Introduction

Bolstered by consistent findings from 9 randomized controlled trials, supported employment, as defined by a set of evidence-based principles, is now recognized as an evidence-based practice for persons with severe mental illness (1, 2). As articulated by Becker and Drake (3), the Individual Placement and Support (IPS) model of supported employment incorporates six commonly accepted principles are:

- Competitive employment is the goal.
- The job search occurs soon after program entry.
- Eligibility is based on consumer choice.
- Job choice follows consumer preference.
- Support is provided over time, based on consumer need.
- Vocational and mental health services are integrated.

Among the many programs identifying themselves as providing supported employment, the principle that differentiates them most from the IPS model is the integration of vocational and mental health services (4) even though close coordination between the employment staff and the mental health treatment team can yield tangible benefits in terms of program effectiveness (5).

A major issue in implementing evidence-based practices concerns identifying strategies that will be palatable to provider agencies. In some cases, agencies create entirely new programs in response to perceived needs; in many such cases, the new program does not replace or compete with an existing program. Resistance to change may be minimal in such circumstances, because introducing the new services may not require abandoning ideological viewpoints or relinquishing habitual patterns of providing services. In other cases, the new, evidence-based practice replaces existing program services. Converting an existing program does challenge cherished beliefs and is often difficult to implement, unless there is dissatisfaction with existing services (6, 7).

In the vocational domain, early proponents of supported employment believed it would logically replace the facility-based programs that had dominated the vocational field for many decades. For individuals with developmental disabilities, there have been some dramatic examples of converting sheltered workshops to supported employment (8). In general, however, the rehabilitation field has generally found that supported employment has been added as a new
service to comprehensive rehabilitation centers instead replacing sheltered workshop and day programs (9, 10).

In the mental health field, there have been some noteworthy demonstration studies showing the successful conversion of day treatment programs to supported employment (11-15). Although there has been a successful closing of a sheltered workshop for individuals with psychiatric disabilities in the UK (Miles Rinaldi, personal communication, 11/12/04), to our knowledge, there have been no published reports documenting the conversion of a sheltered workshop to an evidence-based supported employment program for this target population.

**Case Study**

The Canadian Mental Health Association (CMHA) is a voluntary association that exists to promote the mental health of Canadians. The Vancouver/Burnaby Branch of CMHA has been providing vocational services since the late 1980s, although it does not offer mental health treatment, which is under the jurisdiction and financing of the provincially funded health authorities. This case study examines the transformation of the employment services of organization over a 15-year period as it made successive steps toward improvement. The evolution divides into 4 phases:

**Phase 1: Facility-Based Sheltered Employment.** Starting the late 1980s, CMHA provided vocational services to clients with severe mental illness in Vancouver and Burnaby (a suburb of Vancouver). Three vocational counselors, one business representative, and one coordinator staffed the program. The service offered packing and light assembly work. Clients worked 1-2 days a week and earned $100/month. While clients thought of themselves as working and contributing to the business community, there was little movement from the workshop into competitive employment (less than 5% annually).

**Phase 2: Addition of Prevocational Component.** In the early 1990s, CMHA expanded the services to include employment preparation classes devoted to self-paced life skills training and computer training. No new staff were dedicated to helping clients obtain competitive employment. While significant changes were observed in client behaviors as a result of these classes, there was no increase in the numbers of clients transitioning into competitive employment.

**Phase 3: Brokered Supported Employment Services.** In 1995, growing out of discussions with contract managers from the health authority, CMHA decided to convert their
focus to supported employment. The business representative role was shifted to that of *job marketer*, with vocational counselors providing ongoing support to clients once they obtained jobs. The program coordinator continued to manage the team and assess new admissions. The employment preparation classes continued and most clients attended them for 6 weeks.

Around the same time, CMHA started an Independent Employment Program based in Vancouver to help more “job ready” clients secure competitive employment. The differences between the Independent Employment Program and the Supported Employment Program became less clear as they became more established. By 1997 they were merged into one program.

While these reforms were moving in the right direction, the merged program did not achieve the desired level of success. Although more clients were entering competitive employment, the annual rate of clients achieving competitive employment remained below 25%. Moreover, administrators noted structural problems with the program. One barrier was that the role of case managers in the vocational process was largely limited to referring clients, providing baseline information about the client’s background and treatment history. They rarely met face-to-face with vocational counselors, nor did they collaborate on plans to support the client. A second issue was that the two job marketers could not keep pace with the backlog of clients ready for employment. Clients became discouraged with the delay in finding placements. Consequently, the program had a high dropout rate.

**Phase 4:** In 2000, CMHA and contract managers from CMHA’s funding agencies undertook a review of the supported employment program. Influential in this discussion was the emerging literature on the IPS model of supported employment. The review group recommended converting the brokered supported employment program (in which vocational services were centralized at the CMHA offices) to an integrated supported employment program (in which employment counselors were deployed to the various mental health treatment teams). In collaboration with the mental health provider organizations in Vancouver and Burnaby, CMHA committed to a pilot study involving a complete conversion to the IPS model. Specifically, CMHA would continue to manage the program, but implement the changes in partnership with specific community mental health teams, following a jointly agreed operational plan.
The shift to IPS required significant planning and organizational change. Key milestones were as follows:

**Staff roles** were redefined so that the newly titled Vocational Rehabilitation Counselors undertook responsibility for the full range of services to their caseload from admission through assessment, marketing and placement, to ongoing support, following the “generalist model” advocated by the IPS model. This required a change in position descriptions and complex negotiations with union and employer representatives to reclassify the jobs to a new collective agreement and to ensure the transfer of existing staff. To fund an increase in wages, CMHA agreed to reduce the staffing from 7.0 to 5.5 FTEs (although this was achieved without layoffs).

**Training and orientation** of both vocational and mental health staff was provided by an outside consultant, a senior coordinator of an established IPS program in Manchester, NH. This consultation included a 3-day training event, followed by meeting with the participating mental health treatment teams and a community seminar for other location vocational service providers. The consultation was perceived as extremely helpful in legitimizing the IPS model. The consultant provided testimony to the actual experience with what had been a theoretical model for local staff and partners/funders. One significant shift in the operational plan resulting from the consultation was a decision to create a combined half-time team supervisor position to provide vocational team supervision, ensure communication with the treatment teams, and to coordinate the evaluation.

**Operational plan development** revolved around the formation of two advisory committees for the two regions (Vancouver and Burnaby) involved in the project. The two committees approved almost identical operational plans with the exception of admission procedures. The Vancouver committee decided that clients would be referred by case managers and admitted as openings became available, whereas the Burnaby committee decided that clients who had been on a waiting list would be served on a first come-first served basis.

Between November 2000 and March 2001 the 4 existing CMHA vocational counselors were transferred and 2 newly-hired vocational counselors were assigned to 6 mental health treatment teams. From the inception, vocational counselors continuously educated case managers to help them understand the program and referral process. While the vocational counselors worked out of the treatment team offices, the entire group of vocational counselors continued to meet weekly for group supervision and peer support, consistent with the IPS model.
Staff reported this continued connection as a specialized vocational team to be perceived as an important factor in their effectiveness. Team meetings helped staff clarify and maintain high fidelity to IPS principles, encouraged peer support, and provided a forum for case reviews and joint problem solving. This weekly meeting also allowed the vocational counselors to make practical arrangements for staff coverage in the case of absences.

**Project Evaluation**

**Methods.** Project staff conducted a program evaluation over a 27-month project phase for 5 project sites. During this time, they systematically examined client background characteristics, competitive employment outcome rates, and client and stakeholder satisfaction. Satisfaction was measuring using an 11-item checklist, including 4 yes-items, 7 items with a 5-point Likert scale (Excellent, very Good, Good, Fair, Poor), and one item regarding wait time. Stakeholder referred to occupational therapists, case managers, and team directors from the treatment teams and contract managers from the health authorities.

In addition, fidelity of implementation was assessed using the 15-item IPS Fidelity Scale (16). Each item is rated on a 5-point, behaviorally-anchored scale, for a maximum possible score of 75. An item score of 5 indicates the program has fully implemented the IPS standard, 4 indicates moderate implementation, while a score of 1 indicates the program has not met the standard at all. The first author conducted the fidelity assessment, using operational policies, employment data, and other information provided by the supported employment team. A score of 66 or high is considered “good” fidelity to IPS.

**Communities served.** The communities served by the 5 teams differed, as follows:

- **West Side Vancouver team:** The socioeconomic and educational levels of clients in this community were relatively high. While this environment fostered expectations of higher wages for work, motivation to work was sometimes undermined by financial support to clients from families.

- **Northeast Vancouver team:** This team served a lower income neighborhood of the city, with a high degree of transience. The vocational counselor had a number of clients who she continued to follow even though they moved to distant neighborhoods at some distance. This community also has a substantial Asian population. The IPS program accommodated a large percentage of clients whose 1st language was not English.
- **South Vancouver team:** Located in the most southerly part of Vancouver, this community was culturally diverse with sizeable Indo-Canadian, and Asian populations. There is often a strong work ethic within these multicultural communities. If this is combined with a lack of understanding of mental illness, families can have difficulty understanding why the person is not already working. This team has a multicultural worker providing a bridge to clients who do not speak English.

- **Central Burnaby team:** An urban area adjacent to Vancouver, with a mix of economic and multicultural communities.

- **Maple Ridge team:** Unlike the other sites, Maple Ridge is a small town with a surrounding semi-rural area, located at some distance from downtown Vancouver. The vocational counselor reported that the challenge of identifying potential jobs was significant in a smaller economic market.

**Sample.** Over the project period, 249 clients were admitted to IPS; 129 during the first 15 months and 120 over the final 12 months. The 195 clients enrolled for 6 or more months in IPS when the program evaluation report was completed constitute the primary focus of the outcome analysis. Overall, 58% were women, 57% were 40 or younger, educational attainment varied from less than high school (25%) to college graduates (32%), 51% had a diagnosis of a schizophrenia spectrum disorder, 39% had never worked or had not worked in the last 5 years, and 34% did not speak English as a first language.

**Project Findings**

**Program Fidelity.** The IPS fidelity score was 68, suggesting “good” implementation of the IPS model. The single item that was scored below 4 was Community-Based Services, which suggesting that the amount of time employment specialists spend outside of the office was suboptimal.

**Competitive Employment Outcomes.** Of the 195 clients in the sample, 27 (13.8%) were employed at time of program entry. Of these, 21 (77.8%) were working at the end of the project period (n = 12) or at the time they left the program (n =9), and the remaining 6 were searching for a new job.

Of the 168 unemployed clients in the sample, 84 (50.0%) were competitively employed at some time during the study period. The competitive employment rates were similar for the 5 treatment teams, ranging from 45.6% to 55.0%. At the end of the follow-up period, 62 (36.9%)
were competitively employed (range among the 5 teams: 32.4% to 45.8%). Of those employed, 74% worked 15 hours or more a week, and 31% held full-time jobs; 61% earned a monthly wage of at least $800 (Canadian). All the positions paid competitive wages.

Of those who found work, 73% did so within 6 months after program admission. Staff individualized their job search approaches: 23% of clients received mostly “hands-off” consultative support; 42% received intensive coaching; 35% received both intensive coaching and direct marketing to employers on the client’s behalf.

**Client satisfaction.** In the summer of 2003 satisfaction surveys were sent to 251 clients involved in the project evaluation, of which 53 (21.1%) were return. For most Likert items, approximately 80% indicated that services were excellent or very good. On the item, “Were your employment goals met?” 40% indicated “Yes,” 39% indicated “Partially,” and 21% responded “No.” Seventy-two percent indicated that they waited 2 weeks or less to first meet with their employment counselor.

**Stakeholder satisfaction.** An independent facilitator was hired to gather stakeholder input during a workshop held in April 2003. Attending were 15 case managers, occupational therapists, and program managers from the 5 mental health treatment and contract managers from the health authority. Stakeholders rated their satisfaction with IPS program as follows: 7% extremely satisfied, 42% very satisfied, 35% satisfied, 7% somewhat satisfied, and 7% not satisfied. The workshop focused on a range of specific issues relating to employment specialists’ integration onto treatment teams, the referral process, staff selection, documentation, and organizational structure. In each of these areas, specific recommendations were developed for incorporation into future quality improvements.

**Discussion**

This report describes one agency’s successful efforts converting to evidence-based supported employment. Of interest was the finding of relatively similar outcomes in 5 dissimilar neighborhoods, suggesting that community factors were not an insurmountable barrier to implementation. Several factors help to explain process of change. **First, the agency was committed to quality improvement**, using both process and outcome data to guide its practice. Regarding process measures, during the facility-based period of development, one chronic problem was staff turnover. During the brokered supported employment phase, staff continued to be demoralized because, while they felt proud their individual role performance, they were
disappointed by their lack of tangible results. In addition, collaboration between the employment program and the community treatment teams was inconsistent. Each phase of organizational change also was prompted by the agency’s dissatisfaction with their competitive employment rates. Rapp (17) has long advocated for the power of outcome supervision and planning as a means to improving services, and the current case study supports this view. **Second, the agency was inspired and guided by information on the IPS model** appearing in a special issue of Psychiatric Rehabilitation Journal (18). At the time, because staff were unhappy with their outcomes, they were receptive to change. They decided to reconfigure their services to align with evidence-based principles. **Third, strong leadership, encouragement, and financial support from local health authorities** made organizational change viable. **Fourth, the agency sought out and received expert consultation** from an experienced IPS team leader, who provided the vocational staff with the confidence that the IPS could be implemented and met mental health treatment team staff to build consensus. **Fifth, the agency devoted substantial time to consensus-building and training** prior to launching the new project.

As with any case study, it is a matter of speculation how replicable this process might be in different circumstances. The unique characteristics of the current organization might well foster questions about the generalizability to other settings, particularly to programs in the US. What this case study does suggest is that conversion from sheltered employment to evidence-based supported employment is possible when there is felt need for change, key leaders are motivated, and a systematic change process in followed.
References

8. Murphy ST, Rogan PM: Closing the shop: Conversion from sheltered to integrated work. Baltimore, Paul H. Brookes, 1995