



**Lifetrack**  
Resources

**Occupational  
Therapy in  
Transitional Jobs:  
Innovations to  
Improve Life Skills**

**Submitted to  
Lifetrack Resources by**

***EnSearch:***

determine the merit of programs and materials

**November, 2003**

## Occupational Therapy in Transitional Jobs: Innovations to Improve Life Skills.

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## Chapter 1. Introduction

Since Fall 2000 EnSearch has evaluated Lifetrack Resources' Advancement Plus program, a paid transitional work experience. The first evaluation was funded by a grant from The Joyce Foundation to study the development of the paid work experience model, to answer questions regarding the characteristics of the trainees, and to identify who was and was not successful. A number of reports were produced to document the evolution of the program and the characteristics of the individuals served (Preliminary Evaluation Report, Stockdill et al., 2001; Update, Stockdill et al., 2002; and the Comprehensive Evaluation Report, Stockdill et al., 2002).

In 2002 Lifetrack Resources again received funding from The Joyce Foundation. A portion of the funding was to add one dimension to the model -- Occupational Therapy (OT). During the work of this past year with the Occupational Therapists, located within Lifetrack Resources' Rehabilitation Therapies area, it was learned that some of the trainees may be suffering from Traumatic Brain Injury (TBI). The Speech-Language Pathologists (SLP), who conduct the TBI assessments, and the Occupational Therapists began to work with Advancement Plus staff to identify trainees' needs and to offer social skills classes.

For 2003 two focused reports are provided. Responding to interest generated by the Comprehensive Evaluation Report (2002), the first 2003 report, the Report on Sanctions (Stockdill et al., February 2003), was produced.

This, the second 2003 evaluation report, will focus on use of OT and TBI assessment with paid transitional work experience. This report offers a brief description of the Advancement Plus model (see the Comprehensive Evaluation Report, Stockdill et al., 2002, for a full program description), identifies the learnings to date from the addition of OT and TBI assessment to the model, and identifies initial outcomes.

A report to be distributed Summer 2004 will provide the comprehensive statistical analysis of outcomes and characteristics of the work experience sites and will address the remaining evaluation foci posed in the proposal to The Joyce Foundation: a comparison of the characteristics of the work experience population with the general TANF population and the value of work experience in a recessionary economy.

In brief, what was learned about use of the Occupational Therapy and Traumatic Brain Injury assessment? That many trainees can benefit from OT and TBI assessment services. That some within the MFIP population have undiagnosed medical conditions and Traumatic Brain Injuries. That social skills classes designed by OT and SLP staff hold promise as a recruitment strategy for OT and TBI assessment services and for the development of curriculum that addresses the unique learning needs of a portion of the MFIP population. That for some trainees to be successful at the paid transitional work experience job and to successfully transition into unsubsidized employment, employers may need to recognize trainees' limitations and provide reasonable accommodations.

## Chapter 2. The Advancement Plus Model

**Lifetrack Resources.** Lifetrack Resources has provided transitional work in the community and community-supported employment for persons with disabilities since the 1980s. Its history in welfare began as a provider in the STRIDE program in Ramsey County from 1993 to 1998. STRIDE was mandatory for two-parent families on welfare and voluntary for single parents. Included in the service-delivery design was a large-scale unpaid Community Work Experience Program, CWEP, which placed approximately 400 individuals per year at various work experience sites.

**Advancement Plus.** Staff of Advancement Plus wanted to explore the effectiveness of paid work experience as a vehicle for helping families make the transition from welfare to work. Although the key elements have remained in place, the time since Summer 1999 has been spent trying various approaches, learning what works and what doesn't and making modifications. Advancement Plus:

- Uses paid transitional work experience as an intervention for people with multiple barriers to employment and self-sufficiency, helping them develop skills, work values and a recent work history.
- Adds paid work experience to the public employment services available to TANF recipients in MFIP.

The Advancement Plus Manual for Paid Work Experience introduced the program as follows:

Welcome to Advancement Plus! Advancement Plus is a 6-month paid work experience that will prepare you for long-term successful employment.

Advancement Plus is a Welfare to Work funded work experience created to assist individuals receiving public assistance in their transition to self-sufficiency.

The goal of Advancement Plus is to assist you in building and strengthening your work experience, workplace behaviors and skills that will assist you in becoming a successful competitive employee . . .

The manual continued:

Lifetrack Resources pays your wages. Lifetrack Resources operates Advancement Plus. Advancement Plus will provide you with a positive work experience in which you will learn real job skills and practice good work habits . . .

Advancement Plus offers you three levels of work experience:

**Level One.** Level One work experience offers a wage of \$6.00 an hour and requires no minimum level of English or work experience.

**Level Two.** Level Two work experience offers a wage determined by the work site and requires a higher level of English and skill level.

**Level Three.** Level Three work experience offers a wage determined by the work site and, depending on work site, could require a higher level of English, education and skill level.

**MFIP Vendors.** Advancement Plus, a resource available to all 15 Ramsey County MFIP vendors, received referrals from the following: Lifetrack Resources, City of St. Paul Center for Employment and Training (CET), Chicanos Latinos Unidos En Servicios (CLUES), Ramsey County Career Counseling Unit now Workforce Solutions, Ramsey County Job Training Program now Workforce Solutions, East Metro Opportunity

Industrialization Center (EMOIC), Hmong American Partnership (HAP), HIRED, Lao Family Community of Minnesota (LFC), and Wilder JobsFirst.

**Staffing of Advancement Plus.** During the 2002-2003 program year, the Lifetrack Resources MFIP team included the MFIP Director, Job Counselors, Job Counselor Supervisor, Job Developers, Curriculum Supervisor, Resource Room Specialist. To this team Advancement Plus added four full-time Training Specialists and Work Partners, volunteers from each work site. The Training Specialists, Work Partners and the Job Counselors had daily or weekly contact with Advancement Plus trainees. Training Specialists were responsible for orientation, intake, daily support at the job site, and professional development sessions. Work Partners worked closely with the trainees, directing day-to-day activities and monitoring progress on the job. They acted as mentors and, in some cases, were the work site supervisors. Job Counselors from the MFIP vendors referred individuals to Advancement Plus; provided access to other transitional resources such as, but not limited to, transportation and child care; and monitored progress and compliance with MFIP regulations. Staffing was complemented by the addition of the Mentoring Coordinator and JobPartners, community members who volunteered their time to provide support, friendship and encouragement to job seekers during their job search and subsequent employment.

In 2002, the positions of Occupational Therapist (OT) and Speech-Language Pathologist (SLP), who are responsible for conducting the Traumatic Brain Injury assessments, were added to the model.

**Advancement Plus Work Sites.** Beginning Summer 1999, trainees were placed at Packaging First. The program was expanded to the Science Museum of Minnesota in November 2000 and to Ramsey County in Spring 2001.

**The Advancement Plus Orientation.** Orientation was a 1-day session for the Packaging First site. After visiting other paid work experience programs, Advancement Plus staff created a 1-week orientation for the then newly created Science Museum site. Based on what was learned from the Science Museum effort and a site visit to Transitional Work Corporation--Philadelphia@work, a 2-week orientation session was created.

**Advancement Plus Professional Development Activities.** At Packaging First, Training Specialists held soft-skills classes; GED classes were offered; and trainees who were able to speak very little English (Limited English Proficient) could attend English classes. The 2-week orientation and professional development sessions for the mostly clerical positions at the Science Museum of Minnesota and Ramsey County sites included computer training, interviewing skills, proof reading and filing.

**Financial Support.** Support for Advancement Plus came from sources including U.S. Department of Labor Welfare to Work and MFIP (through TANF funds). As of June 1, 2001, trainees in Ramsey County positions were paid from county resources. The mentoring services were partially supported by a grant from the Junior League of St. Paul. The Joyce Foundation supported incentives, travel for staff to visit other paid work experience sites and the evaluation.

## Chapter 3. Use of OT and TBI Assessment in Paid Transitional Work Experience

### Background -- OT and TBI Assessment Services

#### Adding OT Services to Paid Transitional Work Experience

In 2002 Lifetrack Resources was awarded a grant from the Joyce Foundation to continue evaluating various dimensions of the Advancement Plus model. One feature to be evaluated, and for which funding was received, was employing an Occupational Therapist. This was described in the Joyce Foundation proposal in the following way:

In an attempt to address the recurring issues of attendance and punctuality identified in work experience programs across the nation, Advancement Plus will evaluate the impact of assessing and addressing daily living skills and improving family functioning. A half-time Occupational Therapist will serve the Advancement Plus population with supervision by the Lifetrack Resources Occupational Therapy Department Supervisor.

Occupational therapy means the use of purposeful activity to maximize the independence and the maintenance of health of an individual who is limited by a physical injury or illness, a cognitive impairment, a psychosocial dysfunction, a mental illness, a developmental or learning disability, or an adverse environmental condition. The practice encompasses evaluation, assessment, treatment, and consultation. Occupational therapists offer a unique perspective in their ability to assess the individual and the varied components of his/her environment in which that individual needs to function. This Occupational Therapist would assess the functional life skills that could contribute to an individual's success in employment. These would include such areas as time management, organizational skills, and the pertinent psychosocial components. Assessment results with follow-up recommendations will assist in the understanding of the individual as a whole and thus contribute to successful self-sufficiency.

The individuals who served as OTs were asked about their profession and the requirements for certification. One said:

We work with individuals who are having some sort of difficulty with daily activities. Our goal is independence with daily living activities or the type of activities with which clients occupy their time . . . [Evaluations] may involve formalized assessments and/or interviewing and observing to try to find out what areas the client is having difficulty with . . . It might not mean a person will be totally independent, doing what they want to do, but it may mean they can achieve increased independence through having assistance or equipment that they may need.

[A Masters degree] is required . . . [OTs] take a national exam [to obtain certification] and a license through the State of Minnesota. We also register through the National Occupational Therapy Certification Board (NOTCB).

In a 2002 presentation at the Transitional Jobs Conference in Washington, D.C., the Lifetrack Resources' Occupational Therapy Referral Guide was presented by the MFIP Director to illustrate some of the areas in which the OTs might work with Advancement Plus trainees (see Figure 1).



Initially the plan was for all Advancement Plus trainees to be assessed by the OT. The Training Specialists were having difficulty, however, explaining to trainees why they were referred and how they could benefit from OT services.

The OT staff then created the following flyer (see Figure 2) that Training Specialists could use to describe the OT services.

**FIGURE 2**  
**Occupational Therapy Referral Guide**  
**for Advancement Plus**

Occupational Therapists seek to assist individuals to achieve maximum independence with daily living activities, work and productive activities, and leisure. Though our clients may be focusing on work, there may be many underlying factors that affect their performance. Clients may be referred for an Occupational Therapy Evaluation to address concerns in any of the following areas:

Physical problems such as complaints of pain or weakness.

Vision or hearing difficulties.

Difficulty learning new tasks.

Decreased attention to task.

Decreased completion of work tasks.

Decreased quality of work.

Attendance or tardiness issues.

Decline in personal appearance.

Increased stress.

Home management issues.

Non-compliance with employment plans.

The Training Specialists used this flyer but found that trainees continued to resist having a home visit from an OT. It was then decided to have Training Specialists refer individuals who were having difficulty with their attendance.



The most recent strategy was to have the OT and SLP staff develop and facilitate social skills classes. Feedback from trainees indicated that these classes were valuable. It appears that this is a point of entry and then the OT and SLP staff can follow up with individuals as needed.

### Adding TBI Assessment Services to Paid Transitional Work Experience

**The beginning.** The addition of Speech-Language Pathologists (SLP staff) to the model came about as Advancement Plus staff, located in Lifetrack Resources Employment Services Division, began interacting with the Occupational Therapists and the Director of Rehabilitation Therapies. This was described by two staff members as follows:

. . . It was my understanding that [Advancement Plus staff] were starting to suspect that maybe some of the participants in Advancement Plus had, along with undiagnosed mental illness and LD, possibly TBI. [Lifetrack Resources Rehabilitation Therapies has] staff that work with TBI patients at [hospital]. So then we started having discussions about what kind of role we might be able to play.

. . . This Advancement Plus program came to light through [another staff person at] Lifetrack. What had happened was . . . staff couldn't figure out why [some on MFIP] weren't succeeding. [The other staff member] started saying that [trainees] could possibly have brain injuries that have been undiagnosed. This seems to be a population that gets overlooked.

**The vision.** The vision was described as one where trainees and staff who are working with them can learn about TBI issues and strategies to modify the environment so the trainees can be more successful. This was described in one interview as follows:

I think certain people . . . have sustained injuries to their head or brain, but because of circumstances that might have been currently going on in their life, they haven't pursued medical treatment. If it is because of a domestic abuse situation, they don't often seek medical attention, or if they are currently active in criminal behavior, they are not going to pursue or continue through with formal medical intervention . . . So hopefully we can provide them with a medical diagnosis for the first time. There then may be more community resources available to them other than just the traditional welfare system.

**The referral and assessment.** To provide context, the following is how one SLP staff person described the TBI Assessment:

I work with people that present cognitive linguistic deficits. That means they have cognitive deficits as well as language difficulties, such as word-finding problems, reading difficulties, writing difficulties, thought organization, social pragmatic difficulties and perhaps a wide variety of other difficulties affecting their thinking abilities.

. . . As speech language pathologists we assess these cognitive-linguistic domains. We assess memory using standardized tests or informal assessments, questionnaires, case histories and then take into account their report about how they function in their daily life . . . We also assess other areas such as a person's ability to comprehend directions.

. . . We give structured tests and, at the early stages of brain injury, try to give stimulating tests that hopefully reconnect the brain neurons so they function . . . But at a certain point in time, usually the experts will say one, one and a half, two years, the brain is at a place where it's no longer going to improve. And that is where we come in. Along with the neuropsychiatrist here

at the hospital and the other staff, the physical therapist, occupational therapist, we develop a behavior plan that focuses on changing the environment since the brain isn't going to change anymore.

For instance, if someone is being socially inappropriate in a certain group therapy session, instead of having the expectation that they won't have these socially inappropriate behaviors, because they always will, we want to minimize them by everyone on the staff prompting them in a certain way or redirecting them in a certain way. Or distracting them in a certain way to reduce those behaviors . . .

And that is the same with memory. Once the memory deficit is permanent, then we have to compensate for the memory. What can we do to get around that . . . the most basic is using a memory log or a daily planner . . .

With or without the brain injury, since Advancement Plus has access to us, can we help them in their environment or teach them compensatory strategies? That is yet to be determined.

A TBI assessment was described by another Speech-Language Pathologist as follows:

We start out with an intake form from the referring person [usually the Advancement Plus Training Specialists]. We have asked them to look at behaviors and cognitive functioning and then also, [if the trainees] have ever mentioned . . . getting injured in the head.

We set up a time through the Job Counselor or Training Specialist and meet with the client and take an extensive case history, asking them for as much information as they can provide about their medical history. Were they ever hospitalized for a loss of consciousness? Have they ever been hit in the head? Have they ever fallen? What kinds of things have put them at risk for a brain injury? This includes asking about substance abuse.

Then we usually will give one or two cognitive assessments that are standardized and speech-pathology focused. We look to see how they score and interpret the results. Are they scoring normal on the test or are they exhibiting cognitive-linguistic deficits?

Another Speech-Language Pathologist elaborated on the referral and assessment process:

Someone at Packaging First notices this person and then they call . . . and I [ask for] the psychology report and some reasons why what they want me to take a look at it so I know what assessment tool to bring. Then I set up an appointment with [the trainee] and visit them at Packaging First or wherever their job site is . . . I basically try to establish rapport with them because I think it is an awkward feeling when someone new jumps in . . . And I just do some conversation and some informal observations and then I get into a more detailed case history.

[If they ask why they are meeting with me] I simply state that I am just one more person here to help you out and see if I can help you with some of your difficulties that have been pointed out. I've heard that you have been forgetful or that sort of thing and I want to see if I can help you. Before I can do that I need to get an idea of where you are at.

I let them know that someone had referred them for some reason or other. I interview them, talk about their daily activities, talk about their medical history. I ask them about or I make some informal observations about their social behavioral skills. I also get information from the counselors as to how they do in that area. And then I will give some brief assessment, just to get my feet wet and see what I am dealing with. If I want to assess more thoroughly, I will recommend that. If there is some glaring evidence that there should be some more people involved, like a medical appointment or that sort of thing, I would make that referral.

The referral form for the TBI assessment services is shown in Figure 4.

**FIGURE 4**  
**Speech Pathology Referral Form**

Participant's Name:

Age:

Place of Employment:

Reason for Referral:

Episodes of Possible Acquired Brain Injury:

Behaviors Exhibited at Work (i.e., physical or verbal aggression, manipulative, noncompliance, socially/sexually inappropriate, isolative):

Cognitive Issues: (i.e., poor attention, poor memory, lacks initiation, poor problem-solving):

Physical Issues/Limitations (such as weakness or fatigue):

Any Other Information or Observations:

Person Referring Participant and Phone Number:

Please Fax this to [name] at [hospital] or put in [name's] mailbox at Lifetrack Resources (Building 709).

Two Speech-Language Pathologists talked about other services that might be available:

[After the assessment] we make recommendations . . . [We] meet with the participants to try to develop some compensatory strategies based on their strengths and weaknesses we were able to identify during the cognitive testing. We might recommend further neuropsychological testing to substantiate or add to the testing that we did because our testing isn't as thorough as a formal neuropsychological assessment would be. And also . . . if they haven't already had a medical diagnosis of a TBI is this something to pursue?

If somebody has a formal diagnosis of a TBI, there is a TBI waiver run by the state . . . Those waivers provide money for services . . . There is money that would help with housing needs, transportation needs, assistance, like an independent-living-skills worker, a personal care attendant to help them to get from point A to point B. It certainly opens up the possibility of getting a permanent disability SSI income. It allows them to access the resources of the Brain Injury Association of Minnesota and then the National Brain Injury Association which provides everything from medical and legal counsel to group support. If they are in crisis, they can call and somebody will be assigned to them and help them through the crisis. It opens up another avenue of community resources, other than the traditional welfare.

### Outcomes -- OT and TBI Assessment Services

It is too early to fully document the outcomes from the addition of Occupational Therapists (OTs) and Speech-Language Pathologists (SLPs) to the Advancement Plus model. One administrator suggested that there will be limits to what OT or TBI assessment can do:

I remain convinced that for some it isn't that you're going change the client, it's that you're going to get information to change the work environment so that maybe the client can succeed . . . I think they can identify obstacles and suggest compensatory strategies and that's the value of having Occupational Therapists and Speech Therapists. . .

I think with both speech and occupational therapy the value is to take tasks and break them down into smaller pieces to identify where the problems are. The employment counselor might see following a three-step command as one instruction, the therapists are going to see it as a sequence of events and are going to try to find ways to break it down so the person can succeed.

What strategies might work for somebody? It might be a visual cue, it might be a written cue, for someone else it's an auditory cue. [They look] at all the things in their tool box and figure out what works best for that individual.

### Outcomes for Trainees from OT and TBI Assessment Services

It appears that a number of tangible outcomes have already occurred. Below are examples of outcomes for those who were served by OTs:

Trainee 1 -- Outcome: Uncovered past history of trauma and torture. Took action to have medications evaluated. She was a trainee at Packaging First who was very receptive to working with me. She has a grade-school-age daughter. She has a brother who is in the U.S. who comes to visit. He is a main source of support. She also has made friends with another trainee from Packaging First who lives in her building. They visit with each other and do things with their children together. She has been taking medication for depression and she meets with a therapist weekly. I learned that she was tortured during war in [her country]. She had been forced to walk on hot coals and has discomfort walking for long periods. She also saw many people violently killed. She told me she has nightmares and walks in her sleep and awakens in

different places. She woke up in the trash room at her apartment building. She had been sleeping on the floor and woke up to rats crawling on her and biting her. She told me that since then she sleeps on the floor in her living room and ties her leg to a chair so she cannot sleepwalk. She has also fallen down stairs walking in her sleep. She does not like the building she lives in and would like to find somewhere else. She does not feel safe there. [When I talked with her Job Counselor, I learned] her Job Counselor did not know about [name's] past history of trauma and torture. I got her connected with The Center for Victims of Torture. I took her there the first time and [name] took the initiative to introduce herself and has been going there on a regular basis. On the way there [name] was noting the bus route and seemed confident about using the bus to go there. She has a lot of inner strength in that she has done a lot of things on her own . . . her social skills are very strong. I also talked with the nurse practitioner at the clinic she goes to about her possible PTSD symptoms and about the nightmares and sleepwalking to see if they may want to try another medication.

Trainee 2 -- Outcome: Educated trainee about diabetes management. Got trainee to use glucometer. I first met [name] at Packaging First. She has diabetes and was running very high blood sugars, around 600. She was not monitoring them very well, especially during the day at work. I talked with [the trainee] about diabetes management and educated the Packaging First staff about monitoring blood sugar and what to do if certain symptoms occur. I taught them what to look for if she was having a reaction. I was involved in getting [name] to use a glucometer, which is a device that takes her blood sugar and stores the data in terms of the date and time and blood sugar levels, so it is easier to keep track of how her blood sugars are running. I made sure that the Training Specialists . . . had copies of how to use the glucometer. [Name] feels self-conscious about doing her blood sugars at work because other trainees ask her why she was in [the Training Specialist's] office and want to know her personal business.

Trainee 3 -- Outcome: Assisted trainee with purchase options for a car. I met with [name at the site]. I gave her a list of places to call because she was interested in getting a car. I went to her home and her home was very tidy and neat and no real issues were evident in terms of homemaking or organizational skills.

Trainee 4 -- Outcome: Provided trainee with names of possible resources and a parent support group. [The Training Specialist] and I went out to [name's] house. It was as neat as a pin. [The trainee] was interested in getting a car and a computer so I gave her the numbers of resources she could contact. [Name] has a son who is eight and [the trainee] said he needs a lot of attention. I gave [name] a flier for a support group for African-American parents. I also gave [name] a calendar because it was apparent she did not use one for keeping track of appointments.

Trainee 5 -- Outcome: Assisted with organization skills. Gave moral support. I worked with [name] on organizational skills in her home. Her home was very chaotic. I gave her a calendar and talked with her about making lists for keeping appointments. She had missed medical appointments for her son. I also helped with homemaking activities. I went there two or three times, but then it became unsafe to go there when her husband was there because he did not like me coming and is abusive. Her husband had also been verbally abusive to [the Job Counselor]. [Name's] husband was in the hospital for a time and so I could go [to the home then], but when he got out I couldn't. I could sense that [name] trusted me as a support person. I could see little changes that [name] was making, nothing huge, but little changes. It is hard to organize things when things are so chaotic and stressful for [name] due to her relationship with her husband.

Below is an example of the TBI assessment work with one Advancement Plus trainee. The extensive nature of this quote is to provide an in-depth understanding of the steps involved:

[The Training Specialist] made the initial referral based on information that [the trainee] had shared with her because they had a good rapport, a good relationship . . . I explained to [the trainee] who I was and why I wanted to ask her the questions I did and why I wanted to give her the tests that I did. She has been able to stay sober and has really come a long way from her living situation in [city] and is very much of a mind set, I am going to better myself and I am going to help myself. So she viewed this as an opportunity to do that. And she was also motivated because she feels stuck at [the training site]. She wanted to "learn other jobs and they are not letting me" because the staff were seeing that she had certain limitations and noticing that she had memory problems. Certainly, she verbalized, her co-workers noticed that. Her complaints were that people were "treating me like I was retarded." So she was motivated in that, "I just don't want to keep doing this job that I am doing. I want to continue to advance as well." [We tested] memory for auditory information and memory for visual information. In a functional manner it is how we use [information] on a every-day basis.

It starts out with your taking a personal belonging of the person and telling them, "When I say you have finished this task you need to tell me, 'My wallet is in the drawer. Please give it back to me.'" The whole test takes 20 minutes so they have to hang on to that information for 20 minutes. You show them a series of pictures and then there's a delayed identification of the pictures. They listen to a paragraph, something that you would hear on the ten o'clock news. They have to tell back as many details as they can remember. They are scored on the amount of facts that they are able to accurately give back to you, face recognition, recalling a route to do an activity . . . And then you also set a timer in the beginning and you say, when this timer goes off you have to ask me when our next appointment is. Can they utilize an environmental cue to recall information?

I also made some observations. When I was showing her the picture cards she did have some [difficulty]. She was circumlocuting, she would talk around the object. I would describe the object and then that would help her come up with the name. These pictures are not meant to test vocabulary. The fact that she was circumlocuting said, OK, there is something else going on here.

During testing she had a very limited attention span and would need directions repeated to her three to four times. I concluded that she has working memory deficit, poor attention concentration. You work on the attention concentration and improve their short-term memory which automatically improves their long-term memory. Once she was able to encode information she could recall it. But getting her to encode that information was a struggle because she is very distractible internally and externally and that attention concentration isn't there. She was exhausted after this 20-minute test so we had to stop.

I also gave her portions of the Woodcock test of cognitive ability. I gave her two sub tests, analysis and synthesis, that look at reasoning. She scored 8.2 years for age equivalent and a grade equivalent of 2.8. In the visual, auditory learning, which basically looks at the ability to learn new information and it is not language-based, she scored at the kindergarten level and an age equivalent of 5.2 years. That shows that her new learning is pretty compromised, which fits with what the staff, and probably her co-workers, peers, recognize.

[She had gone through school and had prior higher functioning] which is why we need to look at a brain injury because she had passed the Certified Nursing Assistant (CNA) exam and worked for a period of time as a CNA . . . What she told me one day was not consistently repeated in our next session, which also fits for a brain injury. The whole time frame, explain to me when you first got injured, is very convoluted. But in her case history she self-reported that thirteen years ago, roughly, she was beaten and found by some railroad tracks, for 3 days

unconscious . . . She was stabbed . . . Two motor vehicle accidents somewhere between 13 and 16 years ago with multiple facial lacerations requiring stitches. One time she was driving and hit a steel post and she was in the hospital unconscious 5 days, left Against Medical Advisement (AMA).

During that time she was a homeless prostitute in [state] . . . she kept leaving Against Medical Advisement because I'm sure that had she gotten better and recovered they probably would have put her in the criminal justice system.

During that same time period up until about 8 years ago she sustained numerous beatings from her boyfriend who was also her pimp at the time. At least three times that she could recall she had lost consciousness from the beatings, but she had never sought medical treatment. And one time, she said, her boyfriend pushed her out of a plate glass window and hit her in the head with objects.

So given that, and these test scores, my obvious recommendation was to consider the possibility of obtaining a formal medical diagnosis of a TBI . . . Her test scores fit in very well with an anoxic-type injury.

An anoxic patient will have very limited attention span. Significant memory impairment. Instead of having a focal brain injury, it's a global, it's a diffuse injury . . . I have targeted memory specifically because functionally that is what affects [this trainee]. She has very good social pragmatic skills and communication skills. Without formally testing, I did see . . . confrontational naming which . . . means [difficulty in naming objects, readily retrieving the word for that object]. High frequency, low level. A vocabulary that would be expected for somebody with an eighth grade education. I also recommended a psychiatrist and a neurology consultant, formal psychological testing as part of pursuing a formal TBI diagnosis . . .

My [view] is yes, she can do some kind of work . . . [This trainee] has a lot of strengths, so if they were able to find an employer willing to make modifications for her she could work. But is she going to bring in enough income to support herself? I don't know.

And then the other piece of this puzzle is that she has recently been diagnosed with diabetes. Because her memory is so impaired she doesn't regularly check her blood sugar . . . And she doesn't regularly take her insulin which will also affect her cognition. And so she is not having consistent blood sugars and then the ramifications of that are going to be further medical complications which cause her already to have a high absentee rate. The other thing going on medically is she has DVTs in her legs. Blood clots, deep vein thrombosis. So she needs modifications because there are physical limitations on her because of these blood clots . . . how much can she realistically work given her medical situation is what I need to discuss at the staffing.

[Nobody has identified these problems in all the time she has been on MFIP]. She is the perfect example of somebody getting missed because her social skills are so strong. She is not a trouble maker. She does not have anger-management problems. She is very agreeable. She is motivated. She shows up to work. She calls when she doesn't. [Staff were] completely surprised at how low her scores came out because to look at her and to talk with her you would never know. And that is very common with a mild to moderate brain injury person . . . I worked with her for three sessions. And at the end of the three sessions I basically came to the conclusion that her injuries had probably happened so long ago, she is not a traditional rehabilitation client. Nor would I expect a majority of [MFIP clients] to be. They are not in that spontaneous recovery. And too, because her new learning is so compromised, unless you really focus on the environmental modification, that's up to employers, co-workers, family to do for [this trainee], I don't think you are going to effect a change in her functioning.

I set up a calendar logbook system for [this trainee], made sure that [her site supervisor] understood what her strengths and weaknesses were, and then that [the Supervisor and Training Specialist] knew how to cue her to use her calendar and logbook. If [this trainee] is left to her own devices she is not going to use that tool. . . I am not going to say she can't work. I think she can, but she needs modification. The employer would need to understand that.

She will need an environment that would facilitate good attention concentration. Quiet, working with someone one-to-one, task analyzing what you are asking her to do, and making a written list of all the steps required in a task and having that laminated so she could keep going back and refer to it. And also giving her a set of instructions and having her repeat it back to you. And periodically quizzing her to ensure that she is understanding and retaining.

[Another accommodation that is needed from an employer] is being able to tolerate a certain level of absenteeism because of the diabetes. And then being able to make the physical modifications. She can be on her feet for only a certain amount of time.

Although making a TBI assessment does not always require an MRI, with Advancement Plus trainees missing medical information may necessitate the procedure. A complicating issue is that trainees receive Medical Assistance (MA) and many neuropsychologists won't take MA clients because the reimbursement doesn't cover the cost. These issues were talked about by one staff person:

. . . If you have enough medical history and then the neuropsychology testing, you could conclude that there is a brain injury and make a valid medical diagnosis. But I would think it would be pretty difficult to obtain a lot of medical information on [this trainee] because she kept leaving Against Medical Advisement . . . I thought an MRI would be really important for her and then a full neuron-psych battery test, done by a neuropsychologist who works with brain injury.

We do that for our inpatients at [the hospital] and when approached to see if they would do an outpatient one, one person said no and one person said maybe. The barrier there is these people are on MA. The reimbursement doesn't cover the cost . . . But that is where maybe the brain injury association would come in to pick up and support.

Not all persons referred for TBI testing have been found to have brain injuries. Some individuals may have problems that suggest brain injury but a closer look will show that the major issue is mental illness.

Benefits to trainees have included finding out that there is a reason for their behavior:

She verbalized that it was a relief to know that she wasn't crazy. That she wasn't stupid. She had complained that people treat her like she is retarded but she is not retarded. She thought it was a relief to be able to label something and then be able to have a set of strategies to help compensate for that . . . And she has been very agreeable to trying my strategies.

### Outcomes for Trainees from Life Skills Classes

As the OT and SLP staff worked with Advancement Plus trainees it became apparent that they could offer classes to help trainees make the transition to unsubsidized employment. The classes were described by one interviewee as follows:

We have [at the hospital] what is called a day program with a variety of groups, [such as] a functional thinking group, organizational skills group, life skills group and social skills group . . . We are starting a group at Packaging First. We put together an 8-week program to address some of the major areas that a lot of these people have trouble with. The group is going to be about seven to twelve people. We are going to tackle issues such as relationships, time management,

listening skills, problem solving. The trick is [we] don't know exactly if all these people are going to be receptive to it. Or how [we are] going to have to tailor the content so as to not make them feel like it is a group session. [We're] trying to pull it off as a educational thing more than a therapy session.

In follow-up interviews, the Advancement Plus staff, OT and SLP staff talked about the classes. One talked in depth about their operation:

[We] learned from Ruby Payne's workshop on Generational Poverty that individuals who historically have been poor and involved with the welfare system tend to feel resistant to authority. [We] have made a conscious effort not to emphasize the power differential or come off as authorities. [We] do not sit at the head of the table, [we] sit on either side, intermingled with the trainees. [We] learned very early that having a formal, structured agenda for the classes and teaching the information in a typical lecture format was not going to be effective. [We] decided to turn the entire thing around completely and ask [trainees] questions about what they wanted to learn. [We] let them tell what they wanted, giving the power to them. [We] learned to stay structured in [our minds] about the classes and yet let the members of the group be unstructured. [We] often start introducing a topic by telling a story and allowing others to tell related stories and then summarizing with a review of the ideas brought up and illustrated by the various stories.

[The strategy] went from teaching social skills to teaching functional skills . . . [We] talk about interpersonal interactions. The do's and don'ts about communication between employees and employers. [We] talk about how some times you have to bite your tongue or determine how to word things in order to get the best outcome.

Much of what we are teaching in the classes are "the hidden rules" about filling out applications and resumes, interviewing and conducting oneself at a job in order to be perceived in a positive way, to better ensure advancement in a job and to get a good reference to assist in getting the next job. We talk about goal setting and being realistic about expectations regarding wages related to certain types of jobs and skill levels.

There seems to be a tendency for some not to think ahead but to focus on immediate needs. In the process of the discussions and exercises we have been doing in the group we see people thinking ahead more and considering the long-term impact of their choices.

Also, instead of them thinking, I want a job that pays \$20 an hour, we have them thinking about placing the focus more on progressive advancement, being willing for a time to take a job that pays \$8 to \$10 an hour, establish some work history and a good work record and then ask for a wage increase after having shown themselves to be valuable employees or go outside of the company to seek another higher paying job.

Some did not realize the importance of dressing up for interviews. Some of the women shared how they dressed for interviews, that they got vouchers to pay for interview clothes, and how dressing up gives the prospective employer a good first impression and gives the message that the job matters to you.

We talked about the words used on resumes and in interviews, clarifying strengths and backing them up with examples using action verbs.

We talked about ways of presenting oneself on an resume that places the focus on one's primary skills from past work experience and interpersonal skills rather than laying out the work history in chronological order which may emphasize gaps in work history or limited work history rather than the person's capabilities.

In an e-mail message from the OT and SLP staff to members of the Advancement Plus team, the changing focus of the social skills classes was discussed.

As we built our relationships they began to express their fear and anxiety over the program possibly ending and the fact that they had to get a job fast. We . . . decided to incorporate the "life skills" into a program that really catered to their needs. These needs include: creating a resume, mock interviews, learning questions to ask in interviews, and matching interests, job skills, and possible job leads. We will incorporate the skills of listening, communication, self-esteem into every topic.

Employment training programs often teach that individuals "need" social skills. Advancement Plus has tried to offer social skills classes but some trainees have been resistant. One staff member talked about this resistance and how the OT and SLP staff are trying to address this through their approach:

Some of [the trainees] don't want [the social skills classes] and feel they don't need them. They want hard skills, typing, things like that. From our observation of their behavior, they do need some of those social skills. [It is a matter of] putting in the skills so they don't feel like they are being taught. Like, you need to learn how to get along with others.

They all know they have to have personal development and that's what this is going to be. It's going to be very informal . . . we're not going to use words like social skills, more like a big discussion group, and their ideas are going to be just as valid as our ideas.

After the classes the OT and SLP staff also help individual trainees access community resources to address their unique needs:

Somebody was wondering about expunction of their records and how that worked. I could get them the information they needed . . . [For the] bigger things I would ask for a referral . . . [such as how] they could benefit from credit consumer counseling [if they were] talking about bills and debt.

### Trainees' Perceptions of The Social Skills Classes

Follow-up interviews were conducted with trainees in the classes developed and offered by the OT and SLP staff. The responses were very positive and indicated that trainees found the classes valuable. They commented that these classes increased their awareness of their personal strengths, helped them identify their goals, and taught them a variety of skills including: more effective skills in communication, listening, interviewing, resume writing, and time management. Comments included:

We can talk about anything and everything in that class.

I like those classes. They teach us how to, when you get hired on the job, to listen, and what is important about attendance, and to get along with the people.

They come in and help you recognize where your weaknesses are and where your strengths are.

They teach you how to problem solve and write down goals, what are your strengths and what are your weaknesses, sort of like self-esteem stuff. And what can I change in order to get to the way I want to be.

They help with ideas of what you can put down on applications and how to uplift yourself where you can feel good about yourself and all kinds of neat things. They come up with new words you can put on the application to be able to help you get work.

They have been teaching us how to set goals and mark the steps down of ways to accomplish your goals.

They taught me how to listen. One day we were talking about directions. We had a sheet of paper. We had to make a big square and we were supposed to put the numbers on the top of the box. Most everybody put the numbers on the inside of the box, but I put them on top of the box. And there was something else he told us to do on the left of the box, make something and put it in a different direction and that was the listening test. After he got through explaining it and looked at what everybody did, it made you understand how to listen.

They help you with a lot of things that you didn't know as far as going on interviews and the words to say.

Another thing they taught us is to be able to not only be interviewed, but to interview at the same time.

You learn more about yourself, I think, because we had one paper like how would you describe yourself. Sometimes you're really anxious like how will I describe myself to someone else. So it was helpful in that way.

[They told us] we had to do a paper on what we do from the time we get up to the time we go to sleep. They did the paper, too, and told what they did. So it's not like they're just there listening to us but they tell their story, too. That's good.

They know what they're talking about. They're really kind people. They're understanding. We're all sitting here and someone brings something up, they can talk about anything.

I have been in a few classes like this before and the teachers usually make you feel uptight. These ones have you sit down and relax and feel at ease. So this is a lot better.

They're both great. I just love them! They talk professional, but at the same time they keep it real, like not all high-classed, like they have problems, too, they have struggles, too, and they don't judge us because we're on welfare trying to work our way off.

They're both good. They are relaxed, too, and not like they are just the teacher but they're in the group, too.

They sit there and explain things to us and then they have each one of us go around and talk. They're not doing all the talking. We talk right along with them. Everybody's involved.

We get a chance to talk about skills and other things, goals. I like that class. I like those two people that come. They're understanding . . . straight from the heart.

Every hour I take in there is a good hour.

When they come back next time we're going work on jobs. They decided that since this is coming to almost the end of the session we might as well try to find jobs. And we like, "Cool!" So they are going to bring the newspapers in and whatever else we need.

We talk about self-esteem, skills... yesterday we talked about looking toward the future when our time runs out, which I thought was a good topic because we're sitting here knowing that this job is only temporary and my MFIP is only temporary. That's a lot of stress on you. It's like, "What am I going to do when that happens? How am I going to do this? How am I going to pay that?" So yesterday we talked about what we would like to see in the future meetings that could help us before June 30 gets here, like job leads, doing resumes. That's the kind of stuff we should be doing in the group, getting prepared for a better job right now instead of at the end of June. I want to continue working. I don't want to be home for a whole month and start getting lazy again, you know, not in the routine of getting up every day going to work. I want to keep going and going so that way my time management skills will get better and better. So we're going to focus on job leads and stuff like that. So it's basically like job search right here at work.

Most trainees said there is nothing about the classes they would change. Comments from six of the eleven trainees who had suggestions follow:

I would make it a little longer. I'd make it an hour and a half. It's a good class and once we get into the good conversation it's time to go.

I would like them to add some sessions on budgeting.

Maybe at the last few minutes of the class the teachers could give their input back on how the students were during the class, if there were any problems that we may have caused them and then that way we see what we're doing. If we came off on the wrong angle, on a slant, to see what we're doing wrong so we can correct that if we are doing that in the future.

I would like them to video tape mock interviews so we can learn from being able to see how we present ourselves.

Maybe we could get out of here once in a while and look on the computer and follow up on more jobs, since the program is going to end.

I wish they would bring in more job leads.

### Other Outcomes

A possible outcome from Advancement Plus and Speech-Language Pathologists working together is that some trainees may receive a more appropriate placement.

Maybe this person is going to be better served under the SSI system versus the welfare to work system. So maybe the strength will be being able to move some people off of the welfare system and then to a different social service system.

Advancement Plus staff are learning skills that will help them in the future:

The long-term involvement will be staff education on how to work with difficult behaviors and lower-functioning people. Because a behavior is a behavior. What I am saying, skills are at a certain level and it doesn't matter what the cause is, you are still going to work with it the same way if you are going to achieve a certain level of success. There is a certain way to go about working with this. And so, in my mind it almost doesn't matter if a person is injured or not, the education that we are providing to the Lifetrack staff they are going to be able to generalize and use with a lot of their clients.

### Lessons Learned

#### Learnings from the Use of Occupational Therapists

Two Occupational Therapists worked with Advancement Plus trainees from Summer 2002 through the time data were collected for this report, Spring 2003. There were a number of learnings about melding a transitional jobs program with occupational therapy services:

- Because the strategy of using Occupational Therapists with MFIP clients was new, it took time for the MFIP Advancement Plus staff and the Occupational Therapists, who came from the Rehabilitation Therapies division, to understand how the two may be melded together. The Occupational Therapists and Advancement Plus staff were not sure at first what OT services would be of use to Advancement Plus trainees.
- Because this was a new service, it wasn't certain if all Advancement Plus trainees should be referred and what criteria should be used. The initial strategy to refer all Advancement Plus trainees to OT did not work as well as planned. Over time it was learned that the best approach was to have the Training Specialists identify trainees who were having difficulty with attendance. As the Training Specialists became more familiar with the work of the Occupational Therapists they began to refer other trainees who may have had good attendance but who faced a number of barriers to success.
- Trainees' receptivity to working with an OT differed. Some were receptive and found it helpful. Others who were referred did not want to meet with the OT. The strategy that worked best was for the Training Specialist to identify an issue, talk with the trainee and help facilitate the initial interaction between the trainee and the OT.
- The strategy of having OTs conduct social skills classes holds promise in helping make the offering of OT and TBI assessment services easier.
- The OT staff needed to change their approach when working with Advancement Plus trainees. Advancement Plus trainees, unlike general rehabilitation clients, did not understand what an OT could offer and were defensive and protective of their privacy.

- At times communication was difficult. The OTs found keeping Lifetrack Resources Job Counselors informed was easier than working with Job Counselors from other MFIP vendors.
- Standardized assessments may not always be effective.

Comments from Advancement Plus staff, administrators, and the Occupational Therapists underscore these learnings:

What has been learned about how the OT services can work with MFIP?

I don't think the employment staff had a very clear understanding of what OTs do or what benefit it could be to the client. I think there was a struggle with that initially, but I think it has evolved into being much more effective. I think the social skills groups sound like they've been an effective tool.

The assessments I would do with MFIP clients were very different from those with rehabilitation clients.

The communication with MFIP clients was much more difficult. They didn't all welcome my involvement as most rehabilitation clients do. Some of the referrals were not at all interested in working with me and especially not having me come to their homes. Others were receptive and found it helpful.

When I would go to visit people one thing I was sensitive to and cautious about was not having people feel like I was there to judge them or look for what's wrong. With many of the Advancement Plus clients I could sense they tended to feel defensive and protective, not sure exactly what it was I was going to be doing there or assessing.

Home is a private place for them and they don't always want people coming into their private space until they have developed trust with someone. Many of [the Advancement Plus clients] have spent their lives defending themselves, so when I went out they tended to be defensive. I usually can develop a rapport pretty quickly, but it is much more difficult with Advancement Plus clients. There were some exceptions, one . . . was welcoming, but a bit leery. This was a good visit because [the trainee] could see that I was trying to find out how I could be of help to her . . . I didn't push beyond that or judge or criticize her in any way.

It is important to get the referrals from Training Specialists who work most closely with the individuals and let them determine if there is a real identified reason for having the OT meet with trainees. At first [the OT was to] meet with everyone. One Training Specialist did not think that this was appropriate because she did not see them as having identifiable needs for an OT at the time and she also knew they would be resistant.

I gave assessments and recommendations to the Training Specialists and the Job Counselors. The [Lifetrack Resources Job Counselors] were easier to connect with. Connecting with outside Job Counselors was more difficult [in that it was difficult] to keep everyone in the team informed and to know if you are all working on the same page.

I don't think everyone should be referred. [One of the Training Specialists] had a good sense of who should be referred and she also seemed to prepare them in a positive way to be open to OT services. The trainees at Packaging First may be more comfortable with OT services than are trainees at the county positions because [those placed at the county] may perceive themselves as functioning at a higher level and may view such services as a put-down or interference in their private lives. Many already have so many people in this system involved with them they do not want people involved in their home lives.

Services could be provided at the work site. There may not be as much necessity to go to the home unless the individual is receptive to that and it makes sense to do so.

I think these classes give a way to identify needs and address them without having to do home evaluations. We may do them in addition, but it makes sense to work as a team and start trying to identify and address needs at the work place first. [We] may want to come up with a questionnaire that will help to identify their goals and the obstacles that get in the way of their goals, what would they need to meet their goals. Another question is "What would make things better for you right now?" Asking about goals seem to trigger areas where individuals could use support or specific resources or services. It would be best if the trainees tell you what their needs are rather than the team telling [the trainees] what they think they need.

[Maybe the OT should observe trainees at work]. I think they feel, I've got all these people in my life already and all these forms and give me this, give me that. At home is my security and my peace. I don't want you in my home. If you have older kids, you don't want your kids knowing. Kids do know. That could be difficult, thinking something is wrong with Mom.

As a way to get a sense of [what one trainee needed] I had her fill out a "Daily Routine Inventory." This has a list of things that one might do in a day and the person checks how many times in a day, week, month, they do these things. It asked questions about children, [such as] how often the children bathe. This was the first time I had used this check list with an Advancement Plus trainee because I was trying to see if this might be a good tool to gain a general idea of what the individual's daily life was like and what area they may need assistance or support in. I had [the trainee] fill out the form and then I talked with her and it was like pulling teeth. Right after the meeting [the trainee] told [the Training Specialist] that she did not want to meet with me again. She told [the Training Specialist] it was "stupid" that she had to fill out the form. I learned that this form was not something I would use again since it was not perceived positively.

I wanted to refer [those with poor attendance to the OT] but [an MFIP staff person] had a valid point. She said we don't want it to be seen as punishment. You know, you have been bad so I am sending you to OT. I think it should be . . . for everybody. That they should just say, you are new and this is just an appointment. Get everybody assessed . . . They might see something that we don't see because they are the professionals in that area.

### Learnings from Adding TBI Assessment to the Paid Transitional Work Experience

During this early stage, learnings regarding the addition of TBI assessment to paid transitional work experience were:

- Some trainees had undiagnosed symptoms that could support a diagnosis brain injury.
- Diagnosing a brain injury requires specialized assessment.
- Determining if someone has a brain injury is difficult because it may not be apparent because the individual has strong social skills or because it appears that the individual has a learning disability.
- Some who are experiencing a downward spiral may in fact have an undiagnosed brain injury.
- TBI assessment and identification of effective strategies is pioneering work with the MFIP population and it isn't clear who can and cannot be helped.

Some trainees had undiagnosed symptoms that could support a diagnosis of brain injury. A number of individuals who had possible symptoms had gone undiagnosed:

I have been surprised by how many people seem to have undiagnosed symptoms that could suggest brain injury or low cognitive function. I frankly was fairly shocked yesterday when [the SLP staff] talked about a client who couldn't follow one-step commands. I thought, whoa! How are you going employ someone like that?

I think a surprise has been how severe some people are and how they've gotten this far without anyone getting them on the disability track.

The neuropsychiatrist at the hospital was not surprised that Advancement Plus and SLP staff had started to uncover brain injury in the MFIP population:

When we explained what we were doing [to the neuropsychiatrist at the hospital] his response was, "I am not surprised. I kind of figured it was a matter of time before we started tapping into this population." The [hospital] brain injury program stemmed out of working with people that were institutionalized at the state hospital. And the program started working with them to get them successfully living in a community versus [institutions].

Diagnosing a brain injury requires specialized assessment. This case illustrates how it is possible that brain injury may not be evident from other assessments. Cognitive Based Speech/Language Therapists knew what questions to ask:

In a 30 minute interview, because I knew the questions to ask or I knew what I was looking for, she said, "I was in a car accident back when I was 19 in [state]." She had never said that to anyone else. According to her she had flown out of the car about 30 feet and had to go to the hospital. She had headaches and nausea and all the symptoms [of a concussion] . . . that is just one of the examples where you can find something later where there is no case history of it in the file.

[Staff referred her because] she was showing symptoms of forgetfulness, slowness and difficulty comprehending information at work. She said she had been physically assaulted by her ex-boyfriend. And then she said the last time this occurred was in 2002. She reported having dizziness while lying down and having repeated headaches [after that assault]. She denied losing consciousness then she reported going to her neighbor for an ambulance but does not remember how she ended up at her neighbor's residence. She recalled the ambulance ride, but she doesn't recall [going to the neighbor's house]. She went to the emergency room at [hospital]. They didn't give her any x-rays or scans of the brain, but she reported her mind is more tired and she lacks enthusiasm. Those are symptoms of brain dysfunction. Those are also symptoms of a lot of other things. But [if she didn't have that previously, that is the key]. What was functioning prior to this incident? It is very, very difficult, in my opinion, to tease that information out.

[After screening I gave her some tests]. The tests showed, "The most significant difficulties occurred with her executive functioning skills. That is her reasoning, judgment, insight, planning, self-monitoring, and she also had severe difficulties retaining and recalling auditory information. Very little storage capacity for auditory information." Which fits well with her initial complaints of forgetfulness and comprehending information at work. And so when I see those two pieces fitting, it gives me more confidence that that's some of the bigger area of concern. And then she had some relative strengths, meaning they are not perfect but compared to her other skills she had better visual attention and visual memory. At that point I thought, if we could write things down for her or get her to start writing things down, that might be a help . . . Just in conversation you would never suspect that she has a brain injury. Her personality has

developed so she can almost compensate. People correlate verbal skills with intelligence or cognitive level of functioning and it is extremely not so.

[Somebody can sound really good and have a decent vocabulary and everything else but really be struggling in other areas] such as retaining auditory information. So you could have a conversation with her, she is following you all along, but she can't retain it. [Fifteen minutes later she won't really be able to tell somebody what they talked about.]

[This] is a good example of how things can pop up that weren't detected earlier. The psychologist had said, "the results are indicative of a mild cognitive disorder of unknown ideology." I am kind of the triage person bringing in a lot of different pieces of information. Seeing if we can . . . put something together that people haven't seen before.

Determining if someone has a brain injury is difficult because it may not be apparent because the individual has strong social skills or because it appears that the individual has a learning disability. One of the difficulties in identifying brain injury is that sometimes it appears that an individual has a learning disability. One Speech-Language Pathologist talked about this issue:

It seemed like there was going to be a lot [of referrals] after our first inservice, that a lot of these people fit . . . the type of person we were talking about. Then I think people started . . . saying, well, these people also resemble LD people. [To tease out brain injury versus LD] is a very tough task . . . Right now it seems like staff are viewing it as LD because the psychologist gives the first assessment and I am not sure that they are asking the right questions to screen for brain injury . . . [Also when asked if they have ever been hit to the head] people say no because they can't think of anything recent.

Some who are experiencing a downward spiral may in fact have an undiagnosed brain injury. The following example shows a trainee in a downward spiral and staff wonder if brain injury isn't the primary reason, with complications including a drug dependency:

He had multiple episodes of head trauma in his history . . . He said in high school he fell off a 10-foot-high stairwell and was unconscious. As a child he had a concussion. He reported he was on a bicycle while intoxicated and was hit and knocked unconscious by his uncle driving a station wagon. Then he reported being assaulted with a pipe to his head . . . Said he was beaten with nightsticks and flashlights by policemen. He was hit with an iron on the left side of his head by his cousin. He was hit in the forehead by a vase with his ex-girlfriend. He recorded being hit in the nose with a crowbar and then a lot of, he said, alcohol poisoning. Which brings up a good point. It's not always traumatic brain injury. People can have chemical damage.

On one of the basic assessments he did pretty well . . . but then on one of the other assessments he didn't do so well. So we are getting this variable performance. And then he reported that he didn't remember a lot of information . . . He is extremely disorganized. He carries two wallets. And he has a stack of cards, maybe three inches thick in each wallet. And he doesn't have information organized. So that was one of the areas we were going to work on. But now, things are surfacing as we are trying to work with him that he is currently using [drugs] . . . He doesn't show up to work. I think we had like ten canceled appointments . . . Then we tried switching times for later . . . That didn't work . . . And now we have had one last meeting with him . . . with a lot of the people involved, including a family counselor.

I recommended . . . changing the environment to see if he can succeed.

Each day he is late I ask him why he was late. And so he will say the alarm didn't go off. The electricity was out. So then I will make the recommendation get him a battery-operated alarm clock so he can't use that excuse.

He lacks problem-solving skills and, so if he says, my car ran out of gas, I do the problem solving for him, and say, here is what we are going to do . . . You let me know when it is at half. So then I can prompt him . . . But that is not working either. Every time he is late he has an excuse.

. . . So many things hinder him. Court . . . appearance for himself and for his son. His kids get kicked out of school almost weekly if not daily . . . They are not just easy alarm-clock solutions. So the only goal I have for him, the only goal, is that he either calls in or that he gets to work on time. Consistently. So at this point those are the only expectations I have of him. And he is not meeting those . . . So we suspect that he is using.

. . . A psychologist would recommend out-patient drug treatment. That sounds good but [he] is never going to go. He can't get to work on time . . . [He can't get] to treatment after work at five o'clock consistently when he has all these other issues. So the recommendation is right, but it's not going to be implemented.

The psychological assessment said he was had mental retardation and personality disorder . . . His IQ falls between 73 and 87 . . . His verbal comprehension is in the deficient to borderline range, but then if this was done while he was using according to the neuropsychologist, these would be invalid . . . in the psychological report it said, anxiety disorder and marijuana dependence, alcohol dependence long term.

He is going nowhere. Just staying in that same downward spiral. Lies and deceit and showing up late. I think in the back of my mind, we are his last straw. There is no one else that I know of that is going to really try to help him solve these issues [and if he is at the end of his MFIP time, where is he going to go once the clock runs out]?

TBI assessment and identification of effective strategies is pioneering work with the MFIP population and it isn't always clear who can and cannot be helped. Staff recognize that this is pioneering work and there is more to be learned and the challenges are immense:

The idea has potential. I don't know if people understand the hard work. If people could compensate for their deficits, or someone along the way could have helped them earlier, or if they could have been more successful, we wouldn't be at this point. This is a lifetime of patterns. And so to think that a memory log is going to solve their problems is wrong, I look at it as just one more piece of the puzzle. Maybe we can get them over one barrier. That's better than if we weren't involved.

Staff continue to try to determine who TBI assessment can and cannot help:

A lot of it depends on the environment. Whose support people have. Even though [trainee 1] had some past head injury experiences, she didn't really seem to have enough cognitive dysfunction] to be problematic in her daily functioning. There were no abrupt changes anywhere in her history. Whereas for [trainee 3] this was a change. [Trainee 2] was a different story altogether. His injuries started so young it appeared to have a cumulative effect.

## Factors that Limit and Promote Success of OT and TBI Assessment Services

### Factors that Limit Success

When asked, "How can the OT and TBI assessment strategies be improved with Advancement Plus?" one theme was that there is an ongoing need to improve communication. Three individuals talked about this need:

I am concerned that the information get communicated in enough time so the MFIP employment staff can use it to help shape job placements or job sites . . . there's got to be something in writing that follows the clients so the information gets to the people who need it.

With the turnover in staff . . . it seems to me that you have to have some sort of written record of what the compensatory plan is.

The one thing that we found out at this point is that the communication between staff needs to be very good in order for the people that we are working with to succeed.

### Factors that Promote Success of OT and TBI Assessment Services

When the Training Specialists have established rapport with trainees, are attuned to trainees' needs, and are concerned about trainees, they make the OT and TBI assessment services more effective. A key strength of Advancement Plus and MFIP are the staff involved. They were identified by OT and SLP staff as important advocates for trainees and important sources of information:

[The Training Specialist] has been very instrumental in helping them create their curriculum for these classes [by letting] them know the kinds of things she thought would be valuable for [trainees] to know and skills that would be of value for them to develop. [The Training Specialist] also has been very good at identifying trainees with cognitive or behavioral issues and making the appropriate referrals.

I was just overwhelmed at how the counselors and the Training Specialists and the people know [the trainees] and how they get involved with a person.

The participants feel connected. They know they have a staff person who cares about them and they feel very supported, which in the long run hopefully will be empowering to them and help them want to make the transition to consistent employment . . . I like the fact that the staff are highly motivated and very invested into the clients that they serve and are very accommodating with a what-can-I-do-for-you attitude to me and the participants.

## Value of OT and TBI Assessment from Job Counselor and Advancement Plus Staff Perspectives

MFIP Job Counselors and Advancement Plus staff reported that working with OT and SLP staff is helpful. Job Counselors reported that with the large case loads they don't have time to get out to trainees' homes or to interact with trainees as much as they would like. They reported that they can't find some of these things the OT or SLP staff are finding, in part because of lack of time, in part because they don't know what to look for. They don't know if it's the person being obstinate or if they have some cognitive problems. MFIP Job Counselors and Advancement Plus staff comments follow:

How has having OT and TBI assessment services available been beneficial to Advancement Plus?

Having someone to work with one-on-one on the life issues with someone, and helping them develop a plan for change and identifying the change that needs to happen and develop problem-solving skills.

More individualized attention to individual needs. The Training Specialist is able to do that, but by adding OT they really can get at the root of the situation. The Training Specialist's focus is on behavior in the workplace, each workplace ethic. And they're a supervisor without being a supervisor, so monitoring and coaching and guiding and providing constructive feedback and those sorts of things. The OT is looking more at how are you doing at home and how is your home life impacting your work life, a more holistic approach.

The OT program has helped us identify some of the physical problems that are affecting people who cannot do some of the jobs. Not being an OT, it's hard to identify some of the problems. If somebody says, my wrist is hurting. Well, is it in the skills or is it a chronic problem? The OT can help us identify and document the reports about it. Then it helps us to realize . . . what is happening. Then we can adjust to it. And also it found some people keep coming in late because they say they forget to get up. It helped them organize their life. It helps them come to understand what kind of life style they're living and why it was difficult to get to work.

[The OT] gives me an edge on understanding an individual deeper and helps identify some of the problems that I haven't been able to notice before.

[TBI assessment] allows us to gain a deeper understanding and perhaps support [the fact] that employment might not be the thing for them. Maybe we need to work on some other service for this individual who might suffer brain injuries.

You get lost in the system and nobody asks you any questions . . . They ask you here about domestic violence and things like that . . . a lot of people here had all these things happen to them and nobody ever asked them. They never got help.

It has nothing to do with [the work site] per se so it isn't thought of as a judgment we are making. [The OTs can address things we can't].

My trainee was willing to meet with the OT and TBI assessors and she cooperated. She had a little reputation as not being a team player, but she proved that wrong because she did . . . [In the meeting with the OT she learned] she was a little too abrasive, but she didn't mean to be like that. She didn't realize it . . . She got positive feedback, too. She liked that.

## Chapter 4 -- In Conclusion

Advancement Plus staff have wanted to ensure that their trainees had access to and benefited from a variety of services. Since the beginning of the program, staff have continually sought ways to increase the likelihood that trainees would succeed.

One innovation has been the use of Speech-Language Pathologists (SLPs), who conduct Traumatic Brain Injury (TBI) Assessment, and Occupational Therapists (OTs). The preliminary data indicate that this strategy has had tangible benefits for trainees. The learnings may also be of use to others who are working to help MFIP or TANF recipients succeed in the transition from welfare to work or to receive a more appropriate placement. Learnings included:

Some within the MFIP population have undiagnosed medical conditions and Traumatic Brain Injuries. A brain injury may not be apparent when the individual has strong social skills or if it appears that the individual has a learning disability.

Many trainees can benefit from OT and TBI assessment services.

Over time staff will learn how and when OT and TBI assessment can be of benefit and the criteria needed for a referral.

Trainees may not understand what an OT or SLP can offer and may resist cooperating.

Trusted program staff play a critical role in paving the way for trainees to benefit from OT or TBI assessment services.

Standardized OT assessments may not always be effective. Diagnosing a brain injury requires specialized assessment.

Social skills classes designed by OT and SLP staff hold promise as a recruitment strategy for OT and TBI services and for the development of curriculum that addresses the unique learning needs of a portion of the MFIP population.

For some trainees to be successful at the paid transitional work experience job and to successfully transition into unsubsidized employment, employers may need to recognize trainees' limitations and provide reasonable accommodations.

