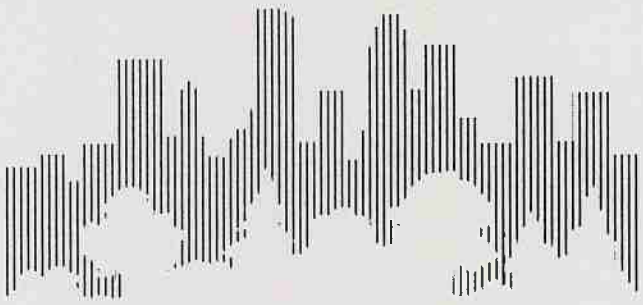
4-10-2001

Program Evaluation of Integrated Community Services

Julie R. Humbert
Augsburg College

AUGSBURG



C • O • L • L • E • G • E

MASTERS IN SOCIAL WORK THESIS

Julie R. Humbert

Program Evaluation of
Integrated Community Services

2001

PROGRAM EVALUATION OF INTEGRATED COMMUNITY SERVICES

JULIE R. HUMBERT

Submitted by partial fulfillment of
The requirement for the degree of
Master of Social Work

AUGSURG COLLEGE
MINNEAPOLIS, MINNESOTA

2001

MASTER OF SOCIAL WORK PROGRAM
AUGSBURG COLLEGE
MINNEAPOLIS, MINNESOTA

CERTIFICATE OF APPROVAL

This is to certify that the Master's Thesis of :

Julie R. Humbert

has been approved by the Examining Committee for the thesis requirement for the Master of Social Work Degree.

Date of Oral Presentation: 4/10/01

Thesis Committee:

Phu Tai Phan
Thesis Advisor: Phu Phan

Laura Boisen
Thesis Reader: Laura Boisen

Cheryl Kazemek
Thesis Reader: Cheryl Kazemek

DEDICATION

I wish to dedicate the following thesis to my husband Shannon, who encouraged me throughout the past three years to continue this journey through the happiest and most difficult times. You were the one who experienced with me all of the joy and anger of working, going to school and trying to stay sane. I thank you for the encouragement and confidence you had in me when I did not have it in myself. You are my fate and my soulmate.

I wish to dedicate this thesis to my mother, who never gave up on encouraging me to attend graduate school. Without you, I would not be on this earth and possibly not in the Augsburg MSW program. Thank you for your phone calls acknowledging my schooling and your interest in what I was doing. I am more appreciative of this than you will ever know. Thank you for your ongoing support, continuous love and guidance.

ACKNOWLEDGMENTS

My experience at Augsburg College has been quite a memorable one. I would like to take time and acknowledge certain individuals who made this experience life-changing.

First of all, thank you God for guiding me each and every day through this grueling, yet rewarding journey. My prayers were answered.

The Augsburg MSW staff and faculty have been incredibly supportive and helpful. I thank you for this. Special thanks to Phu Phan, my thesis advisor and main supporter, Maria Dinis for her vitality with statistics and persistence to help me finish and Laura Boisen, a professor who's joy for life was overflowing, along with her support and encouragement.

I would like to acknowledge my Program director, Cheryl Kazemek, who was a reader for my thesis. Most of all, I thank you for allowing me the flexibility to work, intern and finish my schooling. Without your support, the entire graduate process would have been very stressful and difficult for me to pursue.

Finally, I thank my classmates and friends who supported me through this three year process. I thank my classmates for all of the support, encouragement and laughter you gave to me during "our" experience. I thank my friends for acknowledging my hectic life and for asking about my schooling. By just knowing people out there were interested and understanding, my whole experience was made so much more rewarding. My supporters, thank you so much!

Abstract of Thesis

Program Evaluation of
Integrated Community Services

By
Julie R. Humbert

This is a quantitative study of the program Integrated Community Services for adults with severe and persistent mental illness. This program evaluation compares a random sample of quality of life surveys of adults (N=14) who have been involved in the assertive community treatment program. The survey results include vocational, housing, financial, and mental health needs of adults with severe and persistent mental illness. A case management staff survey (N=5) reports on perceptions of the quality of life of individuals with severe and persistent mental illness and how the Integrated Community Service team works together. This study is important because it evaluates the effectiveness of the Integrated Community Services staff working together as a team and with the population they serve. Findings and implications for social work practice and policy are discussed.

Table of Contents

List of Tables

Chapter I: Introduction

New psychoactive medications, a new philosophy of social treatment and the concern for the lack of civil rights and liberties of psychiatric patients were some issues that influenced the deinstitutionalization movement (Lamb, 1982). In 1963, the Community Mental Health Center Act provided grants to build community mental health and research centers. The services that came out of this were inpatient, outpatient, partial hospitalization, 24-hour emergency services, community consultation and educational services (Isaac & Armat, 1990).

According to Lamb (1982), the Fairweather Community Lodge program of the 1970s housed the discharged hospital patients and worked toward meeting the housing, social and vocational needs of individuals with severe and persistent mental illness. Another important housing program for the individuals was called Satellite Housing, which focused on helping long-term patients live "normal" lives in the community. This program offered a lifestyle of freedom, independence, integration into the community and assisted the individuals with a sense of dignity. Housing programs for people with mental illness should have rehabilitation as their goal, not just providing shelter (Lamb, 1982).

Surviving in the community meant developing skills in day to day living, social interaction and employment (Breakey, 1990). Psychiatric rehabilitation services are concerned with functioning in areas such as social, self-care and occupational skills. Programmed rehabilitation widely adopted the "The Fountain House Model" in the United States. The model started in 1948 and provided a "clubhouse" model that offered employment opportunities, skill building and social interaction with peers (Breakey,

1990). A model called the Assertive Community Treatment (ACT) or Program of Assertive Community Treatment (PACT) is used today in some community support programs.

Problem and Research Questions

In this chapter, the problem and research questions are outlined. This research project is of the program Integrated Community Services (ICS) of South Metro Human Services. The PACT model is utilized within this agency. Adults with severe and persistent mental illness make up the population studied. The ICS program has not evaluated the effectiveness of the PACT model. By evaluating the quality of life of individuals with severe and persistent mental illness and exploring the team members' perspective of the PACT model, future enhancement of services can be implemented. The research project will address the following: 1) What is the difference in client's perceptions of the quality of life before and after the vocational program (PACT) model began? 2) What is the perception of the ICS staff on the effectiveness of the PACT program on the clients?

Significance

The significance of this research is to ascertain whether the PACT model is implemented effectively by the ICS staff. The ICS program consists of an assertive community treatment team that provides the following services: psychosocial rehabilitation, independent living skills, housing, employment, benefit assistance, medication monitoring and crisis intervention. ICS is a Hennepin County Mental Health

Initiative that works together with outside team members to implement the PACT model. Mental health professionals are established as treatment team members from client goals on the individual service plan (ISP). The ISP dictates what team members will provide services (psychiatrist, case manager, vocational coordinator, nurse). ICS staff work closely with the vocational team members to focus on the employment and educational goals.

Chapter II: Review of the Literature

Work is an essential and integral part of our lives (Cnaan, Blankertz, Messinger, & Gardner, 1988). Research has confirmed the ability of individuals with serious mental illness to function independently in the community if provided adequate treatment, rehabilitation and support (Rosenberg & Manderscheid, 1988). The literature review discusses assertive community treatment with vocational services, otherwise known as PACT, in order to identify the strengths and weaknesses of the program. In this chapter, the history of deinstitutionalization, benefits and costs of employment and barriers to successful integration are discussed. Maintaining employment, the assertive community treatment and vocational model, cost-effectiveness and limitations and benefits are discussed also.

Brief History of Deinstitutionalization

During the first part of the 19th century, privately operated facilities existed for individuals with mental illness, but treated only those who could pay (Bloom, 1977). Many people were treated in their homes and communities. People who were physically sick, poor, aged and mentally retarded were put in the same category as individuals with mental illness and housed in prisons and poorhouses when families were unable to pay for hospital treatment. In 1841, Dorothea Dix visited a jail in Massachusetts and found several individuals with mental illness held there and treated inhumanely. Dorothea Dix' name soon became synonymous with the state-hospital movement. Prior to Dorothea Dix' career ending, 32 state mental hospitals were built in the United States (Bloom, 1977).

By the late 19th century, state mental hospitals had grown in size and number and the quality of the treatment deteriorated (Bloom, 1977). Too little money from the states and not enough training for staff were two direct reasons the institutions faltered. In the early 1950s the field of psychopharmacology had grown with the development of new medications. The philosophy of *therapeutic community* evolved and denoted therapeutic alliance with staff and patients. The geographic decentralization resulted in relationships established between hospitals and communities. State hospitals eventually were converted into community mental health centers. Because of these changes, the patient population in mental hospitals began to decline (Bloom, 1977).

Deinstitutionalization assumed the release of long-term institutionalized patients into the community (Grob, 1994). The goal was for individuals with mental illness to receive treatment as outpatients in a community setting. Lerman (1995) suggested that one reason deinstitutionalization was accepted in the United States was because of the widely shared perception that traditional institutions were "snake pits" or places of incarceration rather than for treatment (Lerman, 1995). This attitude of society provoked researching other ways of housing and treating individuals with disabilities.

In 1946, in addition to creating the National Institute of Mental Health, the National Mental Health Act provided funding for the development of pilot community care programs and training of mental health professionals (Mechanic, 1994). The act established both research-grant and training grant programs (Bloom, 1977). Legislative and judicial decisions supported a patient's right to choose or deny treatment and live in

the "least restrictive environment" (Marcos, 1990). This environment promotes self-determination and independence for individuals with severe and persistent mental illness. Institutionalized patients were given the opportunity to live more "normal" lives in the community. Society had mixed feelings and some individuals felt that the very sick people were let loose to do whatever their "craziness" allowed them to do (Johnson, 1990).

In 1963, deinstitutionalization was accelerated by the Aid to Disabled Act in which individuals with SPMI became eligible for federal financial support and the Community Mental Health Care Act. This latter Act provided grants to build community mental health and research centers (Marcos, 1990). The legislation did not take into consideration all the community needs of individuals with mental illness. The community health policy often overlooked the need for supportive services to ensure that people with severe mental illness would have access to housing, food, social networks and recreation (Grob, 1994). Gradually, the deinstitutionalization of individuals with SPMI increased. By 1975, the number of patients in the state and county mental hospitals had declined by 62% (Mechanic, 1995). The increase in the number of community mental health centers and the decrease in the institutionalized population reflected the claim that the mental health centers would eventually replace the mental hospitals (Grob, 1994).

The first generation psychiatric patients in the 1970s to reach adulthood in the community exhibited aggressiveness, volatility and were often noncompliant with medications (Grob, 1997). Other problems such as alcoholism, drug abuse, lack of

functional and adaptive skills exacerbated their behaviors. Homelessness was one of the results of the inability to integrate into the community.

Board and care homes, foster care and the Fairweather Community Lodge program and Satellite Housing were considered long term housing during the deinstitutionalization process (Lamb, 1982). Housing was not the only resource needed for individuals with SPMI to integrate effectively in the community. Programmed rehabilitation adopted the Fountain House model. The model was actually started in 1948 and provided an atmosphere where members participated in activities and programs designed to empower them (Breakey, 1990). In 1977, the National Institute of Mental Health launched the Community Support Program (CSP) due to the barriers associated with uncoordinated systems of treatment, care and financing (Grob, 1994). CSP's are in effect today and implemented out of drop-in-centers. Adults with mental illness are able to spend time at the drop-in-centers staffed by mental health professionals with the main focus of psychosocial rehabilitation. The focus of this research paper is not on the deinstitutionalization process or on community support programs. The focus is on today and how the individuals with SPMI are able to cope and live independently in the community utilizing the services offered. The service specifically researched is the PACT model, which emphasizes employment for individuals with SPMI.

Benefits and Costs of Employment

Work plays an important role in society and in the lives of all people. It is considered important for individuals with SPMI for several reasons. Employment provides an income, structure and social connections and gives meaning to life (Noble,

Honberg & Hall, 1997). Individuals who suffer from a mental illness can flourish with structure and socialization. Work may assist in preventing decompensation and frequent hospitalization (Fellin, 1993). Structure can create a positive attitude. At some point in their lives, individuals with a diagnosis of SPMI may end up depending upon the government for financial stability. Work may end dependence on government and state benefits such as Supplemental Security Income (SSI) or Social Security Disability Income (SSDI) (Bell, Lysaker & Milstein, 1996). Families may feel overwhelmed with taking care of the family member that has a diagnosis of SPMI. Employment can provide respite for families who care for individuals with SPMI each day (Martin, Connely & Noble, 1995).

On the reverse side, work may be a source of stress and anxiety that can lead to decompensation of one's mental health (Hamburg, Elliot & Parron, 1982). Individuals with SPMI may have a low tolerance for stress in which symptoms can appear. Managed care companies have employed narrow definitions of medical necessity (Mallik, Reeves & Dellario). This implies an attempt to reduce services and control costs. Vocational services are not typically included in medical necessity criteria. It is unclear how vocational programming, which includes job finding, placement, coaching and supported employment, will be paid for if managed care will not recognize its worth. Employment is not without barriers for successful integration into the community. The following paragraph will discuss these barriers.

Barriers to Successful Integration

Employment offers unique contributions to successful community stabilization of adults with SPMI through countering impoverishment and social isolation (McGrew, Bond & Dietzen, 1995). Individuals with a diagnosis of SPMI are often unable to seek and maintain successful employment due to the implications of their illness. According to the Minnesota Statute 5211.02 (b)(2), an individual with SPMI is defined by a mental health or human service agency as having one of the following: 1) undergone two or more episodes of inpatient care for a mental illness within the preceding 24 months; 2) experienced a continuous psychiatric hospitalization exceeding six months duration within the preceding 12 months; 3) has a diagnosis of schizophrenia, bipolar disorders, major depression or borderline personality; 4) has a written opinion by a mental health professional stating the person is likely to have future episodes requiring inpatient treatment, unless ongoing case management or community support is provided, and 5) has a commitment of mental illness by a court under the Minnesota Statutes.

According to Mallik, Reeves, and Dellario (1998), people with severe and persistent psychiatric disabilities rate employment resources and vocational adjustment as two of the highest barriers to successful community integration. A group of 92 participants with serious mental illness identified these barriers through an experimental study. Out of 92 participants, 46 were women and 46 were men. Participation was voluntary and clients were asked to fill out the instrument at a team meeting. Clients were to fill out the instrument on their own, unless assistance was requested. The instrument consisted of 25 items split into three sections. Fourteen items

pertained to skill related barriers, 5 items pertained to support systems and 3 items pertained to resources. Each item was rated on a scale from 1-5 (1 was no barrier and 5 was insurmountable barrier). The areas included in successful integration were the ability to perform appropriate behavioral and interpersonal skills, follow directions, make judgements, complete and maintain tasks and comply with regulations (Mallik, Reeves, & Dellario, 1998). Employment resources include opportunities and resources to find, get and keep a job. From the previous 2 studies, one would foresee the need of an intensive support team to identify resources and provide skill training in order to decrease the employment barriers.

Maintain Employment

Substantial employment is a goal for many people with SPMI. The aggregate employment rate for individuals with SPMI is approximately 10-15% (Noble, 1998). Extensive support is required for people with SPMI to maintain employment. An individual with SPMI may encounter problems of unrealistic goals or expectations, limited or non-existent vocational history, poor work habits and limited skill development (Russert & Frey, 1991). Symptoms such as hallucinations, delusions, anxiety, memory and concentration problems, and poor motivation affect the individual in obtaining and maintaining employment (Russert & Frey, 1991).

Russert and Frey (1991) state the environmental factors that affect individuals with SPMI. The level of stimulation, flexibility of hours, amount and type of supervision, and interpersonal requirements are environmental factors that affect individuals with SPMI at work. Environmental factors such as transportation, ongoing

work support, money management, entitlements and comprehensive clinical and vocational follow-up also are factors to take into consideration (Russert & Frey, 1991). According to Marrone, Balzell and Gold (1995), vocational support includes advocacy with supervisors and co-workers, symptom management assistance and access to peer support to maintain employment. In order to decrease barriers and maintain employment for individuals with SPMI, the Program of Assertive Community Treatment (PACT) was developed by Test, Knoedler, Allness, and Senn-Burke in Madison, Wisconsin in 1985 (Russert & Frey, 1991).

Assertive Community Treatment

The central idea of the assertive community treatment (ACT) model is that a community-based team provides a full range of medical, psychosocial, and rehabilitative services to clients with SPMI by maximizing their skills and supports in the community (Drake & Burns, 1995). The ACT team is on-call 24 hours per day and is perhaps the best studied model in the community of psychiatry (Burns & Santos, 1990). Ideally, each staff member works with a caseload of 5 - 7 clients (Essock & Kontos, 1995). Several features of the ACT principles are incorporated into the early version of the National Institute of Mental Health's (NIMH) Community Support Program (CSP) model (Turner & TenHoor, 1978). Stroul (1989) reports that ACT teams continue to be essential in the NIMH model of CSP's. A concern may be funding of the model.

Funding of ACT

Essock and Kontos (1995) researched the ACT model implemented in Connecticut in 1987. Their results concluded that the ACT model can be created by a

variety of routes that do not include fiscal incentives for community programs. By moving staff from state hospitals to the community and reconfiguring current community-based staff, ACT teams can be constructed without additional funding. Three sites of ACT teams were compared with high quality case management. The study included 262 consenting clients who met the screening criteria related to diagnosis and level of functioning and were followed for 18 months. The random sample of clients were monitored for changes in quality of life and in the amount and type of service provided. The Connecticut ACT program results indicate cost-effectiveness and increased quality of life for many adults with SPMI. Clients in the ACT program were in the hospital about half as often as clients in case management services (Essock & Kontos, 1995).

PACT Vocational Model

According to Russert and Frey(1991), the PACT model integrates vocational and mental health services to facilitate community employment of adults with SPMI. Employment options include competitive, supportive or prevocational activity since one type of employment does not fit all individuals. PACT is based on an individualized placement model that provides opportunities for integration, self-sufficiency and improved self-worth (Russert & Frey, 1991). The PACT model includes intensive services provided by an assertive treatment team. The process includes: 1) an assessment of client's strengths and deficits in the work environment; 2) an individualized vocational plan to organize support networks; 3) problem solving and job tailoring to develop appropriate job sites and educate employers; 4) adjustment to

employment for the development of the individual as a worker; 5) follow-along service to monitor clients' functioning and provide guidance; and 6) reassessment for clients who lose jobs or who are not satisfied with their employment (Russert & Frey, 1991). PACT is not time-limited so the process of obtaining employment continues as long as the client wants the service. The lack of time limitations may be difficult when evaluating the effectiveness of the model. Quality of life surveys, progress notes and the number of hospitalizations can be tools used for evaluation. The absence of time limitations with the PACT program is beneficial for SPMI clients who continue to battle ongoing symptoms of their illness. Symptoms often prohibit clients from employment, but the continued intensive service supports clients throughout the vocational process (Russert & Frey, 1991).

Becker, Neil, Stormer, and Brondino (1991) facilitated a study of employment outcomes for clients with severe mental illness in a PACT model replication. State hospital patients viewed as unmanageable in the community by mental health centers were the clientele that participated in the PACT model replication study (Knoedler, 1994). The goal was to train mental health professionals in the PACT model. Client's discharge summaries, case manager's weekly home visit reports, and daily records of all client-staff contact were used as methods in the study. An impressive number of 67% of the clients in this study worked at some point after a one-year time span (Becker, Meisler, Stormer & Brondino, 1991).

According to the PACT replication study, intensive support services are extremely important for "normal" integration into the community of the SPMI population

(Becker, Meisler, Stormer & Brandino, 1999). Other important results of the replication study are, while in the program, an increase of independent living for clients from 29% to 90% and 56% of the clients were not hospitalized. Not only employment percentages increased, but independent living and the absence of hospitalizations increased. The previous literature reported on PACT's positive aspects, but a program called the Support Coalition is concerned that PACT looks good only on the surface (Becker, Meisler, Stormer & Brandino, 1999).

The National Alliance for the Mentally Ill (NAMI) is an organization that promotes the PACT model and is campaigning for Congress to pass laws so the model will be used throughout the United States by the year 2002 (Support Coalition, 2000). *Dendron* is the journal that reports on the Support Coalition, a human rights organization that advocates for vulnerable adults (Support Coalition, 2000). The Support Coalition (2000) argues that the PACT model makes sure people stay on their medications through watching the individuals physically take the medications daily. Part of the philosophy of the human rights organization is that the medications are basically forced on the individuals with mental illness. The concern is that it is a human rights issue and some individuals may not want to take the medications and receive support services. Consumer empowerment and self-determination are other important rights disturbed by forcible treatment, especially when considering that "The neuroleptic medications are very strong and they can kill" (Support Coalition, 2000, p. 3). According to the Support Coalition (2000), another barrier to the PACT program is the cost.

Cost-Effectiveness of PACT

According to Noble (1998), the U.S. General Accounting Office and NAMI, services provided by state vocational rehabilitation agencies do not produce long-term earnings for clients with emotional or physical disabilities. The federal-state program wastes an estimated $490 million each year on time-limited services to consumers with mental illness. Rechanneling money into more appropriate integrated service models, such as PACT programs, would stabilize annual vocational rehabilitation funding for 62,000 to 90,000 consumers with SPMI (Noble, 1998).

According to the U.S. General Accounting Office, increasing psychosocial rehabilitation and PACT programs to provide these services would be the best-practice advice (Clark & Bond, 1996). In retrospect, integrating vocational and psychiatric services with no time limitations would provide more cost-effective services. There is also evidence that integrated mental health and vocational programming will enhance society by reducing expensive hospitalization (Clark & Bond, 1996). Programs like PACT can reduce inappropriate use of the criminal system (jails) through moderating violent behavior in the community and improving social functioning and interpersonal relationships (Torrey, 1994; Dvoskin & Steadman, 1994).

The Support Coalition (2000) concludes that one of the biggest barriers to PACT is the cost-effectiveness. According to a 1996 survey of 11 PACT/ACT programs, the average expense per consumer was $6,914. Approximately 40% of ACT/PACT programs are financed by the federal taxpayers through Medicaid (Support Coalition,

2000). All of this means more money for the drug manufacturers (Support Coalition, 2000).

Gaps and Limitations

The major limitation and gap in this literature review is the fact that the PACT program is fairly new and there is limited information on this model and employment outcomes. The studies are fairly recent. Only a 5 to 10 year span of time was addressed in the studies. There is more information on the ACT teams over the PACT teams in the literature, possibly due to the fact that PACT is developed out of the ACT model. Another gap in the literature is that specific employment types (transitional, supported and pre-vocational) are not elaborated on in the literature. The employment settings are identified in separate articles, but they are not defined directly within the PACT literature.

Self-determination of clients was not addressed in the articles researched. Do the ACT/PACT teams provide too much support resulting in individuals becoming too dependent upon services? How much is too much dependence and intensive services? Are the services taking away from the client's self-determination and fostering dependence?

Benefits of the Study

The literature review discusses assertive community treatment with vocational services in an effort to enhance the quality of life for individuals with SPMI. This model is known as PACT and has been viewed as a best-practice technique. Research studies and empirical evidence concluded that the PACT program is cost-effective and an

effective practice for individuals with SPMI. Noble (1998) reinforced the cost-effectiveness and personal benefits of the PACT model.

The PACT model was addressed in the previous literature from the perspective of a community support program model, which is based out of a drop-in, psychosocial rehabilitation setting. Research supported the effectiveness of the program. The future goal is to evaluate the PACT program's effectiveness from the perspective of an outreach team not based in the drop-in center setting. This study has unique characteristics because of the way it utilizes the PACT model. The PACT program to be researched does not have all of the team members on-site with the other treatment team members. The vocational providers are based out of their own site and maintain contact with the other team members through client and staff meetings or phone correspondence. This study evaluates the effectiveness of the PACT program through studying the quality of life of individuals utilizing the PACT services and a survey of team members' perceptions of effectiveness. It is anticipated that the results will provide valuable information needed to continue enhancing the PACT teams service with individuals who suffer from a severe and persistent mental illness.

Chapter III: Theoretical Framework

In this chapter the ecological systems theory and strengths perspective are described. An application of the frameworks to my research study will be discussed. Although the literature reviewed from Russert and Frey (1991) on the PACT model did not specifically state a theoretical framework, the ecological systems theory appears is the most relevant.

Application of Ecological Systems theory

The "life model" of social work practice is the major formulation of ecological systems theory (Germain & Gitterman, 1980). The ecological theory provides an adaptive, evolutionary view of human beings in constant interchange with their environment (Germain & Gitterman, 1980). Reciprocal adaptation is a term the life model defines as change of the individual supported in the environment (Payne, 1997). Germain and Gitterman (1980) emphasize that people change their physical and social environments and are changed by their environment through continuous reciprocal adaptation. People constantly adapt to their surroundings. Social problems (such as poverty, discrimination, or stigma) pollute the social environment. Living systems (people individually and in groups) must try to maintain a good fit with their environment (Payne, 1997). Individuals with severe and persistent mental illness residing in a community require a good fit in their environment in order to achieve reciprocal adaptation.

Franklin and Jordan (1999) define the ecological systems theory as describing the relationship between an organism and its environment. The PACT model used by the ICS program exists due to the act of deinstitutionalization. Individuals with SPMI are discharged from hospitals and treatment centers into the community and are expected to integrate. These individuals depend upon social workers, psychiatrists, mental health counselors and others for assistance. Adapting into their new environment is difficult and the relationship between the discharged patients, advocates and the environment is an essential part of successful integration.

According to Franklin and Jordan (1999), supportive environments and life skills are two essential elements oriented to the ecological perspective. Vocational rehabilitation, independent living skills and advocacy are goals of the PACT model and utilized by the ICS team (Becker, Meisler, Stormer & Brandino, 1999). Individuals with SPMI discharged from hospital settings are in need of these valuable supports and resources. ICS team members link individuals to financial, emotional and social resources. By building more supportive and nurturing environments for individuals with SPMI and improving their competence through teaching specific skills, successful integration can occur (Franklin & Jordan, 1999). Team members of ICS advocate and support individuals with SPMI in the least restrictive setting (housing), while teaching independent living skills to continue independence in the community. This positive interaction with the individual in his or her environment can be an indicator of an enhanced life, which is the testing tool used in this research project to identify the outcome of the PACT services.

The ecological perspective has a holistic view of people (Ashford, LeCroy & Lortie, 1997). People, including individuals with SPMI, function through interaction between others and the social environment. The interactions consistently shape and form new interactions. The ICS team, utilizing the PACT model, is an integrated team that builds close relationships with the consumers served. Germain and Gitterman (1980) ecological practice approach acknowledges 3 interdependent sources of stress:

- Life transitions such as role demands and crisis events that pose reciprocal tasks for the individual and the environment;
- Issues and tasks associated with harsh social and physical environments and the inability to use available resources; and
- Maladaptive patterns of relationships and communication in families/groups that inhibit the person's growth, needs and achievement of goals.

The ICS team assists individuals with SPMI to: (1) transition into a new life in the community; (2) access crisis resources; (3) use coping methods in harsh situations; and (4) identify maladaptive patterns in relationships that prohibit growth of the individual. Ashford, LeCroy and Lortie (1997) include some of the ecological systems perspective basic ideas:

- Social work practice is based on the person and situation, along with the system and its environment.
- Social work practice occurs at the intersection of the human system and its environment.
- Transactions occur at the interface between the system and the environment.

- In transactional relationships, both systems are influenced by change efforts.
- Social work practice is best conducted when the transactions promote growth and development of the organism and environment, thus making it a better place for all systems that depend on the environment to live.

The ICS program emphasizes the person and his or her environment through acknowledging their independence and self-determination in the community. The PACT model focuses on working with the individual in his or her environment through first prioritizing and then obtaining needs. Food, clothing, and shelter may be the number highest priority. Individuals without adequate resources or the skills to find these resources may end up homeless; therefore the ICS team implementing the PACT model works with consumers on obtaining these basic needs.

Developing and adjusting to new roles or tasks in life is difficult for individuals with severe mental illness. The ICS team adheres to the individual needs by linking individuals to independent living skills programs, or assisting them during weekly visits in their home (e.g., cooking, cleaning, budgeting, shopping). At times, individuals with SPMI need others to assist in advocating their rights. Discrimination is illegal and may occur with individuals who have disabilities.

Housing, employment and activities of daily living can present as barriers to individuals with SPMI, who do not have the adequate resources to access. The ICS team works with individuals in obtaining affordable housing, pursuing vocational assistance and addressing needs that surface during everyday life. Individuals with SPMI live in the community without the assertive community treatment members helping them, but their

quality of life may be less. The quality of life in this study surveys individuals receiving assertive community treatment that emphasizes employment. The ecological systems framework is applicable to this study. The relationship between adults with SPMI and their environment is affected by the ICS team and vocational programming. The goal of the team is to assist individuals with SPMI to overcome barriers in their lives, which in turn may increase the quality of life.

Application of Strengths Perspective

According to Weick, Rapp, Sullivan and Kisthardt (1989), the strengths perspective is a social work value alternative to the negative preoccupation of people and society. The strengths perspective produces encouraging outcomes for the individual with a chronic mental illness. A key approach is to utilize the strengths and resources of the individuals, instead of focusing on the pathology.

Accomplishing goals are part of the strength's perspective as noted by Weick, Rapp, Sullivan and Kisthardt (1989). They state: "The question is not what kind of life one has had, but what kind of life one wants and then bringing to bear all the personal and social resources available to accomplish that goal" (p. 353). The ICS team develops an individual service plan with the client and other team members. The ICS team and PACT model are indicative of the client goals; therefore, it is imperative to address the Social Work principal of client's self-determination through identification of his or her own goals.

The strengths perspective postulates the following assumptions (Saleebey, 1992):

- Despite life's problems, all people and environments possess strengths that can be identified to improve the quality of life for clients;
- Client motivation is fostered by a consistent emphasis on strengths as the client defines them; and
- Discovering strengths requires a process of exploration between clients and workers.

Through testing the quality of life of individuals who have a severe and persistent mental illness, the ICS survey is a tool indicative of the strength's perspective. The strength's perspective seeks out individual's capacities, talents, competencies, visions, values and hopes (Saleebey, 1992). The strengths perspective is applicable to this study. The ICS team and PACT model value and respect the individual's goals and objectives in life. Identifying strengths of each individual with SPMI and assisting in accomplishing these goals is the job of the ICS team. The quality of life surveys assist in identifying needs that are being met and needs that are not for future enhancement of services.

Chapter IV: Methodology

In this chapter, the methods for this study are outlined. Strengths and weaknesses of the research design are discussed. The research design for this program evaluation is described. The quality of life surveys were given to individuals with severe and persistent mental illness prior to the research study; therefore the surveys are secondary data analysis. The staff perception surveys were handed out during the study and are survey analysis.

Research Design

The research design for research question #1 is the one-group pretest-posttest. A pretest (survey) was given to the participants, then later they received a treatment (vocational programming), and finally a posttest (survey). This design was used for the program evaluation of ICS. The research design is an agency based program evaluation in which the results are to be shared with the stakeholders or administrators of the program. The program evaluation is formative because quality of life surveys are used at certain intervals during the collaboration of ICS and vocational services (Rubin & Babbie, 1997). The staff perception survey is indicative of a formative evaluation because it is testing whether the service provided is working effectively.

The quality of life survey is made up of thirteen components that are assessed for whether needs are met of the individual with SPMI. The first variable is friendship and it is defined as finding, keeping or visiting with a person. Food is described as receiving adequate, nourishing meals on a regular basis. Housing is interpreted as safety, comfort and affordability. Leisure or recreation, medical, dental and mental health services are all defined as locating and accessing. Acceptance within the community is when no strange

looks occur and people are friendly. Work is viewed as finding, achieving and maintaining. Education or job training opportunities are described as attending, paying for and locating. Security is specified as feeling safe and protected from harm to yourself. Financial is described as adequate money to meet daily needs. The last variable is transportation and it is defined as availability and convenience.

Concepts/Units of Analysis

The population or clients served by ICS are individuals with severe and persistent mental illness (SPMI) as defined in pages 9-10 of this thesis. Staff members of the ICS program facilitate a quality of life survey when clients are first referred to the program. At six-month intervals, staff continue to facilitate the quality of life survey until a final survey is done at discharge. Researching the quality of life surveys when clients are in the Assertive Community Treatment (ACT) portion of the program and then when they are in the Program of Assertive Community Treatment (PACT or vocational) portion will determine if there is an observable difference from the clients' perception. The unit of analysis is the quality of life survey, which is operationalized by elements on the survey. The vocational program is also part of the Hennepin County Mental Health Initiative implemented to service clients with SPMI in the ICS program and other intensive community support programs. Vocational coordinators become involved when employment or other vocational opportunities are goals in the individual service plans developed by the ICS team and the client.

The ICS program consists of an assertive community treatment team that provides the following services: psychosocial rehabilitation, independent living skills,

housing, employment, benefit assistance, medication monitoring and crisis intervention. A survey of staff perceptions on the effectiveness of the PACT model is the unit of analysis for observing effectiveness of the ICS program. The survey is operationalized by the elements in it. The ACT model is a community-based team (ICS) providing medical, psychosocial, and rehabilitative services to clients with SPMI. The PACT model includes intensive services provided by an assertive treatment team (ICS and the vocational team) to assess clients' strengths, deficits, problem solving, employment needs, advocacy/education with employers, guidance throughout employment and follow-up/reassessment services.

The research study addresses the following: 1) What is the difference in client's perceptions of the quality of life before and after the vocational program (PACT) model began? The independent variable is the vocational program and the dependent variable is the quality of life of individuals with SPMI. 2) What is the perception of the ICS staff on the effectiveness of the PACT program on the clients? The independent variable is the PACT program and the dependent variable is the effectiveness of the ICS staff.

Study Population

Participants in the quality of life surveys of this study were primarily Caucasian males who live in apartments in the urban area of Hennepin County. The age range of this sample population was 25-53. The 5 case managers from the ICS team who filled out the staff perception surveys were all Caucasian, 2 male and 3 female.

Individuals with SPMI run into several obstacles while integrating into the community. Some characteristics of this population include symptoms such as hallucinations, delusions, anxiety, memory/concentration problems, and poor motivation, which affect the individual's skills in every day life. In obtaining and maintaining employment, several issues arise for the individual with SPMI. Transportation, continuous vocational support, managing finances and entitlements are important factors to take into consideration.

Sampling Procedures

The Hennepin County Mental Health Division initiates the ICS referral of clients with SPMI. The number of individuals with SPMI that work with the ICS program varies. At the time of the study, the population served is approximately 70 adults. Because of the small population and the fact that not all of the clients with SPMI are involved with a vocational coordinator, a random sample was not feasible. Instead, the method used was a non-probability quote sampling of 19 individuals who fit into the category of initial involvement with ICS and later with ICS and the vocational team. Out of the 19 individuals, 14 agreed to answer the quality of life surveys. The data sources include a quality of life survey developed by Hennepin County Mental Health and a survey of the ICS staff perceptions on the effectiveness of the PACT model.

Measurement

Both surveys are quantitative methods. Collecting data through the two surveys serves as triangulating information, which deals with systematic error (Rubin & Babbie, 1997). Systematic error is decreased by not divulging the research question in the survey

or questionnaire. The ICS staff facilitate the quality of life survey with clients. Staff are able to clarify and elaborate on questions that appear to be misunderstood by clients. The uniformity of administration of ICS staff during the survey increases the reliability and decreases the random error. A systematic error of social desirability bias is a concern because staff are administering the questions directly to clients (Rubin & Babbie, 1997).

Threats to internal validity include history and maturation. The quality of life surveys are done every 6 months. It is possible that increases or decreases in perceptions were due to extraneous variables other than the vocational programming intervention. Maturation of the subjects within the 6 months is a threat to internal validity also. Individuals in this study continued to grow and change in the 6 month time period. This leads the researcher to believe that these changes can affect the study results.

The staff perception survey was handed out to all ICS staff in order to obtain their perceptions of services provided to clients. The questionnaire is a tool that increases the validity of the study and decreasing the systematic error. The social desirability bias is decreased with the staff survey, because it is anonymous and staff fill out the surveys themselves.

The quality of life surveys and staff perception surveys are rank-ordered. The surveys are measured at the ordinal level because of the rank-order (Rubin & Babbie, 1997). The surveys assess individual needs and staff perceptions in areas such as food, housing, friendship and work. The answers include: (1) not at all, (2) very little, (3) somewhat, (4) fairly well and (5) extremely well. The answers are rated on a five-point

scale. The survey answers are classified as discrete variables because the ordinal scale used does not increase steadily. Because the surveys are coded on a five-point scale, the interval scale also can be used.

Instrumentation

The quality of life surveys (see Appendix E) were secondary data developed and implemented by the Hennepin County Mental Health Division. Jerry Storch at DHS reported to this researcher that the surveys were originally tested at Moose Lake Regional Treatment Center. The survey was adopted from a scale implemented in Pennsylvania called the Alpha Cronbach reliability scale. The scale is a statistical test with a .9 reliability. The staff survey (see Appendix D) was modeled after the quality of life survey and developed by the researcher. The survey was pre-tested on a male and female staff member of a different case management program called the Community Treatment Team (CTT). CTT staff are under the same protocol as the ICS team and provide the same type of service to individuals with SPMI.

Data Collection

The surveys are facilitated by ICS staff (case managers) and take place in the setting of the individual's home. The staff surveys were presented and discussed with the ICS staff at a team meeting. Each staff member received a survey to complete at the team meeting after the vocational programming was implemented for the individuals with SPMI. Once the research project was decided on, this researcher discussed the program evaluation with clinical director Terry Schneider of Integrated Community Services and researcher Jerry Storck from the Department of Human Services (DHS). After receiving

approval letters from both administrators (see Appendix B and C). Approval was granted by DHS and final approval was given by the Augsburg Institutional Review Board (IRB) (see Appendix A). The quality of life and staff perception surveys are the two types of data collected for the research study.

This researcher developed a release of information letter and staff perception survey that was pre-tested with a program affiliated with ICS. The staff perception survey was modeled after the quality of life surveys to maintain cohesiveness of the research. The release of information form along with the staff perception survey were handed out to the six ICS staff members. The ICS staff anonymously turned the surveys into the researcher's mailbox.

The quality of life survey is done at the time a client is referred to the ICS program, every 6 months and at the time of discharge from the ICS program. Case Managers from the ICS program administer the surveys with clients in their preferred setting (usually the home). Case managers feel that the home environment emphasizes a relaxed and comfortable atmosphere for more accurate results.

A release of information form was mandated by DHS in order to receive the quality of life surveys. The researcher drove to nineteen consumer's homes and received consent from all nineteen individuals. After the release forms were collected, the researcher mailed a letter to Jerry Storck requesting the data. The data was sent back to the researcher on a floppy disk that utilized the Excel and Statistical Package for Social Sciences (SPSS) programs.

Thirty-two individuals from the ICS program received community support and vocational services. Out of the 32 individuals, only 19 individuals fit the criteria for the research project (quality of life surveys that were pre-vocational and vocational). Fifteen of these individuals had at least two quality of life surveys; therefore could be analyzed for the research project. Out of the original 19 individuals, 14 were male and five were female. The researcher was unable to detect the gender ratio of the final sample of 14 due to anonymity. These individuals ranged in age from 25 to 53.

Data analysis

The Statistical Package for Social Sciences (SPSS) computer program was used to analyze differences in the quality of life surveys. The Excel program was used to analyze demographics and staff perception survey statistics. Univariate analysis was conducted on demographic characteristics of the participants. In bivariate analysis, the relationship between variable A and variable B was examined to determine the association. Bivariate relationships analyzed included friendship, food, housing, leisure, acceptance in the community, dental, work, education, security, financial, medical, transportation and mental health services. Both the t-test and Mann-Whitney tests were conducted to determine differences between the pre and posttest quality of life surveys.

Protection of Human Subjects

An application was submitted and approval received from Augsburg's Institutional Review Board (approval #2001-9-3). Two separate consent forms (see Appendix F) were developed for the staff and clients. The information in the consent letter was discussed clients. A copy of the signed consent form was sent to each

consumer. The staff consent form stated that when staff filled out the survey this meant consent was granted. The consents are voluntary and can be rescinded for the research study at any time. The quality of life surveys are both anonymous and confidential. The staff perception surveys, however, are only confidential because staff might be identified since there was only six participants surveyed. The Integrated Community Service staff are asked not to put their names on the survey. The anonymity and confidentiality within the study are precautions taken to protect the human subjects.

There are no adverse consequences in regard to the services clients will continue to receive from the Integrated Community Service program. There are no direct benefits to this participation. Indirect benefits to participation is future enhancement of services from the strengths and weaknesses identified. Participants may feel a sense of empowerment in working toward future enhancement of services.

Chapter V: Results and Discussion of Findings

This chapter discusses the findings of quality of life and staff perception surveys. Only certain items were analyzed from the quality of life surveys. The staff perception surveys served as a triangulation factor. The quality of life and staff perception surveys focused on several areas that affected individuals with SPMI. The two research questions will be presented and analyzed separately.

Research Question #1

What is the difference in client's perceptions of the quality of life before and after the vocational program (PACT) model began?

Study Results

Seventy-nine percent of the clients studied (N=14) were male and twenty-one percent were female. Seventy-nine percent of the study population was Caucasian; seven percent were African American, seven percent East African and seven percent of Hispanic descent. The majority of the subjects had a psychiatric diagnosis of Schizophrenia. Fifty-seven percent (N=14) were diagnosed with Schizophrenia, twenty-one percent with Schizoaffective, seven percent each with Bipolar, Post Traumatic Stress Disorder (PTSD) and Major Depression. All individuals in this study were living in an apartment at the time the surveys were implemented. Ages ranged from 25 – 53. (See Table 1.1)

Table 1.1: Demographics of Participants in QOL Survey

Gender	Age	Race	Diagnosis	Housing
Male	25	Caucasian	Post Traumatic Stress	Apartment
Female	31	Caucasian	Schizophrenia	Apartment
Male	33	Caucasian	Schizophrenia	Apartment
Male	34	Hispanic	Schizophrenia	Apartment
Male	37	Caucasian	Schizophrenia	Apartment
Male	37	Caucasian	Schizophrenia	Apartment
Male	37	Caucasian	Schizophrenia	Apartment
Male	40	Caucasian	Schizoaffective	Apartment
Male	41	East African	Schizoaffective	Apartment
Female	42	African American	Major Depression	Apartment
Female	44	Caucasian	Bipolar	Apartment
Male	44	Caucasian	Schizoaffective	Apartment
Male	53	Caucasian	Schizophrenia	Apartment
Male	53	Caucasian	Schizophrenia	Apartment

Total	Age Range	Total	Total	Total
Male = 11	25-53	Caucasian = 11	Schizophrenia = 8	Apartment = 14
Female = 3		African American = 1	Schizoaffective = 3	
		East African = 1	Bipolar = 1	
		Hispanic = 1	Post Traumatic Stress = 1	
			Major Depression = 1	

A negative correlation was found in two areas of statistical significance in the quality of life survey. These areas are security and community acceptance. Friendship, food, housing, leisure/recreation, dental services, employment, education/training, security, finances, medical services, transportation, and mental health services are all the variables addressed in the quality of life surveys. Mann-Whitney and a t-test were used to analyze the quality of life data. The Mann-Whitney is the test presented because it coincides with the ordinal/Likert scale used in the surveys. The relationship between the quality of life need of security was significant between pre and posttest ($U = 52.000$; $p = .037$). That is, the prevocational program had a significant negative impact upon participants' need for security (See Table 1.2). The need of community acceptance was approaching significance at .09 ($U = 62.500$; $p = .090$) (See Table 1.2).

'able 1.2: Mann-Whitney Test for QOL Survey of Needs Met for SPMI Clients

Ranks

	quality of life survey for	N	Mean Rank	Sum of Ranks
Needs Met?: Friendship	pre-test	14	16.29	228.00
	post-test	14	12.71	178.00
	Total	28		
Needs Met?: Food	pre-test	14	14.07	197.00
	post-test	14	14.93	209.00
	Total	28		
Needs Met?: Housing	pre-test	14	13.86	194.00
	post-test	14	15.14	212.00
	Total	28		
Needs Met?: Leisure/recreation	pre-test	14	14.07	197.00
	post-test	14	14.93	209.00
	Total	28		
Needs Met?: Community Acceptance	pre-test	14	17.04	238.50
	post-test	14	11.96	167.50
	Total	28		
Needs Met?: Dental Services	pre-test	14	14.89	208.50
	post-test	14	14.11	197.50
	Total	28		
Needs Met?: Work	pre-test	12	12.08	145.00
	post-test	13	13.85	180.00
	Total	25		
Needs Met?: Education and Training	pre-test	14	11.89	166.50
	post-test	12	15.38	184.50
	Total	26		
Needs Met?: Security	pre-test	14	16.79	235.00
	post-test	13	11.00	143.00
	Total	27		
Needs Met?: Financial	pre-test	14	14.00	196.00
	post-test	14	15.00	210.00
	Total	28		
Needs Met?: Medical Services	pre-test	14	15.00	210.00
	post-test	14	14.00	196.00
	Total	28		
Needs Met?: Transportation	pre-test	14	13.11	183.50
	post-test	14	15.89	222.50
	Total	28		
Needs Met?: MH Services	pre-test	14	14.14	198.00
	post-test	14	14.86	208.00
	Total	28		

able 1.2 (continued): Mann-Whitney Test for QOL Survey of Needs Met for SPMI lients

Test Statistics[b]

	Needs Met?: Friendship	Needs Met?: Food	Needs Met?: Housing	Needs Met?: Leisure/recreation	Needs Met?: Community Acceptance
Mann-Whitney U	73.000	92.000	89.000	92.000	62.500
Wilcoxon W	178.000	197.000	194.000	197.000	167.500
Z	-1.288	-.301	-.477	-.304	-1.693
Asymp. Sig. (2-tailed)	.198	.763	.634	.761	.090
Exact Sig. [2*(1-tailed Sig.)]	.265[a]	.804[a]	.701[a]	.804[a]	.104[a]

Test Statistics[b]

	Needs Met?: Dental Services	Needs Met?: Work	Needs Met?: Education and Training	Needs Met?: Security	Needs Met?: Financial
Mann-Whitney U	92.500	67.000	61.500	52.000	91.000
Wilcoxon W	197.500	145.000	166.500	143.000	196.000
Z	-.275	-.631	-1.274	-2.086	-.343
Asymp. Sig. (2-tailed)	.783	.528	.203	.037	.731
Exact Sig. [2*(1-tailed Sig.)]	.804[a]	.574[a]	.252[a]	.061[a]	.769[a]

Test Statistics[b]

	Needs Met?: Medical Services	Needs Met?: Transportation	Needs Met?: MH Services
Mann-Whitney U	91.000	78.500	93.000
Wilcoxon W	196.000	183.500	198.000
Z	-.380	-1.001	-.265
Asymp. Sig. (2-tailed)	.704	.317	.791
Exact Sig. [2*(1-tailed Sig.)]	.769[a]	.376[a]	.839[a]

a. Not corrected for ties.

b. Grouping Variable: quality of life survey for adults with mental illness

A crosstabulation test identified and compared needs pre and post-test. Security and community acceptance needs were analyzed because of the significance levels (See Table 1.3). The quality of life survey need for security at pre-test indicated 7.1% checked somewhat satisfied, 21.4 % checked fairly well and 71.4% checked extremely well. Post-test percentages indicated 7.7% checked that they were satisfied very little, 15.4% checked somewhat, 46.2% checked fairly well and 30.8% checked extremely well. These findings indicate the treatment of vocational programming in between the pre and post-test had a negative impact on the quality of life of individuals with SPMI. This researcher's opinion is that certain factors may play a role in why this occurred. There was no identified time in the six month period in which participants began the vocational program. Individuals may have started the vocational programming right before the quality of life survey was done, which would mean that rapport hadn't been established and possible safety/security of the individual was decreased.

The quality of life survey need for community acceptance at pre-test indicated 7.1% checked they were satisfied very little, 21.4% checked somewhat, 35.7% checked fairly well and 35.7% checked extremely well. Post-test percentages indicated 7.1% checked not at all satisfied, 14.3% checked very little, 35.7 % checked somewhat, 28.6% checked fairly well and 14.3% checked extremely well. Again, the findings indicate the treatment of vocational programming had a negative impact on the quality of life of individuals with SPMI. This researcher felt that factors such as mental health stability and mood may have played a role in decreased acceptance in the community. (See Table 1.3).

'able 1.3: Community Acceptance and Security Needs of SPMI Clients (Pre and 'ost-Test)

Needs Met?: Community Acceptance * quality of life survey for adults with mental illness Crosstabulation

			quality of life survey for adults with mental illness		
			pre-test	post-test	Total
Needs Met?: Community Acceptance	Not at all	Count		1	1
		% within Needs Met?: Community Acceptance		100.0%	100.0%
		% within quality of life survey for adults with mental illness		7.1%	3.6%
		% of Total		3.6%	3.6%
	Very Little	Count	1	2	3
		% within Needs Met?: Community Acceptance	33.3%	66.7%	100.0%
		% within quality of life survey for adults with mental illness	7.1%	14.3%	10.7%
		% of Total	3.6%	7.1%	10.7%
	Somewhat	Count	3	5	8
		% within Needs Met?: Community Acceptance	37.5%	62.5%	100.0%
		% within quality of life survey for adults with mental illness	21.4%	35.7%	28.6%
		% of Total	10.7%	17.9%	28.6%
	Fairly Well	Count	5	4	9
		% within Needs Met?: Community Acceptance	55.6%	44.4%	100.0%
		% within quality of life survey for adults with mental illness	35.7%	28.6%	32.1%
		% of Total	17.9%	14.3%	32.1%
	Extremely Well	Count	5	2	7
		% within Needs Met?: Community Acceptance	71.4%	28.6%	100.0%
		% within quality of life survey for adults with mental illness	35.7%	14.3%	25.0%
		% of Total	17.9%	7.1%	25.0%
Total		Count	14	14	28
		% within Needs Met?: Community Acceptance	50.0%	50.0%	100.0%
		% within quality of life survey for adults with mental illness	100.0%	100.0%	100.0%
		% of Total	50.0%	50.0%	100.0%

able 1.3 (continued): Community Acceptance and Security Needs of SPMI lients (Pre and Post-Test)

leeds Met?: Security * quality of life survey for adults with mental illness Crosstabulation

			quality of life survey for adults with mental illness		
			pre-test	post-test	Total
Needs Met?: Security	Very Little	Count		1	1
		% within Needs Met?: Security		100.0%	100.0%
		% within quality of life survey for adults with mental illness		7.7%	3.7%
		% of Total		3.7%	3.7%
	Somewhat	Count	1	2	3
		% within Needs Met?: Security	33.3%	66.7%	100.0%
		% within quality of life survey for adults with mental illness	7.1%	15.4%	11.1%
		% of Total	3.7%	7.4%	11.1%
	Fairly Well	Count	3	6	9
		% within Needs Met?: Security	33.3%	66.7%	100.0%
		% within quality of life survey for adults with mental illness	21.4%	46.2%	33.3%
		% of Total	11.1%	22.2%	33.3%
	Extremely Well	Count	10	4	14
		% within Needs Met?: Security	71.4%	28.6%	100.0%
		% within quality of life survey for adults with mental illness	71.4%	30.8%	51.9%
		% of Total	37.0%	14.8%	51.9%
Total		Count	14	13	27
		% within Needs Met?: Security	51.9%	48.1%	100.0%
		% within quality of life survey for adults with mental illness	100.0%	100.0%	100.0%
		% of Total	51.9%	48.1%	100.0%

Research Question #2

What is the perception of the ICS staff on the effectiveness of the PACT program on the clients?

Study Results

Five case managers from the ICS program were surveyed on their perceptions of ICS and vocational coordinators working together using the PACT model. Three case managers were female and four were male. Age range was 28-45. All case managers in the ICS program were Caucasian. The number of year's experience with ICS ranged from less than one year to approximately seven years.

The results indicated that staff felt the PACT program was working mainly between somewhat and always on meeting individuals needs who have severe and persistent mental illnesses (See Table 1.4). The staff perception survey served as a triangulation instrument for the primary research question. The staff survey was modeled after the quality of life survey. (See Appendix 5 and 6). The Likert scale for the staff perception survey included the following answers to how needs were met: not at all, very little, somewhat, fairly well and extremely well Somewhat was the answer checked most of the time (average 2.3) compared to never (average 0), seldom (average 1.5), often (average 2) and always (average 1.6). This researcher's opinion as to why these results occurred are due to the ICS staff acknowledging the effort of the vocational team. The ICS staff may attribute the increased results as gratitude for the decreased work load of each case manager and gaining the ability to focus on other psychosocial rehabilitation areas, while letting go of the vocational piece.

Table 1.4 Results of staff perception survey

Staff Perception Survey

	Never	Seldom	Somewhat	Often	Always
Socialization	0		5		
Housing	0		1	3	1
Acceptance	0		4	1	
Dental	0	2	1	2	
Medical	0		1	2	2
Mental Health	0			2	3
Security/Safe	0		1	3	1
Financial	0		3	1	1
Employment/Volunteer	0		2	2	1
Education	0	1	4		
Transportation	0		1	2	2
Total	0	3	23	18	11
Mean	0	1.5	2.3	2	1.6
Standard Deviation	0	0.707107	1.567021	0.707107	0.786796

VI: Summary and Conclusion

The final chapter discusses strengths and limitations of the research study. Recommendations for future research and for the ICS program are explained. Practice and policy implications are identified also.

Strengths

The purpose of the study was to compare two assertive community treatment models (ACT and PACT) in order to establish which program may assist in a higher quality of life for individuals with SPMI. The findings of this study provide information that will help enhance further services for individuals with SPMI from community based programs such as ICS. Although the quality of life survey data pointed out two areas of significance (acceptance in the community and security) as having decreased quality of life, this was not viewed as a limitation to the researcher because it grants the opportunity for future augmentation of services.

Limitations

Systematic error is decreased by not divulging the research question in the surveys. Threats to internal validity with the quality of life surveys include history and maturation. The quality of life surveys are done every 6 months. It is possible that increases or decreases in perceptions were due to extraneous variables other than the vocational programming intervention. Maturation of the subjects within the 6 months is a threat to internal validity. This leads the researcher to believe that these changes may have affected the study results. Individuals mood, mental health and willingness to participate may have skewed the results as well.

The uniformity of administration of ICS staff during the staff perception survey increases the reliability and decreases the random error. A systematic error of social desirability bias is a concern because staff are administering the questions directly to clients. The staff perception survey is a tool that increases the validity of the study and decreasing the systematic error. The social desirability bias is decreased with the staff survey, because it is anonymous and staff fill out the surveys themselves.

Other limitations of the research study include the small sample size of the staff surveyed and individuals who filled out the quality of life surveys. Out of the 13 areas addressed in the quality of life surveys, only two (security and community acceptance) reached levels of statistical significance for analysis. The fact that this researcher is a staff member of the program evaluated may evoke a concern of bias.

Recommendations

Due to the limited studies found in the literature, the first recommendation for future studies would be to actually research and compare more PACT and ACT programs once a longer time span occurs. A comparison of more than two quality of life surveys may result in a more accurate picture of the effectiveness of the PACT/ACT programs. A replication study of the ICS program could be done for increased reliability of the results. It would be interesting to see results from a research study done on ACT and PACT programs from two separate agencies.

A study regarding the way case managers work with clients would be beneficial for future enhancement of services. Certain case managers may work better with certain

types of clients. Case managers' style of work, along with client personalities and gender are important factors to look at for future studies. Future staff perception surveys would be beneficial to compare and contrast through an open-ended, qualitative study. This would assist in capturing individual ideas that were missed in a quantitative study. Staff perception surveys could be looked at pre and post test for further reliability also.

Practice and Policy Implications

As stated in the literature review, the community health policy of 1963 (Community Mental Health Care Act) often overlooked the need for supportive services to ensure that people with severe mental illness would have access to housing, food, social networks and recreation (Grob, 1994). If individuals with severe and persistent mental illness are given the chance for success in the community, resources such as community support programs need to be continually implemented and evaluated for their effectiveness. Integrated Community Services is a case management program that provides the psychosocial rehabilitation for individuals with SPMI residing in the community.

The ICS program had not been evaluated prior to this study. The ICS program should replicate the study for further reliability or for an indication of more positive results of the implementation of the PACT program from the ICS clientele. Again, an increased number of longitudinal studies would be useful for policymakers when decisions are to be made about the PACT and ACT programs.

If the findings are true, a recommendation for future practice would be to educate the vocational staff on the importance of establishing rapport with clients before starting to work on vocational or educational goals. Establishing specific goals to increase the feeling of security and community acceptance in the clients, along with identifying tools and resources are recommendations as well. Because this study has several other factors that could play a role in why these results occurred (mental health stability, types of employment, length of time), this researcher feels that the best recommendation is to replicate the study in order to validate these results.

References

Ashford, J.B., LeCroy, CW. & Lortie, K.L. (1997). Human behavior in the social environment: A multidimensional perspective. Pacific Grove, CA: Brooks/Cole Publishing Company.

Becker, R.E., Meisler, N., Stormer, G., & Brondino, M.J. (1999). Employment outcomes for clients with severe mental illness in a PACT model replication. Psychiatric Services, 50, 104-106.

Bell, M., Lysaker, P., & Milstein R. (1996). Clinical benefits of paid work in schizophrenia. Schizophrenia Bulletin, 22, 51-67.

Bloom, B.L. (1977). Community mental health: A general introduction. Monterey, CA: Brooks/Cole Publishing Co.

Breakey, W.R. (1990). Networks of services for the seriously mentally ill in the community. Neal L. Cohen (Ed.), Psychiatry Takes to the Streets: Outreach and Crisis Intervention for the Mentally Ill (pp. 16-42). New York, NY: The Guilford Press.

Brown, C., Cosgrove, N., & DeSalem, T. (1997). Barriers interfering with life satisfaction for individuals with severe mental illness. Psychiatric Rehabiliation Journal, 20, 67-71.

Burns B.J, Santos A.B. (1995). Assertive community treatment: an update of randomized trials. Psychiatric Services, 46, 669-675.

Clark, R.E. (1996). Costs and benefits of vocational programs for people with serious mental illness. Economics of Schizophrenia. Sussux, England: Wiley.

Cnaan, R., Blankertz, L., Messinger, K., & Gardner, J. (1988). Psychosocial rehabilitation: Toward a definition. Psychosocial Rehabilitation, 11, 61-71.

Dendron (2000). PACT takes a punch (on-line). Available: http://www.efn.org/dendron/dendron/dendron/41/dendron41content/PACT1.html.

Drake, R.E., & Burns, BJ. (1995). Special section on assertive community treatment: An introduction. Psychiatric Services, 46, 667-668.

Essock, S.M. & Kontos, Nina. (1995). Implementing assertive community treatment teams. Psychiatric Services, 46, 679-683.

Fellin, P. (1993). Reformulation of the context of community based care. Journal of Sociology and Social Welfare, 20, 57-67.

Franklin, C. & Jordan, C. (1999). Family practice: Brief systems methods for social work. Pacific Grove, CA: Brooks/Cole Publishing Company.

Germain, C.B. & Gitterman, A. (1980). The life model of social work practice. New York, NY: Columbia University Press.

Grob, G.N. (1994). The mad among us. Cambridge, MA: Harvard University Press.

Grob, G.N. (1997). Deinstitutionalization: The illusion of policy. Alan I. Marcus & Hamilton Cravens (Eds.), Health care policy in contemporary america (pp. 48-73). University Park, PA: The Pennsylvania State University Press.

Hamburg, D.A., Elliott, D.R., & Parron, D.L. Ed. (1982). Work and health, in health and behavior: Frontiers of research in the biobehavioral sciences. Washington, DC: National Academy Press.

Hepworth, D.H., Rooney, R.H., & Larsen J. (1997). Direct social work practice: Theory and skills. Pacific Grove, CA: Brooks/Cole Publishing Company.

Johnson, A.B. (1990). Out of bedlam: The truth about deinstitutionalization. United States: Basic Books, Inc.

Isaac, R.J. and Armat, VC. (1990). Madness in the streets: How psychiatry and the law abandoned the mentally ill. New York, NY: Free Press.

Knoedler, W. (1949). Comments on "individual placement and support. Community Mental Health Journal, 30, 207-209.

Lamb, H.R. (1982). Treating the long term mentally ill: Beyond deinstitutionalization. San Francisco, CA: Jossey-Bass Inc. Publishers.

Lerman, P. (1985). Deinstitutionalization and welfare policies. Richard A. Lambert & Alan W. Heston (Eds.), The welfare state in america: Trends and prospects (pp.132-155). Beverly Hills, CA: Sage Publications LTD.

McGrew, K.J., Bond, G.R., Dietzen, L, et al. (1995). A multisite study of client outcomes in assertive community treatment. Psychiatric Services, 46, 696-701.

Marcos, L.R. (1990). The politics of deinstitutionalization. Neal L. Cohen (Ed.), Psychiatry takes to the streets: Outreach and crisis intervention for the mentally ill (pp. 3-15). New York, NY: The Guilford Press.

Mallik, K., Reeves, R.J., & Dellario, D.J. (1998). Barriers to community integration for people with severe and persistent psychiatric disabilities. Psychiatric Rehabilitation Journal, 22, 175-180.

Marrone, J., Balzell, A., & Gold, M. (1995). Employment supports for people with mental illness. Psychiatric Services, 46, 707-711.

Martin, D.A., Conley, R.W., and Noble, J.H. (1995). The ADA and disability benefits policy. Journal of Disability Policy Studies, 6, 1-15.

Mechanic, D. (1994). Inescapable decisions: The imperative of health reform. New Brunswick, NJ: Transaction Publishers.

Noble, J.H. (1998). Policy reform dilemmas in promoting employment of persons with severe mental illnesses. Psychiatric Services, 49, 775-778.

Noble, J.H., Honberg, R.S., Hall, L.L., et al: (1997). A legacy of failure: The inability of the federal-state vocational rehabilitation system to serve people with severe mental illnesses. Arlington, VA: National Alliance for the Mentally Ill.

Payne, M. (1997). Modern social work theory (2nd Ed.) Chicago, IL: Lyceum Books, Inc.

Rosenberg, J., & Manderscheid, R.W. (1988). Defining the target population for vocational rehabilitation. Vocational Rehabilitation of Persons with Prolonged Psychiatric Disorders, 19-34. Baltimore, MD: Johns Hopkins University Press.

Rubin, A. & Babbie, E. (1997). Research methods for social work. Pacific Grove, CA: Brooks/Cole Publishing Co.

Russert, M.G., & Frey, J.L. (1991). The PACT vocational model: A step into the future. Psychosocial Rehabilitation Journal, 14, 7-17.

Saleebey, D. (1996). The strengths perspective in social work practice: Extensions and cautions. Social Work, 41, 296-304.

Stroul, B.A. (1989). Community support systems for persons with long-term metnal illness: A conceptual framework. Psychosocial Rehabilitation Journal, 12, 9-26.

Torrey, E.F. (1994). Violent behavior by individuals with serious mental illness. Hospital and Community Psychiatry, 45, 653-662.

Turner, J.C, TenHoor W.J. (1978). The NIMH community support program: Pilot approach to a needed social reform. Schizophrenia Bulletin, 4, 319-348.

U.S. General Accounting Office(1996). People with disabilities: Federal programs could work together more efficiently to promote employment. Washington, DC: U.S. Government Printing Office.

Weick, A., Rapp, C., Sullivan, W.P. & Kisthardt, W. (1989). A strengths perspective for social work practice. Social Work, July, 350-353.

AUGSBURG
C•O•L•L•E•G•E

MEMO

To: Julie R. Humbert

From: Dr. Sharon K. Patten, IRB Co-Chair SKP
Phone: 612-330-1723

RE: Your IRB Application

Date: 13 February 2001

Thank you for your response to IRB issues and concerns. As we discussed, your study, "An Evaluation of the Program Integrated Community Services through Observing Differences in Quality of Life Surveys of Adults with Severe and Persistent Mental Illness and Perceptions of Staff," is approved; your IRB approval number is 2001-9-3. Please use this number on all official correspondence and written materials relative to your study.

Your research should prove valuable and provide important insight into an issue in social work practice. We wish you every success.

SKP/ka

cc: Professor Phu Phan, Thesis Advisor

DEPARTMENT OF SOCIAL WORK
Campus Box #51 • 2211 Riverside Avenue • Minneapolis MN 55454 • Tel. (612)330-1189 • Fax (612)330-1493

January 9, 2001

Julie Humbert
5812 Lyndale Avenue South
Minneapolis, MN 55419

SUBJECT: "An evaluation of the program ICS through observing differences in quality of life surveys of adults with severe and persistent mental illness." **IRB# 169**

Dear Ms Humbert:

Your research project was reviewed by the Minnesota Department of Human Services' Institutional Review Board The Board has approved your proposal. I've attached a copy of the approved consent form per your request.

If your study departs from the original research proposal, you must advise the Board. At that time, a new application must be submitted for IRB approval.

The Board requests that you submit quarterly progress reports to facilitate continuing review of approved research. These reports need not be lengthy or detailed, but should highlight current research activities and any emergent problems. The Board will anticipate receipt of your report in March for inclusion at our April meeting. When your research is complete, the Board requests a report of your research conclusions, an executive summary and the disposition of data collected.

Best wishes on your project.

Sincerely,

Debbie Rielley, Staff
DHS Institutional Review Board

Attachment: Consent form

cc: Jerry Storck, IRB Chair (3828)
Tim Beebe (3865)

November 22, 2000

Julie Humbert
5812 Lyndale Avenue South
Minneapolis, MN 55419

Dear Julie:

This is to approve your request to conduct a program evaluation of the Mental Health Initiative ICS program for your thesis in the Master of Social Work program at Augsburg College.

You may include research on the clients that work with ICS and the Mental Health Initiative Vocational Team.

Sincerely,

Cheryl Kazemek, LICSW
Program Director

Terry M. Schneider,
Executive Director

Staff Perception Survey

The following survey is of staff perceptions of Integrated Community Services (ICS) and vocational coordinators working together in a program of assertive community treatment. I will use this information in a Masters of Social Work thesis project at Augsburg college. Your answers will remain confidential and the survey is anonymous. Please do not put your name on it. By filling out this survey, you grant consent to use the information in the thesis project.

Identify your perceptions on the effectiveness of the vocational team and/or the ICS team in assisting consumers with severe and persistent mental illness toward meeting their needs? Please check only one item column for each area.

	Never	**Seldom**	**Somewhat**	**Often**	**Always**
1. Socialization	_____	_____	_____	_____	_____
2. Housing	_____	_____	_____	_____	_____
3. Acceptance in Community	_____	_____	_____	_____	_____
4. Dental Services	_____	_____	_____	_____	_____
5. Medical Services	_____	_____	_____	_____	_____
6. Mental Health Services	_____	_____	_____	_____	_____
7. Security/Safe from Harm	_____	_____	_____	_____	_____
8. Financial Needs	_____	_____	_____	_____	_____
9. Employment/Volunteer Work	_____	_____	_____	_____	_____
10. Education	_____	_____	_____	_____	_____
11. Transportation Services	_____	_____	_____	_____	_____

Quality of Life Survey

How well are ***your needs*** being met? (Check one box for each item.)

56

MY NEED FOR THE FOLLOWING IS BEING MET	Not At All	Very Little	Somewhat	Fairly Well	Extremely Well
a. Friendship (finding, keeping, visiting with in person or on the phone)	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
b. Food (receiving adequate, nourishing meals on a regular basis)	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
c. Housing (safe, comfortable, affordable)	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
d. Leisure/Recreation (locating, accessing, using)	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
e. Acceptance within the Community (no strange looks, friendliness)	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
f. Dental Services (locating, accessing, receiving)	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
g. Work (finding, achieving, maintaining)	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
h. Education or Job Training Opportunities (attending, paying for, locating)	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
i. Security (feeling safe, protected from harm to yourself)	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
j. Financial (adequate money to meet daily needs)	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
k. Medical Services (locating, accessing, receiving)	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
l. Transportation (availability, convenience)	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
m. Mental Health Services (locating, accessing, using)	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐

CONSENT LETTER

An evaluation of the program Integrated Community Services through observing differences in quality of life surveys of adults with severe and persistent mental illness and perceptions of staff.

You are invited to be in a research study designed to observe the effectiveness of the Integrated Community Services program. You were selected as a participant because you are a staff member of Integrated Community Services. Your participation is completely voluntary. This study is being conducted by Julie Humbert as part of a master's thesis in Social Work at Augsburg College.

Background Information:

The purpose of this study is to evaluate strengths and weaknesses of the ICS team working with vocational coordinators using the program of assertive community treatment team model. The goal is to identify these strengths and weaknesses in order to better serve the consumers in the future.

Procedures:

I am asking that you fill out the survey, put it in the enclosed envelope and then into my mailbox. If you return the survey, this implies consent to participate in the study.

Risks and Benefits of Being in the Study:

Are there any risks?

I will give staff members this voluntary consent letter stating what the staff perception surveys will be used for. The survey specifies that if participants do not want to participate they do not have to. There are no adverse consequences in regard to the services you receive from the Integrated Community Service program. The survey you fill out is anonymous. At any time, participants may withdraw the consent and the data I have obtained will not be used.

Are there any benefits?

There are no direct benefits to this participation. Indirect benefits to participation are possible enhancement of services once strengths and weaknesses have been identified. Participants may feel a sense of empowerment in working toward future enhancement of services.

Confidentiality:

The records of this study will be kept private. In any sort of report that might be published, it will not include any information that will make it possible to identify you. Research records will be kept in a locked file; only the researcher and thesis advisor, Phu Phan will have access to the records. I will have access to the raw data along with my thesis advisor Phu Phan, who will be assisting me with the research process. Raw data will be destroyed by August 1, 2001.

Voluntary Nature of the Study:

Your decision whether or not to participate will not affect your current or future relations with Augsburg College or with Integrated Community Services of South Metro Human Services. If you decide to participate, you are free to withdraw at any time without affecting those relationships.

Contacts and Questions:

The researcher conducting this study is Julie Humbert. If you have questions, you may contact me at (612) 243-4105. My thesis advisor is Phu Phan and he can be reached at (612) 330-1375.

Thank you for your participation.

Julie Humbert

Julie Humbert

CONSENT FORM

An evaluation of the program Integrated Community Services through observing differences in quality of life surveys of adults with severe and persistent mental illness and perceptions of staff.

You are invited to be in a research study designed to observe the effectiveness of the Integrated Community Services program. You were selected as a participant because you are a consumer of Integrated Community Services. Your participation is completely voluntary. This study is being conducted by Julie Humbert as part of a master's thesis in Social Work at Augsburg College.

Background Information:

The purpose of this study is to evaluate strengths and weaknesses of the ICS team working with vocational coordinators using the program of assertive community treatment team model. The goal is to identify these strengths and weaknesses in order to better serve the consumers in the future.

Procedures:

If you agree to be in this study, we would ask you to do the following things. Consumers will need to sign the consent form for the quality of life survey to be used as data in evaluating the ICS program. Please put the consent form and anonymous survey in a sealed envelope and give it to Julie Humbert after you have completed it.

Risks and Benefits of Being in the Study:

Are there any risks?

Julie Humbert will give consumers a voluntary consent form stating what the quality of life surveys will be used for. The survey specifies that if participants do not want to participate they do not have to. There are no adverse consequences in regard to the services you receive from the Integrated Community Service program. The survey you fill out is anonymous and confidential. At any time, participants may withdraw the consent and the data I have obtained will not be used.

Are there any benefits?

There are no direct benefits to this participation. Indirect benefits to participation are possible enhancement of services once strengths and weaknesses have been identified. Participants may feel a sense of empowerment in working toward future enhancement of services.

Confidentiality:

The records of this study will be kept private. In any sort of report that might be published, it will not include any information that will make it possible to identify you. Research records will be kept in a locked file; only the researcher and thesis advisor, Phu Phan will have access to the records.

Julie Humbert will have access to the raw data along with my thesis advisor Phu Phan, who will be assisting me with the research process. Raw data will be destroyed by August 1, 2001.

Voluntary Nature of the Study:

Your decision whether or not to participate will not affect your current or future relations with Augsburg College or with Integrated Community Services of South Metro Human Services. If you decide to participate, you are free to withdraw at any time without affecting those relationships.

Contacts and Questions:

The researcher conducting this study is Julie Humbert. You may ask any questions you have now. If you have questions later, you may contact me at (612) 243-4105. My thesis advisor is Phu Phan and he can be reached at (612) 330-1375.

You will be given a copy of the form to keep for your records.

Statement of Consent:

I have read the above information or have had it read to me. I have received answers to questions asked. I consent to participate in the study.

Signature _____ Date_____

[Signature of parent or guardian _____ Date_____]

[Signature of minor subject's assent _____ Date_____]

Signature of investigator _____ Date_____