



# University of Connecticut Health Center

January 2011

Connecticut Bureau of  
Rehabilitation Services and  
Connecticut Department of  
Mental Health and Addiction  
Services

Collaborative  
Employment Project

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## **Executive Summary**

### **Introduction**

In 2006, the Bureau of Rehabilitation Services (BRS) and Department of Mental Health and Addiction Services (DMHAS) committed staff and resources to implement a pilot program to co-locate BRS Vocational Rehabilitation Counselors on site at three DMHAS-operated Local Mental Health Authorities (LMHAs). BRS counselors provided direct counseling to DMHAS clients as well as technical assistance to other DSS/BRS Vocational Rehabilitation Counselors who are serving individuals from the LMHAs.

A program evaluation examined employment outcomes, systems changes and attitudinal changes brought about by the co-located team model. The evaluation was conducted by Dr. Julie Robison's program evaluation research team at the University of Connecticut Health Center's (UHC) Center on Aging.

### **Methodology and analysis**

The primary methods of data collection included an *Intake Survey*, *Consumer Satisfaction Survey*, *Counselor Survey*, and *Program Evaluation Survey*. To augment the surveys, data were collected on implementation of the program from a focus group, 18 key informants, and 15 BRS and DMHAS project quarterly minutes. Finally, an analysis of BRS administrative data compared employment outcomes for the intervention group to a comparison group of BRS clients with severe mental illnesses.

### **Results**

#### Intake Survey

Data gathered by the BRS counselors during the intake process provided initial information from intervention group participants. Results show that the majority of respondents have either a high school diploma or some college including trade or technical vocational training or a two-year college degree, and 27 percent of those enrolled were employed.

#### Consumer Satisfaction Survey

After the initial intake by the BRS counselors at the time of enrollment into the BRS/DMHAS Collaborative Employment Project, the UConn evaluator did follow-up interviews with the participants over the phone at 3 months, 6 months, and 12 months. These interviews were conducted to capture information about the employment situation of the participant and to evaluate each participant's satisfaction with being involved in the project.

Results show that the percentage of those employed varied only slightly from intake results and that most participants were either very or somewhat satisfied with the employment counseling and vocational rehabilitation services provided by their BRS counselor. Most participants had an employment plan and reported it was adequate. At all interviews, the majority of respondents agreed a lot or somewhat that working with their BRS counselor helped them meet their employment or career goals.

## Counselor Survey

BRS liaison counselors conducted interviews with clients at 3, 6, and 12 months who were both participating and not participating in the UCHC evaluation of the program and asked similar questions to those asked in the Consumer Survey by UConn evaluators. Overall, Counselor Survey results are consistent with those of the Intake or Baseline Survey and the Consumer Satisfaction Survey.

## Program Evaluations

BRS counselors each completed a total of 8 Program Evaluations. During the 8 reporting periods, these evaluations tracked the frequency of interagency communication including number of referrals, positive and negative closures, and number of times consultation services were provided.

## Program Implementation Evaluation

To augment data from the surveys data was collected from one focus group, 18 key informants, and 15 BRS and DMHAS project quarterly meeting minutes. Results focused on program goals, successes, challenges, and suggestions for improving the program. Whenever communication and collaboration were strong, successes of the program were forthcoming, not only for the benefit of the client, but also for the benefit of those staff members taking full advantage of the opportunities offered from BRS.

## Vocational Rehabilitation Administrative Analysis

Vocational Rehabilitation administrative data analysis comparisons included the entire sample, followed by a subgroup analysis of non-white intervention and comparison group participants. Results show that the intervention group, when compared to other BRS consumers with severe mental illness, had higher rates of employment and higher wages 12-18 months after application for services.

## **Conclusions**

The program faced challenges that prevented full program implementation in two of the three sites, such as staff turnover and communication difficulties among project partners. Where implementation was successful, more than half of consumers in the intervention benefited from working with an embedded counselor and were successful in identifying career goals and improving interviewing and job search skills. Nearly 90 percent of participants in the evaluation were positive about the help they received from the BRS counselor and clearly valued the services and support they received during the course of the project.

## I. Introduction

Historically, the high rate of unemployment among people with disabilities has been and remains significant (Burkhauser & Houtenville, 2003). The President's New Freedom Commission on Mental Health (2003) underscores that work serves as a vehicle for people with disabilities to move forward in the recovery process and that competitive employment is one of the most concrete ways to integrate people with disabilities into their communities. While the Americans with Disabilities Act (ADA) has improved accessibility and prospects for people with disabilities (Silverstein, Julnes, & Nolan, 2005), many continue to struggle to find a job that matches their abilities and career goals, and those who have jobs often struggle to retain them (Mueser, Becker, & Wolfe, 2001).

Assisting people with disabilities to find and retain employment has been addressed by the federal government in partnership with states through the Vocational Rehabilitation (VR) program as well as through collaboration between various partners within states. Demonstrating the success of such collaborations is often achieved by evaluating the process and evolution of the partnership.

Several key initiatives at the CT Bureau of Rehabilitation Services (BRS) and the CT Department of Mental Health and Addiction Services (DMHAS) converged to underscore the need for more formal linkage protocols between the two agencies and to help create a system where individuals with psychiatric disabilities can become involved in meaningful employment activities and achieve career and economic success.

- Nationally vocational rehabilitation agencies have had lower rates of job placement and retention for persons with serious and persistent mental illness than other disability groups. Based on its strong commitment to improving outcomes, BRS identified effective services for people with mental illness as a priority goal for the years 2006-2011.
- DMHAS' evidence-based supported employment initiative, which has been implemented in all 14 local mental health authorities, has brought about the integration of employment staff within the clinical treatment teams. This important step indicates DMHAS' commitment to employment as a critical component of recovery for most consumers and provides a context in which BRS counselors can be most effectively embedded within the mental health system.
- DMHAS employment services have traditionally focused on choosing and keeping entry-level positions. Staff increasingly look to BRS to assist consumers in securing more advanced training and jobs that are commensurate with their skill levels.
- BRS' Medicaid Infrastructure Grant and DMHAS' Systems Transformation Grant both emphasize collaboration across agencies and disabilities. Each focuses on the development of structures that promote service coordination and leverage a broader array of services for targeted populations.
- Other initiatives such as BRS' Connect to Work Center that makes benefits counseling available to persons in the DMHAS system and DMHAS' emerging peer advisory system promote community linkages.

In addition to these initiatives, BRS and DMHAS share a designated staff person who has been coordinating services across the two systems. In 2006, the leadership of both systems agreed that the timing was right for this project. Subsequently, both agencies were prepared to commit staff and resources to support the collaboration and to collect outcome data as a means of identifying best practices.

The BRS and DMHAS Collaborative Employment Project developed the following goals:

- To improve employment outcomes for shared consumers with psychiatric disorders by integrating the employment and educational services of BRS and DMHAS
- To build an integrated career development continuum of services that leverages the resources of BRS and DMHAS to enable consumers to move toward economic self-sufficiency
- To identify effective collaborative protocols and practices that promote the integration of Vocational Rehabilitation and Mental Health employment services
- To raise awareness within the DMHAS system of the positive impact of employment on recovery
- To raise awareness within the BRS system of best practices in assisting persons with psychiatric disabilities to obtain and retain employment
- To explore the effective use of such underused career development services as post-secondary education, on-the-job training (OJT), Ticket to Work and the identification of “recovery-friendly employers” to strengthen employment outcomes
- To facilitate effective linkages between BRS and the DMHAS supportive housing, psychosocial clubhouse and addictions systems
- To identify age-appropriate vocational interventions for the DMHAS Young Adult Services population
- To explore the use of peer support staff to strengthen employment outcomes
- To collaborate in accessing community resources that address common barriers to employment such as criminal backgrounds and the pervasive lack of transportation

The BRS and DMHAS Collaborative Employment Project co-located three DSS/BRS Vocational Rehabilitation Counselors on site at three DMHAS-operated Local Mental Health Authorities (LMHAs): Hartford Capitol Region Mental Health Center in Hartford (HCRMHC), Greater Bridgeport Community Mental Health Center in Bridgeport (GBCMHC), and New Haven Connecticut Mental Health Center (NHCMHC). The Greater Bridgeport BRS liaison counselor started her embedded position in January 2007 and continues in the position. The Hartford BRS liaison counselor started her position in February 2007 and ended in May 2008. In New Haven, the BRS liaison counselor began her embedded position in February 2007 and ended in June 2010.

The goal of the three BRS Mental Health Liaison Counselors was to assist in developing collaborative employment and educational protocols to leverage the resources of both agencies to maximize service options, minimize service duplication, and insure the provision of a seamless service delivery system. The Counselors provided direct counseling to DMHAS clients as well as technical assistance to other DSS/BRS Vocational Rehabilitation Counselors that are serving individuals from the LMHAs. Integral to the project was the collection and on-going analysis of employment and educational outcome data, which will inform future service planning in both systems.

The role of the BRS Mental Health Liaison Counselors was to determine eligibility for BRS services and jointly develop a collaborative Employment Plan with the individual and key members of the LMHA clinical treatment team based on the person's individual strengths, abilities, concerns, interests and resources. Counselors were expected to provide vocational rehabilitation services in close collaboration with their DMHAS treatment teams.

The role of the DMHAS LMHA Liaisons was to assist DMHAS clinicians, case managers, employment staff, peer support specialists and supervisors to identify and refer those consumers that can benefit from BRS services to the BRS Mental Health Liaison Counselors. The Liaison was expected to insure that the DMHAS treatment team provides on-going collaborative services and supports.

Staff of both BRS and DMHAS were expected to assist in developing service protocols that link the staff and resources of the two agencies. Detailed outcome data was defined, collected and analyzed as a means of identifying effective collaborative service strategies to guide collaborative service planning at both DMHAS-operated and private/non-profit (PNP) LMHAs. There are four hypotheses for this project:

- 1) BRS will notice improved access to wraparound services, reinforcement of employment goals by team members, and expanded services and supports, (e.g., engagement, psychosocial supports).
- 2) DMHAS will notice improved vocational rehabilitation consultation, or broader disability knowledge, and a longer and stronger continuum of services that promote career development.
- 3) BRS/DMHAS consumers will be more satisfied because of improved coordinated supports and better employment outcomes.
- 4) Teaming will benefit both BRS and DMHAS and both agencies will experience improved communication and access to information and data on shared consumers.

Collaboration between agencies involves overcoming barriers created by differences in institutional cultures (Gray, 1989), and in practice is difficult to achieve (Gilbride, 2000). Because the linkage of mental health and vocational rehabilitation systems has been challenging for most states, findings from this project are important and can inform Connecticut's BRS and DMHAS while also contributing to the national discussion.

## II. Methodology and analysis

The evaluation was conducted by Dr. Julie Robison's program evaluation research team at the University of Connecticut Health Center's (UCHC) Center on Aging and all study procedures and materials were approved by the UCHC Institutional Review Board.

### Data collection instruments

The primary methods of data collection included an *Intake Survey*, *Consumer Satisfaction Survey*, *Counselor Survey*, and *Program Evaluation Survey*. These were jointly developed and informed by the UCHC research team and the BRS and DMHAS employment project team. The instruments comprised both quantitative and qualitative questions. The qualitative questions allow interviewees the opportunity to more completely describe their experiences and perspectives.

All the surveys were web designed and operated on a SQL server platform. The system was available for counselor training before recruitment began and remained operational until data collection ceased in October 2010.

Preliminary data was collected by the BRS counselors at intake. The *Intake Survey* (Baseline) included the following major topics: contact information, demographics, benefits counseling, current work status, and degree of job match to interests and career goals (see Appendix A for a complete copy of the *Intake Survey*). At the time of intake, BRS counselors informed participants that researchers from UCHC would contact them for follow up.

All individuals 18 years of age and older who were recruited by BRS counselors for the project and who agreed to sign the Permission to Contact form were initially interviewed by their BRS counselor and subsequently contacted by UCHC researchers at 3, 6, and 12 months after intake to complete a *Consumer Satisfaction Survey*. This telephone survey includes sections on employment experiences since intake and experiences with the BRS counselor and other service providers (see Appendix B for a complete copy of the *Consumer Satisfaction Survey*).

All individuals 18 years and older who were recruited by BRS counselors for the project, including those who did not agree to sign the Permission to Contact form and were therefore not in the evaluation component of the project, were interviewed by their counselor at 3, 6, and 12 months after intake. The *Counselor Survey* was designed for counselors to use with clients and includes the following major topics: work history, benefits counseling, education, DMHAS enrollment, job match, speed of movement through the BRS/DMHAS systems, and BRS services (see Appendix C for a complete copy of the *Counselor Survey*).

A *Program Evaluation Survey* was developed for counselors to use quarterly to report frequency and quality of interagency communication (e.g., number of referrals from BRS counselor to DMHAS employment specialist, number of referrals from DMHAS to BRS counselor that were opened) (see Appendix D for a complete copy of the *Program Evaluation Survey*).

To augment the above surveys and meet process evaluation goals, data were collected from a focus group, 18 key informants, and 15 BRS and DMHAS project quarterly minutes. The focus group was conducted at Greater Bridgeport Community Mental Health Center in Bridgeport with BRS and DMHAS staff by trained UCHC researchers. Participants were recruited using purposeful sampling and included the BRS and DMHAS staff who work at the LMHA in Bridgeport. Researchers planned to conduct a focus group at the New Haven and Hartford

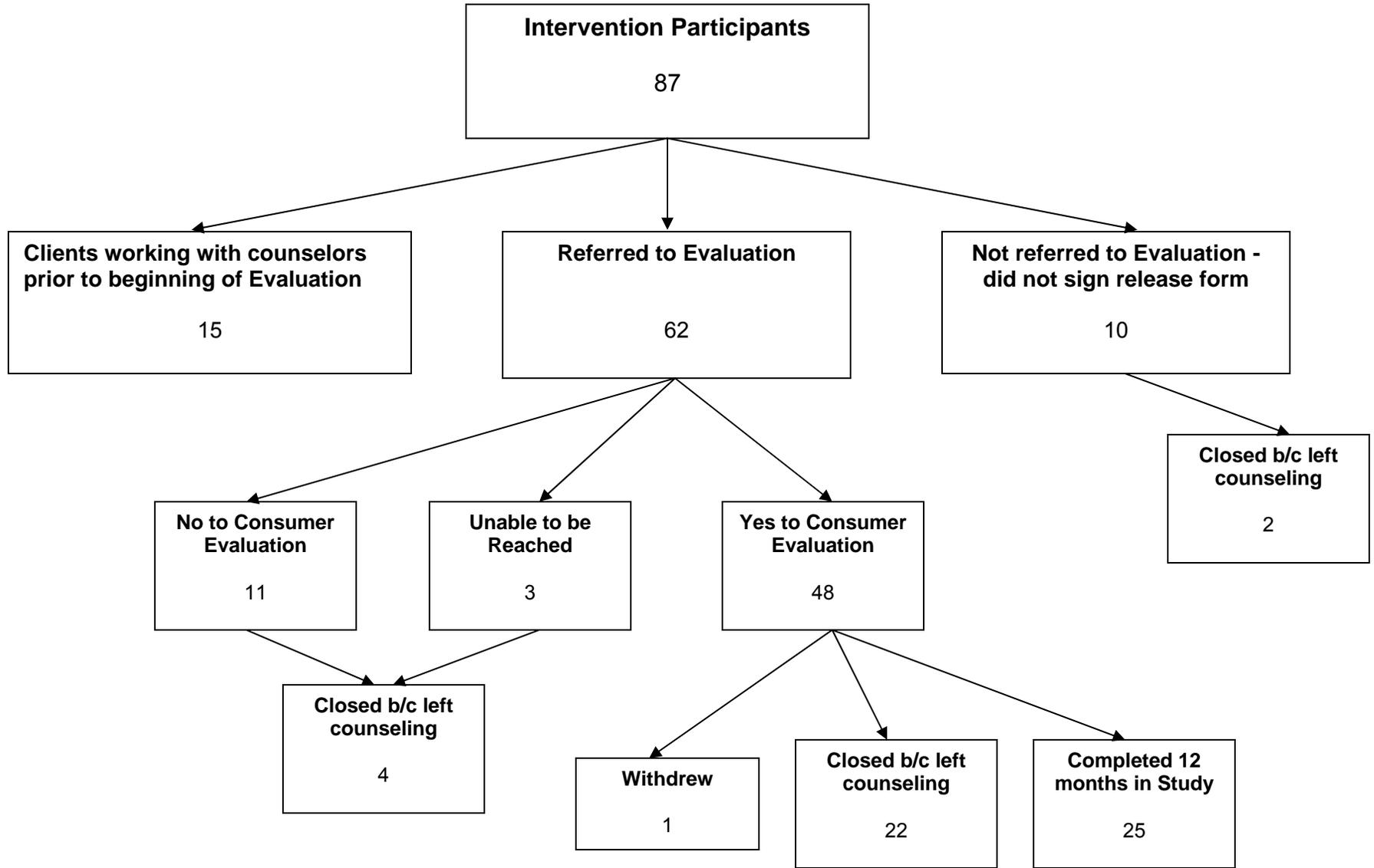
LMHAs, but were unable to recruit enough participants for the New Haven group. The Hartford LMHA was unable to continue participating in the project due to changes in BRS staff and lack of a suitable counselor for the location.

Questions in the focus group and key informant guides centered on systems improvement and sought to generate ideas and information with the goal of gaining a better understanding of the experiences of those involved in the process (see Appendix E and F for a complete copy of the Focus Group and Key Informant Guides). The guides included a number of grand tour questions covered by topic with each followed by probes in order to generate more discussion. The focus group lasted approximately one hour and with consent of the participants was audio taped. In addition to the facilitator, a research assistant was present to take detailed notes that were used during the analysis to supplement the audio as needed.

### Research sample

The BRS and DMHAS Collaborative Employment Project seeks to determine the value of the BRS and DMHAS teamed approach by contrasting the employment outcomes, systems changes and attitudinal changes that are brought about by the teamed model versus stand alone DMHAS employment services. To evaluate consumer satisfaction and the benefits of teaming, an empirical pilot program evaluation was conducted with an intervention group and a comparison group. The intervention group comprised consumers receiving BRS services through two LMHAs, GBCMHC and NHCMHC. Out of 87 intervention participants, a total of 62 consumers completed baseline surveys with the BRS counselor, signed a release and were referred to the UCHC evaluation. Eleven of these subsequently chose not to participate in the UCHC portion of the evaluation and three were unable to be reached by phone or mail. A total of 48 consumers agreed to participate in the UCHC telephone interviews. Twenty-two cases were closed over the course of the project for various reasons (e.g., no longer interested in working, found a satisfactory job, wanted to continue education before seeking employment). At the completion of the project, a total of 25 consumers remained active in the study (Figure 1).

Figure 1. BRS/DMHAS Collaborative Employment Project Participants



This study is a pilot project and by nature small in scope. As the project progressed, it was expected that there would be missing data due to cases closing, refusals to complete the survey or inability to reach participants (Table 1).

Table 1. Activities of participants referred to the evaluation

	Baseline	3 months	6 months	12 months
Enrolled/completed interview	62	37	29	25
Cases closed	—	4	15	22
Refused	11	16	15	11
Unable to be reached	3	5	3	4

A comparison group included all BRS clients with significant mental illness diagnoses. Data from this existing administrative database includes demographic indicators and several employment outcomes; see the Administrative Data Analysis section below for further detail. Consumers in the comparison group were granted eligibility for Vocational Rehabilitation services between June 1, 2008 and September 30, 2009. There are 813 individuals in this group.

#### Recruitment

Initially, all people who began to receive services from one of the three pilot program BRS counselors were recruited. It was expected that each of the counselors would have a case load of up to 50 consumers. Without BRS staff availability at the Hartford LMHA, recruitment occurred at only two sites. Institutional Review Board (IRB) approval for recruitment was received in June 2008. Following training of the counselors by UCHC research staff at the end of June 2008, enrollment began in July 2008 with ongoing enrollment occurring through October 31, 2009.

#### Data management and analysis

All data management and analysis was done by the UCHC evaluation team. Data were stored in Microsoft Access tables, which are suitable to enter both quantitative and qualitative information. All data collected from intervention group participants were entered with a coded ID number. Contact information for telephone follow up purposes was stored in a separate file. Only the UCHC research team was able to link the ID number to the contact information. Following data collection, the data were converted to SPSS version 18.0, a statistical software package designed for both simple and complex analysis.

A three-step analysis strategy was employed in this study. First, a preliminary analysis of the data determined the distribution of the sample across the independent variables (survey items) in the pilot study. Second, data were analyzed question by question, with a series of basic indicators computed: frequency, average, and percentage. The small sample size precluded statistical significance tests for the survey data. A comparison of the differences between test and comparison groups using the de-identified administrative data was made using bivariate statistical tests.

Qualitative data from open-ended questions in the telephone survey, transcripts from the focus group, and 15 BRS and DMHAS project quarterly minutes were analyzed line by line in order to identify and interpret content. Two researchers analyzed each open-ended question in the survey and each question in the transcripts and met to reach a consensus if interpretations varied. Major concepts supported by direct quotes were organized into common themes using the constant comparative technique of Glaser and Strauss (1967) and additional themes were included until no new topics were identified.

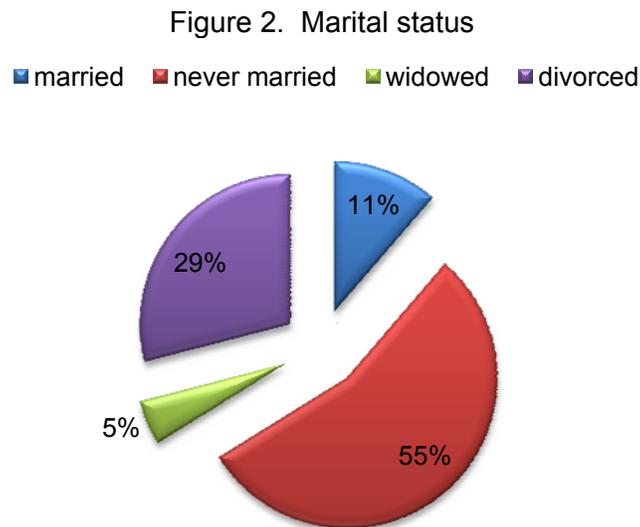
### III. Results

#### Intake Survey

As part of the intake process in the BRS and DMHAS Collaborative Employment Project, the BRS liaison counselor acquired certain initial information from intervention group participants. The following demographic results include information on marital status, level of education, whether or not the client had ever had benefits counseling, and current work experiences.

#### Marital status

Eleven percent (n=7) of those participating in the evaluation indicated that they were married, 29 percent (n=18) were divorced and five percent (n=3) were widowed. The majority of participants, 55 percent (n=34), were never married (Figure 2).



#### Education

The majority of respondents have either a high school diploma or some college including trade or technical vocational training or a two-year college degree. Sixteen percent (n=10) of the group has a four-year college or post-graduate degree (Table 2).

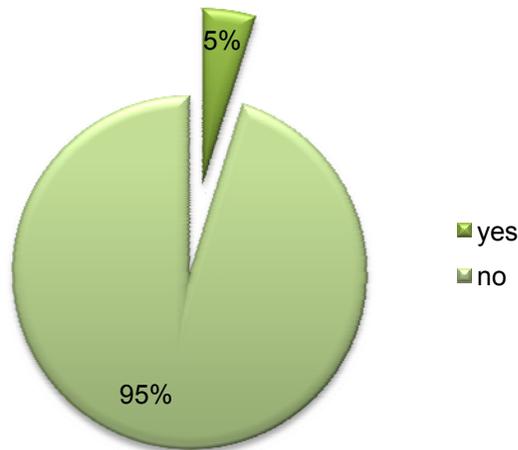
Table 2. Education

	% (n)
8 <sup>th</sup> grade or less/some high school	6 (4)
High school diploma	37 (23)
Some college	41 (26)
Four year college	11 (7)
Graduate school	5 (2)

Degree, certificate or licensure program

At the time of intake, most participants (95%, n=59) were not enrolled in a degree, certificate or licensure program (Figure 3).

Figure 3. Enrolled in a degree, certificate or licensure program



Of the five percent (n=3) enrolled, none were enrolled in a degree program, one person was enrolled in a two year program and two individuals were enrolled in a certificate or licensure program (Table 3).

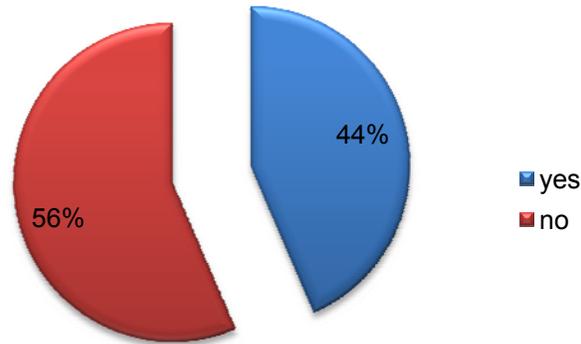
Table 3. Type of degree, certificate or licensure program

	% (n)
Degree program	0 (0)
Two year degree	2 (1)
Certificate or licensure program	3 (2)

Benefits counseling

When asked if they had ever had benefits counseling, 44 percent (n=27) responded they had had benefits counseling and 57 percent (n=35) reported that they had not had this counseling (Figure 4).

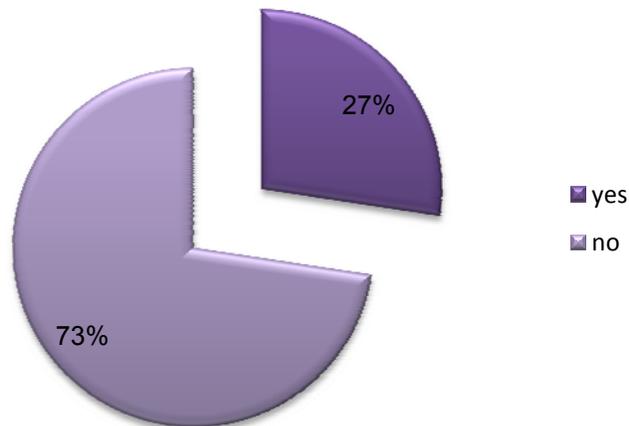
Figure 4. Benefits counseling



Work status

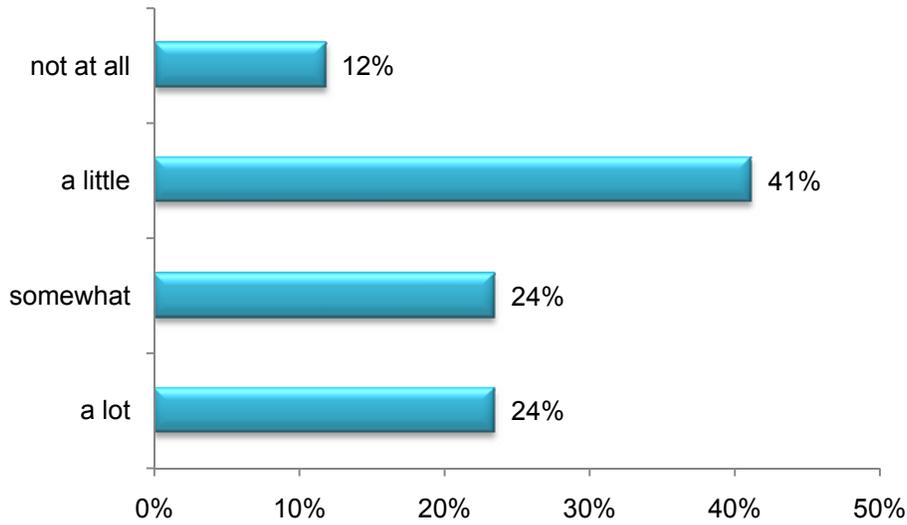
At intake, only 27 percent (n=17) of those who were enrolled were working (Figure 5). For the purposes of this project, “work” or “job” was defined as “paid employment in an integrated setting for competitive wages which are comparable to that of others doing the same job.”

Figure 5. Currently working at intake



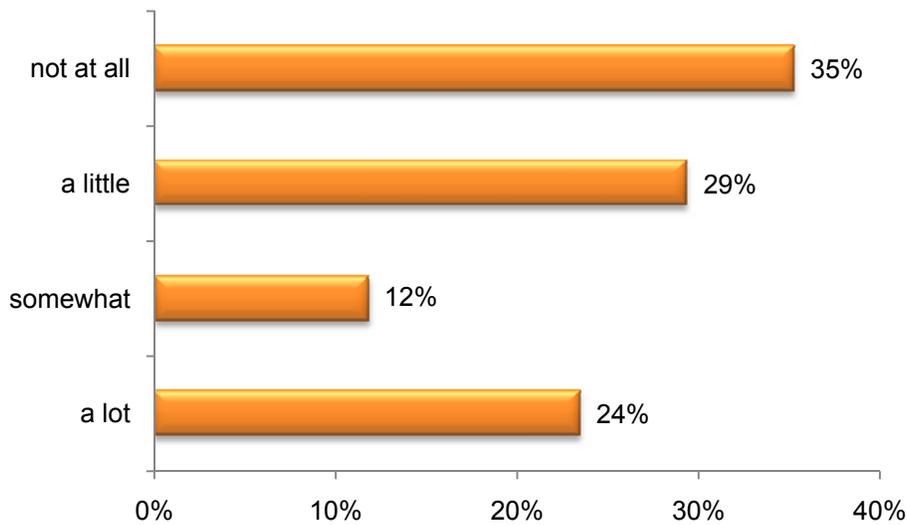
Of those who were currently working, almost half (48%, n=8) indicated that their current job matched their interests either a lot or somewhat. The other group (53%, n=9) reported that their current job only matched their interests a little or not at all (Figure 6).

Figure 6. Current job matches interests



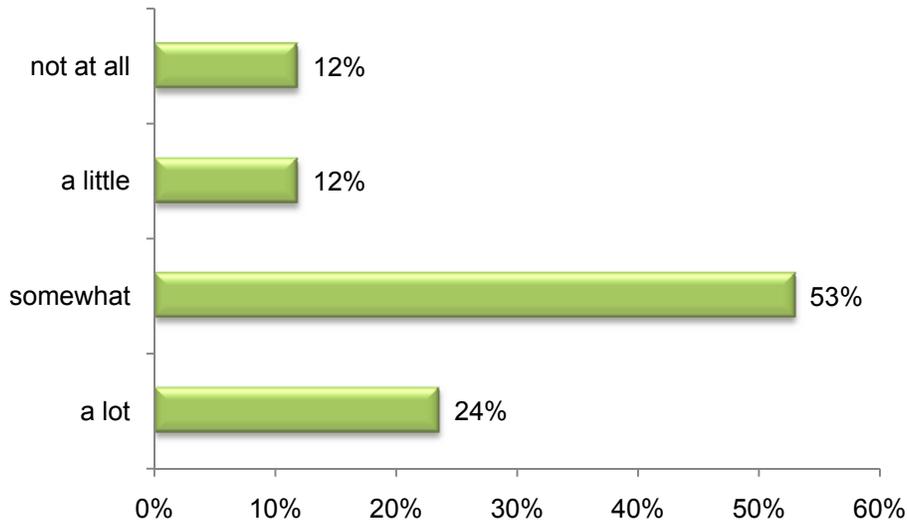
Working respondents also indicated whether their current job matched their career goals and whether they felt that their talents and abilities were utilized. Over a third (35%, n=6) of respondents reported that their current job did not match their career goals at all while 29 percent (n=5) indicated that their current job matched their career goals a little (Figure 7).

Figure 7. Current or most recent job matches career goals



More than half of employed respondents (53%, n=9) reported that their current job only requires them to use their talents and abilities somewhat while 24 percent (n=4) reported that the job requires them to use a lot of their talents and abilities (Figure 8).

Figure 8. Current or most recent job requires consumer to use talents and abilities



**Consumer Satisfaction Survey**

After the initial intake by the BRS counselors at the time of enrollment into the BRS/DMHAS Collaborative Employment Project, the UConn evaluator did follow-up interviews with the participants over the phone at 3 months, 6 months, and 12 months. These interviews were conducted to capture information about the employment situation of the participant and to evaluate each participant’s satisfaction with being involved in the project.

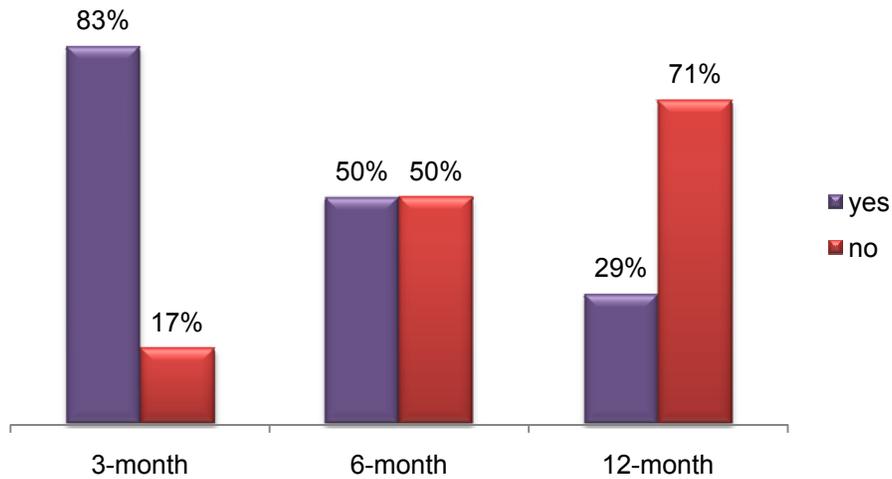
At the beginning of the project, 27 percent of individual participants were currently working at a job. This number changed slightly over the course of the year, from 27 percent at baseline (intake), to 32 percent at 3 months, 48 percent at 6 months, and 56 percent at the one year interview (Table 4). It should be noted that although the percent of people working at each time point increased, the number of participants working rose at each time point due to fewer people participating in the interviews at each time point.

Table 4. Those currently working over the first year

	% (n)
Baseline	27 (17)
3 months	32 (12)
6 months	48 (14)
12 months	56 (14)

Participants who responded they were currently employed were asked if they were working at the job prior to the first BRS liaison counselor meeting. At 3 months, 83 percent (n=10) responded they were working at their job before meeting with the counselor. At 6 months, 50 percent (n=7) and at 12 months 29 percent (n=4) of those currently working reported they were employed at their job prior to meeting with their counselor (Figure 9).

Figure 9. Working at current job prior to first counselor meeting



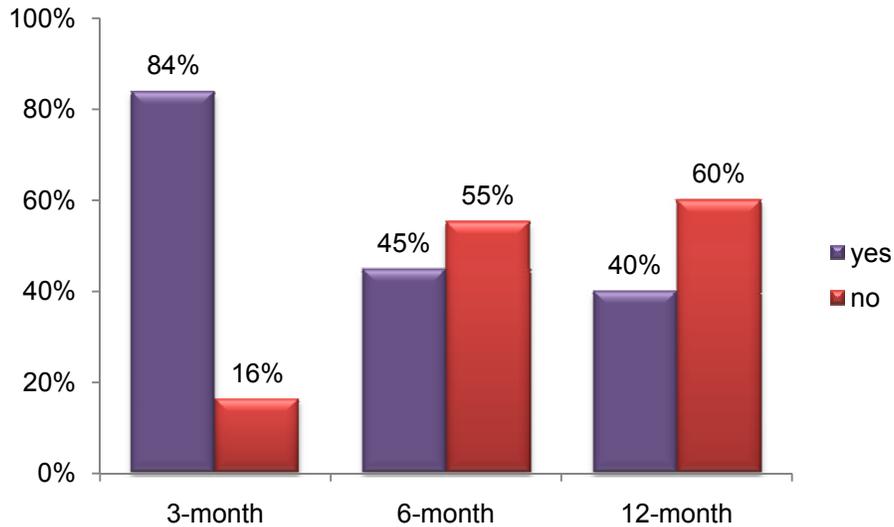
Over the course of a year, whenever participants responded they weren't currently working, they were asked if they had worked in the community for competitive wages since the previous interview. At 3 months, only 12 percent (n=3) of those not currently working reported they had worked in the community for competitive wages since baseline. At 6 months, no participants had worked in the community for competitive wages during the time since their previous interview, and at 12 months, 64 percent (n=7) who weren't currently working had worked for competitive wages at some point since the previous interview (Table 5).

Table 5. Not currently working but worked since the previous interview

	% (n)
3 months	12 (3)
6 months	0 (0)
12 months	64 (7)

If respondents who were not currently employed had worked at some point since the previous interview for competitive wages, they were asked if they were planning on making any job changes (e.g., getting a new job, applying for a job). While at 3 months, most respondents (84%, n=31) stated they planned on making job changes, at 6 months and 12 months less than half (45%, n=13 and 40%, n=10, respectively) responded they planned on making job changes (Figure 10).

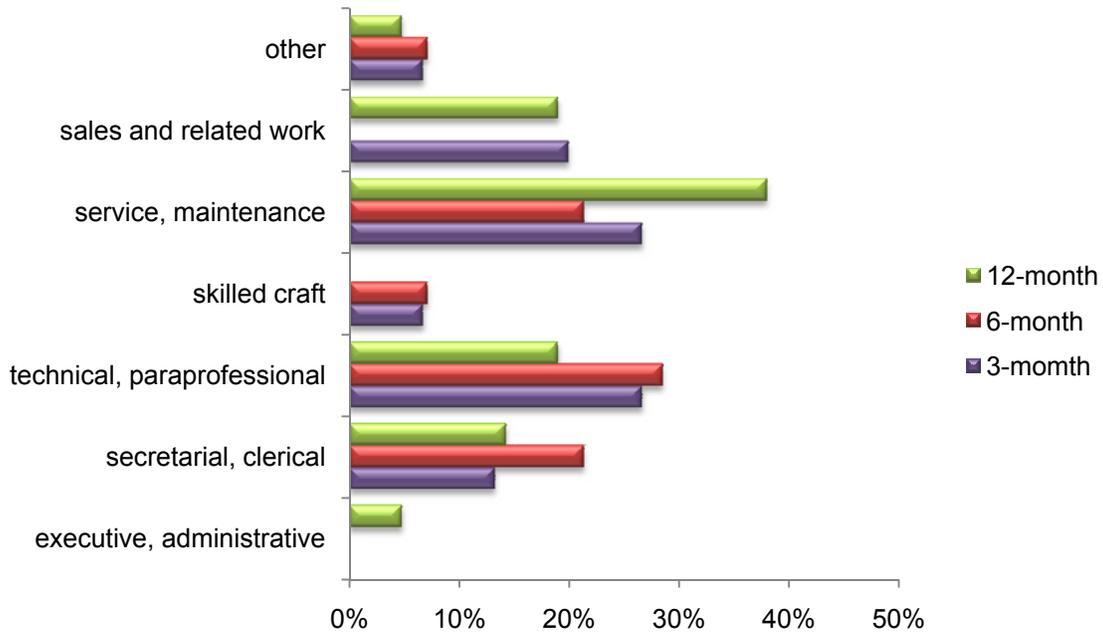
Figure 10. Currently unemployed but planning on making job changes



### Types of jobs

Types of jobs that participants reported working at included administrative/managerial positions, secretarial or clerical positions (e.g., administrative assistants, bookkeepers and tellers), technical or paraprofessionals (e.g., drafters, teachers aides, nurse's aides), skilled crafts (e.g., mechanics, assemblers, carpenters, and electricians), service or maintenance positions (e.g., child care, cafeteria or restaurant workers), and sales and related work (e.g., telemarketers, cashiers, clerks). There were no participants who were in professional positions such as teachers, doctors, or engineers. The majority of the respondents were in sales, technical, or maintenance positions. Over the 12 months of the program, the number of positions in service or maintenance increased (Figure 11).

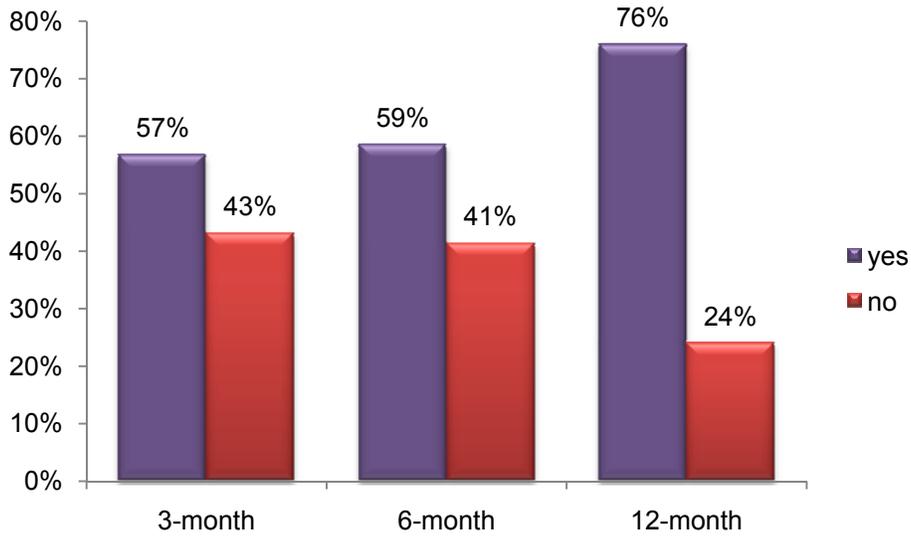
Figure 11. Type of job held by participants (current job or most recent job)



Applying or interviewing for a job

Of those actively participating in the evaluation, 57 percent (n=21) had either applied or interviewed for a position at 3 months, and 59 percent (n= 17) did so at 6 months. By 12 months, 76 percent (n=19) had either applied or interviewed for a job. While the change in percentage increased at 12 months to more than three-quarters from slightly over half at 3 months and 6 months, it should be noted that the numbers of individuals applying or interviewing for a job did not increase. The rise in percentage at 12 months is due to fewer participants completing interviews (Figure 12).

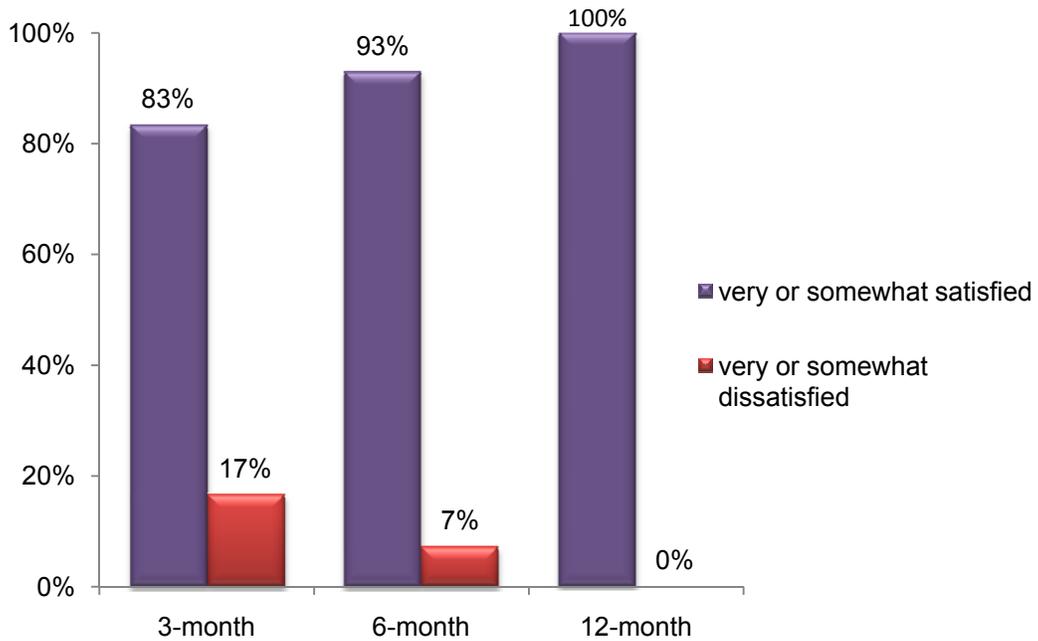
Figure 12. Applied or interviewed for a job



Satisfaction with job

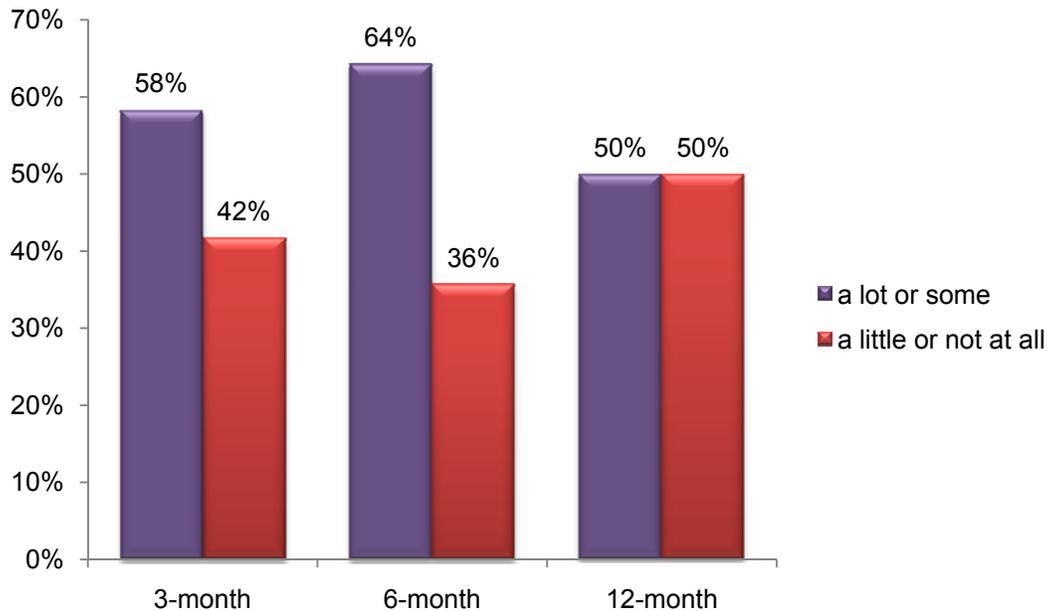
Only individuals who were currently working or had worked since enrollment were asked how satisfied they were with their current or most recent job. Most of these respondents indicated that they were either very or somewhat satisfied with their current job, 83 percent (n=12) at three months, 93 percent (n=13) at 6 months, and 100 percent (n=14) at 12 months (Figure 13).

Figure 13. Satisfaction with current or most recent job



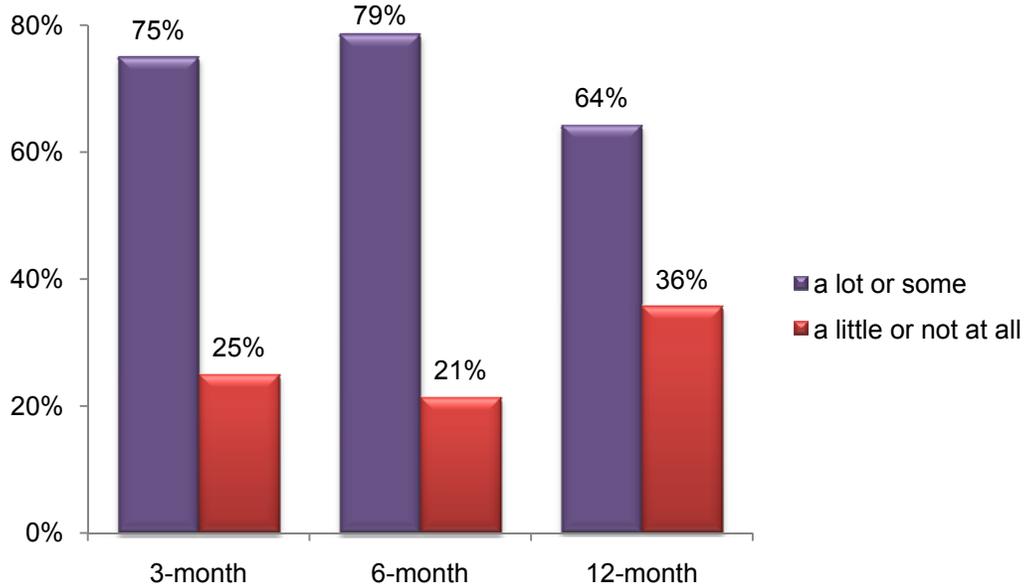
More than half of the respondents reported that their current or most recent job matched their career goals either a lot or somewhat, 58 percent (n=7) at 3 months, 64 percent (n=9) at 6 months, and 50 percent (n=7) at 12 months (Figure 14).

Figure 14. Current or most recent job matches career goals



Compared to baseline numbers, a higher percentage and number (78%, n=9) of respondents felt that their particular job utilized their talents and abilities either a lot or some at 3 months. This number increased slightly to 79 percent (n=11) at 6 months but decreased to nearly two-thirds (64%, n=9) of the individuals at 12 months (Figure 15).

Figure 15. Current or most recent job matches talents and abilities

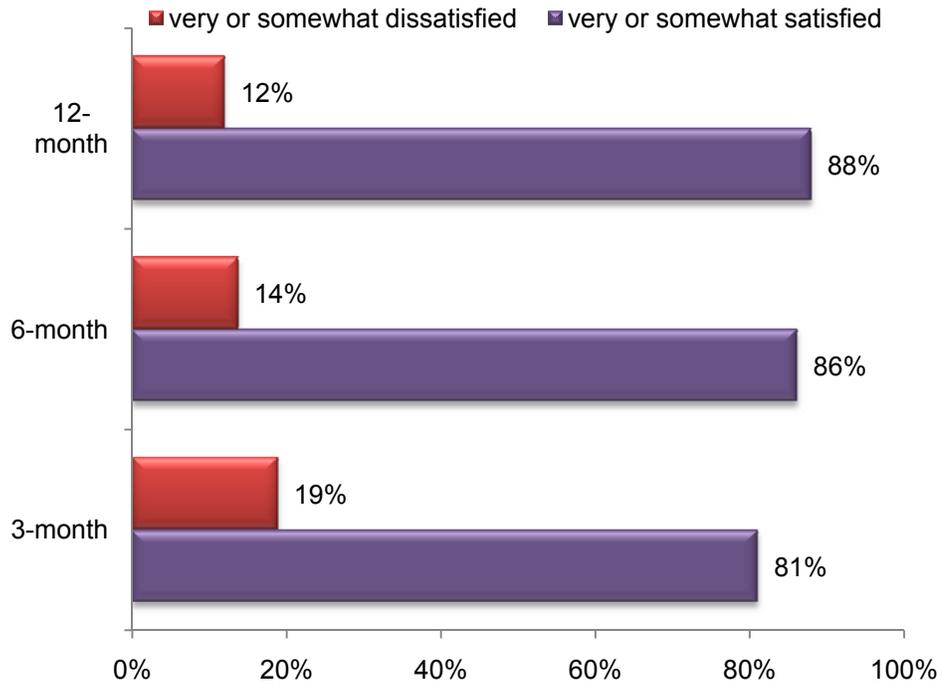


Experiences with BRS liaison counselor

An additional section of the consumer interview dealt with experiences with the BRS liaison counselor. This included satisfaction with employment counseling and vocational rehabilitation services, support and encouragement, and specific ways in which the counselor provided help.

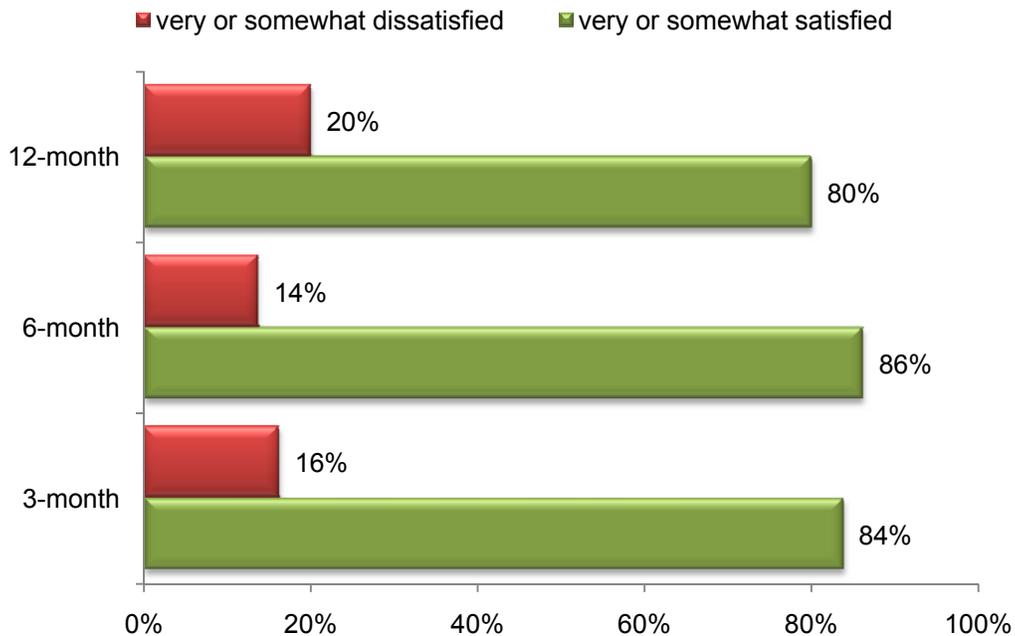
The majority of respondents reported they were either very or somewhat satisfied with the employment counseling and vocational rehabilitation services provided by their BRS counselor, 81 percent (n=30) at 3 months, 86 percent (n=25) at 6 months, and 88 percent (n=22) at 12 months (Figure 16).

Figure 16. Satisfaction with employment counseling and rehabilitation services



Likewise, most respondents reported that they were either very or somewhat satisfied with the support and encouragement they received from their BRS counselor, 84 percent (n=31) at 3 months, 86 percent (n=25) at 6 months, and 80 percent (n=20) at 12 months (Figure 17).

Figure 17. Satisfaction with support and encouragement provided by counselor



Respondents were asked to rate their experiences working with the BRS counselor by agreeing or disagreeing with various statements. These statements focused on career goals, work opportunities, pre-employment skills, and other employment services including the following:

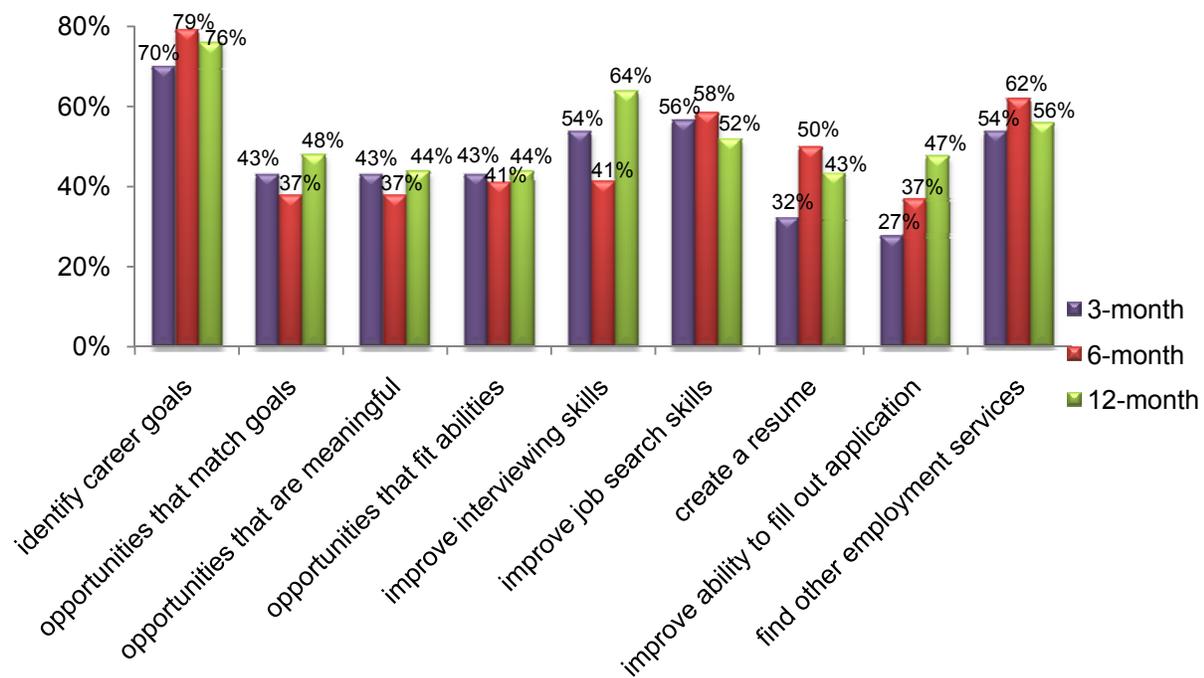
Working with my BRS counselor has helped me...

- identify my career or employment goals.
- find work opportunities that match my career goals.
- find work opportunities that are meaningful to me.
- find work opportunities that fit my abilities.
- improve my interviewing skills.
- improve my job search skills.
- create a resume or description of my work history.
- improve my ability to fill out a job application.
- find other useful employment services such as career development programs, in the job training, or other training or education.

The most helpful experience in working with a counselor was identifying career goals, 70 percent (n=26) at 3 months, 79 percent (n=23) at 6 months, and 76 percent (n=19) at 12 months. Another helpful experience included improving interviewing skills, 54 percent (n=20) at 3 months, 41 percent (n=12) at 6 months, 64 percent (n=16) at 12 months. Improving job search skills and finding other employment services were additional experiences that consumers felt were helpful (Figure 18). Other employment services included organizations such as CTWorks One-Stop Centers and Marrakech, Inc. CTWorks One-Stop Centers provide workforce resources including skills assessment, job counseling, and other employment and training services for both job seekers and employers in the North Central Connecticut region. Marrakech, Inc. is a private nonprofit organization located in New Haven, Connecticut. The organization provides residential, educational, and job placement services to people facing economic challenges.

Areas where consumers disagreed or strongly disagreed that the counselors were helpful did so either because the statement wasn't currently relevant or because the counselor had not helped them with that aspect of employment yet. For example, at the 3 month interviews, 57 percent (n=21) of consumers disagreed or strongly disagreed that the counselors helped them find work opportunities that matched their career goals. Many of these reported that they were still working with the counselors on identifying career goals, were trying to improve their job search skills, or were seeking other employment services and had not yet begun to actively search for a job. Some respondents disagreed or strongly disagreed with the statements related to creating a resume or improving their ability to fill out a job application because they were already familiar with how to do this or had had help in these areas from someone before entering counseling.

Figure 18. Experiences in which working with BRS counselor was helpful (strongly agree or agree)



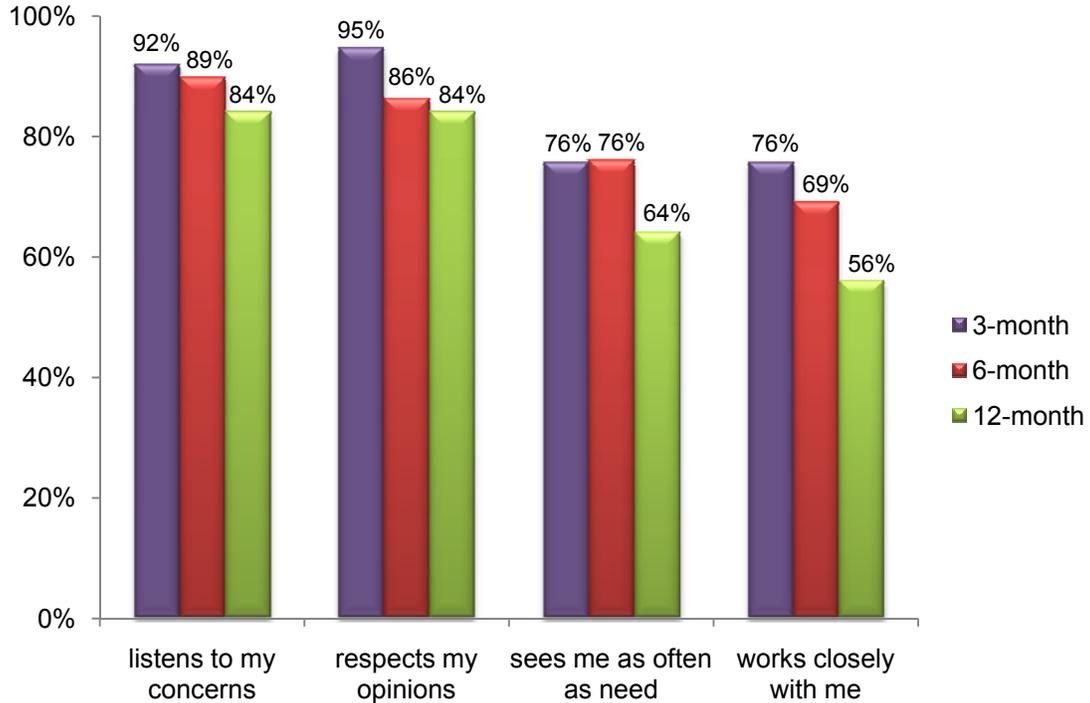
Respondents were asked to rate experiences with their counselor on how supportive or encouraging he/she was by agreeing or disagreeing with the following statements:

My BRS counselor...

- listens to and responds to my concerns.
- respects my opinions.
- sees me as often as I need to see him/her.
- continues to work closely with me.

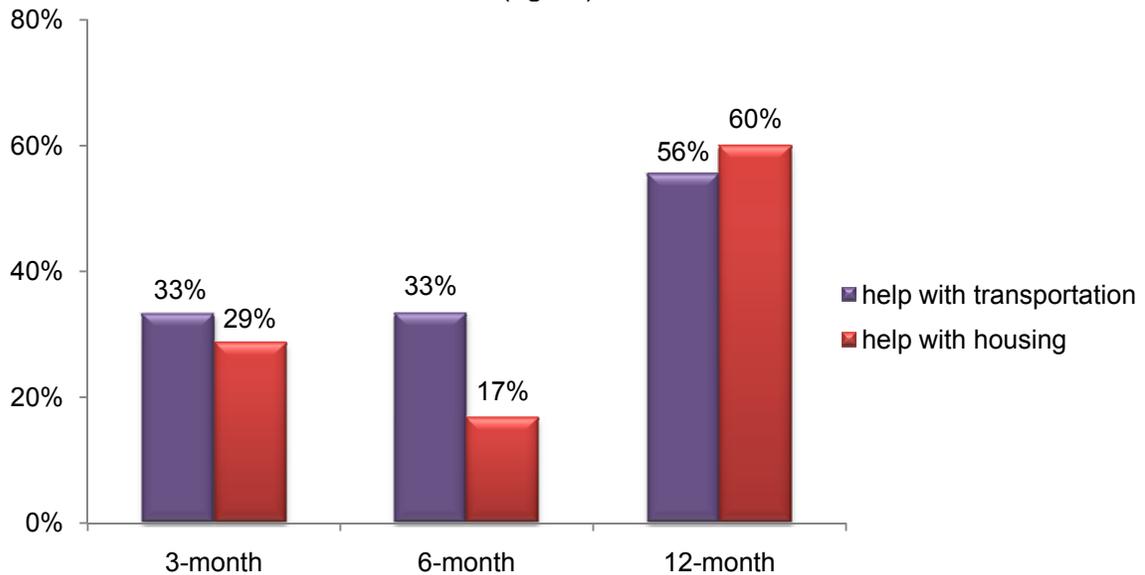
At the 3, 6, and 12 month interviews, most respondents strongly agreed or agreed that their counselor was attentive, respectful, and available. Respondents reported that these qualities were more evident at 3 and 6 months than at 12 months (Figure 19).

Figure 19. Attentiveness and availability of BRS counselor (strongly agree or agree)



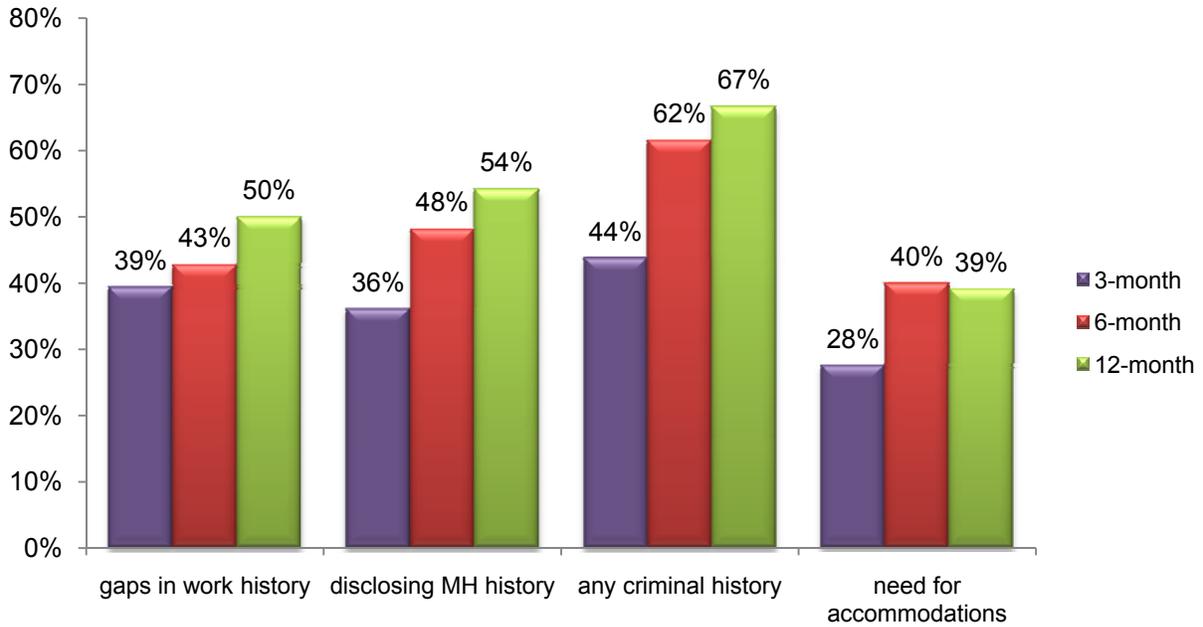
Most respondents did not need help with connections to community programs associated with transportation and housing. The few respondents who had difficulties with transportation and housing were asked to rate their counselors' help with connections to these community resources by agreeing or disagreeing with two statements. More respondents agreed they had a need for and help with connections to community programs for both transportation and housing at 12 months than at 3 and 6 months interviews. At 12 months, 56 percent (n=5) agreed their counselor helped connect them to community programs to help with transportation difficulties and 60 percent (n=3) agreed that their counselor helped connect them to community programs to help with housing difficulties (Figure 20).

Figure 20. Connections to community transportation and housing programs (agree)



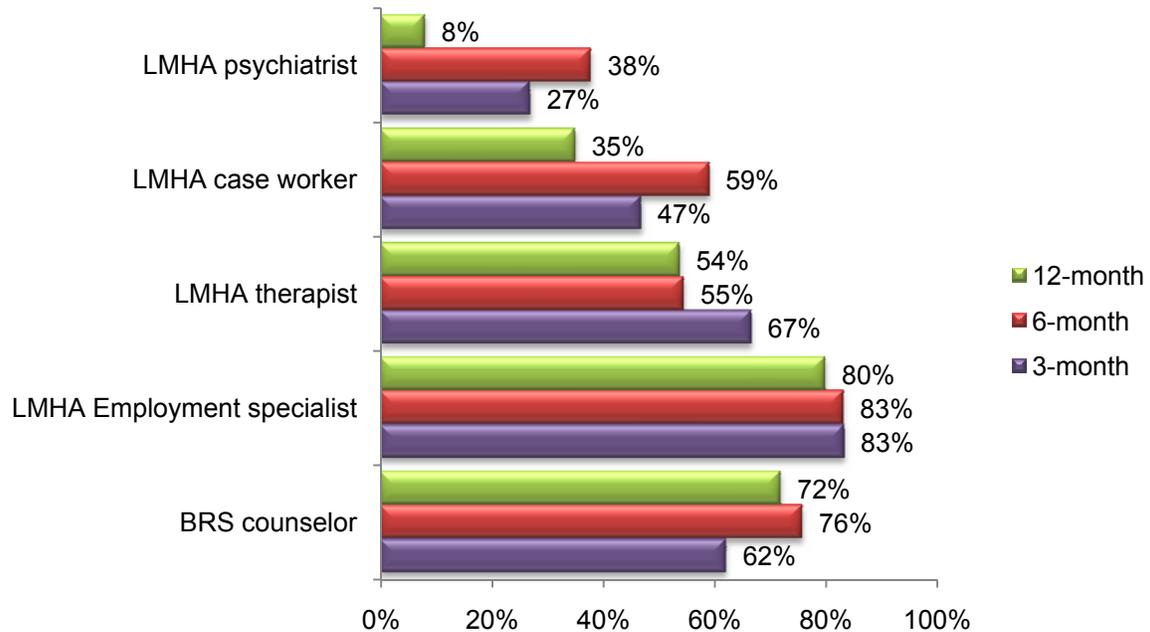
Respondents were also asked how useful counselor advice was regarding gaps in work history, disclosing mental health history, any criminal history, and the need for accommodations based on mental health, such as a flexible schedule. Overall, at 3 and 6 months more respondents disagreed that they had received useful counselor advice on how to talk to a potential employer about personal or employment history or need for accommodations (Figure 21). Comments from respondents suggest that counselors typically did not provide information on gaps in work history, how to disclose mental health history, criminal history, or the need for accommodations until later in the program because they were focusing more on the development of employment skills or addressing other needs (e.g., additional education) in earlier counseling sessions.

Figure 21. Useful counselor advice on how to talk to a potential employer about personal history and need for accommodations (strongly agree or agree)



Most people in the BRS and DMHAS Collaborative Employment Project had an employment plan. Respondents were asked to rate how much their BRS liaison counselor and each of their LMHA staff, including employment specialist, therapist, case worker, and psychiatrist, contributed to the development of their employment plan. At 3, 6, and 12 months, most respondents reported that the LMHA employment specialist contributed more to their employment plan than other professionals. This was followed by LMHA therapists at 3 months and BRS counselors at 6 and 12 months (Figure 22).

Figure 22. Contributions to employment plan



Respondents also gave input about their employment plan and how much they were involved in the development of this plan. Not surprisingly, most respondents reported they were involved a lot in the development of their employment plan, 56 percent (n=18) at 3 months, 72 percent (n=21) at 6 months, and 72 percent (n=18) at 12 months (Table 6).

Table 6. Degree of consumer involvement in development of employment plan

	3 months % (n)	6 months % (n)	12 months % (n)
A lot	56 (18)	72 (21)	72 (18)
Some	27 (9)	17 (5)	16 (4)
A little	18 (6)	10 (3)	12 (3)

In addition, respondents were asked to rate the following statements regarding their employment plan.

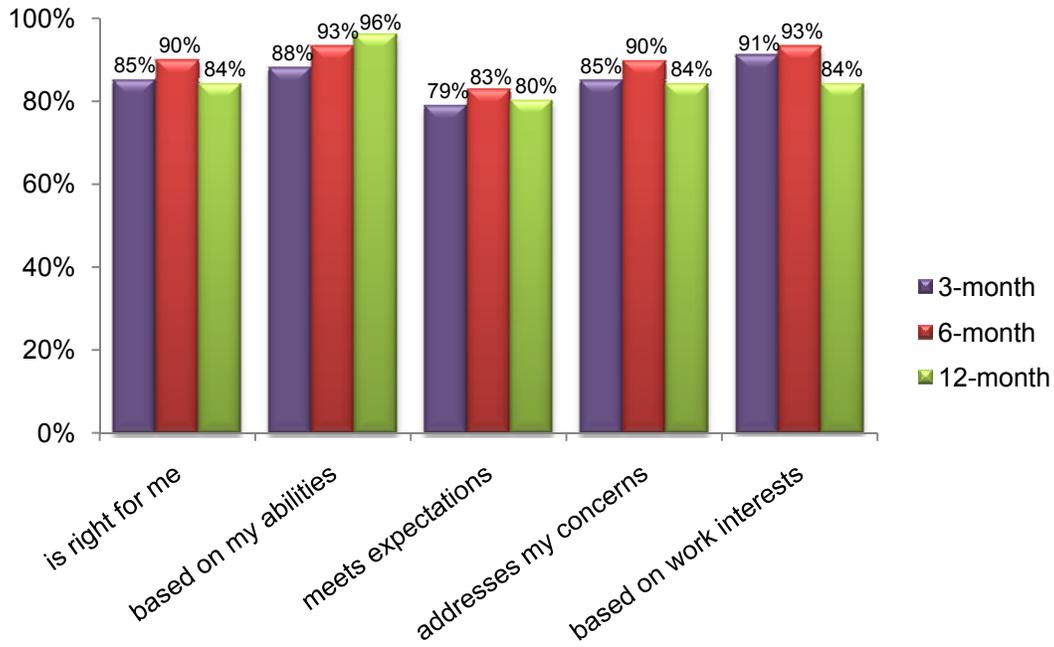
My employment plan...

- is right for me.
- is based on my strengths and abilities.
- meets my expectations.
- addresses my concerns.
- is based on my work interests.

Most respondents strongly agreed or agreed that their employment plan was adequate. While still a majority, slightly fewer consumers reported that their employment plan met their expectations, 79 percent (n=26) at 3 months, 83 percent (n=24) at 6 months, and 80 percent

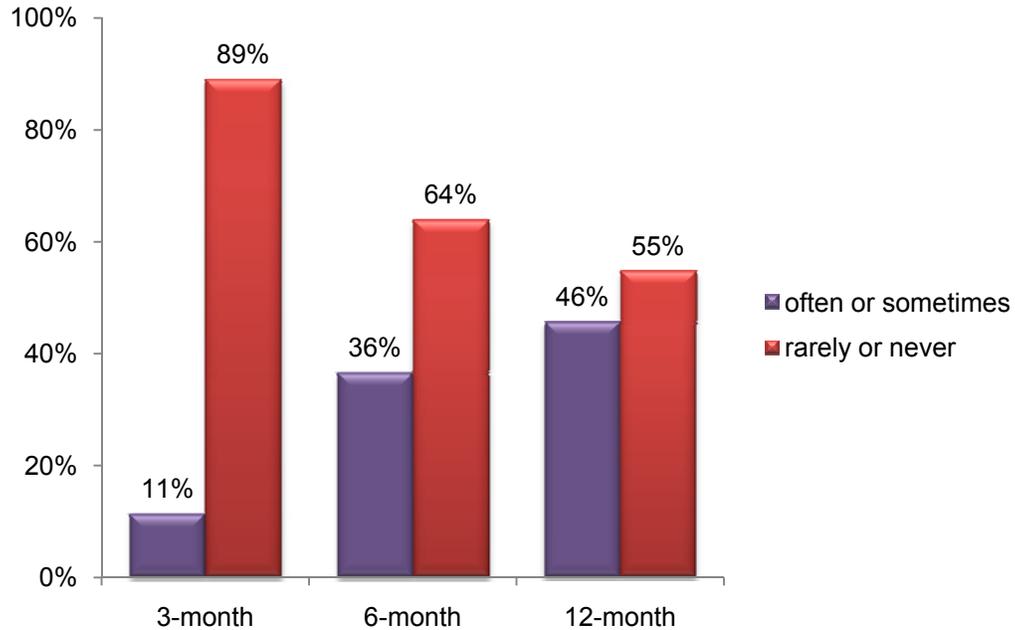
(n=20) at 12 months. Overall, consumers were more positive about the adequacy of their employment plan halfway through the program, at 6 months, than at 3 or 12 months (Figure 23).

Figure 23. Adequacy of employment plan (strongly agree or agree)



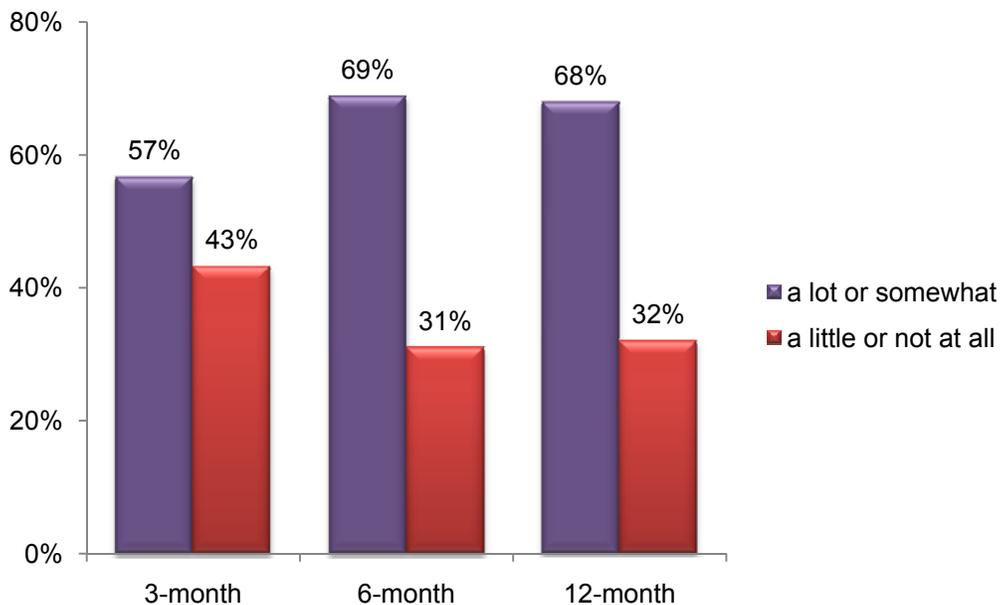
Some consumers did not have a LMHA employment specialist. Of those who did have a LMHA employment specialist, over half of the respondents at 3, 6, and 12 months said that they rarely or never got conflicting or different advice about working from either their BRS counselor or their LMHA employment specialist. As the program progressed, however, some participants experienced receiving conflicting or different advice about working, 11 percent (n=2) at 3 months, 36 percent (n=4) at 6 months, and nearly half (46%, n=5) at 12 months (Figure 24).

Figure 24. Conflicting or different advice about working



Finally, respondents indicated how much working with their BRS counselor had helped them to meet their employment or career goals. At all interviews, the majority of respondents agreed a lot or somewhat that working with their BRS counselor helped them meet their employment or career goals, 57 percent (n=21) at 3 months, 69 percent (n=20) at 6 months, and 68 percent (n=17) at 12 months (Figure 25).

Figure 25. BRS counselor helped consumer meet employment or career goals



### Helpfulness of BRS counselor

Respondents were asked several open-ended questions at the end of the telephone interview. The first question, "What has been especially helpful for you in working with your BRS counselor?" was asked to gain useful feedback for counselors. Eighty-nine percent of responses were very positive and demonstrated how appreciative consumers were of their counselor's expertise and support.

*[Counselor's name] taught me how to believe in myself and tighten up my skills and be more open with my employers and she gave me a lot of confidence. This has gone along ways in helping me be a better worker.*

*[Counselor's name] is very supportive and aware of my efforts to find a job. She has very good clinical skills and is able to discuss my overall health picture with me and is insightful. She's quite available and shows concern, which means a lot to me.*

*[Counselor's name] keeps it real and tries to dig deep. She shows both sides of the coin and advises me about positive and negative aspects of different work or learning situations.*

*[Counselor's name] creates little projects (e.g., revising my resume) for me to do and I do what she suggests. Then we meet to talk about my progress. This process helps provide me with structure in preparing for employment.*

Clearly, respondents valued specific kinds of assistance that counselors provided during counseling sessions.

*[Counselor's name] helped connect me with a lot of resources that were helpful and she taught me how to find out information I was seeking.*

*She's helped me decide what I want to do and has helped me pinpoint my interests and goals.*

*[Counselor's name] gives me direction. She's so very positive and makes everything sound possible.*

*[Counselor's name] helped me apply for a motor vehicle license and helped me know what to expect and to be successful. She's concerned about me, asks me how I'm doing, and makes sure I get my hours at the job I have now.*

*[Counselor's name] got me connected with CTWorks to go for my CNA license.*

*[Counselor's name] helped me find a school and encouraged me to register for training. She helped me get this far and has encouraged me to stay away from drugs.*

*She listens to me and has helped me with my search for an internship. She looked into a lot of internships until she found one that was good for me. She persevered a lot and that's how I got the internship I have now and I love it.*

*[Counselor's name] helped me see the potential I have to start my own business and has helped me learn how to tap into areas that might help me star my own business.*

Eleven percent of responses during the three different interview periods were unable to describe any areas in which counselors had been helpful or were unsure how much help their counselor provided.

*I can't think of anything. I didn't work with her for very long and the job I had was one I got on my own before working with her, so she never helped me get anything better than what I'm doing now.*

*I'm not really sure that [Counselor's name] has been at all helpful. I don't feel like we got anywhere. She wasn't available as much as she could have been when I was unemployed.*

#### Additional employment support or assistance

The second open-ended question, "What additional support or assistance would be helpful for you?" was asked to gain a better understanding of how support services could be improved. Half (50%) of the responses suggest that respondents would like to have additional education and financial aid, training on how to use the computer, or assistance to improve specific skills in preparation for looking for employment.

*The education and financial aid are what I need most right now.*

*I want to go back to school and get more education.*

*I could use more support in utilizing the computers and internet.*

*I need to learn the computer so I could use help to learn the basics in computer...a class or individual help...either one is good for me.*

*I could use help with interviewing skills and job search skills.*

*I really think I need help with applying for jobs on the internet and then following up on the ones I apply for. It's different when it's online and I'm not always sure what I'm doing.*

*Being equipped to go out on my own to look for work without the help of a job coach. I think having a job coach is detrimental sometimes because then people who are thinking of hiring you know you have a mental illness and are wary about hiring you.*

*I'd like to get more training so I can pass the certification test to do peer mentoring in a competitive wage position or get a job in Human Services.*

In ten percent of responses, individuals indicated that they would like to meet more frequently with their counselor than they've been doing or to continue having joint meetings with their counselor and employment specialist. In some cases, respondents mentioned that they would like the opportunity to continue meeting with the employment specialist.

*I'd like to meet with [Counselor's name] more often. Right now we only meet about once a month. It would be helpful to meet 2-3 times a month.*

*It would be helpful to continue meeting with [Counselor's name] and my Employment Specialist. [Counselor's name] supervises my Employment Specialist and checks to make sure she is setting up job interviews for me. The way it works now is helpful and I just hope I can keep this level of support.*

*The employment specialist has been very helpful and I would like to continue with this assistance in the future.*

Five percent of responses indicate that respondents need transportation that is more affordable and accessible.

*I could really use reliable transportation that's cost effective and not a hassle to deal with.*

*I can't get a job because I lack transportation. I'm not on a public bus route.*

In another five percent of responses, respondents expressed a need for legal advice and help in getting a criminal record expunged.

*I need legal advice and help getting a criminal record from a long time ago expunged.*

*I'm trying to get a pardon, but in the meantime there's no local chapter that can help me with this...the nearest is in New York.*

A few responses (3%) suggested that it would be helpful to have an internship in order to gain experience in a particular area.

*It would help if I could get an internship.*

*I would like to have an internship to get more experience, but that hasn't worked out yet.*

Twenty-seven percent of responses indicated that consumers felt the program was meeting their needs or they couldn't think of any additional employment support or assistance that would be helpful.

*I'm thankful for all the help I'm getting and don't need anything right now.*

*Everything is fine. I can't think of anything I need help with at this time.*

### **Counselor Survey**

BRS liaison counselors conducted interviews with clients at 3, 6, and 12 months. Unlike the UConn evaluators, BRS counselors interviewed individuals who were both participating and not participating in the UCHC evaluation of the program. This included the 14 participants who were in the intervention but who were not part of the evaluation. Counselors asked similar questions in the Counselor Survey to those asked in the UCHC Consumer Survey. Similar questions about work history were asked to capture the perspectives of those people who did not agree to be in the evaluation component but were included in the intervention. In addition, similar questions were asked to see if consistency in responses were demonstrated across interview types (e.g., UConn evaluators and BRS counselors). In addition to asking about their

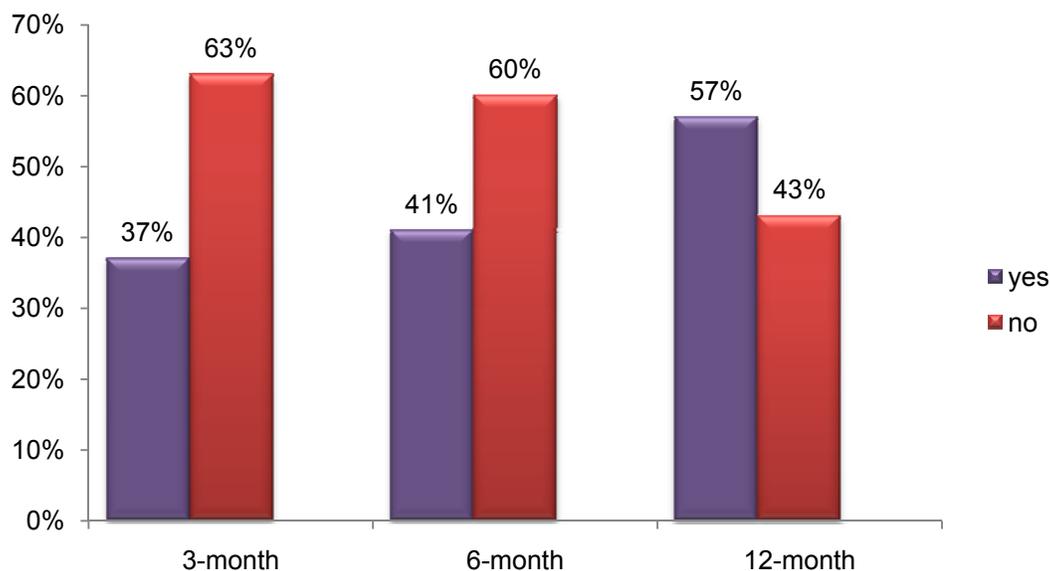
client's work history, counselors collected data on benefits counseling, education, DMHAS enrollment, job match, speed of movement through the BRS/DHMAS systems, and BRS employment services (e.g., job shadowing, volunteer work, informational interviews, etc.).

Overall, Counselor Survey results are consistent with those of the Intake or Baseline Survey and the Consumer Satisfaction Survey. Any differences that exist between the two surveys will be noted throughout the following results.

### Work history

Participants were asked about their current work situation and whether or not they were working. As in the Consumer Survey, "work" or "job" was defined as "paid employment in an integrated setting for competitive wages which are comparable to that of others doing the same job." Less than half of clients responded that they were currently working in the first two interview periods, 37 percent (n=20) at 3 months and 41 percent (n=17) at 6 months. At 12 months 57 percent (n=16) reported currently working (Figure 26). Compared to the Consumer Satisfaction Survey results, more clients reported working in the Counselor Survey. This difference is most likely due to those clients who did not participate in the evaluation and who were working.

Figure 26. Currently working



In addition to keeping track of the particular job position and the name of the company that participants were working for, start date and end dates were recorded by the BRS counselors as part of their client's work history. Counselors tracked this information at 3, 6, and 12 months. During that time, counselors listed an employment start date for 29 clients. Most of these clients were working in sales or related work at grocery or department stores. Other clients reported working in child care or in food preparation in a restaurant. Several clients were employed by Catholic Charities or Goodwill Industries, and a few clients had their own business. One person had a temporary position with the Census Bureau.

Of the 29 clients who were listed as having employment start dates, only five also had employment end dates (Table 7). Length of employment is calculated in months. These clients worked from one to six months with the average length of time being 3.2 months.

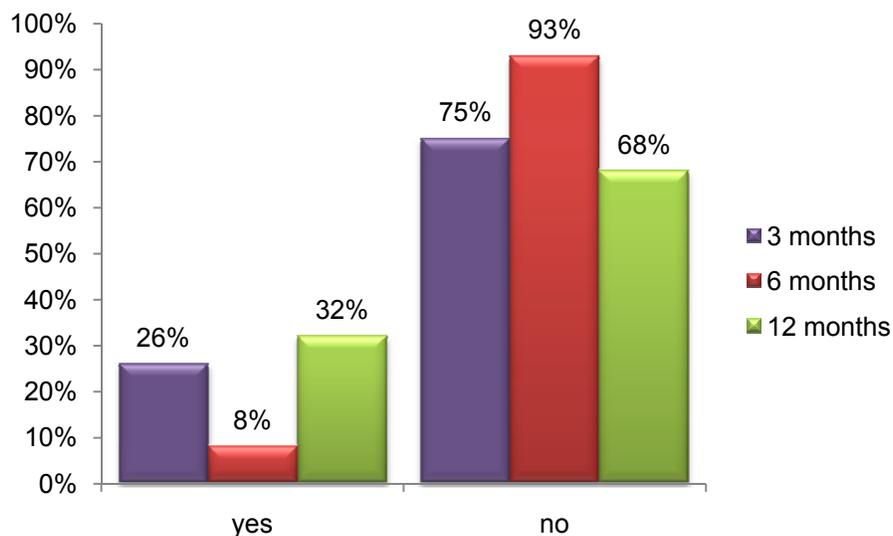
Table 7. Length of employment

Job	Start date	End date	Length of employment in months
Home health aide	12/1/2008	5/27/2009	6
Cashier	7/8/2008	10/8/2008	3
Tutor	12/1/2009	4/30/2010	5
Office clerk	7/1/2009	8/1/2009	1
Census taker	5/15/2010	6/15/2010	1

Benefits counseling

During interviews, clients were asked if they had taken advantage of any benefits counseling over the past three months. Most of the participants indicated that they had not received benefits counseling in the past three months, 75 percent (n=38) at 3 months, 93 percent (n=37) at 6 months, and 68 percent (n=17) at 12 months (Figure 27).

Figure 27. Had benefits counseling in the past 3 months

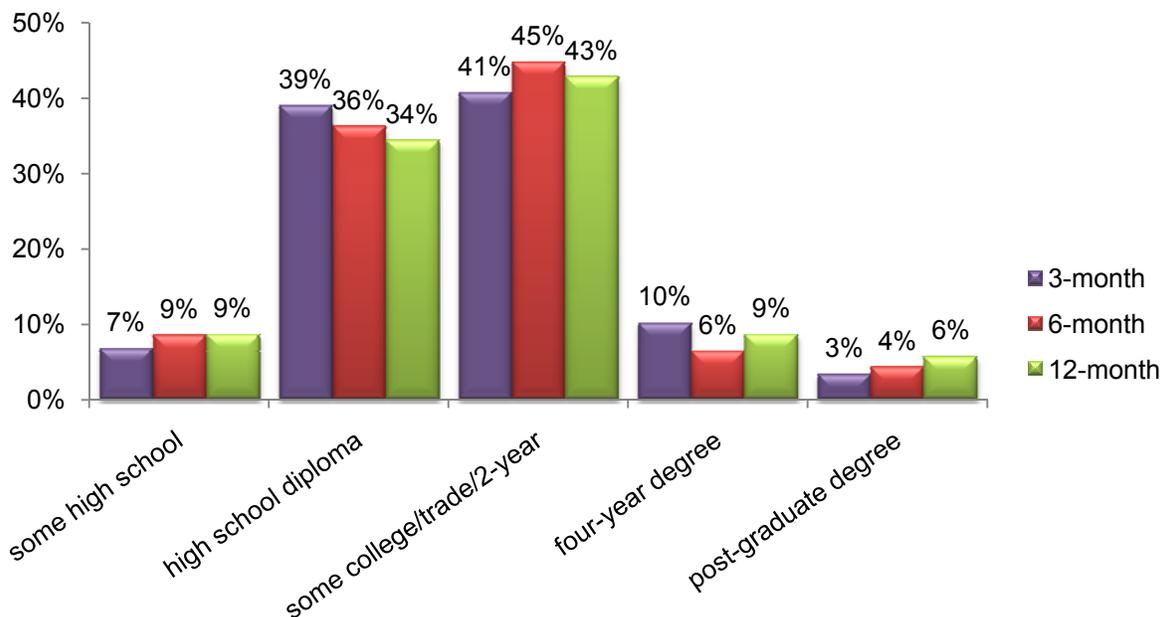


Education

BRS counselors continued to obtain information after the initial Intake Survey about the education of participants and other demographic information pertaining to education, such as what type of educational program participants were enrolled in (e.g., GED, two-year college degree, etc.). Results show that about one-third of the individuals had either a high school diploma or GED, 41 to 45 percent had some college, a two-year college degree, or

trade/technical or vocational training, 6-9 percent had a four-year degree, and 3-6 percent had a post-graduate degree (Figure 28).

Figure 28. Education



Of those who reported still being in school (n=10), four individuals indicated that they were currently in either a two- or four-year degree program and 6 were in a certificate or licensure program (Table 8). The certificate or licensure programs included computer or research training, the DMHAS peer support certificate, and the Marrakech Human Services Program. At the time of the Intake Survey, fewer respondents were enrolled in a degree, certificate, or licensure program. During counseling throughout the program, however, more individuals indicated an interest in and commitment to furthering their education in preparation for employment.

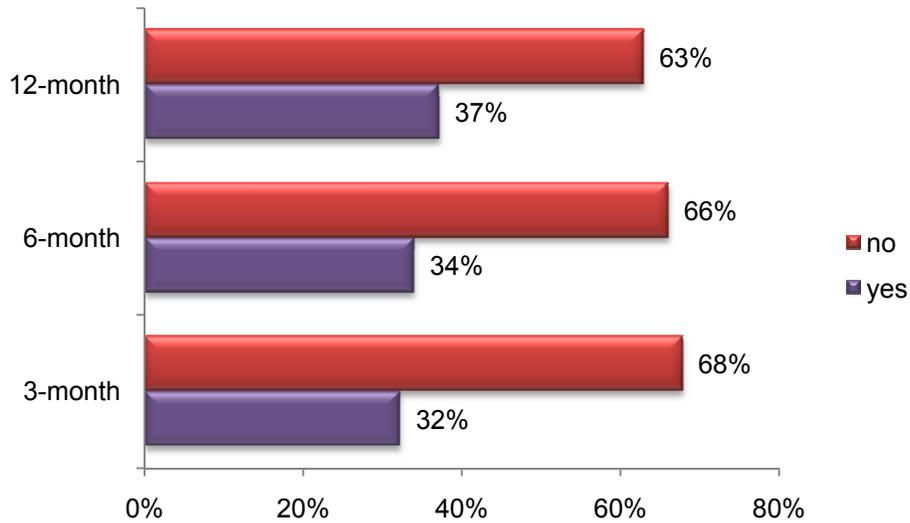
Table 8. Type of degree, certificate or licensure program

	% (n)
Two-year degree	30 (3)
Four-year degree	10 (1)
Certificate or licensure program	60 (6)

DMHAS enrollment

Information about whether the client was working with a DMHAS employment specialist was also obtained by the BRS counselor. During the course of the project, about one-third of the participants were working with a DMHAS employment specialist in addition to the BRS counselor (Figure 29).

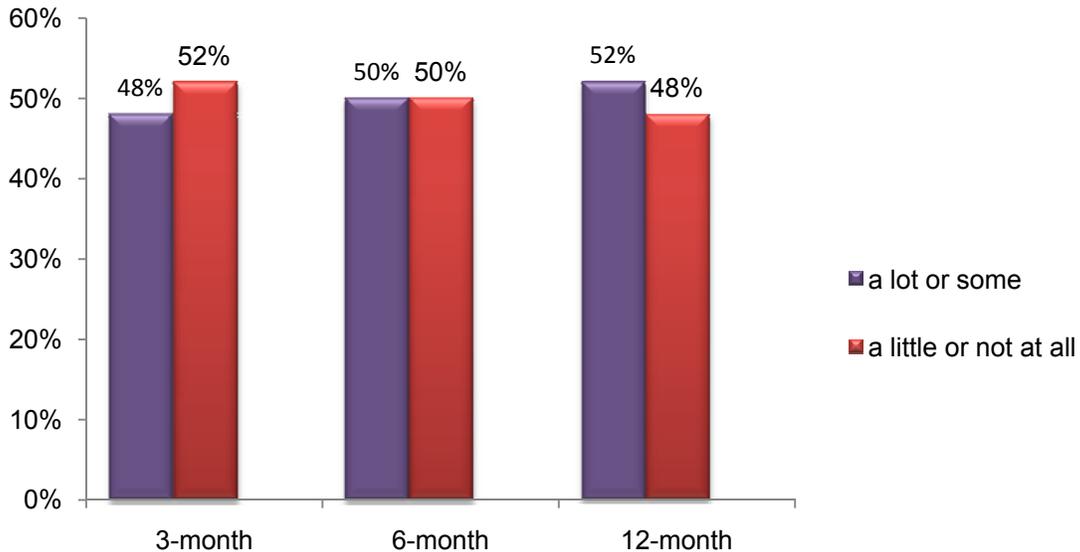
Figure 29. DMHAS enrollment



Job match

BRS counselors acquired information from clients as to how much their current or most recent job matched their interests. At 3 months, nearly half of the respondents (48%, n=10) felt that their job matched their interests, either a lot or some. At 6 and 12 months, half or more than half felt that their job matched their interests, either a lot or some, 50 percent (n=8) at 6 months, and 52 percent (n=11) at 12 months (Figure 30).

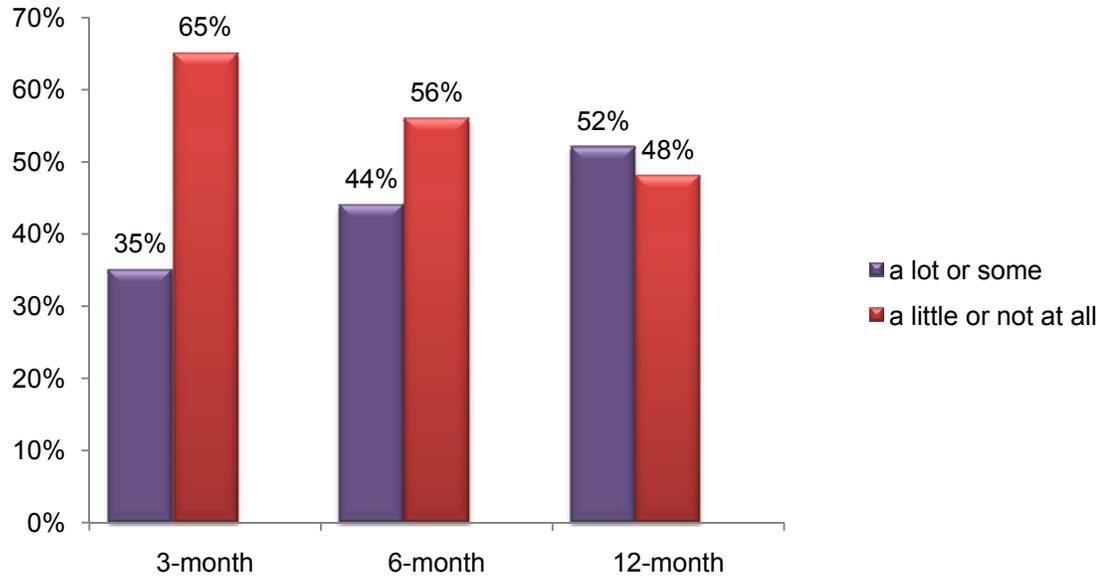
Figure 30. Current or most recent job matches interests



Program participants were also asked how much their current or most recent job matched their personal career goals. Only about one-third of the participants (n=11) responded that this was true, either a lot or some, at the time of the three-month interview. By the final interview at 12

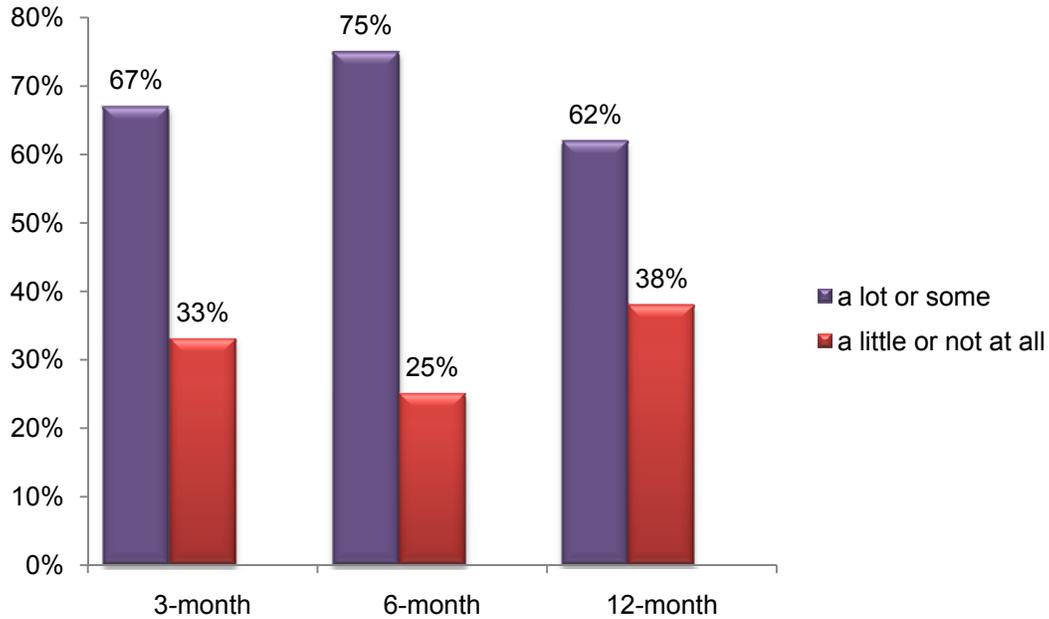
months, fewer participants felt that their current or most recent job matched their career goals, 52 percent (n=7) (Figure 31).

Figure 31. Current or most recent job matches career goals



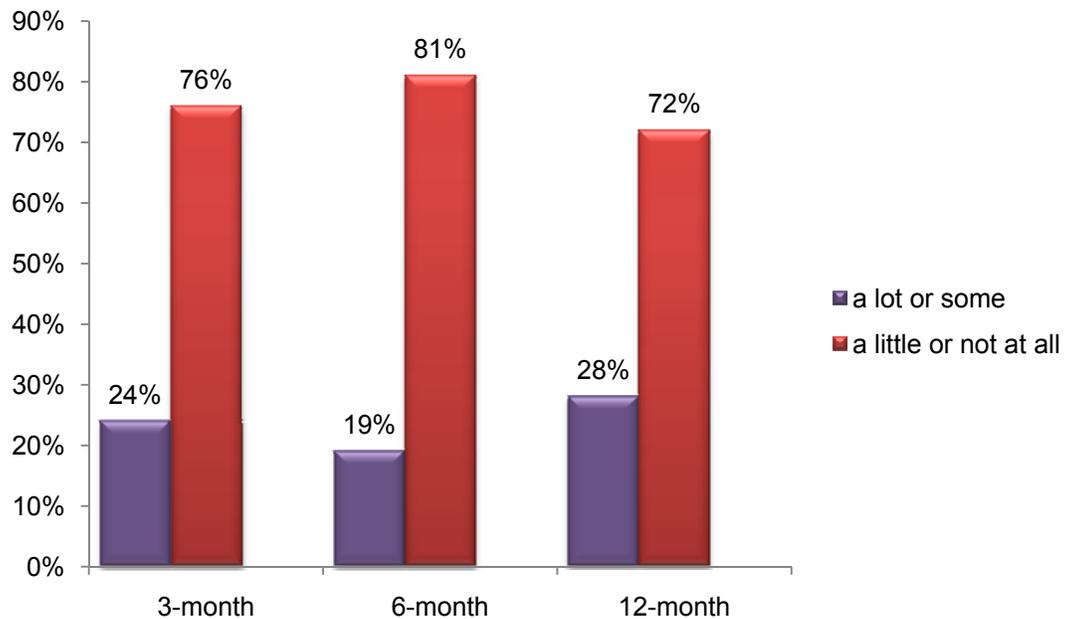
The majority of participants felt that their talents and abilities were well utilized in their current or most recent work situation. More than half of the participants reported that their job required them to use either a lot or some of their talents and abilities, 67 percent (n=14) at 3 months and 75 percent (n=12) at 6 months, and 62 percent (n=13) at 12 months (Figure 32).

Figure 32. How much current or most recent job requires client to use talents and abilities



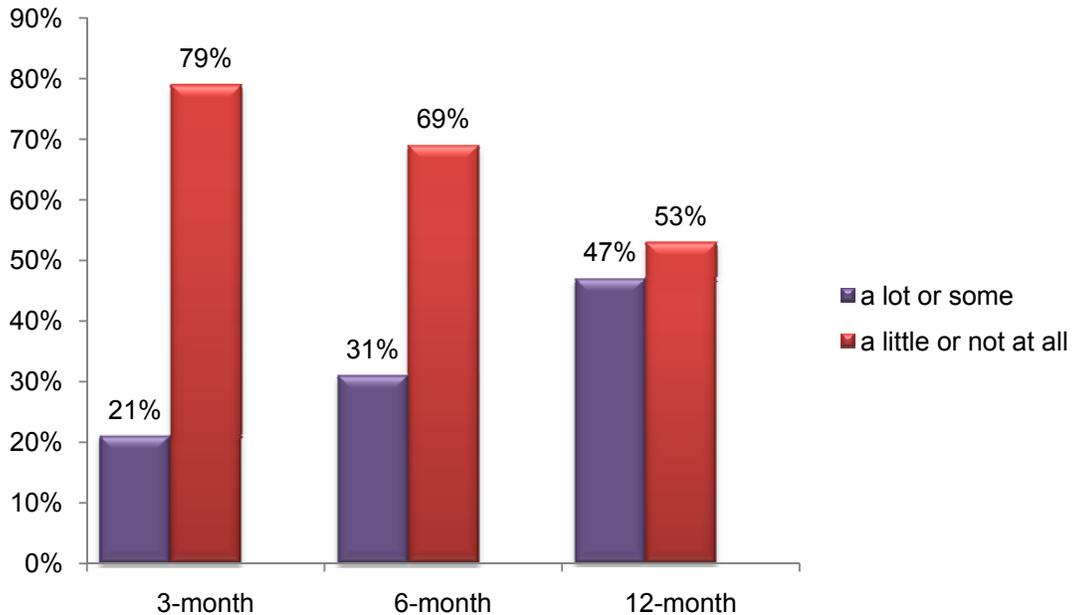
Information regarding how much other aspects, such as co-occurring disability and symptoms, are factored into the client's current or most recent job match was also sought. Less than one-third of the participants felt that these other aspects, either co-occurring disability or other symptoms, had been factored into their current job match either a lot or some, 24 percent (n=5) at 3 months, 19 percent (n=3) at 6 months, and 28 percent (n=5) at 12 months. More than half of participants indicated that these other aspects had been factored into their current job match only a little or not at all, 76 percent (n= 16) at 3 months, 81 percent (n=13) at 6 months, and 72 percent n=13) (Figure 33).

Figure 33. How much other aspects are factored into the client's current job match



Participants were asked if there was an improvement in the job match between their current or most recent job and their previous job. Most participants felt that there was a little or no improvement in their job match between their current or most recent job and their previous job, 79 percent (n=11) at 3 months, 69 percent (n=9) at 6 months, and 53 percent (n=8) at 12 months. However, the number of individuals who saw improvement in the job match more than doubled from 3 months (n=3) to 12 months (n=8) in the program (Figure 34).

Figure 34. Improvement in client's job match



Speed of movement through BRS/DMHAS systems

In order to evaluate the speed at which clients moved through the BRS/DMHAS systems, the date of entry into the BRS system was compared to the following:

- Date of eligibility determination for BRS services
- Date of BRS employment plan completion
- Date of initial employer contact (when client first met with employer)
- Date of job placement
- Date of school placement, if any
- Date of termination of employment service, if terminated

The results for speed of movement through the BRS and DMHAS systems are calculated in days. On average, the transition from entry to date of eligibility took 19 days or nearly three weeks. For 31 individuals, transition from entry to date of BRS employment plan took approximately 88 days or twelve and a half weeks. For those in the program who had an initial employer contact, it took about 160 days or 23 weeks from entry. Fewer individuals (n=16) had job placements, but for those few who did, it took on average 204 days or 29 weeks from date of entry into the program. Those moving through the system from entry to date of termination of employment service took on average 352 days or nearly a year (Table 9).

Table 9. Speed of movement through the BRS and DMHAS systems

	n	minimum	maximum	mean	Std. dev.
Entry to date of eligibility determination	58	0	379	19.12	53.79
Entry to date of BRS employment plan completion	31	0	332	87.71	87.147
Entry to date of initial employer contact	21	7	324	160.10	104.209
Entry to date of job placement	16	36	367	204.31	117.27
Entry to date of school placement	4	82	518	362.50	200.394
Entry to date of termination of employment service	5	109	801	351.80	277.827

BRS counselors also reported the number of employer contacts made on behalf of the client, including face-to-face contacts, e-mail, and telephone contacts over the past 3 months. The results are shown as a mean summary score for each time point (Table 10).

Table 10. Number of employer contacts over the past three months

	n	minimum	maximum	mean	Std. dev.
3 months	59	0	16	2.25	3.335
6 months	47	0	15	2.02	3.117
12 months	35	0	15	2.43	3.398

### BRS employment services

BRS counselors used a number of different employment services and encouraged enrollees to use any of the following as needed: job shadowing, volunteer work, informational interviews, work evaluations, and internships. The most frequently used employment service was informational interviews. Fourteen participants took advantage of this service by the time of the 3-month interview, 12 participants utilized this service between the 3-month interview and the time of the 6-month interview, and 10 respondents used this service between the 6-month interview and their 12-month interview with the BRS counselor (Table 11).

Table 11. BRS employment services utilized

	3 months n	6 months n	12 months n
Job shadowing	1	1	1
Volunteer work	0	0	0
Informational interviews	14	12	10
Work evaluations	2	2	4
Internships	1	1	1

**Program Evaluations**

In addition to the Intake and Counselor Surveys, BRS counselors each completed a total of 8 Program Evaluations. During the 8 reporting periods, these evaluations tracked the frequency of interagency communication including:

- Number of referrals from the BRS counselor to the DMHAS employment specialist
- Number of referrals from DMHAS to the BRS counselor
- Number of referrals from DMHAS to the BRS counselor that were not opened
- Number of positive closures
- Number of negative closures
- Date of termination of employment service, if terminated
- Number of times the BRS counselor provided consultation services for the DMHAS treatment team members on cases he/she did not open

During the course of the program, a total of 53 referrals were made from the BRS counselor to the DMHAS employment specialist. Counselors reported that they opened a total of 80 cases. Referral to the BRS counselor from DMHAS that were not opened comprised 38 cases. Counselors reported they had 10 positive closures. Positive closures occurred when the client achieved his/her vocational goals and is listed as a “26” in the BRS data coding system. There were 45 negative closures. These occurred when cases were closed for any other reason (e.g., client was no longer interested in working, client wanted to pursue more education, client moved out of state or was unreachable, etc.). BRS also provided consultation to DMHAS treatment team members 81 different times on cases that he/she did not open (Table 12).

Table 12. Frequency of BRS/DMHAS communications

Evaluation due dates	Referrals	Cases opened	Referrals from DMHAS not opened	Positive closures	Negative closures	BRS provided consultation
9/30/2008	6	9	11	2	3	13
12/21/2008	6	15	3	0	5	7
3/31/2009	3	11	2	2	11	11
6/30/2009	11	8	6	0	2	9
9/30/2009	5	11	4	1	6	8
12/31/2009	7	9	6	5	9	13
3/31/2010	6	7	3	0	6	9
6/30/2010	9	10	3	0	3	11
Totals	53	80	38	10	45	81

In addition, BRS counselors rated the quality of interagency communications, or teaming, between BRS and DMHAS. During program evaluations, teaming was most often rated as good (2) and on a few occasions as fair (3) (Table 13).

Table 13. Quality of teaming between BRS/DMHAS

n	Minimum	Maximum	Mean	Std. Deviation
16	2	3	2.19	.403

Comments included at the end of the program evaluation indicate that overall teaming with DMHAS went well. Counselors mentioned several opportunities during which they worked closely with employment specialists to help a client. For example, in one case, BRS developed an on-the-job training for a client while the employment specialist provided job coaching and took the client to work until a bus pass could be provided for the individual.

During the program, counselors often consulted with clinicians regarding the process and benefits of referring new consumers to BRS as well as more specific communications regarding individual consumers. Sometimes issues, such as how to provide long term supports, had to be resolved. Other challenges that were faced and resolved involved working with employment specialists and some of the private non-profit agencies (PNPs help individuals find jobs and provide job support as needed) they work with to help them access BRS services, while adhering to the Dartmouth University Center for Evidence-Based Practices that DMHAS uses to work with people with severe mental illness and substance use disorders. In addition, counselors worked closely with clinicians when clinical intervention was needed. For example, in one situation when a BRS counselor was unable to reach a client, she contacted the clinician who was able to get in touch with the client.

## **Program Implementation Process Evaluation**

### **Methods**

To augment data from the surveys and meet process evaluation goals, data was collected from one focus group, 18 key informants, and 15 BRS and DMHAS project quarterly meeting minutes. Nine people participated in the focus group in Bridgeport and included both BRS and DMHAS staff representing directors/supervisors, clinicians, employment specialists, and vocational rehabilitation counselors. Key informants represented program staff from three different regions, with more emphasis on the Hartford and New Haven regions. The reason for this particular emphasis was that many of the key individuals in the Bridgeport region had participated in the focus group. Due to lack of participant availability, focus groups in the Hartford and New Haven regions were not held, hence the stronger representation of individuals from these areas in individual key informant interviews. As in the focus group, key informants represented BRS and DMHAS staff including directors/supervisors, clinicians, employment specialists, and vocational rehabilitation (liaison) counselors. Quarterly project minutes were from December 2006 through April 2010.

Questions for both the focus group and the key informant interviews were similar (see Appendix E and F for a copy of the focus group and key informant interview questions). The questions were formulated to determine how clients enroll in the pilot program, to examine what client characteristics make the program more successful, how duplication of services is avoided between BRS and DMHAS, and what benefits can be obtained for both the clients and clinicians. In addition, specific questions focused on specific program successes and barriers to success, both for the program and for the individual consumer. Data gathered from the focus group, key informant interviews and meeting minutes were analyzed using the constant comparative technique of Glaser and Strauss (1967) and resulted in the twelve themes listed below.

### **Results**

Qualitative data from the focus group and interviews are presented in this section as themes and include the following:

- Program goals
- Program training and solicitation
- Basic differences between BRS and DMHAS
- Program successes
- Components of collaboration
- Areas of successful collaboration
- Client characteristics
- Barriers to employment for clients
- Removing employment barriers
- Characteristics of BRS liaison counselor
- Program difficulties
- Suggestions for improving the program

#### **Program goals**

Early on in the program, BRS liaison counselors identified potential categories of consumers to guide the liaisons' decisions regarding when to open cases (vs. consult on cases) based on those that are the best match with BRS services. Categories included those who are working or

with extensive work experience (e.g., served by a maintenance team), those not working but with limited work experience (e.g., those served by a crisis team), those who have had sporadic work experience, those who haven't worked, and young adults. It was suggested that the BRS liaison work with DMHAS to triage individuals wanting employment services to the appropriate agency. Those who were ready for more significant employment (e.g., wanting to work, having successfully managed their symptoms in a position with limited hours) would be targeted for BRS services. For those not yet stable in their recovery (e.g., needing continuing engagement and/or high levels of supports, wanting to work only very limited hours) the liaison might consult on the case but not yet open it. This would tap the expertise of both agencies; DMHAS employment staff would engage and assist individuals with initial job placements and retention while the BRS liaison could offer a more advanced selection of career development services. Follow-along supports would come from the DMHAS treatment team.

### Program training and solicitation

During the beginning of the project, BRS liaison counselors discussed the importance of ongoing integration with DMHAS staff to develop relationships with key people and to strengthen the teaming process and solicitation of program participants. Attendance at monthly team meetings to do updates and get input on shared cases was also encouraged. It was decided that for people who self-refer from within the LMHA, the liaison counselor would solicit a referral packet through DMHAS or could choose to redirect the consumer back to his/her clinician for a formal referral (or to continue working with DMHAS employment staff). For those who contacted BRS directly, staff decided to attempt to determine on the phone or at orientation if they were DMHAS clients. Those individuals were referred to the liaison, who would then solicit the referral.

BRS liaison counselors were encouraged to work closely with an Employment Specialist whenever they were involved and with clinicians seeking their input on employment decisions. It was deemed important that counselors take on a consultant role for clinicians in order to help them decide the best time to open a case. Early counselor activities involved linking with individual DMHAS teams as well as with the larger agency itself and doing a work evaluation if it was unclear whether or not a person was ready to work. Counselors were prepared to play a key role in helping clinicians see where the best service matches were so they could pursue a more beneficial sequence of services for clients. Engagement is critical for good vocational rehabilitation and counselors were aware of the importance of listening, affirming, and offering support. One BRS liaison counselor shared her checklist of BRS readiness attributes with other counselors suggesting it was helpful in defining appropriate referrals. The checklist also allowed her to discuss what an individual might do in the interim to prepare for BRS and strengthened communication strategies.

### Basic differences between BRS and DMHAS

One of the most evident themes emerging from the focus group, key informant interviews, and project quarterly minutes was the inherent differences between BRS and DMHAS in how employment is approached. BRS's goal is vocational rehabilitation while the DMHAS Employment Specialist's role is job placement and retention. One system meets short-term goals while the other one focuses on long-term planning including career development. Most respondents agreed that the BRS system involves a more lengthy process, but has more resources and funding available to do job assessments/evaluations and offers more opportunities for skill development or going back to school. Respondents suggested that BRS is more concerned with a goodness of fit between clients and their potential employment and

usually works with higher functioning clients than DMHAS. For example, BRS looks at the client's disability and how it affects their ability to work, while also looking for accommodations for that client.

Respondents describe the DMHAS system as one that is more focused on finding and retaining a job for the client. The underlying principle that DMHAS uses for its guidance is the evidence-based model of employment. In this model, mental health treatment teams and vocational rehabilitation specialists help an individual find and keep a job as soon as the client expresses an interest in doing so. While this proactive model has demonstrated effectiveness in helping many people with severe mental illness work their way toward newfound independence and enabled them to achieve their goals, it is a different approach from that used in the BRS system.

*The difference between myself and the employment specialist, is that I am looking more towards a career, so I am looking more longer term. If they need a job to pay their rent tomorrow, I'm not it. But also, sometimes folks will refer for an evaluation, and if all they need is an evaluation, that's not really what BRS does – we're more longer term than that.*

*At BRS, we have to make sure that the employment is consistent to their disability related needs, their concerns and difficulties and that it is going to be a good match. Because sometimes, there was a huge need of collaboration where we could say yes go ahead if you need to do this for your program, for rapid placement. But when it comes to actual placement in the long-term, we will have to make sure that the job is consistent with their disability related needs.*

### Program successes

Program successes were evident wherever the program was working well. Whenever communication and collaboration were strong, successes of the program were forthcoming, not only for the benefit of the client, but also for the benefit of those staff members taking full advantage of the opportunities offered from BRS. Involving professionals from two different systems, both working toward a common goal for the benefit of the client, proved to be advantageous.

*Well I think that one of the biggest advantages [of the project] was that it reduced the confusion and it was not like, why am I working with this agency and not that agency. The fact that we were all communicating, we were able to jump in and address different needs. So I think that that was the best part.*

*I think if somebody were coming just through BRS and had a serious and persistent mental illness, it would be very difficult for them to feel that there was coordination and that all the people that were working with them were supporting common goals, and so either side could be undermining the goal of employment... When you put that whole system together and you get a more intentional set of activities that are going to be coordinated by various or different agencies but hold together into one piece and all support the goal then I think these clients are much better off and it adds opportunities.*

Many of the DMHAS informants recognized the special resources available through BRS that weren't accessible prior to the collaboration. For example, the opportunity to have a work assessment and/or skills training was seen as a huge advantage for the client.

*I think that BRS' job assessment thing is awesome. Because a lot of the people that we work with are – the people that we work with, the population is mentally ill, sometimes dual diagnosed, drug and alcohol addiction and all that. And quite often, due to that, many of them have long lapses in their employment. And getting back into the workforce is stressful for anyone. And the fact that BRS offers this program of assessment where they can, you know, go into a position temporarily, feel what it is like to work, and get there in the morning and get out at night, and feel accomplishment, I think is very positive. I think that is an awesome program.*

*I think they're able to access a wider range of services and resources – being evaluated, looking at job readiness and what not – I think that's a valuable connection for people to make. The ability to review benefits with someone who really knows the facts about it.*

Not only were the clients able to benefit from the additional BRS resources, but some DMHAS employment specialists and clinicians were able to take advantage of and share in the benefits of these resources. Because of funding limitations, certain resources are not available for clinicians but by utilizing BRS services, it makes it more possible for client goals to be accomplished.

*DMHAS will never be able to help a person get a driver's license or go back to school or do some of the job tryout work that are very labor intensive because they just aren't staffed to do that and they don't have money to do that so I think for a clinician it really expands the range of services and if it's done well encourages more intentional conversation about how do we coordinate, what's everybody's role in making this work. I felt that my vision was really limited and what options were available, how people could move toward the success they had in terms of their dream, and because of BRS's ability to tap into different kinds of resources, it really opened up so many more doors that I had no idea were available.*

### Components of collaboration

Good communication was viewed by liaison counselors as the most important component of a strong collaboration and is based on a strong rapport between staff that has developed over several years of joint service. It was recognized that a lack in this component resulted in fewer program successes in other regions of the state. Communication was definitely enhanced by the physical presence of the BRS liaison counselor being embedded within the LMHA building. For those who achieved this maximum presence, communication flourished.

*[A]s long as everybody works together, and everybody knows what services there are – then that helps to remove the barriers right away. For my purposes here, it's very easy to do a referral to me. All they have to do is pick up the phone – I'm right here. Once I have the referral, I can just walk downstairs and get the records. So that makes life easy. If I were across town in the other office, it might take a long time to get an appointment, it might take a long time, if they have to send me the records – that might take a while. ... Those were potential barriers that don't exist by my being here.*

For most LMHA staff, accessibility of the BRS liaison counselor made it easier for collaboration and communication to occur.

*I usually drop it off in [the liaison's] mailbox, and they are going to sign a release from BRS and the process happens very quickly which is a huge advantage. I remember the time when BRS was not located in this building, and we had to send the referral to BRS, the process was very complicated, difficult to just make all of those arrangements. You can see the comparison with [the liaison] being here.*

*[The liaison counselor] makes it easy to do. She's very accessible to the clients that we deal with here. It really has made a significant difference having her here on the site. The big difference that I see is that [the liaison counselor] is part of the team, not an outside provider so, as I mentioned earlier, she is easily accessible for when we need her. But she is part of us now. It makes such a huge difference when working with the consumers.*

Some regions had difficulty in establishing the liaison's physical presence due to lack of office space or other physical plant issues. While this proved to be a detriment to the success of the project in certain regions, it was obvious to all participants how important that physical presence was.

*And to make sure that the counselor is getting out there to the teams – meeting with the groups. That they are getting the information directly from us. And just having a presence that is consistent. I just think that it is very important.*

Effective communication involved meeting regularly with teams to identify and map the steps that are needed for teamed services (e.g., what information is needed when, who's going to attend which meetings). These maps were useful in guiding communication and were referred to at subsequent team meetings. Developing checklists that outline what to expect from BRS services as well as guidelines (e.g., having clear employment goals) for DMHAS staff to help them prepare individuals for meeting with BRS was also considered part of educating the teams. At least one liaison counselor sent out announcements of job openings to the employment staff. This particular type of communication helped build the relationship between staff and opened possibilities for collaboration. Another liaison held bimonthly case conferencing meetings that included employment staff and external clinical and employment providers and found this to be an excellent way to build collaborative support while helping DMHAS providers learn about BRS.

*My presence at team meetings helps distinguish the roles of BRS and DMHAS employment staff, but also gives me an opportunity to communicate with other team members and reorient them on a regular basis regarding my role as liaison.*

Realizing that BRS and DMHAS have different perspectives on employment, some respondents suggested that individuals in both systems need to be flexible and learn to negotiate services effectively in the process of building relationships that are collaborative.

*Flexibility is required of the liaison staff, and it's important to try various approaches even if a counselor isn't sure of the outcomes.*

*Liaison counselors need to negotiate services and tread lightly to build relationships in order to establish a teamed approach to services. DMHAS staff are my key links with the teams, conveying information to and from the team and helping mobilize supports for clients as needed.*

*So, approaching it from the perspective – how can I make your life easier? Make the job easier for you and for the client, how can I help them? Because if ultimately, if we are all trying to help the client and the client does well, everybody wins.*

In one situation during the project, a BRS liaison counselor was involved in numerous interagency conversations to adjust services for a client who was changing his mind frequently about working. In conversations with the treatment team, all agreed that slowing down the process would be helpful for staff to better understand the client's situation, and also give the individual time to build resiliency. A possible "clash" of agency cultures was resolved in a way that honored the client's desires. The Employment Specialist helped the client find an immediate job and the case manager worked with him on the importance of moving at a slower pace and conducting a work evaluation to better understand his support needs. This situation showcases strong collaboration and underscores the importance of interagency teaming to address potential problems and develop common approaches.

In some regions the components of collaboration were lacking. Through no fault of any single individual, staffing issues frequently impeded the process in one of the regions and the program wasn't able to go forward.

*Building the relationship with the LMHA there was difficult and I was trying to work on that and obviously hoping to connect with some of the consumers there so I could introduce the pilot project to them, but it never actually got off the ground or came to fruition... I think it's important that things like being embedded are established as soon as possible.*

In another region, it was suggested that collaboration was hindered by several factors including lack of consistency in supervisory staff and having a regular physical presence at the LMHA.

*I think consistency in having a chain of command is number one. Also consistency in staff availability. It's hard to collaborate and cultivate relationships with other staff when you only are in the building once a week or less, like once a month.*

#### Areas of successful collaboration

The BRS counselor in Bridgeport is embedded within the LMHA and maintains an office on site. As noted previously, this is perhaps one of the most important factors for successful collaboration between BRS and DMHAS. Since DMHAS employment specialists and clinicians are not required to refer clients to BRS, it is important for the liaisons to provide evidence of what he/she can offer the clients. Having a physical presence on site enables this to occur with employment specialists and clinicians more frequently and with greater ease.

*It is important to bear in mind that the DMHAS employment specialists and clinicians are not mandated to refer to BRS as they are in some other states where BRS is a funding source. The employment specialist does not have to refer to us. ... The implication for us is that if we want the cooperation and referral from the individual employment specialist/clinician we have to give them a reason to refer to us and to work with us. When they see that it is in their self interest and the interest of their consumers to work with us then they will refer. We have to view them (the employment specialists and clinicians) as allies or even customers. In this instance we, BRS liaison, have two clients/customers – the consumers and clinicians/employment specialist.*

The BRS liaison counselor in Bridgeport developed a list of characteristics she found useful in building trust and developing a collaborative relationship with DMHAS provider staff. These are listed in no particular order of usefulness.

- Stay in touch and keep them in the loop. Let them know what we are doing with the client. Call them.
- Ask for their input.
- Offer to assist them with getting information, contacting an employer, a school, showing them how to do an informational interview, etc.
- Notify them if one of their clients opens a case with us without their knowledge.
- Be visible by attending their treatment meetings and social events (unit Christmas party or summer picnic).
- Help them to problem solve.
- Offer resources.
- Help their clients get jobs or training.
- Be open to trying new things – be flexible.
- When they do a referral, ask what they want for the client...are they looking for a work evaluation, on-the-job training, so we know if it's possible. If it's not something we can do, we can let them know so they are not disappointed and we can offer other alternatives.
- Get their input before referring the client to CRP [Community Rehabilitation Provider] so they don't think we are taking their clients away. See if they have a preference or if they want to do the work (evaluation, job developing, job coaching) themselves.
- Let them know when we have job leads for their clients.
- Let them know in word and deed that we want them to succeed and are here to help them.
- Use the language of recovery as much as possible.
- Most importantly, we cannot be as directional as we might with a CRP. We have to approach them from the spirit of collaboration if we want to them to work with us.

Some of the benefits of open communication and collaboration in Bridgeport helped strengthen the teamed approach and decreased the potential for duplication of services.

*So if I have a client with her who is looking for a position, I'll meet with that client the first week, she'll meet BRS the second week, and then the third week, we'll all meet – there is never really any gray area because we all keep in contact with each other, whether they are looking for a position or if they are already working.*

*I've been sending our liaison monthly updates on clients that we work with collaboratively – we meet together with the client so we know that we're not stepping on each other's toes or duplicating anything.*

*In some instances I might take the lead, and in some instances ... DMHAS took the lead, so it's just a lot of cooperation and open communication and it seems to work.*

Much of the emphasis of why there was a successful collaboration in Bridgeport focused on the desire of supervisors and staff of both systems to make it happen. Clearly seeing the benefits of the collaboration, supervisors in both agencies consistently reinforced the importance of the collaboration. The commitment and passion of these individuals towards helping the clientele they serve was the driving force for this effort. In addition, having a vision of success for the clients encouraged members of the team to work hard at making the program a success.

*I was in the role of clinician when [the program] was first established, and it was very clear from leadership that this was going to work. Failure was not an option. In a way that – you either jump on the bus or you get off. Because this is what we are doing – consumers are asking for – and it's our job to provide everything that we can to them. This is going to work.*

*It's also a big transition with our documentation, going toward recovery language, strength based methodology to a lot of – we were really moving towards evidence based practices and other realms – and it was just this huge commitment that we are going to move into recovery. ... Peer support was also embedded on teams, so people with lived experiences are also part of the team. That also exemplified a huge transition when you had someone who is very open about their lived experience and is now right in front of you as a colleague, participating in a manner that is effective in a multi-disciplinary team, exemplifies that employment can work for anyone. So it was all this stuff happening at once that really reinforced the successful outcomes.*

Although a BRS liaison counselor is no longer embedded in either Hartford or New Haven regions, liaison counselors who worked in those locations laid the foundation for collaboration between BRS and DMHAS and have many reasons to be optimistic that a teamed approach is still possible in the future.

*We were very impressed with [name] willingness not only to explain their program and some of its limitations, but really showing a willingness – despite some of the past history – a willingness to move forward and work with us. And I think that the picture is going to change a little bit – I don't know if we will actually have somebody embedded on site here in the future but all our teams know that there is still a go-to person there – someone who wants BRS services to be utilized. I feel like they are kind of heading themselves back in the right direction again.*

### Client characteristics

Information from the focus group and key informants key yielded some general information regarding the type of clients who might benefit more from the collaboration between BRS and DMHAS. Although one individual indicated that it had more to do with the motivation of any client, there were other characteristics of clients which might make them more responsive to the intervention by BRS. These characteristics included client follow through, their abilities, their symptoms, and compliance with treatment. Those clients who are consistent in showing up for appointments and do their part of the homework were reported to most likely benefit more from the program. Another important client characteristic mentioned by respondents was level of interest in employment and the existence of a good support system.

*A lot of basics – a stable residence, relatively stable resources available, some good supports either in the form of clinicians or family or friends, some level of previous work experience that could be built upon, at least an openness on the part of the consumer to look at the whole benefits picture and to feel comfortable meeting with a benefits or community work incentives coordinator.*

*I think the biggest thing that I found is the person being stable, both mentally and physically stable depending on the disability and if they are in treatment, making sure that they're adhering to their med program. If they're still actively in therapy, making*

*sure they're attending therapy on a regular basis as well as being committed to the process. In other words, are they open to coming to meetings on a regular basis, what is their level of motivation.*

*They persevere and have resilience. Positive reinforcement, that old model where one positive role model, one positive reinforcement in your life, family support, etc., makes a difference.*

### Barriers to employment for clients

Respondents also elucidated numerous barriers that have the potential to pose problems for a client. Some of these barriers are associated with client characteristics and include symptoms, lack of personal skills, inability to interact with people, and gaps in employment history. A client's consistency in keeping appointments, degree of follow through, compliance with treatment, and coming to terms with their history also impacts employment. Other barriers include felony conviction or concerns about benefits.

*There are so many [barriers]. I mean the illness itself is cyclical. Often that individual is stigmatized. His/her behavior, his looks, or background looks as though or makes an employer more distrustful or fearful about their ability to perform. Lots of the people in the DMHAS field are very limited in their education because the illness tends to become full blown around the time that people are college age and so you see a lot of people who never completed high school or dropped out of college in the first year. The whole thing around benefits. People are very fearful of losing benefits and even though there are systems in place that provide more of a safety net, they are still terrified to take the first step to be earning anything that might be significant funding. People around them don't think they can work, they don't have role models of people who can work. Many of the clinicians don't believe they can work and so a lot of them have spent so many years being dependent on the DMHAS system, on the clinician system, so there are lots of psychological barriers that keep people from self-identifying if somebody could work or would want to work. People are afraid of going out and being embarrassed out in the field or being seen to have mental illness. There's a lot of shame connected to that.*

Some individuals from the DMHAS system felt that one of the barriers for clients was the lengthy process of the BRS system, that the individual might become frustrated in the process of trying to go through BRS because of the added bureaucracy.

*... and I don't understand the full dynamics of working with BRS – but it also seems very evident that they have to look at the people again and get more documentation, you know, all that stuff, which I think is a waste of time. I mean the people are in the system, they are in the system and what we want to do is to help them get out of it, if they want that.*

In another region the feeling was quite the opposite. The fact that the BRS liaison counselor was embedded within the LMHA actually reduced the amount of paperwork and the time to process the individual.

*Without the collaboration, we have to get releases and send out releases to clinicians and then they send some information and we don't have information about their employment interests and abilities – and we have to start from scratch trying to figure out what they want to and what might be a good match – This whole process kind of takes*

*time but when they are already connected with the supported employment provider within the mental health agency, things moves faster.*

Another barrier mentioned by respondents was that of transportation. Since many of the DMHAS clients are economically challenged and do not drive cars, they often have to rely on public transportation. For many regions of the state of Connecticut, transportation is a huge problem.

*I think we lack adequate public transportation. It's not a supportive employment problem. It's a public transportation problem. The frequency of public transportation, the accessibility to places where people live is not good. I think, in some cases, the location of job opportunities and public transportation is just a bad match.*

### Removing employment barriers

Efforts are already in progress to remove some of the employment barriers. For example, changes in policy to offer Medicaid for the Employed Disabled, now called MED-Connect, and rapid reinstatement of Social security address some of the concerns about benefits. Within BRS, benefits counselors are trained to provide clients with information so they might not be as fearful about trying a job and losing benefits. Liaison counselors engage clients and employers in a working evaluation and educate them; this removes a lot of employment barriers for many clients. Supporting a cultural shift to view employment as an essential step in the recovery process is another way that is helping remove barriers to employment. Efforts to resolve transportation issues are also being made. These include peers driving peers and a program that buys old cars for resale to people with disabilities.

*The way people get better is by going to work and being housed. So your therapy is going to be much more effective if you first get them a job and then you can focus on it because they'll feel better, they'll be happier, they can come in and focus on their recovery and their therapy in a positive way ... So we've turned it around, we do housing and employment first now and then we've added the peers and that makes a huge difference. We've added family members and that makes a huge difference. So, some of the attitudinal stuff is what we're really trying to turn around. That's the biggest stuff really.*

*One of the things we've tried to do with the mental health population is the working evaluation. The working evaluation does two things: it gives us a good measure of what the client's abilities are, can they work, what's their stamina like, what's their motivation like, what's their attitude and follow through like – it gives us all that information so we have better confidence when we go into that workplace and the CRP can say I know I've seen them x, y, z, I've watched them do this and this, so I hate to use it as a product but we can sell them and their strengths as recent strengths. Then the next step is to say to that employer, why don't you let him work for a couple of weeks on our dime, no obligations, just a really long interview and then the employer feels what does he have to lose and during the process they kind of fall in love with them because they see how well they work and the stigma starts to go away. We educate them and take some of the fear away at the same time. That helps reduce that barrier and it seems to be a good ticket. It's worked for us and has worked with the longevity on the jobs. We've seen it be a positive thing over and over again. And also the work and evaluation takes away the fear of working from the consumer because they're going into a job where the evaluation doesn't have any expectation.*

### Characteristics of BRS liaison counselor

Most respondents agreed on certain characteristics that would make the BRS liaison counselors better suited for their position of being embedded within the LMHA. The primary characteristic would be for a counselor to be seasoned in his or her work. Being seasoned was defined as having all the skills and essential understanding of your own system so you could then become familiar with another system, such as DMHAS.

*I would say it really has to be a counselor who knows BRS – a seasoned counselor or else it's not gonna work. Having someone who is seasoned – that helps and then going and then trying to understand the other side of it, the mental health side, the DMHAS side.*

*Somebody who is maybe a bit more seasoned – a VR counselor who is a bit more seasoned so they know the rules, they know the expectations, they know the VR program. Then they know how much they can bend or able to navigate too while still being able to do their job.*

Other characteristics of a successful liaison counselor that were mentioned included being passionate about working with individuals experiencing mental illness and being open and consistent in communicating with individuals on the teams.

*I think that someone who has a passion to work with people who have mental health problems... Someone who really values the individual and really sees beyond the disability. To look at the strengths.*

*Being open, being able to keep the communication open – not being concerned about stepping on toes, or turf or trying to look at what is in the best interest of the client. And certainly somebody who is here – as we can see how important we can see for someone to be on site. That makes a huge difference.*

*I would tell them to talk, talk, talk. Ask for meetings repeatedly even if you only had one last week, ask for another one. Have everybody at the table. I'm very big on having everybody at the table. It may be ad nauseam, but that's how you're going to do it. If you need [Name] there, yes he's busy but so are you – get him there, get the Employment Specialist there. You then have a full conversation at the very least with the clinician to find out all the ins and outs of the client before you meet the client. I want to be prepared and comfortable with that client and I want the Employment Specialist to be very comfortable with me and I want them to know they are equally as important as I am in that meeting and that I can't do it without them – the team is crucial.*

*I think that it is important for someone coming in to know that this is a collaboration – it's not one versus the other – not you do this and you do that – that we work together. Like I have already said many times – the communication is so key, I mean, it's really important – it's what is keeping our heads above water and helping our clients out the most.*

### Program difficulties

Many of the respondents felt that the program was not long enough. They suggested that it takes time to develop relationships within the system and it takes time to work with clients to find

appropriate careers. Most agreed that data collection for the project ended too soon to see the final results that were anticipated.

*The other thing too, I think that the study probably stopped too soon – that was the other thing. Because it went for a year and it took a while just – with this population it takes a little while – as an example, the gentleman who I've been working on with his business, it's taken two years. And we're still in the process of it. We had to do so much just to get to where we are now.*

In the Hartford region, losing staff caused difficulties for the program. There also seemed to be a lack of understanding about what BRS was capable of doing for the clients in this region.

*We've kind of gone through at least three folks, two of these were BRS counselors and we considered a third that didn't pan out.*

*I've heard anecdotally that certainly where there is sometimes a struggle between our understanding of what BRS can provide and what they actually can provide. Sometimes that has not meshed well. What we've tried to do over the course of the time ... is to have some meetings where we could try to hash that out. It was frustrating because it would feel as if we'd get to a place where we had kind of done that only to find that the BRS person was going to change or not be with us at all.*

In the New Haven region, even when the BRS liaison counselor was on site, there were difficulties in getting support for the program. There were times when BRS didn't have a DMHAS point person to go to and there seemed to be some reluctance in working with BRS. To some extent, the BRS liaison counselors in the Hartford region had similar experiences.

*I think it was very difficult because there wasn't one key DMHAS person for us to be able to go to. We had multiple meetings with a DMHAS contact, however that person didn't really have, and I don't want to say control, but didn't have the ability to go to all the different teams and say ok this is what BRS needs you to do and you need to follow up and do it this way.*

*Well I think on the part of our staff, if they could have been more visible, more interactive either in the group setting or as individuals, a known quantity a level of trust built up with consumers and a level of confidence built up with the clinicians... and that takes time. Relationship building takes time. The staffing and particularly consumers and an understanding of each other's respective roles and functions and I think that would go a long way and of course that means time – time on site.*

As with program successes, program difficulties resulted from the lack of certain features that were present in the successful implementation of the program. Once again the emphasis was on the actual physical presence of the BRS counselor within the LMHA. This was, in fact, initially the premise for the entire pilot, however it was not achieved to a measurable degree in two of the three regions. There's a lot of truth to the familiar adage that "out of sight is out of mind." When people in both systems weren't in touch with each other on a consistent basis, it was difficult to have the level of communication needed to support the program.

*You know when [name] was attending the meetings, it was much more effective. Now she's – it's over the phone – it's not as easy. You just sometimes forget about that*

*program and I started referring my clients to the vocational specialist at DMHAS, it's the fellowship program.*

Respondents suggested that leadership had a lot to do with whether or not collaboration occurred. In both the New Haven and Hartford regions, staffing was such that the person in the leadership position often had other responsibilities beyond the BRS and DMHAS project so that adequate time was not available to coordinate those involved in the pilot program.

*Although our liaison was a very good person, [that person] was pulled in many different directions and so we didn't have that strong support at [LMHA] that there was in other places, someone that was enmeshed in voc, someone that was available to take part in more vocational tasks. The person we were working with was given other tasks that at times superseded what was needed during the project. Part of the problem was that there was one person kind of assigned to oversee it, but it wasn't really that person's role and they didn't have much authority to ask the team members to call me or set up an appointment with me or invite me to meetings.*

#### Suggestions for improving the program

One of the strongest themes throughout all of the interviews was the importance of having a physical presence of the BRS counselor at the LMHA. It can't be emphasized enough how important this was for the success of the pilot.

*I just think that one piece that is crucial is to have a consistent presence over there. I think that that is really important. So whatever the LMHA that we are collaborating with, to have that presence – also if there is any way to get that established, and established early on instead of losing so much time to , and just trying to get a space. Because far too much time was lost trying to get the space, and I think that people's comfort level, even in regards to making referrals, or understanding the process, is better when you have a face, when you make those connections, and it is consistent. And I think that is a huge thing that was lost.*

*I think we were hoping for more of that kind of a relationship with BRS for whoever was assigned to us to come, to come to clinical rounds, to be able to be in different clinical update meetings and forums whereby they were keeping their services in front of people so that people on the clinical teams knew not only that they existed but that they were available and accommodating and, you know, - nothing like that face to face contact with someone in terms of – or being able to catch someone in the hallways and say, "Hey, I've got somebody" and the BRS counselor is saying, "OK, great – I'll be here on Wednesday at such and such and bring him over."*

Having a chain of command and developing protocols for the system were other common themes. This involves guidance and support from directors and supervisors in laying out goals for how BRS integrates with DMHAS including how decisions are made about whether an individual is appropriate for a referral, what the planning will look like for that person, how paperwork for that person will be exchanged, how a common plan would be developed with the client, and who would take responsibility for different aspects of the plan.

Because long-term supports are handled differently in both systems, it's been difficult for BRS counselors to know which services are in place for an individual and exactly who is providing the supports (e.g., the team, the Employment Specialists, the BRS vendor or someone else).

During the project, there was an awareness that BRS counselors are often unsure of who the consumer is handed off to for long-term retention services at the point of case closure. Within DMHAS there is pressure on Employment Specialists to move people with lower level support needs off their caseloads so they can work with new consumers who need help. DMHAS backs services off as the individual and staff become comfortable with his/her ability to sustain employment. On the other hand, BRS counselors depend on vendors for long-term supports and require specific plans in place with the vendor that state the number of contacts and progress reports. Using a more formalized protocol in the future would guide long-term supports with explicit expectations for what services will be delivered by whom.

*So, I would want to focus on developing the systems, the protocols for how it would happen and then likewise we need to figure out when we close a case for BRS how do long-term supports stay in place and what does that need to look like. I think there's a lot that we've learned that we probably can't at this point articulate and we would need to give a person that level of support. I would want them to have regular meetings with the DMHAS manager too so he or she could resolve problems that were coming up because that first year is tough for BRS counselors, the ones that are embedded.*

Consistency in communicating with teams is an essential part of teaming and should continue to occur more frequently between BRS and DMHAS so they can jointly support cases rather than passing an individual between the two agencies at various points in their service continuum. Regular communication supports teaming and allows for optimal functioning.

*The only way we're going to be able to do that is if the clinician, the vocational support, and us [BRS] work together closely as a team because we all play an important part... You do your part, we'll do ours. Ours [BRS] is to assess this disability and how it's going to interact in the world of work – that's our job. Their job is to assess their mental health and then the vocational specialist's job is to find that job that's going to work with both those combinations. So that's why there are three people or specialties needed... Everybody has to understand what everybody does and how we can help each other.*

Being flexible is also necessary in building a strong collaboration between two different systems. It involves being willing to understand the different perspectives and criteria each system is familiar with and accustomed to using and being committed to working as a team even when there are obvious differences.

*We each come from a different perspective – neither one is right or wrong – it's just different. So they have to be flexible. They also have to understand that the Employment Specialists don't work for BRS – they are not a CRP. So it's different how you approach them. You really have to approach them with the mindset of collaboration. This is what I can do for you, here are some things that maybe you can do for me. So it's a lot of give and take.*

*I think that the collaboration works best when each party understands the system that the other one is working under and works to avoid the turf war. It's not my way is right, this way is right. Having that give and take and looking to see how you can help the other person.*

## Vocational Rehabilitation Administrative Data Analysis

### Methods

Administrative data were drawn from the CT Bureau of Rehabilitation's System 7 vocational rehabilitation (VR) consumer program database and the Department of Labor's Unemployment Insurance (UI) wage database for 62 BRS and DMHAS Collaborative Employment Project participants and a comparison group. The comparison group included 813 VR consumers with severe mental health diagnoses of depressive and other mood disorders (including bipolar disorder) or schizophrenia and other psychotic disorders who were granted VR program eligibility between June 1, 2008 and September 30, 2009. This time frame corresponds to the Collaborative Employment Project implementation.

Sociodemographic data examined included *age*, *ethnicity* and *education*. A number of employment outcomes were compared between the two groups. The *number of days between each of the four VR statuses* (application, eligibility, employment plan completion, and closure) show how quickly people move through the VR program. For cases that were closed during the analysis time frame, *type of closure* shows how many people exited at each VR status point. The two groups were compared on whether they *used MED-Connect*, CT's Medicaid Buy-In Program, and whether they *received benefits counseling* through the Work Incentives Planning and Assistance (WIPA) program. UI wages were keyed to the quarter they applied for VR services. *Employment status* and *quarterly wages* at each quarter, from two quarters prior to application through six quarters post application, were compared between the two groups. The quarter containing the application date is counted as the first quarter post application. UI data were provided from January, 2008 through June, 2010.

Group comparisons were conducted using bivariate tests of statistical significance, including chi-square tests and ANOVAs. Comparisons were conducted first for the entire sample, followed by a subgroup analysis of non-white intervention and comparison group participants. Tests with a p-value below 0.05 are considered statistically significant.

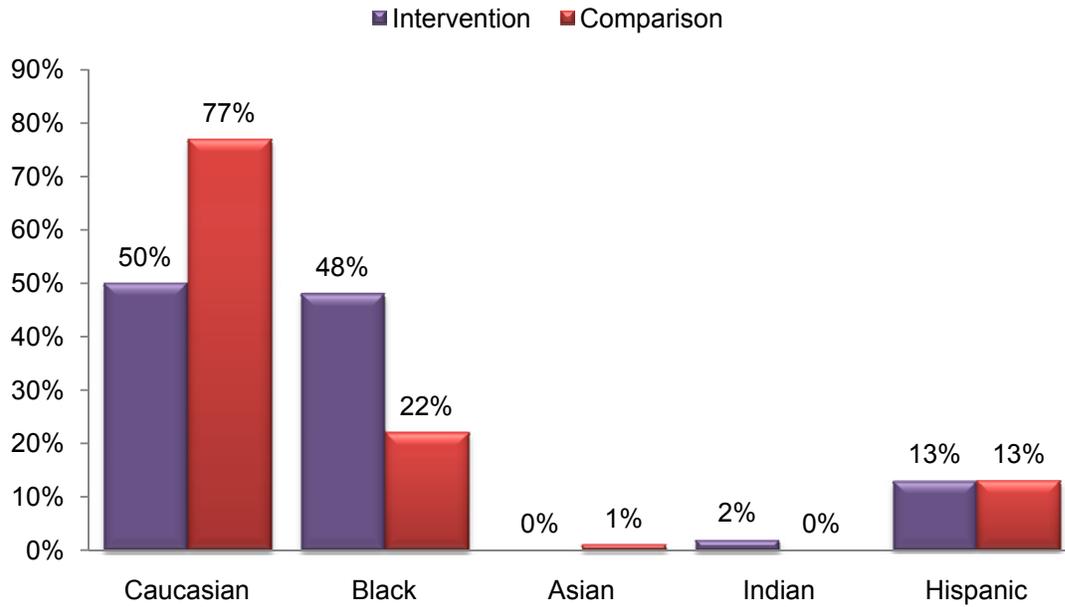
### Results

#### Whole Sample Analysis

##### *Demographics*

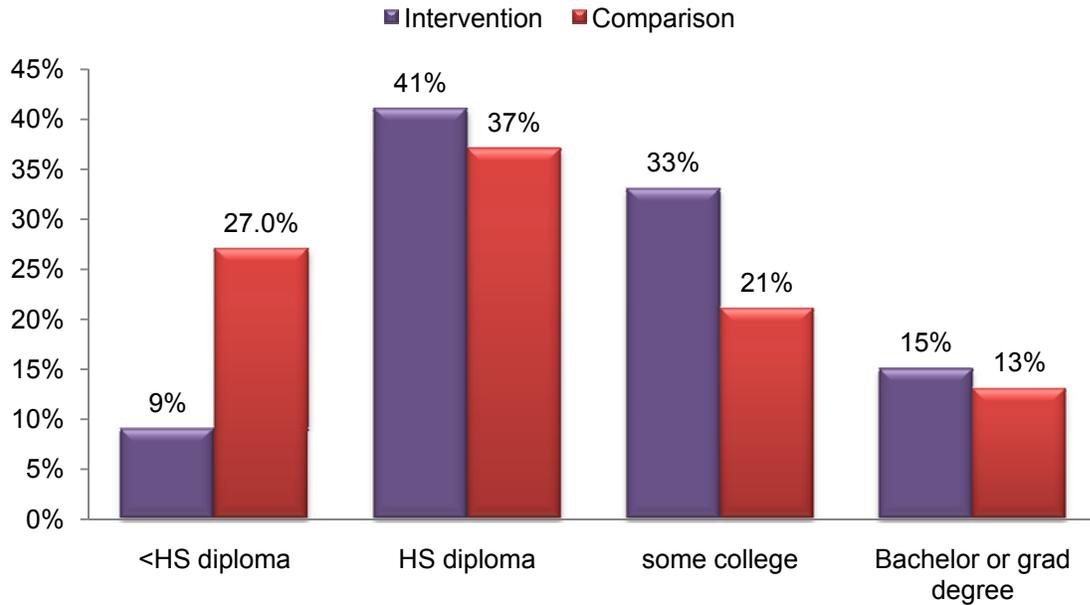
The intervention group age ranged from 19-68, with a mean age of 41; the comparison group on average were 38, ranging from 13-73. The groups did not differ significantly on age. Race (Caucasian, Black, Asian, or Indian) and Hispanic ethnicity were analyzed separately (Figure 35). The intervention group had almost equal percentages of Black and Caucasian members, while a much larger proportion of the comparison group were Caucasian; a statistically significant difference. Both groups were about 13 percent Hispanic.

Figure 35. Race and ethnicity



At the time they applied for VR services, the intervention group were more likely to have completed some college than the comparison group and less likely to have stopped school without graduating from high school (Figure 36).

Figure 36. Education at application



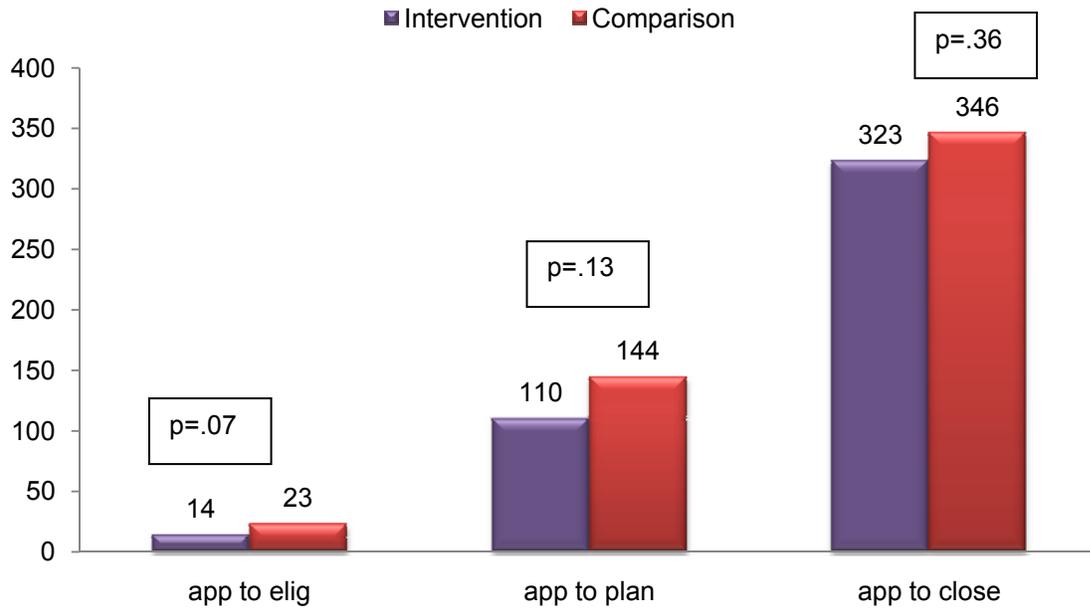
*Moving through the VR system*

The intervention group moved from application to eligibility, and from application to having an employment plan<sup>1</sup>, faster than the comparison group (Figure 37). Although not statistically significant, the first transition, application to eligibility, took two weeks on average for the intervention group, but just over three weeks on average for the comparison group, which may have clinical relevance. The two groups moved from application to closure over comparable time periods of just under a year, on average.

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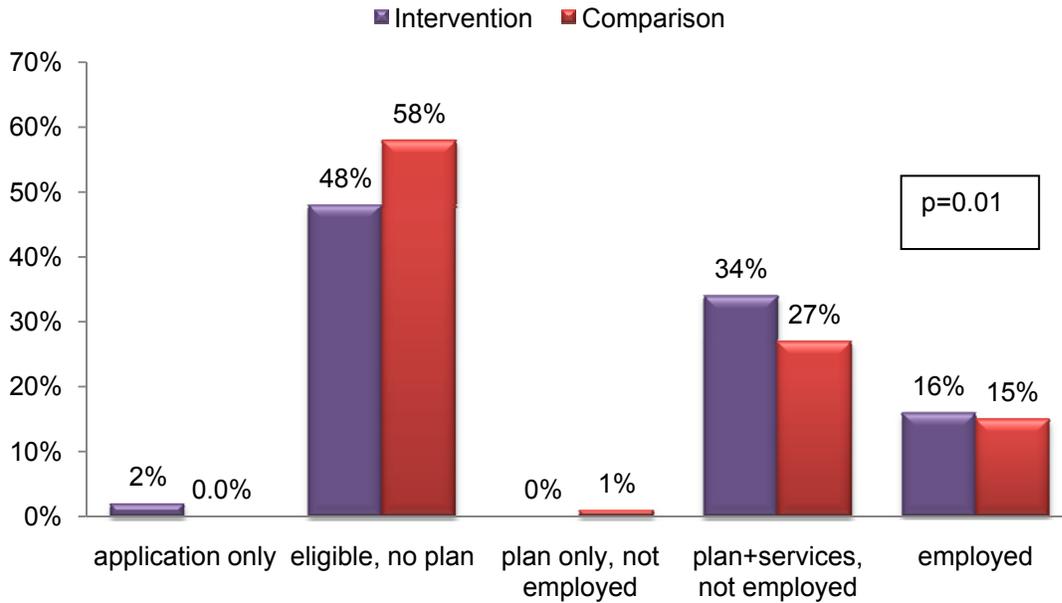
<sup>1</sup> Data on the employment plan dates were somewhat incomplete in the BRS system, making it unwise to draw definitive conclusions about time to employment plan. Dates for application, eligibility, and closure were more consistently provided.

Figure 37. Mean number of days between VR statuses



Next, it is necessary to examine the statuses at closure (i.e., employment versus leaving before reaching particular VR statuses) to understand the complete implications of the number of days it takes to move from application to closure (Figure 38). A majority of both groups' cases were closed before an Individual Plan of Employment (IPE) was signed (50% in the intervention group and 58% in the comparison group). However, the comparison group were significantly more likely to exit after eligibility but before the plan was signed (58%) than the intervention group (48%). Conversely, more intervention participants received services, though closed without being employed (34%) than the comparison clients (27%). Similar percentages of both groups were employed at the closure time (16% and 15%).

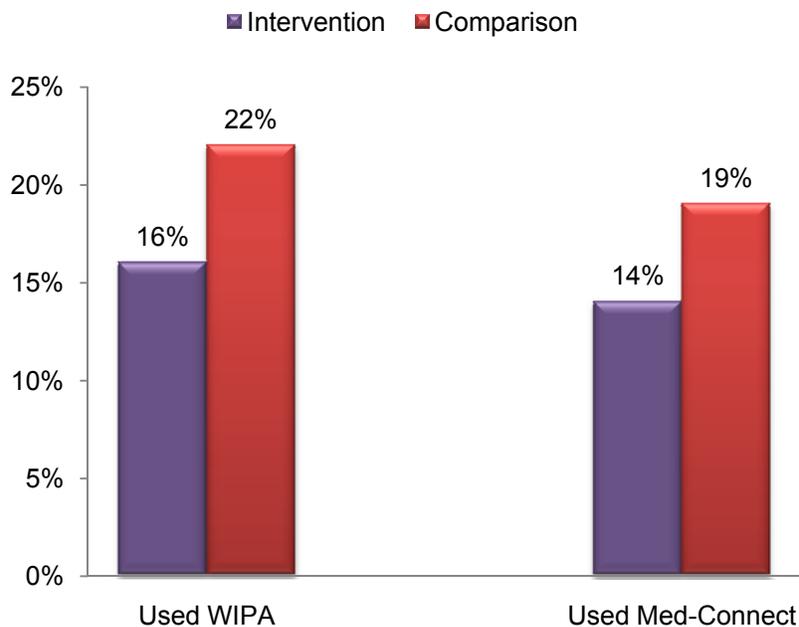
Figure 38. Closure type



*Work incentives*

Less than a quarter of either the intervention or comparison groups used benefits counseling (WIPA) or the Medicaid buy-in program (MED-Connect). Although a smaller percentage of the intervention group used either work incentive versus the comparison group, the differences are not statistically significant (Figure 39).

Figure 39. Use of work incentives



### Quarterly employment status

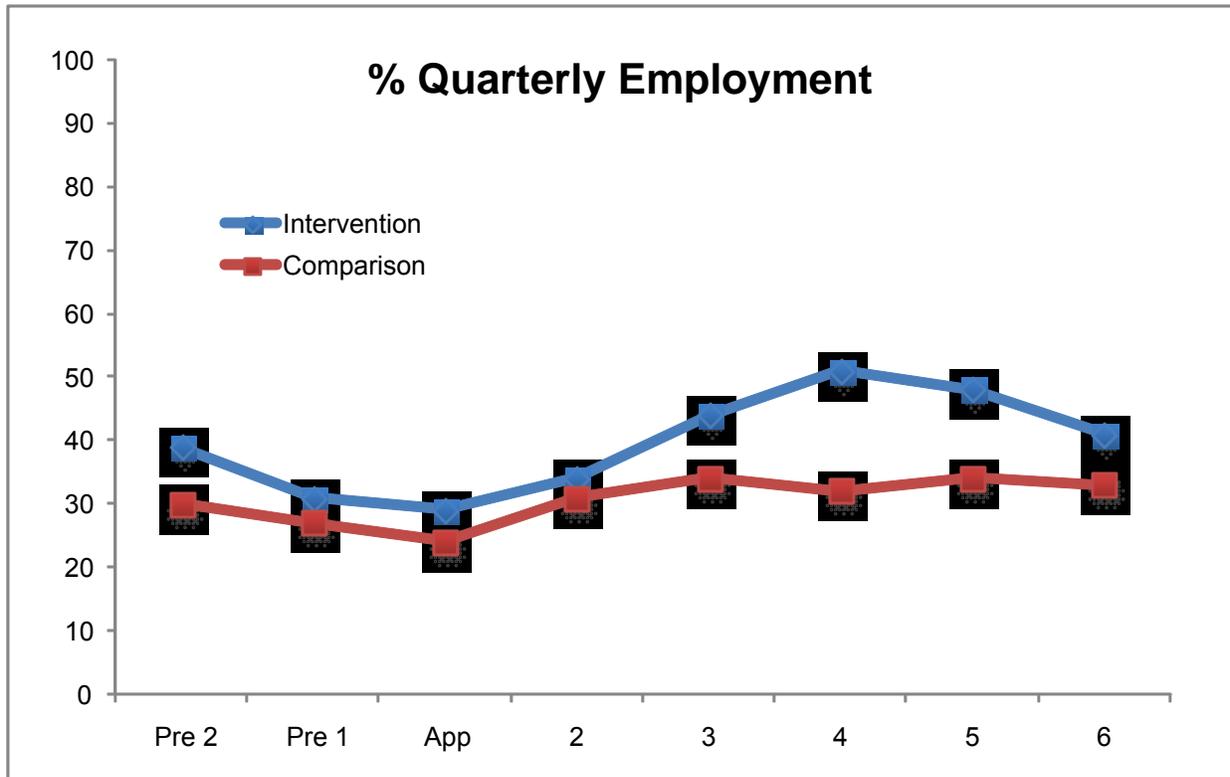
The UI wage data indicated which consumers were employed in any given quarter; if they had any earnings during that quarter they were employed. The analysis compared the percent of participants employed at each quarter between the intervention and the comparison groups, starting two quarters prior to VR application and continuing through six quarters after application. Data were virtually complete for the first quarter pre-application through the fourth quarter after. Due to the date limits we set for the data request, 136 participants (out of 875) were missing data for two quarters pre-application, and 105 and 250 were missing post quarters 5 and 6, respectively, because they had not yet reached these quarters by June 2010. At every quarter, a larger percentage of the intervention group than of the comparison group were employed (Table 14). The differences were significant at four and five quarters after application. At four quarters after, 51% of the intervention group versus 32% of the comparison group were employed. At five quarters post, the results show 48% versus 34%, respectively.

Table 14. Employment status at each quarter by group

Quarter	Intervention Percent Employed	Comparison Percent Employed	Chi square test	P-Value
Pre 2	39	30	2.17	.09
Pre 1	31	27	.38	.31
Application	29	24	.82	.22
2	34	31	.33	.33
3	44	34	2.37	.08
4	51	32	8.50	.003
5	48	34	4.01	.03
6	41	33	1.27	.17

These results are displayed graphically in Figure 40.

Figure 40. Employment status at each quarter by group



*Mean quarterly wages*

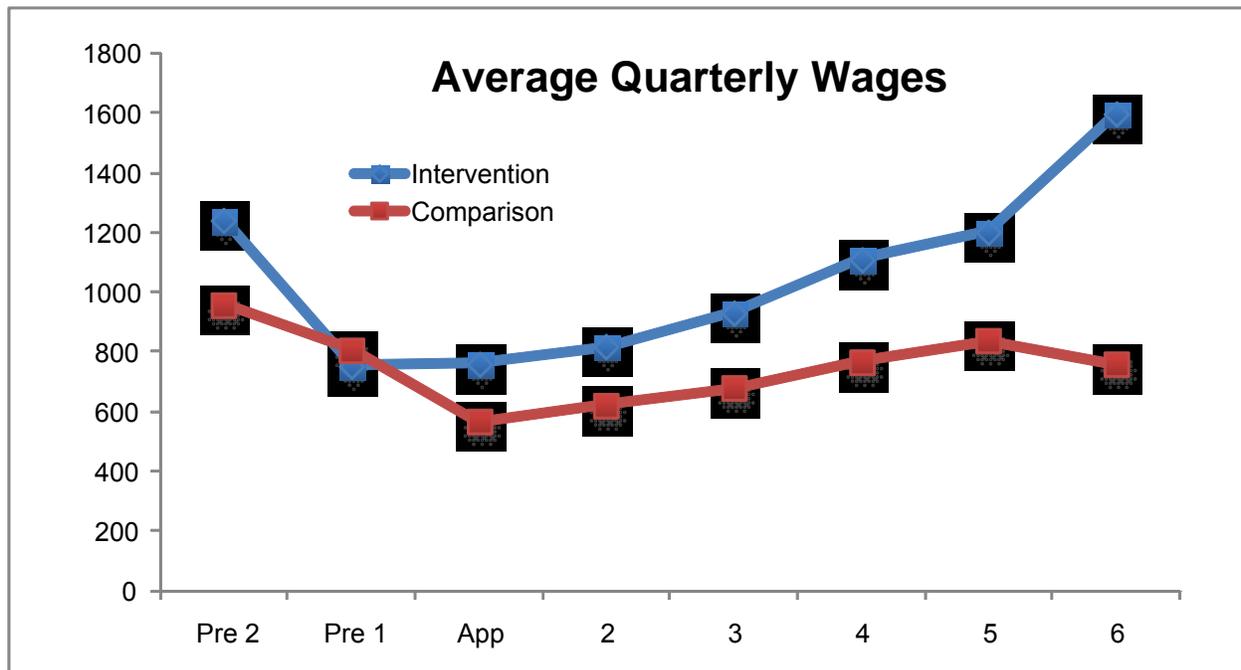
The UI data also provided mean quarterly wage data for both groups. Again, the intervention group's wages were higher than the comparison group's in all quarters except for the first quarter pre-application. The mean wage difference reached statistical significance at six quarters post-application.

Table 15. Mean quarterly wages by group

Quarter	Intervention Group		Comparison Group		F	P-Value
	Mean Wage	Std Dev	Mean Wage	Std Dev		
Pre 2	1243	2378	959	2641	.656	0.42
Pre 1	755	1619	809	2543	.027	0.87
Application	761	1819	568	2087	.495	0.48
2	818	1752	624	1807	.651	0.42
3	933	1803	681	1851	1.059	0.30
4	1111	1843	767	2003	1.697	0.19
5	1205	1922	839	2262	1.245	0.27
6	1599	2331	757	1870	7.503	0.01

Figure 41 displays the data graphically.

Figure 41. Mean quarterly wages by group



### Nonwhite Subgroup Analysis

The race information displayed in Figure 35 demonstrates that a significantly larger proportion of the clients served in the BRS Collaborative Employment Project were non-white than were the clients in the comparison group.

In order to see whether the employment outcome results described for the whole sample are also true for non-white consumers, we restricted the sample to only non-white participants and reanalyzed the same outcomes by test versus comparison group. The intervention group included 31 non-white participants.

On the whole, the results for the nonwhite subgroup exactly mirrored the full sample results. Only the number of days between VR statuses differed slightly: in the nonwhite analysis, the intervention group participants moved from application to eligibility and from application to a signed employment plan significantly faster than the comparison group members. However, as with the full sample, the time from application to closure did not differ between the groups.

### Summary of Administrative Data Findings

Some benefits appear to accrue to the intervention group, when compared to BRS consumers with severe mental illnesses who did not receive their VR services from an LMHA-embedded BRS counselor. The intervention program served a larger proportion of minority clients. Moving from application to eligibility happened about 50% faster for the intervention group, though speed through the rest of the VR statuses did not differ between the groups. Though both groups were equally likely to be employed when their VR case closed, among those who closed

without an employment outcome, the intervention consumers got further along through the VR statuses, receiving more employment services, before closing. Thus the intervention group may be better equipped at closing to subsequently find a job. This theory is supported by the intervention group's greater likelihood of employment and higher wages at 12 to 18 months after they applied for VR services. It is unclear why over a quarter of the comparison group and over a third of the intervention group's cases closed after receiving employment services, but before finding employment. The results were essentially identical for the nonwhite subgroup.

#### **IV. Conclusions**

The BRS and DMHAS Collaborative Employment Project encompassed a wide range of goals in addition to improving employment outcomes for shared consumers with psychiatric disorders. These included building an integrated career development continuum of services to enable consumers to move toward economic self-sufficiency, identifying effective collaborative protocols and practices to promote the integration of VR and mental health employment services, and raising awareness within the DMHAS system of the positive impact of employment on recovery. More specifically, while BRS wanted to achieve improved access to wraparound and expanded services and supports, DMHAS wanted to improve vocational rehabilitation consultation and broader disability knowledge in an effort to promote a more effective continuum of services leading to career development for the population they serve. It was anticipated that both BRS and DMHAS consumers would be more satisfied as a result of improved coordinated supports and better employment outcomes and that teaming would benefit both agencies through increased communication and access to information and data on shared consumers.

Despite the disappointment of having only two functioning sites instead of three and not being able to recruit as many people as had been planned on, the project was successful in accomplishing many of its goals. The accomplishment of these goals and program successes were directly related to consistent and effective communication and improved by the on-site presence of a BRS counselor. When and where this occurred, collaboration was evident and goals were more often realized. For various reasons, this happened more frequently at the LMHA in Bridgeport than in New Haven, but when there was collaboration at either site, the expertise of both agencies was tapped and additional opportunities were provided for shared consumers, allowing them to utilize the services that each agency provides. Because of the collaboration, some consumers were able to have short-term goals met by DMHAS while exploring long-term planning and career development with BRS counselors. While each agency has different responsibilities and exhibits different skills, together they provided expertise and additional opportunities for those in the intervention.

As a result of the collaboration, more than half of consumers in the intervention benefited from working with an embedded counselor and were successful in identifying career goals and improving interviewing and job search skills. By the end of the data collection period for the project, 100 percent of those who were working were very or somewhat satisfied with their current job. Nearly 90 percent of participants in the evaluation were positive about the help they received from the BRS counselor and clearly valued the services and support they received during the course of the project. In addition to consumer satisfaction with the project, employment specialists and clinicians at DMHAS had the opportunity to learn about multiple employment-related resources available through BRS and were better equipped to help their clients access the resources and move closer toward their employment goals as a part of recovery.

Some benefits of being in the intervention group of the project were also evident when comparing the intervention and comparison group using administrative data. These include receipt of a greater number of services, higher percent of employment, and on average higher wages than the comparison group.

Both the comparison and intervention groups had relatively low rates of using Connecticut's Medicaid Buy-In program, Med-Connect, or of receiving benefits counseling. These rates should be compared to the whole VR population. If this group of VR consumers with mental illness are less likely than other VR consumers to utilize these programs, this could represent a target group for program outreach efforts.

In any project where efforts are being made to collaborate between agencies, there are barriers created by the differences in institutional cultures that have to be overcome. In the process, lessons are learned in areas that are more challenging, which certainly characterizes this project. BRS and DMHAS personnel involved in the project realized quickly the importance of communication and meeting regularly to discuss shared consumers and their goals. When communication was lacking, so was collaboration. It took more time and was more challenging for BRS counselors and employment specialists to figure out the division of labor between their roles and how best to collaborate in assisting consumers. It also took time for BRS and DMHAS leadership to learn creative ways to engage the teams and get them more involved in the project and some were more successful than others in doing this. As a result of the project, leadership in both agencies are now more aware that it is necessary for people in these key roles to be able to speak their agency's language, know its goals, and communicate this to the teams within the system. When there is a coordinated effort within the systems under this kind of leadership, there is a greater potential for collaboration with other agencies.

Since most people with severe mental illness want to be employed, there are compelling reasons ethically, socially, and clinically for assisting them to reach this goal (Crowther, Marshall, Bond, & Huxley, 2001). Vocational rehabilitation exists to help people with mental illness and other disabilities find work and the BRS and DMHAS Collaborative Employment Project was successful in uniting the resources of two systems for the benefit of some of the people in this population and in helping them achieve their goals. Awareness of the challenges that occurred during the project and findings from the multi-component project evaluation serve to inform BRS and DMHAS as they explore additional ways to expand the collaboration begun with this project.

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## **VI. Appendices**

Appendix A: Intake Survey

Appendix B: Consumer Satisfaction Survey

Appendix C: Counselor Survey

Appendix D: Program Evaluation Survey

Appendix E: Focus Group Guide

Appendix F: Key Informant Guide

Appendix A: Intake Survey

**Client Intake Survey**

Client's Name (first, last): \_\_\_\_\_

Date of Enrollment (first meeting with counselor) (MM/DD/YYYY): \_\_\_\_\_

Street address: \_\_\_\_\_

Apartment: \_\_\_\_\_

City/town: \_\_\_\_\_ Zip code: \_\_\_\_\_

Home telephone: \_\_\_\_\_ Cell phone: \_\_\_\_\_

**Alternate contact**

Contact Name (first last): \_\_\_\_\_

Contact phone: \_\_\_\_\_

**Client Intake Survey**

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1. What is the client's marital status?  
 Married                       Separated                       Never married  
 Widowed                       Divorced                       Living together as though married
  
2. What is the highest grade or year the client finished in school?  
 8<sup>th</sup> grade or less                       Some college  
 Some high school                       Two-year college degree  
 High school diploma or GED                       Four-year college degree  
 Trade/technical/vocational training                       Post-graduate degree (masters/doctorate)
  
3. Is the client currently enrolled in any degree, certificate or licensure program?  
 No  
 Yes → **If Yes**, What program is the client currently enrolled in?  
 GED  
 Two-year college degree  
 Four-year college degree  
 Certificate/Licensure  
 Other \_\_\_\_\_
  
4. Has the client ever had benefits counseling?  
 No  
 Yes

**For the purposes of this project, "Work" or "Job" is paid employment in an integrated setting for competitive wages which are comparable to that of others doing the same job.**

5. Is the client currently working according to this definition?  
 No → **If No, Intake Survey is complete.**  
 Yes

6. How much does the client's current job match his/her interests?
- A lot
  - Somewhat
  - A little
  - Not at all
7. How much does the client's current job match his/her personal career goals?
- A lot
  - Somewhat
  - A little
  - Not at all
8. How much of the client's talents and abilities does his/her current job require him/her to use?
- A lot
  - Somewhat
  - A little
  - Not at all

Appendix B: Consumer Satisfaction Survey

**Consumer Satisfaction Survey: 3, 6, and 12 months**

Client's Name (first, last): \_\_\_\_\_

Date of Enrollment (first meeting with counselor) (MM/DD/YYYY): \_\_\_\_\_

LMHA:  Bridgeport     Hartford     New Haven

***Please check only one box for each question.***

**Work experiences**

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**For the purposes of this project, “Work” or “Job” is paid employment in an integrated setting for competitive wages which are comparable to that of others doing the same job.**

1. Are you currently working according to this definition?
- Yes
  - No
  - Don't know
  - Refused

**If Yes, is currently employed:**

When did you start working at this job?

Were you working there before your first meeting with [name of BRS counselor]?

What is your current job position?

What company are you working for?

How many hours are you working each week?

Are you planning on making any job changes at this time? (get a different job, add another job, quit this job, etc.)?

What job changes are you planning on making? (probes: get a different job, apply for job, work as volunteer or intern at workplace, etc.)

**If No, is not currently employed:**

Have you worked in the community for competitive wages in the last three months – that is, since [date of enrollment]?

**If Yes, was employed in past 3 months:**

When did you start working at this job?

When did you stop working at this job?

What was your job position at your last job?

What company were you working for?

How many hours were you working each week?

Are you planning on making any job changes at this time? (get new job, apply for job, etc.)?

What job changes are you planning on making? (probes: get a different job, apply for job, work as volunteer or intern at workplace, etc.)

**If No, has not worked at all in past 3 months:**

Are you planning on making any job changes at this time?

- Yes
- No
- Don't know
- Refused

What job changes are you planning on making? (probes: get a different job, apply for job, work as volunteer or intern at workplace, etc.)

2. Have you applied or interviewed for any jobs in the past 3 months, since [date of enrollment]?
- Yes
  - No
  - Don't know
  - Refused

*Interviewer note: For rest of questions, only refer to current job or most recent job since date of enrollment.*

3. How satisfied are you with your current (most recent) job?
- Very satisfied
  - Somewhat satisfied
  - Very dissatisfied
  - Do not know
  - Refused
  - Not applicable – has not worked since date of enrollment
4. How well does your current (most recent) job match your personal career goals? Would you say it matches your career goals:
- A lot
  - Some
  - A little
  - Not at all
  - Do not know
  - Refused
  - Not applicable – has not worked since date of enrollment
5. How much of your talents and abilities does your current (most recent) job require you to use?
- A lot
  - Some
  - A little
  - Not at all
  - Do not know
  - Refused
  - Not applicable – has not worked since date of enrollment

**Experiences with BRS counselor located at Licensed Mental Health Authority (LMHA)**

6. How satisfied are you with the employment counseling and vocational rehabilitation services you have received from [name of BRS counselor]?
- Very satisfied
  - Somewhat satisfied
  - Very dissatisfied
  - Do not know
  - Refused
7. How satisfied are you with the personal encouragement and support you have received from [name of BRS counselor]?
- Very satisfied
  - Somewhat satisfied
  - Very dissatisfied
  - Do not know
  - Refused
8. Thinking about your experiences working with [name of BRS counselor] at [name of LMHA], please tell me how much you agree or disagree with each statement, telling me if you strongly agree, agree, disagree, or strongly disagree.

<b><i>Working with my BRS counselor has helped me ....</i></b>	<b>Strongly agree</b>	<b>Agree</b>	<b>Disagree</b>	<b>Strongly disagree</b>	<b>Do not know</b>	<b>Re-fused</b>	<b>Not applicable to person</b>
Identify my career or employment goals.							
Find work opportunities that match my career goals.							
Find work opportunities that are meaningful to me.							
Find work opportunities that fit my abilities.							
Improve my interviewing skills.							
Improve my job search skills.							
Create a resume or description of my work history.							
Improve my ability to fill out a job application.							
Find other useful employment services such as career development programs, on the job training, internships, or any other training or education.							

9. Please tell me how much you agree or disagree with each statement.

<b><i>My BRS counselor...</i></b>	<b>Strongly agree</b>	<b>Agree</b>	<b>Disagree</b>	<b>Strongly disagree</b>	<b>Do not know</b>	<b>Refused</b>
Listens to and responds to my concerns.						
Respects my opinions.						
Sees me as often as I need to see him/her.						
Continues to work closely with me.						

10. Please tell me how much you agree or disagree with each statement.

<b><i>My BRS counselor...</i></b>	<b>Strongly agree</b>	<b>Agree</b>	<b>Disagree</b>	<b>Strongly disagree</b>	<b>Do not know</b>	<b>Refused</b>	<b>Not applicable to person</b>
Connected me with community programs to help me with transportation difficulties I have.							
Connected me with community programs to help me with housing difficulties I have.							

<b><i>My BRS counselor has given me useful advice on how to talk to a potential employer about...</i></b>	<b>Strongly agree</b>	<b>Agree</b>	<b>Disagree</b>	<b>Strongly disagree</b>	<b>Do not know</b>	<b>Refused</b>	<b>Not applicable to person</b>
Gaps in my work history							
Disclosing my mental health history							
Any criminal history							
Need for accommodations based on my mental health, such as a flexible schedule							

11. Most people in this BRS/DMHAS Collaborative Employment Project have an Employment Plan. How much did each of the following people contribute to the development of your Employment Plan?

	A lot	Some	A little	Not at all	Do not know	Refused
Your BRS counselor						
Your LMHA employment specialist						
Your LMHA therapist						
Your LMHA case worker						
Your LMHA psychiatrist						

12. Were you involved in the development of your Employment Plan?

- No  
 Yes  
 Do not know  
 Refused

- 12a. If Yes, how much were you involved?

- A lot  
 Some  
 A little, or  
 Not at all

13. Thinking of your Employment Plan, please tell me how much you agree or disagree with each statement.

My Employment Plan...	Strongly agree	Agree	Disagree	Strongly disagree	Do not know	Refused
Is right for me						
Is based on my strengths and abilities						
Meets my expectations						
Addresses my concerns						
Is based on my work interests						

14. How often do your BRS counselor and LMHA employment specialist give you conflicting or different advice about working?

- Often  
 Sometimes  
 Rarely  
 Never  
 Do not know  
 Refused

15. How much has working with your BRS counselor helped you meet your employment or career goals?
- A lot
  - Somewhat
  - A little
  - Not at all
  - Do not know
  - Refused
16. What has been especially helpful for you in working with your BRS counselor?
17. What additional employment support or assistance would be helpful for you?
18. Interviewer - write additional comments here.

Appendix C: Counselor Survey

<p><b>Counselor Survey: 3, 6, and 12 months</b></p> <p>Client's Name (first, last): _____</p> <p>Date of Enrollment (first meeting with counselor) (MM/DD/YYYY): _____</p> <p>LMHA: <input type="checkbox"/> Bridgeport    <input type="checkbox"/> Hartford    <input type="checkbox"/> New Haven</p> <p align="center"><b><i>Please check only one box for each question.</i></b></p>
---

**Work history**

**For the purposes of this project, "Work" or "Job" is paid employment in an integrated setting for competitive wages which are comparable to that of others doing the same job.**

- Is the client currently working?
  - No
  - Yes
  - Current information unavailable
  
- Please enter the client's employment history for the past 3 months. Record the start and end date of each job the client has had in the past 3 months.

<b>Job Position and Company</b>	<b>Start Date MM/DD/YYYY</b>	<b>Currently working at this job?</b>	<b>End Date MM/DD/YYYY</b>
		<input type="checkbox"/> No <input type="checkbox"/> Yes	
		<input type="checkbox"/> No <input type="checkbox"/> Yes	
		<input type="checkbox"/> No <input type="checkbox"/> Yes	
		<input type="checkbox"/> No <input type="checkbox"/> Yes	
		<input type="checkbox"/> No <input type="checkbox"/> Yes	

### **Benefits counseling**

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3. Has the client had benefits counseling in the past 3 months?
- No
  - Yes
  - Current information unavailable

### **Education**

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4. What is the highest grade or year the client finished in school?
- |  |   |
|--|---|
| <input type="checkbox"/> 8 <sup>th</sup> grade or less       | <input type="checkbox"/> Some college                             |
| <input type="checkbox"/> Some high school                    | <input type="checkbox"/> Two-year college degree                  |
| <input type="checkbox"/> High school diploma or GED          | <input type="checkbox"/> Four-year college degree                 |
| <input type="checkbox"/> Trade/technical/vocational training | <input type="checkbox"/> Post-graduate degree (masters/doctorate) |
5. Is the client currently enrolled in any degree, certificate or licensure program?
- No
  - Yes → **If Yes**, What program is the client currently enrolled in?
    - GED
    - Two-year college degree
    - Four-year college degree
    - Certificate/Licensure
    - Other (please describe): \_\_\_\_\_
  - Current information unavailable

### **DMHAS enrollment**

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6. Is the client currently working with a DMHAS employment specialist?
- No
  - Yes → **If Yes**, When did they start working with her/him? (date)  
\_\_\_\_\_

### **Job match**

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**If client has not worked at all in the past 3 months, please skip to question 12.**

7. How much does the client's current or most recent job match his/her interests?
- A lot
  - Some
  - A little
  - Not at all
  - Current information unavailable

8. How much does the client's current or most recent job match his/her personal career goals?
- A lot
  - Some
  - A little
  - Not at all
  - Current information unavailable
9. How much of the client's talents and abilities does his/her current or most recent job require him/her to use?
- A lot
  - Some
  - A little
  - Not at all
  - Current information unavailable
10. How much are other aspects, such as co-occurring disability and symptoms, factored into the client's current or most recent job match?
- A lot
  - Some
  - A little
  - Not at all
  - Current information unavailable

**If A Lot, Some, or A Little, what aspects are factored into the job match?**

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11. Has there been an improvement in the client's job match between the current or most recent job and his/her previous job?
- A lot
  - Some
  - A little
  - Not at all
  - Not applicable – this is the only job the client has ever had
  - Current information unavailable

**If A Lot, Some, or A Little, what improvements have been experienced?**

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**Speed of movement through BRS/DMHAS systems**

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- 12. Date of entry into the BRS system: \_\_\_\_\_
- 13. Date of eligibility determination for BRS services: \_\_\_\_\_
- 14. Date of BRS employment plan completion: \_\_\_\_\_
- 15. Date of initial employer contact (when client first met with employer):  
\_\_\_\_\_
- 16. Date of job placement: \_\_\_\_\_
- 17. Date of school placement, if any: \_\_\_\_\_
- 18. Date of termination of employment service, if terminated: \_\_\_\_\_
- 19. In the past 3 months, number of employer contacts made by the client, BRS counselor, or employment specialist on behalf of the client, including face-to-face contacts, e-mail, mail, telephone, etc.  
\_\_\_\_\_ employer contacts in past 3 months

**BRS Employment services**

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- 20. Since enrollment, what other BRS employment services has the client participated in?
  - Job shadowing
  - Volunteer work
  - Informational interviews
  - Work evaluations
  - Internships

**Additional comments**

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- 21. Please enter any additional comments below.

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Appendix D: Program Evaluation Survey

**Program data collection at      months:  
From MM/DD/YYYY to MM/DD/YYYY**

Date survey completed: MM/DD/YYYY

LMHA:    Bridgeport    Hartford    New Haven

***Please check only one box for each question.***

**Frequency and quality of interagency communication**

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1.    Number of referrals from the BRS counselor to DMHAS employment specialist from MM/DD/YYYY. \_\_\_\_
2.    Number of referrals from DMHAS to the BRS counselor that were opened (i.e., deemed appropriate) from MM/DD/YYYY. \_\_\_\_
3.    Number of referrals from DMHAS to the BRS counselor that were not opened from MM/DD/YYYY. \_\_\_\_
4.    Number of positive BRS closures from MM/DD/YYYY. \_\_\_\_
5.    Number of negative BRS closures from MM/DD/YYYY. \_\_\_\_
6.    Number of times from MM/DD/YYYY where you (the BRS counselor) provided consultation services for the DMHAS treatment team members on cases you did not open. \_\_\_\_
7.    From MM/DD/YYYY, what is the quality of teaming between agencies?  
       Excellent  
       Good  
       Fair  
       Poor
8.    Add any additional comments here:

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## Appendix E: Focus Group Guide

### BRS/DMHAS Collaborative Employment Project: BRS Mental Health Pilot Project: Focus Group Guide

Thank you for joining us today. We appreciate you taking the time to talk with us about your views and experiences regarding The BRS/DMHAS Collaborative Employment Project. My name is [NAME]. Assisting me is [NAME]. We are from the University of Connecticut Health Center, Center on Aging.

This project is being conducted as part of the evaluation of this program. Before we begin, I want to go through a few details to help our time together go more smoothly.

1. This session will be one hour long, so we'll be done by XXX. If you need to use the restroom, please feel free to get up and do so, and return as quickly as you can. (Tell where restrooms are located).
2. No full names or identifying information will be used anywhere. We'll only use first names for our discussion. No information will be released that would allow anyone to identify you.
3. You can decide not to answer a particular question, and you can also leave the group at any time.
4. We will be tape recording as well as taking notes in case the recorder breaks.
5. A few tips that will make our discussion go better:
  - a) There are no wrong answers, only different points of view.
  - b) Please speak one at a time, repeating your first name each time, so the recorder can pick up each voice.
  - c) Remember we have a lot to talk about during our time today, so (moderator) will be moving us along.
  - d) Please respect other people's privacy by not discussing the comments you hear today with anyone else.

### Guiding Questions

1. Please describe the process of enrolling a client into this pilot program.  
*Probes:* Who makes the referral? How long until an appointment is set up? What happens next?
2. How prepared are the clients who are referred to start working with BRS to seek employment?
3. Please describe how the treatment team works together.  
*Probes:* Are there regular meetings? Who attends? Do the BRS counselors give and receive input?

4. Please describe how client services are coordinated between BRS liaisons and DMHAS Employment Specialists so duplication of services is avoided.  
*Probes:* How is it determined who delivers specific services or what strategies are used to decide who is responsible for certain services? What steps are taken to ensure duplication of services is avoided?
5. Please describe how client services are coordinated between BRS liaisons and Community Rehabilitation Providers (CRPs), where they're involved.
6. Are there some client characteristics that make this program more or less successful for the individual?
7. What are the benefits for clients of participating in this program?
8. What are the benefits for clinicians of participating in this program?
9. What are the major barriers to employment for participants in this program?
10. What suggestions do you have to remove these barriers?
11. How could this program be improved?
12. Are there differences between the two pilot sites in the way this program operates?
13. What recommendations would you make for a new counselor who is going to be embedded within the DMHAS system

Appendix F: Key Informant Guide

**Information Page about the UCHC evaluation of the:  
BRS/DMHAS Collaborative Employment Project**

**Funded by: Federal Department of Education, Rehabilitation Services Administration, CT  
Department of Social Services, Bureau of Rehabilitative Services**

Principal Investigator: Julie Robison, PhD	Project Director: Kate Kellett
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This evaluation examines whether the BRS/DMHAS Collaborative Employment Project improves the ability of DMHAS clients to attain and retain employment by colocating BRS employment specialists in two LMHAs. This program is designed on the basis of DMHAS' evidence-based supported employment initiative. This important step indicates DMHAS' commitment to employment as a critical part of recovery for most consumers, and provides a basis in which the BRS counselors can be effective within the mental health system.

You have been asked to be a key informant because you are a BRS Employment Specialist or part of the treatment team at an LMHA involved in this pilot program.

Participation as a key informant is voluntary. You may choose not to answer any question during the interview for any reason. Refusing to take part as a key informant or stopping participation in the interview will not have any adverse effect on your employment.

The interview will last about 20 minutes. The researchers will audiotape the interview as well as take notes in case the recorder breaks. You may ask that the recorder be shut off at any time.

A researcher from the University of Connecticut Health Center will ask questions regarding the process of enrolling clients in this pilot program, client readiness, and treatment team interaction. We are interested in client characteristics that may make this program more or less successful and the benefits for clients and clinicians for participating in the program. We will also explore the major barriers for participants in this program and suggestions for removing these barriers and improving the program.

Your answers to questions will remain confidential and will not affect your relationship with BRS or the Dept. of Mental Health and Addiction Services in any way. Completing this key informant interview implies consent.

In no way will you be connected with any of the information that you give, either in the research findings or any other publications. The records will be destroyed when all study related activities are complete. Study records may be reviewed by the University of Connecticut Health Center's Institutional Review Board to ensure that your rights are being protected and that the study is being conducted properly.

If you have any questions, you may call the Principal Investigator or the Project Director listed above at any time.

## Guiding Questions

1. Please describe the process of enrolling a client into this pilot program.  
*Probes:* Who makes the referral? How long until an appointment is set up? What happens next?
2. How prepared are the clients who are referred to start working with BRS to seek employment?
3. Please describe how the treatment team works together.  
*Probes:* Are there regular meetings? Who attends? Do the BRS counselors give and receive input?
4. Please describe how client services are coordinated between BRS liaisons and DMHAS Employment Specialists so duplication of services is avoided.  
*Probes:* How is it determined who delivers specific services or what strategies are used to decide who is responsible for certain services? What steps are taken to ensure duplication of services is avoided?
5. Please describe how client services are coordinated between BRS liaisons and Community Rehabilitation Providers (CRPs), where they're involved.
6. Are there some client characteristics that make this program more or less successful for the individual?
7. What are the benefits for clients of participating in this program?
8. What are the benefits for clinicians of participating in this program?
9. What are the major barriers to employment for participants in this program?
10. What suggestions do you have to remove these barriers?
11. How could this program be improved?
12. Are there differences between the two pilot sites in the way this program operates?
13. What recommendations would you make for a new counselor who is going to be embedded within the DMHAS system?
14. Is there anything else you'd like to add that hasn't been covered and is related to this project?