michon, et. al., 2004).

There are serious limitations in the findings by Michon et. al. (2004) presented here. The research draws conclusions based on studies that are only loosely associated to the criteria the researchers are investigating in terms of variables, populations, and outcomes. Consequently, the findings of that research should be considered very limited but the issues raised should be considered for future study.

Larson (2008) suggests that supported employment is best achieved through the use of evidence-based practices and motivational interviewing in conjunction with the application of stages of change theory. "Motivational interviewing is a form of collaborative conversation for strengthening a person's own commitment to change. It is a person-centered counseling style for addressing the common problem of ambivalence about change by paying particular attention to the language of change. It is designed to strengthen an individual's motivation for and movement toward a specific goal by eliciting and exploring a person's own reasons for change within an atmosphere of acceptance and compassion" (Motivational Interviewing Network of Trainers, 2011). Stages of change theory has long been applied in the substance abuse arena when determining the individual's readiness for recovery work. Larson applies the same stages of change concepts to supported employment. In terms of costs and benefits, individuals in the early stages perceive high costs and little benefit to competitive employment. As the individual moves through the stages of change, the balance between costs and benefits shifts until the benefits significantly outweigh the costs and the individual prefers competitive employment to unemployment. To support movement between the stages, Larson suggests that motivational interviewing in conjunction with evidence-based practice tools, such as those disseminated by the Substance Abuse and Mental Health Services Administration (SAMHSA), result in better employment outcomes (Larson, 2008).

That study is relevant to understanding the role of personal motivation in the attainment of employment by the mentally ill. While the stages of change theory is more descriptive than prescriptive, it does address the need for motivational support and encouragement by program staff throughout the process. In addition, the recognition that

evidence-based practices and tools produce better employment outcomes continues to be an outgrowth of the literature. SAMHSA (2011), in their toolkit for supported employment cited a claim by the New Freedom Commission on Mental Health that "state-of-the-art treatments, based on decades of research, are not being transferred from research to community settings" (SAMHSA, 2011). Research, such as the Larson study, demonstrates that evidence-based practices are effective in improving outcomes.

The importance of stable, quality housing for individuals with serious and persistent mental illness is another factor that must be considered in assessing the effectiveness of psychosocial and vocational rehabilitation. Research has found correlations between derelict housing and disruptive neighborhoods and anxiety, depression, and fear for personal safety (Gary, et. al., 2007; Silver, et. al., 2002). Given that the seriously mentally ill are often low income, finding and keeping affordable and quality housing is often a major challenge. It is not surprising that the literature indicates that the seriously mentally ill population changes residence at a rate double that of the general population (Newman, 1994). In Mississippi, the Department of Mental Health has identified housing as a primary need for individuals with mental illness (DMH, 2011). To address the housing issue, a number of programs focus on supported or supervised housing which ranges from rent assistance to income-based housing with integrated clinical services. Kloos and Shah, (2009) cite research indicating that supported housing is correlated with longer residence (Hurlbert, et. al., 1996; Shern, et. al., 1997; Tsemberis, 1999); a reduction in institutionalization (Dickey, et. al., 1996); and a reduction in substance abuse and the exacerbation of the symptoms of mental illness (Newman, 2001; Siegel, et. al., 2006).

Kloos and Shah, (2009) developed an empirical model of evaluating the adaptive functioning of individuals with SMI within a social ecology theoretical framework. The continuing trend toward deinstitutionalization of the mentally ill necessitates an understanding of the role of housing in psychiatric recovery. Kloos and Shah (2009) emphasize an independent, community-integrated model of housing for the SMI, independent of the community mental health providers. In Mississippi, deinstitutionalization is occurring at a slower pace than most states. In fact, according to NAMI (2011), Mississippi has the highest rural per capita state mental health hospital bed cost in the country and is second only to New York City in the overall per capita psychiatric bed cost in the nation. As the deinstitutionalization slowly evolves, fully independent housing may be premature. Additional research is needed to determine which populations might be better served by integrated models. The research does, however, clearly support housing as a factor in psychosocial rehabilitation and, in a much broader sense, as a factor in recovery for the mentally ill.

Priebe, et. al., (2009) compared housing services and costs relative to treatment needs for individuals with mental illness in England. That study is important in recognizing the group of individuals with serious mental illness that have been deinstitutionalized but are not yet ready for fully independent housing. Priebe, et. al. (2009) found that support by community mental health professionals was a significant factor in meeting resident needs. At the same time, the researchers found a large deficit in the amount of care-coordination provided to housing residents with mental illness. The study also found that the majority of the residents that were receiving care coordination were likely to be diagnosed with schizophrenia (Priebe, et. al., 2009).

The study concluded that costs were highest in care homes and lowest in floating care support housing (Priebe, et. al., 2009). Care homes provide ongoing treatment for mental illness as an integrated service with housing. Floating care support housing provides interventions only after a problem is recognized and generally on a limited and short term basis focused on problem resolution. While the variations in cost is an expected finding, it does not translate directly to housing and integrated service coordination for the mentally ill in the United States for a variety of reasons, both definitional and cost-related. The researchers also chose to exclude input from residents, obtaining survey response data only from housing providers (Priebe, et. al., 2009). Despite this, the study does confirm the need for integrated clinical care in the housing aspect of the reintegration of the seriously mentally ill into the community.

Reasonable accommodation under the Rehabilitation Act of 1973 and the Americans With Disabilities Act of 1990 has long been recognized by employers in terms of accommodating physical disabilities. MacDonald-Wilson, et. al. (2002) studied psychiatric accommodations in the workplace available to individuals with mental illness. To identify reasonable accommodations for psychiatric disabilities, the researchers deferred to earlier studies by Fabian, Waterworth, and Ripke (1993) that identified reasonable accommodations as including the following: modifying job tasks; modifying hours or schedules; providing orientation and training to coworkers and supervisors; modifying work rules and procedures; modifying job performance expectations; modifying the non-physical work environment by providing physical assistance at the job site; and modifying workplace social norms" (MacDonald-Wilson, et. al., 2002, p. 37).

The literature contains a number of studies suggesting that the cost of the majority of overall workplace accommodations for any disability is less than $500 per person (The

Job Accommodation Network, 1994; The Berkley Planning Associates, 1982; MacDonald-Wilson, et. al., 2002). The researchers also cite studies that indicate that "the few studies that have reported cost data on accommodations for people with psychiatric disabilities suggest that 90% of accommodations cost less than $100 per person (Granger, et. al., 1996) or nothing in direct costs (Fabian, et. al., 1993)" (MacDonald-Wilson, et. al., 2002, p. 37). Although direct costs associated with the accommodation of psychiatric disability in the workplace was found to be minimal, MacDonald-Wilson, et. al. (2002) found that indirect costs were significant in the reallocation of coworker and supervisory time, training time for staff, and reduced productivity. In terms of cost, this level of accommodation may exceed "reasonable" for a small business operation.

Despite accommodations, MacDonald-Wilson, et. al. (2002) found that job tenure was significantly lower in the observed population with psychiatric disabilities than in the general population. Although the researchers acknowledge problems with the generalizability of their findings, this research does suggest two important issues for consideration. First, accommodation for psychiatric disabilities is complex and requires more extensive training of the employer's staff in the workplace than general physical accommodations. Second, accommodations alone are not adequate to increase job tenure; adequate supported employment and clinical integration should be considered as necessary components in vocational interventions.

Comparing Work Programs for Employing/Re-employing the Mentally Ill

Psychosocial rehabilitation programs, operating in the Clubhouse model, mirror a work-ordered day in which consumers are assigned to work units to accomplish the tasks necessary for the daily operation of the Clubhouse. Clubhouse consumers also have

access to clinical services for management of their mental illness. The primary focus within the Clubhouse is the development and improvement of consumer social skills that will assist the consumer with entry or re-entry into the community workforce. The vocational intervention model used in the Clubhouse is known as transitional employment. In this model, consumers receive job training in the Clubhouse and then are placed in employment positions within the community. Clubhouse staff work with local businesses to obtain jobs. A staff member from the Clubhouse is trained to do the job by the employer and, in turn, trains consumers to do the job. Although the consumer receives payment from the community employer for the work done, the Clubhouse provides the training, support, and coverage in the event the consumer cannot work. Transitional employment participants work an average of fifteen to twenty hours per week and are required to rotate from a job every six to nine months. Employers are free to hire transitional employment participants on a full time basis but, should that occur, participants generally leave the transitional program and often leave the Clubhouse program as well.

An alternative vocational intervention for the mentally ill is Individual Placement and Support. This model has become the choice for Vocational Rehabilitation agencies and employment programs independent of clinical services for the mentally ill. Individual Placement and Support is a person-centered model, with the work preferences of the consumer being the focus of the job search. Unlike the train and place approach of transitional employment models, Individual Placement and Support models place the consumer in a job, based on consumer interest, as quickly as possible and then provide the training and support necessary to keep the consumer employed. Individual Placement and Support staff invest the necessary time to educate the supervisors and co-workers of

the newly-placed consumer to make the placement successful. The actual job training is the responsibility of the employer. Participation in the Individual Placement and Support program can be full or part time and the optimal goal of the program is long term, meaningful employment for the consumer.

Integrated Supported Employment models of vocational intervention are similar to the vocational aspects of Individual Placement and Support models. Integrated Supported Employment models also function independently of clinical services for the most part. The fundamental difference between Integrated Supported Employment and Individual Placement and Support is an additional training component provided to the consumer to develop and improve social skills. Bond, et. al. (2001) found comparative research difficult among the program options. To overcome this, the researchers developed a standardized method of defining characteristics of the Individual Placement and Support method of supported employment for research and discussion purposes as well as program duplication. Based on their very limited analysis, Bond, et. al. (2001) concluded that Individual Placement and Support was more successful in work attainment than Psychosocial Rehabilitation. While the population in the research analysis could be argued more vastly different than the general population of psychosocial rehabilitation programs associated with community mental health centers, the research is important in defining characteristics on which to base further comparative research.

Justine Schneider (2003) evaluated the cost-effectiveness of supported employment. Schneider presented evidence supported by research (Mueser, et.al., 2001; Lehman, et. al., 2001) that indicated that Individual Placement and Support participants had better outcomes in obtaining paid employment than standard psychosocial

rehabilitation programs: 75% versus 34% and 42% versus 11% respectively. The Lehman study included individuals with active psychosis, ethnic minority status, and co-occurring substance abuse issues (Lehman, et. al., 2001); a group with multiple and difficult occupational challenges.

L. Dixon, et. al. (2002) looked at individuals with severe mental illness receiving Individual Placement and Support in both the competitive environment and paid training in the sheltered environment. While acknowledging that a true cost analysis was difficult and somewhat ambiguous, Dixon, et. al. (2002) concluded that "it is statistically highly likely that Individual Placement and Support both costs more and produces more competitive employment."

Earlier attempts at cost analysis are present in the literature. E. Sally Rogers, et. al. (1995) presented a cost-benefit analysis based on a limited study of nineteen participants. Participants were selected based on willingness to work part time (20 hours per week) in a university setting. Criteria for participation required that the applicant be stable with adequate housing. The population demographics included the following: 95% white; 74% male; 79% never married; and 89% with an educational level beyond high school. The study identified "society's values of promoting self-sufficiency and preference for work" (Rogers, et. al., 1995) as the motivation for undertaking the study. The research concluded that the loss of SSI benefits was a wash in terms of cost-benefit since it was a cost to the participant and a benefit to the nonparticipant (taxpayer). In actual costs incurred, the research noted an increase in the cost of local mental health services necessary to support the individuals in the community that was offset by a much greater reduction in the cost of the more costly mental health services, including institutionalization. Finally, the study noted no increase in psychiatric symptoms during

the employment period, but clarifies this by stating that all participants were asymptomatic at the beginning of the program (Rogers, et. al., 1995). The Rogers, et. al. (1995) study epitomizes the difficulty in comparative analysis and generalizable outcomes. The participants in that study are not remotely representative of populations served in CMHC psychosocial rehabilitation programs in Mississippi, who are predominantly low income, Afro-American, female, and with less than a high school education (CMHC, 2011).

Koletsi, et. al. (2009) completed a qualitative study of 48 people with psychotic disorders comparing satisfaction between the Individual Placement and Support Model and traditional vocational rehabilitation. The study found that Individual Placement and Support was more effective in assisting with independent employment while traditional vocational rehabilitation directed more clients toward sheltered employment (Koletsi, et. al., 2009). While limited in scope, that study contributed two important findings to the understanding of vocational recovery for the mentally ill. First, positive effects, including increased self-esteem and a reduction in the symptoms of mental illness, were reported by clients who worked regardless of the model of vocational intervention. Second, both models fell short in providing adequate support to individuals after employment was obtained (Koletsi, et. al., 2009). This latter criticism suggests that researchers should consider the level at which individual programs conform to the actual program models, including Individual Placement and Support, Integrated Supported Employment, Vocational Rehabilitation, and Psychosocial Rehabilitation, before drawing comparative conclusions.

The literature demonstrates a limited number of reported long term research studies focused on the comparative advantages of different models of vocational

intervention for the mentally ill. Tsang, et. al. (2010) completed a 39-month study of 189 individuals with mental illness in Hong Kong participating in the Individual Placement and Support Model and a newly-developed Integrated Supported Employment Program for vocational intervention. According to the researchers, "Individual placement and support is currently regarded as the most evidence-based supported employment approach for people with severe mental illness" (Tsang, et. al., 2009, p. 49). This claim is largely based on studies that found Individual Placement and Support programs had an average success rate of finding employment for individuals with mental illness greater than 50% (Latimer, 2008; Tsang, et. al., 2009). Tsang, et. al. (2010) note, however, that Individual Placement and Support is considerably less successful when considered in terms of job retention. The researchers isolate deficits in social functioning and interpersonal skills as found by Corrigan, et. al. (1992) as a major contributing factor to reduced job retention. To address these deficits, Tsang, et. al. (2010) developed a vocational intervention program that combined Individual Placement and Support with a social skill training module developed by Tsang and Pearson (2001). The research concluded, "the long term effectiveness of the Integrated Supported Employment program in enhancing employment rates and job tenures among individuals with severe mental illness has been well demonstrated in the present randomized controlled trial" (Tsang, et. al., 2010).

This study further recognizes the importance of psychosocial rehabilitation in conjunction with vocational intervention although it pairs social skills training with the Individual Placement and Support model of vocational training. The study also found no difference between Individual Placement and Support and Integrated Supported Employment in the outcomes of self-esteem and quality of life issues (Tsang, et. al.,

2010), suggesting that the model of vocational intervention is less relevant than the actual act of working to the individual with mental illness.

In comparing models of employment programs for the mentally ill, a further difficulty lies in the inability of researchers to determine what the ultimate goals should be. Johnson, et. al. (1993) claims "evaluators have yet to reach a consensus about the goals and outcomes of supported employment." Research has shifted focus in some studies away from the outcome of employment as the primary goal to non-vocational positive outcomes. Addressing the effects on psychiatric symptoms, G.R. Bond, et. al. (2001) concluded from their research, "the findings indicate that it is the continued employment, rather than temporary exposure to employment, that has positive effects." This statement is a criticism against the temporary non-competitive transitional employment component of psychosocial educational programs in favor of the competitive Individual Placement and Support Model. Bond, et. al. (2001) also found that "contrary to the assumption of clinicians and caregivers, working does not appear to lead to deterioration in psychiatric symptoms." Earlier work by Drake, et. al. (1999) and subsequent work by Schneider (2003), share similar findings. Specifically, according to Schneider (2003), "while Individual Placement and Support has considerable evidence in its favor when employment is the outcome of interest, there is only limited evidence of its effects on symptoms, self-esteem and other non-vocational outcomes.

While much of the literature takes a stand on a specific model of employment program, and much of the literature favors the Individual Placement and Support model based purely on the primary outcome goal of employment, Kramer, et. al. (2003) suggests that multiple treatment models can be effectively blended to produce better outcomes for individuals suffering from mental illness. Kramer, et. al. (2003) looked at

the introduction of Assertive Community Teams to enhance services provided by traditional psychiatric rehabilitation and case management services with the goal of decreasing hospital psychiatric readmissions. “The present study shows the potential of producing a new generation of interventions by combining the ingredients of separately developed approaches” (Kramer, et. al., 2003).

Burns, White, and Catty (2008) conducted a randomized control trial to compare the effects of Individual Placement and Support and what they referred to as “high-quality train-and-place” vocational rehabilitation to determine the most effective vocational intervention in six European countries including the United Kingdom, Germany, Italy, Switzerland, the Netherlands, and Bulgaria. The researchers cited extensive research validating the effectiveness of the Individual Placement and Support model of supported employment in the United States. Burns, White, and Catty (2008) questioned whether cultural differences and European welfare benefits as a disincentive to work would render the Individual Placement and Support model less effective in Europe. The study confirmed that Individual Placement and Support was as effective in Europe as in the United States. However, the comparison model of vocational intervention was not clearly articulated and therefore, difficult to evaluate. Despite this, the study claimed to confirm three important findings: no significant impact on the success of Individual Placement and Support resulting from fear of loss of benefits; a direct correlation between local unemployment rates and Individual Placement and Support effectiveness; and a reduction in hospitalization rates for individuals receiving Individual Placement and Support (Burns, White, & Catty, 2008).

The findings in that study are somewhat problematic and require further investigation. Given the large geographic area, the different nationalities, and the wide

range of cultural diversity, the sample population (generally approximating 150) was extremely small, placing the generalizability of the study in doubt. The researchers acknowledged that identifying willing participants in the higher welfare benefit countries was problematic but claimed that fear of loss of benefits did not affect the success of the Individual Placement and Support model. The comparison is unclear. Another concern is the finding that hospitalization was reduced, further clarified by claims that this was likely to be the result of the European vocational integration with clinical services (Burns, White, & Catty, 2008). Not only was the sample population too small to validate this claim, the comparison was made with Individual Placement and Support models in the United States that are clinically integrated along a vast continuum. Individual Placement and Support models in the United States range from programs parented by clinical service organizations with full clinical and vocational integration, to models loosely linked with clinical services that only deal with clinical issues when issues of mental illness interfere with work abilities, to Individual Placement and Support models that are fully independent of clinical services. The study further fails to acknowledge that other methods of vocational intervention, including psychosocial rehabilitation and integrated vocational rehabilitation, must be considered before claiming efficacy in reducing institutionalization.

CHAPTER IV

RESEARCH AND METHODOLOGY

Mixed Methods Research

This research will follow a mixed methods research methodology utilizing a quantitative survey questionnaire administered to 168 consumers and 23 staff members and a qualitative case study consisting of open ended responses from the 191 completed questionnaires as well as in depth interviews of 12 consumers and 6 staff members to support the findings. "Mixed methods research is an approach to inquiry that combines or associates both qualitative and quantitative forms. It involves philosophical assumptions, the use of qualitative and quantitative approaches, and the mixing of both approaches in a study. Thus, it is more than simply collecting and analyzing both kinds of data; it also involves the use of both approaches in tandem so that the overall strength of a study is greater than either qualitative or quantitative research" (Creswell, 2009; Creswell & Plano, 2007).

According to Creswell (2009), a number of names have been used to describe the combination of quantitative and qualitative research methods including "integrating, synthesis, quantitative and qualitative methods, multimethod, and mixed methodology." Research by Bryman (2006) and Tashakkori & Teddlie (2003) have emphasized the term mixed methods when describing combined quantitative and qualitative research (Creswell, 2009). Mixed methods research traces its roots to the discipline of psychology and the multi-trait and multi-method matrix of Campbell and Fiske (1959) and has been

increasingly present in the literature since that time (Creswell, 2009). Mixed methods developed over time and found extensive support with researchers in the last two decades. "Numerous published research studies have incorporated mixed method research in the social and human sciences in diverse fields such as occupational therapy (Lysack & Krefting, 1994), interpersonal communication (Boneva, Kraut, & Frohlich, 2001), AIDS prevention (Janz et al., 1996), dementia caregiving (Witzman & Levkoff, 2000), mental health (Rogers, Randall, & Bentall, 2003), and in middle-school science (Houtz, 1995)" (Creswell, 2009). Mixed methods research provides a number of research challenges. These include the required knowledge of both qualitative and quantitative research methods, the need for extensive data collection and the extensive research time investment (Creswell, 2009).

This research will follow a concurrent triangulation strategy. "In a concurrent triangulation approach, the researcher collects both quantitative and qualitative data concurrently and then compares the two databases to determine if there is a convergence, differences or some combination. This method generally uses separate quantitative and qualitative methods as a means to offset the weaknesses inherent within one method and the strength of the other (or conversely, the strength of one adds to the strength of the other). In this approach, the quantitative and qualitative data collection is concurrent, happening in one phase of the research" (Creswell, 2009). In this research, a survey questionnaire for quantitative data collection (See Appendices B & C) was administered to the identified population of approximately 168 consumers and 23 staff members. Based on responsiveness, interest, length of time in the program, and willingness to participate, a non-random sample of two consumers and one staff member from each of the six clubhouses was invited to participate in an in depth interview initiated by the

open-ended survey questions. Weight was given equally to both quantitative and qualitative data. “The mixing during this approach, (discussion section) is to actually merge the data or integrate or compare the results of two databases side-by-side in a discussion. This side-by-side integration is often seen in published mixed methods studies in which a discussion section first provides quantitative statistical results followed by qualitative quotes that support or disconfirm the quantitative results” (Creswell, 2009).

Finally, the theoretical perspective guides the design of the methodology (Creswell, 2009). Theories reviewed in Chapter II, which include New Public Management, Public Value Theory, Social Justice Theory, Active Citizenship Theory, and Intrinsic Work Motivation Theory, are expected to provide the overarching perspective from which this research is drawn. A discussion of the theoretical perspective has been included in the conclusion of this research.

Quantitative Research Methodology

In conjunction with the qualitative analysis, data for quantitative analysis was obtained from a consumer survey questionnaire developed to assess the influence of demographic characteristics and barriers to employment on a consumer’s willingness to participate in transitional employment. By triangulating the findings of the quantitative and qualitative research, the researcher was able to identify similarities in the data and subsequent findings from multiple sources, strengthening the reliability of the conclusions.

Based on the literature review, it can be determined that a significant number of factors may affect the willingness of an individual to participate in transitional employment. For purposes of this research, the following variables have been defined:

Dependent Variable

Y_0 = willing to participate in transitional employment (labeled 'willing to work')

Y_1 = not willing to participate in transitional employment (labeled 'not willing to work')

Research data was obtained from structured interviews of one hundred and sixty-eight psychosocial rehabilitation program consumers and twenty-three psychosocial rehabilitation program staff. Willingness to participate in transitional employment includes both transitional employment and competitive community-based employment. It does not include participation limited to only the clubhouse activities of the work-ordered day.

Independent Variables

The literature review identifies research that comingles many of the variables of interest in assessing willingness to work. Most are addressed in qualitative findings or in response percentages. This study focused on the demographic characteristics of age, living arrangements, and length of time in program, while adding the clinical component of diagnosis. Level of education was excluded from analysis in this study as a result of problems in consistency within the variable coding. A number of consumers identified as having twelve years of formal education had attended Special Education programs. The information system does not always make this distinction and consumers do not appear to be fully aware of the distinction. Household income was also excluded as a result of reporting inconsistencies and the inability of consumers to confirm household income. As a result, these variables were not found to be valid for inclusion in this research. For purposes of this research, the independent variables were defined as follows:

X_1 = Age: Program participants range in age from 18 to 64 years of age. Actual age at the time of the interview was used in this study.

X_2 = Living Arrangements: Categories include independent living; supervised/supported living; and living with parents and/or extended family.

X_3 = Length of Time in Program in years: For purposes of this research, individuals with less than one year of attendance are not eligible for transitional employment and were excluded.

X_4 = Diagnosis: Categories include Schizophrenia/Schizoaffective Disorders; Major Depressive Disorders; and Other Psychoses and mental illness.

Additional Independent Variables

While the literature is heavily weighted toward program comparisons, the obstacles and barriers are similar to participants across all vocational intervention program models. Based on the literature, these obstacles are further categorized as stigma/attitudes; external influence; symptoms of mental illness; training/educational/experience deficits; social/behavioral/cognitive deficits; and financial barriers to employment. These variables are further clarified by the following:

X_5 = Stigma/Attitudes: defined as a perception of discrimination or negative feeling toward the mentally ill in the workplace or in the general public.

X_6 = External Influence: defined as the perceived influence by family members and/or staff members related to the ability or willingness of the consumer to work and threats to loss of benefits. This was measured by an affirmative or negative response by the consumer as to whether or not external influence affected the consumer's willingness to participate in transitional employment.

X_7 = Symptoms of Mental Illness: defined as the exacerbation of the symptoms of mental illness to the point that the individual is unable to work or the perception that an exacerbation of that magnitude will occur if an individual participated in community-based employment. This was measured by an affirmative or negative response by the consumer as to whether or not the

consumer is unwilling to participate in transitional employment because they fear, or have previously experienced, an exacerbation of the symptoms of mental illness in the workplace.

X_8 = Training/Experience/Education Deficit: defined as reported deficits or lack of GED/high school education or less than 1 year previous work experience.

X_9 = Social/Cognitive/Behavior Deficit: defined as impairments that impede the ability to perform work activities or impairments that are perceived will occur or increase if an individual participates in community-based employment. This was measured by an affirmative or negative response by the consumer when asked if social/cognitive/behavior deficits or the fear of such deficits in the workplace affected the willingness of the consumer to participate in transitional employment.

X_{10} = Financial Barriers to Employment: defined as the perception or belief that loss of benefits (SSI/SSDI or Medicaid) will occur as a result of participation in paid employment. This was measured by an affirmative or negative response by the consumer when asked if financial barriers to employment affected the consumer's willingness to participate in transitional employment.

X_{11} = Total Barriers to Employment: defined as the sum of the findings for all defined barriers to Employment ($X_5 - X_{10}$) including Stigma/Attitudes, External Influence, Symptoms of Mental Illness, Training/Experience/Education Deficit, Social/Cognitive/Behavior Deficit, and Financial Barriers.

Each questionnaire has a variety of questions that address each of the barriers to employment. For purposes of the study, specific answers to questions were assigned to indicate a barrier to employment when appropriate. Table 6 below illustrates the coding of questions in the consumer questionnaire to the appropriate barriers to employment. Appendix D contains each relevant question's specific coding response.

Table 6 Consumer Questionnaire Variable Relationships

Obstacle/Barrier	Corresponding Responses from Consumer	Employment interest	Barriers to Employment
Stigma/Attitudes	20, 70, 71	20, 21	#9 ranked in top 3
External Influence	20, 56, 57, 58, 61, 62, 63, 66, 67, 69	11, 12, 15, 16, 18, 19	#7 ranked in top 3
Symptom of Mental Illness	9, 24, 26, 45, 55	10	#6 ranked in top 3
Training/Experience/Education Deficits	22, 32 .34, 38, 39, 43, 47,.72, 74, 76	1, 2, 6, 7, 8	#1 or #2 or #8 ranked in top 3
Social/Cognitive/Behavior Deficits	12, 21, 22, 25, 31, 35, 36, 43	4, 13	#5 ranked in top 3
Financial Barriers	59, 60, 62, 65, 68	3, 14, 17	#3 or #4 ranked in top 3

(See Consumer Questionnaire, Appendix B)

Hypotheses

Theorizing that multiple variables affect the willingness of a consumer to participate in transitional employment in the psychosocial rehabilitation model, the research proposed to test the following directional hypotheses:

H_1 = Older consumers are more likely to be willing to participate in transitional employment than younger consumers.

H_2 = Individuals that live independently are more likely to be willing to participate in transitional employment than individuals that live with family and individuals that live in group homes/supported housing.

H_3 = Individuals with Major Depressive Disorders and other Psychoses and Mental Health Disorders will be more likely to be willing to participate in transitional employment than individuals with Schizophrenia.

H_4 = Individuals with less years of attendance in the PSR program are more likely to be willing to participate in transitional employment than individuals with more years of attendance in the PSR program.

H_5 = Individuals that report less Stigma/Attitudes as a barrier to employment will be more willing to participate in transitional employment than individuals that report more Stigma/Attitudes as a barrier to employment.

H_6 = Individuals that report less External Influence as a barrier to employment will be more likely to participate in transitional employment than individuals that report more External Influence as a barrier to employment.

H_7 = Individuals that report less Symptoms of Mental Illness as a barrier to employment will be more willing to participate in transitional employment than individuals that report more Symptoms of Mental Illness as a barrier to employment.

H_8 = Individuals that report less Educational/Training/Experience Deficits as a barrier to employment will be more willing to participate in transitional employment than individuals that report more Educational/Training/Experience Deficits as a barrier to employment.

H_9 = Individuals that report less Social/Cognitive/Behavior Deficits as a barrier to employment will be more willing to participate in transitional employment than individuals that report more Social/Cognitive/Behavior Deficits as a barrier to employment.

H_{10} = Individuals that report less Financial Barriers as a barrier to employment will be more willing to participate in transitional employment than individuals that report more Financial Barriers as a barrier to employment.

H_{11} = Individuals that report a high number of Total Barriers as a barrier to employment will be more willing to participate in transitional employment than individuals that report a low number of Total Barriers as a barrier to employment.

A summary of the hypotheses is illustrated in the Quantitative Research Model presented below:

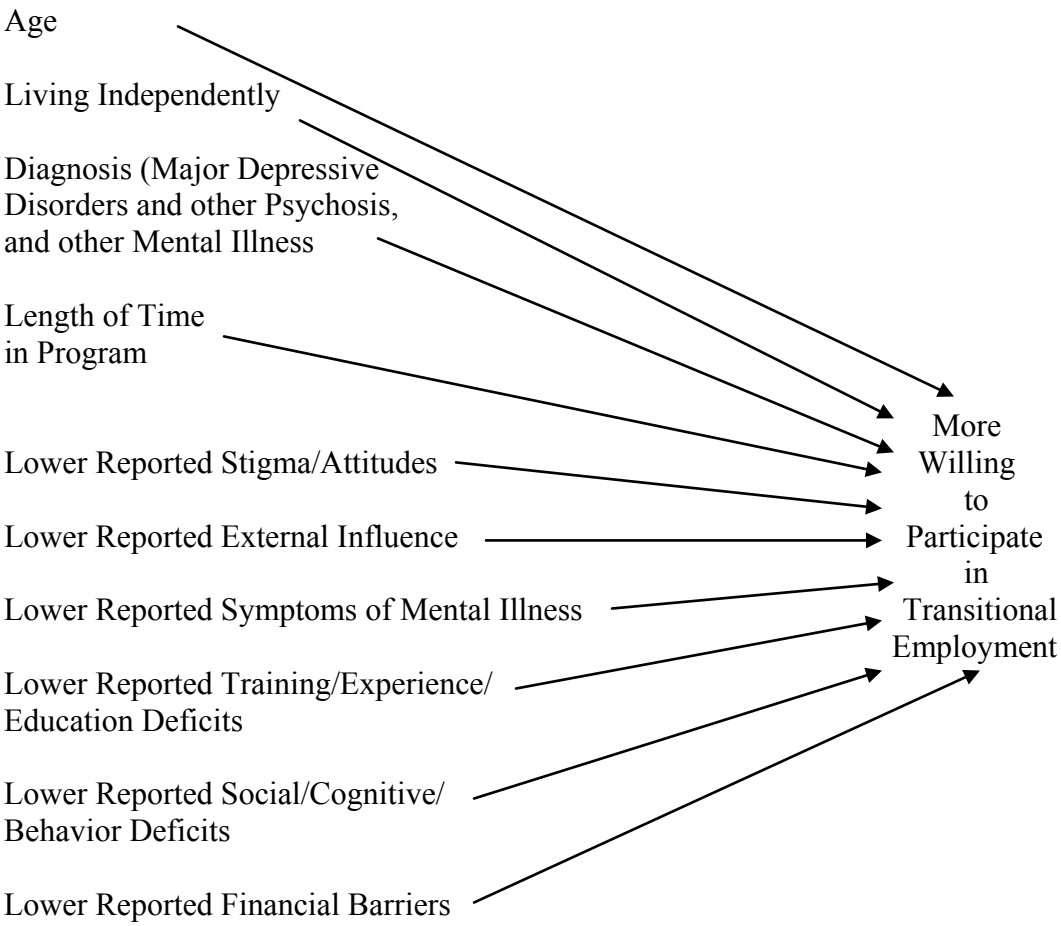


Figure 3 The Quantitative Research Model

Sample Determination

According to the Mississippi Department of Mental Health (2011), there are sixty-four certified psychosocial rehabilitation clubhouse programs in Mississippi. In the 2010 fiscal year, the programs served 5158 consumers (DMH, 2011). The number of participating consumers includes individuals that participated less than the full fiscal year and elderly consumers. Excluding these individuals from the population, the total population of psychosocial rehabilitation participants eligible for transitional employment and relevant to this study is 2648. The total population of staff members in the sixty-four certified programs is 246. The sample population will be drawn from six psychosocial

rehabilitation clubhouse programs in north central Mississippi. Observations for more than fifteen years, collaborative trainings, and annual consumer conferences have determined that all clubhouse populations are remarkably similar in demographics and clinical diagnoses. This experience suggests that focusing on clubhouses in one regional area will not differ from random program selection across the state. Semi-structured interviews, using questionnaires developed to solicit research data, were conducted with all psychosocial rehabilitation consumers and staff in the designated area. Initially, 256 consumers and 30 staff comprised the sample population. Consumers above the age of 65, or in the program less than one year, or with a co-occurring diagnosis of moderate or severe mental retardation totaled 56, leaving the total sample of 200 consumers. 21 consumers are listed on the role of the PSR programs but not currently attending and could not be reasonably accessed for participation and 12 consumers refused to participate. 168 consumers participated resulting in a response rate of 84%. Of the 30 eligible staff members, 5 were vacant positions and 2 refused to participate leaving a 77% response rate and an n=23 staff.

IRB Approval

As the research project involves human subjects, Institutional Review Board approval was necessary. Communication was initiated with Nicole Morse, IRB Assistant Compliance Administrator, Mississippi State University, on IRB Study #11-114: "Determining Effective Outcomes in Psychosocial Rehabilitation for the Mentally Ill: a Knowledgeable Citizens' Perspective." The IRB application was reviewed and approved via expedited review in accordance with 45 CFR 46.110 #7 on 6/08/2011.

Recruitment

In order to recruit participants, a general meeting was held in each psychosocial rehabilitation program introducing the research, its purpose and intent, discussion of the informed consent, and inviting participation. No inducements or incentives were provided other than informing the participants that their voice is valuable in helping others understand their program and how it should be measured in terms of success. The primary researcher conducted the consent interview. This interview included permission to access the face sheet of each consumer's medical record for demographic and diagnostic information. All permissions and access were HIPAA compliant. Participants were given a brief overview of the role of the Department of Mental Health, the Division of Medicaid, evidence-based practices, and the role of outcome measures. There was clear communication that participation was voluntary and that all personal identifiable information would be protected and destroyed at the conclusion of the study.

Pilot Testing

The quantitative survey questionnaire was pilot tested with one consumer and one staff member randomly selected from each of the six clubhouses before being conducted with the full population to assess content validity. All participants in the pilot test were able to complete the survey in thirty to forty minutes with appropriate answers, although the questions had to be read to four of the consumers and the answers recorded by the primary researcher due to literacy issues. With content validity affirmed, the survey questionnaire was not modified. Any difficulties incurred when administering the survey questionnaire to the full sample population has been documented in the research findings.

Qualitative Research Methodology

This research consisted of both a qualitative and a quantitative component, lending strength to the empirical conclusions. Qualitative research, derived from a case study approach, was utilized to identify consistencies and conflicts between the standards and requirements, the policies and procedures, and the defined outcome measures of the Department of Mental Health as the certifying agency, the Department of Medicaid as the funding agency, the psychosocial rehabilitation model in place, and the perspectives of the knowledgeable citizens in the dual roles of citizen and consumer and citizen and staff member respectively. "Case studies are a strategy of inquiry in which the researcher explores in depth a program, event, activity, process, or one or more individuals. Cases are bounded by time and activity" (Creswell, 2009; Stake, 1995). Concurrent with the collection of quantitative data, two consumers and one staff member from each of the six clubhouses (n=18) will be invited to participate in an in depth interview to explore the topic of work motivation and barriers to employment.

The qualitative aspects of this research project consisted of responses to open-ended questions by consumers and staff members, case study data obtained from the in depth interviews, as well as demographic and clinical data obtained from the medical record, and a review of the standards, regulations, and relevant documents related to the certification and funding of psychosocial rehabilitation by the Mississippi Department of Mental Health and the Mississippi Division of Medicaid respectively. The semi-structured interview questionnaire was developed based on primary and secondary issues identified in the literature review and requiring further investigation. To obtain both qualitative and quantitative data from the knowledgeable citizens identified in this study, a semi-structured interview questionnaire was developed. This multiple item document

contained definitive as well as open-ended questions aimed at data collection for both case study and quantitative analysis. (See Questionnaires: Appendix B and Appendix C). The open-ended questions within the survey served as the starting point for the in depth interviews. With consumer consent, demographic and diagnostic information were obtained from the consumer's computer-based medical record. The information obtained from this source was verified for current accuracy with the consumer at the time of the interview. Figure 4 below illustrates the Qualitative Research Model employed in this study.

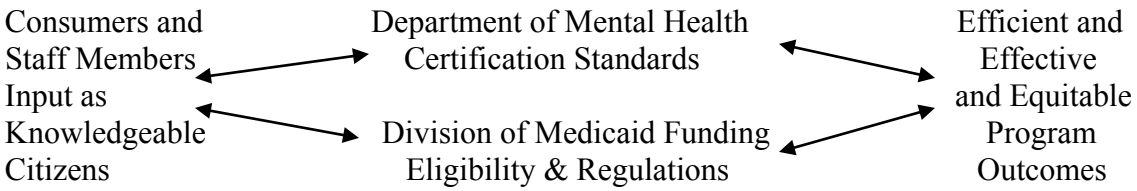


Figure 4 The Qualitative Research Model

It was expected that the qualitative research would demonstrate the applicability of a blending of the theories of New Public Management, Public Value Theory, Social Justice Theory, and Active Citizenship Theory in explaining the appropriate determinants of program outcomes. The case study of the psychosocial rehabilitation program model was also expected to address the relevance of Intrinsic Work Motivation Theory in explaining participant motivation to initiate and sustain work-oriented task completion in the clubhouse. This semi-independent aspect of the research was intended to evaluate whether the program structure and management are congruent with the goal of transitional employment and consistent with the standard of providing "meaningful" work.

Case Study

Psychosocial rehabilitation is a treatment method for mental illness that fosters the development of social skills and positive consumer interaction as a foundation for reintegrating adults with mental illness into communities. Historically, the benefits of the program have been anecdotal and were best described by Social Justice Theory reflected in the entitlements of the state Medicaid program. As the tenants of New Public Management and Public Value Theory have gained a foothold, agencies have struggled with the identification of appropriate outcome measures. This study utilized a knowledgeable citizen approach adopted from Active Citizenship Theory to assist with the identification of appropriate outcomes. This premise incorporates input from consumers and staff into the decision process.

Six Clubhouses in north central Mississippi were selected for study. From experience, observation, and data reporting by mental health centers across the state, these programs were identified as representative of Clubhouses across the state. The demographics of the consumers and staff are illustrated in Table 7 below.

Table 7 Program Staff and Consumer Demographics

Sex	Consumers	52% male	48% female
	Staff	22% male	78% female
Age	Consumers	Range 19 - 65 yrs.	Average age = 41 yrs.
	Staff	Range 28 - 65 yrs.	Average age = 47 yrs.
Race	Consumers	87% African-American	13% White
	Staff	87% African-American	13% White
Length of Time in Program	Consumers	Range 1 - 20 yrs.	Average = 12 yrs.
	Staff	Range 1 - 20 yrs.	Average = 6.7 yrs
Level of Education	Staff	78 High School 13 Bachelor 9 Masters	13 Bachelor Degree

The confidential nature of the diagnoses and treatment issues of the consumers makes access somewhat difficult. The primary researcher did have an employment relationship with the agency in which these programs are located during the data collection phase of the research, but did not have any direct responsibility for or interaction with these programs in an employment capacity. The program staff and consumers were receptive to participating in the survey and interview process. Consumers incorporated the research process into their daily Clubhouse activities. In each location, the primary researcher was greeted by a consumer, given a tour of the facility, provided information about the work units and current activities of the program, and introduced in a general meeting of consumers and program staff.

Completing the questionnaires turned out to be a time-consuming process due to literacy and attention-span issues. Several consumers had physician appointments, were absent from the program, or had work conflicts that necessitated rescheduling the survey for a later time. The literacy issues were addressed by reading the questionnaire to consumers with limited reading ability and writing their responses on the document. This generally added fifteen to twenty minutes to the survey time which, without assistance, averaged thirty to forty minutes and did not require one-on-one assistance. In addition to the primary researcher, staff members and other consumers also assisted consumers with literacy issues under the supervision of the primary researcher to ensure that accurate answers were documented. When the surveys were reviewed, a number of questions were found to have been left blank. These responses were obtained, whenever possible, by returning to the Clubhouse to complete the document or contacting the consumer at the Clubhouse by telephone.

In addition to the survey process, eighteen interviews were completed with consumers and staff members. The interviews were conducted in the Clubhouse settings in an area away from current activities. The process consisted of two interviews for each participant. The initial interview was conducted face-to-face and lasted from thirty minutes to an hour. After summarizing the interview notes and reviewing the questionnaires, interview participants were contacted for a second interview. Nine of the second interviews were conducted in the Clubhouse setting face-to-face and nine of the second interviews were conducted by telephone. Second interviews ranged in length from fifteen minutes to forty-five minutes depending on the range of topics and participant responses. Three follow-up telephone third interviews lasting approximately ten to twenty minutes each were conducted for clarification of comments. For consumers, the

interviews focused largely on personal issues, their illness, how they were hoping to improve their lives, and the role the Clubhouse played in their lives. Program staff were more likely to focus on immediate issues and concerns in the program. Management staff were also more likely to characterize the program in the 'ideal,' with discrepancies between managers and assistants and staff and consumers very apparent. Although the observations of the programs were limited to the time spent during the research, in only one of the six programs were consumers fully engaged in work units and activities during the observation periods. In the other programs, more than half of the consumers were idle and at least twenty consumers throughout the programs were observed to be sleeping.

The kitchens and snack bars appeared to be well-stocked, although the snacks available were, for the most part, non-nutritious. Each program contained a washer and dryer and dining and office furniture. Only two cash registers and one copy machine were observed throughout the six programs. All computers were dated, had limited software, and did not have internet access. Consumers reported that much of the equipment was broken or inoperable. Despite limitations, consumers were upbeat and easily engaged in social contact. Seventeen transitional employment placements were reported currently active. However, only two of these were in positions outside the parent agency. Fourteen of the positions were housekeeping or janitorial related.

The current program structure consists of work units located in designated areas of the Clubhouse facilities. Common Clubhouse units include clerical, kitchen, snack bar, thrift store, and janitorial. Some Clubhouses have added library units, garden units, and vehicle maintenance units. Transitional Employment is a separate function within the Clubhouse and is managed by staff. Clubhouses provide a modified or full breakfast and a full noontime meal. According to staff, more than 50% of consumers identify

themselves as smokers. Facilities and grounds have been designated as ‘smoke free’ in recent years by agency management. Each Clubhouse begins the day with a morning meeting where issues are discussed, rules are reinforced, and activities are planned. Some meetings include prayer and singing to start the day.

Due to Medicaid constraints, leisure activities such as shopping trips, eating out, bowling, skating, parties, and holiday celebrations are planned for after program hours. Training and educational activities are limited to that gained by working in the units or related activities planned for after program hours as well. Transportation to and from the Clubhouse is provided by agency staff driving agency-owned vehicles. Less than 5% of consumers provide their own transportation.

CHAPTER V

RESEARCH FINDINGS

Quantitative Analysis

Descriptive statistics for the variables identified in the Quantitative Research Model are presented in Table 8 below. (Response frequencies are detailed in Appendix H.)

Table 8 Descriptive Statistics

Independent Variable	*Minimum Responses*	*Maximum Responses*	*Mean*	*Standard Deviation*
Age (in actual yrs)	19	64	41.0417	12.58521
Living Arrangements 0 = Independent Living 1 = other arrangements	0	1	.2440	.43081
Diagnosis 0 = Schizophrenia/Schizoaffective 1 = Major Depressive Disorders, other psychoses, other mental illness	0	1	.3810	.48707
Length of Time in PSR (in actual yrs.)	1	20	8.6786	6.27086
Stigma/Attitudes (6 possible responses)	0	6	2.7738	1.76358
External Influence (17 possible responses)	1	16	7.5893	3.71166
Symptoms of Mental Illness (7 possible responses)	0	7	2.7798	2.18439
Training/Experience/Education Deficits (19 possible responses)	2	16	9.3631	3.07866
Social/Cognitive/Behavior Deficits (11 possible responses)	0	9	3.8036	1.80239
Financial Barriers (10 possible responses)	2	10	6.5357	1.89629
Total Barriers (70 possible responses)	1	53	32.8571	9.62052
Dependent Variable	*Minimum Responses*	*Maximum Responses*	*Mean*	*Standard Deviation*
Willingness to Participate in Transitional Employment 0 = willing 1 = not willing	0	1	.5119	.50135

(n = 168 for all variables)

Table eight provides a descriptive assessment of the data included in the analysis. The results indicate that the average research participant is 41 years of age and has participated in the psychosocial rehabilitation program for 8.68 years. The youngest and oldest participants are 19 and 64 years of age, respectively. The participation rate ranges from a low of 1 year to a high of 20 years of participation in the psychosocial rehabilitation program. The remaining demographic variables, living arrangements and diagnosis, are dichotomous. Living arrangements is coded by identifying those that live independently as the referent category. Accordingly, approximately 24.4% of the participants live on their own. The remaining population maintain residency in some form of supported living arrangement or with family or other family caregivers. Approximately 38% of participants have been diagnosed with schizophrenia or schizoaffective disorders. The remaining sample has been diagnosed with major depressive disorders, other psychoses, or other mental illnesses.

Five variables gauge different types of barriers to respondents' willingness to participate in transitional employment The two variables with the largest number of barriers identified by survey respondents include External Influence and Training/Experience/Education Deficits. The variable External Influence assesses the level of influence by family members, close friends, respected peers, and staff on consumer's willingness to participate in transitional employment, while the variable Training/Experience/Education Deficits assesses deficiencies that may also affect the willingness of consumers to participate in transitional employment. A maximum of 16 barriers were reported for both variables. The average number of barriers for External Influence is 7.59, while the average number of barriers for Training/Experience/ Education Deficits is slightly higher at 9.36. The barrier with the least number of items

identified is Stigma/Attitudes (maximum of 6 and minimum of 0). The average number of financial barriers identified is 6.54 (range of 2 to 10). The mean number of Social/Cognitive/Behavior Deficits is 3.80. Lastly, the mean number of responses to Symptoms of Mental Illness as a barrier is 2.78 (minimum of 0 and maximum of 7).

A full logistic regression model, including all variables except Total Barriers, was completed utilizing SPSS. This quantitative model was utilized to determine the influence and predictive value of each variable in the model. The findings of this full model are provided below.

Full Regression Model

Model Summary

Step	-2 Log likelihood	Nagelkerke R Square
1	88.892[a]	.767

a. Estimation terminated at iteration number 6 because parameter estimates changed by less than .001.

Table 9 Full Regression Model

Variables in the Equation	*B*	*S.E.*	*Wald*	*Df*	*Significance*
Age	.004	.028	.018	1	.894
Living Arrangements	-.576	.746	.595	1	.440
Variables in the Equation	*B*	*S.E.*	*Wald*	*Df*	*Significance*
Diagnosis	.504	.645	.611	1	.435
Yrs. of Attendance in PSR	.000	.057	.000	1	.997
Stigma/Attitudes	-.327	.197	2.753	1	.097
External Influence	-.205	.111	3.417	1	.065
Symptoms of Mental Illness	-1.074	.240	20.095	1	.000
Training/Experience/Education Deficits	-.086	.099	.741	1	.389
Social/Cognitive/Behavior/Deficits	-.169	.178	.014	1	.343
Financial Barriers	-.022	.182	.014	1	.905
Constant	6.843	2.008	11.619	1	.001

Nagelkerke R square indicates that there is a strong relationship between the variables in the full model and Willingness to Participate in Transitional Employment. The full model indicates that Age, Living Arrangements, Diagnosis, Years of Attendance in PSR, Training/Experience/ Education Deficits, Social/Cognitive/Behavioral Deficits, and Financial Barriers are not statistically significant in this model and, therefore, are not predictive of Willingness to Participate in Transitional Employment. The model does confirm that three variables are statistically significant and predictive as to whether an individual will be willing to participate in transitional employment. Stigma/Attitudes is statistically significant at the .1 level in a two-tailed test. External Influence is significant at the .1 level in a two-tailed test. While the level of significance for these two variables is less than preferred, it will be accepted in this research. "In the business world if something has a 90% chance of being true (probability = .1), it can't be proven but it is probably better to act as if it were true than false" (The Survey System, 2012). Symptoms of Mental Illness were found to be the most predictive of willingness to participate in transitional employment. Symptoms of Mental Illness are statistically significant at the < .001 level in a two-tailed test.

To further investigate the interaction of variables, a reduced logistic regression model was developed to analyze the influence of the demographic variables. Independent variables of Age, Years in Attendance at PSR, Living Arrangements, and Diagnosis were regressed against the dependent variable Willing to Participate in Transitional Employment. The findings of this reduced logistic regression model are presented below.

Demographic Variables Only Regression Model

Model Summary

Step	-2 Log likelihood	Nagelkerke R Square
1	224.327[a]	.066

a. Estimation terminated at iteration number 6 because parameter estimates changed by less than .001.

Table 10 Demographic Variables Only Regression Model

Variables in the Equation	*B*	*S.E.*	*Wald*	*Df*	*Significance*
Age	-.024	.015	2.327	1	.127
Living Arrangements	-.397	.383	1.074	1	.300
Diagnosis	.574	.335	2.932	1	.087
Yrs. of Attendance in PSR	-.010	.030	.108	1	.742
Constant	.984	.556	3.133	1	.077

Nagelkerke R square indicates there is a very weak relationship between the demographic variables and Willingness to Participate in Transitional Employment. The model found no statistical significance between Age, Years of Attendance in PSR, and Living Arrangements, and Willingness to Participate in Transitional Employment. The model did find that Diagnosis is statistically significant at the .1 level of significance in a two-tailed test. As indicated in the full logistic regression model, this level of significance is accepted in this research. In this reduced model, only Diagnosis is predictive of Willingness to Participate in Transitional Employment.

A second reduced logistic regression model was developed to determine the predictive value of the six barriers to employment. In this model, the independent variables of Stigma/Attitudes; External Influence; Symptoms of Mental Illness; Training/Experience/Educational Deficits; Social/Cognitive/Behavioral Deficits; and

Financial Barriers were regressed against the dependent variable Willingness to Participate in Transitional Employment. The findings of this logistic regression model are presented below.

Barrier Variables Only Regression Model

Model Summary

Step	-2 Log likelihood	Nagelkerke R Square
1	90.045[a]	.763

a. Estimation terminated at iteration number 6 because parameter estimates changed by less than .001.

Table 11 Barrier Variables Only Regression Model

Variables in the Equation	*B*	*S.E.*	*Wald*	*Df*	*Significance*
Stigma/Attitudes	-.317	.188	2.836	1	.092
External Influence	-.175	.103	2.874	1	.090
Symptoms of Mental Illness	-1.102	.235	21.918	1	.000
Training/Experience/Education Deficits	-.095	.095	.998	1	.318
Social/Cognitive/Behavior Deficits	-.183	.175	1.085	1	.297
Financial Barriers	-.079	.170	.215	1	.643
Constant	7.414	1.701	19.005	1	.000

Nagelkerke R square indicates there is a strong relationship between the independent variables in this research model and Willingness to Participate in Transitional Employment. Three variables, Training/Experience/Education Deficits, Social/Cognitive/Behavioral Deficits, and Financial Barriers were found to have no statistical significance in this reduced model and are, therefore, not predictive of Willingness to Participate in Transitional Employment. Stigma/Attitudes as a barrier to employment is statistically significant at the .1 level of significance in a two-tailed test.

External Influence is also statistically significant at the .1 level of significance in a two-tailed test. While the level of significance is again less than preferred, this research will accept the significance level as indicating that Stigma/Attitudes and External Influence are predictive of Willingness to Participate in Transitional Employment. The strongest finding in this reduced model is the significance of Symptoms of Mental Illness as a barrier to employment. In this model, Symptoms of Mental Illness is found to be statistically significant at the < .001 level in a two-tailed test indicating that this variable is the greatest predictor of Willingness to Participate in Transitional Employment in this reduced logistic regression model.

Finally, the demographic variable model, which included Age, Years of Attendance in PSR, Living Arrangements, and Diagnosis, was revisited and a variable of Total Barriers (to employment) was introduced to determine the predictive value of a variable that combines the findings of the six identified individual barriers to employment. The findings of this reduced logistic regression analysis are presented below.

Demographic Variables and Total Barriers Regression Model

Model Summary

Step	-2 Log likelihood	Nagelkerke R Square
1	140.079[a]	.566

a. Estimation terminated at iteration number 6 because parameter estimates changed by less than .001.

Table 12 Demographic Variables and Total Barriers Regression Model

Variables in the Equation	B	S.E.	Wald	Df	Significance
Age	-.040	.020	4.021	1	.045
Living Arrangements	-.841	.530	2.515	1	.113
Diagnosis	.342	.453	.570	1	.450
Yrs. of Attendance in PSR	.021	.041	.273	1	.602
Total Barriers to Employment	-.220	.033	44.459	1	.000
Constant	8.898	1.427	38.900	1	.000

Nagelkerke R square indicates that there is a moderate to strong relationship between the variables in this reduced regression model and Willingness to Participate in Transitional Employment. When Total Barriers are introduced as an independent variable in the model, Age becomes statistically significant at the .05 level of significance in a two-tailed test. Diagnosis is no longer statistically significant in this model. Neither Years of Attendance in PSR, nor Living Arrangements are statistically significant in this model. The strongest predictor of Willingness to Participate in Transitional Employment in this new model is Total Barriers (to employment). Total Barriers was found to be significant at the < .001 level of statistical significance in a two-tailed test.

While demographic characteristics are often found to be good predictors of behaviors in social science research, this study did not produce similar findings. In the full model, no demographic variables were found to be statistically significant. In a reduced model that considered only demographic variables, Diagnosis was found to have a low statistically significant level of predictability for Willingness to Participate in Transitional Employment. When Total Barriers was introduced to the model, Diagnosis was no longer determined to be statistically significant but Age became statistically significant at a very low level. Total Barriers, however, was found to be statistically significant at a very high level and the best predictor in the model for Willingness to

Participate in Transitional Employment. A reduced model was also developed to determine the influence of each of the barriers to employment on Willingness to Participate in Transitional Employment. Only three variables were identified as statistically significant. Stigma/Attitudes and External Influence were found to be statistically significant at a very low level, while Symptoms of Mental Illness demonstrated a high level of statistical significance and was found to be the best predictor of Willingness to Participate in Transitional Employment in this reduced model. Overall, the quantitative research indicates that barriers to employment are the best predictors of willingness to participate in transitional employment.

Qualitative Analysis

Case Study Findings

A thematic coding process was developed to analyze the data obtained from the open-ended questions on the survey questionnaires administered to 168 consumers and 23 staff, and the in-depth interviews conducted with 12 consumers and 6 program staff. The themes were identified as Program Design and Elements; Employment/Barriers to Employment; and Program Evaluation. Based on the subject matter of each question and interview topic, responses were thematically coded and assembled in tables to document the findings and facilitate conclusions and discussion. (See Appendix G

Theme 1: Program Design and Elements

In the initial interview process, staff and consumers were asked to discuss the current program structure and whether or not it accurately described their Clubhouse model. Interviews disclosed that, while all Clubhouses had operational work units, the work units did not always have adequate tasks and activities available to keep consumers

engaged in meaningful work for more than short periods of time. Most of those interviewed agreed that, while about half of the consumers remained in their work units for most of the day, they were only actively participating for two to three hours. Both staff and consumers agreed that the remaining consumers were non-participatory most of the day, except for meals. They attributed this lack of participation to lack of work in the Clubhouse and lack of interest in work tasks on the part of consumers. The questionnaire asked staff and consumers to choose the elements they would include in a psychosocial rehabilitation program. Staff focused on elements that they found lacking in current psychosocial rehabilitation programs, including more educational services, leadership/strong supervisory skills, coordinated housing, computers, and the availability of daycare for consumers while they attend program. Consumers focused more on current program elements, including more activities, more outings, more outside things to do, more work/work units, and more jobs in the community. Twenty percent of consumers reported that they wanted their Clubhouse program to remain the same. The most frequently mentioned elements that consumers wanted to include in a psychosocial rehabilitation program were work and education/training related.

Staff and consumers were asked during the interview how the additional program elements would make the program more successful. One discussion focused on the improvement of the work units. “I think it should start by identifying member’s preferences and creating units to reflect this.” Another discussion focused on increasing job opportunities in the community. A suggestion was made “to create an Advisory Board consisting of employers, community officials, and community members” to facilitate and promote community employment for the mentally challenged. The interviews also identified ways in which an enhanced program with educational and

training services would demonstrate an improvement in the quality of life for consumers. Responses include that "through the testimonies of families, consumers, local agencies, community members, etc., we would be able to gage just how well the program is affecting the lives of the individuals" and "through surveys and staff documentation of long term monitoring, there should be data that would tell whether or not consumers are being helped and/or improving their quality of life."

Staff and consumers were asked to identify the resources needed to meet program goals. Once again, education, training, and work related resources were most frequently identified by respondents. Staff identified computers/printers, educational materials, and internet service most frequently. Consumers identified educational services/GED classes, job training, more jobs in the community and computers/printers as their most needed additional resources. Staff and consumers were asked directly if educational services and work training should be offered by the Clubhouse. Sixty-five percent of staff and 63% of consumers responded that educational services should be provided by the Clubhouse; while 65% of staff and 52% of consumers responded that work training should be provided by the Clubhouse as well.

The lower rate of consumers responding that work training should be provided by the Clubhouse was discussed in the interview process. Several participants suggested that educational services are desired by consumers whether or not they wish to obtain employment, while work training is only preferred by those that desire employment. It was also suggested in one consumer interview that many consumers are content with low stress janitorial or menial labor that does not require additional work training.

Coordination with Vocational Rehabilitation Services was identified by staff as one reason the Clubhouse should not provide educational or training services. Several

staff members, in written survey responses, suggested that education and training do not affect the ability of consumers to obtain paid work. This suggestion was presented to several staff members in the interview process. Each of the staff members interviewed expressed disagreement with the statement and further suggested that there is a bias on the part of many psychosocial rehabilitation program employees that consumers are limited to menial janitorial work that does not require education or training.

A number of questions were posed to ascertain the importance of transitional employment as a part of the Clubhouse services. Forty-four percent of consumers responded that transitional employment was the most important component of the psychosocial rehabilitation program, while only 26% of staff members similarly responded. Despite this, 83% of staff and 81% of consumers stated that transitional employment should continue to be a component of the psychosocial rehabilitation program. (Survey responses for Theme 1: Program Design and Elements are summarized in Tables 14-23 in Appendix G.)

Theme 2: Employment/Barriers to Employment

In addition to exploring issues related to defining a psychosocial rehabilitation program, this study explored consumer employment and barriers to employment. Two aspects of consumer employment were investigated: consumer participation in the Clubhouse work units and consumer participation in the transitional employment program. When asked to identify the percentage of consumers actively participating in Clubhouse work units, staff responses varied widely, ranging between 2% and 100%, with an average of 52%. Within Clubhouses, the range of responses was somewhat narrower, but a difference of thirty to forty percentage points was not uncommon. In one

program, participation was consistently reported at 95%. This program was also observed during the research as having nearly all consumers engaged and actively participating in work activities. Staff most frequently mentioned 'liking work' and 'gaining work experience/learning work skills' as the reasons they believed consumers participated in the work units.

Staff were more likely to be consistent in identifying reasons that they believed consumers do not participate in Clubhouse work units. The most frequently reported reasons staff believed consumers do not participate include 'not interested/don't want to participate', 'some are not able', 'symptoms of mental illness', 'not getting paid', and 'lack of education'. Ten percent of staff reported that consumers were lazy. This finding was further explored with staff participating in the interview process. While none of the staff interviewed stated that they thought consumers were lazy, they did express the opinion that a number of consumers were unmotivated to work, particularly those that had never worked before. It was also stated that staff often found themselves frustrated by the effort required to motivate and encourage consumers to sustain participation in the work units. This frustration was sometimes manifested in characterizations such as lazy, resistant to treatment, and uncooperative.

Staff were asked what percentage of consumers were able to participate in transitional employment. Once again, responses varied widely, from 2% to 70%, with an average of 15%. The most frequently mentioned reasons staff believed consumers were unable to participate were sleep issues. When asked about consumers sleeping during the program, staff most often reported sleep as a symptom of boredom. Only one of the staff members interviewed suggested that sleeping might be a side effect of medication that should be discussed with a physician. Functional ability was also identified as inhibiting

ability to participate in transitional employment. One staff member interviewed commented that there are "very few high functioning consumers that would be able to function in a real work setting." Another commented that "the [consumers] that are able to participate have worked in the past." Finally, one staff member described the interaction of reasons consumers are believed to be unable to participate by stating that there is a "low percentage physically able and able to read and write."

Both staff and consumers were asked whether or not consumers were willing to participate in transitional employment. Staff responses varied widely, ranging from 3% to 100%, with an average of 21%. Staff in the majority of Clubhouses responded that low percentages of consumers were willing to participate. Also, managers responded that considerably higher percentages of consumers were willing to participate than the proportion reported by program assistants. When asked about this discrepancy, two of the managers interviewed stated that assistants were more likely to assume that, if consumers did not participate in transitional employment, it was because they were unwilling to do so. "They will do what you ask them to do and do a good job and are willing to do what you ask." Conversely, one of the program assistants replied, "they all say they are willing to participate but they do not participate at PSR," referring to work unit participation in the Clubhouse. Fifty-two percent of consumers responded that they were willing to participate in transitional employment. In addition, 58% of consumers responded that they believed transitional employment helps people return to paid work in the community. Consumers were asked to determine why the psychosocial rehabilitation program should be continued if the transitional employment component was eliminated. Consumers reported 'support/self-help/ take care of each other', 'place to go/something to do/get out of the house', helps with mental illness/treatment of mental illness', and

'develop socialization skills' most frequently. Although the question stated that transitional employment would no longer be a part of the psychosocial rehabilitation program, consumers continued to want the psychosocial rehabilitation program to provide work-related skill-training and services and further mentioned 'practice working' and 'help finding jobs' as reasons to continue a psychosocial rehabilitation program.

Staff were asked whether or not employers were willing to hire individuals with mental illness. Forty-four percent responded that they did not believe employers were willing, citing 'employers are afraid of people with mental illness' as the most frequent reason employers are unwilling to hire. Of those that did respond in the affirmative, 50% qualified their response with 'some' or 'few' but not all employers are willing to hire. Interview participants voiced a number of opinions related to community employment. Among the responses, "it would be unlikely that they [consumers] would be able to maintain long term employment based on employer prejudice and/or consumer's own mental illness." This was clarified to mean that sometimes the problem lies with the employer and sometimes with the consumer. In any event, the long term sustainability of employment was believed to be doubtful. Another interview participant expressed optimism about employer receptiveness, but blamed the economy for lack of community employment. "Most employers in the community understand consumers with mental illness and are willing to help them. Despite this, because of the economy, employers are not hiring anyone." Finally, an interview participant expressed concern that the symptoms of mental illness were the greatest barrier to employment. This individual suggested "[Employers] would [hire] if they believed the mental illness of the consumer could be controlled with medications."

Fifty-two percent of staff reported that family members have told them that a consumer's illness or symptoms of illness prevent them from working in the community. "Family members are afraid for their safety and also for the safety of others," was disclosed in the interview process. A number of staff members reported that they believe that family members expressed the belief that mental illness prevented a consumer from working when 'fear of loss of benefits' was the real issue. Expressing this sentiment, one staff member commented, "this is the reason given but the real reason is fear of loss of benefits." Seventy percent of staff reported that family members have told them that a consumer could not work in the community because they would lose their benefits. Of those responding that a family member had not expressed this concern, 86% of staff indicated that they believed family members did not want their consumer to work in the community because they would lose their benefits. However, family members had not specifically made a statement to them indicating this belief.

Staff and consumers were asked to rank a list of barriers to employment frequently identified in the literature. Staff identified 'fear of loss of benefits', 'need more education', and 'need more training' most frequently as the top three barriers. Staff further ranked 'fear of loss of benefits' as their highest ranked barrier to employment. Consumers identified 'fear of loss of benefits', 'need transportation', and 'symptoms of mental illness will increase' most frequently as their top three barriers. Consumers further identified 'fear of loss of benefits' as their highest ranked barrier to employment.

When interviewed, younger consumer participants (under age 30) often stated that their family said they should not work or were unable to participate in transitional employment. Older consumers (over age 50) that were interviewed were more likely to state that they couldn't participate because they were "too old," "couldn't do that

anymore," or were limited by medical illness and, as a result, were "not able." Participants consistently reported that, if they were not able, they were also not willing to participate in transitional employment. Two consumers who participated in the interview process were diagnosed with schizophrenia. These individuals were frequently reluctant to answer questions and chose to focus on the symptoms of their mental illness, particularly hearing voices, as their primary barrier to employment. The survey questionnaires utilized in this study also suggested that schizophrenics were the least likely to respond to open-ended questions and the most likely to respond "don't know" when asked to 'describe' or 'provide reasons for' a response.

Only four of the consumers, out of the eight consumers interviewed, reported that they lived independently. Of these, two stated that they were willing to participate in transitional employment. Of the eight consumers that participated in the interviews that did not live independently, four expressed a willingness to participate in transitional employment. Two of these consumers were currently participating in transitional employment and another had done so recently. All three consumers with transitional employment experience responded favorably when asked about the experience. One consumer reported that he had been reluctant to participate because he didn't think he "could do it." The consumer stated that the transitional employment experience improved his confidence and self-esteem and that he now believed he would be able to return to full time work in the community at some point in the future. He did, however, also state that he needed additional education and work training to be successful, focusing on computer access and training as key elements.

Several questions were asked in order to assess staff and consumer knowledge of SSI/SSDI and Medicaid benefits related to consumer employment. Of staff members

responding, only 4% were found to be knowledgeable about consumer SSI/SSDI and Medicaid benefits; 39% were determined to have some knowledge; and 57% of staff were determined to be fully lacking in knowledge as to how consumer employment affects SSI/SSDI and Medicaid benefits. Consumers were asked to report whether or not they could fill out an employment application without assistance. Thirty percent stated they did not require assistance. Seventy percent stated that they could not fill out an employment application without assistance. (Consumer and staff responses for Theme 2: Employment/Barriers to Employment are summarized in Tables 24-36 in Appendix G.)

Theme 3: Program Evaluation

This study defines program evaluation as the third thematic code for investigation. Staff members were asked to characterize the current goals of the psychosocial rehabilitation program. With the ability to choose more than one category, 30% identified 'work/employment of consumers'; 44% identified 'socialization'; 17% identified 'support'; and 52% said other goals were relevant. According to one staff member, "all we do is designed to empower consumers to improve their circumstances according to their choices so they are satisfied with their lives." Staff were also asked if they believed that their psychosocial rehabilitation programs were meeting program goals. Fifty-seven percent of staff stated that programs were meeting program goals, while 43% said goals were not being met. While one staff member stated, "it is the responsibility of the Clubhouse to establish and meet goals," with failure to meet goals, for the most part, attributed to consumers, Medicaid, and outside factors.

Staff and consumers were asked how most members benefit from attending the psychosocial rehabilitation program. Seventeen percent of staff reported 'work' benefits;

44% reported ‘social’ benefits; 26% reported ‘support’ benefits; and 30% reported there were ‘other’ benefits. The most frequently mentioned ‘other’ benefits included a ‘sense of belonging/caring environment’, ‘food/meal’, and ‘a place to come to be with others with similar problems’. Twenty-four percent of consumers reported ‘work’ benefits; 52% reported ‘social’ benefits; 39% reported ‘support’ benefits, and 11% reported that there were ‘other’ benefits. The most frequently mentioned ‘other’ benefit by staff was ‘learn practical living and work skills’. Staff and consumers were asked to identify what they believed should be the goals of a successful psychosocial rehabilitation program. More than one category of goals was available for selection. Fifty-two percent of staff thought ‘work’ goals should be included; 35% thought ‘social’ goals should be included; 30% thought ‘support’ goals should be included; and 57% thought ‘other’ goals should be included as a measurement of success. ‘Training’ and ‘helping each person meet individual’s goals’ were the most frequently mentioned ‘other’ program goals identified by staff. Thirty-eight percent of consumers identified ‘work’ goals as necessary to program success; 22% identified ‘social’ goals; 53% identified ‘support’ goals; and 17% identified ‘other’ goals. The most frequently 'other' goals mentioned by consumers include ‘education/training’, ‘treatment/help people stay out of the hospital’, and ‘GED’.

Staff and consumers were asked how the Department of Mental Health and the Division of Medicaid, respectively, should evaluate a psychosocial rehabilitation program. When responding to the survey questions, both staff and consumers responded with answers defining the process of the evaluation as well as what they felt should be evaluated. Staff were more likely to identify ‘work unit participation’ as one area appropriate for evaluation by the Department of Mental Health. Staff most frequently identified ‘attendance’, consumer feedback/satisfaction’, and ‘consumers meeting goals’

as appropriate evaluation criteria for the Division of Medicaid. Referring to the Division of Medicaid, one staff member stated, "they [Medicaid] need to spend some time in the programs to see the discrepancy between what people need and what they [Medicaid] will currently pay for." Forty-three percent of consumers responded that the Department of Mental Health should 'ask consumers' when evaluating a psychosocial rehabilitation program. During the interview process, this response was clarified to mean that consumers wanted representatives from the Department of Mental Health to ask them directly about their progress and whether or not they were meeting their individual goals. Nine percent of consumers responded that the Department of Mental Health should 'evaluate work', while 25% said there should be 'other' criteria for evaluation. The lower cost of psychosocial rehabilitation relative to hospitalization or long term residential treatment was mentioned by consumers and staff in the interview process. Many consumers and staff believe that psychosocial rehabilitation assists consumers with functional stability and deters consumers from more restrictive and costly treatments such as hospitalization and long term residential treatment.

Fifty-four percent of consumers also responded that the Division of Medicaid should 'ask' consumers directly in the evaluation process; 5% stated that 'work' should be evaluated; 24% stated that 'other' criteria should be used; and 29% said they didn't know. The most frequent methods of evaluation that consumers recommended for the Division of Medicaid included 'read progress notes/medical records/treatment evaluation', 'should observe/see what we do', and 'interview staff'. Finally, staff and consumers were asked whether or not taxpayer money is well-spent on a psychosocial rehabilitation program. Eighty-three percent of staff and 70% of consumers stated that they believed taxpayer money is well-spent. This sentiment was expressed during the

interview process by the statement, "if just one person is able to function at a level of stability that makes them employable, when they weren't previously, society benefits."

During the research process, several issues were identified that should be addressed in the findings of this study. Both consumers and staff identified leisure activities, such as outings and fun things to do, as relevant activities in a psychosocial rehabilitation program. With current Medicaid regulations, these activities cannot occur during program hours and are not reimbursable. During the interviews, concerns were raised about the limitations of leisure activities. Staff and consumers believe that leisure activities are part of a socialization process as well as beneficial in the treatment of mental illness as they contribute to stress reduction and building self-esteem. Participants in the interview process discussed the financial limitations of the program and the need for the revenue generated by the psychosocial rehabilitation program to pay for agency overhead, leaving limited funding available for program development. They discussed the belief that leisure activities were very limited due to the lack of reimbursement. When asked what other services the psychosocial rehabilitation program provided that were not reimbursed, transportation was most frequently mentioned.

According to managers interviewed, Medicaid is the primary reimbursement source for the program. The mechanism is to pay a rate per 15 minute increments of service. Components of the program are not individually reimbursed. In addition, services are limited by the Division of Medicaid to five hours per day and five days per week. Managers expressed the concern that they are caught between the limits of reimbursement, the need to produce Medicaid revenue, and the needs of the consumers, which staff believe include educational services, work training, leisure activities, and transportation. In one Clubhouse, a tension between the manager and the program

assistants became apparent during the survey and interview process. While the reasons for this tension are beyond the scope of this study, it does explain why leadership and strong supervisory skills were identified by a number of staff as additional resources necessary to achieve program goals.

Consumers demonstrated a high level of education deficit in terms of identifying the medications they were taking. In reviewing the questionnaire, it was expected that literacy issues would interfere with the ability of consumers to complete questionnaires without verbal intervention and writing assistance. It was not expected, however, that two of the program staff would have literacy deficits so severe that they would require assistance with reading questions and writing responses. Literacy issues were found to be an underlying factor in all aspects of the themes investigated in this study. (Consumer and staff responses for Theme 3: Program Evaluation are summarized in Tables 37-48 in Appendix G.)

CHAPTER VI

CONCLUSIONS AND DISCUSSION

Convergence Between Quantitative and Qualitative Findings

Convergence between the quantitative and qualitative findings in this study was found with respect to seven of the eleven independent variables and the dependent variable Willingness to Participate in Transitional Employment. These variables include Age, Living Arrangements, Years of Attendance in PSR, Stigma/Attitudes, External Influence, Symptoms of Mental Illness, and Total Barriers to employment.

Age

Logistic regression found no statistical significance between Age and Willingness to Participate in Transitional Employment in the full model. However, a reduced model, consisting only of demographic characteristics as independent variables, found a low level of statistical significance but this was not sustained when Total Barriers (to employment) was introduced as an additional independent variable. Qualitative analysis found that consumers over fifty years of age did report more frequently that they were "not able" to participate in transitional employment but the sample was very small. Only three consumers over fifty years of age participated in the interview process. Mixed methods findings do not support Age as a variable that predicts a consumer's Willingness to Participate in Transitional Employment in this research.

Living Arrangements

Living Arrangements as an independent variable was not found to be statistically significant in the full or reduced model utilizing logistic regression. Of the consumers participating in the interview process, four lived independently and eight lived in other living arrangements. Of those that did not live independently, 50% indicated they would be willing to participate in transitional employment, lending no support for the hypothesis that consumers who live independently are more willing to participate in transitional employment than those in other living arrangements. Mixed methods findings do not support Living Arrangements as a variable that predicts willingness to participate in transitional employment in this research.

Years of Attendance in Psychosocial Rehabilitation Program

Logistic regression found no statistical significance between Years of Attendance in PSR and Willingness to Participate in Transitional Employment. Case study analysis found that many consumers who had been in the program for many years were actually willing to take the next step and participate in transitional employment. Those consumers identified themselves as stable in terms of symptoms, ready to work, and motivated to earn money. Offsetting this group of willing respondents was a large group of consumers that had been attending the program for an extended period of time and stated they were not willing to work for many reasons including fear of loss of benefits, feeling unable to work, or identifying other barriers to employment. Mixed methods found no support for Years of Attendance in the PSR program as a predictor of Willingness to Participate in Transitional Employment.

Stigma/Attitudes

Logistic regression did identify a statistical significance between the independent variable Stigma/Attitudes and the dependent variable Willingness to Participate in Transitional Employment. Qualitative analysis found support for this predictor as well. Forty-four percent of staff reported that they believed employers were unwilling to hire individuals with a mental illness. When asked to rank a list of nine barriers to employment, 13% of staff chose 'Employers Do Not Hire People With Mental Illness' as the greatest barrier to employment, while 8.1% of consumers ranked this barrier in their top three. Interviews confirmed this finding with only two of the eighteen staff and consumers interviewed stating that most or all of community employers were unwilling to hire people with mental illness. Fifty percent of those interviewed qualified their responses by stating that they believed employers were selective in choosing individuals with mental illness that they were willing to hire. This study also found a number of concerns related to staff attitudes toward the mentally ill. Within the programs, several of the staff interviewed, as well as several responding to open-ended questions in the staff survey questionnaire, referred to consumers as "lazy, unmotivated, disinterested, or uncooperative." These references suggest that attitudes toward the mentally ill may influence the way some staff relate to consumers and the level of support for work participation they provide. Despite a relatively low ranking of Stigma/Attitudes by consumers as a barrier to willingness to participate in transitional employment, the collective responses to questions which address this barrier, as well as quantitative analysis, indicate that mixed methods findings support Stigma/Attitudes as a predictor of Willingness to Participate in Transitional Employment.

External Influence

Convergence is also found between mixed methods relative to External Influence and Willingness to Participate in Transitional Employment. Logistic regression found External Influence to be statistically significant and having a negative impact in both the full model and a reduced model that only considered individual barriers to employment and Willingness to Participate in Transitional Employment. When interviewed, most staff voiced the opinion that family members depend on the consumers' checks for contribution to household income. Seventy percent of staff reported that a family member had directly told them that a consumer could not work because they would lose their benefits. Consumers also frequently stated that family members told them they should not work because they would "get sick" or "lose their benefits." The low level of statistical significance may be the result of the large number of consumers that live independently of family and are less influenced by the opinions and pressures of family members. Mixed methods research supports External Influence as a predictor of Willingness to Participate in Transitional Employment.

Symptoms of Mental Illness

Logistic regression found Symptoms of Mental Illness to be the most statistically significant independent variable in both full and reduced quantitative research models, indicating that Symptoms of Mental Illness is the most predictive variable of a consumer's willingness to participate in transitional employment. In the qualitative analysis, staff members confused symptoms of mental illness, such as sleeping while at the Clubhouse, as indicating that consumers were disinterested in participation or unwilling to participate. Staff also stated that functional ability prevented many consumers from participating in transitional employment, although they were generally

unable to identify functional ability that could be improved by mental health treatment. Staff identified Symptoms of Mental Illness as one of the top three reasons that consumers do not participate in the Clubhouse work units. Interviews confirmed that consumers who were unwilling to participate in Clubhouse work units were almost always unwilling to participate in transitional employment. Most important, 16.7% of consumers identified 'Symptoms of Mental Illness Will Increase' as their greatest barrier to employment. This finding supports the conclusion clinical service integration with the psychosocial rehabilitation program is essential to fostering willingness to participate in the transitional employment. This finding further differentiates psychosocial rehabilitation from other vocational programs that do not include an integration of clinical services. Mixed methods findings support the independent variable Symptoms of Mental Illness as a strong predictor of Willingness to Participate in Transitional Employment.

Total Barriers to Employment

The Quantitative Research Model includes Total Barriers to Employment as an independent variable. Since this variable is defined as the sum of the responses of the six other barriers to employment, this independent barrier was not included in the logistic regression of the full model. However, this variable was introduced in a reduced model to determine the influence of barriers to employment relative to demographic variables in predicting Willingness to Participate in Transitional Employment. Logistic regression found Total Barriers the most significant variable in predicting Willingness to Participate in Transitional Employment in the reduced model. For all the reasons cited in supporting the convergence of mixed methods with regard to the individual variables discussed

above, mixed methods findings also support the finding that Total Barriers is strongly predictive Willingness to Participate in Transitional Employment.

Differences Between Quantitative and Qualitative Findings

Differences between quantitative and qualitative findings were found in the variables of Diagnosis, Training/Experience/Education Deficits, Social/Cognitive/Behavior Deficits, and Financial Barriers with respect to Willingness to Participate in Transitional Employment.

Diagnosis

Diagnosis was not found to be statistically significant in the full quantitative model utilizing logistic regression. Diagnosis was found to be statistically significant at a very low level in a reduced model that only considered demographic variables. Qualitative analysis revealed that individuals diagnosed with schizophrenia were less likely to respond to open-ended questions in the survey questionnaire and more likely to respond "don't know" to questions that required reflection or cognitive reasoning. Individuals diagnosed with schizophrenia were more likely to self-identify as being unwilling to participate in transitional employment than individuals with other diagnoses of mental illness. Individuals diagnosed with schizophrenia were least likely to discuss questions related to the evaluation of the program by the Department of Mental Health and the Division of Medicaid, and questions that asked consumers to design a psychosocial rehabilitation program, identify goals, and identify necessary resources. During the research process, a number of consumers were observed demonstrating active hallucinations and delusions.

The reluctance of individuals with schizophrenia to participate in the interview process and to participate fully participate in completing the survey questionnaires suggests that individuals diagnosed with schizophrenia may be more likely to manifest symptoms such as paranoia that inhibit the individual's willingness to engage in social interaction or new activities such as employment. As a result, diagnosis should be considered a factor in whether or not an individual is willing to participate in transitional employment. While quantitative analysis did not find Diagnosis statistically significant, qualitative analysis finds support for this variable in predicting Willingness to Participate in Transitional Employment. The findings of the quantitative analysis may have been influenced by another factor. The symptoms of mental illness, which may be active or inactive, may have been a factor in the responses. Therefore, those individuals with a diagnosis of schizophrenia and active symptoms of their illness may have responded differently than individuals with a diagnosis of schizophrenia and symptoms of their illness in remission. This hypothesis was not tested in this research.

Training/Experience/Education Deficits

Logistic regression found no significant correlation between training/experience/education deficits and the consumers' willingness to work. Despite this, training/experience/education deficits were reported by a high percentage of consumers and staff both during the interviews and in open-ended survey questions. Five staff reported educational deficits as a reason that consumers do not participate in work units in the Clubhouse; 9% of staff and 16.7% of consumers reported the need for more education as their number one barrier to employment in an Employment Barrier Ranking List; and staff and consumers frequently mentioned educational materials, computers,

educational programs and classes, and educational services and GED classes as additional resources necessary to meet program goals. In addition, 63% of consumers and 65 % of staff said that educational services should be provided in the Clubhouse. Functional illiteracy was identified as a pervasive underlying issue in the ability of consumers to fill out employment applications and obtain employment that was more than janitorial or menial labor in nature.

Training was similarly found to be a strongly desired component of the psychosocial rehabilitation program. Staff also reported that individuals with previous work experience were more likely to be willing to participate in transitional employment. It may be that Training/Experience/Education Deficits are more associated with ability than willingness to participate in transitional employment. Consumers that were both willing to participate and not willing to participate in transitional employment reported deficits in education. Consumers found deficits in education an area in need of improvement when they wanted to participate in transitional employment and a shortcoming that prevented them from participating in transitional employment, depending on their point of view. Despite the quantitative findings of no statistical significance between Training/Experience/Education Deficits and Willingness to Participate in Transitional Employment, qualitative analysis indicates that this variable is correlated with Willingness to Participate in Transitional Employment.

Social/Cognitive/Behavior Deficits

Although binary logistic regression found a statistically significant relationship between Social/Cognitive/Behavior Deficits and Willingness to Participate in Transitional Employment, logistic regression of the full quantitative model and a reduced

model of only barriers to employment did not find this independent variable to be statistically significant in predicting Willingness to Participate in Transitional Employment. Thirty-two percent of consumers stated that transitional employment was not the most important component of a psychosocial rehabilitation program, citing socialization-related components as being more important. When interviewed, both staff and consumers stated that providing a work-ordered day encouraged consumers to attend daily and develop a sense of responsibility. Consumers were reluctant to identify areas of personal improvement but a number of consumers stated that they needed help to control their anger and verbal aggression.

When asked what they liked least about the Clubhouse, a number of consumers identified noise, conflict, and confrontations between consumers as being a source of stress. This suggests that both socialization skills and appropriate behavior are deficits for a number of consumers. In the survey questionnaire, consumers frequently identified staff complaints about the adequacy and quality of their work performance and the need to be reminded to perform their work unit duties. A large number of consumers also reported that they participated in their work units less than two hour per day. While arguably, deficits in Social/Cognitive/Behavior may be more predictive of ability to participate than willingness, more than 90% of individuals who reported being "able" to participate in transitional employment also reported that they were willing to participate. While quantitative analysis found no statistical significance between this variable and Willingness to Participate in Transitional Employment, qualitative analysis suggests that Social/Cognitive/Behavior Deficits may influence the willingness of consumers to participate in transitional employment.

Financial Barriers

Although binary logistic regression found a statistically significant relationship between Financial Barriers and Willingness to Participate in Transitional Employment, logistic regression of the full model and a reduced model of only barriers to employment did not find Financial Barriers to be statistically significant in predicting Willingness to Participate in Transitional Employment. Qualitative analysis repeatedly found 'fear of loss of benefits' as a barrier to employment, with both staff and consumers reporting this as their number one barrier. One plausible reason for the quantitative finding that is supported by the case study is that almost all consumers fear loss of benefits whether or not there are willing to work. Case study analysis also indicated that consumers and staff lack knowledge of the effects of employment on SSI/SSDI and Medicaid. Only 4% of staff has a reasonable level of knowledge of employment and benefits. Another possibility is that consumers believe that by working only a limited number of hours, as is the case in transitional employment, their benefits will be protected. Finally, it is also possible that the benefits of work in terms of self-esteem, compensation, and self-confidence outweigh the financial barriers and result in some consumers responding that they are willing to participate in transitional employment, despite the barriers.

This barrier may have more predictive ability in determining whether a consumer will accept full time employment or will continue to be willing to participate in transitional employment if benefits are threatened by level of income. When interviewed, most staff members expressed confidence that many consumers were willing to participate in transitional employment when the hours of paid employment were limited and unlikely to reduce benefits. However, those same staff members also stated that they believed most consumers would be unwilling to participate in transitional employment if

doing so reduced their SSI/SSDI or Medicaid benefits. While quantitative methods found Financials Barriers not statistically significant, there is considerable evidence in the qualitative research to suggest that Financial Barriers influence Willingness to Participate in Transitional Employment.

Theoretical Perspective Conclusions

Research Question 1:

How are the differences in outcome expectancies between the Department of Mental Health and the Division of Medicaid best reconciled?

- What are the barriers to reconciliation?

Research Question 2:

Based on Public Value Theory, Social Justice implications, and the claims of Active Citizenship, what outcomes are deemed appropriate to the psychosocial rehabilitation program by citizens with a dual role as consumers or professionals?

- How are the suggested outcomes reconciled with the New Public Management tenants embraced by the Department of Mental Health and the Division of Medicaid?
- What are the barriers to adopting the proposed outcomes?
- What does the psychosocial rehabilitation program look like after the reconciliation?

From a theoretical perspective, Public Value Theory, Social Justice Theory, and Theories of Active Citizenship build on the tenants of New Public Management to better explain the justification for the psychosocial rehabilitation program in the areas where New Public Management is weak or deficient. Public Value Theory offers the best understanding of the conflict psychosocial rehabilitation consumers experience between

their role as beneficiaries of public welfare benefits and their willingness to risk these benefits to enter or reenter the workforce. In this research, 44% of consumers stated that they are willing to take the risk, indicating that work is more valued than welfare for a substantial number of consumers. Public Value Theory also defines citizens as being able to act in the collective public interest. This is demonstrated in the finding that while 44% of consumers stated that they are willing to participate in transitional employment, 83% of consumers believe that transitional employment should continue to be included in the psychosocial rehabilitation program, with the most frequent explanation being that "consumers benefit" even if they do not. Public Value Theory also recognizes the necessary collaborative interaction between public managers and citizen consumers. This research supports the ability of managers and citizen consumers to be consistent in advocating for similar program components, additional resources, and outcome measures that address the goals of a successful psychosocial rehabilitation program, as well as to be consistent in the identification of barriers to meeting these goals.

Social Justice Theory suggests that individuals with mental illness have a right to the resources necessary to pursue the same employment and social opportunities as any other citizen. Social Justice Theory, therefore, supports the components of work, socialization, support, education, work training, and leisure activities as they relate to socialization for inclusion in a psychosocial rehabilitation on the basis of fairness and equity. This research demonstrates that staff and consumers, as knowledgeable citizens identified in Active Citizenship Theory (Stivers, 1990), are capable of identifying relevant program goals based on a program design that they believe will be effective in addressing the needs of consumers with mental illness. These citizens call for a program that includes work, socialization, support, education, work training, and leisure activities

and have further identified the appropriate outcome measures that are derived from these activities. Table 13 summarizes the goals and related measurable outcomes recommended by this research.

Table 13 Recommended Program Goals and Related Measurable Outcomes

Goal	*Measurable Outcome*
Work	100% participation in Clubhouse work units
	Consumer reported meaningful work with autonomy and consumer decision making
	90% reported willingness to participate in transitional employment
	Documented efforts to obtain job placements in the community
	Compliance with transitional employment expectations
	Transitional employment work performance evaluations
Social	Documented improvement in socialization skills
	Level of participation in Clubhouse activities
	Assessment of daily living skills and documented improvement
Support	Successful completion of transitional employment placements
	Decreased psychiatric hospitalizations and comparisons with other programs
	Consumer satisfaction with program
Education	Assessment and reassessment of verbal, reading comprehension, and writing skills
	Development of education service plans and documented progress
	Number of consumers enrolled in GED services
	Number of consumers completing GED
Work Training	Completion of work interest surveys
	Development of work readiness service plans and documented progress
	Ability of consumers to fill out employment applications without assistance
	Ability of consumers to perform basic computer skills
	Work unit performance evaluations
Leisure Activities	Appropriate interaction with others when participating in leisure activities
	Participation in leisure activities
	Consumer satisfaction

The Department of Mental Health and the Division of Medicaid subscribe to the tenants of New Public Management that are driven by outcome measures that promote effectiveness and efficiency. The recommended outcome measurements of this research are consistent with these tenants but will require adjustments and considerations by the Department of Mental Health, the Division of Medicaid, as well as the psychosocial rehabilitation programs to resolve interagency conflicts and to maximize effectiveness and efficiency. The barriers to this reconciliation are unique to each of the stakeholders in this program.

The primary components of the psychosocial rehabilitation program are currently defined by the Department of Mental Health. The Department of Mental Health requires that transitional employment be included in psychosocial rehabilitation and prescribes the standards for implementation. The Division of Medicaid does not address transitional employment in its guidelines for reimbursement and refuses to pay for education and work training in the Clubhouse; services which are believed to be necessary for successful work placements in the community.

Department of Mental Health Adjustments and Considerations

- Implement outcome measures suggested in Table 13 above.
- Establish clear expectations for transitional employment and hold psychosocial rehabilitation programs accountable.
- Allow flexibility for creative and meaningful work opportunities.
- Limit janitorial positions allowable; promote quality over quantity of work placements.
- Add willingness and ability of the consumer to work as an eligibility criteria for enrollment in the psychosocial rehabilitation program.

This research considered separating the transitional employment component from the psychosocial rehabilitation as an option to reconcile the conflict between the Department of Mental Health and the Division of Medicaid. However, over 80% of consumers and staff participating in this research indicated that they believed the transitional employment component should continue to be a part of the psychosocial rehabilitations program. While the Department of Mental Health prescribes the number of transitional employment placements required in each psychosocial rehabilitation program, the agency has been lenient in recent years when expectations were not met. Consequently, programs have lowered their efforts to comply and the Department of Mental Health has lost the leverage it may have had to persuade the Division of Medicaid to support the activities necessary for successful consumer participation in transitional employment.

This research finds that the Department of Mental Health must establish clear expectations for the transitional employment component and hold the program accountable for meeting expectations. At the same time, consideration must be given to the economic recession and the resulting limited employment opportunities. Instead of leniency for failure to comply with transitional employment expectations, the Department of Mental Health should exercise flexibility in allowing the program or the parent mental health center to establish creative and meaningful consumer transitional employment opportunities. The Department of Mental Health should further limit the number of janitorial placements that qualify as placements, promoting job quality over quantity.

The Department of Mental Health should also consider the eligibility criteria for consumers that attend psychosocial rehabilitation programs. Currently, eligibility only requires that a consumer's age be over eighteen, that the consumer has a primary

diagnosis of a serious mental illness, and that a qualified professional, such as a psychiatrist, has authorized the service based on the recommendations of a clinical treatment team. The Department of Mental Health should consider willingness and ability to participate when defining program eligibility criteria. For consumers that don't qualify for enrollment in the psychosocial rehabilitation program, alternative treatment programs are available including Elderly Day Treatment for consumers over the age of fifty and Day Support for individuals that need structured day services but are unable or unwilling to participate in transitional employment. Changing transitional employment expectations and eligibility criteria will promote effectiveness and efficiency; effectiveness by reducing the participants to those willing to participate and, therefore willing to overcome the barriers to employment; and efficiency because resources will be spent with the greatest chance of program success and because individuals not willing to participate in all aspects of the program are more likely to be enrolled in an alternative program such as Day Support that is less costly.

Division of Medicaid Adjustments and Considerations

- Support the implementation of outcome measures (See Table 13 above) by the Department of Mental Health.
- Fund the inclusion of work training, education services, and limited leisure activities for inclusion in the psychosocial rehabilitation programs.
- Authorize one five-hour day per month for psychosocial rehabilitation programs to participate in leisure activities in the community billed at the Day Support Program rate.
- Allocate fifteen minutes billable daily time to and from the program and to and from the workplace for each participating consumer to help psychosocial rehabilitation programs offset transportation costs.

The Division of Medicaid should provide funding for psychosocial rehabilitation services that include work training, education services, and limited leisure activities in the community that promote social skill development and reinforcement. While it is acknowledged that other agencies, such as the Department of Vocational Rehabilitation Services and the Department of Education, traditionally fund these services, a waiver should be granted to the psychosocial rehabilitation programs to provide these services within the Clubhouse. There is a strong argument, supported by this research, that education and work training services are the foundation for transitional employment and fundamentally integrated in the process. This position is further defended by the finding that 70% of consumers report that they cannot fill out an employment application without assistance. This change in service authorization by the Division of Medicaid will not result in the need for additional funding since the Division of Medicaid pays for psychosocial rehabilitation based on time-defined units of consumer attendance. It will, however, reduce education and training deficits as a barrier to employment and contribute to the effectiveness of the psychosocial rehabilitation program as well as the ability of consumers to obtain better quality transitional employment placements.

Consumers and staff also indicated that leisure activities in the community are necessary to promote and evaluate socialization skills. Leisure activity is currently not reimbursable by Medicaid. It is recommended that the Division of Medicaid authorize one five-hour day per month for this purpose. This activity should be billed at the Day Support rate to promote efficiency. Finally, transportation, also not currently reimbursable by Medicaid in a psychosocial rehabilitation program, is a critical element to consumer attendance in the psychosocial rehabilitation but it is a non-reimbursable expense. Each consumer should be allocated fifteen minutes transportation time to and

from the program and to and from the workplace that is reimbursed by Medicaid if the transportation is provided by the program. For the Division of Medicaid to reimburse education, work training, leisure activity for socialization purposes, and transportation may require a waiver from the Centers for Medicare and Medicaid.

Psychosocial Rehabilitation Program Adjustments and Considerations

- Develop program goals based on outcome measures (See Table 13 above).
- Increase community job development efforts including adding a Work Specialist position and developing a Community Advisory Board.
- Increase relevant staff education and training by implementing individualized staff education and training plans.
- Implement consumer work training, education, and leisure activity plans to meet program goals when approved by the Department of Mental Health and the Division of Medicaid.

This research has determined that changes in psychosocial rehabilitation programs are also necessary to meet goals and establish outcome measures that promote effectiveness and efficiency. Psychosocial rehabilitation programs will be initially downsized by changes in program eligibility. However, it is expected that additional qualified individuals will request referral to the program when work, socialization, support, education, and training components are enhanced. Psychosocial rehabilitation programs will continue to be responsible for job development in their respective communities. Expectations by the Department of Mental Health will require the programs to substantially increase current efforts. Two plausible suggestions for improving the effort include the addition of a Work Specialist position, dedicated to job development, and the creation of an Advisory Board in each community made up of employers, community officials, and citizens, to promote job development in the community.

Psychosocial rehabilitation programs need to make a commitment to staff education and training. Problems of functional illiteracy, stigmatizing attitudes, inability to recognize symptoms of mental illness and medication side effects that require intervention, and lack of knowledge regarding SSI/SSDI and Medicaid benefits with regard to employment were identified in this research. These staff deficits prevent consumers from overcoming barriers to employment. The program needs to implement a staff training program to correct these deficits and further develop a continuing staff education plan so that staff are qualified to implement the enhanced program components recommended in this study.

The additional costs associated with hiring a Work Specialist will be partially offset by the regaining of staff time, now involved in motivating individuals that are not willing to participate in transitional employment, to complete other job duties. The program will also benefit from transportation revenue. Additionally, increased staff education will improve the effectiveness of the program, not only by reducing barriers to employment, but also benefitting from the efforts of qualified staff to achieve expected outcomes.

Psychosocial rehabilitation programs should implement program changes immediately, as these changes will improve program outcomes regardless of whether or not the Department of Mental Health and the Division of Medicaid implement changes. The Department of Mental Health and the Division of Medicaid should implement changes simultaneously as changes by both state agencies are necessary for resolution of the conflict.

The Psychosocial Rehabilitation Program After the Reconciliation

- Participants share program goals and expectations.
- Enhanced work-ordered day.
- Education and work training with resources and equipment added.
- Development of individualized consumer education and work training service plans.
- Increased staff training and qualifications.
- Clinical services integration continued with local mental health center.
- Monthly community leisure activity added.
- Transportation to and from psychosocial rehabilitation program continued; transportation to and from the workplace while attending psychosocial rehabilitation program added.
- Implementation of the suggested outcome measures (See Table 13).
- Implementation of family, community, and employer education.

After the reconciliation, and subject to the implementation of changes by the Department of Mental Health, the Division of Medicaid, and the Psychosocial Rehabilitation Programs, the psychosocial rehabilitation program will have participants enrolled that share the program goals and expectations. The program model will continue as a work-ordered day with additional work unit opportunities and a work climate that fosters intrinsic work motivation through meaningful work, autonomy, and consumer decision-making. Education and work training will be added to the program components and computers, cash registers, and education and training materials will be added to support education and training efforts.

Consumers will be assessed for education levels and training needs, service plans developed, and progress toward education and training goals documented. Qualified staff

will provide educational, training, and work support services. Staff will also be knowledgeable in the effects of employment with respect to SSI/SSDI and Medicaid benefits. Mental health treatment will continue in collaboration with the mental health center. Staff will be trained to recognize symptoms of mental illness and medication side effects that require intervention to reduce Symptoms of Mental Illness as a barrier to employment. One day a month will be set aside for a leisure activity in the community that promotes socialization skill development and reinforcement.

Transportation will continue to be provided to and from the program and will be provided to and from the consumer's workplace when necessary for participation in transitional employment. The transitional employment component of psychosocial rehabilitation will be continued with substantially increased effort in job development, including the addition of a Work Specialist and a Community Advisory Board for each program. Suggested outcome measures will be implemented and will relate to the program goals of work, socialization, support, and education, work training, and leisure activities. Family, community, and employer education will be provided by the program to reduce Stigma/Attitudes and External Influence as barriers to employment.

Program Evaluation

Department of Mental Health

- Evaluates compliance with established program expectations.
- Evaluates collective progress toward program goals.
- Solicits staff and consumer input into program and consumer evaluations through surveys and interviews.
- Reviews program documentation for compliance and evaluation purposes.

Division of Medicaid

- Evaluates consumer progress toward individualized goals.
- Solicits staff and consumer input into program and consumer evaluations through surveys and interviews.
- Reviews consumers' medical records.

Psychosocial Rehabilitation Programs

- Complete self-evaluation of program compliance and progress toward program goals.
- Evaluate consumer's individualized treatment, work training, and education plans and address changes necessary to meet the needs of the consumer.

The Department of Mental Health will evaluate the program based on the collective progress toward program goals, while the Division of Medicaid will evaluate individual progress toward treatment and service goals. Both the Department of Mental Health and the Division of Medicaid will solicit consumer and staff input into program and consumer evaluations and outcome measures through surveys and interviews. Additionally, the Department of Mental Health will review program documentation for evaluation purposes; while the Division of Medicaid will review consumer medical records to validate the provision of services and to evaluate consumer progress toward treatment goals. The psychosocial rehabilitation programs will also initiate a self-evaluation process to evaluate program compliance and progress toward program goals. Concurrently, psychosocial rehabilitation program staff will evaluate the consumers' individualized treatment, work training, and education plans at least quarterly to determine the effectiveness of the current service delivery. Staff will make necessary changes and updates to the plans when indicated to meet the needs of the consumers.

Limitations of the Study

While the sample population in this study is believed to represent psychosocial rehabilitation program participants in Mississippi, generalization of the findings of this study to other states cannot be assumed without further study. This study found that almost all participants reported educational deficits, had limited or no previous work experience, and reported significant barriers to employment. The rural nature of Mississippi further suggests that generalizability is limited. Differences in treatment issues and strategies between states characterized as predominantly urban, rural, or frontier in terms of mental health and addictions services have been well documented by the Substance Abuse and Mental Health Services Administration (SAMHSA, 2010).

Urban settings, such as New York City, Chicago, Los Angeles, and Atlanta, have the support systems in place for the full continuum of mental health services from outpatient services to inpatient treatment. Urban settings are also more likely to have options for vocational services for the mentally ill which include Individual Placement and Support options discussed in the literature (Koletsi, et. al., 2009; Bond, et. al., 2001). Rural settings are more restricted. In Mississippi, for example, the psychosocial rehabilitation program offers one of the few employment interventions specifically for the mentally ill. Frontier settings, such as North Dakota and Alaska, have limited mental health and employment services for the mentally ill available due to the vast dispersion of their populations and the difficulty accessing services from great distances. Frontier settings often develop telemedicine methods to manage clinical treatment and are unable to provide widespread access to vocational services for the mentally ill (SAMHSA, 2010).

Differences in state unemployment rates, as well as unemployment rates within local areas, affect the availability of employment opportunities for the mentally ill. Urban areas, for example, are more likely to have more employment opportunities as well as more diversity in the type of work available. Rural north central Mississippi has limited employment opportunities and high unemployment with overqualified unemployed workers competing for entry level employment positions.

Medicaid eligibility and service funding varies by state. Mississippi Medicaid is funded at the highest federal Medicaid match in the nation, currently receiving more than four federal Medicaid dollars for every state Medicaid dollar spent (Mississippi Division of Medicaid, 2011). Other states, such as Colorado and Connecticut, receive only one federal Medicaid dollar for every state Medicaid dollar spent (The Kaiser Family Foundation, 2012). Such states are more likely to restrict Medicaid eligibility as well as limit the type and scope of services funded by their state's Medicaid program. In Mississippi, psychosocial rehabilitation services are funded by Medicaid. Other sources of funding may be used in other states. Friendship House in Greensboro, South Carolina, for example, receives a grant from the state of South Carolina and does not receive Medicaid funding (Friendship House, 2005). Consequently, this psychosocial rehabilitation program has more flexibility in the way it operates and is not subjected to the requirements of conflicting state agencies. Treatment interrelationships with mental health providers and participant demographics may also vary by state and potentially limit the generalizability of the study beyond Mississippi.

This study explored the impact of barriers to employment on willingness to participate in transitional employment. The reasons that some barriers are more influential than others are likely found in the way consumers responded to the survey

questionnaire. In some cases, there was a lack of consistency in responses which addressed similar issues. For example, a consumer might state that they did not believe that they would lose their SSI/SSDI benefits if they became employed but might also rank 'fear of loss of benefits' as their number one barrier to employment. The thought processes of individuals with mental illness sometimes interfere with the ability to provide consistent responses. An affirmative response to Willingness to Participate in Transitional Employment by a consumer is a summary of many personal perceptions about themselves and their environment. Consequently, willingness to participate may transcend the barriers to employment with some consumers believing they can participate despite any barriers they may encounter.

Consumers were asked to confirm their demographic information and diagnosis at the onset of the survey questionnaire process. Approximately 60% of consumers were unable to confirm their household income. As a result, the accuracy of reported household income was determined to be unreliable and not included in this study.

Qualitative studies are limited in scope, which further limits generalizability. However, it is believed that adding quantitative methods in a mixed methods approach strengthens the findings of this study. Finally, every effort has been made to strengthen the reliability of this study through the transparency of the research methods.

Issues for Further Study

During the course of this research, several issues were identified that need additional future analysis. In this study, 'years of education' and 'household income' were found to be unreliable variables as recorded in the information system and could not be reliably reported by consumers. Further investigation of these variables might prove

beneficial. In addition, medical problems such as high blood pressure and diabetes were identified with some frequency by consumers either directly or suggested by the medications they reported taking. Further study is indicated to determine if medical illnesses and overall health status affect the willingness of consumers to participate in transitional employment or whether this issue was already reflected in consumer responses to 'able to work'. This study recommends staff and consumer education as a means to reduce consumer barriers to employment particularly in the area of 'fear of loss of benefits'. In the event such education is implemented, a reassessment of the influence of 'fear of loss of benefits' would be indicated. This research recommends changes in program components and outcome measures for the Department of Mental Health, the Division of Medicaid, and the psychosocial rehabilitation programs. Follow-up studies are needed to determine the impact of any changes in program components and outcome measures. This study has identified and ranked barriers to employment for consumers in six psychosocial rehabilitation programs in north central Mississippi. Similar regional and national studies are recommended for comparative analysis and to improve the generalizability of the current findings.

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APPENDIX A

0PERATIONAL STANDARDS FOR ADULT PSYCHOSOCIAL REHABILITATION PROGRAMS

PART X

PSYCHOSOCIAL PROGRAMS

Psychosocial Rehabilitation Services are therapeutic activity programs provided in the context of a therapeutic milieu in which individuals can address personal and interpersonal issues with the aim of achieving/maintaining their highest possible levels of independence in daily life. Psychosocial Services include: Psychosocial Rehabilitation/Clubhouse Services, Senior Psychosocial Rehabilitation, Day Support, and Day Treatment Services.

SECTION A- PSYCHOSOCIAL REHABILITATION/CLUBHOUSE SERVICES

X.A.1. Psychosocial Rehabilitation/Clubhouse Services are a community support service for people with serious mental illness which consists of a network of services that help the service recipient develop the potential to live independently and/or become employed. Psychosocial Rehabilitation/Clubhouse is a program of structured activities designed to support and enhance the role functioning of individuals with serious and persistent mental illnesses who are able to live in their communities through the provision of regular, frequent environmental support. Program activities aim to improve reality orientation, social adaptation, physical coordination, daily living skills, time and resource management, and task completion, as well as to alleviate such psychiatric symptoms as confusion, anxiety, disorientation, distraction, preoccupation, isolation, withdrawal and feelings of low self-worth.

X.A.2. The Psychosocial Rehabilitation/Clubhouse must operate in one location for a minimum of four (4) hours per day, four (4) days per week, excluding travel time.

X.A.3. A Psychosocial Rehabilitation/Clubhouse program must have an annual average daily attendance of more than eight (8) individuals.

X.A.4. All activities of the Psychosocial Rehabilitation/Clubhouse must be established around a work-ordered day structured by task activity units. The work-ordered day must exclude outside interruptions and activities. All individuals/members must be given an opportunity to participate in all units.

X.A.5. There must be a minimum of two (2) task activity units, which can include but not be limited to:
a. Clerical unit
b. Kitchen unit
c. Snack bar unit

d. Gardening unit.

X.A.6. Transitional, supported and independent, employment opportunities must be an integral part of Psychosocial Rehabilitation/Clubhouse Services and must be available to at least 10% of the number of participants the program is certified to serve.

X.A.7. A minimum of one (1) transitional employment placement must be available in a competitive employment setting in the community in which individuals without disabilities are also employed and that is not operated by the provider program. Transitional employment placements must be part-time and time limited, generally fifteen (15) to twenty (20) hours per week and six (6) to nine (9) months in duration.

X.A.8. Recreational and social activities must also be offered during evening hours and/or on weekends to further develop relationships and interactions. However, recreational and/or social activities must not be conducted during the structured program hours.

X.A.9. The Psychosocial Rehabilitation/Clubhouse must have its own identity, including its own name.

X.A.10. The Psychosocial Rehabilitation/Clubhouse must be located in its own physical space, separate from other mental health center activities or institutional settings and impermeable to use by other programs during hours of program operation. The clubhouse is to be designed to facilitate the work-ordered day and at the same time be attractive, adequate in size, and convey a sense of respect and dignity.

X.A.11. All program space must be accessible to both individuals receiving services and staff. There are to be no "staff-only" or "individual-only" spaces.

X.A.12. The Psychosocial Rehabilitation/Clubhouse site must have sufficient space to accommodate the full range of program activities and services and must provide at least fifty (50) square feet of multipurpose space for each individual.

X.A.13. Psychosocial Rehabilitation/Clubhouse staff must include at each site a full time supervisor (as defined in Standard VI.C.1(c)) who plans, coordinates, and evaluates the psychosocial rehabilitation program.

X.A.14. Psychosocial Rehabilitation/Clubhouse programs must maintain a minimum of one (1) qualified staff member to each eight (8) or fewer individuals the program is certified to serve.

X.A.15. There must be, on file, a written plan and a description of the service that must include but not be limited to the following:
a. The purpose, goals, and objectives
b. The population to be served, including the number of individuals to be served by location
c. The physical environment surrounding the program, at each site
d. Mechanisms to be used to establish members as decision makers in the operation of the service
e. Plan for developing and maintaining transitional employment placements

X.A.16. The program must maintain an evaluation system which addresses at a minimum:
a. Total number of members on roll
b. Daily attendance
c. Annual attendance by subgroups (age, sex, race)
d. Average length of stay
e. Reasons for leaving the program (recidivism vs. progression toward community integration)
f. Member satisfaction with psychosocial services
g. The number and type of transitional employment jobs
h. The number of individuals participating in transitional employment
i. The number of hours available in the transitional employment program by placement
j. The number of hours worked and income earned by each individual participating in the transitional employment program
k. Degree of individual involvement in decision making.

X.A.17. Individuals must have a method defined by policy and procedures to communicate their desires to the director of the psychosocial/clubhouse and to the Executive Director of the program, and there must be documentation of such communication on site.

X.A.18. Individuals must have the opportunity to participate in all the work of the clubhouse, including orientation, outreach, training, hiring, and evaluation of staff, or documentation requirements.

X.A.19. The program must be voluntary and must be available to individuals ages eighteen (18) and older who have a serious mental illness unless that person poses a significant or current threat to the general safety of the Clubhouse community.

X.A.20. All staff members must receive training on Psychosocial Rehabilitation/Clubhouse policies and standards prior to service delivery. The training must be documented.

APPENDIX B

CITIZEN QUESTIONNAIRE - CONSUMER LEVEL

Consumer Questionnaire

Age: _____ ***Sex:*** M F

Marital Status: S M W D

Race: African-American Caucasian Hispanic Asian Other _____

Living Arrangements: Independent Supervised/Supported Housing Living w/ Family

Highest Grade of Education: _____

Can you fill out an employment app. w/o assistance: Y N

Income: SSI $ _____ per month

SSDI $ _____ per month

Other $ _____ per month Source: _____

Healthcare payer: Self-pay Medicaid Medicare Private Insurance

Diagnosis (es) Information:

Axis I: _____

Axis I: _____

Axis I: _____

Axis II: _____

Axis II: _____

Questions:

1. When were you first diagnosed with a mental illness?

   _____

2. Please describe your symptoms:

   _____

   _____

   _____

3. What makes your symptoms better?

   _____

   _____

   _____

4. What makes your symptoms worse?

   _____

   _____

   _____

5. When did you start receiving treatment for your mental illness?

   _____

   _____

6. What medications are you taking?

   _____

   _____

   _____

   _____

7. When did you start attending Clubhouse?

_____

_____

8. How often do you attend?

_____

_____

9. Does attending Clubhouse reduce the symptoms of your mental illness? If so, how?

_____

_____

_____

10. What do you like most about the Clubhouse?

_____

_____

_____

_____

11. What do you like least about the Clubhouse?

_____

_____

_____

_____

12. How important is it to you to be around people in the Clubhouse? Describe:

_____

13. If you didn't come to Clubhouse, what would you be doing during the day?

14. What activities go on in the Clubhouse that are meaningful to you? How?

15. Open-ended exploration dependent on the above responses.

16. What Unit do you work in at the Clubhouse? Did you choose to work there or were you assigned?

17. What are your job duties?

18. Do you like your job duties? Why or why not?

19. Do you believe you do a good job? Why or why not?

_____

_____

20. Do other people tell you that you do a good job?

_____

_____

21. What complaints have you received about your behavior, your work, or other things about you?

_____

_____

_____

_____

22. What would you like to improve about yourself?

_____

_____

_____

_____

_____

23. What resources would you need to make improvements?

_____

_____

_____

_____

24. Is your work in the Clubhouse stressful?

_____

_____

25. How do you know when you are stressed?

_____

_____

_____

_____

26. Do the symptoms of your illness get worse when you are stressed? Describe.

_____

_____

_____

_____

_____

27. Have you worked in other Units in the Clubhouse?

_____

_____

28. What were your job duties?

_____

_____

_____

_____

29. Of all the job duties you have performed in the Clubhouse, what were you the best at doing? Why?

_____

_____

_____

_____

_____

30. Of all the job duties you have performed in the Clubhouse, what did you like to do the most? Why?

_____

_____

_____

_____

_____

31. Of all the job duties you have performed in the Clubhouse, what was the most important to the Clubhouse? Why?

_____

_____

_____

_____

_____

32. Of all the job duties you have performed in the Clubhouse, did you receive any training? If so, describe:

_____

_____

_____

_____

_____

33. Have you ever trained another Clubhouse member to do a job? If so, describe:

_____

_____

_____

_____

_____

34. Do you determine how to get your job done or does someone tell you what to do?

_____

_____

_____

_____

35. How often do you have to be reminded to perform a job task?

_____

_____

36. Of your 5 hour Clubhouse day, how much time do you spend working in your Unit?

_____

_____

_____

37. Do you feel that you have enough work to do? What would you do differently?

_____

_____

_____

_____

_____

38. Have you participated in the transitional employment program in the Clubhouse? If so, please describe:

_____

_____

_____

_____

39. How many times have you held a transitional employment position? For how long each time?

_____

_____

_____

40. What was your position and job duties for each transitional employment?

_____

_____

_____

_____

_____

_____

41. What did you like about transitional employment work?

_____

_____

_____

_____

_____

42. What did you dislike about transitional employment work?

_____

_____

_____

_____

_____

43. Why were your transitional employment positions ended?

_____

_____

_____

_____

44. If you are not currently in a transitional employment position, are you willing to accept a position if one becomes available? What support do you need?

_____

_____

_____

_____

_____

45. If you have never participated in transitional employment, do you think you are able to do so? Please explain:

_____

_____

_____

_____

_____

_____

46. If you have never participated in transitional employment, are you willing to do so? Please explain:

_____

_____

_____

_____

_____

47. Have you ever held a job in the community for which you were paid? If so, please describe:

_____

_____

_____

_____

_____

48. If you held a paid job in the community, what was your highest hourly rate of pay?

_____

49. If you held a paid job in the community, did you have any benefits? Please describe:

_____

_____

_____

50. If you held a paid job in the community, were you full time or part time?

_____

51. If you held a paid job in the community, how long did you work in each position and what was your reason for leaving?

_____

_____

_____

_____

52. Compare the work you did in the community with the work you do in the Clubhouse.

_____

_____

_____

_____

_____

53. Would you like to return to your previous job? Why or why not?

_____

_____

_____

_____

_____

54. If you have never been paid to work a job in the community before, would you like to get a job? Why or why not?

_____

_____

_____

_____

_____

55. If you were to get a paid job in the community, which of the following statements do you believe would be most true about the symptoms of your mental illness?

____ My symptoms would increase so much that I would be unable to work

____ My symptoms might increase a little but they would be manageable

____ My symptoms would probably stay about the same

____ My symptoms might actually decrease because work would give me something positive on which to focus

56. Do you think that your family thinks that your symptoms will get worse if you take a job in the community? Please explain.

_____

_____

_____

_____

57. Has a member of your family ever told you that your symptoms will get worse if you take a job in the community?

_____

58. Has a staff member ever told you that your symptoms will get worse if you take a job in the community?

_____

59. Do you think that you will lose your SSI/SSDI if you go to work in the community?

_____

60. Your SSI/SSDI will be replaced by your paid income after a period of time. Is that an area of concern? Please describe.

_____

_____

_____

_____

_____

61. Has member of your family or a close friend ever told you that you should not go to work in the community because you will lose your SSI/SSDI?

_____

62. Does your family rely on your SSI/SSDI for a part of their support?

_____

63. Has a staff member ever told you that you should not go to work in the community because you will lose your SSI/SSDI?

_____

64. Has anyone ever explained to you how working in the community will specifically affect your SSI/SSDI?

_____

65. Do you believe that you will lose your Medicaid if you go to work in the community?

_____

66. Has a member of your family or a close friend ever told you that you will lose your Medicaid if you go to work in the community?

_____

67. Has a staff member ever told you that you will lose your Medicaid if you go to work in the community?

_____

68. What do you believe will happen if you lose your Medicaid?

_____

_____

_____

_____

69. Has anyone ever explained to you what effect taking a job in the community will have on your ability to receive Medicaid?

_____

_____

_____

70. Do you believe that employers are willing to hire people with mental illness? Please explain.

_____

_____

_____

71. Do you believe that employers are willing to provide the support necessary to employ someone with a mental illness? Please explain.

_____

_____

_____

_____

72. Do you believe that there are currently jobs available in the community for which you are qualified? If so, please provide examples.

_____

_____

_____

_____

73. What type of job would you be interested in obtaining?

_____

_____

_____

_____

74. If you are not currently qualified to do the job you would like, what additional education do you need?

_____

_____

_____

75. Should this educational program be provided by the Clubhouse or through another agency or governmental department? If not the Clubhouse, how should your further education be coordinated?

_____

_____

_____

76. If you are not currently qualified to do the job you would like, what additional training do you need?

_____

_____

_____

_____

77. Should this additional training be provided by the Clubhouse, or through another agency or governmental department? If not the Clubhouse, how should this additional training be coordinated?

_____

_____

_____

78. Do you believe that transitional employment should be a component of the PSR program? Why or why not?

_____

_____

_____

_____

79. Do you believe that transitional employment through the Clubhouse helps members return to paid work in the community? Why or why not?

80. If transitional employment were not a part of the Clubhouse, why should the Clubhouse be continued and how would it be a benefit to members?

81. Finally, if you were to design a PSR program, what would you include and how would you know if the lives of the members were improved by attending the program?

_____

_____

_____

_____

_____

_____

_____

_____

Employment Interest Summary Checklist

_____ I can work but I need additional education to get a job.

_____ I can work but I need additional training to get a job.

_____ I can work but I need my benefits to last longer than SSI/SSDI currently allow.

_____ I can work but I need additional support on the job.

_____ I can work but I need transportation.

_____ I can't work because I don't have a GED or a high school diploma.

_____ I can't work because I have no work experience.

_____ I can't work because I don't have the training I need to get the job I want.

_____ I can't work because there are no jobs available.

_____ I can't work because the symptoms of my illness will get worse.

_____ I can't work because my family believes the symptoms of my illness will get worse.

_____ I can't work because the staff believes the symptoms of my illness will get worse.

_____ I can't work because it is too stressful to be around people.

_____ I can't work because I am afraid I will lose my SSI/SSDI.

_____ I can't work because my family says I will lose my SSI/SSDI.

_____ I can't work because staff members say I will lose my SSI/SSDI.

_____ I can't work because I am afraid I will lose my Medicaid.

_____ I can't work because my family says I will lose my Medicaid.

_____ I can't work because staff members say I will lose my Medicaid.

_____ I can't work because employers do not want to hire people with a mental illness.

_____ I can't work because people in the community are afraid of people with mental illness.

Barriers to Employment Ranking List

Please Rank the Following Barriers to Employment from 1 to 9, with 1 being the most important difficulty you face when considering employment.

_____ Need more Education

_____ Need more Training

_____ Need transportation

_____ Fear of Loss of Benefits (I will lose my SSI/SSDI or Medicaid)

_____ Work will be too Stressful

_____ Symptoms of Mental Illness will Increase

_____ No Jobs are Available in which I am Interested

_____ No Previous Work Experience

_____ Employers do not hire people with mental illness

Citizenship Questions:

82. How do most members of the Clubhouse benefit from attending the program?

_____

_____

_____

_____

_____

83. What should be the goals of a successful PSR program?

_____

_____

_____

_____

_____

_____

_____

84. What additional resources are necessary to reach these goals?

_____

_____

_____

_____

85. How should the Department of Mental Health evaluate a PSR program?

_____

_____

_____

_____

_____

86. How should the Division of Medicaid evaluate a PSR program?

_____

_____

_____

_____

_____

_____

_____

87. Is transitional employment the most important component of the PSR program? If not, what should be and why?

_____

_____

_____

_____

88. Should transitional employment continue to be included in the PSR program? Why or why not?

_____

_____

_____

89. Do you think taxpayer money is well-spent on a PSR program? Why or why not?

_____

_____

_____

_____

_____

APPENDIX C

CITIZEN QUESTIONNAIRE - STAFF LEVEL

Staff Questionnaire

Position: _____ Length of Service: _____

Sex: M F Age: ____ Race: African-American Caucasian Other _____

1. What are the goals of the PSR program relative to the consumers?

_____

_____

_____

_____

_____

2. Does the program meet its goals? Why or why not?

_____

_____

_____

_____

3. What percentage of your consumers actively participate in the Work Units?

_____

4. What are the reasons consumers participate in the Work Units?

_____

_____

_____

_____

_____

_____

5. What are the reasons consumers do not participate in the work units?

_____

_____

_____

_____

_____

6. What percentage of your consumers are able to participate in the transitional employment program? Why or why not?

_____

_____

_____

_____

7. What percentage of your consumers are willing to participate in the transitional employment program? Why or why not?

_____

_____

_____

_____

8. Do you believe employers in your community are willing to hire people with a mental illness? Please explain.

_____

_____

_____

_____

9. Do you believe there are jobs available in your community for people with mental illness?

_____

_____

_____

_____

10. Describe the differences between transitional employment through the Clubhouse and independent paid employment in the community?

_____

_____

_____

_____

_____

11. Do you believe that independent work is too stressful for people with mental illness? Please explain.

_____

_____

_____

_____

_____

_____

12. Have consumers ever told you that work in the community is too stressful for people with mental illness? Please describe.

_____

_____

_____

_____

13. Have family members ever told you that their family member is too sick to work in the community? Please describe.

_____

_____

_____

_____

14. If a consumer participates in transitional employment or obtains paid employment in the community, which of the following do you believe about the symptoms of mental illness?

____ Symptoms would probably increase so much that the consumer would be unable to work

____ Symptoms might increase a little but they would be manageable

____ Symptoms would probably stay about the same

____ Symptoms might actually decrease because work would give the consumer something positive on which to focus

15. How will paid work in the community affect a consumer's SSI/SSDI? Please explain.

_____

_____

_____

_____

_____

_____

16. How will paid work in the community affect a consumer's Medicaid benefits? Please explain.

_____

_____

_____

_____

_____

17. Do you believe that consumers are unwilling to accept paid work because they fear a loss of benefits?

_____

_____

18. Do you believe that consumers are unable to accept paid work because they need more education? If so, what type of education?

_____

_____

_____

_____

19. Should additional education be provided in the Clubhouse? If not, by what agency or governmental department and how should it be coordinated?

_____

_____

_____

20. Do you believe that consumers are unable to accept paid work because they need more training? If so, what type of training?

_____

_____

_____

21. Should additional training be provided by the Clubhouse? If not, by what agency or governmental department and how should it be coordinated?

_____

_____

_____

22. Do you think family members discourage consumers from working because they believe the consumer's symptoms of mental illness will increase? Have consumers or family members ever said this to you?

_____

_____

_____

_____

23. Do you think family members discourage consumers from working because they believe the consumer will lose his/her benefits? Have consumers or family members ever said this to you?

_____

_____

_____

Barriers to Employment Ranking List

Please Rank the Following Barriers to Employment from 1 to 9, with 1 being the most important difficulty you face when considering employment.

_____ Need more Education

_____ Need more Training

_____ Need transportation

_____ Fear of Loss of Benefits (I will lose my SSI/SSDI or Medicaid)

_____ Work will be too Stressful

_____ Symptoms of Mental Illness will Increase

_____ No Jobs are Available in which I am Interested

_____ No Previous Work Experience

_____ Employers do not hire people with mental illness

Citizenship Questions:

24. How do most members of the Clubhouse benefit from attending the program?

_____

25. What should be the goals of a successful PSR program?

26. What additional resources are necessary to reach these goals?

27. How should the Department of Mental Health evaluate a PSR program?

28. How should the Division of Medicaid evaluate a PSR program?

_____

_____

_____

_____

_____

29. Is transitional employment the most important component of the PSR program? If not, what should be and why?

_____

_____

_____

_____

30. Should transitional employment continue to be included in the PSR program? Why or why not?

_____

_____

_____

31. Do you think taxpayer money is well-spent on a PSR program? Why or why not?

_____

_____

_____

_____

_____

32. Finally, if you were to design a PSR program, what would you include and how would you know if the lives of the members were improved by attending the program?

APPENDIX D

RESPONSES FROM CONSUMER QUESTIONNAIRE THAT WOULD INDICATE AN OBSTACLE OR BARRIER

Stigma/Attitudes

Question # 20 – no
Question # 70 – no
Question # 71 – no

External Influence

Question # 56 – yes
Question # 57 – yes
Question # 58 – yes
Question # 61 – yes
Question # 62 – yes
Question # 63 – yes
Question # 66 – yes
Question # 67 – yes
Question # 72 – no

Symptoms of Mental Illness

Question # 9 – no
Question # 24 – yes
Question # 26 – yes
Question # 45 – no
Question # 55 – unable to work

Training/Experience/ Education Deficits

Question # 32 – no
Question # 34 – have to be told what to do
Question # 38 – no
Question # 47 – no
Question # 64 – no
Question # 69 – no
Question # 74 – educational need identified
Question # 76 – training need identified

Social/Behavioral/ Cognitive Deficits

Question # 12 – important or very important
Question # 21 – complaints identified
Question # 35 – need reminding
Question # 36 – less than 2 hours
Question # 43 – problems identified

Social/Behavioral/ Cognitive Deficits (continued)

Question # 45 – no
Question # 46 – no

Financial Barriers

Question # 59 – yes
Question # 60 – yes
Question # 62 – yes
Question # 65 – yes
Question # 69 - yes

Responses from Consumer Questionnaire that Would Indicate an Obstacle or Barrier from the Employment Interest Checklist (indicated by a checkmark)

Stigma/Attitudes

Statement # 20
Statement # 21

External Influence

Statement # 11
Statement # 12
Statement # 15
Statement # 16
Statement # 18
Statement # 19

Symptoms of Mental Illness

Statement # 10

Training/Experience/Education Deficits

Statement # 1
Statement # 2
Statement # 6
Statement # 7
Statement # 8

Social/Behavioral/Cognitive Deficits

Statement # 4
Statement # 13

Financial Barriers

Statement # 3
Statement # 14
Statement # 17

Responses from Consumer Questionnaire that Would Indicate an Obstacle or Barrier from the Barriers to Employment Ranking List (9 items)

Stigma/Attitudes
Item # 9 ranked in the top 3

External Influence
Item # 7 ranked in the top 3

Symptoms of Mental Illness
Item # 6 ranked in the top 3

Training/Experience/Education Deficits
Item # 1 ranked in the top 3
Item # 2 ranked in the top 3
Item # 8 ranked in the top 3

Social/Behavioral/Cognitive Deficits
Item # 5 ranked in the top 3

Financial Barriers
Item # 3 ranked in the top 3
Item # 4 ranked in the top 3

APPENDIX E

THEMATIC CODING - STAFF INTERVIEWS AND QUESTIONNAIRES.

Program Goals:

Work: 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25

Total: ____

Socialization: 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25

Total: ____

Support: 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25

Total: ____

If Other, Describe:

_____

_____

_____

_____

_____

Meeting Goals:

Yes: 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25

Total: ____

No: 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25

Total: ____

Comments:

_____

_____

_____

_____

_____

Staff reported % of consumers actively participating in work units: ___ ___ ___

___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

___ ___ ___ ___ ___ ___ ___ ___ ___

Average reported percentage: ____

Reasons for participating:

_____

_____

_____

_____

_____

Reasons for not participating:

_____

_____

_____

_____

_____

Staff reported % of consumers able to participate in TEP: ___ ___ ___ ___ ___

___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

___ ___ ___ ___ ___ ___ ___

Average able to participate: ____

Comments:

_____

_____

_____

_____

Staff reported % of consumers willing to participate: ___ ___ ___ ___ ___

___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

___ ___ ___ ___ ___ ___ ___

Average willing to participate: ____

Comments:

_____

_____

_____

Are employers willing to hire individuals with mental illness:

Yes: 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25

Total: ____

No: 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25

Total: ____

Comments:

_____

_____

_____

_____

Have family members ever told you that a consumer's illness or symptoms prevented them from working in the community?

Yes: 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25

Total: ____

No: 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25

Total: ____

Comments:

_____

_____

_____

_____

Have family members every told you that a consumer could not work in the community because they would lose their benefits?

Yes: 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25

Total: ____

No: 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25

Total: ____

Staff reported barriers to employment for consumers: (Barrier identified in the top three)

Need more Education: 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25

Total: ____ Percentage: ____

Need more Training: 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25

Total: ____ Percentage: ____

Need Transportation: 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25

Total: ____ Percentage: ____

Fear of Loss of Benefits: 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25

Total: ____ Percentage: ____

Work will be too Stressful: 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25

Total: ____ Percentage: ____

Symptoms of Mental Illness will Increase: 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25

Total: ____ Percentage: ____

No Jobs are Available in which I am interested: 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25

Total: ____ Percentage: ____

No previous work experience: 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25

Total: ____ Percentage: ____

Employers do not hire people with mental illness: 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25

Total: ____ Percentage: ____

Staff reported #1 barrier to employment for consumers: (Barrier identified as #1)

Need more Education: 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25

Total: ____ Percentage: ____

Need more Training: 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25

Total: ____ Percentage: ____

Need Transportation: 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25

Total: ____ Percentage: ____

Fear of Loss of Benefits: 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25

Total: ____ Percentage: ____

Work will be too Stressful: 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25

Total: ____ Percentage: ____

Symptoms of Mental Illness will Increase: 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25

Total: ____ Percentage: ____

No Jobs are Available in which I am interested: 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25

Total: ____ Percentage: ____

No previous work experience: 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25

Total: ____ Percentage: ____

Employers do not hire people with mental illness: 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25

Total: ____ Percentage: ____

SSI/SSDI and Medicaid Staff Knowledge relative to employment:

Knowledgeable: 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25

Total: ____

Some Knowledge: 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25

Total: ____

Lack of Knowledge or incorrect information: 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25

Total: ____

Should educational services be offered in the clubhouse?:

Yes: 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25

Total: ____

No: 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25

Total: ____

Comments:

_____

_____

_____

_____

_____

Should work training be offered in the clubhouse?:

Yes: 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25

Total: ____

No: 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25

Total: ____

Comments:

_____

_____

_____

Citizenship Questions:

How do most members benefit from attending the program?

Work: 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25

Total: ____

Social: 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25

Total: ____

Support: 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25

Total: ____

Other: 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25

Total: ____

If other, describe:

What should the goals of a successful PSR program be?

Work: 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25

Total: ____
Social: 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25

Total: ____

Support: 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25

Total: ____

Other: 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25

Total: ____
If other, describe:

_____

_____

_____

What additional resources are needed?:

_____

_____

_____

_____

_____

How should the Department of Mental Health evaluate a PSR program?:

_____

_____

_____

_____

_____

_____

_____

_____

How should the Division of Medicaid evaluate a PSR program?:

_____

_____

Is transitional employment the most important component of the PSR program? If not, what should be and why?:

Yes: 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25

Total: ____

No: 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25

Total: ____

Comments:

Should transitional employment continue to be included in the PSR program? Why or why not?:

Yes: 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25

Total: ____

No: 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25

Total: ____

Comments:

_____

_____

_____

_____

_____

_____

_____

_____

Do you think taxpayer money is well-spent on a PSR program? Why or why not?:

Yes: 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25

Total: ____

No: 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25

Total: ____

Comments:

_____

_____

If you were to design a PSR program, what would you include and how would you know if the lives of the members were improved by attending the program?:

APPENDIX F

THEMATIC CODING - SURVEYS AND INTERVIEWS

Willing to participate in transitional employment:

Yes Total: ____

Willing to participate in transitional employment – confirmation question:

Yes Total: ____

Educational services should be provided by the Clubhouse.

Yes Total: ____

Training should be provided by the Clubhouse.

Yes Total: ____

Transitional employment should be a part of PSR.

Yes Total: ____

Transitional employment helps people return to paid work in the community.

Yes Total: ____

Without transitional employment, why should PSR be continued:

_____

_____

_____

_____

_____

_____

_____

_____

Things to include in a PSR program.

_____

_____

_____

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_____

_____

_____

Consumer Reported Barriers to Employment:

Barriers ranked in the top 3:

Need more Education: 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100 101 102 103 104 105 106 107 108 109 110 111 112 113 114 115 116 117 118 119 120 121 122 123 124 125 126 127 128 129 130 131 132 133 134 135 136 137 138 139 140 141 142 143 144 145 146 147 148 149 150

Total: ____ Percentage: ____

Need more Training: 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100 101 102 103 104 105 106 107 108 109 110 111 112 113 114 115 116 117 118 119 120 121 122 123 124 125 126 127 128 129 130 131 132 133 134 135 136 137 138 139 140 141 142 143 144 145 146 147 148 149 150

Total: ____ Percentage: ____

Need Transportation: 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100 101 102 103 104 105 106 107

108 109 110 111 112 113 114 115 116 117 118 119 120 121 122 123 124 125 126 127 128 129 130 131 132 133 134 135 136 137 138 139 140 141 142 143 144 145 146 147 148 149 150

Total: ____ Percentage: ____

Fear of Loss of Benefits: 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100 101 102 103 104 105 106 107 108 109 110 111 112 113 114 115 116 117 118 119 120 121 122 123 124 125 126 127 128 129 130 131 132 133 134 135 136 137 138 139 140 141 142 143 144 145 146 147 148 149 150

Total: ____ Percentage: ____

Work will be too Stressful: 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100 101 102 103 104 105 106 107 108 109 110 111 112 113 114 115 116 117 118 119 120 121 122 123 124 125 126 127 128 129 130 131 132 133 134 135 136 137 138 139 140 141 142 143 144 145 146 147 148 149 150

Total: ____ Percentage: ____

Symptoms of Mental Illness will Increase: 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100 101 102 103 104 105 106 107 108 109 110 111 112 113 114 115 116 117 118 119 120 121 122 123 124 125 126 127 128 129 130 131 132 133 134 135 136 137 138 139 140 141 142 143 144 145 146 147 148 149 150

Total: ____ Percentage: ____

No Jobs are Available in which I am interested: 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100 101

102 103 104 105 106 107 108 109 110 111 112 113 114 115 116 117 118 119 120 121 122 123 124 125 126 127 128 129 130 131 132 133 134 135 136 137 138 139 140 141 142 143 144 145 146 147 148 149 150

Total: ____ Percentage: ____

No previous work experience: 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100 101 102 103 104 105 106 107 108 109 110 111 112 113 114 115 116 117 118 119 120 121 122 123 124 125 126 127 128 129 130 131 132 133 134 135 136 137 138 139 140 141 142 143 144 145 146 147 148 149 150

Total: ____ Percentage: ____

Employers do not hire people with mental illness: 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100 101 102 103 104 105 106 107 108 109 110 111 112 113 114 115 116 117 118 119 120 121 122 123 124 125 126 127 128 129 130 131 132 133 134 135 136 137 138 139 140 141 142 143 144 145 146 147 148 149 150

Total: ____ Percentage: ____

Consumer Reported Barriers to Employment (Barrier ranked #1)

Need more Education: 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100 101 102 103 104 105 106 107 108 109 110 111 112 113 114 115 116 117 118 119 120 121 122 123 124 125 126 127 128 129 130 131 132 133 134 135 136 137 138 139 140 141 142 143 144 145 146 147 148 149 150

Total: ____ Percentage: ____

Need more Training: 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100 101 102 103 104 105 106 107 108

109 110 111 112 113 114 115 116 117 118 119 120 121 122 123 124 125 126 127 128 129 130 131 132 133 134 135 136 137 138 139 140 141 142 143 144 145 146 147 148 149 150

Total: ____ Percentage: ____

Need Transportation: 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100 101 102 103 104 105 106 107 108 109 110 111 112 113 114 115 116 117 118 119 120 121 122 123 124 125 126 127 128 129 130 131 132 133 134 135 136 137 138 139 140 141 142 143 144 145 146 147 148 149 150

Total: ____ Percentage: ____

Fear of Loss of Benefits: 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100 101 102 103 104 105 106 107 108 109 110 111 112 113 114 115 116 117 118 119 120 121 122 123 124 125 126 127 128 129 130 131 132 133 134 135 136 137 138 139 140 141 142 143 144 145 146 147 148 149 150

Total: ____ Percentage: ____

Work will be too Stressful: 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100 101 102 103 104 105 106 107 108 109 110 111 112 113 114 115 116 117 118 119 120 121 122 123 124 125 126 127 128 129 130 131 132 133 134 135 136 137 138 139 140 141 142 143 144 145 146 147 148 149 150

Total: ____ Percentage: ____

Symptoms of Mental Illness will Increase: 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100 101 102

103 104 105 106 107 108 109 110 111 112 113 114 115 116 117 118 119 120 121 122 123 124 125 126 127 128 129 130 131 132 133 134 135 136 137 138 139 140 141 142 143 144 145 146 147 148 149 150

Total: ____ Percentage: ____

No Jobs are Available in which I am interested: 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100 101 102 103 104 105 106 107 108 109 110 111 112 113 114 115 116 117 118 119 120 121 122 123 124 125 126 127 128 129 130 131 132 133 134 135 136 137 138 139 140 141 142 143 144 145 146 147 148 149 150

Total: ____ Percentage: ____

No previous work experience: 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100 101 102 103 104 105 106 107 108 109 110 111 112 113 114 115 116 117 118 119 120 121 122 123 124 125 126 127 128 129 130 131 132 133 134 135 136 137 138 139 140 141 142 143 144 145 146 147 148 149 150

Total: ____ Percentage: ____

Employers do not hire people with mental illness: 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100 101 102 103 104 105 106 107 108 109 110 111 112 113 114 115 116 117 118 119 120 121 122 123 124 125 126 127 128 129 130 131 132 133 134 135 136 137 138 139 140 141 142 143 144 145 146 147 148 149 150

Total: ____ Percentage: ____

Can you fill out an employment application without assistance?:

Yes: 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59

60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

Total: ____ Percentage: ____

No: 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

Total: ____ Percentage: ____

Citizenship Questions:

How do most members benefit from attending the program? (each consumer may have identified more than one area of response)

Work: Total: ____

Social: Total: ____

Support: Total: ____

Other: Total: ____

If other, describe:

_____

_____

_____

_____

_____

_____

_____

What should the goals of a successful PSR program be?

Work: Total: ____

Social: Total: ____

Support: Total: ____

Other: Total: ____

If other, describe:

_____

_____

_____

_____

_____

_____

What additional resources are needed?

_____

_____

_____

_____

_____

_____

_____

_____

_____

How should the Department of Mental Health evaluate a PSR program?

Ask consumers: Total: ____

Evaluate Work: Total: ____

Other: Total: ____

If other, describe:

_____

_____

_____

_____

_____

_____

_____

How should the Division of Medicaid evaluate a PSR program?

Ask consumers: Total: ____

Evaluate Work: Total: ____

Other: Total: ____

If other, describe:

_____

_____

_____

_____

_____

Is transitional employment the most important component of PSR?

Yes Total: ____

If not, what?

_____

_____

_____

Should transitional employment continue to be included in PSR?

Yes Total: ____

Do you think taxpayer money is well-spent on a PSR program?

Yes Total: ____

Comments:

_____

_____

_____

_____

_____

APPENDIX G

TABLES OF QUALITATIVE RESEARCH FINDINGS

Theme 1 – Program Design and Elements

Table 14 Staff Reported Elements to Include in a PSR Program

More educational services (reading, GED, money management, hygiene skills (7)
Leadership/strong supervisory skills (5)
Coordinated housing/with monitoring of housing services (5)
Computers/internet (4)
Day care so parents could attend (4)
More training including work skills, independent living skills, and social skills (3)
Consumer work interest surveys with corresponding work opportunities (2)
More activities (1)
Age appropriate activities (1)
Outreach
Increase program hours for 5 hours to 8 hours daily (1)
Encourage attendance (1)
More realism in work units (1)
Speakers from potential employees to generate work interest (1)
More work units (1)
A PSR Assistant for each work unit (1)
A Food pantry (1)
Coordination with other agencies (1)
Creation of a potential employer/community leader Advisory Board (1)

Table 15 Consumer Reported Preferred Elements of a PSR Program

Educational services should be provided by the Clubhouse	63 %
Training should be provided by the Clubhouse	52 %
Transitional employment should be a part of a PSR program	76 %
Consumer Reported Specific Elements to include in a PSR program (listed in order of frequency of mention)	
More activities (62)	
More outings (35)	
Stay the same as the current program (34)	
More outside things to do (32)	
Trainings/training classes (22)	
More jobs in the community (19)	
Computers/computer training (16)	
Work training (16)	
GED classes (14)	
More work/more work units (11)	
More fun things to do (10)	
Quiet space/down time (5)	
Consumer interest survey/needs assessment (2)	
Transportation to workplaces (2)	
More staff (1)	
Discussions (1)	
Cook-outs (1)	
Visit other Clubhouses (1)	
Longer hours (1)	
Social setting with support (1)	
Help with applications (1)	
Self-esteem training (1)	
Social skill training (1)	
A book library (1)	
Rotate TEP jobs more often (1)	
Not requiring work (1)	
Attendance monitoring (1)	
Newspaper (1)	
Community education (1)	
More celebrations (1)	

Table 16 Staff Reported Additional Resources Needed to Meet Goals

Computers/printers (7)
Educational materials (6)
Internet service (5)
Games/leisure activities (4)
More qualified and dedicated staff (3)
Education programs (2)
More activities (2)
Training equipment (i.e. cash registers) (2)
Job trainers (1)
Driver education (1)
More outside activities (1)
More staff training (1)
Grants (1)
Cooperation between consumers, staff, and families (1)
Time for outreach (1)
Expansion of reimbursable services by Medicaid and DMH (1)
Community/employer education (1)

Table 17 Consumer Reported Additional Resources Needed to Meet Goals

Education services/GED classes (28)
Job training (23)
More jobs in the community (18)
Computer/printers (17)
More staff (16)
More activities (9)
Transportation (4)
More jobs/work in the clubhouse (3)
More staff education/training (3)
More funding (2)
Mental health treatment coordination (2)
Community speakers (1)
Staff support (1)
Needs assessment/interest survey (1)
Community education (1)
Internet (1)
Training materials (1)

Table 18 Staff Responses - Should Educational Services be Offered in Clubhouse

Yes	65 %
No	35 %
Comments: (listed in order of frequency of mention)	
Should be coordinated with Vocational Rehabilitation (5)	
Education and training do not affect the ability of consumers to obtain paid work (4)	
Basic reading and writing (1)	
In conjunction with other agencies (1)	
Along with an agency that helps to promote employment (1)	
Staff education including benefit training (1)	
Addiction education (1)	
Completing a work application (1)	

Table 19 Staff Responses - Should Work Training be Offered in the Clubhouse

Yes	65 %
No	35 %
Comments: (listed in order of frequency of mention)	
Education and training do not affect the ability of consumers to obtain paid work (4)	
Should be coordinated with Vocational Rehabilitation (3)	
Clubhouse should be involved but not primary (1)	
Need a Work Specialist position (1)	
Community Colleges (1)	
GED providers (1)	
County Extension Offices (1)	
Don't know (1)	

Table 20 Staff Responses - Is Transitional Employment the Most Important PSR Component

Yes	26 %
No	74 %
Other components considered more important (listed in order of frequency of mention)	
Functional stability of consumers (4)	
Keeping people out of the hospital (3)	
Functioning in the community with a mental illness (2)	
Treatment compliance/medication compliance (2)	
Socialization (1)	
Independent living skills (1)	
Not all consumers are able to work (1)	
Continuing education (1)	
Self-satisfaction and improved confidence (1)	
All work units (1)	
Meeting consumer expectations (1)	

Table 21 Consumer Responses - Is Transitional Employment the Most Important PSR Component

Yes	44 %
No	32 %
Don't Know	25 %
Other components considered more important (listed in order of frequency of mention)	
Place to come/place to come to talk/communication (8)	
Socialization (5)	
All work units (2)	
Working together (1)	
Treatment (1)	
Training (1)	
Most important is what is important to each person (1)	
Helps people with mental illness that can't work (1)	
Activities in which everyone participates (1)	
Learning environment (1)	

Table 22 Staff Responses - Whether or Not Transitional Employment Should Continue to be Included in the PSR Program

Yes	83 %
No	17 %
Comments: (listed in order of frequency of mention)	
Gives hope to consumers (1)	
Something to do (1)	
Contributes to consumer stability (1)	
Important to some (1)	
Employers do not want to hire mentally ill people (1)	
Employment is an issue across the country (1)	
Makes consumers feel productive (1)	
Fosters independence (1)	
Allow consumers to earn money (1)	
Provides a goal with a sense of accomplishment (1)	

Table 23 Consumer Responses - Whether or Not Transitional Employment Should Continue to be Included in the PSR Program

Yes	81 %
No	8 %
Don't Know	11 %

Theme 2: Employment/Barriers to Employment

Table 24 Staff Reported % of Consumers Actively Participating in Work Units

Range: 2 % - 100 %
Average: 52 %

Staff Reported Reasons for Participating: (listed in order of frequency of mention)

Like working (6)
Gain work experience/learn work skills (4)
Learn independent living skills (3)
Build self-esteem (2)
Gives a sense of responsibility (2)
Social benefits/socialization (2)
Positive reinforcement (2)
Compliance/required (2)
Desire to learn (1)
Work focus (1)
Better themselves (1)
Contribute to the Clubhouse (1)
Encouragement to participate (1)
Adequate work to do (1)

Staff Reported Reasons for Not Participating: (listed in order of frequency of mention)

Not interested/don't want to participate (11)
Some are not able (6)
Symptoms of mental illness (6)
Not getting paid (5)
Lack of education (5)
Lazy (3)
Told in the past that they don't have to work (2)
Medication side effects (2)
Lack of encouragement (1)
Don't want to work together (1)

Table 25 Staff Reported % of Consumers Able to Participate in TEP

Range: 2 % - 70 %
Average: 15 %
Comments: (listed in order of frequency of mention)
Sleep issues (5)
Lack of education (3)
Lack of communication skills (2)
Limited social skills (2)
Previous work experience (2)
Transportation (2)
Decreased level of functioning (1)
Not able to complete job duties without being reminded (1)
Not willing (1)
Family fear loss of benefits (1)
Immaturity (1)
Instability of symptoms of mental illness (1)
Low percentage physically able (1)
Can't follow directions

Table 26 Staff Reported % of Consumers Willing to Participate in TEP

Range: 3 % - 100 %
Average: 21 %
Comments: (listed in order of frequency of mention)
Supporting comments:
Better life for their family with employment (1)
Some have higher levels of social and educational skills (1)
Some have better communication skills (1)
Like to work (1)
Like extra income (1)
Will do a good job (1)
Concerns and Obstacles:
Fear loss of check (benefits) (2)
Do not want to work (1)
Low level of functioning (1)
Some like to do the work but don't know how (1)
Physical restrictions (1)
Lack of transportation (1)

Table 27 Consumer Responses to TEP Questions

Consumers willing to participate in transitional employment	52 %
Transitional employment helps people return to paid work in the community	58 %
Without transitional employment, why should PSR be continued? (listed in order of frequency of mention)	
Support/self-help/take care of each other (29)	
Place to go/something to do/get out of the house (22)	
Helps with mental illness/treatment of mental illness (18)	
Develop socialization skills (18)	
Practice working (16)	
Help finding jobs (12)	
Work on problems (12)	
Learn job skills/work training (9)	
Food/meals (8)	
Helps consumers stay out of the hospital (3)	
Helps people stay out of trouble (3)	
Be around others with similar problems (2)	
Help people stay on their medications (2)	
A place to get well to return to work someday (1)	
Meaningful work but less pressure than the real world (1)	
Learning environment based on abilities (1)	
Community participation (1)	
Transportation/access to other services (1)	
Help people reach their potential (1)	

Table 28 Staff Reported Employers Willing to Hire Individuals with Mental Illness

Yes	44 %
No	56 %
Favorable Comments: (listed in order of frequency of mention)	
Some are still employed (1)	
Concerns and obstacles: (listed in order of frequency of mention)	
Employers are afraid of people with mental illness (5)	
Economy/ no jobs available (2)	
Very few willing employers (1)	
Too many qualified workers (1)	
Employer education needed (1)	
Unwilling to support/accommodate (1)	
Don't want to train (1)	
Not willing due to the ongoing stigma of mental illness (1)	
Liability concerns (1)	
Previous negative experience (1)	
Note: 50% of staff that responded yes to this question clarified the response with "some" or "few" but not all employers are willing to hire.	

Table 29 Staff Reported Family Members Have Told Them that a Consumer's Illness of Symptoms Prevent Them from Working in the Community

Yes	52 %
No	48 %
Comments: (listed in order of frequency of mention)	
"voices" hinder employment (1)	
Medicine makes them too sick to work (1)	
Reason given but real reason is families fear loss of income (2)	
Safety concerns (1)	

Table 30 Staff Reported Family Members Have Told Them that a Consumer Could Not Work Because They Would Lose Their Benefits

Yes	70 %
No	30 %
Note: 86 % of staff that responded "no" indicated that they believed family members did not want their consumer to work in the community because they would lose their benefits but that families members had not specifically made a statement to them indicating this belief.	

Table 31 Staff Reported Barriers to Employment for Consumers

(Barriers Ranked in the Top 3)	
Need More Education	15 %
Need More Training	13 %
Need Transportation	11 %
Fear of Loss of Benefits	23 %
Work Would Be Too Stressful	6 %
Symptoms of Mental Illness Will Increase	9 %
No Jobs Are Available in Which I am Interested	6 %
No Previous Work Experience	6 %
Employers Do Not Hire People With Mental Illness	11 %

Table 32 Consumer Reported Barriers to Employment

(Barriers ranked in the top 3)	
Need more Education	9.5 %
Need more Training	8.1 %
Need Transportation	17.1 %
Fear of Loss of Benefits	23.8 %
Work will be too Stressful	9.1 %
Symptoms of Mental Illness will Increase	13.7 %
No Jobs are Available in which I am interested	8.0 %
No previous work experience	2.6 %
Employers do not hire people with mental illness	8.1 %

Table 33 Staff Reported Barriers to Employment for Consumers

(Barrier Ranked as #1)	
Need More Education	9 %
Need More Training	4 %
Need Transportation	0 %
Fear of Loss of Benefits	44 %
Work Would Be Too Stressful	4 %
Symptoms of Mental Illness Will Increase	8 %
No Jobs Are Available in Which I am Interested	0 %
No Previous Work Experience	18 %
Employers Do Not Hire People With Mental Illness	13 %

Table 34 Consumer Reported Barriers to Employment

(Barrier ranked as # 1)	
Need more Education	16.7 %
Need more Training	4.2 %
Need Transportation	14.3 %
Fear of Loss of Benefits	34.5 %
Work will be too Stressful	4.7 %
Symptoms of Mental Illness will Increase	16.7 %
No Jobs are Available in which I am interested	3.6 %
No previous work experience	.6 %
Employers do not hire people with mental illness	4.7 %

Table 35 Staff Reported SSI/SSDI and Medicaid Knowledge Relative to Consumer Employment

Knowledgeable	4 %
Some Knowledge	39 %
Lack of Knowledge	57 %

Note: Some knowledge = knowing that the level of benefits is in some way tied to income or to the number of hours worked.

Table 36 Consumer Reported Ability to Fill Out an Employment Application

Yes	29.8 %
No	70.2 %

Theme 3: Program Evaluation

Table 37 Staff Reported Program Goals

(more than one category may have been reported)	
Work/ Employment of Consumers	30 %
Socialization	44 %
Support	17 %
Other	52 %
Other goals: (listed in order of frequency of mention)	
Teaching work skills (4)	
Teaching independent living skills (4)	
Teaching daily living skills (4)	
Rehabilitation (3)	
Establishing meaningful relationships (2)	
Meet individualized goals (1)	
Provide a nourishing meal (1)	
Keep people in the community with necessary support services (1)	
Achieve optimal quality of life (1)	

Table 38 Staff Reported Whether a Program is Meeting Program Goa

Yes	57 %
No	43 %
Comments: (listed in order of frequency of mention)	
Supporting comments:	
Improvement in individual activity are seen over time (1)	
There have been successes in TEP placements (1)	
Concerns and obstacles:	
Need educational training (4)	
Example: Need help to read and write	
Example: The consumers can't fill out an employment application	
Consumers are bored/not enough to do (3)	
Need to help people become employable (1)	
Outside factors interfere with ability to meet goals (1)	
Medicaid does not pay for activities outside the PSR building (1)	
Consumers are not given a chance to work (1)	
It's the responsibility of the Clubhouse to establish and meet goals (1)	
Depends on consumers' willingness to participate (1)	
Obstacles include instability of consumer, transportation, and lack of work training (1)	
Meet socialization goals but not work goals (1)	
Note: 4 staff member responded "yes" but stated that not all goals were met	

Table 39 Staff Reported How Most Members Benefit from Attending

(multiple areas may have been selected)	
Work	17 %
Social	44 %
Support	26 %
Other	30 %

Other ways members benefit (listed in order of frequency of mention)

Sense of belonging/ caring environment (6)
Food/meal (5)
Place to come to be with others with similar problems (4)
Learning work skills, independent living skills, daily living skills (3)
Do not benefit (3)
Stay out of trouble (2)
Something to do (1)
Access to community services (1)
Learn to function in the community (1)
Encouragement to try things (1)
Increased self-confidence (1)

Table 40 Consumer Reported Benefits from Attending

(each consumer may have identified more than one area of response)	
Work	24 %
Social	52 %
Support	39 %
Other	11 %

Other identified benefits from attending the program (listed in order of frequency of mention)

Learn practical living and work skills (6)
Builds self-esteem (2)
Receive treatment for mental illness (2)
Stay out of the hospital (1)
Learn about mental illness (1)

Table 41 Staff Reported Goals of a Successful PSR Program

(multiple areas may have been selected)	
Work	52 %
Social	35 %
Support	30 %
Other	57 %
Other goals measuring success (listed in order of frequency of mention)	
Training (6)	
Help each person meet individual's goals (3)	
Rehabilitation/return to society (2)	
More interaction between staff and consumers (2)	
Coordination of Vocational Rehabilitation services (2)	
Education (1)	
Money management (1)	
Increased attendance (1)	
Outreach (1)	

Table 42 Consumer Reported Goals of a Successful PSR Program

Work	38 %
Social	22 %
Support	53 %
Other	17 %
Other Goals Identified by Consumers (listed in order of frequency of mention)	
Education/training (12)	
Treatment/help people stay out of the hospital (6)	
GED (6)	
Provide meals/food (3)	
Building self-esteem (2)	
Living independently (1)	
Go to college (1)	
Meaningful activity (1)	
Encourage attendance (1)	
Treat people with kindness and dignity (1)	

Table 43 Staff Responses - How Should the Department of Mental Health Evaluate a PSR Program

(listed in order of frequency of mention)
Evaluate work unit participation (5)
Ask consumers/staff (2)
Observation (2)
Evaluate TEP success over a period of time (2)
Consumer feedback/satisfaction surveys (2)
Don't know (2)
Attendance (1)
Good work activities (1)
Establish rules and make unannounced visits to assess compliance (1)
Show support for job training and placement (1)
Comparison of improvement between those attending and those not attending PSR (1)
Quarterly consumer and staff assessments (1)
Evaluate consumer goal achievement (1)

Table 44 Consumer Responses - How Should the Department of Mental Health Evaluate a PSR Program

Ask Consumers	43 %
Evaluate Work	9 %
Other	16 %
Don't Know	25 %

Other Responses (listed in order of frequency of mention)
Observation (8)
Record review (5)
Ask staff (5)
Consumer satisfaction survey (4)
Attendance (2)
Match goals to outcomes (2)
Staying out of the hospital as a measurement (1)
Monitor improvement (individual) (1)
Support job training (1)

Table 45 Staff Responses - How the Division of Medicaid Should Evaluate a PSR Program

(listed in order of frequency of mention)

Attendance (6)
Evaluate work unit participation (5)
See if people are satisfied/consumer feedback (4)
See if people are meeting their goals (3)
Observation (3)
Don't know (3)
Show support for job training and placement (1)
Hospitalization rates and frequency (1)

Table 46 Consumer Responses - How the Division of Medicaid Should Evaluate of PSR Program

Ask Consumers	34 %
Evaluate Work	5 %
Other	24 %
Don't Know	29 %

Other Responses (listed in order of frequency of mention)

Read progress notes/medical records/treatment evaluation (16)
Should observe/see what we do (10)
Interview staff (7)
See if resources match goals (2)
Satisfaction survey (2)
Monitor individual improvement (2)
Attendance (1)
Evaluate participation (1)
Hospitalizations (1)

Table 47 Staff Responses - Is Taxpayer Money Well-Spent on PSR

Yes	83 %
No	17 %

Comments: (listed in order of frequency of mention)
Clubhouse activities contribute to functional stability (4)
Program needs improvement (3)
For some, the only way to remain stable and able to live at home (2)
On the bottom of the list (1)
Helps those that are unable to work due to mental illness (1)
Opportunity to function normally in a controlled environment (1)
For some, the only meal of the day (1)
Keeps people off the streets (1)
Prepare for jobs (1)
Keeps people off the streets (1)
Provides a positive environment for at-risk adults (1)
Well-spent relative to the cost of hospitalization or long term residential placement (1)

Table 48 Consumer Responses - Is Taxpayer Money Well-Spent on PSR

Yes	70 %
No	18 %
Don't Know	12 %

APPENDIX H

DESCRIPTIVE STATISTICS RESPONSE FREQUENCIES

(n = 168 for all response categories)

Frequencies Supporting Table 8

Age (range 19 to 64)	Percentage of Respondents
19	3 %
20	.5 %
21	2.4 %
22	1.2 %
23	2.4 %
24	1.2 %
25	4 %
26	2.4 %
27	3.6 %
28	1.8 %
29	2.4 %
30	3 %
31	3 %
32	.5 %
33	1.2 %
34	1.8 %
35	1.2 %
36	.5 %
37	1.2 %
38	3.6 %
39	3 %
40	3 %
41	1.8 %
42	.5 %
43	3 %
44	4.8 %
45	1.2 %
46	1.8 %
47	3 %
48	2.4 %
49	5.5 %
50	1.2 %
51	4.8 %
52	2.4 %
53	3 %
54	3 %
55	1.8 %
56	1.2 %
Age (range 19 to 64)	**Percentage of Respondents**
57	.5 %
58	1.8 %

59	.5 %
60	6 %
61	.5 %
62	0 %
63	0 %
64	2.4 %

Living Arrangements	**Percentage of Respondents**
Independent	25 %
Living with family or Supervised/supported Housing	75 %

Diagnosis

Schizophrenia/ Schizoaffective disorders	38 %
Major Depressive Disorders	42 %
Other psychoses or Mental illness	20 %

Length of Time in Psychosocial Rehabilitation	**Percentage of Respondents**
1	9.5 %
2	7.7 %
3	8.3 %
4	8.9 %
5	7.2 %
6	7.7 %
7	3.6 %
8	6 %
9	2.9 %
10	2.4 %

Length of Time in Psychosocial Rehabilitation	**Percentage of Respondents**

11	4.2 %
12	1.2 %
13	3.6 %
14	4.8 %
15	3.6 %
16	1.8 %
17	1.8 %
18	1.8 %
19	2.9 %
20	10.1 %

Stigma/Attitudes (range of number of responses 0 – 6)	**Percentage of Respondents**
0	16.7 %
1	8.9 %
2	18.5 %
3	13.7 %
4	22.6 %
5	17.8 %
6	1.8 %

External Influence (range of number of responses 1 – 16)	**Percentage of Respondents**
1	3 %
2	7.1 %
3	6.6 %
4	3.6 %
5	8.3 %
6	13 %
7	11.9 %
8	6.6 %
9	8.9 %
10	10.1 %
11	6.5 %
12	1.8 %
13	4.2 %

External Influence (range of number of responses 1 – 16)	**Percentage of Respondents**

14	4.8 %
15	1.2 %
16	2.4 %

Symptoms of Mental Illness (range of number of responses 0 – 7)	**Percentage of Respondents**
0	23.8 %
1	8.9 %
2	17.3 %
3	8.3 %
4	16.7 %
5	10.1 %
6	11.9 %
7	3 %

Training/Experience/ Education Deficits (range of number of responses 2 – 16)	**Percentage of Respondents**
2	.6 %
3	2.4 %
4	3.6 %
5	6 %
6	9.5 %
7	7.1 %
8	8.3 %
9	11.3 %
10	9.5 %
11	13.7 %
12	11.9 %
13	8.9 %
14	4.2 %
15	2.4 %
16	.6 %

Social/Cognitive/ Behavior Deficits (range of number of responses 0 – 9)	**Percentage of Respondents**

0	1.2 %
1	7.1 %
2	19 %
3	20.8 %
4	14.9 %
5	17.3 %
6	13.1 %
7	4.8 %
8	1.2 %
9	.6 %

Financial Barriers (range of number of responses 2 – 10)	**Percentage of Respondents**
2	2.4 %
3	7.1 %
4	7.1 %
5	9.5 %
6	15.5 %
7	23.2 %
8	24.4 %
9	6.6 %
10	4.2 %

Dependent Variable	**Percentage of Respondents**
Willing to participate in transitional employment	51.2 %
Not willing to participate in transitional employment	48.8 %