Mainstream Career Training: Accessing Community Resources For People with Serious Psychiatric Disabilities

**Final Report
The Research Fellowship Program
of the
National Institute on Disability and
Rehabilitation Research
(Grant # H133FO60044)**

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March 2008**

Author's Note

Thanks are due to the many individuals and organizations that cooperated in this study. First, the UPenn Collaborative on Community Integration of Individuals with Psychiatric Disabilities – a National Institute on Disability and Rehabilitation Research (NIDRR) rehabilitation research and training center within the University of Pennsylvania's Department of Psychiatry – provided both a home base for the author and access to the Collaborative's research staff for advice and support. Dr. Mark Salzer, the Collaborative's principal investigator, provided generous advice and an encouraging sounding board throughout the process.

Representatives of each of the mental health, vocational rehabilitation, and workforce development administrative offices in Philadelphia and Montgomery counties, in Pennsylvania, were accessible and tremendously honest, as were the individual nonprofit provider agency personnel interviewed for the study.

Two groups of respondents were exceptionally important in delineating the issues explored here. Faculty and staff from local mainstream career training resources – in community colleges, technical schools, and other nonprofit training agencies – were more than willing to lend their time to the study and to offer a straightforward "outsider" perspective to issues that are often only the focus of mental health and/or vocational rehabilitation professionals and the consumers they serve.

Most importantly, however, the participation of nearly three dozen consumers from psychiatric rehabilitation programs in the two counties provided insights into the educational and employment ambitions, experiences, and outcomes of those with serious mental illnesses that could not have been obtained in any other way. As with any research in the mental health arena, it is useful to remember an observation of John Dewey's: "*The man who wears the shoe knows best that it pinches and where it pinches . . . .*" (Dewey, 1927)

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Abstract

Despite accumulating evidence that people with serious mental illnesses in public mental health systems consider employment a core component of their recovery, unemployment among them remains staggeringly high. Supported employment, an evidence-based practice, has demonstrated considerable success in moving people into the workforce; but there is concern that this approach – in which entry-level, unskilled, low-wage, and short-term job placements have predominated – may not meet the needs or respond to the potential of many consumers. This study sought information on the degree to which public mental health systems use an alternative strategy by referring mental health consumers to existing mainstream career training programs in community colleges, for-profit technical schools, and nonprofit agencies. These are all training resources *outside* the traditional network of mental health programming, but they may provide consumers better preparation for the competitive job market by developing their students' capacities for a range of skilled and semi-skilled jobs offering better pay and more career mobility.

This report draws on a series of qualitative interviews with 86 individuals: human services administrators, mental health provider staff, consumers, and mainstream career training providers in urban Philadelphia and suburban/rural Montgomery County, Pennsylvania. An intensive qualitative analysis of the interview data, seeking common themes and disparate perspectives, was conducted. Preliminary results of this analysis were shared with six working groups composed of consumers and providers, and their responses have contributed to the study's delineation of core issues.

Respondents across all categories in both counties were unanimous in observing that it is rare for someone receiving public mental health services to be referred – by either mental health or vocational rehabilitation personnel – to mainstream career training resources in their communities. Although respondents differed in the weight attached to varying issues, there were two broad explanations for the predominance of referrals to specialized mental health providers and the failure to use mainstream resources. On the one hand, respondents often focused on the capacities of consumers and the priorities of the systems that serve them. They said that consumers are neither vocationally motivated nor focused; that mental health systems do not prioritize employment; that consumers lack the educational qualifications for demanding training programs; and that funding is unavailable for the supports consumers need to succeed in mainstream career training.

On the other hand, the respondents acknowledged a profound wariness about the use of mainstream career training resources. They reported that consumers are more comfortable and more likely to participate successfully in job programs within the reassuring network of mental health provider agencies. They also noted that mental health staff and consumers had little knowledge about these local resources or harbored an antipathy toward them. Many were concerned about the potential for admission discrimination, student harassment, and crippling indebtedness, although little evidence of these problems could be cited. The study found that mental health personnel are relatively uninformed about the job sectors for which mainstream career training programs prepare their students, and knew little about mainstream training opportunities.

1. Introduction

Employment prospects for people with serious mental illnesses remain bleak. It has been 40 years since the deinstitutionalization movement prompted the development of a national network of community mental health centers to assist ex-patients in their adjustment to community life, and 30 years since a federal focus on Community Support Programs first identified work as one of several fundamental aspects of independent living; yet employment remains an unfulfilled promise. It has been nearly 20 years since supported employment was first identified as an evidence-based practice for helping people enter or re-enter the competitive labor market, and over a decade since the recovery movement reasserted the importance of work in the lives of those with serious mental illnesses; yet funding for employment programs remains minimal and national unemployment rates remain unchanged.

Even where providers in psychiatric rehabilitation agencies and consumer-operated programs have been able to cobble together funding and establish innovative models to address the challenge of employment, results have been modest at best. Supported employment has helped a relative handful of mental health consumers to find entry-level jobs; the hiring of peer specialists within the mental health system has created opportunities for rewarding work only for those consumers who want to work in human services; and new federal policies extending Medicaid benefits to individuals with disabilities who are working are infrequently used. Neither these efforts nor the legal mandates of the Americans with Disabilities Act (ADA), nor the exhortations of the President's New Freedom Commission on Mental Health, have yet demonstrated a measurable impact on work outcomes for those with serious psychiatric disabilities.

For the most part, people with serious mental illnesses are – and are likely to remain – unemployed, with only an occasional foray into poorly paid, part-time, and short-term work, despite ample evidence that people with serious mental illnesses should, would, and could work in the competitive marketplace if there were adequate supports to prepare them for work and sustain them in their jobs. There is clearly much to be done to ensure that, a decade from now, we will have made meaningful progress in supporting people with serious mental illnesses to prepare for independent careers. However, there are significant challenges to creating such supports.

This report explores one of those challenges: the degree to which people with serious mental illnesses served by public mental health systems make use of the same career training resources used by their non-disabled neighbors. In an increasingly demanding labor market – in which the level of skill required to obtain a decent job is on the rise – this report examines whether people with serious mental illnesses have access to career training opportunities in community colleges, for-profit technical schools, and nonprofit training programs (resources outside of the mental health field) that constitute the nation's existing workforce development infrastructure. It also asks whether some of those receiving job placement services only from mental health agencies could find better jobs by utilizing these mainstream career training resources.

In the process of studying these issues, however, a second major concern has emerged: the career training programs offered by community colleges, technical schools, and many nonprofit agencies prepare their students for specific jobs that are a part of the skilled and semi-skilled workforce. These jobs – electrician, home health aide, medical billing assistant, paralegal – constitute approximately half of the jobs in the country, some of them among the fastest growing job categories in the national economy. These are not entry-level jobs: they require specific skills and specific training, yet do not require a four-year diploma. These are the jobs for which few mental health programs provide training, placement, or long-term support.

This study explored the gap between job programs that helped to place consumers in entry-level positions and educational programs that prepared consumers for more professional employment. On the one hand, workers with serious mental illnesses typically are employed in entry-level, low-wage, and short-term jobs. While these jobs may be appropriate for some and/or a useful initiation into the world of work for others, many consumers continue to look for better paying, more secure and more interesting work. On the other hand, those interested in professional careers often must return to four-year colleges. This may be the best vocational plan for some, although many consumers are reluctant to face the performance pressures of either a regular college program or a professional career. In between these two broad employment categories are the numerous skilled and semi-skilled jobs that offer more rewards than entry-level work but make fewer demands than professional positions. It is in mainstream career training programs – in community colleges, technical schools and specialized nonprofit agencies – that one can find career-focused training for this sector of the job market. One of the questions posed here is how mental health, vocational rehabilitation, and workforce development systems can help people with mental illnesses access those resources.

This study explores four related questions:

> . To what degree are people with serious mental illnesses in public mental health systems currently referred to and supported in the nation's network of community colleges, technical schools, and nonprofit training centers preparing people for skilled and semi-skilled jobs?
> . Would it be useful to increase the participation of people with serious mental illnesses in this existing network of mainstream career training programs?
> . What are the barriers that have kept people with serious mental illnesses from making better use of local mainstream career training programs?
> . What changes – in policies, programs, and practices – would make it more likely that those with mental illnesses will enter and succeed in these career-focused programs?

This qualitative study involved extensive interviews with a wide range of individuals in two Pennsylvania communities, in both an urban setting (Philadelphia) and a nearby suburban/rural environment (Montgomery County). Interviews were held with mental health, vocational rehabilitation, and workforce development system administrators in both counties, with consumers of mental health services and the nonprofit mental health

agency staff who work with them, and with key personnel in local mainstream career training programs. This provided a rich and in-depth portrait of the issues. As the complexity of the questions became clear, additional interviews explored emerging themes with state and national leaders in the nonprofit community college and for-profit technical school fields. Finally, preliminary results were presented for feedback to six groups of providers and consumers working on similar issues in their own communities. This report provides a scan of the current workforce development field as it relates to individuals with serious mental illnesses, the results of the interviews, and respondents' recommendations for new approaches.

2. An Environmental Scan: Jobs and Job Training for People with Mental Illnesses

This study is based on three broad concerns: the continuing and startlingly high unemployment rate of persons with serious mental illnesses; the poor-to-moderate success of mental health programs in helping consumers who want to work to gain and maintain self-sustaining employment in the competitive labor market; and the failure of many mental health and vocational rehabilitation systems, in light of these problems, to make broader use of mainstream career training programs that assist other populations who are unemployed, disadvantaged and/or disabled to thrive in new careers.

Unemployment Remains Stubbornly High. The rate of unemployment for people with serious mental illnesses is generally estimated to be at or near 75% (Anthony & Blanch, 1982), a staggering rage of disengagement from the nation's labor market. This rate has not changed significantly over several decades (Baron & Salzer, 2002; Judith A. Cook & Razzano, 2000), and is higher than for any other disability cohort (Hennessey & Dykacz, 1989; "Social Security Administration," 1997). The implications of such pervasive unemployment have been noted by many authors. At the individual level, the negative impact of unemployment on self-regard, financial independence, emotional stability, and social integration is considerable (Dixon, Goldberg, Lehman, & McNary, 2001; Rutman, 1994). At a broader level, such pervasive unemployment has played a role in the development of what some identify as a "sub-culture of serious psychiatric disability," in which unemployment is the norm, further compounding the isolation of its members (Estroff, 1989).

The reasons for such widespread and long-term unemployment have been the focus of considerable research. Summarized as "the usual suspects" in one article (Baron & Salzer, 2002), they include: the impact of the disability on the focus, stamina, and cognitive abilities of consumers; the disinclination of many clinicians and counselors to discuss employment with consumers until other aspects of their lives have been stabilized; the hiring practices and prejudices of employers; the changes in the labor market that have seen a gradual erosion in the number of decent-paying and benefit-bearing jobs for those without educational qualifications or stable, long-term work histories; the unavailability in many communities of effective rehabilitation programs for individuals with serious mental illnesses (McQuilken et al., 2003); and – most frequently mentioned – the fiscal disincentives inherent in the financial and medical support programs of the Social Security Administration (SSA) that those with serious mental illnesses rely upon.

But this daunting array of explanations has begun – with glacial slowness – to give way to modest changes. New medications have tended to moderate the impact of mental illnesses on cognitive functioning and energy levels. President Bush's New Freedom Initiative (House, 2001) has served to re-emphasize the importance of employment as a core goal for state mental health systems. The ADA has put employers on notice that the

most flagrant forms of discrimination are not likely to go unchallenged. And the Social Security Administration's work incentive regulations (GAO, 2005a, 2007) and Ticket-to-Work programs (GAO, 2003, 2005b) make work both more possible and more financially rewarding to the consumer. Of particular importance are the relatively new Medicaid programs that permit states to offer Medicaid coverage at very low costs to working people with disabilities (DPW, 2008; "NJ Workability Frequently Asked Questions (FAQs),"). Nonetheless, employment rates remain disastrously low.

Baron and Salzer (2002) noted the additional impact of education on the employment of those with serious mental illnesses. Few demographic realities are as implacable as the relationship between years of education and annual earnings among the general U.S. population (U. S. Department of Labor) – with earnings rising along with years of education, leaving those with lesser educational achievements at the bottom of the earnings curve. The earnings of those with only a high school diploma or less (47% of the workforce) are significantly below those reporting "some college" (25% of the workforce). Their earnings are, in turn, less than those with four-year and graduate degrees (28% of the workforce).

Indeed, most advocates for national workforce development initiatives see career education as the economy's most urgent need (Newman, 1999; "Workforce development policies: Background and current issues," 2002). A wide range of programs – addressing the unemployment or underemployment of individuals on welfare, emerging from incarceration, or displaced by macro-economic shifts, etc. – focus on "human capital theory" interventions (Borjas, 2005), using skill training to improve individuals' competitiveness and earnings in the national labor market. In this context, the fact that so many consumers of public mental health services lack the educational credentials for positions beyond entry-level employment becomes a critical contributor to their unchanging high unemployment rate.

Supported Employment and Supported Education Report Modest Results. Mental health systems and mental health provider agencies have begun to focus on employment issues, and new education and employment programs are emerging in many communities. In part, this is a response to the growing importance of recovery principles (GAO, 2003) and the increasing attention given to the goals of community integration (Salzer, 2005). Recovery within the mental health community has tended to emphasize the importance of hope – a pervading faith in the ability of individuals with serious psychiatric disabilities to take control of their lives and move toward their goals – and there is an increasing recognition that a decent job is a major component of many consumers' hopes for themselves. Similarly, community integration suggests that consumers can re-establish themselves in valued roles within the community, rather than only within the sub-culture of psychiatric disability. This, too, has spurred new interest in competitive employment outcomes. Several authors on the topic (G. R. Bond, Salyers, Rollins, Rapp, & Zipple, 2004) noted that

> . . . community integration entails helping consumers to move out of patient roles, treatment centers, segregated housing arrangements and work enclaves, helping

them to move toward independence, illness self-management, and normal adult roles in community settings. . . . One way to describe community integration is by stating what it is not: community integration is not immersion in worlds created by and managed by mental health professionals, such as day treatment programs, sheltered workshops, group homes, and segregated educational programs.

The two most significant programmatic initiatives responding to consumers' employment goals have been supported employment and supported education. Sheltered workshops as training grounds for entry into the labor market have all but disappeared for people with serious psychiatric disabilities, and in-house work assignments in clubhouse and psychiatric rehabilitation programs are less popular than before. They have been replaced by supported employment and supported education, and although each is a dramatic and welcome reversal of long-held assumptions about individuals with serious mental illnesses, both still struggle to achieve more than modest outcomes.

Supported Employment. An amalgam of transitional and supported employment models (Baron, 1997; Beard, 1982; Clark, Bush, Becker, & Drake, 1996; NIDRR, 1992) has emerged as the most prominent programmatic alternative, with supported employment now widely designated as an "evidence based practice" (Gary R. Bond et al., 2001). While local programs differ in emphasis and pace, the supported employment approach typically relies on vocational counseling, job training, rapid placement into a competitive job, and long-term follow-up delivered by mental health agencies. Many supported employment programs have proven to be terrifically valuable to individual consumers, and current research estimates that at least 50% of supported employment participants find work (Gary R. Bond, Drake, & Becker, 2008; Judith A. Cook et al., 2005). There is as well a consistent finding that supported employment programs outperform both 'services as usual' and other vocational rehabilitation models.

However, there are several persistent areas of concern. First, many of the jobs obtained by supported employment participants are entry-level positions that are poorly paid, part-time, and without substantial benefits (Gary R. Bond et al., 2001; Robert E. Drake, Becker, & Bond, 2003; R. E. Drake et al., 1999; Lehman et al., 2002; Mueser et al., 2004). One multi-site study (Judith A. Cook et al., 2005) reported average annual earnings of $2,447 – a significant increase in income but one that still does not approach a level of economic self-reliance. Others, Crowther, Marshall, Bond, & Huxley, (2001), report the mean monthly earnings of supported employment graduates to range from a low of $42 to a high of $189, and even the most current review of randomized controlled trials reports no income data at all (Gary R. Bond et al., 2008). Indeed, most supported employment participants earn so little that they remain eligible for SSA financial and medical benefits (Gary R. Bond et al., 2001). Along with reported high rates of job loss – 50% of people in supported employment placements are unemployed within six months (Gary R. Bond et al., 2001; J. A. Cook & Rosenberg, 1994) – this suggests that supported employment programs do not yet offer strong evidence that they help most consumers develop a long-term attachment to the labor market. Such modest results argue that, at least for some consumers, other approaches might profitably be explored.

Supported Education. Supported education programs represent an alternative approach. The educational ambitions of mental health consumers have often been ignored. Unger (1998) noted that

> . . . consumers who have educational aspirations have often been discouraged from pursuing such goals, because they have been seen as unrealistic. As competitive employment goals gradually have become more accepted, it has become increasingly apparent that consumers are profoundly disadvantaged in terms of education achievements required to pursue meaningful careers.

A significant number of people with serious mental illnesses have at least some college experience, and consumer surveys often report that two-thirds to three-fourths of consumers want to increase their educations (Mowbray, Brown, Furlong-Norman, & Soylan, 2002), although it is unclear how tied their educational goals are to . However, career goals. Supported education programs, using many of the same principles as supported employment, have emerged over the past decade as a way to assist consumers in expanding their academic achievements. There are several supported education models that provide consumers with the supports they need to identify and apply to higher education, develop the study skills they need to succeed, and to use both academic resources and mental health staff to meet those needs.

Mowbray (2002) has provided an excellent summary of supported education approaches and achievements; and one is struck by the disparity between the rhetoric of these programs – focusing on the "educational achievements required to pursue meaningful careers" – and the reality of their implementation. Many supported education programs focus on helping students to take college classes or complete four-year degrees, without a consistent emphasis on the relationship between these educational achievements and future careers. When outcomes are reported, they often relate to self-esteem and personal satisfaction, or class attendance and courses passed, but rarely to the movement from education to employment. It is useful to note that supported education remains a new and evolving approach, and that the time frame for moving from education to employment is an elongated one for most students. However, while the value of "education for education's sake" is not to be diminished – for either the general population or for mental health consumers – the competitive labor market, particularly at the level of skilled and semi-skilled employment, has made appropriate training, certification, and/or licensure critical.

Mental Health Systems Remain Isolated. Despite the growing importance of career training in the U.S. labor market, the delivery of employment and educational services for those with serious psychiatric disabilities remains isolated from the array of mainstream programs that can, at least theoretically, assist people with serious mental illnesses toward achieving more rewarding careers. *Supported employment* programs focus on rapid placement into entry-level positions and the provision of supportive services over the long-term. Yet, without more specialized training, consumers do not have the skills or certifications they need, nor the ability to pass required state licensing examinations, for the skilled and semi-skilled jobs that might otherwise await them. *Supported education* programs tend to assist consumers in expanding their educational

horizons and occasionally attain four-year college degrees (and the potential for professional careers). However, few such programs support people with mental illnesses in obtaining the specialized training available in community colleges and technical schools that focus on careers in skilled and semi-skilled jobs. Ignoring these opportunities may not serve every consumer well.

Even a partial listing of the job opportunities available in the skilled and semi-skilled labor market provides a rich sense of the career paths untaken. Programs are available in most communities to provide an introduction, specific skills training, certification, and preparation for state licensing exams in a wide range of fields. Within the health care and human services sector, for instance, there are in-depth training programs and abundant job opportunities for certified nursing assistants, home health aides, day care workers, home visiting specialists, medical assistants, respiratory care technicians, phlebotomists, and medical billing personnel. Building trades programs prepare people to be plumbers and electricians, certified truck drivers, heating/ventilation/air conditioning personnel, and automotive technology mechanics. Skilled office workers can find jobs in data entry, paralegal work, accounting assistance, and business communication. Veterinary assistants, forensic technicians, dental hygienists, physical therapist assistants, and physician assistants, for instance, were listed by the U.S. Department of Labor in 2004 as the nation's fastest growing occupations (*Pennsylvania workforce development: Keeping Pennsylvania competitive creating opportunity*). None of these careers require a four-year degree. In fact, nearly half the jobs in the U.S. economy are in skilled and semi-skilled technical fields, commanding better salaries and working conditions than entry-level work but not requiring a four-year college degree (U. S. Department of Labor)

Many fields are regulated by state government entities, so that both certification (which may vary from completion of a six-week course to graduation with an associate's degree in the arts or sciences) and passing a state licensing exam are necessary. Many are in fields where the demand for trained workers is quite high and jobs are readily available to graduates (Holzer & Lerman, 2007). Such jobs offer substantial salaries, often with reasonable health care and other benefits. Several offer workers a wide range of part-time and full-time options. Some lead to self-employment, others to positions with large employers. Most offer the successful worker both more satisfying work and greater opportunities for career mobility. The fundamental question raised in this research is whether consumers in the public mental health system are referred to the programs that prepare people for these jobs, assist them in completing the programs, and help them to translate certifications and degrees into careers – and, if not, why not?

3. Defining Mainstream Career Training Resources

Where are mainstream career training programs available? Almost without exception, they are not available from mental health agencies offering vocational services, and for a few good reasons. If they have any vocational focus at all, mental health agencies must attempt to address the needs of a wide range of individuals with varying talents and interests. Shaping one or two specialized skill training programs – to prepare clients to work as data entry personnel or home health aides, for instance – would often leave the agency without the resources to meet the education and training needs of the majority of their consumers. Second, training for skilled and semi-skilled jobs requires an investment in materials and machinery, experienced teachers, and workforce connections that is beyond the resources of most mental health agencies, particularly with so diverse a set of interests among consumers.

But an abundance of such programs are available within most communities across the country. This report focuses on three particular settings:

Community Colleges. Community colleges were initially established as an opportunity for people not yet prepared for the rigors of a four-year college program to work toward a two-year associate arts (AA) degree and then transfer to a four-year program in more traditional colleges. More recently, however, community colleges have also offered a wide array of career-focused programs – some as short as one semester, others offering a two-year degree in a specialized field – that prepare many students to enter the job market and help many others acquire the academic qualifications for career advancement. In the process, community colleges have become a central component of the nation's workforce development infrastructure, particularly with regard to the needs of economically and/or socially disadvantaged populations. With 1,195 community colleges nationally, 11.5 million students, low costs, and literally hundreds of programs preparing people for careers in such fields as health care, information technology, and homeland security ("American Association of Community College's CC STATS," 2008), these programs offer people with mental illnesses a wide range of opportunities to move beyond entry-level employment.

Technical Schools. There are at least as many for-profit educational institutions throughout the country, offering six-week, two-year, and four-year programs with a very targeted career focus. While not inexpensive, each school tends to focus on a handful of areas – e.g., juvenile justice, computer-assisted design, cosmetology – that offer basic training, support for passing state licensing exams, and referral to an interested employer network. There is a tremendous variety in these programs. Some are licensed by state education agencies and some are not; some are quite small and others quite large; some operate independently and others are part of a national chain (ACCSCT, 2006, 2007); some have excellent reputations and a few have been cause for concern. All promise to prepare and place students in the most rapid way consistent with quality outcomes. Although more expensive than community colleges, they are less expensive than more general four-year programs in university settings.

Specialized Nonprofit Programs. A variety of nonprofit entities offer comparable programs. These specialized programs – focusing on the development of a particular skill – are based in community centers, union offices, and nonprofit agencies serving other disabled or disadvantaged populations. Over the past decade, specialized training programs in non-profit agencies have expanded rapidly to serve welfare-to-work clients, ex-offenders, those with physical disabilities, or immigrants and refugees, among others. These programs – like community colleges and technical schools – could provide those with serious mental illnesses the opportunity to develop marketable skills, but – like community colleges and technical schools – do so in a more integrated environment.

There are a variety of ways in which people with mental illnesses can access community colleges, technical schools, and nonprofit programs. While individuals can explore the options on their own, consumers in public mental health systems often rely either on their case managers and/or career counselors for assistance. Such help might include career exploration, assistance in selecting the right career training program, and both the provision of direct financial support and help in applying for financial aid packages. Alternatively, mental health agencies often begin by referring consumers to their local state offices (or bureaus or divisions, etc.) of vocational rehabilitation, specifically designed to help people with disabilities of all kinds – including those serious mental illnesses – return to productive, independent employment. More recently, federal legislation has established a national network of county-level Workforce Investment Boards (WIBs) designed to oversee local workforce policies and programs for anyone (e.g., displaced workers, welfare recipients, homeless individuals, as well as people with disabilities) seeking to improve their vocational status. In turn, the WIBs operate One-Stop Career Centers, where citizens have access to varied information and financial resources for career training; and the state offices of vocational rehabilitation are part of the array of services offered in these one-stop settings.

As this report will detail, all of these programs face their own challenges in meeting the needs of their current consumers – and many report that they already struggle to assess the best ways to meet the needs of consumers they identify as having behavioral health problems. The question raised here is whether these programs represent an underutilized resource for mental health systems seeking to meet their commitment to recovery and community integration principles.

A key assumption should be made explicit. First, although this study sought to explore the use of mainstream training opportunities for mental health consumers as an avenue out of entry-level work, there is no implied denigration of entry-level work. Millions of Americans make their living in the low-wage sector of the economy. Whether they do so as a career or as a stepping stone to better jobs, those employed in entry-level jobs make a valuable contribution both to the nation's prosperity and to the worker's self-regard and self-sufficiency. For many people with serious mental illnesses, entry-level work is the right choice, and for some a good temporary choice on the way to more satisfying and rewarding careers.

Rather, it is the perspective of this report that, for many other clients, entry-level work may not be either an appropriate long-term or even short-term option. While some may have the capacity, interest, and drive required to complete a four-year program and succeed in the professions, for many other people – as for many of the national workforce without disabilities – skilled and semi-skilled work may be more appropriate. We have no reliable estimate of how many consumers of mental health services could benefit from such programs primarily because – as this report will demonstrate – we haven't attempted to refer consumers to and support them in these programs.

4. Methodology

Research Questions. The study has four central research questions:

1. To what degree are people with serious mental illnesses in public mental health systems currently referred to and supported in the nation's network of community colleges, technical schools, and nonprofit training centers preparing people for skilled and semi-skilled jobs?

The first challenge of the study was to assess whether it is accurate to say that there is little participation of people with serious mental illnesses in mainstream career training programs. A number of research initiatives (Erickson-Cornish, Riva, Henderson, Kominars, & McIntosh, 2000; Pledge, Lapan, Heppner, Kivilighan, & Roehlk, 1998; Salzer, Wick, & Rogers, In Press; Sharpe, Bruininks, Blacklock, Benson, & Johnson, 2004; Souma, Rickerson, & Burgsthler, 2002) suggest that many colleges and universities are host, sometimes unknowingly, to many persons with psychiatric disabilities, and that these students' level of participation in college life was a source of concern (Baron & Piasecki, 1981; Collins & Mowbray, 2005) and some confusion with regard to ADA requirements to provide reasonable accommodations. However, most of the studies cited above focus on four-year programs, rather than community colleges and technical schools, and the students were often those who were pursuing their educational goals without the support of private or public mental health professionals, and sometimes in defiance of a psychiatrist's professional advice. This study sought information on the degree to which mental health programs themselves referred consumers of public mental health services to career-focused programs and offered them the support needed to succeed.

2. Would it be useful to increase the participation of people with serious mental illnesses in the existing network of mainstream career training programs?

The study sought the opinions of varied constituencies – mental health, vocational rehabilitation, and workforce development professionals; consumers and mental health providers; and community colleges, technical schools, and nonprofit programs – with regard to the advisability of expanding consumer participation. Would this be a good idea or not, from varying perspectives?

3. What barriers have kept people with serious mental illnesses from making better use of local mainstream career training programs?

The study explored in some depth, and from the same range of constituency perspectives, the barriers that keep people with serious mental illnesses from greater participation in these programs. In particular, the study attempted to uncover any policy, program, or practice barriers that limited consumer choices to either unemployment or entry-level work.

4. What changes – in policies, programs, and practices – would make it more likely that those with mental illnesses would enter and succeed in these career-focused programs?

The study sought recommendations from interviewees with regard to increasing the participation of people with serious mental illnesses in career training programs. That is, if participation is low and more participation is desirable, what changes – in the focus of mental health programs, in the accessibility and supports provided by career training programs, in counselor practices, and in public funding – would overcome the existing barriers?

Research Setting. The study provides a qualitative exploration of these four issues, consisting of in-depth interviews with mental health, vocational rehabilitation, workforce development, and provider agency administrators, counselors and consumers, along with interviews with personnel in community colleges, technical schools, and nonprofit training programs. The study sought to better understand the issues as they played out in two settings in southeastern Pennsylvania:

. *Philadelphia.* A populous, demographically diverse, and intense urban environment, Philadelphia has a progressive public mental health system and a wide range of community mental health centers, psychiatric rehabilitation programs, and consumer-run mental health services. The city's vocational rehabilitation and workforce development programs are sizable; and there is a well-established and substantial community college, an abundance of technical school choices, and a wide array of nonprofit human services agencies with varying training program emphases.

. *Montgomery County.* Nearby Montgomery County provides a considerable contrast: a suburban and rural county, it is far more demographically consistent on issues such as race, income, and educational level. While the county mental health program for this largely white, prosperous, and college-educated county is well-oriented to the principles of recovery and community integration, the county has far fewer mental health service providers, technical schools, and nonprofit training programs outside of the mental health system.

The study was initially designed to contrast the experiences of mental health consumers in these two settings. However, few differences emerged in respondents' answers across the two counties. The issues respondents spoke to reflected broader concerns than geography, socio-economic status, or local resources. These are systemic issues, having to do with professional orientations, consumer beliefs, and the public policies and practices that shape both program designs and agency resources.

Research Methods. The research process slowly developed a mixed-methods approach. Qualitative interviews were conducted with 86 people in the two counties, using both individual interviews and focus group discussions in different settings and with different subjects. Although not part of the original design, it was determined important after perhaps a dozen initial interviews to also gather information from key national and state

organizations in the community college and technical school fields to address topics that emerged in the course of the earlier interviews. Finally, several mental health planning groups in other New Jersey and Pennsylvania counties had an opportunity to review and help to interpret preliminary findings before the development of this final report..

Research Subjects. Representatives of several constituencies were interviewed in both counties:

. *System Administrators and Staff (10 people).* Three systems – mental health, vocational rehabilitation, and workforce development – dominate the delivery of employment services to people with serious mental illnesses. Administrators and staff in these systems were individually interviewed in both Philadelphia and Montgomery counties.

. *Consumers (34 people) and Providers (23 people).* While the study had originally intended to conduct individual interviews with six consumers, four group interviews were conducted instead. This was partly because consumers indicated a greater level of comfort in group settings and partly because of the considerable interest in the study expressed by consumers. Four "focus group"-styled interviews were conducted on the premises of four psychiatric rehabilitation programs. The psychiatric rehabilitation programs that hosted the consumer focus groups also agreed to have program supervisors and direct service workers interviewed, two in Philadelphia and two in Montgomery County. In addition, supervisory staff in four consumer-operated programs – all in Philadelphia – were interviewed from their perspective as consumer-directed programs offering residential and vocational rehabilitation programs.

. *Mainstream Career Training Programs (13 people).* Community college staff – from the colleges' offices of disability services – were interviewed at both Philadelphia Community College and Montgomery County Community College. Administrative personnel and admissions staff from five technical schools (three in Philadelphia and two in Montgomery County) were also interviewed. In addition, program managers in five nonprofit agencies offering specialized training programs to citizens with other disabilities or disadvantages participated in the research.

. *National and State Officials in Community College and Technical School Accrediting and Professional Organizations (six people).* Several interviews were conducted with state and national organizations in order to gather additional information about mainstream career training programs that would place the local programs in a broader context. To gather more information on technical schools, for instance, interviews were conducted with one of the national professional organizations representing technical schools and with one of the national accrediting bodies for technical school education. Additional informational interviews with state education officials in Pennsylvania were also conducted. More information on each of the individuals and organizations that participated in the study is included below.

Finally, and unexpectedly, the research investigator was fortunate to develop a consulting relationship with six county-level workgroups – two in Pennsylvania and four in New Jersey – interested in expanding career training opportunities for people with serious mental illnesses. This provided an opportunity for preliminary findings to be shared with workgroup members (consisting of consumers, mental health providers, vocational rehabilitation personnel, and workforce development staff). Their interpretations and explanations of the preliminary findings are reflected in this report as well.

Both individual and focus group interviews consisted of a loosely structured series of inquiries that addressed each of the four research questions. However, in keeping with qualitative research theory, the interviewers tended to respond to the comments and concerns of interviewees. In each interview, of approximately 60 to 90 minutes, the principal investigator explained the purposes of the study, then raised a series of questions and followed up interviewee comments. The interviewer also asked for advice on other questions to be asked and other individuals it might be important to interview. The participating consumers were paid for their time.

Protection of Human Subjects. Many of the mental health, vocational rehabilitation, and workforce development personnel interviewed had readily agreed to participate in the study when initially contacted, either by phone or letter, as did administrators and staff at mental health agencies providing rehabilitation services. Administrators at community colleges and specialized training nonprofits were often also eager to participate when contacted by the principal investigator by phone or mail, although several other technical school administrators were uninterested in the study and declined to be interviewed. Those who did participate in the study went out of their way to be accessible and informative. At the beginning of every interview, each subject was asked to read and sign an informed consent form approved by the University of Pennsylvania Institutional Review Board.

Mental health provider agencies were asked to identify consumers who might be interested in participating in the interviews. The principal investigator provided agency staff with a one-page summary of the project, and asked staff to share this information with consumers and then ask for volunteers. The principal investigator only met with consumers once they had volunteered and agency personnel had established the time for the focus group. At each focus group the principal investigator again explained the focus of the project and the questions involved, and then asked group members to read and sign an informed consent form, also approved by the University of Pennsylvania Institutional Review Board.

The principal investigator took notes at each interview, and transcribed these notes within 24 hours; the notes served as the basis for ongoing and final analysis. Summaries of each interview were constructed and reviewed to identify key themes and develop interpretations (Charmaz, 2000). This occurred on an ongoing basis, following the completion of each interview, and again at the conclusion of all of the individual and focus group interviews. The interview summaries were reviewed several times to develop categories of responses. As noted above, preliminary results were shared in several

settings, and the understanding of the issues and interpretations of the findings generated by the six workgroups contributed to a further refinement of major themes.

Research Limitations. The broad applicability of the findings is limited by the focus on only two county settings – Philadelphia and Montgomery counties, in Pennsylvania. However, given the similarity of the comments in these two very different environments, there is reason to believe that the issues identified here are more systemic to the delivery of human services than to any specific place or environment. The study's findings are also somewhat limited by the qualitative nature of the investigation. The study reflects consensus and disagreement as it was expressed by interviewees. However, no effort was made to sit in on consumer/counselor meetings, to follow individual referrals through these systems, or to chart finances in each system or with regard to individual service provision. No quantitative data were collected independently by the principal investigator; rather, the research relied upon existing documents about individual programs and national initiatives. However, the relative unanimity of responses argues that these interviewees' sense of how the system works – and where it does not work well – may represent the reality in this complex human services environment.

5. The Current and Potential Pattern of Referrals

This section explores the first two research questions of the study: a) to what extent are those with serious mental illnesses in public mental health systems currently referred to career training programs outside of the mental health system; and, b) would it be useful to increase their participation in these external programs? The questions are dealt with separately from the other two research questions primarily because the answers to each of these questions were so similar: not only did the responses not vary in the two very different counties, but they were nearly identical across each category of interviewees.

To what degree are people with serious mental illnesses in public mental health systems currently referred to and supported in the nation's network of community colleges, technical schools, and nonprofit training centers preparing people for skilled and semi-skilled jobs?

The answer was consistent: there is very little connection between public mental health systems and mainstream career training programs, and no discernable pattern of referrals from mental health provider agencies or individual mental health counselors to community colleges, career schools, or nonprofit training programs outside of the mental health system. To the degree that they are addressed at all, the career education and competitive job ambitions of people with serious mental illnesses are largely met by the network of job programs within mental health agencies. Three major themes emerged in respondents' answers, providing an initial framework for grasping the reasons for this lack of connection.

A Knowledge Gap. At the most fundamental level, there is a profound lack of information within the mental health system about community resources in this arena. Many mental health respondents – system administrators, program directors, and direct service personnel – acknowledged that they knew nothing or very little about community colleges, technical schools, or other specialized training programs, nor the skilled and semi-skilled jobs for which they prepared students. Many reported that they had never considered these options: the system has been oriented toward referral from mental health agencies to the regional Office of Vocational Rehabilitation, with anticipation of a referral back to the mental health agency's own vocational programs. Indeed, respondents in the mental health system had only a vague sense of the services and supports of their local Workforce Investment Board and the resources available in its One-Stop Career Centers. Workforce development respondents, similarly, acknowledged that they knew very little about people with mental illnesses, their career prospects, the agencies they utilize for career training, and their prospects for effective use of the One-Stop Career Centers' resources.

Given such an information gap, it was not surprising that mental health agencies reported they rarely if ever referred the consumers they counseled to mainstream career training resources, or that only one or two of the consumers interviewed in this study could recall

being encouraged to explore these resources as options. The respondents in the offices of disability services in the two county community colleges "almost never" received a call from a mental health case manager, a job coach, or even a private psychiatrist about one of their consumers. A similar lack of connection to the mental health community was reported by both technical schools and other nonprofit programs. One of the psychiatric rehabilitation programs participating in the study is only a half-block away from one of the area's best-known technical schools, but no connection exists and no referral from one to the other has ever been made. These are systems and services unconnected to, and often unaware of, one another, operating in separate worlds.

A History of Failure. The only respondents with a reasonable working knowledge of both mental health issues and career training resources in the two counties were the administrators and counselors of the two participating Offices of Vocational Rehabilitation (OVR), in Philadelphia and Montgomery counties. OVR counselors are responsible for vocational rehabilitation across the entire spectrum of the disability field, and they maintain strong relationships with community colleges, technical schools, and other nonprofit training programs through their referrals to and funding of these career training programs. They support many people with other disabilities in these settings, and have a good sense of which of these programs are effective. However, the OVR respondents reported that they rarely refer people with serious mental illnesses into these mainstream career training programs.

VR administrators and counselors attributed the failure to connect mental health consumers to mainstream career training programs mainly to a history of failure in working with the individuals referred to them by the mental health system. Both OVR offices reported that the consumers referred from community mental health centers and psychiatric rehabilitation programs have often been vocationally unfocused, unprepared for the rigor of mainstream programs, and often unwilling to accept referral to training facilities outside the reassuring environment of the mental health agencies. With the emergence of supported employment programming as an "evidence-based practice" in the mental health arena, the individuals referred from local mental health service programs are most often referred back to them for specialized support.

Participation Without Support. Yet there is no shortage of students with serious mental illnesses in community colleges, technical schools, and other nonprofit career training programs, according to the mainstream career training programs. As noted previously, there is considerable evidence that college campuses host a significant number of students with psychiatric disabilities. Many students with emotional problems go to school "under the radar" – never revealing their psychiatric conditions to other students, faculty, or the campus offices specifically designed to assist students with disabilities. The mainstream career training programs in this survey all reported that, regardless of the lack of connection to or referrals from mental health programs, there were substantial numbers of students who either were identified by faculty as displaying serious behavioral problems or who contacted administrators on campus to seek support, accommodations, or special understanding because of their emotional problems. For these students, however, there appeared to be no support from mental health personnel.

In such instances, the career training programs reported, they made every effort to meet students' needs; but they were far more likely to contact the mental health system once a behavioral health problem had emerged and been acknowledged than to receive information ahead of time from public or private mental health providers about particular students. Several consumer respondents to the survey reported that they had once taken the initiative to enroll in a mainstream career training program, but did so either against the advice of their mental health professional supports, or simply chose not to tell their psychiatrist or case manager for fear of being discouraged. What emerges from these interviews is some evidence of a pattern of referrals from mainstream career training programs to mental health providers, rather than the other way around.

Would it be useful to increase the participation of people with serious mental illnesses in this existing network of mainstream career training programs?

Given the ascendancy of recovery and community integration approaches to the delivery of public mental health care – the emphasis on a hopeful journey toward "valued social roles" and the rebuilding of one's own life within the context of community – it was surprising to find that the consistent response across all the respondent categories to the prospect of increasing consumer participation in these opportunities was a hesitant "maybe." While a few respondents did recognize that these existing resources had been overlooked, most were wary of proceeding in this direction. Each category of respondents had their own reasons for wariness – detailed in the next section of this report – but respondents consistently warned that such an approach needed to be undertaken, if at all, with considerable caution. Several explanatory themes emerged.

Theory vs. Practice. Many respondents spoke about the difference between a theoretically attractive approach and an achievable set of changes. The barriers to implementation – detailed in the next section – appeared, if not innumerable, then substantial; and many doubted that the changes in public policy, program funding, and on-the-ground practice could be implemented in the foreseeable future for more than a handful of consumers.

There was a disquieting sense of satisfaction with the status quo, as well as a reluctance to confront the modesty of the success of existing supported employment and supported education programs. On the one hand, the consistency of respondents' wariness suggests the inadvisability of policy or programmatic efforts to expand consumers' use of mainstream career training resources: many respondents did not feel that the expanded use of mainstream career training programs was likely to lead to successful outcomes. On the other hand, the consistency of the response might suggest the limited impact, thus far, of recovery and community integration approaches in shifting the expectations of mental health and vocational rehabilitation personnel – or of consumers themselves – about what might be possible.

The Scope of Change. Respondents within the mental health and vocational rehabilitation systems frequently asserted that mainstream career training programs were

appropriate for only a very limited number of consumers in the public mental health system. Yet they acknowledged that the current and nearly exclusive reliance on programs based within mental health settings closed off opportunities for entering skilled and unskilled employment even for those for whom mainstream career training could be the right choice. Respondents in both the workforce development system and mainstream career training programs often expressed concern that they were unprepared to address the needs of a significant number of new students with serious behavioral problems.

More positively, there was willingness by many to consider changes on a case-by-case basis. Mental health and vocational rehabilitation agencies were willing to consider expanding the career training options available to individuals with mental illnesses given an array of conditions, detailed below, that would help to ensure their success; and mainstream career training programs were willing to consider the occasional new student with behavioral health problems under the same sorts of conditions. What remained unknown is the number of consumers for whom these programs would be appropriate under these conditions.

Consumer Choice. Many respondents observed that it was difficult to discern a high level of consumer demand for work opportunities, the goal of both mental health and mainstream career training programs. Given the importance attached to consumer choice within both recovery and community integration philosophies, consumers who were not strongly motivated to exchange their dependency on SSA support for the rigors of a job in the competitive labor market, or who were either ambivalent or anxious about such a change in their circumstances, were generally only lightly encouraged to consider work and then no longer pressed – or badgered – to identify and pursue employment outcomes, much less referred to mainstream career training opportunities.

This reality suggested to more than a few respondents that pursuing greater use of mainstream career training programs might be futile. Only a handful of the respondents suggested that the widespread disinterest in work they reported was contextual: in a system of care in which unemployment is a norm; in which few family members, friends, or mental health personnel encouraged work goals; and in which seeking employment entailed substantial risks but left consumers with few resources, the decision not to pursue a job (and career training) might be more of a forced choice than a personal expression of preferences.

6. System Perspectives: Barriers to Utilization of Mainstream Career Training Resources

Each of the respondent categories had varying interpretations of the difficulties consumers face in accessing and succeeding in career training for skilled and semi-skilled positions. The respondent categories are grouped here into three major clusters:

a) system responses – the perspectives of county-level mental health, vocational rehabilitation, and workforce development officials, who carry major responsibility for public policy, program funding, and priority setting in each of the counties;

b) on-the-line responses – the perspectives of consumers on these issues as well as of the mental health practitioners in community mental health centers and psychiatric rehabilitation programs, with key case management and service delivery mandates; and

c) mainstream career training responses – the perspectives of the community colleges, technical schools, and specialized nonprofit programs that might be better utilized in the delivery of career training services to those with serious mental illnesses.

This section of the report provides an assessment of the perspectives of the three major systems of care on the difficulties they face in connecting people with serious mental illnesses to mainstream career training resources.

A. County Systems of Care

Three human services systems have major roles in the design and funding of employment services for people with serious mental illnesses: 1) mental health programs in Pennsylvania are primarily organized with major responsibilities at the county level; 2) the state/federal vocational rehabilitation system, organized in Pennsylvania in regional offices; and 3) workforce development programs, with Pennsylvania hosting county Workforce Investment Boards, each of which operates at least one One-Stop Career Center. Each of these systems has developed separately, with differing missions and priority populations, as well as funding streams.

Relationships between mental health providers and their corresponding regional vocational rehabilitation offices are longstanding and often a source of friction: there are perennial arguments about both individuals and programs. While OVR counselors often believe that the individuals referred for OVR services are either uninterested or unready, and frequently question the effectiveness of the employment services offered by mental health agencies for OVR funding, mental health agencies often complain that OVR counselors are overly negative about the work potential of consumers and too demanding about the work outcomes that can be rapidly obtained with OVR funds.

Further, while OVR has a mandated presence in every One-Stop Career Center, they are widely perceived to be there to relieve the staff of the burden of grappling with the special problems inherent in assisting people with disabilities. As a consequence, there is a only a very tangential relationship between the county mental health offices and their corresponding workforce development networks: several times in the course of this study, the principal researcher was asked by county mental health administrators to explain how the workforce development system worked and its relevance to individuals with serious mental illnesses. While there are periodic efforts to improve coordination among these programs, the systemic differences among these three key systems of care has made this unusually difficult.

    1. Mental Health System Perspectives. In Pennsylvania, the delivery of public mental health care in community settings is the responsibility of county government. While the state plays a central role in managing the state psychiatric hospitals and sets both regulations and funding levels for the county programs, local priorities for services and allocation of funding for individual programs are the task of county government. Pennsylvania's Office of Mental Health and Substance Abuse Services has strongly promoted recovery and community integration for years, and has encouraged the counties to give serious consideration to the employment aspirations of those with serious mental illnesses. However, as is described below, both federal regulations and state priorities have limited the funding and the flexibility of programs to address these needs. Two of the most progressive county mental health offices – that is, those with the most immediate and vigorous response to recovery and community integration principles – were the focus of this study; and respondents from the two counties were the individuals with central responsibility for addressing the rehabilitation needs of those with serious mental illnesses.

    . *Philadelphia.* Philadelphia has a large, vibrant, and progressive mental health community. It eagerly responded to deinstitutionalization in the 1960's, establishing 13 federally funded community mental health centers covering every neighborhood; funded one of the nation's earliest and best-regarded psychiatric rehabilitation programs (Horizon House); and, unique in the nation, has established its own city-run managed care entity for Medicaid-eligible consumers. Most community mental health services are delivered by a wide range of nonprofit mental health agencies under contracts with the Philadelphia Department of Behavioral Health and Mental Retardation Services or its Medicaid managed care subsidiary, Community Behavioral Health. Meeting the needs of those with serious mental illnesses has proven difficult nonetheless; and the City's high level of poverty, low level of education, diminishing industrial tax base, and increasing numbers of immigrants and refugees have posed significant challenges, not least of which has been the difficulty of returning people with serious mental illnesses to work.

    . *Montgomery County.* Just north and west of Philadelphia is Montgomery County, a predominantly white, middle-class community with a far more modest investment in public mental health services. Services for Medicaid-eligible clients are contracted to a private managed care company, which – along with the County – contracts with a small number of nonprofit agencies for a range of case-management, counseling, and rehabilitation services. The county has been a leader in the state with

regard to promoting recovery and community integration principles, but with far fewer financial resources and programmatic options. A high percentage of the consumers in the public mental health system reside in two or three of the county's small towns – Norristown, Pottstown, etc. – where more practical problems (e.g., transportation and housing costs) can be more readily addressed. The county has a smaller job base, yet a higher percentage of jobs requiring a college education. These factors, along with the problems many poor county residents face in getting to work without a car in a county with a bare-bones transportation system, have made it difficult to address the training and employment needs of those with serious mental illnesses.

Despite the demographic and geographic differences between the counties, respondents had very similar assessments of the barriers to increasing the use of mainstream career training opportunities. Several major themes emerged from the interviews:

     a) **Work is not a system priority.** Mental health officials in both counties noted, with regret, that consumer employment has not been a priority of their mental health systems in the past. This is reflected in county mission statements, the level of funding allocated for vocational programs, and/or the outcomes the county expects from provider agencies. In that context, provider agencies – which view themselves as under-funded for their wide-ranging responsibilities – have not often made employment a program priority or a focus of the individual counselor-consumer interaction. A few programs, utilizing a clubhouse or psychiatric rehabilitation model, have addressed employment issues for the consumers they serve, with modest results. Respondents in both counties noted that the failure to make use of mainstream career training resources reflected a broader and more longstanding lack of commitment to helping their consumers find and maintain employment.

     b) **Consumer work motivation is low.** County mental health officials do not believe that consumers express an overwhelming interest in work-oriented programs or career training of any type. Respondents believe that many consumers see themselves as incapacitated by their mental illnesses and too prone to stress-related relapse to succeed in competitive jobs. Respondents in the county offices of mental health said they hear from consumers that families are unsupportive of their work goals, that their friends with serious mental illnesses have found comfortable lives within the mental health system, and that there are few pressures from program staff to consider work alternatives. No issue was mentioned more often in this study than the fear expressed by clients with regard to losing their eligibility for the financial support and medical benefits of SSI/SSDI (Supplemental Security Income/Social Security Disability Insurance) if they return to work, and it has proven difficult to convey the tangible benefits of SSA's work incentive provisions and Medicaid Buy-In programs in mitigating consumer and family concerns about being left without a safety net. In this context, referrals to mainstream career training resources, respondents suggested, were likely to be minimal.

     c. **Staff is uninformed.** County personnel are also concerned about the level of information available to direct care staff. They are unsure that line staff believe (and convey) a hopefulness about each consumer's job potential, or have the time to learn

more about such central issues as the SSA work incentives. Indeed, staff were likely to share consumers' concerns about their ability to face the stresses of either career training programs or competitive employment without risk of relapse. Further, county mental health officers feel certain that provider agency personnel are largely unaware of the mainstream career training resources available in their communities or the types of careers – work roles and career prospects, salaries and benefits, training requirements and licensing tests, etc. – within the skilled and semi-skilled workforce.

d) <u>Programs cannot provide necessary supports.</u> County mental health officials acknowledged that there were few resources available to support consumer participation in mainstream career training programs. Few supported education options were funded; and the current pattern of funding under Medicaid restricted most support services in the community to "facility-based" programming (e.g., partial hospitals, day programs, etc.), with more flexibility in staff roles only available to intensive case managers, who can work off-site but whose services are targeted to those with the most acute mental illnesses, and, thus, those least likely to make good use of career training programs. Few scholarship programs (for tuition) or specialized philanthropic resources (for programming) were available to provide support to consumers who might benefit from career training.

2. Vocational Rehabilitation System Perspectives. Vocational rehabilitation services at the local level are driven by both federal legislation and funding – a result of successive Vocational Rehabilitation Acts of the Congress to provide for the vocational counseling and job training needs of individuals with disabilities. Each state government matches federal dollars, and must meet the federal requirements with regard to the people served, the programs supported, and the outcomes anticipated. In general, the vocational rehabilitation (VR) budget is evenly divided between support for VR counselors and the purchase of job training or adaptive devices for consumers. VR counselors provide an array of career counseling, job interview preparation, résumé development, and job finding services; but they can also purchase career education and/or job training for consumers from either nonprofit or for-profit agencies. Thus, VR counselors have a wide range of knowledge both about disabilities and about career training. They support many persons with serious disabilities in four-year colleges, community colleges, and technical schools; and provide program funding or per person allocations for job training to both mental health agencies and other nonprofits.

In Pennsylvania, the Office of Vocational Rehabilitation (OVR) allocates dollars to its regional offices, but closely monitors performance. Individual counselors, regional offices, and state VR programs are assessed and rewarded in accordance with the success they achieve, as measured by the percentage of those they accept for services who find competitive employment. This gives the system an incentive for declining to serve those who they do not believe have a reasonable chance of success in the marketplace. This has been the source of ongoing tension between the mental health and vocational rehabilitation systems for several decades. Despite the perception of mental health providers that the VR system has often been unresponsive to the needs of mental health

consumers, those with mental illnesses remain the largest cohort of persons with disabilities served by the state/federal VR system.

For this study, interviews were conducted with the directors of the Philadelphia and Rosemont regional OVR offices, serving Philadelphia and Montgomery counties respectively. Additional interviews were held with other administrative staff, supervisors and counselors. Again, the interviews reflected few differences in perspectives between the two counties, but also a pervasive sense of discouragement in their ability to help persons with serious mental illnesses return to work, and, thus, their sparing referral of mental health consumers to mainstream career training programs. An analysis of the interviews identified six main explanations for this.

a) **Respondents reported that many of those with serious mental illnesses referred to OVR have too many significant employment deficits.** VR administrators, supervisors, and staff find the consumers referred to them from mental health agencies to be among the most difficult cases they confront. The respondents noted the most prominent issue: consumers' expressed lack of motivation for work, variously due to their fears about the loss of SSA support, the absence of strong family support, and concerns about stress-related re-hospitalization. Further, VR counselors argued that many of those referred to them either have limited educational achievements (which make them ineligible for the demanding career training programs in the mainstream) or an expressed desire to be referred back to their community mental health center or psychiatric rehabilitation program (and their transitional and/or supported employment programs), where they feel more comfortable. Even those who are referred to career training opportunities outside of the mental health system, these respondents reported, either fail to graduate, or graduate but then either refuse to seek employment or soon leave the jobs they do obtain.

b) **Mental health workers have only a limited sense of "readiness."** The OVR respondents all commented that mental health staff often refer persons with serious mental illnesses who remained too disabled to succeed in career training programs or who were not yet ready to meet the demands of the workplace. Some respondents argued that mental health workers continue to refer consumers in order to increase funding for the mental health agencies' own vocational programs or offer clients a more normative social setting in a college environment, rather than because of an individual consumer's level of motivation or work capacity. This is a long-standing complaint of the VR system. Other respondents felt that mental health workers were not able to accurately assess their consumers' readiness for the rigors of career training and competitive work.

c) **No supports are available for individuals with mental illnesses if they are referred to mainstream career training programs.** The study's VR respondents asserted that those mental health consumers OVR might fund in mainstream career training would need substantial counseling and support to succeed. The large caseloads for VR counselors limit the counselors' time to respond to consumers' ongoing needs, periodic crises, and practical problems. Further VR counselors reported that they do not have the knowledge base or skill level required to serve individuals with unique disabilities. It is – or they feel it ought to be – the responsibility of the mental health

system to provide those supports. But their experience has been that mental health staff are themselves too busy or too restricted by their regulations to provide the supports consumers with mental illnesses have needed in either jobs or training programs outside the mental health system.

d) **Limited financial resources to support career training makes VR counselors cautious of approving training programs for consumers who are not yet ready.** With limited funding, OVR can allocate only so many dollars to each consumer for training. Starting too early (before the consumer is prepared for the rigors of career training) or without a clear focus (before the consumer has identified and committed to a career direction) is likely to lead to consumers failing in programs. This not only wastes VR dollars but is likely to leave the consumer without needed financial support from OVR when he or she is more ready for career training.

e) **If consumers of mental health services were better prepared for career education, career education providers could readily meet their needs.** On a more positive note, VR respondents felt that better preparation and support of mental health consumers could lead to broader utilization of career training resources. The VR administrators in both counties felt that their counselors have a strong sense of the adequacy or inadequacy of each of the career training programs in their regions, and that they make cautious judgments of the appropriate "fit" between a specific consumer and a community college, technical school, or other nonprofit specialized program. While they question the integrity and effectiveness of some private for-profit schools, which they feel may too often offer training in a declining job category or too quickly accept students all-too-obviously unlikely to succeed, they were also clear that they had rarely, if ever, found that either community colleges or technical schools were likely to discriminate against students with mental illnesses. They also found that there were few instances in which students with mental illnesses had complained about harassment by faculty or other students in these settings. This challenged the strong perceptions among mental health personnel that these were frequent problems.

f) **For a few consumers with serious mental illnesses, however, utilization of mainstream career training programs can be a great success.** All of those interviewed in the VR system had individual stories of great success in mainstream career training programs with one or two consumers with serious mental illnesses, many dependent upon the support systems that the individual was able to draw upon. However, respondents often pointed out, many of those individuals with serious mental illnesses who were supported by the VR system in mainstream career training programs had sought out VR support independently, and were not engaged with local mental health providers.

3. Workforce Development Systems. The 1998 Workforce Investment Act (WIA) consolidated a wide range of previously uncoordinated federally funded workforce training programs for displaced workers, immigrants and refugees, welfare-to-work recipients, homeless individuals, ex-offenders, people with disabilities, etc. WIA established in each county a local Workforce Investment Board (WIB) with responsibility for allocating and coordinating all federal dollars designed to assist individuals seeking a

job, a new career, or the opportunity to advance. Each WIB was to develop one or more One-Stop Career Centers that would provide an array of workforce supports to anyone who walked in the door. One-Stop services are often organized around the delivery of services in three sequential clusters:

> . core services: individuals are offered several basic supports when they first enter the One-Stop Career Center, including access to computer listings of available job openings, access to classes on résumé development and job interviewing, etc.;
> . intensive services: for individuals who need additional assistance, the One-Stop Career Center can provide career assessment, job counseling, and several individual sessions with skilled personnel to identify career paths; and
> . training services: for only a limited number of individuals, the One-Stop Career Center can provide referral to and financial support for participation in career training programs to help in the development of specific skills and capacities.

The state/federal Vocational Rehabilitation program is one of the partners in the operation of the One-Stop Career Center programs. In Pennsylvania, the regional OVR offices often have an on-site presence at the One-Stop Career Center as a resource for other One-Stop counselors who feel unprepared to meet the needs of people with significant disabilities. Indeed, given the relative lack of information One-Stop counselors are provided about disability and disability training programs, most people with significant disabilities are quickly referred to the local OVR contact; OVR then provides a separate set of services often unrelated to those available to others without disabilities through the One-Stop Career Center.

Further, it is common for the OVR counselor to refer people with serious mental illnesses to one of the mental health specialty programs offering transitional or supported employment. This further distances these individuals from the mainstream career training opportunities that can be accessed by other One-Stop visitors. While a few Pennsylvania One-Stop Career Centers have encouraged counselors there to meet consumer needs without further referral to OVR and local mental health programs, there is little evidence that this has been broadly effective.

Study respondents included administrative staff from both the Philadelphia and Montgomery County Workforce Investment Boards. While Montgomery County's WIB directly operates its own One-Stop program, Philadelphia's WIB has played a more policy-focused role and has subcontracted the operation of its several One-Stop Career Centers to a quasi-city agency – The Philadelphia Workforce Development Corporation (PWDC) – which in turn contracts with for-profit and nonprofit providers for career training services. The workforce development respondents in this study – WIB staff in both counties and administrators from PWDC – reflected the degree to which workforce development systems often have little contact with and little information about local mental health systems and the vocational needs of people with serious mental illnesses. As one respondent noted, the mental health and workforce development systems "exist in different worlds." None of these WIB/One-Stop Career Center recipients could recall a recent instance in which mental health or vocational rehabilitation agencies had referred

someone with a serious mental illness to their programs. In exploring the reasons for the distance between the two, several themes emerged.

a) **One-Stop counselors know very little about serious mental illnesses or the supports people with mental illnesses need to enter the labor market**. The WIB respondents were quick to point out that the One-Stop counselors have a responsibility to meet the needs of several different categories of job seekers. The special needs of those with behavioral health problems are well beyond their expertise, respondents argued; and when the initial core services provided at the One-Stop Career Center are not sufficient, referral to OVR for specialized disability care has been the preferred option. This was deemed an appropriate response, they said, due to two prevailing factors: the contrast between the relatively high work motivation of many other One-Stop consumers and the perceived lack of motivation of individuals with serious mental illnesses; and the often lower educational levels of those with serious mental illnesses that made them ineligible for many of the career training programs – in community college and technical school settings – that the One-Stop Career Center has the option (and funding) to use.

b) **One-Stop Career Center personnel are very busy, and are not looking to expand the number of people with behavioral health problems on their caseloads.** Not only did the workforce development respondents in this study have trouble citing evidence that people with serious mental illnesses were less well motivated and less well educated than their other clients, they also perceived consumers of mental health services as more troublesome, behaviorally difficult, and burdensome to already hard-pressed counselors. As in the community colleges and technical schools, One-Stop system personnel feel that they already confront a significant number of people who, although not referred by or in treatment with mental health agencies, nonetheless have substantial behavioral health deficits. Referring people with mental illnesses to OVR for evaluation, services, and programming through area mental health providers relieves the One-Stop Career Center of more time-consuming responsibilities and, it is believed, offers these consumers the specialized assistance they need.

c) **Limited dollars argue for cautious investments in career training for high-risk consumers.** The costs of career training are considerable. Although the One-Stop Career Center can purchase community college, technical school, or nonprofit career training for individuals with serious mental illnesses, there are financial limits to how much money the workforce development system can spend on each client. This – the study's respondents asserted – warrants cautious use of training funds. In the Montgomery County WIB, individuals can draw down as much as $3,500 from an Individual Training Account (ITA), while in Philadelphia the ceiling varies from $6,000 to $10,000. When individuals enter a program before they are fully prepared to succeed in it, they may use up – to no avail – this source of financial support and will not be able to draw down new financial support when they are ready. The One-Stop Career Centers, like OVR, are eager to – must – demonstrate reasonable outcomes to continue receiving federal training dollars. Thus, counselors remain wary of individuals, such as those with histories of mental illnesses, who strike them as high-risk investments of scarce funds.

d) <u>Contacts with the mental health system have been difficult.</u> While the workforce development and mental health systems may be "in different worlds," occasional contact between them has been troubled. On the one hand, the One-Stop Career Centers believe that mental health provider agencies are somewhat suspicious of them, critical of the difficulty that their consumers have in accessing One-Stop services, and reluctant to refer other consumers to the One-Stop Career Centers for fear of unresponsive or insensitive services at the counselor level. On the other hand, our respondents reported, on the few occasions when they have worked with those with serious mental illnesses, One-Stop counselors found the mental health provider agencies were unable to provide the intensity, duration, and necessary supports the consumers needed. This concern mirrors the reports from the vocational rehabilitation system: the supports needed for consumers to succeed in career training cannot come from either the OVR or One-Stop programs and is unavailable from the mental health system. This makes the provision of mainstream career training for many of those with serious mental illnesses both a poor investment of training dollars and a likely failed venture for individual consumers.

7. Provider and Consumer Perspectives: Barriers to Utilization of Mainstream Career Training Resources

This section reviews the responses of individuals from the two categories of respondents most directly impacted by the patterns of referral to career training programs. First, consumers report on the barriers they face in accessing and succeeding in mainstream career training programs. Second, program staff – in community mental health centers, psychiatric rehabilitation programs, and consumer-operated services – share their perceptions on the same issues. What emerged most prominently from an analysis of the interviews was the significant insularity of mental health services. Consumers repeatedly expressed their higher comfort level in receiving job training services from mental health providers, where they felt there was less pressure and more sensitivity. Providers expressed a nearly identical preference for providing job training themselves, for identical reasons.

1. Consumer Perspectives. Because the study focuses on the degree to which people with serious mental illnesses are referred by mental health providers in the public sector to mainstream career training resources in their communities, it was important to hear from consumers themselves about their preferences and experiences.

Consumers of public mental health services are an intensely diverse group, and researchers need to be wary of broad generalizations that overlook their individuality. That individuality ought to be most pronounced in the delivery of employment services, with each consumer assisted in defining his or her specific areas of interest and competence, helped to identify and utilize training programs targeted to his/her specific employment ambitions, and provided with only the services and supports needed. While larger scale programs can be built around some common rehabilitation issues, at the very heart of recovery and community integration philosophies is the need for mental health systems to strengthen their capacity to individualize their assistance.

To some extent, the systems interviews reported above suggest that those with serious mental illnesses were seen by mental health, vocational rehabilitation, and workforce development personnel less as individuals and more as a group sharing several profound vocational deficits that limited their collective ability to enter and succeed in mainstream career training programs. Interviews with consumers, however, always demonstrate the fallacy of such generalizations. Programs that target entry-level jobs – appropriate career choices for some and useful stepping stones for others – may be misjudging the potential of those consumers who are ready for more challenging career training and more rewarding jobs. Programs that focus on helping individuals return to school for their bachelor's degrees – a very important step for many academically focused and capable consumers – may be overlooking the narrower career training needs of those whose interests and skills could lead to successful skilled and semi-skilled jobs.

To explore these issues further, the study relied on three focus groups with consumers and a number of individual interviews with consumers in administrative roles within

consumer-operated programs. While the original design of the survey involved individual interviews with a more limited number of consumer respondents, staff in the community mental health centers and psychiatric rehabilitation programs contacted for help in identifying consumer subjects strongly suggested that the research would be strengthened by talking to a broader range of individuals. They also suggested that these individuals might be more comfortable responding to the research questions within a group framework.

This section of the report reviews the major themes that emerged from group interviews, involving six to 20 consumers each, in three settings:

. an urban psychiatric rehabilitation program in Philadelphia with a long history of vocational rehabilitation programming, including in-house workshops, transitional and supported employment, and supported education programming;

. an urban clubhouse program, built around the engagement of consumers in program operation, with consumers involved in a variety of janitorial, secretarial, dietary, and management tasks as a precursor to community jobs; and

. a rural clubhouse program, with a similar structure, involving consumers in the day-to-day tasks of clubhouse operation, leading to transitional employment in the community and, ultimately, to independent jobs.

These interviews were supplemented by individual interviews with consumers in administrative positions within the consumer-directed network of services provided by the Mental Health Association of Southeastern Pennsylvania. These services include a residential program for homeless individuals with psychiatric disabilities, a consumer-operated clubhouse facility, and a consumer drop-in center.

a) **Consumers are conflicted about employment.** While almost every survey of consumers identifies work as a primary life goal (Baron, 2002; Rogers, Walsh, Masotta, & Danley, 1991), in these interviews consumers expressed a range of doubt and concern that mirrored the perspectives of the systems interviews. Many of those interviewed were unsure that they could manage work, either because they worried about the impact of work stressors on their emotional stability or they felt they were neither intelligent nor skilled enough for the jobs available to them. Most prominently, consumer respondents expressed their concerns about the prospect of losing the financial and medical benefits accompanying their SSI and/or SSDI eligibility. Despite the opportunities for work represented by the SSA Work Incentives programs and the Medicaid Buy-In program in Pennsylvania for workers with disabilities, the myth persisted among these respondents that work would result in a potentially devastating loss of benefits.

b) **Consumers are not confident they can succeed in career training.** These consumer respondents often doubted their ability to benefit from career training, whether in community colleges, technical schools, or other nonprofit specialized programs. While some did have college degrees or "some college," and others had attended and a few had graduated years earlier from technical school programs, many reported a series of failures

– in both school and work – that left them reluctant to try again. One or two individuals reported they were attending local community college programs and receiving support to do so from psychiatric rehabilitation program counselors. But most respondents reported that no one had discussed these options with them, and that they were unlikely to risk another failure by enrolling in a program they do not believe they can complete.

c) **Consumers felt at home in the psychiatric rehabilitation, clubhouse, and partial hospitalization programs that offered them an alternative lifestyle.** To some extent, these programs had succeeded, perhaps too well, in making those with serious mental illnesses feel at home and supported. Consumers talked about the comfort zone such programs provided: the sense of acceptance; the lack of pressure; the access to non-judgmental friends in similar circumstances; the enjoyable activities provided by staff; and the availability of in-house, transitional, or supported employment jobs on a half-time and/or occasional basis that did not stress them unduly. One or two consumers acknowledged that they were becoming too dependent on this comfortable and affirming environment; but most expressed some anxiety about further engagement in mainstream training or competitive employment, with the potential such training and/or jobs might provide for embarrassment, harassment, or failure.

d) **Nonetheless, consumer histories and in-house performance suggested substantial capacity for career training and independent employment.** Those consumers with a modest history of success in either four-year, community college, or technical school settings – as well as those holding down skilled and semi-skilled positions within their agency programs – were more optimistic, if still cautious, about their own capacity, even with appropriate supports, to succeed in the competitive labor market. In one of the group interviews in a clubhouse, the consumers articulated both their anxiety about mainstream career training and their conviction that they would be unable to manage the stress of competitive employment. However, when the interview ended suddenly - members of the group realized they were going to be late in returning to their in-house jobs, including preparing the payroll, planning the following week's meals, and organizing a field trip – a few of the group noticed the difference between their expressed fears of being unable to success in educational and employment settings and their rigorous attention to the demands of the skilled and semi-skilled jobs they already held, albeit within the warm embrace of the clubhouse atmosphere.

2. Provider Perspectives. In Pennsylvania, as in most states, community-based services for people with serious mental illnesses are provided through state or county contracts to private nonprofit agencies, including comprehensive community mental health centers, psychiatric rehabilitation programs, and other mental health nonprofits specializing in residential, case management, or vocational services. Although many of these facilities do refer consumers with serious mental illnesses to their state vocational rehabilitation programs (state VR offices report that persons with mental illnesses represent nearly 50% of their caseload), persistent and ubiquitous unemployment among people with serious mental illnesses is the norm in the state, as across the country.

The number of agencies invested in pursuing vocational outcomes remains limited. A few progressive community mental health centers, many psychiatric rehabilitation programs,

and most specialized job training programs offer a mixture of job counseling, transitional work opportunities, and supported employment programming. As reported here, however, they rarely make use of mainstream career training resources in their communities. The survey sought to understand provider perspectives by interviewing directors, key staff, and counselors in several provider agencies in Philadelphia and Montgomery County:

> . Horizon House – one of the nation's oldest psychiatric rehabilitation programs, operating an in-house work program (dietary, maintenance, secretarial), a transitional and supported work program helping clients to find and sustain community jobs, and a newer supported education program taking referrals from Philadelphia Community College;

> . Wellspring – a well-regarded clubhouse, modeled on Fountain House in New York City, serving a suburban/rural population in Montgomery and Bucks counties and offering an array of in-house work assignments and transitional employment positions, along with both scholarships and support for a handful of consumers attending school;

> . COMHAR Clubhouse – a traditional community mental health center serving an inner-city population of Latinos, African-Americans, and Whites, COMHAR's clubhouse offers a mix of in-house work assignments and transitional employment supports; and

> . ACT NOW – a consumer-run vocational program operated by the Mental Health Association of Southeastern Pennsylvania, offering a classroom-based training program that focuses on vocational counseling, résumé preparation, interview skills, a 12-week internship in nonprofit settings, and job placement.

Given the prominence of employment in the guiding philosophies of these agencies, their commitment to recovery and community integration, and their status as some of the longest-standing vocational programs in the region, these agencies and their mental health staff would be the most likely to encourage consumers to acquire skills training needed to compete effectively in the regional labor market. However, as noted previously, these programs also made scant use of mainstream career training programs, referring few – if any – consumers to them over the past several years. As the study explored why this is so, a now-familiar set of themes emerged from the interviews.

a) <u>Staff viewed consumers in their programs as either unlikely to benefit from mainstream programs or uncomfortable in moving beyond the comfort zone of mental health specialty care.</u> Respondents in all of these interviews expressed a wide range of doubt about the ability of consumers in their programs to benefit from mainstream career training services. They mentioned low educational levels, susceptibility to stress, inappropriate behavior, and staff concerns – echoing and reinforcing consumer concerns – that skill training in such programs that would lead to skilled or semi-skilled employment would put the consumers' SSI and SSDI benefits at risk. They argued – reasonably enough, given the responses from consumer respondents –

that the consumers in their programs were reluctant to move beyond the comfort zone the agencies had created for them. In many instances, agency respondents felt that the principle of consumer choice made it inappropriate for them to press consumers toward the more ambitious outcomes represented by engaging with existing mainstream career training resources.

b) **Program staff acknowledged that they had little knowledge either of mainstream career training resources or the types of jobs for which they prepared their students.** In many instances, mental health program staff were largely unaware of the career training programs offered by local community colleges, technical schools, or the other nonprofits offering specialized skill training. In most instances, they had never considered such a referral, had no information to help consumers with choosing among programs or obtaining financial aid, and had few resources to help consumers succeed in those settings. Respondents in these mental health facilities also acknowledged a rather limited understanding of the skilled and unskilled labor market; the training, certification or licensing requirements for those types of jobs; or the work demands, pay rates, or career prospects in this employment arena.

c) **Staff were both protective of their own vocational programs and critical of mainstream career training opportunities.** Several program staff noted that transitional and supported employment programs were "what we do," and that no substantial effort went toward exploring other options – other choices – for those consumers who might benefit from them. Respondents noted that supported employment was the "evidence-based model" receiving the strongest fiscal support and thus was the program of choice, and that referring consumers to other mainstream resources would tend to weaken the funding base for their own vocational services. At the same time, many staff expressed concern that consumers were not likely to receive sensitive and supportive services from mainstream career training programs. These respondents considered consumers likely to face embarrassment and harassment at the hands of both faculty and students in these settings because of their disabilities; yet the respondents were unable to cite past instances of such problems. Respondents in mental health agencies were particularly wary of for-profit technical schools. They argued that such schools readily admitted unprepared students for the tuition money, would not or could not provide the supports and accommodations needed by those students they did accept, and then allowed those students to fail or to withdraw from the program with substantial financial debts.

d) **Staff had few or no resources with which to support clients in mainstream career training programs.** Although Wellspring did support a few of its consumers in career training programs – providing both counseling and scholarship assistance – this was rare. Most programs felt unable to shift staff resources in this direction and had not been able to locate new financial resources to assist consumers in meeting the financial requirements of these programs. Without knowledge of the costs of such programs or how to make use of the financial aid resources used by students without psychiatric disabilities, staff felt unable to provide much guidance. Further, regulatory limitations on their activity in the community – rather than within the agency – made it difficult for them to envision how to provide the support students would need.

e) <u>Separately funded supported education programs were unavailable in most of these settings.</u> While many staff were aware that supported education programs could provide the resources needed to assist those students who could benefit from mainstream career training programs, there were only two of these programs in the area: at Horizon House and Montgomery County Community College. The Horizon House supported education program, funded primarily by grants from a local foundation, assisted local colleges to refer students to mental health supports, and had not addressed the need to help their current mental health consumers consider educational options for themselves. The Montgomery County Community College program, funded by the county mental health office, provided on-campus classes specifically for students with psychiatric disabilities, and was only beginning to experiment with integrating these students into regular classes.

8. Mainstream Career Training Resources: Community College, Technical School, and Nonprofit Training Perspectives

The study focuses on three categories of mainstream career training resources: nonprofit community colleges, for-profit technical schools, and an array of specialized training programs in nonprofit agencies not specifically targeted to those with serious mental illnesses. These programs offer an array of educational and training opportunities to prepare students for careers in the skilled and semi-skilled labor market. Almost every community across the country has a few of these resources, and both urban and suburban communities are likely to have an abundance of them. The study did not explore the availability and use of four-year bachelor of arts programs or the participation of consumers in personal interest and personal development classes. Rather, the emphasis was on a narrower range of career training services that provide students with general knowledge, specific skills, and, when necessary for employment, preparation for passing state licensing tests for skilled and semi-skilled jobs.

Initially, the interviews addressed the same central research questions: Do public mental health consumers with serious mental illnesses receive referrals to mainstream career training programs? Would it be desirable to increase referrals from mental health system providers to these programs? What barriers would need to be addressed in doing so? What recommendations would respondents make for policy, program, and practice changes? However, the array of issues raised in the interviews with mental health, vocational rehabilitation, and workforce development systems representatives, and in the focus groups of consumers and individual interviews with mental health service providers, argued for broadening the interviews to address some additional concerns:

. How open are mainstream career training programs to the participation of individuals with serious mental illnesses?

. To what degree were these new students likely to face discrimination from admissions personnel and harassment from other students?

. How affordable are these programs, what financial support mechanisms exist, and how can students with mental illnesses avoid crushing debt?

. What reasonable accommodations can students with serious mental illnesses expect within these rigorous programs? and

. What kind of student is likely to do best?

1. Community Colleges. There are 1,195 community colleges throughout the United States, with 11.5 million students ("American Association of Community College's CC STATS," 2008). Indeed, half of all "college" students are in community colleges and 39% of community college students are the first in their families to attend a

post-secondary school. Because the average community college student is 29 years of age, 60% attend part-time so that they can meet child-raising and income-producing obligations. Many community colleges operate on an "open enrollment" basis with few academic prerequisites for admission, although most community college students must take placement tests to determine their level of academic readiness. Students who do not pass are asked to take remedial classes at the community college before enrolling in regular classes, although some programs allow students to start regular classes while they are also doing remedial work.

The community college was initially seen as a preparatory program that would allow students who had graduated from high school unprepared for a four-year college program to sharpen their skills before moving on to a bachelor's degree (or its equivalent). Over the past 20 years, however, it has become commonplace that no more than half of the students receiving an associate arts (or its equivalent) degree go on to earn a bachelor's. Instead, many students have chosen to use the AA as a credential to allow them to move directly into skilled and semi-skilled jobs. Thus, community colleges have become one of the nation's primary resources for retooling the American workforce. Community colleges now typically also offer a range of shorter programs: one-year certificate programs in specific fields as well as six-month programs to develop highly specialized skill areas. Those career-specific programs that lead students to jobs in state-regulated fields – certified nursing assistant, plumber, hairdresser, etc. – also prepare students for passing state licensing exams upon completion of their academic courses.

The array of programs offered in most community colleges is impressive. Business and management programs are the most popular; but nearly as numerous are programs in the health professions and the computer information field. Narrowly focused programs are offered in security and protective services, mechanic and auto repair technologies, the visual and performing arts, precision production, culinary services, paralegal studies, the construction trades, engineering, biological and biomedical sciences, transportation and materials moving, mathematics and statistics, science technologies, library science, as well as more traditional liberal arts programs in English, philosophy and human services, etc. More recently, some community colleges have established "career institutes" within the community college framework to provide a focus for career training activities in particularly high-demand fields in their region. This enables students to move more rapidly to "assistant" and "technician" jobs in their fields of study.

However wide-ranging the opportunities they offer, community colleges face considerable challenges. Nationally, only 20% of students who enter these schools graduate with an associate arts (AA) or an equivalent two-year degree. Those who do typically graduate after three or four years, due to their part-time status and demanding lives: competing domestic responsibilities and practical problems (such as transportation or child care or ailing relatives) make progress both slow and episodic for many. Also of concern has been the atmosphere of the typical community college campus: students who have not done well in high school are often unprepared for the self-discipline and academic courtesies of the community college environment, and faculty are often frustrated by the unfocused commitment and sometimes uncivil behavior of students.

On the other hand, community colleges are eminently affordable. Although tuition is purposely low as a consequence of public support, tuition costs are often financed through federal grants (Pell Grants) and state loan programs. (The Pennsylvania Higher Education Authority provides an array of financial support mechanisms.) Additional scholarship opportunities exist to cover the costs of books, daily living, transportation expenses, and tutoring. For students with disabilities, the state Vocational Rehabilitation programs can provide tuition support, and the One-Stop Career Centers have additional funds for students studying in high-demand fields.

Yet, as we have seen, mental health and vocational rehabilitation agencies make very sparing use of these resources for individuals with serious mental illnesses. The study explored these issues with personnel from the college offices that focus on students with disabilities, in these two settings:

> . Community College of Philadelphia (CCP), in a sprawling downtown campus readily accessible by several forms of public transportation; it provides education to approximately 4,500 students each year, across a dizzying array of fields. The office of disability services provides support to several hundred students – with various disabilities – who choose to identify themselves: 50% of their students with disabilities have identified themselves as struggling with mental illnesses. The office provides an array of accommodations for students with disabilities: counseling, negotiating specific accommodations with instructors, providing a quiet room and more time for completion of tests, tutoring assistance, etc. Although the office serves as an advocate within the school for appropriate accommodations, they are unable to pay for very costly specific accommodations, which must be provided by the student or his/her OVR counselor.

> CCP is a partner in the Horizon House supported education program. When the office of disability services is approached by a student with a serious mental illness, or identifies a student they believe has a serious mental illness, the student can be referred (if he/she chooses to be) to the Horizon House supported education program for educational guidance, emotional support, clinical help, practical problem-solving, and peer-run counseling. As noted earlier, referrals have tended to run from CCP to Horizon House, with few of the current Horizon House consumers entering the community college.

> . Montgomery County Community College (MC3) occupies a large, lovely campus in the middle of suburban sprawl and is only somewhat accessible by public transportation. MC3 has a smaller student body, a less diverse range of students, and a more limited – but still expansive – array of course offerings. Like CCP, it is essentially a commuter college, with little in the way of dorms, campus life, and student clubs and social interaction. As in other community colleges, most students are only there during the day (or part of the day), and have an array of other obligations to which they must attend. The office of disability services at MC3 provides a range of supportive and advocacy services, often acting as a liaison between students with disabilities and their instructors.

MC3 also participates in a supported education program, in collaboration with the county mental health office. A small group of students from local mental health programs who are interested in earning an AA degree begin together in separate on-campus classes to prepare themselves for both the academic work and the integrated environment of the MC3 campus. Interested students can then move to individual classes in their specific areas of interest. Many of these students are particularly interested in MC3's human services curriculum, with still indistinct employment goals in the helping professions.

Staff from the two community college disability offices were interviewed with regard to their current programs, the prospects for other students with serious mental illnesses, the barriers, and the changes needed to integrate more students with serious mental illnesses into the career training programs available. Again, the answers from these two different settings in two different counties were similar, focusing on several key themes:

a) **Students with serious mental illnesses do not present entirely unique problems within the community college environment.** The respondents emphasized that many community college students face a considerable array of emotional difficulties. Some students have been unaware of their emotional problems and others have chosen not to reveal their "mental health status" in the admissions process. Some are referred to the disability office by concerned faculty and others approach the disability office on their own when facing significant problems. In neither case, however, are these students typically involved with public or private mental health providers; nor in the past have there been well-defined links to local mental health providers who can offer assistance. These respondents reported that the diversity of the student body, the frequency with which most students are unprepared for the rigors of college-level work, the practical demands on many students' time, and their confusion about vocational goals make it relatively easier for those with serious mental illnesses to blend in.

b) **The most important contributor to success in community college is a commitment to gaining the specific academic credentials needed for employment.** Respondents emphasized that community colleges are primarily designed to help students discover a career path and then provide them with the needed skills and credentials to successfully enter the competitive labor market. However, the respondents report that many students – with or without mental illnesses – enter community college for other purposes and soon find themselves adrift. Many students enter the school because it is a socially acceptable substitute for either a four-year program or an entry-level job. Others take individual classes to pursue personal interests but have no clear career path in mind. And others have been sent there by parents, and sometimes therapists, simply to have a focus for their days or social contact with other students. These are the students who either quickly drop out, fail, or hang on for years without ever graduating.

c) **Students who succeed are those with strong support systems.** Again, the respondents were reluctant to draw a distinction between those with serious mental illnesses and the rest of the student body. Most students, they noted, require someone – a parent or spouse or child, a therapist or case manager or friend – to provide support. One respondent referred to an influential article in the field documenting that only 15% to

25% of students drop out of schools due to academic failure: the rest leave as a result of economic pressures, social conflicts, psychological problems, or the failure to connect to the campus community – a particularly prevalent problem in community colleges with their non-residential atmosphere and anemic campus life (Crowther et al., 2001). Those with mental illnesses who succeed in community colleges are likely to be those with strong support systems.

 d) <u>Students with serious mental illness are not subject to discrimination, harassment, or embarrassment on campus.</u> Despite the fears of mental health professionals and the expressed concerns of consumers (Salzer et al., In Press) that they will have to face insensitive faculty, fight for reasonable academic accommodations, or experience humiliation by other students because of their emotional problems, these respondents could not recount instances of students being dismissed, conflicts with faculty remaining unresolved, or reasonable accommodations being denied. Because these are commuter schools, they argued, the opportunities for interpersonal conflicts with other students are minimized as well. They acknowledged that it only took one "incident" – of a student becoming difficult or dangerous – for attitudes to shift throughout the college community, but maintained that this was a rare occurrence. While tragic incidents – such as the still recent shootings at Virginia Tech at the time of these interviews – often made people uneasy, these respondents had no sense that this discomfort had been targeted toward their current students with emotional problems.

 e) <u>More engagement between mental health programs and community college programs would strengthen the chances for success for students with serious mental illnesses.</u> The respondents were not eager for a sudden and continuing flood of seriously troubled students into their community colleges. They feel stretched to the limit meeting the needs of students who enter on their own and then acknowledge or display behavioral health problems. Respondents felt that more connection between mental health programs and the colleges as well as more supportive services from the mental health system could open the door to career education for carefully chosen and carefully prepared students with serious psychiatric disabilities. They argued that many programs permit students to attend part-time and to move forward at their own pace, which can be especially important for those with serious mental illnesses. They also noted that if Pell Grants, state loan programs, and OVR tuition payments could be more readily available to part-time students (which is not currently the case), consistent emotional and academic support from the mental health system could make a significant difference.

 2. Technical Schools. For-profit technical schools, abundant in most communities, are another resource potentially offering individuals with serious mental illnesses access to skilled and semi-skilled careers. The "technical school" designation is used here to embrace a variety of other identifiers, including "career college" and "private technical institute." The most distinguishing characteristic of this educational sector is that each of these schools is privately owned and operated for profit. This has created considerable unease within the nonprofit sector. Public and nonprofit mental health programs are especially wary of, and often openly hostile to, the prospect of referring consumers with serious mental illnesses to what they perceive – as many other respondents expressed – to be unresponsive and potentially damaging programs.

There is, however, an immense network of for-profit technical schools. Almost every community in the country has at least a handful of such schools, and urban areas may have dozens of competing programs offering an array of training focused on skilled and semi-skilled careers. There are, by one estimate, approximately 4,600 technical schools nationally; and one of the nation's largest professional associations in the field, the Career College Association, estimates that in the 2005-06 academic year, over 2 million students were enrolled in 200 different fields of study (ACCSCT, 2007). In Pennsylvania, the Commonwealth's Department of Education – which licenses most of these programs – identifies 250,000 students each year, in the 2,735 different programs offered by 326 for-profit technical schools ("2004-2005 Annual report on schools licensed or registered by the Pennsylvania state board of private licensed schools," 2006).

There is considerable variation from program to program. Most programs are relatively small, with 100 to 300 students at a time, focusing on two or three courses of study. Others are considerably larger, with hundreds of students studying in multiple career areas. Two-thirds of the technical schools offer either a quite brief training curriculum (an intensive 16-week introduction to medical billing technology, for instance) or a one-year certificate program; but 28% offer a two-year degree program, and 8% also have bachelor's programs. In Pennsylvania, nearly 50% of the programs are either entirely or partially based on distance-learning technologies, but some larger programs have substantial buildings and a small campus. Some schools are independent operations, but others are part of a regional or national chain, and some programs have "articulation" agreements with nearby four-year colleges that encourage students to use their two-year degree as a start toward a more traditional bachelor's program. Many programs are regulated and licensed under state guidelines – it is estimated that 50% of the nation's technical schools are accredited by one of the several professional bodies in the field – but quite a few do not seek licensing or accreditation.

It is also important to note that, while many technical schools are well-run and effective institutions, some have a more questionable reputation. The vocational rehabilitation respondents to this study – who rely upon technical schools to provide many people with disabilities the educational advantage they need – noted that it is critical to assess each program's educational strengths and job placement track record.

In some respects, the technical schools are similar to their competitors in the community colleges. First, they offer career training in many of the occupations where significant job growth is expected over the next decade. These occupations include computer support, information systems, business, nursing, dental and medical assisting, occupational and physical therapy, health technology, and legal assistance. Second, a high percentage of students are the first in their families to pursue post-secondary educations. Third, there is a higher percentage of minority enrollment in these programs than in traditional four-year colleges.

Finally, there is considerable reliance by students on federal Pell Grants and state loan programs to meet tuition costs. These programs are not inexpensive. Tuition varies by program intensity and length and the reputation of the particular institution, but costs run from $2,500 to $5,000 for short-term or one-year certificate programs, and from $10,000

to $25,000 for two-year degrees. It is possible for students in these programs to build up a level of indebtedness that they find difficult to pay off, particularly if they later face problems finding or keeping a job. Perhaps as a consequence, the technical schools offer almost no general degree programs or personal growth courses. These programs are for students who want an edge in a secure sector of the competitive labor market.

There were several respondents to this survey from this sector. A few of the technical schools contacted for interviews were not interested in participating, and some seemed quite wary of the topic as well as of the research process. However, those who did participate were gracious, welcoming, and eager to present themselves in the most positive light. Nonetheless, respondents were quite clear that a technical school education was "not for everyone," and the interviews focused equally on the schools' defense of their reputations and cautions about referrals of students with mental illnesses unprepared for the rigor of their programs. The respondents were the directors of four local schools:

. CDM is a regional network of four programs, each with a focus on medical billing, certified nursing assistance, or computer-assisted design (CAD). CDM's instructors are a mix of CDM staff and part-time instructors from each industry. The relatively short programs offered by CDM – almost none of which are longer than six months – are briefer and less expensive than many of the programs in the same fields offered by local competitors. Located in an ordinary office park in the suburbs, the half-dozen classrooms are fitted out, variously, with computers, nursing environments, and up-to-date CAD display systems.

. Thompson Institute offers one-year and two-year programs preparing plumbers, electricians, nursing assistants, and medical billing personnel for state licensing examinations. Located in downtown Philadelphia, it is accessible to several forms of public transportation, provides training to several hundred students each year, and is part of the Kaplan network of schools, a national chain that has been the focus of investigation in the past for questionable practices that have since been resolved. The school offers students one of three schedules – morning, afternoon, evening – to accommodate their personal obligations.

. Katherine Gibbs School is part of a national chain of the well-known Gibbs Schools, itself part of a larger corporation of educational for-profits. Gibbs offers several different programs, including business skills, medical billing, security officer training, and data entry. The local school, in its own handsome building in a suburban office park, offers technologically sophisticated classrooms, a library, study areas, and a cafeteria – some of the elements of a more traditional college missing in many other programs. Gibbs was also the only technical school among those that responded with a separate "student services" office and staff focused on offering struggling students support to help them complete the programs.

. PJA is a smaller school in a crowded building on a busy commercial street in Montgomery County. It offers six different programs, with an emphasis on paralegal training and legal assistance. Accessible to public transportation, the school's four floors hold several classrooms, a law library, a small student lounge and cafeteria, and

administrative offices. The school has a small on-staff faculty but relies on lawyers, legal secretaries, and other working professionals for most of the instruction; PJA asserts that this is because of the program's highly technical nature. PJA also maintains articulation agreements with two local four-year colleges that make it possible for students to more readily transfer their PJA credits to the four-year institutions in their area with a working agreement with PJA.

While different from one another in many respects, the technical schools in this respondent pool shared several characteristics relative to this study. First, none could recall ever receiving a referral of a person with a serious mental illness from either a mental health provider or the local vocational rehabilitation office, nor had they been in touch with mental health providers about either prospective or current students. Students with disabilities of any kind were relatively rare in these programs. Respondents could only recall referrals of two OVR clients: one was blind and the other used a wheelchair. A mental health or vocational rehabilitation referral of someone with a serious mental illness had simply not occurred, as far as they knew. Second, none of these programs had – or were large enough to support – either part-time or full-time staff to address disability issues specifically, particularly since all reported that they were struggling to find the funds to support counselors for their general student body. Third, in each setting the program director who agreed to be interviewed had a family member with either a physical or psychiatric disability that helped to frame the six themes in their responses.

a) **Technical schools are demanding, with few opportunities for unprepared students to succeed**. Technical schools pose a considerable challenge to students, respondents indicated. First, many certificate and degree programs require both academic skills and consistent work. Students generally need English and math competencies at the high school level; and there is a tremendous amount of information to be absorbed, through classroom lectures, readings, and experiential exercises. Second, there is an unforgiving schedule. Classes are generally held every weekday, and because an entire certificate or degree program is scheduled in a series of necessarily sequential courses, students who fall behind or fail one course will likely need to wait six months or a year to begin again. Third, instructors have little time to accommodate the special needs of students. Instructors often have jobs within the industry they teach about, and there is little they can provide beyond the classroom experience. Fourth, the small size of most schools and the for-profit orientation of these programs limit their supportive services. None of these programs had disability offices or officers. Few had more than a rudimentary ability to assist struggling students with academic, practical, social or psychological problems. Any significant supports students with serious mental illnesses might require would need to come from within the human services environment, the respondents indicated.

b) **Most students with psychiatric disabilities were unlikely to stand out within the technical school population.** Respondents acknowledged that the existing student body posed many challenges. There is a growing consensus among technical school administrators that the academic preparation, study habits, support systems, and emotional stability of students in their schools had declined over the years, and that the schools are only slowly responding. The schools test all incoming students to determine

their academic skills – an "ability to benefit" test required for federal student aid – and offer remedial classes as either a prerequisite for entry or alongside initial courses. In addition, the technical schools find they must regularly remind students of the importance of preparation for classes and the need to attend to school requirements. Finally, so many students face obstacles to continuing in their programs – the same range of economic pressures and family responsibilities that trouble community college students – that technical schools find they are forced to provide some rudimentary support. This has also meant that when they recognize that a student has more than the usual behavioral health problems, they will offer to refer the student for more professional mental health care.

c) Because federal and state agencies evaluate technical schools on their graduation rate, the schools are likely to attempt to dissuade high-risk students from entering their programs. Respondents somewhat reluctantly admitted that their admissions officers do what they can to gently dissuade students they feel are at high risk of failure, encouraging them to either look elsewhere or delay entry into the program. For many reasons – the federal Pell Grant regulations that require technical schools to demonstrate specific graduation rates, their own commitment to student progress, and the importance of maintaining an internal atmosphere of achievement – the schools are eager to avoid the later problems of drop-outs and dismissals by suggesting to students that they might not – or not yet – be ready for the demanding programs offered. While some schools – particularly those that are unlicensed and unaccredited – may be more willing to accept unprepared students who will not graduate so long as the tuition is paid up front, others have a strong investment in student success.

d) Technical schools have very limited knowledge about serious mental illnesses, the nature of accommodations for people with such illnesses, the ADA, and/or local networks of mental health agencies. While the respondents were – often vaguely – aware of the Americans with Disabilities Act, they were not so sure that it applied to people with psychiatric disabilities. They felt that the level of accommodations they could make for students with emotional problems would be very limited. Few had any knowledge about or sustained connections to local mental health programs. While one program had for years contracted with a local transitional employment program at a psychiatric rehabilitation agency for janitorial services in their classrooms, the possibility of one of the program's consumers enrolling in the school had never been raised.

e) Respondents were open to the enrollment of individual students with serious mental illnesses, as long as a student's need for support could be met by mental health or vocational rehabilitation agencies. While none of the respondents was eager for an influx of students with special needs, they were – at least in the context of the interview – open to offering career training to occasional, qualified, and motivated students with mental illnesses. They suggested that mental health workers – or the potential students themselves – would do well to contact admissions officers to discuss course demands and the special supports that would be needed and how they would be provided. They noted as particular barriers the fast-moving schedule of most of these programs, the federal/state financial support mechanisms that require full-time attendance, and the schools' limited ability to make accommodations. However, they did

not feel that students, faculty or admissions personnel were likely to discriminate in their response to students with emotional problems.

f) <u>Respondents insisted that the negative reputation of their operations was largely unfair.</u> Respondents – as well as the Career College Association (CCA) and the Accrediting Commission of Career Schools and Colleges of Technology (ACCSCT) – acknowledged that past criticisms had often been well-deserved: a series of scandals and Congressional hearings in the 1980s had focused on the schools' pattern of accepting unprepared students, drawing down substantial Pell Grant support for students who later dropped out, and providing career training in declining industries. Since then, a series of federal legislative reforms has encouraged technical schools to meet new federal guidelines in order for their students to receive Pell Grants and/or state loans. Schools must now demonstrate not only that an appropriately high percentage of their students graduate, but that graduates find competitive jobs in the industries for which they have been prepared. Respondents maintained that their track record on both of these criteria now exceeds that of community colleges and is almost as good as that of the nation's four-year schools.

3. Nonprofit Training Programs. This study also explored the career training opportunities within nonprofit training programs outside the orbit of the mental health system. Nonprofit career training programs that serve other groups of people with disabilities or economic disadvantages – ex-offenders, welfare-to-work clients, homeless people, those with HIV/AIDS, displaced homemakers, substance abusers, people with physical disabilities, etc. – are available in many communities. While some of these programs offer a more generic introduction to work skills, many others have begun to offer targeted skills training in specific employment arenas.

Indeed, the emerging field of "sectoral employment" (Pindus, O'Brian, Conway, Haskins, & Rademacher, 2004) encourages social service agencies to focus on one or two sectors of the local economy (e.g., the shipping industry in San Diego; the medical community in Philadelphia) and provide targeted skills training to prepare clients to enter the local labor market. Like both community college and technical school career training, such programs do not prepare their clients for low-skill, low-pay, entry-level jobs, specializing instead in the burgeoning demand for workers with specific capabilities in skilled and semi-skilled positions. These programs are more likely to use experienced instructors from the industries focused upon, more likely to have working relationships with local companies who are hiring, and better able to attract participants prepared to learn and then work. And, because they are in nonprofit settings, they are mostly free, with tuition costs met by government grants, foundation support, and contributions.

The survey explored the level of utilization of these "other" nonprofit programs by mental health agencies. Respondents from four local nonprofit training providers participated in the study:

. <u>District 1199C's Training and Upgrading Fund,</u> a Philadelphia-based hospital and social services workers' union, supports a training program for union members and others in the human services. Funded primarily by union agreements to devote 1% of

union-negotiated salaries to training, 1199C offers training for certified nursing assistants, behavioral health care technicians, and workers in related fields. The program also offers remedial education, the basics of computer technology, and other classes designed to enhance the upward mobility of both union members and others.

. CITE, founded 20 years ago by a social worker who was interested in helping economically disadvantaged persons to move into the business world, offers a range of relatively short-term programs in several fields: computer technology, office management, accounting, etc. The program has had great success and is one of the City of Philadelphia's best-regarded welfare-to-work grantees. Its hallways are solidly covered with pictures of graduates and the jobs and salaries they have landed.

. Impact Community Services, a large multi-service agency in an economically disadvantaged Philadelphia community, offers vocational training, placement, and counseling to (among others) ex-offenders returning to the city without family or jobs. The program offers an array of career counseling services, including help with the development of a résumé and job search and job interview skills, as well as help – when possible – in expunging a criminal record if this will be a bar to employment, as it is in some – but not all – economic sectors.

. Metropolitan Career Center, founded in the 1970s as a nonprofit job training program for those who are economically disadvantaged, is a well-established agency that focuses on the business sector. Its programs provide an introduction to office skills, computer technology, accounting, etc. Metropolitan draws its financial support from City welfare-to-work dollars, foundation support, and special project grants. Like many similar programs, welfare-to-work grants have forced the agency to shorten the training provided so that students can move more quickly into independent employment.

These are but a few of the programs operated by local nonprofit and government agencies that provide career training for "other" populations. The Job Corps, for instance, is a federally financed program focusing on career training for at-risk youth from economically disadvantaged backgrounds. Although they are not focused on youth with serious mental illnesses, they find that many of those who have a history of contact with law enforcement over petty crimes or the use of drugs also present significant behavioral problems. Their one-year residential program, operating in dozens of communities across the county, explicitly excludes individuals who "pose a risk to themselves or other residents." While they do not exclude youth with a history of mental illnesses, they do provide an array of counseling and support opportunities to help ensure that those who need it get specialized help while in the program.

All of the respondents in these programs reported little or no formal contact with mental health providers. Several themes – familiar from the interviews with community college and technical school respondents – emerged:

a) **These programs work with a substantial number of trainees with a wide range of problems, many of whom indicate significant mental health problems.** These respondents report that while they rarely, if ever, receive a referral from a mental

health provider, a significant number of their students do have behavioral health problems. The programs respond in two ways. First, they are likely to talk to a student about their concerns and offer to provide limited supports and/or accommodations to assist the student in successfully completing the training. Second, they will offer either to connect the student to mental health resources or – if the student is already connected – to contact the student's counselor for guidance in meeting the student's needs within the program. In many instances, they report, faculty concerns are quickly resolved through one of these efforts.

b) At both administrative and faculty levels, these programs have very little knowledge about mental health issues, people with serious mental illnesses, or how to accommodate students with behavioral health issues. The respondents were quick to point out that due to the demanding nature of their training programs, which seek to prepare students for competitive employment within a few weeks or months of training, the programs have little capacity to respond to students with extraordinary needs: students cannot be disruptive or unresponsive. Although these respondents reported that few students in these settings present especially difficult needs in this regard, they are quick to react when a student appears to be failing. Nonetheless, the respondents maintained, when students with serious mental illnesses need intensive support, primary support must come from the mental health agency.

c) Students with serious mental illnesses rarely face discrimination or harassment from other students. As in community colleges and technical schools, these programs have not experienced, and would not anticipate, the antipathy of other students to those with serious mental illnesses. In part this is because, as in these other settings, social interaction in these programs is very limited – people are in class all day and then go home – and in-class problems are generally resolved between the student and a faculty member. Students who can do the work and manage the pressures despite their disabilities are admired rather than harassed, they reported.

9. Recommended Practices, Programs, and Policies: Utilization of Mainstream Career Training Resources

Mainstream career training programs – in community colleges, technical schools, and other nonprofit training programs – are largely untapped resources for those with serious mental illnesses. The career training programs in this study offer a focus on specific skills for specific market sectors, experienced instructors, appropriate learning environments, and job placement connections – qualities rare among mental health agencies' employment programs. For millions of Americans without serious mental illnesses, these programs provide the qualifications for semi-skilled and skilled jobs with decent pay and benefits and the potential for modest upward mobility. The students they currently serve are not so different from mental health consumers, and these programs declare themselves ready – for the right student with the right level of support – to open their doors a little wider. Yet mental health, vocational rehabilitation, and workforce development systems make little use of these important resources for consumers with serious mental illnesses.

Preoccupied with the rapid placement approaches that lead to entry-level work (and often no further) and excited about working with the relative handful of consumers who want to earn their bachelor's degrees (whether or not these lead to professional jobs), our systems of support have all but overlooked the capacity of mainstream career training in the skilled and semi-skilled sectors to provide a middle course that can enhance self-esteem and promote self-reliance. There is no way to estimate the number of people with serious mental illnesses for whom this middle course would be appropriate. For the most part, the vocational options available to most consumers – supported employment leading to entry-level work and supported education with the potential to lead to professional careers – have been unable to explore the capacity of consumers for skilled and semi-skilled career training leading directly to competitive employment. Respondents to this study, however, suggested that we could begin to explore these options.

Even a modest initiative – one that the mainstream career training programs might well be able to absorb – could offer substantial rewards. In the geographic area studied – Philadelphia and Montgomery counties, in Pennsylvania – if only ten percent of those with a serious mental illness were enrolled in one of the local career training programs and then provided with the academic, economic, and emotional support needed to graduate and find a satisfying and economically self-sustaining job, over time hundreds of people would be able to leave behind a life of stifling dependency and long-term poverty. But even a modest initiative of this kind poses an array of complex challenges. What would it take? What practice, program, and policy changes would be required? We focus on five clusters of issues suggested by the respondents.

1. Attitudes. The mental health system respondents and program staff who participated in this research consistently spoke about the need to make employment a higher priority. They noted that this task would include changing the attitudes of both staff and consumers about the possibility of work. Even in these two counties, where

there was a strong and genuine commitment to a recovery-oriented transformation of care, there remains widespread ambivalence about the role of work in the recovery process and the potential of those with serious mental illness to succeed in competitive employment. Unless staff and consumers have the sense that a job is possible, economically and psychologically valuable, and a foundation for progress in life, encouraging consumers to consider the pursuit of mainstream career training becomes an empty exercise.

Mental health staff – and a handful of consumers – recommended that clinical and rehabilitation personnel be asked to focus as early as possible on consumers' vocational futures, e.g., in intake sessions, initial goal-setting meetings, and WRAP training. The respondents also talked about the importance of ensuring that staff and consumers have access to success stories in which other consumers' recovery has led to competitive jobs. Several respondents noted the need for an intensive initiative targeted to staff working with younger consumers and to such consumers themselves before they accommodate themselves to the low expectations of the unemployment norms of the prevailing subculture of serious psychiatric disability. In addition, there was a clear sense that the two other systems of care in this arena – the state/federal vocational rehabilitation program and each county's workforce development program – also needed to improve their staff's attitudes about the employment prospects for those with serious mental illnesses.

2. Information. Respondents identified a wide range of information needs, cutting across each of the constituencies involved in the complex process of assisting people with serious mental illnesses to pursue mainstream career training:

. *work incentives* – Despite the centrality of consumer concerns about the potential loss of Medicaid eligibility, many consumers, as well as many mental health, vocational rehabilitation and workforce development staff, remain unaware of or confused about both Social Security work incentives and state Medicaid Buy-In provisions that provide ongoing health care coverage to workers with disabilities.

. *skilled and unskilled work* – Mental health staff, and many consumers, have no clear vision of the job opportunities in the vast skilled and semi-skilled labor market in their communities. Preoccupied by entry-level work goals or college-based professional careers, mental health programs with an employment focus need to ensure that counseling staff have a better understanding of the job categories available, those jobs where local demand is increasing, and the certification/licensing requirements that apply.

. *mainstream career training* - While both vocational rehabilitation and workforce development personnel had a broader sense of the array of local community college, technical school and other nonprofit training programs offering targeted career training, many mental health personnel had little knowledge of these opportunities – much less their schedules, demands, or costs – and the state and federal tuition and grant programs that make consumer participation feasible.

. mental illness and the student with mental illness – Local workforce development agencies acknowledged that they knew little about both mental illness and the workforce needs and potential of those with serious mental illnesses. Mainstream career training programs – in community college, technical school, and other nonprofit career programs – knew very little about the students, the mental health resources they could draw upon, or the types of educational accommodations they might need.

. the right student at the right time – Even when the unique nature of each person with a serious mental illness is acknowledged, a yardstick is still needed to help determine the right consumer to benefit from mainstream career training programs as well as the right time for that individual to get started. This includes assessing consumers' energy and commitment to career goals, the clarity of their career choices, their academic skill and emotional stability, and the supports they will need to succeed in these programs.

The information needs identified by respondents are considerable, and several involve levels of detail that are daunting as well. For example, community colleges in each of the study sites offered as many as 40 career training opportunities; financial assistance opportunities are complex enough to frustrate any student; and Medicaid regulations covering workers with disabilities have kept as many as 75% of those who could apply from ever doing so. This suggests an almost impenetrable tangle of information that few in the current systems of care can be expected to master, given the already great demands on their time. To some degree, however, the responsibility to pursue the information must be shared among systems of care and between counselor and consumer.

3. Supports. No recommendations emerged more clearly than the need to identify and sustain a network of supports for individuals with serious mental illnesses who choose to enter mainstream career training programs. The community college, technical school, and nonprofit training program respondents to this survey were adamant that they did not have the knowledge base or clinical skills to provide the kinds of supports students with serious mental illnesses were likely to need. With so many of their current students in need of remedial education, academic tutoring, behavioral health guidance, career counseling, and/or practical advice on financing, child care, and family responsibilities, they were clear that all they could provide were the most rudimentary and inexpensive accommodations.

Vocational rehabilitation and workforce development respondents similarly recognized the likely support needs of those with serious mental illnesses if they were going to succeed in mainstream career training programs. However, they insisted that their systems cannot provide the intensive services some students will need, and that mental health systems in the past have often been unavailable to step in when a crisis is developing. Mental health agencies were wary of assuming these responsibilities. Stretched to the limit in providing the services for which funding is available, with few fiscal resources to draw upon for new services and unable to interpret existing Medicaid regulations or state requirements to supports to these student, programs felt hampered in their ability to respond.

All agreed that effective support mechanisms are a pre-condition for success in these demanding career training environments. Even the student who appears ready and able to benefit from these programs may have difficult times, and the failures born of our systems' past inability to support consumers play a large role in the current pattern of avoidance. No one – beginning with consumers themselves, but extending throughout the constituencies interviewed – is eager for an expanded engagement in mainstream career training programs that results in failure. Many of these systems and services depend on funding that demands a high level of success; this is a reality of program survival in the state vocational rehabilitation, career college, and nonprofit environments. At the same time, no one wants to encourage consumers to enter programs that will further eat away at their self-esteem and hopefulness.

   4. Funding. There were several core policy changes that respondents felt could help to generate the supports needed. And, because policy is often best reflected in the allocation of scarce fiscal resources, several recommendations focused on finding funding within existing allocations and/or developing new financial resources:

   . *Medicaid Policy* – Respondents looked to a change in the Medicaid regulations governing reimbursable services, with an emphasis on revising the requirements that mental health services be facility-based. A change of this kind could provide mental health programs the flexibility to use their staff to provide just the supports many respondents said that consumers would need to succeed in mainstream career training programs.

   . *Redirecting Program Dollars* - Respondents also felt that some current program dollars might be directed toward the provision of career training supports. Several mentioned that partial hospitalization or day program staff might be redirected toward providing support services for career training. Others noted that the ways in which agencies are making use of the growing number of "peer specialists" within mental health agencies could be redesigned to provide career training assistance.

   . *Work Incentives* – While the current SSA work incentives and Medicaid Buy-In programs remain underutilized, respondents felt that further changes, strengthening the financial work incentives and lengthening medical coverage, would be effective both in encouraging more people to work and promoting the use of mainstream career training programs as a pathway to better-paying skilled and semi-skilled jobs.

   . *Financial Aid* – Respondents argued for a variety of tuition payment programs, including tuition allocations as part of longer-term supported education programs, a loan forgiveness provision for people with disabilities in the existing federal and state grant/loan programs, and matching programs encouraging consumer and family contributions. Special initiatives with both public and foundation funding, or a revolving loan fund, were also recommended.

   . *Supported Education* – Expanding supported education programming and then infusing them with a greater emphasis on career education would be very helpful. Respondents suggested that supported education programs could be more effective if they

placed a stronger emphasis on education as a pathway to employment, with these programs prepared to help those who do succeed in career training to find and hold jobs.

5. *Outcomes.* Respondents in several systems believed that the participation of people with serious mental illnesses could be expanded if the outcome measures applied to their programs could be modified. Vocational rehabilitation personnel and workforce development personnel both felt that federal regulations held them to a high standard of effectiveness – moving eligible clients at a rapid pace toward competitive employment – that discouraged their engagement with those with serious mental illnesses and forced some wariness in supporting consumers in career training prior to job placement. Similarly, the technical schools believed that the standards for course completion and job placement that they had to meet to continue to be eligible for accreditation, Pell Grants, and state loans for students made it more difficult for them to accommodate the needs of students with serious psychiatric disabilities who might require a slower-paced program.

6. *Connections.* Finally, respondents often recommended a concerted effort to build stronger connections among the different systems of care, with both formal and informal agreements of cooperation. Pilot programs that developed more effective assessment instruments and established referral guidelines for potential students, that documented support needs and success rates, that identified the characteristics of successful students, etc., might move the field forward most rapidly. Letters of understanding between mental health providers and workforce development One-Stop Career Centers to collaborate on client needs, joint funding of supported education initiatives, and greater engagement by the human services community with the network of mainstream career training programs (in both the nonprofit and for-profit sectors) could, respondents felt, greatly enhance the opportunities for individual consumers to move into the skilled and semi-skilled labor market.

10. Discussion

The implications of the research findings presented above weigh most heavily on the systems of care designed to meet the needs of those with serious mental illnesses. Mental health providers, vocational rehabilitation agencies, and workforce development programs can and must do considerably more to help people to prepare for, enter, and succeed in skilled and semi-skilled labor markets in their communities.

Respondents to this survey argued that any initiative to make greater use of mainstream career training resources needed to begin from a 'realistic' framework. First, they argued, there are already many people with serious emotional problems in community colleges, technical schools, and nonprofit training programs, but these individuals have tended to pursue career training on their own, either because they are unconnected to mental health providers or because they choose to hide their participation from psychiatric professionals for fear of discouragement. In either case, these individuals often struggle to succeed and may frequently fail. A system of supports for such people – in which acknowledgement of one's psychiatric disability leads to non-stigmatizing treatment and a range of reasonable accommodations – would very likely improve graduation and employment rates, without appreciably changing referral rates from mental health agencies. This has been the focus of several supported education programs in the past, and provides an enormously valuable service. It does not, however, address the unmet needs of consumers already enmeshed in the public mental health system.

Second, increasing the referral to mainstream career training programs of people who are in treatment or receiving another form of rehabilitation services from public mental health systems may not be appropriate or effective for everyone, or even for most consumers. For many consumers, the right goal may be unemployment, in order to help ensure no exacerbation of symptoms. For other consumers, entry-level part-time or full-time work is just what is needed. And still others have the talent and desire for professional work. But for some percentage of others, although we have little idea of for how many, career training for skilled or semi-skilled work may provide a way forward.

Respondents to this inquiry were nearly unanimous: mental health, vocational rehabilitation, and workforce development personnel rarely, if ever, refer people with serious mental illnesses to mainstream career training programs; and many remain dubious of the likelihood of success if they do so. The problem is blamed on many complex factors: weak consumer work motivation; educational levels that disqualify consumers for career training; a history of failure; unresponsive treatment in mainstream programs; and the absence of resources to provide the supports consumers will need if mainstream programs cannot or will not provide more than basic accommodations.

Each of these issues can be addressed for those with serious mental illnesses who could – with appropriate supports and services – play productive and valued roles in the skilled and semi-skilled sectors of the national labor market. It will certainly not be easy or inexpensive to address these issues: mental health providers will need to learn a great deal more about these sectors of the economy, the training programs that prepare people

for skilled and semi-skilled jobs, and the supports – financial, academic, practical, and psychological – that will be needed for consumers ready for this challenge. And mental health systems will have to change attitudes – not only their own, but also those of vocational rehabilitation and workforce development "brokers," and those of admissions personnel and faculty in community colleges, technical schools and other nonprofit training programs.

However, change most hinges – as it should – on the transformation needed in the way that consumers of mental health services view their own capabilities and prospects. Having been told they cannot work by family and friends, therapists and counselors, the Social Security Administration and their local state vocational rehabilitation programs, they have resigned themselves to an idle and dependent existence, occasionally interrupted by pre-vocational training, supported employment initiatives, and short-term stints in entry-level jobs.

This is no way to live, and for many consumers of mental health services it is an unnecessary entrapment. We can do more to identify those consumers who have both the interest and the ability to be trained for the same kinds of jobs that millions of other Americans are proud to hold and through which they support themselves and their families. Our systems articulate a commitment to both recovery and community integration – to helping people with serious mental illnesses have the same opportunities as everyone else. But they have not done enough to assist consumers to approach work and their careers as do many of their family members and neighbors. If we are serious about the precepts of community integration, we need to reach beyond the current limitations of rehabilitation programming to draw on the resources all around us, or risk condemning another generation of people with serious mental illness to 30 or 40 years – an adult lifetime - of unemployment.

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