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Vocational services offered to people with severe mental illness

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Abstract
Background: Vocational services offered to people with severe mental illness represent a cornerstone for their social integration. Differences in terminology and the adaptations or modifications in vocational services make it difficult for stakeholders to have a clear understanding of the goals and content of the vocational services offered to people with severe mental illness.
Aims: To facilitate comparisons of vocational services worldwide; this paper describes the most common types of vocational services identified in the literature.
Conclusion: An empirical investigation of the effectiveness of specific vocational services components is warranted in order to determine which types or combinations of services work best for which individuals with severe mental illness.

Keywords: *Vocational services, people with severe mental illness*

Introduction

Close to 80% of people with severe mental illness are unemployed, yet working offers people with severe mental illness multiple advantages: (a) developing basic processes such as a sense of responsibility and judgment, and reinforcing or improving self-esteem if work conditions are appropriate; (b) decreasing the number of hospitalizations if work accommodations are offered; (c) developing social skills, thus regaining a certain amount of personal power and control (empowerment), and gaining higher autonomy and a feeling of self-determination; (d) acquiring a social and vocational identity or, simply, gaining the ability to be like others; and (e) developing the possibility of being granted full citizenship in the community and contributing to the community (Arns & Linney, 1993; Jacobs, 1991; Kirsh, 2000; Mueser, Becker, & Torrey, 1997; Phillips & Biller, 1993; Provencher, Gregg, Mead, & Mueser, 2002; Scheid & Anderson, 1995; Storey, 2000; Vostanis, 1990).

In the last three decades, a myriad of vocational services have been implemented, both in psychiatric hospitals to keep people occupied and in the community to help people with severe mental illness get and maintain competitive employment (Black, 1988; Cochrane, Goering, & Rogers, 1991). Because of the growing number of vocational services implemented internationally, stakeholders in this field, such as researchers, clinicians, policy makers, and individuals with severe mental illness, often encounter difficulties in

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understanding the various terminologies and underlying goals for different approaches to vocational services (Corbière, Bond, Goldner, & Ptasinski, 2005a). Though the primary focus for most vocational agencies or services is the rehabilitation of people with severe mental illness through work integration, multiple terms are used to identify similar services, and marked differences exist between the implemented components for services identified using the same terminology. These differences most often represent cultural, economic, and political qualities, but they also correspond to a particular rehabilitation/vocational agency's philosophy.

In terms of the cultural and economic influences on vocational programs, social security assistance for individuals with severe mental illness varies greatly between countries (Latimer, 2005; Waghorn & King, 1999). Consequently, the meaning of work can change according to the country, i.e., work can be perceived as an obligation for ensuring an individual's social security or it can be a personal choice during the recovery process. In certain settings, such as Eastern Europe, every citizen "should" be productive regardless of limitations, thus leading to the implementation of sheltered workshops with such work values (Dabrowski & Stanczak, 1988). Also, specific social contexts, such as the closing of psychiatric hospitals in Italy have led to the development of community initiatives such as work cooperatives (Ramon, 1995).

With respect to a vocational agency's philosophy, two main categories emerge: Train-Place and Place-then-Train (Corrigan, 2001). Train-Place programs aim to help participants develop specific skills to allow them to reintegrate the workplace. The vocational agencies following this philosophy believe that individuals must develop vocational maturity, abilities, and skills incrementally; they advocate a step-by-step process whereby clients complete a rehabilitation program before getting a competitive employment (Blankertz & Robinson, 1996; Bozzer, Samsom, & Anson, 1999; Corrigan, 2001). Jacobs (1991) stipulated that people with severe mental illness who present different levels of social functioning, work skills, and stress management should receive a continuum of vocational services tailored to their needs and level of function. As such, he proposed seven stages of vocational services: (a) assessment of clients' competencies and skills, (b) assessment of clients' coping strategies, (c) skills training, (d) sheltered workshop, (e) transitional employment, (f) searching for competitive employment, and (g) maintaining competitive employment. In this system, clients may start the work integration process at any time and at any stage depending on their needs and skills.

The vocational agencies offering Prevocational programs, including Sheltered Workshops, Enclaves, Transitional programs, Hospital-based programs, Industrial-therapy, Volunteer placement, Clubhouse, Mobile work crews, and Work-ordered days, are considered to be offering Train-Place programs (Boardman, Grove, Perkins, & Shepherd, 2003; Creegan & Williams, 1997; Lehman, 1995; O'Flynn, 2001; Sartorius, Girolamo, Andrews, German & Eisenberg, 1993). According to Crowther, Marshall, Bond, and Huxley (2001), the Train-Place programs could all be considered prevocational activities or traditional psychiatric rehabilitation.

Place-then-Train philosophy aims at placing the person in real work situations prior to offering them specific training to help them quickly achieve their vocational and community integration goals. Training is offered on-site, with ongoing support by a vocational coach, and the job is selected according to the person's abilities and interests (Corrigan, 2001). This approach focuses on rapidly placing the person in a competitive employment position, often within weeks after their initial enrolment in the program. Supported employment services are often considered Place-then-Train programs. In fact, even though several authors refer supported employment programs to the Place then train philosophy (Becker &

Drake, 2003; Corrigan, 2001), this mostly depends on the disclosure of the mental illness in the workplace or to the potential employer. When there is disclosure, it is possible to offer work accommodations, to provide training or information to the workplace personnel, and for the employment specialist to support or train clients on the job site (Banks, Novak, Mank, & Grossi, 2007). Supported employment programs include specific models such as the Individual Placement and Support model (Drake, Becker, Clark, & Mueser, 1999) or slightly modified models such as Australia's Open Employment model (Waghorn & Lloyd, 2005), and others in Europe (Burns, 2005), in Asia (Wong et al., 2004) and in Canada (Corbière et al., 2005a; Oldman et al., 2005) to name a few.

It should be noted that these approaches (i.e., prevocational/traditional services or supported employment services) and, consequently, their associated vocational services are often not mutually exclusive when implemented in the community. Furthermore, the countries employing these approaches may use different terminology, making it difficult to make direct comparisons between programs. For instance, supported employment programs have been implemented in countries other than the USA with various adaptations or transformations, such as the programs existing in Canada or in the UK (Corbière et al., 2005a, Leff et al., 2005). Among these, some vocational agencies offer supported employment programs to individuals who have already received prevocational services (Corbière et al., 2005a; Leff et al., 2005). Others follow the supported employment model but also offer transitional employment in conjunction with competitive employment such as the programs implemented in Japan (Fuller, Oka, Otsuka, Yokoyama, Liberman, & Niwa, 2000). Given such operational versatility, there is enormous potential for misinterepretation and therefore a clear terminology for describing these services is warranted (Lucca & Allen, 2001). In certain countries, other poorly documented vocational approaches, such as the social enterprise model, also exist (Righetti, 1994). The philosophy of the social enterprise model is to offer remunerative work just as any other firm, and to promote the physical, social, and mental health of their employees, though often in a setting with a high ratio of individuals with severe mental illness or other disabilities (Savio & Righetti, 1993; Black, 1988).

This paper presents and compares the main components of a certain number of vocational services and programs offered in different countries by attempting to offer a clear terminology of vocational services. The most common vocational services offered to people with severe mental illness that we were able to find in a comprehensive literature review are presented, as well as a few others, less publicized, such as the social enterprise model from Europe. Following the descriptions, the programs' or services' specific and overlapping components are discussed.

Sheltered workshops

Sheltered workshops, Hospital-based programs (Lehman, 1995), Industrial workshops (Sartorius et al., 1993) or Enclaves (Gilman, 1987) were conceived for people with severe mental illness who presented a low level of functioning and who were not ready to integrate the workplace. Clients may be paid according to the piece rate or achievement, but the salary is usually low and does not affect the client's existing benefits (Storey, 2000; Modestin & Lieb, 2002). This type of vocational service offers an opportunity to develop basic work skills and habits (Jacobs, 1991). Sheltered workhops create a certain environmental security where everyone working suffers from mental illness, and where there is acceptance and tolerance in regard to the varying levels of productivity from each worker. Depending on the management of the sheltered workshop, the focus is either on client rehabilitation and

therapy, or on the actual production and performance (Yip & Ng, 1999). Most of the time, the work task is repetitive and monotonous (Kates et al., 1989), and the time-unlimited aspect of sheltered workshops can become an obstacle to regular workplace integration if clients never move on to other jobs (Schuster, 1990). Sheltered workshops typically solicit factory contract work that is carried out in a segregated and protected environment such as a psychiatric institution (Cochrane et al., 1991), but these programs can also be developed in conventional factories or enterprises, as is the case in China (Luo & Yu, 1994). Sheltered workshops within such real work settings are considered more integrated in the real labour market than hospital-based workshops (Yip & Ng, 1999). A few exceptions exist, such as the White Farm, a sheltered worshop in Belgium that is not based in a psychiatric hospital or an existing enterprise, but where clients can work at one of the sheltered activities and where many of the products are sold at a small shop (Lissens, & van Audenhove, 1996).

Transitional programs

Transitional employment is offered to people with severe mental illness as a possible and significant step for members registered in Clubhouses – it is considered to be the ''lifeblood of clubhouse'' (Alden, 2001; Phillips & Biller, 1993; Waters, 1992). Although Marrone (1993) noted that certain Clubhouses did not include transitional employment in their services; a study by Macias, Jackson, Schroeder, and Wang (1999) found that 82% of Clubhouses ($N = 173$) included transitional employment programs. In general, Clubhouses use participation in activities (work-ordered day) to develop the clients' motivation to enter transitional employment (Blankertz & Robinson, 1996; Macias, Kinney, & Rodican, 1995). Transitional employment is generally negotiated by vocational staff with employers, and usually takes the form of part-time community jobs where another person replaces the client if they experience a relapse (Bond et al., 1999). Close links are created with employers, who typically agree to receive rotating groups of clients over an extended period of time (Waghorn & King, 1999). Most transitional employment can be taught quickly without the need for specific skills (Marrone, 1993; Marrone, Balzel, & Gold, 1995). The ultimate goal is for clients to attain a certain level of self-confidence and independence that will help them get competitive employment. An important limitation of transitional work is that the job usually belongs to the vocational agency, even if it is located in a community setting. All employees in transitional employment are perceived as interchangeable, with work time limited to 6 – 9 months (Marrone, 1993; Marrone, Balzel & Gold, 1995). In certain settings, prevocational activities within sheltered workshops are mandatory before accessing transitional employment, whereas others promote accelerated placement in transitional settings (Bond & Dincin, 1986). According to Marrone (1993), there are some advantages to transitional employment, such as the fact that the contracts are time-limited and give employees the possibility of attaining significant work experience in various settings. The disadvantages are that the jobs offered are often unskilled and time-limited; regardless of their job performance and satisfaction, the worker will eventually need to vacate the position. Table I summarizes the transitional employment components defined by Beard, Propst, and Malamud (1982), and Macias and colleagues (1995).

Social enterprise/social firm

A social enterprise/firm is described as a program midway between sheltered work and competitive work (Eikelmann & Reker, 1993) and is similar to work crews, where groups of clients are trained and supervised among both handicapped and non-handicapped workers

Table I. Vocational services essential components.

Sheltered workshop	Transitional employment	Social enterprise	Supported employment programs
Develops work habits. Tolerates job failures. Job coaching at work site.	Realistic job experience (essentially entry-level employment). A staff worker first performs tasks with new placements. Part-time employment (15–20 hours/week). Temporary (6–9 months). Staff members guarantee a replacement if a consumer is absent. Tolerates job failures. Job coaching at work site. Employees are encouraged to participate in activities offered in the Clubhouse when not at work.	Promotes collaborative management of workers while focusing on autonomy and self-initiatives. Focuses on improving interpersonal relationship skills. Develops and reinforces a vocational identity. Vocational successes are transferable to other enterprises.	Eligibility is based on client choice. Rehabilitation and mental health integration. Benefits counselling is provided. Goal is competitive employment without requiring extended prevocational training. Attention to consumer preferences. Select a job compatible with the consumer's values and qualifications (possible career exploration). Rapid job search. Acquire a job from an employer in a desired competitive work setting. Continuous and comprehensive assessment. Time-unlimited support. Services are provided in the community. Maintain employee success and satisfaction by developing and enhancing consumer skills and supports. Buddy system on the job-site or other work accommodation if there is disclosure of mental illness.

in an industry or business. Social enterprises are mostly found in Europe and developing countries, and are typically implemented in the competitive labor market as affirmative businesses, cooperatives, collectives, consumer-run businesses, or social firms (Savio & Righetti, 1993; Warner & Polak, 1995). They aim to offer a holistic setting where the participant's vocational and mental health goals can be met (Black, 1988; Savio & Righetti, 1993). According to Savio and Righetti (1993), the minimum percentage of employees with a disability in a cooperative or social enterprise should be 30%. The social enterprise should be financially viable and, ideally, profitable without subsidies. Some social enterprises, such

as the cooperatives in Trieste, Italy, are non-profit businesses where workers are also co-owners and vote on business decisions (Ramon, 1995). Consumer-run businesses distinguish themselves from other social enterprises by their consumer-only orientation (Latimer, 2005; Trainor & Tremblay, 1992). The major advantages of the social enterprise model are real-world remuneration and a sense of belonging to the enterprise, not to mention the accommodations offered to compensate for deficits or symptoms. However, social enterprise programs can be perceived as ghettos that make it difficult for people to eventually integrate into regular competitive settings. The characteristics of social enterprises are summarized in Table I.

Supported employment

The larger definition of supported employment programs is: "Supported employment programs typically provide individual placements in competitive employment—that is, community jobs paying at least minimum wage that any person can apply for—in accord with client choices and capabilities, without requiring extended prevocational training .... They actively facilitate job acquisition, often sending staff to accompany clients on interviews, and they provide ongoing support once the client is employed" (Bond et al., 2001). The most widely researched supported employment approach for people with severe mental illness is the Individual Placement and Support (IPS) model developed by Becker and Drake (1994). As indicated by Corbière and colleagues (2005a), the main difference between the broad definition of a supported employment program and the specific IPS model is that the latter integrates vocational and mental health treatment teams. Other authors also mention that IPS differs from other supported employment programs with their zero exclusion criteria, i.e., all clients who express interest in competitive employment can be registered in IPS programs (Becker & Drake, 2003; Bond, Becker, Drake, & Vogler, 1997). The IPS model has been by far the most studied supported employment program for people with severe mental illness, with several studies supporting it as an evidence-based practice in the United States (Bond, 2004; Crowther et al., 2001; Twamley, Jeste, & Lehman, 2003). Australia's Open Employment model differs from the IPS model in that it does not integrate vocational and mental health services, and it screens the clients who are to receive the services (Waghorn & Lloyd, 2005). The Netherlands Supported Employment program includes all of the basic supported employment model principles but different people function as job finders and job coaches. It has also added a buddy system on the job-site, i.e., a co-worker who acts as a support person and helps the client adjust to the work setting (Hoekstra, Sanders, van den Heuvel, Post, & Groothoff, 2004). The Choose-Get-Keep (CGK) psychiatric rehabilitation approach from Boston offers support in competitive work settings but only after extensive prevocational career exploration (Rogers, Anthony, Lyass, & Penk, 2006; Waghorn & Lloyd, 2005). See Table I for a description of the most common supported employment components (13) found in various countries. The major advantage of supported employment programs over other vocational services is that the clients actually obtain real-world competitive jobs, therefore promoting the clients' role in society, and facilitating their integration while working against the stigma of mental illness. However, like most vocational services, the jobs obtained are often entry-level jobs (Bozzer et al., 1999). Furthermore, job tenure for people who beneficiate from supported employment services is typically brief, often less than five months (see McGurk, Mueser, & Pascaris, 2005).

Various hybrid versions of supported employment programs exist, either integrating multiple components from the different supported employment models (Wong, Chiu, Chiu, &

Tang, 2001; Wong et al., 2004) or integrating prevocational services with supported employment (Fuller et al., 2000). In some settings, supported employment programs have been integrated into existing vocational agencies that offer their services to individuals who have received prevocational services (Bond et al., 1999; Corbière et al., 2005a; Leff et al., 2005). Even within the programs following a specific model, such as IPS, differences exist in the actual application of the components (Corbière et al., 2005a).

In addition to the existing programs, specific treatments or adjunctive programs have been developed to further help individuals in their rehabilitation process. Of these, occupational therapy and skills training are probably the most widespread, though newcomers such as cognitive-behaviour therapy and cognitive remediation in the workplace are also being studied and offered in specific contexts. *Occupational therapy* involves various tasks aimed at improving the person's performance at work. Examples might include improving attendance, promptness, and sustained participation in work-related activities (Oka et al., 2004). *Skills Training* interventions are offered to help develop work-related social skills or job seeking skills through modeling, role-playing, and positive reinforcement. For instance, the ''Workplace fundamental skills module'' (Wallace, Tauber, & Wilde, 1999; Wallace & Tauber, 2004) help participants acquire and practice specific work-related social behaviors and overcome difficulties that could hamper the performance of these behaviors. Similarly, Tsang (2003) conceptualized a training method for learning the social skills necessary for job search and job tenure that includes: (a) basic social skills and basic survival skills on the job; (b) core skills for general and specific work related situations; and (c) learning the benefits of using the basic and general work-related skills. *Cognitive behaviour therapy* in vocational programs can be used to modify dysfunctional beliefs that might hinder the person's optimal performance or even entry into the workplace. Such interventions can be offered to individuals or to groups and aim to modify cognitions by helping people monitor their thoughts and develop specific coping strategies (Davis, Lysaker, Lancaster, Bryson, & Bell, 2005; Rose & Perz, 2005). *Cognitive remediation and cognitive training* are used to help individuals overcome or compensate for specific cognitive deficits in learning or memory, attention, problem solving, psychomotor speed, and executive functions. Studies have demonstrated improvements in work performance via specific remediation strategies such as errorless learning (Bell, Bryson, Greig, Corcoran, & Wexler, 2001; Kern, Liberman, Kopelowicz, Mintz & Green, 2002) or cognitive training used in the context of supported employment programs (McGurk, Mueser, Feldman, Wolfe, & Pascaris, 2007; McGurk et al., 2005).

Discussion

We have defined and described the most commonly offered vocational services/programs as well as potential adjunctive programs. Whereas some authors perceive these services as a continuum in which a client would graduate from one service to another, other authors distinguish traditional services from supported employment programs, with only the latter being an evidenced-based practice.

The most important aspects of these services are, of course, their outcomes. The outcomes of the services described here are as diversified as the services themselves, though all are related to work integration. For example, sheltered workshops aim to develop clients' work habits, transitional employment aims to help clients gain work experience, and social enterprises aim to have clients work productively within a social work environment, whereas supported employment programs aim to help clients obtain competitive jobs quickly. Therefore, when studies compare these services to each other, the results can be biased by the outcomes and whether or not they correspond to the goals of the vocational services

assessed. Another important consideration in terms of work outcomes is which ones are assessed, i.e., getting a job, maintaining a job, type of job, salary, number of hours worked per week, etc. (Cook & Razzano, 2000). Depending on the outcomes targeted, the most significant predictors will vary (Corbière, Mercier, Lesage, & Villeneuve, 2005b).

Of the services described, supported employment programs have been the most extensively studied and have demonstrated their superiority to other services in obtaining competitive employment for clients (Bond, 2004; Crowther et al., 2001; Twamley et al., 2003). As such, a recent initiative helped disseminate and increase accessibility to supported employment programs in seven States in the USA by following best practices in implementation (Drake, Becker, Goldman, & Martinez, 2006). This initiative is supported by the SAMHSA toolkits, which includes comprehensive guidelines for employment specialists and other stakeholders (Becker & Bond, 2002). Other vocational services, though fewer and not as well studied, have also seen positive results for employment outcomes (Corbière et al., 2005b; Corbière, Lesage, Villeneuve, & Mercier, 2006; Macias et al., 1995; Phillips & Biller, 1993). These studies suggest that certain services, when adapted to the appropriate social and cultural context, can have positive and significant vocational outcomes.

As illustrated in this paper, even though each service follows a specific model with precise goals, there can be overlaps and adaptations, the nature of which depend on the social, economic, and cultural contexts of their implementation. These overlaps and adaptations further emphasize the need to better identify and understand the most important components of vocational services to help people with severe mental illness successfully integrate into the workplace. Bond (2004) identified four components of the supported employment model, linked to either obtaining or maintaining employment: (a) services focused on competitive employment, (b) eligibility based on consumer choice, (c) rapid job search, and (d) integration of vocational and mental health teams. Similarly, Gowdy, Carlson, and Rapp (2003) identified several significant factors for getting employment such as de-emphasizing prevocational programming, rapid vocational assessment, quick approval for vocational rehabilitation, disclosure of mental illness to employers and work accommodation; and significant factors for maintaining employment such as frequent contact with employers, and high degree of support from vocational staff if a problem occurs on the job site. Leff and colleagues (2005) investigated job development, defined as "direct or indirect contact with potential employers or networking with individuals or organizations that had job information" (p. 1238), and job support, defined as "on-site counseling, support, and problem solving" (p. 1239), using a sample of more than 1000 people with severe mental illness. They found that job development was very effective but results were not as clear for job support. Already 20 years ago, Harding, Strauss, Hafez, and Liberman (1987) discussed the need for four components to help people with severe mental illness integrate into the workplace: (a) flexibility (for the interface between services), (b) collaboration (between agencies and with families, using a common language for different professionals), (c) a unified theoretical framework integrated from different disciplines, and (d) a database system across the rehabilitation process. Others, such as Clark (1995) suggest that no single approach is successful for everyone presenting with a mental illness and wishing to work since individuals vary in terms of their cognitive deficits and in their readiness to obtain employment. Corrigan (2001) recommends first and foremost evaluating the level of readiness for work of those participating in vocational programs – since motivation is a key factor to obtaining work.

This paper further illustrates that certain combinations of components are used in various vocational programs and these combinations are linked to specific outcomes. Implementation issues, such as governmental or administrative barriers, difficulties in restructuring

services, and lack of administrative leadership have been studied in the United States, with little attention given to specific components (Becker, Torrey, Toscano, Wysik, & Fox, 1998; Bond et al., 2001). More studies should be conducted on service components to describe the variations and adaptations made during implementation and to better understand their effectiveness in specific cultural contexts (Corbière et al., 2005a). Mowbray, Holter, Teague and Bybee (2003) suggested using fidelity scales to assess the degree of implementation of a practice, and, more specifically, the assessment of vocational programs' implementation to better understand vocational successes for people with severe mental illness (e.g., IPS Fidelity Scale (Bond et al., 1997), QSEIS (Bond et al., 2001) or the International Center for Clubhouse Development (ICCD; Macias et al., 2001). Other approaches, such as social enterprises, could also be evaluated, to determine their effects on work outcomes.

Another avenue of research would be to merge different evidence-based approaches. For instance, Lehman (2005) described the following services as evidence-based practices for individuals with severe mental illness: skills training, dual-disorder (substance abuse and mental health) integrated treatment, cognitive remediation, cognitive behavioral therapies, family interventions, assertive community treatment, and supported employment programs. Unfortunately, these services are often offered separately rather than as a comprehensive rehabilitation program. Such integrations could potentially offer relevant and significant tools for people with mental illness who are engaged in the work integration process. One example: McGurk and collaborators (2007) demonstrated that clients in supported employment programs who received cognitive training held significantly more jobs, worked more weeks over the follow-up, and earned more wages when compared to clients who received supported employment services alone. Also, the utilization of cognitive behaviour therapy with a specific focus on work-related irrational beliefs demonstrated preliminary positive effects for Veterans in a prevocational work program (Davis et al., 2005). Finally, another crucial component in vocational programs is probably the training of vocational staff. Drake, Bond, and Rapp (2006) reported wide variations of vocational success within programs following the supported employment model, specifically between employment specialists. Behaviors, attitudes, and knowledge in employment specialists or in vocational counselors warrant a closer investigation (Corbière, Neduha, & Lanctôt, 2007).

In conclusion, various combinations, adaptations, and integrations of specific vocational services components are used in order to help people with severe mental illness attain their vocational goals. These combinations and adaptations warrant further investigations, particularly in regard to the essential program components needed to help individuals succeed in the workplace. It might be useful to empirically investigate the effectiveness of specific components and to determine which types or combinations of services work best for which individuals, i.e., consider specific client profiles along with the service components when evaluating vocational outcomes.

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