1998

Improving employment outcomes for individuals with mental illness: A constructivist approach

Bonnie Jean Houlihan

IMPROVING EMPLOYMENT OUTCOMES FOR INDIVIDUALS WITH MENTAL ILLNESS: A CONSTRUCTIVIST APPROACH

A Project

Presented to the

Faculty of

California State University,

San Bernardino

In Partial Fulfillment

of the Requirements for the Degree

Master of Social Work

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ABSTRACT

Work is an important stage in the treatment of the psychiatrically disabled individual, yet a significant number of this population are unemployed. With mandatory work requirements of welfare reform fast approaching, significant numbers of people are competing for jobs. How can service providers and community members who labor individually to empower the mentally ill collaborate to increase the employment possibilities of this disenfranchised group? This constructivist study delved into the constructs of those vested in the employment of individuals with psychiatric disabilities within a hermeneutic circle of key players brought together in a Southern California city. It is hoped that the identified stakeholders will elect to continue collaboration in an organized fashion for improved employment services and quality of life for the persons with mental illness in their community.

To Edie and John

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FOCUS OF INQUIRY

The reestablishment of work is an important stage in the treatment of individuals with psychiatric disabilities. Work creates secure attachments between the individual, reality, and the human community, and provides the means to support life and to afford gratifying and meaningful leisurely pursuits. Work enables the individual to maintain a role and status in the family and community (Ginsburg, 1963). "To have work to do is to be needed and to be needed is essential for life" (p. 182). Yet, a significant number of adults with mental illness are not working; only 11% to 15% of the severely mentally ill are employed (Frey, 1994). With the arrival of welfare reform and mandatory work requirements looming over communities, a significant portion of the population will be competing for jobs. How can the service providers and other community members who now labor individually to empower people with mental illness to enhance their lives, work together to increase the employment and employability of this disenfranchised group? What are their perceptions of the barriers to employment of persons with psychiatric disabilities? How can such a group increase the employment prospects of mentally ill individuals?

This constructivist study draws out the constructs of those invested in the employment of persons with mental

illness via canvassing a hermeneutic circle of key players brought together in a moderately sized city in Southern California. The goal of this action research was, at its completion, to have set in place a core group of key stakeholders who will continue to collaborate for the improved employment services and quality of life for the individuals with mental illness who reside in their community.

PROBLEM DEFINITION

Of the approximately 45 million persons who are limited in one or more major functional areas due to psychiatric impairments, about 5 million are considered seriously mentally ill (SMI), and about 70% to 90% of the SMI are unemployed (Rutman, 1994). No single disability group has a lower rehabilitative success rate than persons with psychiatric disabilities (Frey, 1994). In fact, the psychiatrically disabled are much less likely to be hired than paraplegics or nonmentally ill persons (Farina & Feldner, 1973) and are considered about as unappealing as ex-convicts in hiring practices (Rutman, 1994).

Characteristics of Employed Consumers, Employers and Jobs Offered

Characteristics of employed SMI individuals include married persons with few symptoms and no criminal justice system involvement (Rogers, Anthony, Toole & Brown, 1991) and those receiving employment assistance (Mowbray, Bybee, Harris & McCrohan, 1995). Additional predictors of work status include psychiatric hospitalization history, service setting, individual's functioning level, family relationships (Mowbray et al., 1995), attitudes towards work (Klein, 1995), and amount of social support (Lewis, 1990) ongoing vocational support and community support (Cook, Jonikas & Solomon,

1992). However, the best predictors of work status are prior work performance and work adjustment skills ratings (Anthony, 1994; Rutman, 1994).In a study of gender and employment rates of the SMI, men in early adulthood were far more likely to be employed than women of the same age, and women were 50% more likely to be employed than men after both SMI groups reached age 35 (Rimmerman, Botuck & Levy, 1995). Surprisingly, psychiatric symptoms and diagnosis have been found to have little correlation with successful vocational outcomes (Rutman, 1994).

Personal obstacles to individuals with mental illness in obtaining employment include lack of motivation, medication side effects, physical health problems, substance abuse (Braitman et al., 1995), and cognitive, perceptual, affective and interpersonal deficits intrinsic to or resulting from the mental illness (Rutman, 1994; Forte, 1991). Rutman adds that the lack of motivation results from the attitudes of professionals within the mental health system, and from secondary symptoms arising from the episodic and unpredictable nature of mental illness. These factors create frustration and dependency within the labeled "client" or "impaired person", whose knowledge of self, skills, interests and work values are often minimal because of lack of encouragement to test themselves in the work market. Those

who succeed at employment have developed specific, conscious responses: a positive outlook, avoidance of substance abuse, a diverse support network, strategic medication use, avoidance of relapse, and overcoming illness and stigma on the job (Alverson, Becker & Drake, 1995).

Characteristics of employers who are likely to hire individuals with psychiatric disabilities include those who have friends or relatives with psychiatric problems, who are managers or supervisors rather than executives, who possess accurate information about psychiatric disabilities (Cook, Razzano, Straiton & Ross, 1994) who have a sense of altruism, who have had previous exposure to the SMI via supported and transitional employment programs, and who have had endorsements from other employers (Rutman, 1994). Personal contact with employers, rather than canned presentations, is by far the most effective method in convincing employers to provide work opportunities (Rutman, 1994). Consumer networks and business advisory committees were not found to be successful for job networking (Gerbey & Kowal, 1995).

Job retention needs to be addressed. A significant relationship has been found between the number of employer accommodations and job retention of the SMI (Fabian, Waterworth & Ripke, 1993), but Akabas (1994) points out that there is a lack of studies on the characteristics of

employers and work places that promote successful employment of the mentally ill individual. Akabas theorizes that the same conditions and circumstances that distinguish a good place to work for employees in general serve to define an effective site for the employment of the psychiatrically disabled: clear expectations, empowerment and responsibility, flexibility of means, and support and reinforcement for achievements.

Most employed individuals with psychiatric disabilities find it easiest to obtain employment in the food service industry and maintenance field (Gervey & Kowal, 1995). Recent legitimization of peer support, the consumer movement and expansion of disability rights have led to the hiring of persons with psychiatric illnesses within the mental health industry as peer job coaches, case manager extenders, outreach workers and other staff positions (Mowbray, Moxley, Thrasher, Bybee, McCrohan, Harris & Clower, 1996).

Existing and Evolving Models of Support

Multiple models exist to assist mentally ill individuals get and keep jobs: clubhouses, transitional and supported employment, individual placement, enclave, work crew, natural supports, and assertive community treatment (Barker, 1994). Most programs contribute to at least partial vocational restoration for SMI individuals, but a review of the models

suggests significant gaps in knowledge surrounding how program activities actually benefit the individuals receiving service, and which types of people benefit from which type of services (McGurrin, 1994). Some recent studies indicate helpful models. Drake, McHugo, Becker, Anthony & Clark (1995) found a combined vocational rehabilitation services/mental health program located at a mental health center helped clients get competitive jobs faster and keep them longer than preemployment training and skills support located in the community.

But supported employment in competitive jobs has been found to be the most viable work alternative for the severely mentally ill (Clark, 1995; Torrey, Becker & Drake, 1995). Schultheis & Bond (1993) found that clients prefer real work opportunities over prevocational preparation placement or "in house" work crews, and that clients performed better in paid community positions than in pre-vocational settings. However, McGurrin (1994) cites numerous barriers to developing supported employment programs: a lack of experienced staff, transportation and funding, and a lack business/public relations and marketing knowledge necessary to access and communicate with the business community.

The development of natural supports as a powerful adjunct to professional vocational services has been cited.

Kaufmann (1995) points out that professional vocational rehabilitative services cannot provide the lifetime of support needed to sustain employment for the SMI population. Kaufmann's project produced evidence that self help and peer mutual support groups were an effective adjunct to professional services. West & Parent (1995) agree, identifying key factors in finding and keeping natural supports: relationship building, consumer driven services, employer involvement and circles of support. Natural on-the-job supports have been identified: employer accommodations such as modifying performance expectations (Fabian et al., 1993), flexible scheduling, matching jobs to strengths and limits of employee abilities; and pairing the mentally ill individual with a nonhandicapped employee as a mentor (Cook et al., 1992). The best mentors tended to be older and female, well liked, team players, and had high levels of productivity.

Institutional and Informal Support Attitudes

Employer attitudes have been found to impede the employment of the mentally ill. Cook et al. (1994) cite business concerns surrounding fears of low productivity, increased insurance costs, high absenteeism, difficulties controlling behaviors, lack of resources and support services, creation of work place accommodations, and

integration with non disabled workers as impediments to hiring the mentally ill. Additionally, a survey of Fortune 500 corporate policies discovered that fewer than one in four responding companies have a current policy concerning individuals with psychiatric disabilities (Jones, Gallagher, Kelley & Massari, 1991). Employee attitudes have not been adequately explored. Only one study on attitudes was located, which found negative reactions of employees to hiring the mentally ill (Farina & Felner, 1973).

Persons with psychiatric disabilities face tough opposition when deciding to work. Welfare and entitlement policies make consumers and their family members fearful of employment due to threatened loss of benefits in the means-tested system (Clark, 1995; Rutman, 1994). Some consumers are willing to take the chance. In Braitman, Counts, Davenport, Zurlinden, Rogers, Clauss, Kulkarni, Kymla & Montgomery's (1995) study comparing employed people versus unemployed mentally ill individuals, about 98% of those unemployed were dependent on entitlements, compared to 62% of the employed. The wages of the disabled are 30% to 40% lower than those paid to the nondisabled in similar positions (Clark, 1995).

Consumers who choose to work prefer seeking employment over lengthy pre-vocational assessments, and competitive jobs

in integrated work settings rather than sheltered workshops or volunteer work (Becker & Drake, 1994; Rogers, 1995). Consumers would also like more control over their vocational programs. Howie the Harp (1994), a consumer of mental health services, stresses empowerment for consumers via involvement at every level of the planning, implementation and ongoing operation of vocational rehabilitation services. Rogers (1995), another consumer of mental health services, sees work as critical to recovery because it boosts self esteem and provides a sense of purpose and accomplishment. He prefers individualized mental health treatment plans that include work as the first priority, rather than cookie cutter approaches that blame clients or pathologies instead of ill-suited plans when failure occurs. McGurrin (1994), agrees. In a review of the effectiveness of current programs, McGurrin found that evaluations of the nature and effects of the interactions among the many elements of a client's treatment, community life and vocational rehabilitation are the most neglected areas of the field.

Significant tensions and discontinuities exist within and between the two major agency systems that work to employ the population with psychiatric disabilities. First, neither the Department of Rehabilitation (DR) nor the Mental Health system is optimistic about long term employment abilities of

persons with mental illness (Rutman, 1994). Second, DR asserts Mental Health should provide more extensive job preparation services, while Mental Health staff complain about delays and difficulties getting their clients accepted for service at local DR offices. Thus, consumers are often caught between the two systems.

Rutman (1994) identifies conflicting definitions between the two systems regarding psychiatric rehabilitation that hinder favorable outcomes: the psychiatric or medical model which stresses symptoms, pathologies, diagnosis and treatment, versus the rehabilitative model which focuses upon functional assessments, reduction of deficiencies and the learning or relearning of needed life skills. Weinstock & Barker (1995) further delineate the differing views and roles of DR and Mental Health staff that affect outcomes. The DR staff role is time limited; cases are closed upon 60 days of job retention. Job loss is considered a failure. DR counselors are trained in employer relations and exigencies of the work place, but not in the nature and course of mental illness or the employment capacities of consumers. As a result, DR counselors are rigid in their reliance on symptoms as a factor in determining eligibility for services.

Mental Health staff focus upon stabilizing the consumer in the community and reducing the risk of rehospitalization.

Staff time commitments are open ended and lifelong if necessary. Work is seen as stress and therefore detrimental to the client, and job loss is viewed as an opportunity for growth. Mental Health staff are not trained to work with employers or to do vocational assessments, and thus do not take employers' perceptions and needs into account. In spite of the critical philosophical differences between the two service systems, coordination between them is known to produce better outcomes for participants than fragmented services. Waiting times are reduced, less consumers drop out in the beginning, services are better coordinated and getting back to work after a crisis episode is easier (Weinstock & Barker, 1995).

In response to system problems, some consumers, with the help of social workers, have begun their own therapeutic member-employing business, Rainbow Services, utilizing the beliefs and values of early settlement house workers: all people have the potential to be productive citizens; meaningful work is a regenerative force in troubled people's lives; the work place can meet people's yearning to be needed; and social activity and common endeavors promote growth (Forte, 1991). These beliefs shift the attention away from illness and towards competencies or strengths, and is

directly indicated as the reason for this program's 13 years of business success.

Community attitudes surrounding employment of individuals with mental illness have been found to change as a result of contact with challenged individuals (Tice, 1994). Community members were significantly more willing to work with challenged individuals and believed such were capable of learning new skills after a 6 month supported employment program involving twice weekly residential contact with consumers. Preexisting community attitudes can play a positive role. Neighbors who had a commitment to philanthropy and valued contributing to the welfare of others became favorably involved in a consumer-run and neighborhood-based program (Forte, 1991). Further research needs to be done on community responses to supported employment, as examples are rare (Tice, 1994).

Effective Collaboratives

In a review of community based models of vocational rehabilitation for individuals with psychiatric disabilities, Cook et al. (1992) found that to get and keep consumers on the job, it is crucial that such programs have ongoing vocational support that includes advocacy to soothe coworker's and employer's fears, and community support that utilizes and increases natural supports already in place.

Barker (1994) adds several ingredients that are essential for community based programs: the program must offer a wide array of choices and flexibility; the program must be an integral part of the community in which services are based, i.e. responsive to particular needs of specific persons within a specific community; must build on the strengths, resources, relationships and unique aspects of a particular community; and must develop relationships with businesses. Barker also identifies common attributes of successful programs: dedication to consumer empowerment via involvement of consumer in all facets of service delivery; ability to develop effective working relationships with various actors in the community; the WIT factor (Whatever It Takes) or being creative and flexible; and the provision of long term support (1994).

A review of six collaborative efforts between local DR and mental health departments determined that several factors could improve services: cooperative funding agreements; interagency meetings, cross-training and internal agency changes; improvement of partnership between DR and Mental Health staff for sharing expertise and resources; locating DR and Mental Health staff in one place; redefining traditional staff roles to combine rehabilitation and mental health case management services; and offering presumptive disability to

speed DR services (Weinstock & Barker, 1995). However, the most important collaborative efforts were found to occur at the level of service to individuals. Thus, service providers should not wait for systems to change, but should start the discussion with associates of other service systems at the service delivery level. As cooperation develops, the benefits of collaboration can propel the system towards formalizing and institutionalizing these arrangements.

Benefits of Employing Consumers

Benefits of work for the consumer include: significant positive impacts upon the self concepts and life satisfactions of persons with severe and persistent mental illness (Arns & Linney, 1993), a reduction of both negative and positive symptoms, reduced depression, and an increase in self esteem and hope for the future in persons suffering from schizophrenia (Bell, Milstein & Lysaker, 1993). Financial benefits have been identified. Financial costs of work programs were found to be offset by lower costs for rehospitalization in a review of a veteran's administration work program for individuals with schizophrenia (Bell & Lysaker, 1995). However, due to methodological problems it is difficult to discern whether or not the cost-benefits ratios involved in getting consumers with mental illness back to work are favorable (Rogers, 1997).

California's Response

In a move to improve the dismal employment prospects for individuals with mental illness in California, the State Department of Mental Health (DMH) and the Department of Rehabilitation (DR) developed 22 cooperative vocational programs (cooperatives) between county mental health departments and their local DR's to provide employment services for persons with severe psychiatric disabilities (Covent, 1996). DMH/DR cooperatives embrace a common set of values promoting consumer career choice, comprehensive service linkages, competitive and integrated employment placements, and reasonable work site accommodations and ongoing support for the severely mentally ill (DMH/DR Cooperative Overview Sheet).

Recognizing that coordinated vocational and employment services could not be successful without community support, the DMH/DR Cooperative Unit developed ongoing community focus groups labeled BEST (Building the Employment Services Team) Networks. BEST Networks have been charged with promoting public awareness via collaboration and coordination to enhance employment opportunities for the severely mentally ill in local communities. (Covent, 1997). There are currently fifteen BEST Networks serving thirty-one counties in California. The intended outcome of this study was to

strengthen the ongoing development and community collaborations of a new BEST Network.

The BEST Network system was established through a partnership between DR, DMH and transportation (Caltrans) and is overseen by the DMH/DR Cooperative Unit. BEST's primary mission is to build the local resource partnerships, technical expertise and collaborative systems needed for the delivery of employment and independent living services for those with severe psychiatric disabilities (Field Practicum Description for CSU Stanislaus). BEST core membership has included a consumer, family member, employer (Caltrans), local mental health and rehabilitation staff and a local service provider. Dictated by community and consumer needs, BEST membership roles have expanded and can include members from agencies such as Social Security, Employment Development Department, local community colleges, Independent Living Centers, Private Industry Council, Regional Occupational Programs, Regional Center, Alliance for the Mentally Ill (AMI), Goodwill and private sector employers.

Network ventures are decided by local needs and interest and have included the following activities: technical and assistance training for agencies and employers on employee assistance programs; work site accommodations for persons with mental illness; coping with a changing work place and

specialized career planning; assessment of community resources; coordination of local job developers; development of transportation consortium; implementation of transition teams for 16-21 year olds; placement of on-campus mentors; regional conference planning; creation of liaisons with local law enforcement, mental health boards and local A.M.I. groups; and attendance at local business association meetings, including participation in their speakers' bureaus.

The need for local support to ensure successful employment outcomes for individuals with mental illness has been identified. In a review of current literature on vocational rehabilitation for this population, two primary external support systems were specified as crucial (Cook et al., 1992): ongoing vocational support involving advocacy to allay coworkers' and employers' fears, and community support that utilizes and increases the natural supports already in place on the job and in the community. BEST Networks are an excellent vehicle to address these issues.

METHODOLOGICAL CONSIDERATIONS

A Constructivist Paradigm

The problem has been identified: What can be done to improve the employment prospects of persons with psychiatric disabilities? Relevant literature suggests that collaboration between local entities is related to positive outcomes in employment for this group. In order to build a cohesive collaborative, all persons whose lives are touched by mental illness need to participate in the integrative process. The principles of action research as defined by Stringer (1996) are germane to this "constructivist" process, as well as to social work ethics and community organizing practices. Constructivist, or hermeneutic dialectic circles, operate at intellectual, social, cultural, political and emotional levels, thus building an integrated vision and strengthening the sense of community. Such collaborations enable diverse groups to learn to work together in an amiable and productive fashion to achieve common goals. Too, action research promotes methods which ensure the well being of everyone involved by taking into account the impact of its activities upon the lives of people. Each stake holder's constructs are sought out individually and collectively: consumers, family members, employers, social service representatives, treatment teams, service providers, and other identified members.

Traditional approaches to research operate on object-subject distance modes that are counterproductive to building coalitions. Action research and constructivist methods require full enmeshment and participation of the researcher within the target population to obtain cohesive, rich and useful data. Traditional positivist and post positivist designs are not appropriate vehicles for action projects. Positivist designs function primarily to predict and control phenomenon, to test theory, are done in a controlled setting, and are meticulously fashioned to be objective in order to eradicate researcher bias and values. Because the researcher is removed from the process, he cannot fully comprehend the constructs involved. Results must be repeatable and generalize to all times and contexts. Action, or constructivist research is generalizable only within specific contexts and time frames and does not seek to control or predict, but to build a collaborative process that hopefully continues after the research is completed.

Post positivist designs do occur in natural settings, but a modified objectivity is still required; the researcher voids her subjectivity by admitting her personal slants and prejudices, and by including elaborated triangulation methods within her design. Results create theory, not collaborations. Generalization to wide contexts and time frames is still

sought. Again, the researcher is removed from context and cannot fully appreciate or respect the processes involved.

In constructivist and action research, the focus is on process within particular contexts and times, building constructs, and forming a working group which may continue after the researcher vanishes. Objectivity does not exist, as the researcher is part of the process; in order to ferret out the relevant questions, the researcher must be involved. Findings are shaped by the interactions, are socially based, local and specific, and dependent on the persons who hold the realities. The results emerge as mutually beneficial to the researcher, the institutions involved in the collaboration, and the respondents (Erlandson, Harris, Skipper & Allen, 1993). Constructivism, or action-based research is the best solution to the question posed here.

Investigator

The researcher, armed with a pertinent literature review, general starter questions and supportive strategies, is the primary instrument utilized to elicit data in constructivist research. Sharing literature reviews and previously uncovered constructs helps augment information and expand themes during future interviews. Supportive strategies are more likely to uncover accurate information. For instance, integrating the researcher's personal experiences

as a case manager for individuals with psychiatric disabilities with expressions of respect and concern for their dilemma shows sensitivity and encourages honest, accurate responses.

Stringer (1996) advocates the use of personal self within relationships as the main instrument in action research strategies. The researcher's role is not an expert, but a "facilitator or consultant who acts as a catalyst to assist stakeholders in defining their problems clearly and to support them as they work toward effective solutions to the issues that concern them (p. 22)." The researcher as instrument was actualized in this study via three components: relationships, communication and inclusion. Researcher's relationships with participants promoted equality, harmony, acceptance, cooperation and sensitivity (p. 26). The researcher practiced the communication skills identified as effective by Stringer (p. 29): attentiveness, acceptance, understanding, truth, sincerity, appropriateness and openness. Inclusion principles were practiced by inviting all relevant individuals to share their issues privately within interviews, and publicly at a focus group scheduled after all relevant issues and constructs were identified.

Methods

The information dissemination of this study will transpire as follows: The researcher's initial methodological intentions will be outlined first in each phase of inquiry. The actual implementation of the study and any subsequent modifications will follow.

Successive phases of inquiry.

Data sources.

Guided by the literature review, existing natural supports, and the researcher's personal experience with individuals with psychiatric disabilities, key stakeholders within the targeted city who are vested in the employment of this population were identified and invited to participate. The realities or constructions held by these diverse individuals were sought out for developing a context in which those with divergent perceptions and interpretations could formulate a construction of the situation that made sense to them (Stringer, 1996). Hopefully, this hermeneutic dialectic process achieved a higher level synthesis or consensus by clarifying different perspectives.

Members comprising the hermeneutic circle were persons who had previously agreed to participate in the BEST network's formation. These individuals were sought from relevant institutions and agencies who were already

attempting to increase the quality of cooperation among them. These established "owners" included representatives from the Department of Rehabilitation, Department of Mental Health, the Economic Development Agency, a local vocational services program, consumers and parents of adult individuals with psychiatric disabilities.

To ensure the study's applicability to relative and contextual conditions of this Southern California community, the individuals interviewed were from local services already in place. It was hoped that identified "owners" would derive from both natural and institutionalized support systems and would also include persons from the Department of Public Social Services, the Greater Avenues for Independence Program, the Office of Education, Employee Assistance Programs, coworkers of individuals with mental illness and employers against hiring persons with disabilities. However, sampling procedures utilized did not identify key players in these arenas.

The final sample consisted of four men and seven women from various backgrounds and relatedness: two supervisors from local vocational and socialization agencies serving individuals with mental illness; two experienced job coaches/developers; two employers from local businesses vested in hiring disabled individuals; a Department of

Rehabilitation counselor assigned solely to mentally ill persons; two parents of adult persons with mental illness, and two consumers (one employed) with mental illness.

Phase one: orientation overview.

The interview format began with the presentation of a detailed informed consent which included particular attention to confidentiality issues. The researcher introduced her affiliation, motives, intentions and purpose while reviewing the consent form with each potential member. A set of general, open-ended questions surrounding issues of employment of individuals with psychiatric disabilities, as well as the possibility of community collaboration to deal with these issues was then utilized to begin the interview.

1. In your opinion, what are the key issues surrounding employment of mentally ill individuals here in Riverside?

2. What are your perceptions of the barriers to the employment of mentally ill individuals?

3. In your opinion, what is needed to improve the prospects of the employment of the mentally ill individual?

4. How can existing and natural supports work together to increase the employability and employment possibilities of this group, particularly in the wake of welfare reform and mandatory work requirements?

5. Would you be willing to participate in a community focus group for the purpose of creating solutions to the problems identified?

Each successive interview included a sharing of the constructs elicited from previous interviews while further broadening or narrowing the focus, as needed. Salient points were covered and checked off. The circle of members was closed and interviews stopped when responses become similar and new constructs or perspectives could not be elicited. Data collection was deemed complete at this juncture.

Data collection.

Access to key stakeholders was assured via the researcher's field placement as facilitator of the new BEST Network, which began in the fall quarter of 1997. Preliminary visits to various related agencies occurred naturally during the course of building the BEST Network, providing easy accessibility and enough time to ensure the trustworthiness and credibility of the researcher in participant's minds.

Purposive sampling, specifically snowball (Ruben & Babbie, 1996) or opportunistic (Erlandson et al.,1993) sampling was utilized to identify and expand further ownership of this collaboration for the empowerment of persons with mental illness. Participants were asked to identify who else should be included in the discussion, who had a different viewpoint, or who might supply more information about issues surrounding the employment of persons with psychiatric disabilities. These specified

persons were invited to elaborate, explicate or add to the constructions previously identified for the researcher's and group's synthesis process. A deviant case sample, an employer against hiring the mentally ill individual, was sought to identify constructs involved in denying such individuals access to the work place, however, this goal was not achieved.

Data recording.

Qualitative data deduced from observations and communications were collected via handwritten notes and, with permission, simultaneous tape recordings during interviews. Immediately following each interview, notes were examined, clarified, corrected and expanded upon in precise detail. In constructivist research, qualitative data collection methods are utilized and thus data collection and analysis occur simultaneously. Pertinent categories were identified according to Glaser & Straus' (1967) constant comparative method in preparation for the next interview. Constructs developed in previous interviews were shared in subsequent sessions to broaden identified categories and to elicit new ones. Note cards, field journals and original notes were utilized to ensure fidelity. Tape recordings were not relied upon except as an adjunct to avoid gaps in handwritten data recording.

Phase two: focused exploration.

Once the above themes and constructs were identified, clarified and analyzed, key members with the motivation, expertise or ability to carry out a cooperative agenda were invited to participate in a focus group to further elucidate data on salient elements. Constructs revealed by the first phase were shared via a handout mailed along with an invitation to participate in the focus group. Four respondents attended the final meeting: three vocational system members and one mental health professional. Additional constructs arose, which are identified within the respondent interview constructs outlined in Substantive Considerations.

Data analysis.

Data analysis in constructivist research is a progressive, ongoing process that proceeds alongside the collection of data and occurs at all points during data collection process: during, between, and after interviews and observations, and prior to and after data collection completion (Erlandson et al., 1993). The physical and mental steps of analysis utilized in this study complied with the constant comparative method formulated by Glaser & Straus (1967), and illustrated by Lincoln & Guba (1985) and Erlandson et al. (1993).

Constant comparative method involves three phases: comparing incidents applicable to each category, integrating categories and their properties, and delimiting the theory. The practical steps include: unitizing data; emergent category designation; negative case analysis; and bridging, extending and surfacing data. Simply put, analysis involves taking constructions gathered from context and reconstructing them into contextually significant wholes that accurately represent the constructs of the study participants.

First, the data elicited from observational and interview notes obtained from interviews were unitized or whittled down into individual units and written onto separate note cards. Each unit of data was heuristic, focused upon the understanding of some aspect of the context, and was the smallest pieces of information able to stand alone, per Lincoln & Guba (1989) guidelines. These units served as the basis for defining categories.

Each note card contained one unit of data. The back of each note card contained three salient pieces of information to assist in data analysis, authenticity, the audit trail, and the credibility and dependability of the analysis process: the source or interviewee number; the page and line number of notes from which the unit of data was derived; and

the type of interviewee, i.e., job coach, consumer, employer, or agency representative.

Once data had been unitized and labeled, emergent category designation began. Units of data written on note cards were sorted into category piles. As note cards became too wieldy and numerous, data was entered into a computer. Constant comparison between units of data and categories occurred throughout this sorting process. Data that "looked alike" or "felt alike" or that related to the same context were put in common category piles. Titles or descriptive sentences distinguishing one pile from another were formulated after all presently existing units had been grouped. Frequent notes were taken describing the ideas that led to the uncovering of the properties of categories. In order to justify the inclusion of each unit of data, and to render the category set internally consistent, rules were devised that precisely describe each category's properties.

All units of data were resorted according to the newly-defined categories by comparing each unit to the primitive versions of the rules, rather than to the data within each category. This resorting is done to verify current properties and to allow the emergence of new categories or the dissipation of old ones. Categories were also reviewed to detect overlaps, to certify internal homogeneity and external

heterogeneity, to uncover relationships among categories, and to identify categories that are subsumable, unwieldy or missing for follow-up. This "reconstruction" process is the foundation for establishing the credibility of the study because it enables alternative constructions to emerge and constructs realities that are contextually consistent and compatible with the interviewees' constructions. Later data collection efforts were specifically aimed at identifying new categories, filling in gaps, clearing up anomalies or conflicts, and extending the range of information to be accommodated.

The delimiting of the construction occurred as more data was processed and fewer modifications were required. Improved articulation and integration reduced the number of categories. When exhaustion of sources, saturation of categories, emergence of regularities and overextension occurred, data collection ceased. This became apparent when new information gleaned was removed from the core of emerged categories, and when categories became so well defined that there was no point in adding to them.

There are several limitations of constructivist methods to remember during analysis. First, difficult-to-retrieve information may receive less attention. Second, there could be a tendency for the researcher to ignore information that

disagrees with previously identified constructs, while emphasizing that which confirms them. Third, more extreme or unusual constructs may be discounted. Fourth, some sources are more credible than others. And last, categories where information is missing or incomplete may be devalued. Negative case analysis, described by Erlandson et al. (1993) was utilized to overcome some limitations. Alternative interpretations of the data, particularly data that would refute the researcher's reconstruction of reality, was addressed by seeking out dissenting or minority opinions throughout data collection.

The last step in the analysis of data: review the entire category set once again to be certain that nothing had been overlooked. The final reconstructions were taken back to the respondents in written form for their examination via a final member check. Four respondents agreed to meet together to be introduced to and empowered by each other's constructs, with the intentions of coming to a consensus concerning plans for action.

Phase three: member check.

Member checks are the most essential procedures performed by the constructivist to establish the credibility of the final report (Erlandson et al., 1993), and to exhibit respect for the participants (Stringer, 1996). Member checks

ensure that constructs elicited are understood by the researcher and thus presented to others within a personal and local social, cultural and professional context.

Member checks occurred continuously via reflective listening during all interviews, but specifically and formally transpired at three junctures. First, immediately following each interview a summary of its contents was verbalized by the researcher to correct facts and interpretations. Second, soon after the interview each member was presented a written summary of their interview to allow clarification and verification of the constructs elicited. Third, a copy of the completed report was presented to members prior to the meeting of the hermeneutic circle or "focus group." General themes or constructs surrounding employment of individuals with psychiatric disabilities emerged: current conditions that enhance employment and job retention, positive outcomes, barriers, and action strategies for the dissolution of barriers to employment for persons with psychiatric disabilities.

Trustworthiness Steps

Protection of human participants.

A constructivist or action research project requires that perceptions and ideas be shared among the members: privately within the individual interview; successively

through each member of the hermeneutic dialectic circle; and finally, publicly via the resulting focus group. This lack of confidentiality means the researcher must explain the process carefully to each member before beginning to elicit constructs, while painstakingly outlining the purpose of sharing constructs with other potential hermeneutic circle members. Therefore, an informed consent was prepared and then thoroughly reviewed by the researcher and the member prior to each interview.

The respondents were considered full and equal partners in the study. Constructivist research requires members to work from a position of integrity, with no attempt to mislead, deceive, or hide. It also requires a willingness to share power, to change if negotiations are persuasive, to reconsider value positions and to make the commitments of time and energy necessary for the process. The researcher personified these ethical ideals by revealing personal motives, intentions and the study's purpose within both the hermeneutic dialogue and the consent form. Integrity and trustworthiness of the project were maintained by the respect and value given to each member's input. Participants were given access to the researcher via shared phone numbers, and contact was invited. This approach intended to promote the trustworthiness of the researcher, to ensure that each member

felt included in the process, and to assure that each member's input was considered significant and valuable by both the researcher and other members.

Quality control.

Multiple techniques have been identified for establishing the authenticity and confirmability of naturalistic research (Erlandson et al., 1993). The first of these is "prolonged engagement", or conducting a study over an extended time period in order to soften distortions and to establish trust and rapport with the researcher. A substantial length of time gives the researcher a chance to show respondents he or she has an avid interest in the topic, is concerned about the target population, and will maintain the integrity of the persons and situations encountered. Prolonged engagement was easily met, as the researcher was introduced to most respondents prior to the data gathering phase of the study due to facilitation duties surrounding the BEST Network formation in the fall 1997 quarter of field placement.

"Going native" could have been a problem with prolonged engagement, as this researcher is particularly familiar with the problems of individuals with psychiatric disabilities, due to a lengthy career as a case manager for this population. The use of an experienced reviewer was paramount

to prevent researcher over-identification with the professional groups.

"Persistent observation", or purposeful, assertive investigation practiced by the researcher provided in-depth, accurate data, sorted relevancies from irrelevancies and recognized deceits. Clarification of constructs and the filling-in of data gaps were promptly addressed via phone calls after each data analysis session. Observations of particular sites, the perusal of related literature, and the integration of various perspectives were utilized to avoid premature closure of the investigation. Such observations included attending a consumer-run support group and four specific focus groups that were sponsored by the local BEST Network for consumers, job coaches/developers and case managers for individuals with mental illness.

Triangulation practices established credibility via the utilization of multiple sources, methods and theories. Respondents were selected from multiple role groups involved in the employment of individuals with mental illness: consumers and their family members, practitioners, employers, and vocational and social service agency representatives. Observations of related sites, interviews conducted with selected respondents, and the review of pertinent documents combined with the literature review fulfilled the multiple

methods required for triangulation purposes. Theoretical triangulation was achieved via the identification of several constructs or perspectives within the analysis of the completed data set.

Credibility was maintained through the use of referential adequacy materials obtained via obtrusive and unobtrusive measures. Interviews were taped when permitted. Notes jotted down during the interview process were amplified immediately after each session. Brochures from relevant agencies, the local newspaper, consumer newsletters, and demographic data relating to employment of the disabled within the targeted city were reviewed. Some features were used for the analysis of data, but most were used after the analysis to support the audit process and to enrich the identified constructs.

Peer debriefing was provided every other week by Dr. Nancy Mary, a faculty member with experience in constructivist research and knowledgeable surrounding the employment concerns of individuals with disabilities. Materials and emerging constructs were analyzed, with the peer debriefer asking probing questions, playing devil's advocate and identifying alternative constructs or categories. Following each session a written, reflective dialogue summarizing the issues, concerns, emerging

constructions and designs was entered into a reflexive journal to establish documentation and credibility for the audit trail. Information about the researcher's schedule, logistics, insights and reasons for methodological decisions was entered into the journal on an as-needed basis.

Establishment of authenticity was also addressed by bringing the respondents together in a hermeneutic dialectic encounter after individual interviews were completed. The goal of this meeting was to collectively examine diverse and common realities and to empower, educate and connect the study participants to the struggle to improve the quality of the lives of individuals with psychiatric disabilities. The researcher's success in establishing a partnership with the stakeholders allowed a free and honest exchange of the individual constructions of all participants, while building on the collaborative process. This will hopefully enhance consumer opportunities for growth and empowerment, the foremost goals of this constructivist research.

SUBSTANTIVE CONSIDERATIONS

Four major constructs surrounding employment issues for persons with mental illness (clients) emerged from the qualitative interviews: employment and job retention enhancement factors; positive outcomes of hiring persons with mental illness; employment and job retention impediment factors; and the "action plan" for the dissolution of barriers to productive employment for this population.

Five subcategories were found to be inherent within all four major constructs: environmental and external features; personal characteristics of clients; system factors; employer characteristics; and vocational support elements. The five subcategories will be illustrated within each of the four major constructs.

The origins of specific constructs will be identified by group types: parent, client, and employer respondents; "mental health system" participants, or respondents who provide mental health treatment; and "vocational system" respondents, or job developers, job coaches and rehabilitation counselors. The term "consumer" has been replaced by the word "client" at the request of the respondents with mental illness.

Employment and Job Retention Enhancement Factors

To honor the social work strengths perspective, a review of positive features, i.e. factors that lead to employment procurement and job retention for individuals with psychiatric disabilities will be described first.

Environmental and external features.

Environmental and external factors encompass attributes of society and the quality of systems affecting employment that are outside of an individual's control. Living in close proximity to job and treatment sites is an important job retention enhancement, parent respondents claim. Working close to home provides individuals with mental illness an opportunity to recover during lunch breaks, eliminates transportation problems, and allows easier linkage with vocational assistance and mental health treatment.

Personal characteristics of clients.

Persons with mental illness that are motivated, willing to endure long bus rides to work, want to please the boss, try to do a good job and display a solid work ethic are able to retain employment according to employer respondents. All stakeholders pointed out that individuals who are successful in the work force tend to display a positive attitude, are delighted and grateful to be employed, feel intrinsically worthwhile, are self-accepting, desire independence and the

ability to pay their own bills, enjoy being useful and want to better themselves. Individuals who disclose mental illness have strong vocational supports, which respondents believe assist in job retention.

System factors.

Formal supports refer to the established local, state and federal employment, mental health, entitlement and rehabilitation systems. State-funded financial incentives and prompt attention to decompensating employees by vocational programs were identified as the primary motivations for employers who hire individuals with psychiatric disabilities. Parents recognized mental health system attitude changes as helpful to their adult children. Relatives are now invited to participate in treatment planning, and are permitted unlimited visitation with hospitalized offspring on the psychiatric unit.

Natural Supports include the human connections and assistance that develop informally among families, friends, neighborhoods and communities. According to clients and parent stakeholders, family members help offspring achieve employment success by networking for jobs (a primary resource for clients with felonies); providing emotional support, praise, recognition and medication assistance; and by teaching basic skills of daily living. Clients particularly

emphasized the importance of support: "Encouragement is gold to us."

Parents felt the mental health education classes provided by the Alliance for the Mentally Ill ("Journey of Hope") were pivotal to restoring family stability. Such classes assisted families back to homeostasis by reducing anxiety and promoting empathy, by providing technical explanations of mental illness and by teaching families how to "navigate the system." Parent participants noticed that once family members recognize that psychiatric illnesses are caused by physiological processes rather than defective characters, family relationships and the stability of the individual with mental illness improve dramatically.

Characteristics of employers.

Employer and vocational stakeholders identified particular values and attitudes displayed by employers who hire persons with psychiatric disabilities: a belief in the development of self-reliance and autonomy via education and employment, a view of disability as a normal fact of life, a sense of responsibility towards their community to provide vocational training and jobs for disabled individuals, and an appreciation for the resulting "kinship of humanity" experience. One employer expressed that working alongside

individuals with mental illness also met a spiritual need to "do what I do best. Provide care, support and encouragement."

Exposure to employees with mental illness in the work place reduced employers' discomfort, normalized and humanized the disabled person, built employer-employee relationships, and focused attention upon abilities rather than disabilities. Parent stakeholders pointed out that employers who were respectful of nondisclosure decisions and who were willing to make accommodations for those who need to work in solitude helped their children retain employment.

Vocational support elements.

Vocational supports build a bridge between employers and clients. Vocational program staff erect this bridge by promoting the client to the employer and by providing prompt assistance when mental illness interferes with job performance. Without vocational support provisions, employers are unlikely to seek out disabled individuals to employ, or to hire individuals who disclose mental illness, said participants. The skill attributes and motivation levels of job coaches and job developers were the features considered most helpful by respondents.

For example, the availability of an experienced, motivated job coach is a primary incentive for hiring individuals with mental illness, according to employer

participants. Coaches prepare employers for client job participation, smoothing the adjustment. Clients, too, appreciate the attentions of a caring job coach, believing employment wouldn't be possible without these individuals. Respect for clients, previous experience as a coach or mental health client, and a strong commitment to and a belief in human growth potential are the features identified as the best indicators of successful job coaches. "Job coaching can be effective if the right mix of compassion and expertise is paired up with the right person to coach" said one vocational system respondent.

Motivation, previous experience, sound community connections and good business savvy are the qualities identified as crucial for job developers, according to respondents. Having a sense of humor and a caring nature was also cited as helpful.

Summary of employment enhancement factors.

Proximity of work, transportation and treatment sites were identified as the primary environmental enhancement to job preservation. Characteristics of clients that foster employment reflect strong motivation, a positive attitude, the desire for independence, and the willingness to disclose mental illness to employers. Financial incentives and prompt vocational support responses were cited as the chief formal

system provisions motivating employers to hire persons with mental illness. Families that network for jobs, teach basic life skills and provide encouragement comprise natural support enhancements. Employers who value self reliance through paid labor, view disability as normal, have a sense of responsibility to the community and who possess previous work place exposure to clients enhance job opportunities. The provision of support by skilled, motivated vocational system personnel who are well versed in the business culture were the primary vocational service enhancements to employment identified.

Positive Outcomes of Hiring Persons with Mental Illness

Now that the elements which enhance employment opportunities for these individuals have been identified, a review of the positive outcomes that were derived from constructivist respondent interviews will be related.

Environmental and external features.

As coworkers, customers and employers begin to realize that people can work despite mental illness, reintegration of individuals with mental illness into work life and the wider community takes place. Family stability improves as parents witness the longed-for growth of their employed offspring's potential.

Personal characteristics of clients.

Employers, clients and vocational system respondents identified developmental growth as a positive outcome for persons with mental illness who sustain employment. Increased self esteem due to the ability to solve difficulties, the mastering of relationship and job skills, a sense of pride in accomplishment, increased empowerment from earned monies, a fulfillment of the desire to "better" oneself and a strengthening of identity were the features of growth respondents mentioned.

System factors.

Natural or informal supports are built "naturally" when clients become employed. Employer and rehabilitation participants stressed the development of coworkers' self-initiated care and support of clients as a positive outcome. Caring often develops spontaneously and without the realization that it is occurring. If mental illness is disclosed, the employer can become an additional natural support for the worker with psychiatric difficulties, according to a mental health participant. Benefits to formal support systems from the employment of persons with mental illness did not emerge from participant constructs.

Characteristics of employers.

Vocational system and employer respondents have discovered some positive benefits from employing clients: such employees have a strong work ethic, an excellent show rate, less absenteeism, are motivated to do good work, and stay on the job longer than non-disabled individuals. These beneficial outcomes motivate employers to accommodate a decompensating worker's need for time off to recuperate, assisting in job retention. Too, supporting workers with mental illness stimulates altruism in employers, which often spills over into relationships with other employees.

Vocational support elements.

Job coach and developer respondents cited personal satisfaction and a sense of privilege for having the opportunity to assist persons with psychiatric disabilities as a positive outcome of the hiring of such individuals.

Summary of positive outcomes to hiring.

Reintegration into community life, improved family stability, increased self esteem and developmental growth, evolution of natural support on the job, beneficial effects of strong client work ethics for employers, and the personal satisfaction obtained by vocational support system personnel are the identified positive outcomes of hiring individuals with mental illness.

Employment and Job Retention Impediments

Focusing solely on the positive could negate the possibility of developing strategies to further enhance employment. To formulate a plan that can improve job access and retention difficulties for individuals with mental illness, the sources of such difficulties must be identified.

Environmental and external features.

The stigma of mental illness, cited as widespread in the mainstream culture by one stakeholder, was the barrier most often reported by participants. This stigma was actualized by labeling and false beliefs. One prime example of labeling pointed out to me by a vocational services participant is the common use of the term "mentally ill person" instead of "person with a mental disability." Such labeling suggests human frailties are abnormal, rather than a natural part of life. Prevailing false assumptions, such as believing persons with psychiatric illnesses are unemployable and incapable of handling responsibility or progressing professionally, were seen as stifling successful employment by most participants.

According to every stakeholder, the prevailing negative stereotype of mental illness suggests that there are inherent disclosure difficulties facing persons with mental illness. One employer stakeholder explained that employees who reveal their psychiatric history are often teased by their coworkers

when decompensation occurs. While coworkers generally express charitable feelings toward such employees, if decompensation occurs coworkers become frightened and "lash out" at the ill coworker in defense. Peer pressure to conform to this ridicule develops rapidly among both adolescent and adult employees, fueling the needling. Teasing toward those who disclose occurs even without the precursor of decompensation, and has led to the recurrence of mental illness for some, according to parent stakeholders.

Clients detest the associated stigma and fear rejection and discrimination, so they elect to hide their illness, according to vocational system stakeholders. One parent lamented, "You never know how people are going to respond to disclosure. It is scary. People are cruel when they know. I tell my (child) not to disclose." The results of nondisclosure are a reluctance for newly employed clients to continue with mental health and vocational supports. "We can only work with nondisclosers in ways that clients define, and their ways do not always work" cited a vocational system member.

Mental health and vocational participant statements support the parent constructs of nondisclosure, identifying employer discrimination against persons with mental disabilities as a major underlying barrier to job

procurement. "Employers are gun-ho to hire the disabled, until they find out you mean a mental patient!" stated one participant. Reluctance to disclose is the result, rendering it difficult to know just how many people with psychiatric disabilities are successfully employed.

Lack of transportation was the second most frequently mentioned obstacle. The bus system is inadequate; it takes hours each day for working clients to ride to employment and treatment sites. Long bus rides mean missed medication doses that can lead to relapses. One parent stated that his adult child would have to live and work near a mental health treatment center to be successful at work. Otherwise, a 2 1/2 hour bus ride twice daily would have to be endured, and mental health appointments would mean missed work hours. Treatment centers are not accessible by time or location for working clients.

Isolation was mentioned less often, but was still considered a significant factor in failed employment endeavors. Members of society who might offer caring, support and encouragement to the struggle to overcome mental illness instead respond to prevailing stereotypes and avoid individuals with this disability. Reintegrating into the larger community then becomes difficult. Stigma toward psychotropic medications was also mentioned as problematic by

a few participants, leading to medication noncompliance and subsequent decompensation on-the-job for clients.

Isolation can also lead to the use of alcohol and illegal substances. Vocational and mental health system stakeholders pointed out the wide availability of illegal substances and alcohol as alluring to lonely clients, which creates obstacles for successful employment outcomes.

Limited resources leads to significant obstacles for those seeking to get or keep jobs. Lack of funds for meals, transportation, child care and proper work attire create stressors that are difficult to overcome, according to client and vocational system participants. Homelessness is also a significant problem. A vocational system participant at the final focus group stated that a substantial portion of her caseload is homeless.

Personal characteristics of clients.

A variety of respondents identified specific psychological features, criminal behavior histories, and limited life and vocational experiences of persons with mental illness as influential to employment outcomes. Life experience is affected by the individual's course and degree of mental illness and the opportunities available to develop coping mechanisms for managing symptoms and stress.

Vocational system members perceived that some persons internalized the stigma into their personalities. "One (person) thought he wore his mental illness on his sleeve." Never having a job or being out of the job market for a length of time, coupled with stigma erodes self-confidence. "Anything that happens, they take it personally." Too, accepting an illness that affects life skills and emotions is fearsome, according to parents. The resulting negative impact upon self esteem was seen as a major cause of the low job-seeking motivation of clients.

Another troublesome feature arose during the final focus group. A criminal record of felonies committed prevents or terminates employment of many persons with mental illness. Outstanding warrants for various minor offenses also present employment dilemmas. According to vocational participants, legal issues are frequent problems, affecting up to 30% of rehabilitation caseloads. Criminal behavior of clients usually follows decompensation from medication noncompliance.

To get a job, clients must be strong enough to insist on client-driven services from system supports. To keep a job, clients must know how to negotiate with employers surrounding reasonable accommodations and relapse plans. Vocational system respondents felt some clients were accustomed to the protective and seclusive milieus of board and care facilities

and so had not had the opportunity to develop sufficient assertiveness skills for self-advocacy in the community.

Being cloistered in the security of board and care homes or the isolation of independent living hampers opportunities to practice interacting successfully with the public, a minimum requirement of most jobs. Individuals must function comfortably in a work setting and be able to socialize with coworkers, according to employer participants. Those with limited public exposure tend to display inappropriate behavior out of ignorance and lack of feedback. Clients agreed, citing the need to get out more and "learn to talk to people better."

Quality of employment history is a significant barrier for clients, according to most participants. Those with no or sporadic employment history, or with only part time employment history have considerable difficulty getting and keeping jobs. Work experience aids in developing positive vocational behavior, such as wearing appropriate work attire and hairstyles, using an alarm clock, getting to work on time, packing a lunch and knowing to call in when indisposed.

Lack of on-the-job exposure also translates into limited or no work skills, minimal transferable skills and a dearth of knowledge surrounding what it means to be an employee or how to keep a job, according to vocational support members.

Learning disabilities and the lack of education and job training also hinders persons with mental illness from entering the work force.

The length, type and degree of mental illness endured by clients can affect their life cycle expectations, stability, relapses and recovery, and structure or "routine" formation, items that are essential for life skill development. The degree of impact suffered alters an individual's ability to get and keep employment, say vocational stakeholders. The quality of life skill development subsequently influences the client's ability to manage psychiatric symptoms aggravated by the unfamiliar situations that work force participation brings. Too, employment bestows new expectations upon clients. When they naturally falter under stress, clients want to revert to their previous coping measure of retreating from society.

Medication non-compliance reduces the ability to manage psychiatric symptoms and stressors which leads to a cycle of relapses and failed employment, according to parents and vocational support participants. Also, clients who reject mental health and long term vocational services when becoming employed often experience money management difficulties, compounding the stressors that subsequently lead to job loss

and homelessness, according to mental health system stakeholders.

System factors.

Mental illness usually strikes individuals during adolescence and young adulthood, negatively impacting educational, social and job skill development. These individuals are then forced to rely on the existing formal and natural supports for enhancement of life opportunities. Stakeholders view the existing support systems as fragmented and fostering dependency.

Natural supports are invaluable and can be provided or generated by agencies. However, there is little motivation to do so because the activities involved do not generate income or translate easily into reimbursable activity. Most persons with severe and persistent mental illness are treated by government funded agencies that receive financial reimbursement for specific therapies only. Natural support development is not considered therapy and thus is not eligible for financial compensation from either medicaid or private insurance funds. Natural supports could automatically emerge as individuals become employed, but some participants believe we cannot rely upon spontaneity. Others felt "the pieces to the puzzle of keeping the mentally ill employed are there, but are not all working together as a unit."

A vocational support respondent commented upon the lack of a "circle of support" for mental patients, which was methodically set up years ago for individuals with developmental disabilities. "Mental health is behind other agencies in natural support development." Parents are often the only informal supports, yet many agencies still do not include families in treatment planning, according to parents and a mental health professional. Too, families often discourage working because they fear their child will lose hard-to-get Supplemental Security Income (SSI) and Medi-Cal benefits.

The existing formal supports do not promote independence or employment for persons with disabilities. The system is overburdened and is not set up to help individuals become gainfully employed, stated some participants. Clients and their families are penalized for working with a reduction in or loss of benefits. Income for working clients is usually less than Social Security Disability Income (SSDI) or SSI would be. One parent lamented the fact that his mentally ill child cannot earn as much money to support his offspring as SSDI provides these children, now. Too, clients have to pay for their own medication and physician appointments when medicaid eligibility is lost, according to parents.

Vocational support participants believe labor regulations and the new Americans With Disabilities Act stipulations confuse employers and thus scare them away from hiring individuals with mental illness. Fear of lawsuits was also cited as a barrier to hiring.

Mental health system ideology was cited as a primary barrier to employment success by clients, vocational and mental health stakeholders. Mental health administrators and professionals do not envision work as part of recovery. Therefore, public mental health agencies do not adequately fund employment activities or provide sufficient vocational support staff. Treatment is provided in socialization centers and day treatment programs, further encouraging the social isolation and institutionalization that prevent clients from developing appropriate public behavior and integrating successfully into the community.

The current treatment system overlooks the client's preferences surrounding stigma. Vocational peer support groups that could be beneficial for client job retention are held at mental health treatment centers, locations long associated with stigma. Clients sometimes apply the stigma to each other and refuse to go to "that place with those low functioning people." Stigma prevents disclosure of mental illness on the job, yet methods to provide job support in

these circumstances have yet to be fully developed by mental health and vocational systems, said associated professionals.

A shortage of case workers and case management services was cited by parents and vocational system stakeholders. Most case management services appear destined for clients needing help with SSI applications, rather than for employed clients requiring community support to sustain jobs.

One vocational program participant stated, "Getting a job is easy. Keeping it is the challenge." Individuals can work unimpeded by symptoms for months at a time, yet suddenly hit a point where they cannot continue working without support. Current job support provisions are time limited (90 days) and insufficient to the task. If long term support and intervention are not available, clients lose jobs and employers become reluctant to hire persons with mental disabilities. Therefore, lack of funding for the provision of long term employment support services and independence training was considered the biggest challenge to successful employment by vocational services participants. Voluntary donations and public programs are problematic "because mental illness is not a 'nice' disability." People prefer funding causes that are socially sanctioned.

The current outcome-oriented system prevents discovering what interventions work to get and keep jobs for persons with

mental illness, say vocational system stakeholders. Outcome oriented systems drive a "get them in, get them assessed, get them trained, get them placed and leave it at that" process aimed at manufacturing enough successful closures per year, not at client job retention.

The new welfare reform system does not address issues related to chronic and persistent mental illness according to vocational system stakeholders. Welfare reform does not meet the needs of ongoing vocational support, substance abuse treatment, transportation, child care and mental health problems. "Persons with mental illness who are not eligible for SSI will crash and burn if expected to work twenty hours a week without supports" said one vocational system participant. Too, formal support system efforts are not coordinated. The new CALWORKS program and the Department of Rehabilitation (DR) requirements for benefits are quite different. CALWORKS demands immediate employment as an outcome; DR moves clients into careers via education, first. CALWORKS recipients must work 32 hours a week in order to attend college, a tough load for any individual.

Characteristics of employers.

One employer stated that in a perfect world, educating coworkers about mental illness would be ideal. However, the logistics are too difficult: most jobs accessible to persons

with mental illness are in the service sector, an industry short of time and money for education. This employer also believes that people do not understand or care why it is important to learn about mental illness. "There are many other things people would rather learn than how to work with a person with mental illness."

The lack of education surrounding mental illness causes misconceptions according to vocational service respondents. Preconceived notions cluster around accommodation issues, low motivation, poor attendance, rising medical insurance and workmen's compensation premiums, and fear of lawsuits. Employers feel unable to handle symptomatic workers, and think that such individuals will only cause problems. Misconceptions blind employers to their positive attributes. The result is that there is a dearth of flexible, negotiable employers willing to hire persons with mental illness.

Vocational support elements.

Vocational programs themselves have shortcomings that can impede employment progress, according to all stakeholders. One employer said that when vocational programs do not take responsibility for promptly helping their decompensating worker, the job is lost. Parents state that vocational programs do not provide paths to get back to jobs that pay a living wage.

The quality of the job coach system was cited as problematic by employers for the following reasons. Some job coaches have not been trained in coaching techniques, are coaching only for monetary reasons, are poorly paid and become discouraged when clients fail. Thus, job coach turnover is high. The resulting lack of continuity renders client job retention and the sustaining of employer motivation difficult. Also, some job coaches lack the skills required to successfully aid persons with psychiatric disabilities to get and keep jobs. Clients complain that job coaching doesn't help. "Job coaches don't understand what it is that people need, or what it means to be disabled on the job," further characterizing a failure to support or encourage employed clients.

Currently, the marketing of persons with mental illness prior to hiring is not done. Job developers working with disabilities typically come from a social science rather than a business background, so they are uncomfortable with the business world and unfamiliar with personnel issues. Vocational service providers target the service industry and entry level positions because these jobs are perceived as easy. Entry level jobs are demeaning for clients, who feel silly working alongside teenagers. Older clients have more family responsibilities; they require higher paying jobs, yet

only low paying jobs are targeted. Finally, job development is expensive, time consuming, requires flexible hours and yields meager outcomes.

Summary of barriers to employment.

Several environmental and external features that lead to employment failures for persons with mental illness were identified: stigma, disclosure, transportation, discrimination, isolation, illegal substances and limited resources. Contributing client barriers include lack of assertiveness; low motivation and self esteem; insufficient interpersonal and vocational skill development; degree of illness; medication non-compliance; and criminal behavior records.

System factors include a lack of natural support development because such activities do not generate reimbursable income, and the failure of systems to work together. Mental health system ideology and existing formal supports do not promote independence via employment, and penalize workers with a reduction in benefits. Legal issues which scare employers, lack of funding for long term employment support services, an outcome oriented system, and an inadequate, uncoordinated welfare reform system response complete the identified formal system barriers.

Employer characteristics indicate an unwillingness to obtain education about the logistics of mental illness for employees or themselves, making eradication of misconceptions and promotion of positive attributes of clients difficult. Vocational arena barriers include inept job coaching, inexperienced job development and marketing, and types of jobs pursued.

Action Plan for Dissolution of Barriers

Most of the following strategies for addressing the dissolution of barriers to employment were derived by the author from the respondents' answers to the question "In your opinion, what is needed to improve the prospects of the employment of the mentally ill individual?" Others were extrapolated from the remaining interview questions. The purpose of formulating the action plan is to provide guidance to the local BEST Network for future collaborative and networking activities.

Environmental and external features.

Increased funding for community education to combat stigma emerged as a primary construct from parent and vocational support participants. Use of audio, visual and print media to publicize proven successes and normalize mental illness were mentioned as interventions. Respondents suggested that mental health awareness education programs

begin by targeting young people, stressing that "anyone in our lives" can be affected by psychiatric illness. Clients underscored the importance of focusing upon "ability awareness" and positive image development through emphasizing their strengths and capabilities.

All respondents asserted that a better transportation system is needed. Two suggestions were contributed: provision of free transportation and increasing the amount of bus routes to reduce long rides and waiting times.

Personal characteristics of clients.

Specific client education features required for job retention emerged from respondents' constructs. It is essential that people with psychiatric disabilities comprehend the benefits of initial vocational program representation for success in obtaining employment. Vocational instruction should include how to interact with supervisors and coworkers, how to present oneself in the work place and how to get help. Working clients need guidance to develop a relapse plan with employers. Training in medication and psychiatric symptom management, in anxiety and stress reduction, in anger management and in money management skills are also needed. Paid labor can reduce or suspend disability payments, therefore strategies to maintain in spite of these

reductions need to be developed. Practical job training and advanced schooling were also identified as crucial.

Client empowerment via peer support, assertiveness and the acceptance of personal responsibility for growth were identified as pivotal to job success. Client attitudes such as "I can do it. I am worthy of working" need to be strengthened, according to mental health system participants. Client respondents felt taking personal responsibility for becoming independent is essential. "We look for people to help us, but we have to help ourselves, also." Clients suggested going along with the job developer during job searches to market their personal strengths and to outline how their abilities can serve the employer's business. Clients also want to be trained to provide peer support.

Vocational system participants stressed that when failure occurs, clients need to develop the mind set that "what happened today is not forever." Clients must also learn to set realistic goals, and to discern, define and verbalize their job skills and preferences, limitations, relapse plans, family stressors and personal problems. Finally, parents want clients to recognize that stigma is part of life, thus one must develop the skills to cope with adversity.

System factors.

All respondents believe there needs to be a thorough formal system mind set change from a paternalistic custodial perspective to a client-driven independent living design. Several suggestions were presented. Mental health participants felt paid labor must be viewed by mental health administrators as a part of recovery that must be initiated soon in the recovery process. Such an attitude adjustment would fuel funding for the job development, vocational and case management positions that are needed for job retention. It would also send a message to the community that clients can and should spend time in constructive endeavors and reintegrate into community life through employment activities.

Vocational system participants suggested offering employers incentives to hire persons with mental illness, such as lucrative tax breaks, standardized services to locate workers with psychiatric disabilities for hiring, and needs assessments to determine what assistance employers require to hire such individuals. All respondents believe that if the Social Security system removed financial and medical benefit penalties for paid employment, more clients would be willing to enter the work force.

Respondents believe that a firm commitment to the task from all formal support systems is essential. Clients who are not chronic enough to qualify for SSI could go to work if supported enough, according to vocational system participants. "We must do the things we know it takes to place the (individual with mental illness) in a situation where they can be successful."

The need to specifically address an increase of the quality, accessibility, and appeal of natural supports emerged from all respondents during construct solicitation. Natural supports are thought to reduce the need for formal supports. A skillfully cultivated plan produced by knowledgeable people that includes teams of community members willing to link with workers with mental illness was suggested by several respondents. Other suggestions for natural support development follow.

Worker support groups offered at convenient times and at locations that are not associated with the stigma of mental illness have been helpful for client job retention, according to vocational system participants. Groups should be run by peers experienced in business, supervision and management issues so that newly employed clients can learn proper work place behavior and how to negotiate relapse plans.

Family education groups that address medications, relapses, and relating to relatives with psychiatric disabilities should be prolific, suggested parent and vocational system respondents. Parents stressed expressing faith and confidence in ill offspring; treat them normally. "Mental illness is serious, but so is cancer and diabetes for those who have it, so no special concessions!" believed one parent. Families should be included in treatment planning, and the impact of selected goals upon family members should be considered, according to mental health respondents. Finally, families should be led to natural supports that are already in place, such as the Alliance for the Mentally Ill support group.

Blending natural supports with formal systems was deemed essential by vocational and mental health respondents. Collaboratives that integrate clients, families, friends and neighbors with communities, public organizations, private agencies, and local businesses need to be developed. "Teaming" rather than territorial rights should be the goal, so that the "road map clients must maneuver to successful employment" can be established.

Characteristics of employers.

Work place training and education specific to employers and employees who work alongside persons with mental illness

were suggested by vocational system and parent participants, although doubt was cast about the willingness of management to contribute the time and money to provide such. The importance of taking medication, the spectrum of mental illnesses and "how to relate" to individuals with psychiatric disabilities were cited as the primary work place educational goals.

Participants targeted employers as needing more specific education surrounding medication side effects, the necessity for work schedule flexibility, and client advancement capabilities. Clients want employers to understand that time off is sometimes helpful to stave off relapses. Parents felt that employer decisions about responsibility and ability levels of disabled individuals should be based on the person and not the disability. Participants also want a vehicle that encourages discussion between employers who hire persons with psychiatric disabilities and those who do not, that incorporates working clients' stories. Vocational participants believe such discussions would dispel the myths of mental illness. The final focus group concluded that employers could be the best advocates for hiring workers with psychiatric disabilities.

Vocational support elements.

Multiple constructs emerged from all respondents' reflections surrounding vocational programs and their components. Overall, vocational program workers should be considerably familiar with the business culture. Knowledge of personnel issues, organizational structure, company politics and chain of command issues help vocational programs "sell" clients to local businesses. A positive attitude coupled with sound values and ethics communicated via empathic skills, understanding, respect and adherence to confidentiality are essential, according to client respondents. "Clients don't care what we know, but they want to know that we care" added a vocational program supervisor.

Employers cited that the reliability of the vocational program is their foremost consideration when hiring persons with mental illness. Program philosophy and level of experience dictate whether or not such assistance for workers will be provided promptly when needed. Employers must trust that the vocational program will follow through when workers relapse.

Teamwork must be fostered among family members, clients, employers, mental health and vocational program staff. For ample success, the interests of each team member merit attention. Not only clients require a good job match; job

coach interests should weighed. Team members should be familiar with Social Security work incentive rules and be adept at soliciting jobs that offer medical benefits and pay a living wage. For employment to be sustained, teamwork must cross all spheres of clients' lives; work is only one "slice of the life pie." Each slice affects the others. Knowledge of the referral process and local human service agencies, plus good advocacy skills are needed by all team members for succinct addressing of client concerns. The team should also be prepared to accept and manage nondisclosure of client mental illness.

The knowledge and skills possessed by vocational team members should include familiarity with psychiatric illnesses and medications, and the ability to perform a complete job task analysis, work history, client assessment and vocational preparation. Vocational system participants stressed above all to "know your client" so that maneuvers around the challenges of mental illness can be accomplished.

Client and vocational system participants want to see the language of disability changed. Respondents felt the term "mental health" should be downplayed. The term "job coach" was universally disliked. A new title should apply positively to the needs of any employee. "Work site trainer" and "employment services specialist" were suggested. The labels

"consumer" and "mentally ill person" were also soundly vetoed by clients and vocational team members. One respondent carefully crossed out each reference to "mentally ill people" and changed it to "person with mental illness" in her member check document.

The creation of a career ladder to increase earnings and status was also considered important by parents and clients. Clients expressed an interest in learning a trade or going back to school to accomplish this. Parent respondents hoped offspring could work up to full time hours gradually, and return to previous levels of high functioning. Vocational programs need to address these hopes.

Job development marketing skills and salesmanship were specifically targeted by vocational system participants as pivotal to employment success. Developers should be persistent salespersons, know the right approach, and recognize that "no doesn't always mean no, but is a way of asking for more information. It means you haven't told the employer enough (to overcome his fears)." Additionally, job developers should be shrewd enough to spot a good match between the employer's business needs and the client's skills. Inexperienced developers can "shadow" seasoned staff initially for skill development. Job developers should also be willing to address client limitations, such as length of

work day, physical and mental demands of work tasks, and work site proximity to home, treatment centers and bus routes.

Formalized training for job coaches was identified as crucial to improving vocational team success according to participants. Respondents specified particular educational components for integration: delineation of the spectrum of psychiatric symptoms and psychotropic medications, relapse strategies, debriefing skills, linkage and consultation mastery, assessment procedures, discrimination laws, and navigation of the Social Security benefit system. Vocational and mental health system participants targeted boundary issues and informed consent as particularly important to grasp. Individuals new to the human services industry often confuse guidance with friendship, blurring personal boundaries. In addressing whether or not to reveal mental illness to employers, coaches should be adequately prepared to discuss the risks and benefits of disclosure with clients.

Clients want job coach training to include supervised experience for the cultivation of respectful communications and attitudes towards persons enduring psychiatric illness. Aggression, bossiness and "blaming everything that happens on my mental illness" are current job coach behaviors that clients want extinguished.

Vocational system respondents would like to see the professionalization of job coaching to reduce turnover rates and to attract motivated individuals to the vocational support system field. Length of job coach employment is linked to job retention in clients, according to vocational and employer constructs. Frequent turnover of job coaches disrupts continuity of care and the building of trust between team members and employers. Motivation can be enhanced by providing higher salaries for coaches and expanding employment choices for clients.

Summary of action plan for dissolution of barriers.

Community education that focuses upon strengths and abilities, and transportation system improvements emerged as environmental action plans. Provision of vocational education; client empowerment strategies via peer support; the acceptance of personal responsibility for growth; and gaining the ability to discern and verbalize factors relevant to life improvement emerged as goals for client action.

A system mind set change that is firmly committed to a client-driven independent living design that regards work as part of recovery, offers employers incentives to hire, and removes financial and medical benefit penalties for working is needed. An increase of the quality, accessibility and appeal of natural supports by incorporating community members

onto vocational teams and worker support groups, and by offering family education and inclusion in treatment team decisions should be attempted. Collaboratives that blend natural and formal supports with the integration of public and private interests were seen as essential goals.

Action plans for employers included work place education and training dealing with medications, symptoms of mental illness, relating to workers with mental illness, and relapse planning. Vocational support element action plans suggest increased familiarity with the business culture, improved vocational program reliability, teamwork addressing all spheres of life, familiarity with psychiatric and vocational processes, creation of a career ladder, and changes in the language of disability. Upgrading marketing and salesmanship skills, formalized training and the professionalization of job coaching were also targeted for action plans.

DISCUSSION

This constructivist study delved into stakeholders' perceptions of the fundamental issues pertaining to the improvement of employment outcomes for individuals with psychiatric disabilities. These constructs were elicited from the unique blending of the political, social, intellectual, emotional and cultural contexts of a moderately sized city in Southern California. Construct emergence, analysis and a closing focus group were instigated as a catalyst for the development of collaborative strategies that might empower all team members vested in getting persons with mental illness back to work. Findings of this study will also be used to build membership and provide salient direction for the BEST Network, a local collaborative effort set up to bring all the partners serving individuals with disabilities together to ferret out and meet the employment needs of this population.

Noteworthy moments experienced by the researcher during this study will be outlined. An extrapolation of respondent constructs, relevant literature and the researcher's own joint constructions of collaborations believed to be helpful for the employment and job retention of clients will follow. Based upon the experience of the constructivist process, the final portion of this project will present this researcher's

opinion of the skills and values social workers must incorporate to nurture collaborative processes in the community.

One unforeseen predicament arose during construct solicitations: interviews with parents were considerably and unexpectedly painful. Parents experienced renewed grief over lost opportunities for their afflicted children. This researcher felt responsible and decided to do a follow-up contact after member checks to ensure parent respondents had recovered from the interview process. Concerns were alleviated when one parent exclaimed how helpful the written summary of this project's findings was for her and the parents with whom she shared these findings at the Journey of Hope meetings. However, parent respondents declined to attend the final focus group.

Other unexpected features proved to be beneficial to the study. Most individuals interviewed represented two or more respondent groups. Vocational and mental health system participants presented dual perspectives, as some were also parents of persons with mental illness, or were former clients themselves. A few respondents had been employed in a variety of positions in both the mental health and vocational assistance fields, and thus relayed data rich in depth and context. Respondents also varied in levels of responsibility;

line workers, supervisory and administration constructs were represented.

This researcher was struck with the degree of insight and devotion vocational system participants displayed while advocating for the rights of persons with mental illness and presenting solutions for employment dilemmas. Sadly, all agreed that funding to implement a full-fledged action plan to get these individuals back to work was desperately needed and probably not forthcoming.

There were remarkable similarities in respondents' descriptions of barriers and solutions. Most participants recognized the need to "come to the table" for solution development, and were eager to do so. The effects of welfare reform were viewed as a fortuitous opportunity for agencies to finally get together, ferret out what service gaps and overlaps exist, and collaborate to conserve dwindling resources. The effects of this cooperative mood have become evident; membership of the BEST Network has surged in recent months, with key individuals from various government and private employment agencies asking to come on board. Thus, one goal of this project has been met; the BEST Network is flourishing.

Recommendations

The window of opportunity revealed by welfare reform that is igniting collaborative energies should not be wasted. This researcher would like to present the following suggestions for implementation.

1. Team Membership: As the partners who provide services for persons with mental illness continue to collaborate, vocational assistance team membership should now include the full spectrum of employment specialists and beneficiaries: clients, job coaches, job developers, family members, mental health professionals and employers. Training sessions for vocational teams should not be divided by discipline or beneficiary type, but include the complete spectrum of team partners at each session.

First steps:

A) The Department of Rehabilitation/Mental Health Cooperative unit can target key vocational programs who serve persons with mental illness, interested clients and family members, and employers who currently hire individuals with disabilities for team recruitment

B) Split the membership clusters into diverse neighborhood teams and assign to specific business areas.

C) Conduct a full assessment of each team member and assigned business area to determine training needs.

2. An Employment Service Agency: Families of persons with mental illness could collaborate to create an employment service agency for networking to locate jobs for their members with psychiatric disabilities. Local Alliance for the Mentally Ill chapters (AMI) could spearhead this activity. Since mental illness is an equal opportunity ailment, there are sure to be couple of prominent employers in the community who have a family member afflicted with mental illness. Such employers can be welcomed into AMI and encouraged to share their skills, resources and employer networks with parents, and to assist with the employment service agency development.

First steps:

A) The local BEST Network needs to invite a member from AMI on board.

B) The BEST representative from AMI can take this collaborative employment service idea back to a local AMI meeting for input.

C) AMI members who agree to participate can affiliate with BEST via workgroup formation in order to access BEST expertise, alliances and resources.

3. Marketing Teams: The infiltration of rotaries, chambers of commerce, service clubs and other business guilds by vocational program staff, parents and clients teaming up as speakers to present the positive features of hiring persons with mental illness should be attempted. Additionally, correcting the community's misconceptions surrounding mental health issues with modern advertising techniques should be started.

The Alliance for the Mentally Ill and the BEST Network are in choice positions to spearhead these marketing activities, as memberships of both networks span citizens and agencies with diverse skills and resources. Members of AMI with graphic design skills or who work in the journalism and advertising fields can organize media blitzes to correct public misconceptions about mental illness, and to promote the hiring of individuals with psychiatric disabilities.

First steps:

A) Vocational teams that have been previously set up in recommendation 1 could perform the speaking engagements, starting with the employer-member's local rotary club.

B) Members of the BEST Network can become active in the chambers of commerce and rotary clubs to

increase network visibility and build relationships with local businessmen.

C) Award banquets honoring employers and coworkers who "make a difference" in the work place for employees with mental illness can be hosted by the BEST Network.

4. Natural Helpers: Collaborative interventions conducted by informal neighborhood helping networks should be encouraged by local mental health agency advocates. Guay (1994) reports that in a demonstration project developed to test informal methods of intervention, citizens as support systems were on their way to becoming the "most important interlocutors with the psychiatric system (p. 150)." Guay goes on to say that:

> Citizens are the forgotten actors in the rehabilitation process, even though they are the ones who have to live alongside the persons who are sent back to the community; they are part of what we call the informal support systems who need to be supported and revitalized in our inner cities. (p. 151)

Local businessmen, landlords and neighbors that have been identified by clients, parents and mental health staff as "natural helpers" who are already involved with particular clients can be informally tapped to provide emotional, vocational and case management support.

First steps:

A) The Department of Rehabilitation (DR) and Mental Health Cooperative Unit can provide training for case managers surrounding the identification, guidance and support of the natural helpers that are already aligned with individuals with mental illness in their communities.

B) AMI members and vocational support staff that belong to local churches or Young Men's and Women's Christian Associations can help employed individuals with psychiatric disabilities begin their own support group meetings at these institutions.

C) The BEST Network can hold focus groups and conferences for client empowerment, and to ferret out what clients need and want from families, employers and the community in order to keep mentally fit and employed.

Implications for Social Workers

Social workers can assume a pivotal role in wielding the current collaborative mood to affect beneficial policy and community transformations for persons with mental illness and the community at large. Effective collaborations include a thorough self assessment, creating a common vision,

establishing open communication, building trust and measuring results (Collaboration: How to, 1997), activities that are very familiar to social workers. As social justice advocates trained in assessment, communication and organizational skills, social workers convey the principles and expertise that are required to motivate partners to work together for enhanced community living (Bailey & Koney, 1996).

Well developed personal skills are another necessity for competent organizers. Social workers must cultivate specific personal qualities: an ability to share credit for success and blame for failure; to think beyond personal interests to what is in the best interest of the community; to be generous with praise; and to recognize the assets of all partners (Collaboration: How to, 1997). They must approach community work as finely-tuned instruments poised to orchestrate the interventions needed to achieve the goals selected by stakeholders for addressing community problems.

To be successful, social workers must regard the empowerment of others as the fruit of their labors, rather than power over others. "...Support from professionals is based on a deep respect for the natural helpers' own way of doing things (Guay, 1994; p. 147)." They must grasp that the use of self in enabling the connections of others often leads to self-growth and personal fulfillment. A sense of joy in

the resulting web of human alliances is a prerequisite for effective community organizing. Constructivist research is excellent preparation for social workers entering the community organizing realm.

APPENDIX A: INFORMED CONSENT STATEMENT

The study in which you have been asked to participate is designed to explore the employment needs of the psychiatrically disabled within the context of the local community. It is being conducted by Bonnie Houlihan under the supervision of Dr. Nancy Mary, Professor of Social Work. This study has been approved by the Human Subjects Committee of the Department of Social Work which is a Sub-Committee of the Institutional Board of California State University, San Bernardino.

This naturalistic study is different from traditional research in that the issues are identified individually by the participants themselves. At the conclusion of the study, the results will be shared in a required meeting with other participants, in the hope that solutions can be uncovered. The final product will be the formation of a "working group" to address the most important issues, mutually agreed upon by the participants, who are considered equal owners of this project.

During the course of the research you will be asked to share your knowledge and opinions regarding the needs of individuals with psychiatric disabilities surrounding employment, including how you think these needs are or are not being met, as well as what types of strategies you believe might improve their work prospects. Potential benefits of participating in this process might include improved employment prospects of mentally ill adults and improved collaborations with other agencies, while potential risks might include the surfacing of unwanted or unforeseen feelings surrounding the topic being discussed, or unforeseen reactions from other participants.

It is important to be aware that in a constructivist project like this one, the key part of the process is the sharing and integration of information supplied by others within the individual interview process in order to fully define and clarify what needs to be dealt with to improve the situations of mentally ill individuals in this community. Therefore, confidentiality does not exist in the same way that it does in more traditional research projects. Participants will not be deliberately named, but identities may become obvious within the context of what is being shared. Every effort will be made to be sure that all information gathered is accurate and expressed within its proper context. Indeed, there is a built-in method called "member checks" which accomplishes this. A written summary of your interview will be given to you for approval before any

ideas are shared with other participants. However, if you feel uncomfortable about your viewpoints being shared, then you may not want to participate in this study. Your participation is entirely voluntary and you are free to terminate your participation and withdraw any information given at any time without penalty. Additionally, at the conclusion of this study you may receive a report of the results, if desired.

I acknowledge that I have been informed or, and understand the nature and purpose of this study, and I freely consent to participate. I acknowledge that I am at least 18 years of age.

Participant's Signature	Date
Researcher's Signature	Date

APPENDIX B: STATEMENT OF DEBRIEFING

This research project is being conducted to create strategies to address the improvement of the employment prospects and quality of life for the psychiatrically disabled in the City of Riverside. California State University San Bernardino and the researcher conducting this study have a responsibility for insuring that participation in any research sponsored by this university causes no harm or injury to its participants. In fulfilling this responsibility, a debriefing session will be available to any participant who has further questions about his or he participation in the present study. For further information, please contact either Bonnie Houlihan or Dr. Nancy Mary at (909) 880-5560. Additionally, any questions or concerns regarding this research or its findings may also be directed to the above number.

REFERENCES

Akabas, S. (1994). Work place responsiveness: Key employer characteristics in support of job maintenance for people with mental illness. Psychosocial Rehabilitation Journal, 17(3), 91-101.

Alverson,M., Becker, D. & Drake, R. (1995). An ethnographic study of coping strategies used by people with severe mental illness participating in supported employment. Psychosocial Rehabilitation Journal, 18(4), 115-128.

Anthony, W. (1994). Characteristics of people with psychiatric disabilities that are predictive of entry into the rehabilitation process and successful employment. Psychosocial Rehabilitation Journal, 17(3), 3-13.

Arns, P. & Linney, J. (1993). Work, self, and life satisfaction for persons with severe and persistent mental disorders. Psychosocial Rehabilitation Journal, 17(2), 63-79.

Bailey, D. & Koney, K. (1996). Interorganizational community-based collaboratives: A strategic response to shape the social work agenda. Social Work, 41(6), 602-611.

Barker, L. (1994). Community-based models of employment services for people with psychiatric disabilities. Psychosocial Rehabilitation Journal, 17(3), 55-65.

Becker, D. & Drake, R. (1994). Individual placement and support: A community mental health center approach to vocational rehabilitation. Community Mental Health Journal, 30(2), 193-206.

Bell, M. & Lysaker, P. (1995). Paid work activity in schizophrenia: Program costs offset by costs of rehospitalizations. Psychosocial Rehabilitation Journal, 18(4), 25-34.

Bell, M., Milstein, R. & Lysaker, P. (1993). Pay and participation in work activity: Clinical benefits for clients with schizophrenia. Psychosocial Rehabilitation Journal, 17(2), 173-177.

Black, B.J. (1988). Work and Mental Illness. Baltimore: Johns Hopkins University Press.

Braitman, R., Counts, P., Davenport, R., Zurlinden, B., Rogers, M., Clauss, J., Kulkarni, A., Kymla, J. & Montgomery, L. (1995). Comparison of barriers to employment for unemployed and employed clients in a case management program: An exploratory study. Psychiatric Rehabilitation Journal, 19(1), 3-9.

Clark, R. E. (1995). Creating work opportunities for people with severe mental illness (Response to :The economic advancement of the mentally ill in the community"). Community Mental Health Journal, 31(4), 397-401.

Collaboration: How to start and make it work. Volunteer Leadership (April/June), 22-23.

Cook, R.A., Jonikas, J. A. & Solomon, M.L. (1992). Models of vocational rehabilitation for youths and adults with severe mental illness. American Rehabilitation, 18(3), 6-12.

Cook, J. A., Razzano, D., Straiton, D. & Ross, Y. (1994). Cultivation and maintenance of relationships with employers of people with psychiatric disabilities. Psychosocial Rehabilitation Journal, 17(3), 103-117.

Covent, E. (1996). Fact Sheet On California BEST Networks.

Covent, E. (1997). Outcome sheet. California BEST Network Accomplishments.

Drake, R., Mc Hugo, G., Becker, D., Anthony, W. & Clark, R. (1995). The New Hampshire study of supported employment for people with severe mental illness. Journal of Consulting and Clinical Psychology, 64: 391-399.

Erlandson, D. A., Harris, E. L., Skipper, B., & Allen, S. D. (1993). Doing Naturalistic Inquiry. Newbury Park: Sage.

Fabian, E., Waterworth, A. & Ripke, B. (1993). Reasonable accommodations for workers with serious mental illness: Type, frequency, and associated outcomes. Psychosocial Rehabilitation Journal, 17(2), 163-173.

Farina, A. & Felner, R. (1973). Employment interviewer reactions to former mental patients. Journal of Abnormal Psychology, 82(2), 268-272.

Forte, J. (1991). Operating a member-employing therapeutic business as part of an alternative mental health center. Health and Social Work, 16(3), 213-233.

Frey, J. (1994). Long term support: The critical element to sustaining competitive employment: Where do we begin? Psychosocial Rehabilitation Journal, 17(3), 127-134.

Gervey, R. & Kowal, H. (1995). Job development strategies for placing persons with psychiatric disabilities into supported employment jobs in a large city. Psychosocial Rehabilitation Journal, 18(4), 95-113.

Ginsburg, S. (1963). A psychiatrist's view on social issues. New York: Columbia University Press.

Glaser, B. & Strauss, A. (1967). The discovery of grounded theory. Hawthorne, NY: Aldine.

Guay, J. (1994). Involving citizens in the rehabilitation process. Psychosocial Rehabilitation Journal, 18(1), 145-151.

Howie the Harp. (1994). Empowerment of mental health consumers in vocational rehabilitation. Psychosocial Rehabilitation Journal, 17(3), 83-89.

Jones, B., Gallagher, B., Kelley, J. & Massari, L. (1991). A survey of Fortune 500 corporate policies concerning the psychiatrically handicapped. Journal of Rehabilitation, 57, 31-35.

Kaufman, C. (1995). The self help employment center: Some outcomes from the first year. Psychosocial Rehabilitation Journal, 18(4), 145-162.

Klein, M. E. (1985). Influences on the employment of psychiatrically disabled clients. Dissertation Abstracts International, 46, 3221-B.

Lewis, P. K. (1990). Factors related to employment among chronically mentally ill patients. Dissertation Abstracts International, 51, 1534-B.

Lincoln, Y. & Guba, E. (1985). Naturalistic Inquiry. Newbury Park: Sage Publications.

McGurrin, M. (1994). An overview of the effectiveness of traditional vocational rehabilitation services in the treatment of long term mental illness. Psychosocial Rehabilitation Journal, 17(3), 37-53.

Mowbray, C., Bybee, D., Harris, S. & McCrohan, N. (1995). Predictors of work status and future work orientation in persons with a psychiatric disability. Psychiatric Rehabilitation Journal, 19(2), 17-29.

Mowbray, C., Moxley, D., Thrasher, S., Bybee, D., McCrohan, N., Harris, S. & Clower, G. (1996). Consumers as community support providers: Issues created by role innovation. Community Mental Health Journal, 32: 47-67.

Rimmerman,A., Botuck, S. & Levy, J. (1995). Job placement of individuals with psychiatric disabilities. Psychiatric Rehabilitation Journal, 19(2), 37-44.

Rogers, E. S. (1997). Cost-benefit studies in vocational services. Psychiatric Rehabilitation Journal, 20(3), 25-33.

Rogers, E. S., Anthony, W., Toole, J. & Brown, M. (1991) Vocational outcomes following psychiatric rehabilitation: A longitudinal study of three programs. Journal of Vocational Rehabilitation, 1(3), 21-29.

Rogers, J. A. (1995). Work is key to recovery. Psychosocial Rehabilitation Journal, 18(4), 5-11.

Rutman, I. (1994). How psychiatric disability expresses itself as a barrier to employment. Psychosocial Rehabilitation Journal, 17(3), 15-35.

Schultheis, A. & Bond, G. (1993). Situational assessment ratings of work behaviors: Changes across time and between settings. Psychosocial Rehabilitation Journal, 17(2), 107-120.

Stringer, E. T. (1996). Action Research: A Handbook for Practitioners. Thousand Oaks: Sage.

Tice, C. (1994). A community's response to supported employment: Implications for social work practice. Social Work, 39(6), 728-736.

Torrey, W., Becker, D. & Drake, R. (1995). Rehabilitative day treatment versus supported employment: II. Consumer, family and staff reactions to a program change. Psychosocial Rehabilitation Journal, 18(3), 67-75.

Weinstock, P. & Barker, L. (1995). Mental health and vocational rehabilitation collaboration: Local strategies that work. Psychosocial Rehabilitation Journal, 18(4), 35-50.

West, M. & Parent, W. (1995). Community and work place supports for individuals with severe mental illness in supported employment. Psychosocial Rehabilitation Journal, 18(4), 13-24.