

International Encyclopedia of Rehabilitation

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Vocational Rehabilitation for People with Psychiatric and Psychological Disorders

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Introduction

Over the past 20 years high quality research originating from the USA (Bond 2004, Bond et al. 2008) has revolutionised the way vocational rehabilitation is conceptualised and provided to people with the most severe forms of psychiatric and psychological disorders. Traditional vocational rehabilitation was typically considered a gradual stepwise process over months or years (train then place). People often began with pre-vocational training in group settings, followed by long periods of assessment preceding the provision of more customised employment assistance. Unpaid positions and forms of sheltered employment were considered helpful or even necessary to prepare people for competitive employment in the open labour market (Waghorn and Lloyd 2005).

The evidence now supports the opposite approach (place then train). This approach is characterised by seven principles including rapid commencement of a competitive job in line with the person's explicit preferences. This is now considered the beginning rather than the end point of vocational rehabilitation. Assessment of work performance is ongoing, and all assistance provided is closely aligned with individual preferences. No mandatory elements are included. Employers are often assisted simultaneously by the employment consultant measuring the client's work performance, providing additional on site training, and by providing general mental health education for the workplace. Mental health treatment and care are closely coordinated with employment services, usually through the employment consultant being a member of the treatment team or by being co-located with the community mental health team. Close integration of vocational and clinical services significantly improves both employment commencements and duration of employment (Bond 2004, Cook et al. 2005).

This approach has now set the standard for all forms of vocational rehabilitation to people with psychiatric and psychological disorders. Over 60% of people with severe mental illness who receive evidence-based supported employment services, manage to commence competitive employment. The average competitive employment outcomes for other types of vocational rehabilitation is 24% (Bond 2004). However, many traditional forms of vocational rehabilitation continue even though the evidence no longer supports that approach. This article summarises the benefits of employment, employability issues, major barriers to employment, vocational rehabilitation methods, and evidence-based approaches. Finally we discuss emerging interventions that promise to further enhance evidence-based supported employment programs.

Benefits of employment

Employment is a basic right of citizenship often taken for granted. Yet, many people with severe mental illness, through the non-availability of evidence-based services, are excluded from this basic right. Employment has many advantages for people. Besides earning an income, work provides opportunities for social interaction, a means of structuring and occupying time, enjoyable activity and involvement, and a sense of personal achievement (Rinaldi and Perkins 2004). People with a mental illness are sensitive to the negative effects of unemployment. For example, additional stigma, demoralization, loss of hope, social isolation and inactivity (Waghorn and Lloyd 2005). Employment is challenging, yet when successful, encourages people to maintain their mental health. The confidence developed from employment promotes recovery. In retrospect, many people with mental illness identify employment as crucial to their recovery process (Provencher et al. 2002).

Employability

Individuals with the more severe psychiatric disabilities have the lowest rates of labor force participation, and the lowest employment among all disability groups (Loveland et al. 2007). For instance, in the last official Australian population survey of people with psychotic disorders, 16% of people with schizophrenia, and 27% of people with bipolar affective disorders, were employed (Waghorn et al. 2007). Similar employment rates are reported by population style surveys in the UK and in the USA. Although it is possible to identify individual characteristics from population surveys that predict employment status, in the presence of an evidence-based service, individual client characteristics are no longer important as outcome predictors. Individual characteristics such as diagnostic category, illness course pattern, illness severity, educational attainment (Nordt et al. 2007), social skills and work history (Tsang et al. 2000), are useful predictors of service intensity and therefore the likely cost of the assistance required. At the service level, individual characteristics give way to two key predictors: (1) the person's interest and motivation towards employment; and (2) the quality, continuity and intensity of the service to be provided (Bond et al. 2008).

Major barriers

People with psychiatric or psychological disorders face many barriers and disincentives when returning to work. Demands of the labor market, work restrictions caused by illness, complications associated with disability benefits, limited availability of evidence-based programs, all contribute (Loveland et al. 2007). McQuilken et al. (2003) found that most consumers in their study were working or wanted to work. Over half of the participants stated they could not risk losing their benefits by getting a job. This implies that in some countries, consumers who say that they are not interested in employment or who are not looking for work, may be interested if they were better educated about how to maximise the financial benefits and minimise the impact of welfare disincentives.

Severe mental illness presents substantial challenges in vocational rehabilitation. Schizophrenia for instance, is characterized by impairments in cognitive functioning and the presence of positive and negative symptoms. Cognitive deficits may include

impairments in attention, working memory, learning, general knowledge, ideational fluency, or problems solving skills. Negative symptoms can include loss of interest and motivation, an inability to initiate action, apathy, and social withdrawal (Waghorn and Lloyd 2005). The associated low energy can undermine an individual's ability to engage in rehabilitation services (Harvey et al. 2004, MacDonald et al. 2003). Other functional limitations include social (difficulty interacting with others), emotional (difficulty managing emotions and symptoms), meta-cognitive (self monitoring work performance), and physical strength and work stamina (MacDonald et al. 2003). Johannesen et al. (2007) found that having a mental illness is a critical concern for people with severe mental illness when seeking employment.

Social competence is an important component of vocational functioning among people with severe mental illness (Tsang and Pearson 1996, 2001). This is because most jobs require a high standard of social interactions with customers, co-workers, supervisors and managers. Interpersonal difficulty was reported to be the most frequently reported job problem (58%) that led to job terminations among people with severe mental illness (Becker et al. 1998). If not addressed, social skill deficits can become an added obstacle to job acquisition and retention.

Other vocational services

Clubhouse

The clubhouse model grew from Fountain House, a consumer self-help organisation first established in 1948. There are now approximately 300 clubhouses in various countries around the world, many of which are accredited by the International Center for Clubhouse Development (ICCD). Clubhouses are communities where members can gain confidence and support, and can receive assistance to lead vocationally productive and satisfying lives. The clubhouse is organized around a work-ordered day program that provides opportunities for members to work within a rehabilitative environment.

Transitional employment

Transitional employment (TE) is the primary vocational approach used by clubhouse programs, and is designed to give members real work experience, work confidence, skills, and the opportunity for properly paid work. The staff member provides training on the job, and assists the member with any other issues that may arise. The main features of TE programs are: positions involve 6-9 months of temporary work; members are paid award wages; members complete the work at the employer's place of business; all work is entry level and does not require qualifications. Limited work history or recent hospitalization will not affect a member's opportunity to obtain a position. No resume or interview is required as the position is 'owned' by the clubhouse and the selection process is managed by the Clubhouse staff and members (Mental Health Council of Australia 2007).

Social firms

Social firms originated in Italy in the 1960s and since spread throughout Europe and the United Kingdom. They are not-for-profit businesses that provide accessible employment for people with disability. Social firms usually have the following features: 20-50% of positions are reserved for employees with disabilities; all workers are paid the same award rate or productivity based rates; all employees have the same employment opportunities, rights, and obligations. The social firm generates the majority of its income through the commercial activity of the business, although most are not self-sufficient (Mental Health Council of Australia 2007).

Pre-vocational services

Pre-vocational services use a traditional step-wise train and place approach to vocational rehabilitation. Training is provided in generic work skills and personal development such as self-esteem, assertiveness, and stress management (Rinaldi and Perkins 2007). Participants must learn pre-vocational and work readiness skills before they are considered ready to be placed in competitive work settings. However, placements are often sheltered through being owned by the hospital or rehabilitation agency (Corrigan et al. 2007).

Sheltered work

Sheltered workshops were originally designed for people with intellectual disabilities. At the time it was commonly thought that competitive employment would be impossible. Sheltered work was also used for family respite and for activity therapy for those who did not have an employment goal. In the late 1980's access was extended to people with severe mental illness who presented with a low level of functioning and who appeared unable to participate in competitive employment.

Workshop clients are often paid a small allowance or piece rate well below that paid to employees in the wider community. Sheltered workshops provide an enclave type of work environment where every worker has a disability. The work is usually repetitive and monotonous, and the jobs are time-unlimited. Workers seldom receive assistance to move on to a competitive job of their choice in the open labor market. The workshop is usually a competitive business competing for contracts along with other businesses in the community. In the past, sheltered workshops sought commercial contracts while operating in a protected and segregated environment such as in a psychiatric institution (Corbiere and Lecomte 2007).

An evidence-based approach

One particular approach to supported employment has become accepted as an evidence-based psychosocial intervention for people with severe mental illness. Bond (2004) and others have isolated the evidence base for the essential principles which predict better employment outcomes. These include (1) a focus on competitive employment as the primary goal; (2) a rapid job search approach is used; (3) clients are intensively assisted to find jobs of their choice; (4) all assistance is individualised and provided according to client preferences; (5) follow-on supports are maintained indefinitely if required; (6) the

supported employment program is closely integrated with the mental health treatment program; and (7) financial counseling is provided to help overcome the many welfare disincentives associated with returning to work. Together these principles serve as a foundation for basic evidence-based practices by effective supported employment services.

The Individual Placement and Support (IPS) model of SE has demonstrated superiority to the best alternative approaches to vocational rehabilitation for people with mental illness. Over the past 15 years, 16 randomised controlled trials have tested this approach against the best available alternative approaches (Bond et al. 2008). The most recent of these was conducted in six European countries Burns et al (2007). Although high fidelity implementations were difficult to achieve, this study showed that the IPS approach was consistently more effective in countries with widely differing labor markets, health and welfare systems. Bond et al. (2007) conducted a randomized controlled trial, which compared two vocational models (IPS and diversified placement approach). IPS was again superior to the diversified placement approach in achieving vocational outcomes. They concluded that IPS is more effective for helping people with mental illness achieve competitive employment outcomes than any other psychiatric rehabilitation approach.

An effective employment service can also help with non-vocational outcomes. Bond et al. (2001) found that clients who worked in competitive employment for an extended period of time showed a greater rate of improvement in several non-vocational outcomes, for example, a reduction in psychiatric symptoms, satisfaction with vocational services, leisure and finances, and in self-esteem. Programs that adhere closely to the principles of evidence-based supported employment achieve better employment outcomes (Becker et al. 2006, Bond et al. 2008). Agencies who fully implemented the critical components of supported employment (high fidelity) have better outcomes (Becker et al. 2006, MGrew and Griss 2005). The lesson from this research is that high order employment outcomes can only be expected from high fidelity implementations of evidence-based practices.

Enhancing evidence-based supported employment

A variety of interventions are emerging that appear to enhance employment outcomes attained by high fidelity evidence-based supported employment. As a first step other programs and low fidelity SE programs can move towards greater adoption of evidence based practices. Once high fidelity has been achieved, a range of supplementary programs can be considered. A key success criterion is the proportion attaining competitive employment. If this falls below the average 60% reported in the research, more program development is indicated.

Improving the fidelity of SE

Fidelity scales measure the degree of implementation of a practice, that is, the degree of attainment of practice standards. The Quality of Supported Employment Implementation Scale (QSEIS) is a 33-item telephone-administered instrument measuring fidelity of supported employment for people with mental illness. Each item is rated on a five-point behaviorally-anchored scale, with a score of 5 indicating full implementation, 4 indicating moderate implementation, and the remaining scale points increasingly larger

departures from the standards of supported employment. The items cover job placement, integration and mental health treatment, long-term support, teamwork, and engagement/enrollment (Bond et al. 2002). Bond et al. (2002) suggest that the use of fidelity scales is an essential component of evidence-based practice.

Augmenting SE with supported education

Supported education is a promising intervention, which can help individuals meet the demands of the labor force. There are a variety of models of supported education, including skills training, classrooms on campus, group support on campus, and community-based models. Results have been encouraging in that most studies have found improvements in self-confidence, cognitive functioning, and completion of college courses for people receiving supported education (Collins et al. 1998).

Increase access to benefits counseling

People with a mental illness fear losing benefits. Increasing access to benefits counseling is another intervention that has been shown to improve income levels for individuals with mental illness (Tremblay et al. 2004). Ongoing planning and guidance to help clients make well-informed decisions regarding social security, health insurance and other government entitlements is important (Bond 2004, Burns et al. 2007). Benefits counseling assists the participant to develop and plan to manage his or her benefits through the transition to employment.

Integration of mental health and employment services

Cook et al. (2005) found that when clinical and vocational staff worked together in multidisciplinary teams at the same location using a unified case record and meeting together regularly, participants were more likely to work competitively and work 40 hours or more per month. The results of this study confirm the importance of provider communication and the co-ordination of psychiatric and rehabilitation services in working towards vocational goals.

Skills training

Skills training techniques include a variety of delivered strategies that individuals can use to help manage and cope with the symptoms of their psychiatric condition, reduce their susceptibility to relapse, and improve their adaptive functioning in life. Skills training strategies usually consist of highly-structured, manualized interventions that may include psychoeducation, behavioral interventions, cognitive techniques, or a combination of interventions (Loveland et al. 2007). Tsang (2001), in a pilot study, showed that the social skills training module together with appropriate professional support afterwards is effective in enhancing the social competence and vocational outcomes for people with a mental illness. The module was translated to different languages and was found to be effective in other countries such as Germany (Roder et al. 2006). An Integrated Supported Employment program (ISE Tsang, 2003) was developed, which combines IPS with work-related social skills training. An Randomized Controlled Trial has shown that more ISE participants became competitively employed and worked longer than IPS (Tsang et al. in press).

Conclusion

Recent advances in vocational rehabilitation research have identified the active ingredients of effective supported employment, which have become accepted as foundation evidence-based practices. Several promising emerging ingredients can further enhance employment outcomes. This evidence sets the performance benchmarks for all forms of vocational rehabilitation currently being provided to people with psychological and psychiatric disorders.

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